ENDNOTES AND SUPPLEMENTAL MATERIALS

[1] Barbara Martinez, *Cash Before Chemo: Hospitals Get Tough*, WALL ST. J., April 28, 2008, at A1.
[2] *The AARP Medical Advantage Plan*, at http://www.aarpmedadvantage.com.
[3] AARP, Let Me Tell You How the Plan Works! (2008).
[4] AARP, Untitled Chart of Plan Benefits (2008).
[5] AARP, The AARP Medical Advantage Plan, Sample A Sample's How-To Guide (2008).

Additional Materials:

[6] AARP, SHIP Indemnity Product Suite (2008).
[7] AARP, AARP Health Care Options, Product Availability (2008).
[8] AARP, Standard Limits by Benefit and Product (2008).
[9] AHIP, Low-Income & Rural Beneficiaries with Medigap Coverage (2007).

Standard Limits by Benefit and Product – Indemnity Plans

Benefit	MAP/EPHIP	EHIP	HAP	HIP (R/V Plans)
Inpatient Hospital	• 365 day maximum per benefit period for medical/surgical stays • 730 day lifetime maximum • 45 day calendar year maximum for mental health/substance abuse stays	• 365 day maximum per benefit period • 730 day lifetime maximum • 45 day calendar year maximum for mental health/substance abuse stays	• 365 day maximum per benefit period • 60 day lifetime maximum for mental health/substance abuse stays	• 180 day lifetime maximum for mental health/substance abuse stays
Hospital Outpatient	• $25k, $37.5k, and $50k calendar year maximums respectively for Bronze, Silver and Gold plans			
Surgery	• $5k, $7.5k, and $10k per procedure maximums respectively for Bronze, Silver and Gold plans	• 3 or 4 procedures per year (depending on plan)	• $4k, $7k, and $10k per procedure maximums respectively for $300 DHB, $500 DHB and $700 DHB plans	• 1 procedure per day (outpatient surgery only)
Outpatient Radiology	• $1350, $2000, and $2700 per procedure maximums respectively for Bronze, Silver and Gold plans	• 3 or 4 procedures per year (depending on plan)		
Outpatient Lab/Pathology	• $800, $1200, and $1600 per procedure maximums respectively for Bronze, Silver and Gold plans	• 3 or 4 procedures per year (depending on plan)		
Healthcare Practitioner	• 10 visits per year	• 3 or 4 visits per year (depending on plan)	• 4 visits per year	
ER/Observation Room	• 2 visits per year	• 1 visit per year		
Post-Hospital SNF	• 30 days per hospital stay	• 30 days per hospital stay	• 30 days per hospital stay	• 20 days per hospital stay (SNF only) • 30 days per hospital stay (nursing home only, not covered under all plans)
Post-Hospital HHC	• 30 visits per hospital stay	• 30 visits per hospital stay	• 30 visits per hospital stay	• 30 visits per hospital stay (not covered under all plans)

Standard Limits by Benefit and Product – Indemnity Plans

Post-Hospital Prescription Drugs			• $500 per calendar year	• $500 per calendar year (not covered under all plans)
Outpatient Prescription Drugs	• $2,000 per calendar year			
Preventive Care				• $125 per calendar year (not covered under all plans)

AARP HEALTH CARE OPTIONS
PRODUCT AVAILABILITY

State	UHC Med Select C	Std Med Supp A-J	Std Med Supp K&L	HIP	HIP 65	HAP	SMP	MAP I	MAP II	MAP Dep (EPHIP)	PHIP	EHIP	EHIP Dep	HIP RIDERS D1, DH, DI, DL, DM, OH	Comments
Alabama	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	NLM	Y	Y	Y	
Alaska	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Med Select – No regulations adopted yet.
Arizona	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	NLM	Y	Y	Y*	*D1 Rider (not available) - Not filed due to LTC concerns.
Arkansas	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	NLM	Y	Y	Y	
California	N	Y	Y	Y*	Y	Y	P	TBD	TBD	TBD	N	Y	Y	Y*	*Effective 1/1/02, HIP products cannot be marketed to people age 65 and over.
Colorado	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	NLM	Y	Y	Y	
Connecticut	N	Y	Y	Y	Y	Y	Y	Y	Y	P	NLM	Y	P	Y	Med Select – withdrawn due to Travel Benefit objections.
Delaware	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	NLM	Y	Y	Y	
Dist. Of Columbia	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	NLM	Y	Y	Y	Med Select – No regulations adopted yet.
Florida	Y	Y	Y	Y	Y	Y	Y	Y	Y	TBD	NLM	TBD	TBD	Y	
Georgia	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	
Hawaii	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Med Select – No regulations adopted yet.
Idaho	N	Y	Y	Y	N	Y	Y	Y	Y	P	N	Y	P	Y	HIP 65 – Not filed – requires 31-day benefit period. Med Select – No regulations adopted yet. EPHIP/EHIP Dep. product approved – app pending.
Illinois	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	NLM	Y	Y	Y	
Indiana	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	
Iowa	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	Med Select – Open only for inquiry.
Kansas	Y	Y	Y	Y	Y	Y	Y	Y	P		N	Y		Y	
Kentucky	Y	Y	Y	Y	Y	Y	Y	Y	Y	P	N	Y	P	Y	EPHIP/EHIP Dep. product approved – app pending.
Louisiana	Y	Y	Y	Y	Y	Y	Y	Y	Y	P	NLM	Y	P	Y	EPHIP/EHIP Dep. product approved – app pending.
Maine	N	Y*	Y	Y	Y	Y	Y	Y	Y	P	N	Y	P	Y	*Med Supp – Plans H and I are not available. EPHIP/EHIP Dep. product approved – app pending.
Maryland	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	NLM	Y	Y	Y	
Massachusetts	N	Y*	N	Y	Y	N	Y	N	N	N	N	Y**	Y**	Y	*Med Supp – only Waiver Plans MX and MY are available. HAP-Cannot market or issue on or after 10/1/97. **EHIP – maximum DHB = $500
Michigan	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	

AARP HEALTH CARE OPTIONS
PRODUCT AVAILABILITY

State	UHC Med Select C	Std Med Supp A-J	Std Med Supp K&L	HIP	HIP 65	HAP	SMP	MAP I	MAP II	MAP Dep (EPHIP)	PHIP	EHIP	EHIP Dep	HIP RIDERS D1, DH, DI, DL, DM, OH	Comments
Minnesota	N	Y*	TBD**	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	*Med Supp – only Waiver Plans SB, SF, SD and Standardized Plans H, I, J are available. **Identified as "Plan K with 50 Percent Coverage" and "Plan L with 75 Percent Coverage"
Mississippi	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	NLM	Y	Y	Y	
Missouri	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	NLM	Y	Y	Y	
Montana	N	Y	Y	Y	P	Y	P	Y	P	P	N	P	P	Y	
Nebraska	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	NLM	Y	Y	Y	
Nevada	N	Y	Y	Y	Y	Y	Y	Y	P		N	Y		Y	PF Med Select – Product and Rate approval received 7/15/99. Advertising approvals received. Pending network development.
New Hampshire	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	TBD	Y	Y	EPHIP/EHIP Dep – 7/1/08 launch.
New Jersey	N	Y	Y	Y	Y	N	Y	N	N	N	N	N	N	Y	HAP – Sales and Marketing discontinued 3/21/07. Med Select – No regulations adopted yet.
New Mexico	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	
New York	N	Y	Y	Y	Y	N	Y	N	N	N	N	P		Y*	*HIP Riders – only D1 is available. HAP – Small Group Law requires open enrollment and community rating; R/V's not available due to Small Group law. Med Select – Product and Rate approval received 5/10/01. Advertising not filed.
North Carolina	Y	Y	Y	Y	Y	Y	Y	Y	Y	P	NLM	Y	P	Y	
North Dakota	N	Y	Y	Y	P	Y	Y	Y	P		N			Y	
Ohio	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	NLM	Y	Y	Y	
Oklahoma	Y	Y	Y	Y	Y	Y	Y	Y	TBD	P	NLM	Y	P	Y	
Oregon	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	
Pennsylvania	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	NLM	Y	Y	Y	
Rhode Island	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	PF Med Select – Product and Rate Approvals received 6/15/99. Pending network development.
South Carolina	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	NLM	Y	Y	Y	
South Dakota	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	
Tennessee	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	NLM	Y	Y	Y	
Texas	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	NLM	Y	Y	Y	
Utah	Y	Y	Y	Y	Y	Y	Y	Y	Y	P	N	Y	P	Y	

AARP HEALTH CARE OPTIONS
PRODUCT AVAILABILITY

State	UHC Med Select C	Std Med Supp A-J	Std Med Supp K&L	HIP	HIP 65	HAP	SMP	MAP I	MAP II	MAP Dep (EPHIP)	PHIP	EHIP	EHIP Dep	HIP RIDERS D1, DH, DI, DL, DM, OH	Comments
Vermont	N	Y*	Y	N	P	N	Y	P	P		N			Y**	*Med Supp – Plans F, G, I are not available. HIP/HAP - Non-marketable due to the Small Group Law which requires guaranteed acceptance and one or more health care plans with specified benefits. ** HIP Riders: Only DH and DL are available; D1 initially approved, discontinued due to HIP requirements.
Virginia	N	Y	Y	Y	Y	Y	Y	Y	Y	TBD	NLM	Y	Y	Y	
Washington	Y	Y	Y	Y*	N	Y	Y	Y	P		N	N		Y*	*HIP – effective 11/9/06, Plans RD through RL, and Riders DH, DI, DL and DM are available. HIP 65 – withdrawn – requires 31-day benefit period.
West Virginia	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	NLM	Y	Y	Y	
Wisconsin	N	Y*	TBD**	Y	Y	Y	Y	Y	P	TBD	N	N	TBD	Y	*Med Supp – only Waiver Plans IW, WA, WB are available. **Plans are identified as "50% Cost-Sharing Plan" and "75% Cost-Sharing Plan" – include all WI mandated benefits. Med Select – withdrawn due to grievance procedure requirements. MAP II – app. Pending (product approved).
Wyoming	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	NLM	Y	Y	Y	
Puerto Rico	N	Y	Y	Y	Y	Y	P	P	P	P	N	TBD	P	Y	MAP I & II – app. pending (product approved).
Virgin Islands	N	Y	Y	Y	Y	Y	Y	Y	Y	Y	N	Y	Y	Y	
Guam	N	Y	Y	N	Y	N	N	Y	Y	Y	N	Y	Y	N	EPHIP/EHIP Dep – 7/1/08 launch.

Bold and Shaded = New or updated materials

Y = Available
N = Not Available (Not yet filed unless otherwise noted)
P = Pending Product Approval (unless otherwise noted)
TBD = Approval received – availability scheduled in the future or yet to be determined
NLM = No Longer Marketed – available prior to transition to new carrier

Med Select = Medicare Select Plans
PF Med Select = Project Future Medicare Select Plans
Std Med Supp = Standardized Medicare Supplement Plans
Std Med Supp K & L = Standardized Medicare Supplement Plans K & L
HIP = Hospital Indemnity Plans
HAP = Hospital Advantage Plans
SMP = Supplemental Medical Plans
MAP = Medical Advantage Plans
PHIP = Personal Health Insurance Plans
EHIP = Essential Health Insurance Plans
MAP Dep = Medical Advantage Plans Dependent
EHIP Dep = Essential Health Insurance Plans Dependent

HIP RIDERS
D1 = Post Hospital Rider
DH = Daily Hospital Benefit Increase Rider
DI = Daily Hospital Benefit Increase Rider
DL = Daily Hospital Benefit Increase Rider
DM = Daily Hospital Increase Rider
OH = Outpatient Hospital Rider

SHIP INDEMNITY PRODUCT SUITE

SEPTEMBER 10, 2008

HOSPITAL INDEMNITY PLAN (HIP) AND SUPPLEMENTAL MEDICAL PLANS (SMP)

- **Benefit Structure** – Fixed dollar benefits are paid primarily on hospital stays with daily hospital benefits (DHBs) ranging from $50-$150 (benefits decrease at age 65)
  - Other covered services include SNF, HHC, and surgery
  - SMP plans also provide coverage for other services including ER, diagnostic tests, screenings, complementary medicine, and wellness
  - Value-added services include prescription and vision discounts

- **Underwriting** - Plans are not medically underwritten

- **Rating Structure** - Plans are community-rated by region

HOSPITAL ADVANTAGE PLAN (HAP)

- **Benefit Structure** – Fixed dollar benefits are paid on a variety of services including hospital stays, doctor's visits, surgery, SNF, and HHC
  - 3 levels of coverage ($700 DHB plan, $500 DHB plan, and $300 DHB plan)
  - Surgery benefits based on fee schedule
  - Value-added services include prescription discounts, vision discounts, and Provider Discount Network (added in January 2007)
  - Plans terminate at age 65

- **Underwriting** - Medically underwritten for acceptance and to determine rate based on smoker status

- **Rating Structure** - Nationally community-rated with smoker/non-smoker rates

ESSENTIAL HEALTH INSURANCE PLAN (EHIP)

- EHIP was launched in April 2007. Product offerings were extended to dependents of AARP members in September 2007. Agent distribution channels were added in February 2008.

- **Benefit Structure** – Fixed dollar benefits are paid on a wide variety of medical services including doctor's visits, hospital stays, surgeries, outpatient lab, outpatient radiology, and more
  - 4 levels of coverage ($700 DHB Plan, $500 DHB Plan, $300 DHB Plan, and $200 DHB Plan)

- Surgery and outpatient benefits paid based on a fee schedule
- Value-added services include prescription discounts, vision discounts, NurseHealth Line, and Provider Discount Network
- Plans terminate at age 65

- **Underwriting** - Medically underwritten for acceptance and to determine rate based on smoker status

- **Rating Structure** - Nationally attained age rated with smoker/non-smoker rates

MEDICAL ADVANTAGE PLAN (MAP) / ESSENTIAL PLUS HEALTH INSURANCE PLAN (EPHIP)

- MAP launched in January 2003. MAP was expanded in April 2006 to include an additional lower benefit level plan and outpatient prescription drug coverage. The name change to EPHIP and the extension of the product offering to dependents of AARP members were introduced in September 2007. Agent distribution channels were added to EPHIP in February 2008.

- **Benefit Structure** – Fixed dollar benefits are paid on a wide variety of medical services including doctor's visits, hospital stays, surgeries, outpatient lab, outpatient radiology, prescription drugs and more
  - 3 levels of coverage ($1500 DHB Plan, $1200 DHB Plan, and $900 DHB Plan)
  - Surgery and outpatient benefits are paid based on a fee schedule
  - Value-added services include prescription discounts, vision discounts, NurseHealth Line, and Provider Discount Network (added in January 2007)
  - Plans terminate at age 65

- **Underwriting**
  - Medically underwritten for acceptance and to set rates

- **Rating Structure**
  - MAP is nationally entry age rated except for WA (WA has slightly lower rates due to loss ratio requirements in the state)
  - EPHIP is nationally attained age rated

AARP Health Care Options®
Medical Advantage Plan

INSURED BY
United HealthCare
Insurance Company

The security you want.
The essential benefits you deserve.
Now in one affordable plan.

The AARP Medical Advantage Plan

Sample A Sample's How-To Guide

L051 (50) 12/05

Welcome

AARP Health Care Options Welcomes You

Thank you for your interest in the AARP Medical Advantage Insurance Plan. It's just one of the many fine supplemental products offered through AARP Health Care Options®, a collection of health insurance and health care services that are endorsed by AARP as best-in-class products for people who are 50 and older.

With 37 million members, AARP is the largest organization in America devoted to assisting people age 50+. Your $12.50 annual membership fee gives you access to exclusive information, great discounts and special products like the AARP Medical Advantage Plan. Insured by United HealthCare Insurance Company, this plan can be a real lifesaver for early retirees, part-time workers or people who just need to supplement their current health insurance.

Read on and you'll discover the many advantages of this plan. Plus, find out about additional ways to save on your premium. In addition, you'll receive a few special extras like access to services that provide discounts on Eye Care and Prescription Drugs. The free Health Essentials catalog for great values on vitamins, supplements, and many other products for healthy living. A 24-hour toll-free nurse health information line. And as an added bonus, there's the outstanding customer service you'd expect from insurance that's endorsed by AARP.

Questions?

Call us toll-free at 1-866-218-8607, weekdays from 7 a.m. to 11 p.m. and Saturdays from 9 a.m. to 5 p.m., Eastern Time.

AARP wants to make health insurance easier to understand... so this Guide is written in "people" talk. There's an overview of the AARP Medical Advantage Plan benefits in a simple chart. There's also a rate chart, so you can see what you might pay, and a handy Question and Answer section. Even though we've tried to make it simple, you still may have questions, so please don't hesitate to call us toll-free at 1-866-218-8607.

TABLE OF CONTENTS

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AARP Medical Advantage Plan Benefit Highlights

This chart shows you the plan's "fixed" cash benefits. For example, if you go to see the doctor for a covered checkup, you'll get $75 (a "fixed" amount) no matter what the actual bill is. We didn't have room to show you all the medical services that are covered—there are many covered surgeries, lab and radiology procedures, and prescription drugs. When your application is approved, you'll receive a list showing additional procedures and benefits. Also, note that there are three levels of coverage. The Gold Plan provides higher benefits than the Silver or Bronze Plan (and costs more, too), but the kind of coverage you choose is up to you.

With all AARP Medical Advantage Plans you receive additional value with the new prescription drug benefit. This benefit applies to thousands of FDA-approved prescription drugs. Depending on the AHFS (American Hospital Formulary Service) therapeutic class of your drug, you will receive a benefit between $5 and $70 for prescriptions of 31 days or less, and double the benefit for prescriptions over 31 days. The AHFS therapeutic class associated with your Outpatient Prescription Drug is based on the NDC (National Drug Code) number provided by your pharmacy. (Prescription drug therapeutic classes are groups of drugs that act similarly. For a more detailed explanation of "drug classification/AHFS therapeutic class codes", please refer to the definition section in the brochure.) The Benefit Examples for Common Prescription Drug Categories on page 6 will help you to further understand how this added benefit works for you. (See next page for details on how to receive preferred pricing on your prescriptions in addition to this prescription drug benefit).

COVERED SERVICE	GOLD PLAN	SILVER PLAN	**NEW!** BRONZE PLAN
Daily Inpatient Hospital Stay Benefit:			
There's a one-day deductible (the first day of each stay). For mental health/substance abuse stays, there's a 45-day maximum per calendar year. For all hospital inpatient stays (combined or separate), there's a 365-day maximum per period of hospital stay and a 730-day lifetime maximum.			
For a surgery	$1,500 a day	$1,200 a day	$ 900 a day
For a medical procedure	$1,200 a day	$ 900 a day	$ 600 a day
For mental health/substance abuse	$ 800 a day	$ 500 a day	$ 300 a day
Surgery Benefit:			
Just a few of the many of covered procedures. The maximum procedur e payment for the Gold Level is $10,000; for the Silver Level it's $7,500; for the Bronze Level it's $5,000.			
Coronary artery bypass (3 venous grafts)	$7,856	$5,892	$3,928
Total hip replacement (with or without graft)	$5,399	$4,050	$2,700
Mastectomy (modified radical)	$3,765	$2,824	$1,883
Lithotripsy/fragmenting of a kidney stone	$2,697	$2,023	$1,349
Diagnostic colonoscopy (separate procedure)	$1,413	$1,060	$ 707
Needle biopsy of prostate	$ 718	$ 539	$ 359
Needle biopsy of breast (separate procedure)	$ 624	$ 468	$ 312

COVERED SERVICE (continued)	GOLD PLAN	SILVER PLAN	NEW! BRONZE PLAN
Outpatient Hospital Benefits:* Calendar year max.: $50,000/Gold Level; $37,500/Silver Level; $25,000/Bronze Level.			
Emergency Room/Observation Care * –Max. 2 benefits per calendar year.	$ 175/stay	$ 125/stay	$ 75/stay
Lab/Pathology*–Procedure max.: $1,600/Gold Level; $1,200/Silver Level; $800/Bronze Level.	$ 25/avg.	$ 20/avg.	$ 15/avg.
Radiology*–Procedure max.: $2,700/Gold Level; $2,000/Silver Level; $1,350/Bronze Level.			
Chest x-ray	$ 58	$ 44	$ 29
CT scan of head or brain	$ 474	$ 356	$ 237
MRI spinal canal, lumbar	$1,170	$ 878	$ 585
Other Hospital Outpatient Services**			
Electrocardiogram, tracing	$ 33	$ 25	$ 17
Esophagus, acid reflux test	$ 298	$ 224	$ 149
Night Electroencephalogram	$ 966	$ 725	$ 483
Health Care Practitioner Visits:* 10 per year.	$ 75	$ 75	$ 50
Post-Hospital Benefits: For charges incurred within 90 days of a covered Hospital Inpatient Stay.			
Skilled Nursing Facility Stay–30-day max.	$ 300/day	$ 200/day	$ 150/day
Home Health Care Visit–One visit a day; 30 visits per covered hospital stay.	$ 75/visit	$ 50/visit	$ 50/visit
NEW! Prescription Drug Benefit:* Maximum annual benefit $2,000.00	$ 5 - $ 70 Based on the AHFS therapeutic classification	$ 5 - $ 70 Based on the AHFS therapeutic classification	$ 5 - $ 70 Based on the AHFS therapeutic classification

* See Definitions and Exclusions for important plan definitions, disclosures, exclusions and limitations.
**Other Outpatient Services cover Cardiovascular Services, Chemotherapy Administration, Gastroenterology Services, Neurology Services, Photodynamic Therapy, Pulmonary Services, Special Dermatological Services and Therapeutic or Diagnostic Infusions.

AARP Medical Advantage Plan Special Extras

When you enroll in the AARP Medical Advantage Plan, you get some "special extras." Just read on for more details. REMEMBER: as long as YOU are an AARP member, your spouse is eligible for the plan even if he or she is under 50 years of age.

Service and Discount Highlights

Provider Discount Network‡

- Offers members discounts on medical expenses on many health and medical services when visiting the Provider Discount Network of over 250,000 provider locations across the country
- Get discounts on primary and specialist care; hospitals and outpatient surgery centers; x-rays and other imaging; diagnostics and labratory fees; physical therapy and rehabilition

Please refer to the Provider Discount Network insert to learn more about typical services and discounts offered.

Eye Care†

- Save on eyewear and eyecare at participating optical centers, or at one of thousands of independent Doctors of Optometry
- Get a customized Eye Health Exam Report that details the results of your exam
- Save over your regular AARP member discount for routine eye exams

Prescription Discounts and More†

- In addition to receiving the prescription drug benefit outlined in the Plan Benefit Highlights chart, take advantage of additional savings on any FDA-approved prescription drugs through preferred pricing at more than 56,000 participating retail pharmacies nationwide, including neighborhood pharmacies and many national chains
- Request your free Health Essentials catalog for great values on vitamins and supplements, home and personal care products, over-the-counter medications and more.

24-Hour AARP Nurse HealthLine†

- Registered nurses on call to help you with your medical questions
- Access an audio library covering more than 1,100 health and wellness topics
- Get information on prescription drugs and over-the-counter medications

Discounts

Electronic Funds Transfer (EFT)

- Save $2 on your total monthly household premium
- Payments are automatically forwarded by your bank
- No checks to write and no postage to pay

‡ The Provider Discount Network program is administered by HealthAllies®, Inc., a discount medical plan organization located at at 505 N. Brand Blvd., Suite 850, Glendale, CA, 91203, 1-800-748-7151. **HealthAllies is not insurance and may be discontinued at any time.** HealthAllies provides discounts at certain health care providers for medical services. HealthAllies does not make payments directly to the providers of medical services. The program member is obligated to pay forall health care services but will receive a discount from those health care providers who have contracted with the discount plan organization.

† These are not insurance programs and may be discontinued at any time. In some states, there are a limited number of eye health providers available.

Benefit Examples for Common Prescription Drug Categories

(See the Certificate of Coverage for a listing of specific AHFS therapeutic classes and associated benefit amounts.)

The listing below represents a sampling of commonly used categories of prescription drugs for people 50-64 and their common benefit. Prescription drug benefits with this plan are payable on thousands of different outpatient prescription drugs.

Prescription Drug Categories	Common Benefit (For a 31-day supply)
Acid Reflux Medications	$ 40
Allergy Medications	$ 20 (Tablet Form)
	$ 5 (Nasal Spray)
High Cholesterol Medications	$ 10
Depression Medications	$ 10
Arthritis Medications	$ 10
Asthma Medications	$ 5 or $10
High Blood Pressure Medications	$ 5

What It Costs

Find your age. Choose the Gold, Silver or Bronze Plan (see Benefit Chart on opposite page to decide which is right for you). Then see what your monthly premium might be. Your answers to the health questions on the enclosed application will determine if you qualify for the Level One, Level Two or Level Three rate. It's easy to apply–just send in your completed application. Remember, you also have to be an AARP member or spouse of a member to apply (that's easy too...the enclosed AARP Membership Application tells you how). Once you're approved, we'll send you a Certificate of Insurance, along with a bill for your first month's premium. If you're not satisfied, just return the Certificate to us within 30 days of its receipt and it will be canceled.

	Under 50 (spouses only)	**Age 50-54**	**Age 55-59**	**Age 60-64**
		(Rates are per person, per month)		
Gold Plan				
Level One	$211.00	$226.50	$247.00	$264.25
Level Two	$248.25	$266.50	$290.50	$311.00
Level Three	$372.25	$399.75	$436.00	$466.25
Silver Plan				
Level One	$173.00	$185.00	$202.00	$216.50
Level Two	$203.50	$217.75	$237.75	$254.75
Level Three	$305.25	$326.50	$356.50	$382.00
Bronze Plan				
Level One	$124.75	$133.00	$145.75	$156.50
Level Two	$146.75	$156.50	$171.50	$184.00
Level Three	$220.25	$234.75	$257.25	$276.25

Questions? Call us at 1-866-218-8607, weekdays from 7 a.m. to 11 p.m. and Saturdays from 9 a.m. to 5 p.m., Eastern Time.

Questions & Answers

Questions:	Answers:
How do I know if the AARP Medical Advantage Plan is right for me?	This plan is a good option for anyone unable to afford or qualify for major medical insurance. Whether you've retired early, are working part-time or are looking to supplement your current health insurance, it may be a good "bridge" until you have access to primary health insurance. It is not a major medical plan, but does offer a significant level of supplemental fixed cash benefits.
I already have some health insurance through work. Can I still get benefits?	Yes. You collect benefits regardless of what you receive from any other insurance plan you may have.
Are cash benefits paid to me or my doctor?	Either one. We can send you the check, (and, by the way, you can use the money for whatever you want). Or we can pay your doctor, hospital or other provider directly. It's up to you.
Can I still use whatever doctors and hospitals I want?	You are not required to use network doctors or Hospitals and no referrals are needed. The plan pays you for covered stays and services in any eligible facility. However, you can save on health and medical services when you visit a participating provider in the Provider Discount Network of over 250,000 provider locations across the country. *Please see the enclosed insert for more information on typical services & discounts offered.*
Is it hard to file a claim?	There are no claim forms. Just send us a copy of your bill. Or, have your doctor or other health care provider send the bill for you.
If I'm hospitalized for surgery, will I collect the surgical benefit and the daily hospital benefit?	Yes. The surgical benefit is a fixed payment and varies by procedure. You'll also get the hospital benefit for each covered day that you're hospitalized, starting the second day.
If I file a lot of claims, will my insurance be canceled?	You cannot be singled out for cancellation. As long as you pay your premiums on time and you're an AARP member (or a member's spouse) and the Group Policy remains in force, your coverage cannot be canceled.
Will my rates go up as I get older? What about if I file a claim?	Your rate will not increase just because you get older. Also, you cannot be singled out for a rate increase, no matter how many claims you file. Your rate may change, but any rate change will apply to all members of the same class, insured under your plan, who live in your state. And all rate changes must be approved by AARP.
What happens when I turn 65?	Your coverage will end on the first day of the month in which you become eligible for Medicare, which is usually age 65. At that time, you may want to consider enrolling in an AARP Medicare Supplement Plan.
What if I change my mind about this insurance?	If you are not satisfied, return your Certificate of Insurance to United HealthCare Insurance Company within 30 days of its receipt. The insurance will be canceled and United HealthCare will treat the Certificate as if it had never been issued.
Do I have to be an AARP member to apply for this insurance?	Yes. To apply, you must be an AARP member or a spouse of a member. If you're not a member, annual membership is just $12.50 and there are four easy ways to enroll. You can mail in an AARP Membership Application and a check along with your AARP Medical Advantage Plan application. Or you can contact AARP directly. Call 1-800-424-3410, visit www.aarp.org or mail in the AARP application with payment.

Benefit Descriptions, Definitions and Exclusions

BENEFIT DESCRIPTIONS

Emergency Room/Outpatient Observation Care Benefit - If you incur an emergency room charge or an outpatient observation care charge and you are not admitted to the Hospital as an inpatient, an Emergency Room/Outpatient Observation Care Benefit is payable. Your emergency room charge must be for services performed in an emergency room of a Hospital and must be due to a Medical Emergency. Outpatient observation care must be furnished by a Hospital on the Hospital's premises; and must provide the use of a bed and periodic monitoring to evaluate your condition to determine your need for an inpatient admission. The outpatient observation care must meet all of the following conditions: (1) you must receive medical advice, tests or treatment while confined in a Hospital on an outpatient basis for at least 12 hours; (2) a room charge (other than inpatient room and board charge) must be incurred; (3) such care must meet the definition of Covered Service(s); and (4) such care must be ordered by a Physician. Confinement in an outpatient surgical unit is not considered outpatient observation care.

Only one Emergency Room/Outpatient Observation Care Benefit is payable for each emergency room stay or outpatient observation care stay. If you receive emergency room services and outpatient observation care during the same stay, only one Emergency Room/Outpatient Observation Care Benefit is payable for the entire stay. The Emergency Room/Outpatient Observation Care Benefit is subject to a Calendar Year Maximum of two benefits.

Note: If you receive emergency room services or outpatient observation room care and you are admitted to the Hospital as an inpatient directly from the emergency room or observation room, benefits will be considered under the Hospital Inpatient Stay Benefit and no Emergency Room/Outpatient Observation Care Benefit will be payable.

Health Care Practitioner Services Benefit - If you incur a charge for a service provided by a Health Care Practitioner which is not otherwise eligible for consideration under the Hospital Outpatient, Surgery, Radiology, Laboratory/Pathology or Post-Hospital Benefits, and not otherwise excluded under this plan, a Health Care Practitioner Services Benefit will be paid. The Health Care Practitioner Services Benefit is payable for no more than 10 visits in any one Calendar Year.

Hospital Inpatient Stay Benefit - If you are confined in a Hospital as an inpatient, the Hospital Inpatient Stay Benefit is payable beginning on the second day of a covered Hospital Inpatient Stay, for those days that the Hospital makes an inpatient room and board charge. (If you receive covered emergency room services or outpatient observation room care and are admitted to the Hospital as an inpatient, time spent in the emergency room or outpatient observation unit will count toward the first day hospital stay deductible.) The applicable Hospital Inpatient Stay Benefit will be determined based on the corresponding Diagnostic Related Group (DRG) classification as follows: Medical; Surgical; or Mental Illness/Substance Abuse.

The Hospital Inpatient Stay Benefit is subject to: a Calendar Year maximum of 45 days for Hospital Inpatient Stays that are classified as Mental Illness/Substance Abuse confinements; a maximum of 365 days per Period of Hospital Stay for all Hospital Inpatient Stays; and a total lifetime maximum of 730 days for all Hospital Inpatient Stays.

Hospital Outpatient Benefit - If you incur a charge for a covered outpatient service performed only in a Hospital, or Ambulatory Surg cal Center, a Hospital Outpatient Benefit is payable. The applicable Hospital Outpatient Benefit will be determined based on the services performed and reported by the facility. The Hospital Outpatient Benefit is subject to a total Calendar Year Maximum of $25,000.00 for the Bronze Level, $37,500.00 for the Silver Level and $50,000.00 for the Gold Level. Covered Hospital outpatient services are limited only to Cardiovascular Services, Chemotherapy Administration and Chemotherapy Drugs, Gastroenterology Services, Neurology Services, Photodynamic Therapy, Pulmonary Services, Special Dermatological Procedures, and Therapeutic or Diagnostic Infusions.

Laboratory/Pathology Benefit - A benefit is payable, up to a maximum of $800.00 per procedure for the Bronze Level, $1,200.00 per procedure for the Silver Level and $1,600.00 per procedure for the Gold Level, if you incur a charge for a Laboratory/Pathology Service performed in an outpatient setting. The applicable Laboratory/Pathology Benefit will be determined based on the service performed and reported by the provider and the corresponding Laboratory/Pathology Current Procedural Terminology (CPT) code(s). Only one Laboratory/Pathology Benefit is payable for each Laboratory/Pathology Service performed. Separate benefits will not be paid for the technical and professional components of a Laboratory/Pathology Service.

Note: If you are admitted to the Hospital as an inpatient directly from the emergency room or observation room, no Laboratory/Pathology Benefits are payable for services performed while you were confined in the emergency room or observation room.

Post-Hospital Benefit - A benefit is payable for the following, if you incur a charge within 90 days of a Hospital Inpatient Stay for which benefits are payable under this plan and due to the same or related condition for which you were hospitalized:

A) Skilled Nursing Facility Stay - If you incur a charge for a stay in an eligible Skilled Nursing Facility for skilled nursing care, benefits are payable for each day of such stay, up to a maximum of 30 days.

B) Home Health Care Visit - If you incur a charge for home health care as described below, benefits are payable for one visit per day, up to a maximum of 30 days.

   (i) Nurse Visit - Nursing care provided by a Nurse.

BENEFIT DESCRIPTIONS (continued)

(ii) Therapist Visit - Physical, occupational, or speech therapy by a qualified Therapist. Benefits are payable whether the visit is received at home or in the Therapist's office.

(iii) Home Health Aide Visit - Services which consist of the following: bathing, dressing, personal hygiene, preparing meals, feeding, administering prescribed drugs, or changing bandages and other dressings, when provided by a Home Health Aide.

Radiology Benefit - A benefit is payable, up to a maximum of $1,350.00 per procedure for the Bronze Level, $2,000.00 per procedure for the Silver Level and $2,700.00 per procedure for the Gold Level, if you incur a charge for a Radiology Service performed in an outpatient setting. The applicable Radiology Benefit will be determined based on the service performed and reported by the provider and the corresponding Radiology Current Procedural Terminology (CPT) code(s). Only one Radiology Benefit is payable for each Radiology Service performed. Separate benefits will not be paid for the technical and professional components of a Radiology Service.

Note: If you are admitted to the Hospital as an inpatient directly from the emergency room or observation room, no Radiology Benefits are payable for services performed while you were confined in the emergency room or observation room.

Surgery Benefit - A benefit is payable, up to a maximum of $5,000.00 per procedure for the Bronze Level, $7,500.00 per procedure for the Silver Level and $10,000.00 per procedure for the Gold Level, if you incur a Physician charge for Surgery performed on an inpatient or outpatient basis. The applicable Surgery Benefit will be determined based on the Surgery performed and reported by the Physician and the corresponding Surgery Current Procedural Terminology (CPT) code(s). Only one Surgery Benefit is payable for each Surgery performed. Separate benefits will not be paid for the services of a primary surgeon, assistant surgeon, co-surgeon, or anesthesiologist.

DEFINITIONS

Ambulatory Surgical Center - The following facilities qualify as an Ambulatory Surgical Center: a facility licensed as an ambulatory surgical center by the state in which it is located; or a freestanding facility, other than a clinic or Health Care Practitioner's office, where surgical and diagnostic services are provided on an ambulatory basis, and which has written agreements with local Hospitals for the immediate acceptance of patients who develop complications or require post-operative confinement.

Calendar Year - January 1st through December 31st.

Cardiovascular Services - Only those procedures designated as "Cardiovascular" and "Non-Invasive Vascular Diagnostic Studies" in the Physicians' Current Procedural Terminology (CPT), except those procedures designated as "Cardiac Catheterization" or "Cardiovascular Therapeutic Services" which require introducing, positioning or repositioning of catheters.

Chemotherapy Administration - Only those procedures designated as "Chemotherapy Administration" in the Physicians' Current Procedural Terminology (CPT).

Chemotherapy Drugs - Only those drugs designated as "Chemotherapy Drugs" in the Health Care Common Procedure Coding System Level II National Codes (HCPCS).

Covered Service(s): Stays or services incurred while your coverage is in force and determined by United HealthCare to meet all of the following: (1) the stay or service must meet United States medical standards; (2) the stay or service must be necessary for the prevention, diagnosis or treatment of a Sickness or Injury; (3) the stay or service must not be primarily for your convenience; (4) the stay or service must be certified by a Physician, upon United HealthCare's request, as being appropriate for the diagnosis and treatment of your Sickness or Injury; and (5) the stay or service must meet all other applicable terms and conditions of this plan.

Current Procedural Terminology (CPT) - Current Procedural Terminology codes are identifying codes which are used nationwide for reporting medical services and procedures performed. A complete listing, entitled Physicians' Current Procedural Terminology, is published by the American Medical Association.

Diagnostic Related Group (DRG) - A patient classification system established and published by the Department of Health and Human Services which is used to classify inpatient Hospital stays into categories of Medical, Surgical or Mental Illness/Substance Abuse, based on the principal diagnosis treated and the principal procedure(s) performed as reported by the Hospital.

Drug Classification/Therapeutic Class Codes - AHFS (American Hospital Formulary Service) therapeutic class codes, published by the ASHP (American Society of Health-System Pharmacists), are identifying codes which are used to classify drug products into major classes based on drugs' pharmacologic-therapeutic actions. The therapeutic class associated with your Outpatient Prescription Drug is based on the NDC number provided by your pharmacy. Please note that the AHFS therapeutic classification system is subject to change.

Experimental or Investigational - Medical, surgical, diagnostic, psychiatric, substance abuse or other health care services, technologies, supplies, treatments, procedures, drug therapies or devices that, at the time United HealthCare makes a determination regarding coverage in a particular case, are determined to be any of the following: (1) not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service or the United States Pharmacopoeia Dispensing Information as appropriate for the

DEFINITIONS (continued)

proposed use; (2) subject to review and approval by any institutional review board for the proposed use; or (3) the subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 clinical trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight.

Gastroenterology Services - Only those procedures designated as "Gastroenterology" in the Physicians' Current Procedural Terminology (CPT).

Health Care Practitioner - Means only a licensed Physician, Physician's assistant, nurse practitioner, physical therapist, occupational therapist, speech therapist, chiropractor or mental health care provider acting within the scope of his or her license.

Health Care Common Procedure Coding System (HCPCS) Level II National Codes - A uniform method for health care providers and medical suppliers to report professional services, procedures and supplies. This coding system was developed and is updated by the Centers for Medicare and Medicaid Services (CMS).

Home Health Aide - A person whose main function is to provide post-hospital health aide services. If state or local licensing or certification is required, the person must be licensed or certified as a home health aide where the service is performed. If licensing or certification is not required, any person who meets the minimum training qualifications recognized by the National Home Caring Council, National League of Nursing, or Centers for Medicare and Medicaid Services will be considered a home health aide, provided that they are employed through a licensed or Medicare-certified home health care agency.

Hospital - A Hospital must operate mainly for the medical care and treatment of sick or injured persons as inpatients, and must be approved for payment of Medicare benefits or it must be properly state-licensed as a Hospital, and it must provide organized facilities for, or make provisions for, major surgery and diagnosis. It must have registered or graduate nurses providing on-duty 24-hour-a-day nursing service and licensed physicians must always be on call. **Note:** Institutions or units thereof (by whatever name called) will NOT be considered a covered hospital when functioning primarily as: (1) a clinic, rest home, convalescent home, home for the aged or assisted living center; (2) a nursing home unit or a facility or unit providing skilled nursing care, intermediate care, extended care or custodial care; (3) a domiciliary unit or a facility or unit providing housing or residential care; (4) a hospice; (5) an ambulatory surgical center or dialysis center; or (6) a facility or unit providing scheduled classes, training, education or recreation.

Hospital (For Utah Residents) - An institution which provides medical care and treatment of such injured persons and is duly licensed by the State of Utah and is operating within the scope of that license. Note: Institutions or units thereof (by whatever name called) will NOT be considered a covered hospital when functioning primarily as: (1) a clinic, rest home. convalescent home, home for the aged or assisted living center; (2) a nursing home unit or a facility or unit providing skilled nursing care, intermediate care, extended care or custodial care; (3) a domiciliary unit or a facility or unit providing housing or residential care; (4) a hospice; (5) an ambulatory surgical center or dialysis center; or (6) a facility or unit providing scheduled classes, training, education or recreation.

Hospital Inpatient Stay - The continuous period of time that begins on the day you 1) enter a Hospital as an inpatient, or 2) enter an emergency room or observation room and are admitted to the Hospital as an inpatient directly from the emergency room or observation room, and ends when you have been out of a Hospital for at least 24 hours. This applies even if you move from one Hospital or to another.

Laboratory/Pathology Services - Only those procedures designated as "Pathology and Laboratory" in the Physicians' Current Procedural Terminology (CPT).

Medical Emergency: The sudden and unexpected onset of symptoms, sickness, injury, or a condition that would be deemed, under appropriate United States medical standards, to carry substantial risk of serious medical complication or permanent damage to you if care or services are delayed or withheld.

Neurology Services - Only those procedures designated as "Neurology and Neuromuscular Procedures" and "Central Nervous System Assessment/Tests" in the Physicians' Current Procedural Terminology (CPT).

Nurse - For the purpose of the Post-Hospital Benefit, a professional nurse legally designated "RN" (registered nurse) or "LPN" (licensed practical nurse) who, where licensing is required, holds a valid license from the state in which the nursing service is performed. "LPN" shall include a licensed vocational nurse ("LVN") and any other similarly designated nurse in those jurisdictions in which a professional nurse is designated as other than an "LPN" and for whom licensing is required.

Outpatient Prescription Drug - A medication that has been approved by the Food and Drug Administration and that can, under federal or state law, be dispensed only pursuant to a Prescription Order or Refill. An Outpatient Prescription Drug includes a medication that, due to its characteristics, is appropriate for self-administration or administration by a non-skilled caregiver.

Period of Hospital Inpatient Stay - The total number of days of all successive Hospital Inpatient Stays. Such Hospital Inpatient Stays which are separated by more than 90 days are NOT part of the same Period of Hospital Stay. If you re-enter a Hospital after your coverage stops, that Hospital Inpatient Stay is NOT covered.

DEFINITIONS (continued)

Photodynamic Therapy - Only those procedures designated as "Photodynamic Therapy" in the Physicians' Current Procedural Terminology (CPT).

Physician: A licensed doctor of medicine or osteopathy acting within the scope of his or her license.

Prescription Order or Refill - the directive to dispense an Outpatient Prescription Drug issued by a duly licensed Physician whose scope of practice permits issuing such a directive.

Prescription Proof of Loss - Satisfactory proof of loss must be furnished no later than 15 months from the date of loss, except in the absence of legal capacity. Satisfactory proof of loss includes an itemized statement from a duly licensed pharmacy that identifies the name of the person to whom the Outpatient Prescription Drug is dispensed, the amount charged, and provides the name and address of the pharmacy, name of Outpatient Prescription Drug, NDC (National Drug Code) number, date dispensed, quantity, strength, and days supply.

Pulmonary Services - Only those procedures designated as "Pulmonary" in the Physicians' Current Procedural Terminology (CPT).

Radiology Services - Only those procedures designated as "Radiology" in the Physicians' Current Procedural Terminology (CPT).

Skilled Nursing Facility - A Skilled Nursing Facility is an institution (or unit of a hospital) which: (1) is operated or licensed pursuant to state law or is approved for payment of Medicare benefits or is qualified to receive such approval if requested; (2) is primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under a licensed Physician's supervision; (3) provides on-duty 24-hour-a-day nursing service under the supervision of registered or graduate nurses; and (4) maintains a daily record for each patient. The unit of the institution in which you are confined must meet fully all four of these requirements.

Note: Institutions or units thereof (by whatever name called) will NOT be considered a Skilled Nursing Facility when functioning primarily: (1) as a clinic, rest home, or convalescent home; (2) as a domiciliary, residential, or custodial care unit; (3) as an assisted living center; (4) as a home for the aged; (5) as an educational care unit; (6) for the treatment of substance abuse; or (7) for the convenience of the insured.

(For Utah Residents - An institution (or unit of a Hospital) licensed by the State of Utah as a skilled nursing care facility that provides licensed nursing care and related services to patients who need continuous health care and supervision. Note: An institution whose primary function is residential, or for the treatment of drug addiction, alcoholism, or mental illness, is NOT an eligible skilled nursing facility.)

Special Dermatological Procedures - Only those procedures designated as "Special Dermatological Procedures" in the Physicians' Current Procedural Terminology (CPT).

Surgery - Only those procedures designated as "Cardiac Catheterization," "Cardiovascular Therapeutic Services" which require introducing, positioning or repositioning of catheters, and "Surgery," as stated in the Physicians' Current Procedural Terminology (CPT).

Therapeutic or Diagnostic Infusions - Only those procedures designated as "Therapeutic and Diagnostic Infusions" in the Physicians' Current Procedural Terminology (CPT).

Therapist - A licensed physical therapist, occupational therapist, or speech therapist who is acting within the scope of his or her license where the services are performed.

WHAT IS NOT COVERED

- Dental services involving one or more teeth, the tissue or structure around them, the alveolar process or the gums. This applies even if a condition requiring any of these services involves a body part other than the mouth such as treatment of Temporomandibular Joint Disorders (TMJD) or malocclusion involving joints or muscles by methods including, but not limited to, crowning, wiring, or repositioning teeth. This exclusion does not apply to a charge made for treatment or removal of a malignant tumor.
- Emergency Room Visit, unless the visit is due to a Medical Emergency.
- Emergency Room Visits/Outpatient Observation Care Stays, beyond a Calendar Year maximum of 2 visits or stays.
- Examinations to determine the need for, or the proper adjustment of, glasses, contact lenses, or hearing aids; or laser vision correction surgery solely for the purpose of eliminating the need for corrective lenses.
- Health Care Practitioner services by an uncovered provider.
- Health Care Practitioner Services, beyond a Calendar Year maximum of 10 visits.
- Home Health Care Visits, beyond a maximum of 30 days, or charges incurred more than 90 days following a covered Hospital Inpatient Stay.

WHAT IS NOT COVERED (continued)

- Hospital Inpatient stays if the primary purpose is to provide any of the following types of care: (1) care of the type provided in a clinic, rest home, convalescent home, home for the aged or assisted living center; (2) skilled nursing care; (3) intermediate care, extended care or custodial care; (4) residential care or care of the type provided in a domiciliary unit; (5) care of the type provided in a hospice; (6) care of the type provided in an Ambulatory Surgical Center or dialysis center; or (7) care consisting primarily of scheduled classes, training, education and/or recreation. Such confinement is not covered even when the facility or unit in which such care is provided is part of or a unit of a Hospital.
- Hospital Inpatient Stays that are classified as Mental Illness/Substance Abuse confinements, beyond a Calendar Year maximum of 45 days.
- Hospital Inpatient Stays, beyond a maximum of 365 days per Period of Hospital Stay.
- Hospital Inpatient Stays, beyond a total lifetime maximum of 730 days.
- Hospital Outpatient Benefit, beyond a Calendar Year Maximum of $25,000.00 for the Bronze Level, $37,500.00 for the Silver Level and $50,000.00 for the Gold Level.
- Laboratory/Pathology Benefit, beyond a maximum of $800.00 per procedure for the Bronze level, $1,200.00 per procedure for the Silver Level and $1,600.00 per procedure for the Gold Level.
- Medical and surgical supplies, including but not limited to dressings, prosthetics, orthotics, diabetic shoes, durable medical equipment, and enteral and parenteral therapies.
- Pregnancy (for Idaho residents, except for complications of pregnancy) unless the pregnancy begins more than 12 months after the Effective Date of the mother's coverage under this plan. After 12 months, the applicable benefits will be payable for the care of the insured mother during antepartum, delivery, and postpartum.
- Radiology Benefit, beyond a maximum of $1,350.00 per procedure for the Bronze Level, $2,000.00 per procedure for the Silver Level and $2,700.00 per procedure for the Gold Level.
- Radiology services and laboratory/pathology services performed in a Hospital's emergency room or observation room, if you are subsequently admitted to the Hospital as an inpatient.
- Services or care provided by your immediate relatives or members of your household.
- Services performed for the treatment of the following:

  1) a weak, strained, flat, unstable or imbalanced foot or for a metatarsalgia or bunion. This does not apply to a Physician charge for a Surgery that meets the qualifications of the Surgery Benefit.

  2) one or more of the following: corns, calluses, or toenails. This exclusion does not apply to a charge for: (a) removal of part or all of one or more nail roots; and (b) services in connection with treatment of a metabolic or peripheral vascular disease.
- Skilled Nursing Facility Stay, beyond a maximum of 30 days, or charges incurred more than 90 days following a covered Hospital Stay.
- Stays and services received outside the United States and its possessions.
- Stays or services caused, wholly or partly, by intentionally self-inflicted injury, or attempted suicide, while sane or insane.
- Stays or services for cosmetic surgery performed mainly to change your appearance. This includes surgery to treat a mental, psychoneurotic, or personality disorder through change in appearance. Cosmetic surgery does not include surgery to correct the result of an accidental injury, surgery to treat a condition which impairs the function of a body organ, or surgery to reconstruct a breast after mastectomy.
- Stays or services for injury or sickness resulting from or caused, directly or indirectly or wholly or partly, by any future act of war, even if the war is not declared. (For Oklahoma Residents, war or acts of war when serving as a member of any military, airforce, naval organization or any auxiliary unit thereof. This exclusion includes any Injury sustained or Sickness contracted while in the service of any military, naval, or airforce of any country engaged in war or act of war).
- Stays or services for which benefits are available under Medicare or other governmental programs (except Medicaid), unless required by law.
- Stays or services for which no charge would be made to you in the absence of insurance.
- Stays or services that are educational, experimental or investigational, or are provided for research purposes.
- Stays, services, or procedures performed for treatment related to fertility, infertility, or contraception.
- Stays which began, services provided, or expenses incurred prior to your plan's Effective Date or in connection with a stay that began prior to your plan's Effective Date.
- Stays which begin, or care received, within 12 months after the Effective Date, if caused by or resulting from a pre-existing condition. (A pre-existing condition is any injury, sickness or other condition for which you received medical advice or treatment during the 12 months (for Idaho residents, 6 months) prior to the plan's Effective Date,

WHAT IS NOT COVERED (continued)

regardless of whether the condition is declared on the application.) The Pre-Existing Conditions Limitation does not apply to the "Health Care Practitioner Services Benefit."

- Transportation by ambulance and related services.

In addition to the above list, the following exclusions apply to the Outpatient Prescription Drug Benefit:

- Outpatient Prescription Drugs which are dispensed or purchased prior to the Effective Date of the Rider.
- Drugs which are prescribed, dispensed or intended for use while you are a patient in a Hospital, Skilled Nursing Facility, Ambulatory Surgical Center, or other outpatient facility.
- Experimental or Investigational drugs
- Outpatient Prescription Drugs furnished by the local, state or federal government.
- Outpatient Prescription Drugs for any condition, Injury, or Sickness arising out of, or in the course of, employment for which benefits are available under any workers' compensation law or other similar laws, whether or not a claim for such benefits is made or payment or benefits are received.
- Any product dispensed for the purpose of appetite suppression and other weight loss products.
- A specialty medication Outpatient Prescription Drug (such as immunizations and allergy serum) which, due to its characteristics as determined by United HealthCare, must typically be administered or supervised by a qualified provider or licensed/certified health professional in an outpatient setting.
- Durable Medical Equipment. Prescribed and non-prescribed outpatient supplies, other than the diabetic supplies and inhaler spacers specifically included in the definition of Outpatient Prescription Drug.
- General vitamins, except as noted in the Certificate.
- Medications used for cosmetic purposes.
- Outpatient Prescription Drugs as a replacement for a previously dispensed Outpatient Prescription Drug that was lost, stolen, broken or destroyed.
- Outpatient Prescription Drugs when prescribed to treat infertility.
- Outpatient Prescription Drugs for smoking cessation.
- Compounded drugs that do not contain at least one ingredient that requires a Prescription Order or Refill.
- Drugs available over-the-counter that do not require a Prescription Order or Refill by federal or state law before being dispensed.
- Any Outpatient Prescription Drug that is therapeutically equivalent to an over-the-counter drug. Outpatient Prescription Drugs that are comprised of components that are available in over-the-counter form or equivalent.

OTHER DISCLOSURES

- As long as you are a member of AARP, age 50-64, or the spouse of a member under age 65, and are not covered by Medicare, you are eligible to apply for the AARP Medical Advantage Plan.
- Your coverage will become effective on the first of the month following acceptance of your completed Enrollment Application, provided your first month's payment is received within 30 days from the effective date shown on your Certificate of Insurance.
- Your coverage cannot be canceled while the Group Policy remains in force unless you cease to be an AARP member age 50-64 or spouse of a member under age 65, or fail to make your payments when due. Your coverage will end on the first day of the month in which you turn age 65 or become eligible for Medicare.
- Benefits under the Outpatient Prescription Drug coverage terminate on the first day of the month in which you become eligible for Medicare (whether or not you enroll in Medicare); or when the Base Plan terminates (if earlier), or the end of the grace period if you fail to pay the required Premium when due.
- Once you are enrolled, if you are not satisfied with your coverage in any way, return your Certificate to United HealthCare Insurance Company within 30 days of its receipt. The insurance will be canceled and United HealthCare will treat the Certificate as if it had never been issued.
- Your rates are subject to change. Any rate change will apply to all members of the same class insured under your Plan who reside in your state. All changes must be approved by AARP.

OTHER DISCLOSURES (continued)

- Benefits payable for stays or services under any and all AARP Medical Advantage Plans insured by United HealthCare Insurance Company during the Calendar Year will be applied to the satisfaction of any Calendar Year maximum or limit.
- When benefits are payable, no more than one applicable benefit will be payable for each charge for any one covered stay or service. Separate benefits will not be paid for the technical and professional components of a covered service.
- These plans provide indemnity benefits in a stated amount for covered hospital stays and services regardless of the expenses incurred.
- These plans provide hospital confinement benefits and additional supplemental benefits only; they are not Major Medical, Medicare Supplement, or Long Term Care Insurance Plans.
- To help prevent the possibility of becoming over-insured, you may not be enrolled at any time in more than one of the AARP Group Hospital Indemnity Insurance plans or similar plans available through the AARP Health Care Options program.
- If you are covered under Medicaid, you generally do not need this Plan and should not enroll since, in such case, benefits payable under the Plan may be paid to your health care provider, as required by law.
- This package describes insurance plans available through the AARP Health Care Options program but is not a contract, policy, or insurance certificate. Please read your certificate of insurance, upon receipt, for plan benefits, definitions, limitations, and exclusions.
- Benefits and cost vary depending upon the Plan selected.
- The Policy Form No. GRP 79171 GPS-1 is issued in the District of Columbia to the Trustees of the AARP Insurance Plan.
- The AARP Insurance Trust retains income from the investment of monies on deposit in trust accounts. United HealthCare Insurance Company pays a fee to AARP and its affiliate for use of the AARP trademark and other services. Amounts paid are used for the general purposes of AARP and its members.
- AARP Health Care Options is the name of AARP's insurance and service program. It is not the insurer. AARP contracts with insurers to make coverage available to AARP members.

United HealthCare Insurance Company (United) contracts with licensed pharmacy vendors and other service providers to provide pharmacy and related services. Optum is the provider of AARP Nurse HealthLine. Optum nurses cannot diagnose problems nor recommend specific treatment and are not a substitute for your doctor's care. All decisions about medications, vision care, and health and wellness care are between you and your health care provider. **These are not insurance programs and may be discontinued at any time.** These discounts cannot be combined with any other discounts, promotions, coupons, or vision care plans. Products or services that are reimbursable by Medicare are not available on a discounted or complimentary basis. United and EyeMed pay license fees to AARP and its affiliates for use of the AARP trademark and other services. Amounts paid are used for the general purposes of AARP and its members.

IMPORTANT INFORMATION FOR MINNESOTA RESIDENTS. This is a supplemental hospital indemnity plan, and does not meet the requirements of a Minnesota qualified plan. You may only enroll for this coverage if you are currently covered under a Minnesota qualified plan (the front page of the certificate or policy of a qualified plan is labeled as such) or a health maintenance plan.

IMPORTANT INFORMATION FOR NORTH CAROLINA RESIDENTS. The Plan(s) contain(s) an exclusion for Pre-existing Conditions: Your coverage will stop if: you are no longer an eligible member (or spouse of a member) of AARP; you fail to pay the required monthly payments due; or the Group Policy is terminated.

AARP Health Care Options®

1-866-218-8607

AARP Medical Advantage Plan insured by:
United HealthCare Insurance Company

AARP APPROVED

Products	Summary	2008 Monthly Premium	VAS	Underwriting	Details	DHB	Inpatient Hospital	Surgery Benefits	Skilled Nursing Facility	Emergency Room / OP Observation	Pharmacy Benefit	Outpatient Lab/Pathology	Outpatient Radiology	Practitioner Visits	Home Health
HIP	Fixed daily cash benefits.	$8.00-$46.50	Eyecare Discounts, PSS	No	3 month PECE (not currently enforced)	$50/day $60/day $70/day $80/day $90/day $100/day $110/day $120/day $150/day	DHB Day 1; 2X DHB for ICU (180 day lifetime max on mh/sa stays)	2X DHB (outpatient only); includes cosmetic surgery	1X DHB; 20 day max/stay	OP Observation Only 1X DHB (12-24hrs); 2X DHB (24hrs-2days)	50% of costs up to $500 annual max (post hospital stay) - not covered under all R-Series plans	Not Covered			$50/visit, maximum 30 visits/stay (post hospital stay) - not covered under all R-Series plans
SMP	Fixed daily cash benefits and wellness benefits	$9.00-$68.00	Eyecare Discounts, PSS	No	3 month PECE (not currently enforced)	$50/day $100/day $150/day	DHB Day 1 (190 day lifetime max on mh/sa stays)	1X DHB; 3 procedures/yr; includes cosmetic surgery	1X DHB; 20 day max/stay	ER - 1 visit/yr at $35-$50/visit OP Observation- 1X DHB (12-24hrs); 2X DHB (24hrs-2days)	PSS	1-2 diagnostic/preventive screening tests per year at $10-$70; 1 immunization/year at $10; $50 for one wellness program/year		1-3 visits/year at $25 for HCP visits; 2 visits/year at $25 for complementary	Not Covered
HAP	Higher DHB than HIP + surgical and provider visits	$48-$115 (NS) $53-$127 (S)	Eyecare Discounts, PSS, PDN	Medically underwritten to accept/deny; nationally community rated based on smoker status	6 month PECE	$300, $500, $700/day	DHB Day 2 (365 limit; 60 day lifetime max on mh/sa stays)	Per fee schedule; $4,000 - $10,000 max per procedure	$100/day; 30 day max/stay (post hospital stay)	Not Covered	50% of costs up to $500 annual max (post hospital stay)	Not Covered		$60/visit; 4 visits per year	$50/visit, maximum 30 visits/stay (post hospital stay)
EHIP	Fixed cash benefits (dependent coverage available)	Age 58, NS: $42.25 Age 58, S: $46.50	Eyecare Discounts, PSS, PDN, Nurse Healthline	Medically underwritten to accept/deny; nationally attained age rated based on smoker status	6/6 PECE (enforced on Hospital Inpatient Benefit Only)	$200/day	DHB Day 2: (365/730 limit; 45 day annual max on mh/sa stays)	Office-Based: $50; Facility-Based: $100; 3 procedures/year	$100/day; 30 day max/stay (post hospital stay)	$50/visit; 1 visit/year	PSS	$10/test; 3 tests/year	$25/test; 3 tests/year	$50/visit; 3 visits/year	$50/visit, maximum 30 visits/stay (post hospital stay)
		Age 58, NS: $56.25 Age 58, S: $62.00				$300/day		Office-Based: $75.; Facility-Based: $150; 3 procedures/year				$15/test; 3 tests/year	$50/test; 3 tests/year		
		Age 58, NS: $74.75 Age 58, S: $82.25				$500/day		Office-Based: $100; Facility-Based: $200; 4 procedures/year				$15/test; 4 tests/year	$50/test; 4 tests/year		
		Age 58, NS: $94.75 Age 58, S: $104.25				$700/day		Office-Based: $125.; Facility-Based: $250; 4 procedures/year				$20/test; 4 tests/year	$75/test; 4 tests/year	$50/visit; 4 visits/year	
EPHIP/MAP Bronze	Highest DHBs of supplementals (dependent coverage available)	**MAP** Level 1, Ages 55-59: $145.75 **EPHIP** Level 1, 57yr old: $136.25	Eyecare Discounts, Nurse HealthLine, PSS, PDN, Chronic Care	Medically underwritten for acceptance and to set rates (4 tiers); nationally entry age rated except for WA (MAP) or nationally attained age rated (EPHIP)	12/12 month PECE	$900/day	DHB Day 2: $900 surgical $600 medical (365/730 limit) $300 mental/substance (45 day max/yr)	Per fee schedule, $5,000 max per procedure	$150/day; 30 day max/stay (post hospital stay)	$75; 2 visits/year	$5-$70 (for days supply <=31); $2000 annual max	Per fee schedule, $800 max per procedure	Per fee schedule, $1350 max per procedure	$50/visit; 10 visits per year	$50/visit, maximum 30 visits/stay (post hospital stay)
Silver		**MAP** Level 1, Ages 55-59: $202 **EPHIP** Level 1, 57yr old: $188.75				$1200/day	DHB Day 2: $1,200 surgical $900 medical (365/730 limit) $500 mental/substance (45 day max/yr)	Per fee schedule, $7,500 max per procedure	$200/day; 30 day max/stay (post hospital stay)	$125; 2 visits/year		Per fee schedule, $1,200 max per procedure	Per fee schedule, $2000 max per procedure	$75/visit; 10 visits per year	
Gold		**MAP** Level 1, Ages 55-59: $247 **EPHIP** Level 1, 57yr old: $230.75				$1500/day	DHB Day 2: $1,500 surgical $1200 medical (365/730 limit) $800 mental/substance (45 day max/yr)	Per fee schedule, $10,000 max per procedure	$300/day; 30 day max/stay (post hospital stay)	$175; 2 visits/year		Per fee schedule, $1,600 max per procedure	Per fee schedule, $2700 max per procedure		$75/visit, maximum 30 visits/stay (post hospital stay)

Let me tell you how your plan works!

AARP Health Care Options®

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How the Essential Plus Health Insurance Plan Works

In order to help you navigate your new insurance plan, we have included a series of examples to help you understand how your plan works.

Surgery Benefit

Let's look at two examples of the same type of outpatient surgery - a diagnostic colonoscopy. This is a procedure where a doctor uses a tiny camera to check for cancer in the colon and small bowel. Charges in the examples below were based on charges for different doctors and facilities in the same city for the same surgery*.

Example 1

Let's say John has surgery performed in a center that is separate from a hospital. Both the doctor and the facility are part of the Provider Discount Network (PDN). Separate bills are charged for the facility fees (including anesthesia) and the doctor's fee.

Example 1- Diagnostic Colonoscopy, Ambulatory Surgical Center		
Doctor surgical charges	$795	
Facility charges (including anesthesia)	1,525	
Total Charges		**2,320**
PDN discount (doctor)	-119	
PDN discount (facility)	-229	
Total Discounts		**-348**
Benefit- Gold Plan		**-1,413**
Total Out of Pocket Cost		**$559**

The total cost is reduced by $348 due to the PDN discounts. The Essential Plus Gold Plan pays $1,413 for this procedure. After the benefit is paid to the providers, John owes $559 for these charges.

TIP

It is wise to compare. Fees vary. Oftentimes, clinics within the same hospital system charge different rates for use of a treatment room.

As you compare, make sure to ask about all three types of charges. The three most common types of charges include anesthesia, facility, and doctor fees. Some places include the cost of anesthesia in the facility fee. However, others bill for each service separately.

Example 2

Suppose John goes to a Hospital for his care. He is not admitted for an overnight stay. Neither the doctor nor the hospital are in the Provider Discount Network. At this hospital, the anesthesia is billed separately.

Example 2- Diagnostic Colonoscopy, Hospital		
Doctor surgical charges	$555	
Hospital facility charges	2,075	
Anesthesia charges	1,100	
Total Charges		**3,730**
PDN discount (doctor)	0	
PDN discount (facility)	0	
PDN discount (anesthesia)	0	
Total Discounts		**0**
Benefit- Gold Plan		**-1,413**
Total Out of Pocket Cost		**$2,317**

Since neither the doctor nor the hospital is part of the discount network, there are no discount savings. After the benefit is paid to the providers, John owes $2,317 for these charges.

TIP

Colonoscopy is most commonly provided in an Ambulatory Surgical Center, or an Endoscopy Center. However, occasionally care is rendered in a hospital which costs significantly more.

Did you notice the benefit amount of $1,413 is the same in both examples? The benefit amount is determined based on what procedure is performed, not where it was performed or the total amount of the charges.

- The same benefit amount applies even if the provider is not part of the network.
- There is one benefit paid for each procedure. No additional benefits are paid for anesthesia, facility charges, or other miscellaneous charges.

See also the Outline of Coverage in Section 2 of this booklet, part D for a sample list of surgical procedures and the benefit amounts assigned. Or call 1-800-523-5800 (TTY:1-800-232-7773).

See next page for more examples >

Costs vary by provider, facility, location, and other factors. PDN is a network of participating providers and facilities that provide a discount to eligible members. Percentage of discount varies by provider. For more information on PDN visit www.aarphealthcare.com/providerdiscountnetwork or call 1-800-870-2101.

*Examples are for illustrative purposes only. Actual benefits are subject to the terms, conditions, limitations, and exclusions of the Group Policy and Certificate of Coverage. Please review the Certificate of Coverage for a full description of the plan. Insured by United Healthcare Insurance Company, Fort Washington, PA.

How the Essential Plus Health Insurance Plan Works

Outpatient Radiology Benefit

Here are two examples of the same type of radiology service - a bilateral screening mammogram. This is a procedure where a low-dose x-ray is used to screen both breasts for cancer.

Charges in the examples below were based on charges for different doctors and facilities in the same city for the same type of screening*.

Example 1

Let's say Jane has a mammogram by a doctor and hospital that are both in the Provider Discount Network (PDN). She is not admitted to the hospital. Separate bills are charged for the doctor and the facility.

Example 1- Bilateral Screening Mammogram		
Doctor charges	$66	
Facility charges	211	
Total Charges		**277**
PDN discount (doctor)	-20	
PDN discount (facility)	-63	
Total Discounts		**-83**
Benefit- Gold Plan		**-167**
Total Out of Pocket Cost		**$27**

The outpatient radiology benefit applies since the service was performed in an outpatient setting. The total cost is reduced by $83 due to the PDN discounts. The Essential Plus Gold Plan pays $167 for this procedure. After the benefit is paid to the providers, Jane owes $27 for these charges.

TIP

The radiology benefit is for outpatient services only. If Jane had a mammogram during an inpatient hospital stay, the radiology benefit would not apply.

See the Outline of Coverage in Section 2 of this booklet, part A for more information on the Hospital Inpatient Stay benefit.

Example 2

Suppose Jane goes to a different outpatient medical facility. While the doctor participates in the network, the facility does not.

Example 2- Bilateral Screening Mammogram		
Doctor charges	$51	
Facility charges	189	
Total Charges		**240**
PDN discount (doctor)	-11	
PDN discount (facility)	0	
Total Discounts		**-11**
Benefit- Gold Plan		**-167**
Total Out of Pocket Cost		**$62**

Since the facility is not part of the network, only the doctor's discount of $11 is taken from the total charges. The plan pays $167 for this procedure. After the benefit is paid to the providers, Jane owes $62 for these charges.

TIP

In some cases, the charges for the radiology will be split into two bills - one for doctor's services and one for facility charges. There are no additional benefits for facility charges.

See also the Outline of Coverage in Section 2 of this booket, part E for a sample list of radiology services and the benefit amounts assigned. Or call 1-800-523-5800 (TTY: 1-800-232-7773) to ask about benefits for a specific procedure.

See next page for more examples >

Costs vary by provider, facility, location, and other factors. PDN is a network of participating providers and facilities that provide a discount to eligible members. Percentage of discount varies by provider. For more information on PDN visit www.aarphealthcare.com/providerdiscountnetwork or call 1-800-870-2101.

*Examples are for illustrative purposes only. Actual benefits are subject to the terms, conditions, limitations, and exclusions of the Group Policy and Certificate of Coverage. Please review the Certificate of Coverage for a full description of the plan. Insured by United Healthcare Insurance Company, Fort Washington, PA.

How the Essential Plus Health Insurance Plan Works

Outpatient Services Benefit

Below are three examples of the same type of outpatient service - an electrocardiogram. Also called an EKG or ECG, this test records electrical activity of the heart. It is used to detect and locate the sources of heart problems.

Charges in examples below were based on charges for different doctors and facilities in the same city for the same type of procedure*.

Example 1

Let's say Sue has an EKG as part of her routine annual checkup. She has the test at a hospital that is in the Provider Discount Network (PDN). She is not admitted to the hospital.

Example 1- Routine Electrocardiogram, without interpretation or report		
Facility charges	$252	
Total Charges		**252**
PDN discount (facility)	-76	
Total Discounts		**-76**
Benefit- Gold Plan		**-33**
Total Out of Pocket Cost		**$143**

The total cost is reduced by $76 due to the PDN discount. The Essential Plus Gold Plan pays $33 for this procedure. After the benefit is paid to the provider, Sue owes $143 for these charges.

Example 2

Suppose Sue goes to an outpatient hospital facility for the EKG. The hospital is in the Provider Discount Network.

Example 2- Routine EKG, without interpretation or report		
Hospital facility charges	$68	
Total Charges		**68**
PDN discount (facility)	-7	
Total Discounts		**-7**
Benefit- Gold Plan		**-33**
Total Out of Pocket Cost		**$28**

The cost is reduced by $7 for the discount. After the benefit is paid to the hospital, Sue owes $28 for these charges.

TIP

Note that the Outpatient Services benefit does not apply for services performed during an inpatient hospital stay.

See also the Outline of Coverage in Section 2 of this booklet, part A for more information on the Hospital Inpatient Stay benefit.

See also the Outline of Coverage, part B for more information on the Outpatient Services Benefit.

Example 3

Suppose Sue goes to a different outpatient hospital facility. She has not been admitted to the hospital. This hospital is not part of the Provider Discount Network.

Example 3- Routine Electrocardiogram, without interpretation or report		
Hospital facility charges	$58	
Total Charges		**$58**
PDN discount (facility)	0	
Total Discounts		**0**
Benefit- Gold Plan		**-33**
Total Out of Pocket Cost		**$25**

Since the hospital is not part of the network, there are no discount savings. After the benefit is paid to the providers, Sue owes $25 for these charges.

TIP

Sometimes a better rate can be found outside the Provider Discount Network. While it is wise to shop for discounts, don't forget to compare rates and fees.

Costs vary by provider, facility, location, and other factors. PDN is a network of participating providers and facilities that provide a discount to eligible members. Percentage of discount varies by provider. For more information on PDN visit www.aarphealthcare.com/providerdiscountnetwork or call 1-800-870-2101.

*Examples are for illustrative purposes only. Actual benefits are subject to the terms, conditions, limitations, and exclusions of the Group Policy and Certificate of Coverage. Please review the Certificate of Coverage for a full description of the plan. Insured by United Healthcare Insurance Company, Fort Washington, PA.

The AARP Medical Advantage Plan

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AARP Health Care Options is the name of AARP's health insurance and service program. It is not the insurer. Insured by United HealthCare Insurance Company, Fort Washington, PA. Policy Form No. GRP 79171 GPS-1 (G-36000-5); AARP Medical Advantage Plans provide supplemental health insurance benefits and are not Medicare supplement plans. Click above to view a free, no-obligation information kit, including benefits, costs, limitations, exclusions and eligibility requirements. This plan may not be available in your state/area. This is a solicitation for insurance.

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PAGE ONE

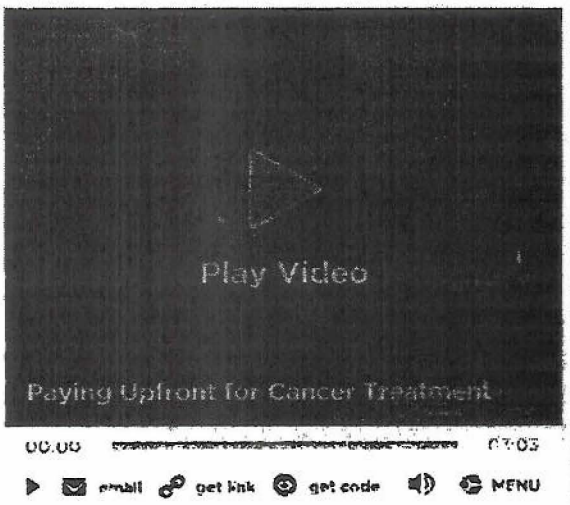
Cash Before Chemo: Hospitals Get Tough

Bad Debts Prompt Change in Billing; $45,000 to Come In

By BARBARA MARTINEZ
April 28, 2008; Page A1

LAKE JACKSON, Texas -- When Lisa Kelly learned she had leukemia in late 2006, her doctor advised her to seek urgent care at M.D. Anderson Cancer Center in Houston. But the nonprofit hospital refused to accept Mrs. Kelly's limited insurance. It asked for $105,000 in cash before it would admit her.

Sitting in the hospital's business office, Mrs. Kelly says she told M.D. Anderson's representatives that she had some money to pay for treatment, but couldn't get all the cash they asked for that day. "Are they going to send me home?" she recalls thinking. "Am I going to die?"



A growing trend in the hospital industry means cancer patients like Lisa Kelly are being asked to pay cash upfront before receiving treatment.

Hospitals are adopting a policy to improve their finances: making medical care contingent on upfront payments. Typically, hospitals have billed people after they receive care. But now, pointing to their burgeoning bad-debt and charity-care costs, hospitals are asking patients for money before they get treated.

HEALTHY FUNDING AT M.D. ANDERSON

M.D. Anderson Cancer Center is part of the University of Texas System. It was created by the Texas legislature in 1941 to focus on cancer treatment and research. Five other hospitals, including UT Southwestern Medical Center in Dallas and UT Health Sciences Center in Houston, also operate under Texas's state university system.

Like private nonprofit hospitals, state-university hospitals are exempt from taxes.

Today, M.D. Anderson is considered one of the world's best cancer hospitals. It is also among the most profitable hospitals in the U.S. Last year, it posted net income of $310 million, bringing the total value of its cash, investments and endowment to $1.88 billion. M.D. Anderson paid its president, John Mendelsohn, $1.18 million last year.

About 6% of M.D. Anderson's revenues come from state funding. The hospital also attracts sizable donations. In 2007, it received philanthropic gifts and pledges of $173.6 million, including $50 million from oil baron T. Boone Pickens.

M.D. Anderson's revenues from patients have risen 27% over the past two years to nearly $2 billion, yet the hospital's spending on charity care has declined. In 2005, the year it began to institute its upfront payment policy, it allotted $144 million to indigent care. In 2007, the amount allotted to indigent care fell to $98.9 million. M.D.

Hospitals say they have turned to the practice because of a spike in patients who don't pay their bills. Uncompensated care cost the hospital industry $31.2 billion in 2006, up 44% from $21.6 billion in 2000, according to the American Hospital Association.

The bad debt is driven by a larger number of Americans who are uninsured or who don't have enough insurance to cover medical costs if catastrophe strikes. Even among those with adequate insurance, deductibles and co-payments are growing so big that insured patients also have trouble paying hospitals.

FINANCIAL HEALTH

- **The Issue:** Hospitals are asking patients for payment before receiving treatment.
- **The Background:** Hospitals say the practice is needed because of an increase in the number of people not paying their bills.
- **The Bottom Line:** While hospitals provide care to the poor, uninsured and underinsured people are likely to be hardest hit.

Letting bad debt balloon unchecked would threaten hospitals' finances and their ability to provide care, says Richard Umbdenstock, president of the American Hospital Association. Hospitals would rather discuss costs with patients upfront, he says. "After, when it's an ugly surprise or becomes contentious, it doesn't work for anybody."

Anderson calculates its indigent-care spending based on marked-up list prices for services and procedures, so the actual costs it incurred for indigent care are likely lower.

An M.D. Anderson spokeswoman said its charity-care figures have gone down because the hospital has been lending doctors to the local county hospital. As a result, fewer poor patients have been coming directly to M.D. Anderson to seek cancer treatment, she said.

—Barbara Martinez

M.D. Anderson says it went to a new upfront-collection system for initial visits in 2005 after its unpaid patient bills jumped by $18 million to $52 million that year. The hospital said its increasing bad-debt load threatened its mission to cure cancer, a goal on which it spends hundreds of millions of dollars a year.

The change had the desired effect: The hospital's bad debt fell to $33 million the following year.

Asking patients to pay after they've received treatment is "like asking someone to pay for the car after they've driven off the lot," says John Tietjen, vice president for patient financial services at M.D. Anderson. "The time that the patient is most receptive is before the care is delivered."

Lisa Kelly

M.D. Anderson says it provides assistance or free care to poor patients who can't afford treatment. It says it acted appropriately in Mrs. Kelly's case because she wasn't indigent, but underinsured. The hospital says it wouldn't accept her insurance because the payout, a maximum of $37,000 a year, would be less than 30% of the estimated costs of her care.

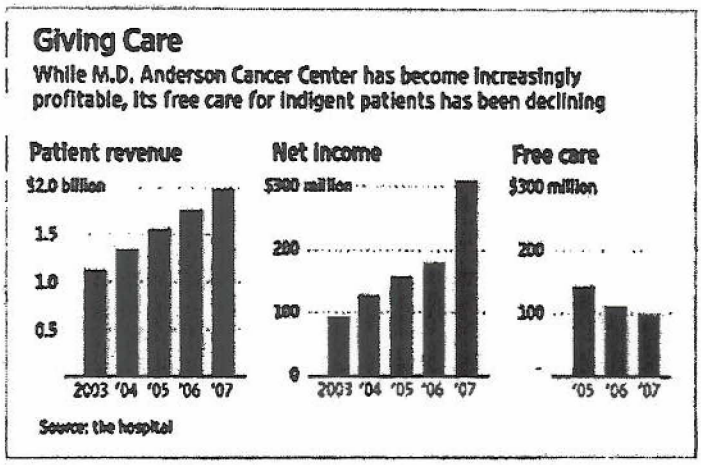
Tenet Healthcare and HCA, two big, for-profit hospital chains, say they have also been asking patients for upfront payments before admitting them. While the practice has received little notice, some patient advocates and health-care experts find it harder to justify at nonprofit hospitals, given their benevolent mission and improving financial fortunes.

In the Black

An Ohio State University study found net income per bed nearly tripled at nonprofit hospitals to $146,273 in 2005 from $50,669 in 2000. According to the American Hospital Directory, 77% of nonprofit hospitals are in the black, compared with 61% of for-profit hospitals. Nonprofit hospitals are exempt from taxes and are supposed to channel the income they generate back into

their operations. Many have used their growing surpluses to reward their executives with rich pay packages, build new wings and accumulate large cash reserves.

M.D. Anderson, which is part of the University of Texas, is a nonprofit institution exempt from taxes. In 2007, it recorded net income of $310 million, bringing its cash, investments and endowment to nearly $1.9 billion.



"When you have that much money in the till and that much profit, it's kind of hard to say no" to sick patients by asking for money upfront, says Uwe Reinhardt, a health-care economist at Princeton University, who thinks all hospitals should pay taxes. Nonprofit organizations "shouldn't behave this way," he says.

It isn't clear how many of the nation's 2,033 nonprofit hospitals require upfront payments. A voluntary 2006 survey by the Internal Revenue Service found 14% of 481 nonprofit hospitals required patients to pay or make an arrangement to pay before being admitted. It was the first time the agency asked that question.

Nataline Sarkisyan, a 17-year-old cancer patient who died in December waiting for a liver transplant, drew national attention when former presidential candidate John Edwards lambasted her health insurer for refusing to pay for the operation. But what went largely unnoticed is that Ms. Sarkisyan's hospital, UCLA Medical Center, a nonprofit hospital that is part of the University of California system, refused to do the procedure after the insurance denial unless the family paid it $75,000 upfront, according to the family's lawyer, Tamar Arminak.

The family got that money together, but then the hospital demanded $300,000 to cover costs of caring for Nataline after surgery, Ms. Arminak says.

UCLA says it can't comment on the case because the family hasn't given its consent. A spokeswoman says UCLA doesn't have a specific policy regarding upfront payments, but works with patients on a case-by-case basis.

Federal law requires hospitals to treat emergencies, such as heart attacks or injuries from accidents. But the law doesn't cover conditions that aren't immediately life-threatening.

At the American Cancer Society, which runs call centers to help patients navigate financial problems, more people are saying they're being asked for large upfront payments by hospitals that they can't afford. "My greatest concern is that there are substantial numbers of people who need cancer care" who don't get it, "usually for financial reasons," says Otis Brawley, chief medical officer.

Mrs. Kelly's ordeal began in 2006, when she started bruising easily and was often tired. Her husband, Sam, nagged her to see a doctor.

A specialist in Lake Jackson, a town 50 miles from Houston, diagnosed Mrs. Kelly with acute leukemia, a cancer of the blood that can quickly turn fatal. The small cancer center in Lake Jackson refers acute leukemia patients to M.D. Anderson.

When Mrs. Kelly called M.D. Anderson to make an appointment, the hospital told her it wouldn't accept her insurance, a type called limited-benefit.

"When an insurer is going to pay the small amounts, we don't feel financially able to assume the risk," says M.D. Anderson's Mr. Tietjen.

An estimated one million Americans have limited-benefit plans. Usually less expensive than traditional plans, such insurance is popular among people like Mrs. Kelly who don't have health insurance through an employer.

Mrs. Kelly, 52, signed up for AARP's Medical Advantage plan, underwritten by UnitedHealth Group Inc., three years ago after she quit her job as a school-bus driver to help care for her mother. Her husband was retired after a career as a heavy-equipment operator. She says that at the time, she hardly ever went to the doctor. "I just thought I needed some kind of insurance policy because you never know what's going to happen," says Mrs. Kelly. She paid premiums of $185 a month.

A spokeswoman for UnitedHealth, one of the country's largest marketers of limited-benefit plans, says the plan is "meant to be a bridge or a gap filler." She says UnitedHealth has reimbursed Mrs. Kelly $38,478.36 for her medical costs. Because the hospital wouldn't accept her insurance, Mrs. Kelly paid bills herself, and submitted them to her insurer to get reimbursed.

M.D. Anderson viewed Mrs. Kelly as uninsured and told her she could get an appointment only if she brought a certified check for $45,000. The Kellys live comfortably, but didn't have that kind of cash on hand. They own an apartment building and a rental house that generate about $11,000 a month before taxes and maintenance costs. They also earn interest income of about $35,000 a year from two retirement accounts funded by inheritances left by Mrs. Kelly's mother and Mr. Kelly's father.

See documents related to Mrs. Kelly's case.

- Mrs. Kelly's certificate of coverage[1] through the AARP.
- Mrs. Kelly's May 2007 bill[2] from M.D. Anderson.
- One of the letters Ms. Wallack sent[3] on behalf of Mrs. Kelly, questioning some of M.D. Anderson's charges
- The hospital's response[4]
- Letter from M.D. Anderson[5] to Mrs. Kelly, regarding a refund for a misbilled item
- Collection notice[6] sent to Mrs. Kelly
- Letter from M.D. Anderson[7] offering a 10% discount for paying the balance in full by April 30.

Mr. Kelly arranged to borrow the money from his father's trust, which was in probate proceedings. Mrs. Kelly says she told the hospital she had money for treatment, but didn't realize how high her medical costs would get.

The Kellys arrived at M.D. Anderson with a check for $45,000 on Dec. 6, 2006. After having blood drawn and a bone-marrow biopsy, the hospital oncologist wanted to admit Mrs. Kelly right away.

But the hospital demanded an additional $60,000 on the spot. It told her the $45,000 had paid for the lab tests, and it needed the additional cash as a down payment for her actual treatment.

In the hospital business office, Mrs. Kelly says she was crying, exhausted and confused.

The hospital eventually lowered its demand to $30,000. Mr. Kelly lost his cool. "What part don't you understand?" he recalls saying. "We don't have any more money today. Are you going to admit her or not?" The hospital says it was trying to work with Mrs. Kelly, to find an amount she could pay.

Mrs. Kelly was granted an "override" and admitted at 7 p.m.

Appointment 'Blocked'

After eight days, she emerged from the hospital. Chemotherapy would continue for more than a year, as would requests for upfront payments. At times, she arrived at the hospital and learned her appointment was "blocked." That meant she needed to go to the business office first and make a payment.

Daniel Kramer/WSJ

Lisa Kelly

One day, Mrs. Kelly says, nurses wouldn't change the chemotherapy bag in her pump until her husband made a new payment. She says she sat for an hour hooked up to a pump that beeped that it was out of medicine, until he returned with proof of payment.

A hospital spokesperson says "it is very difficult to imagine that a nursing staff would allow a patient to sit with a beeping pump until a receipt is presented." The hospital regrets if patients are inconvenienced by blocked appointments, she says, but it "is a necessary process to keep patients informed of their mounting bills and to continue dialog about financial obligations." She says appointments aren't blocked for patients who require urgent care.

Once, Mrs. Kelly says she was on an exam table awaiting her doctor, when he walked in with a representative from the business office. After arguing about money, she says the representative suggested moving her to another facility.

But the cancer center in Lake Jackson wouldn't take her back because it didn't have a blood bank or an infectious-disease specialist. "It risks a person's life by doing that [type of chemotherapy] at a small institution," says Emerardo Falcon Jr., of the Brazosport Cancer Center in Lake Jackson.

Ron Walters, an M.D. Anderson physician who gets involved in financial decisions about patients, says Mrs. Kelly's subsequent chemotherapy could have been handled locally. He says he is sorry if she was offended that the payment representative accompanied the doctor into the exam room, but it was an example of "a coordinated teamwork approach."

On TV one night, Mrs. Kelly saw a news segment about people who try to get patients' bills

reduced. She contacted Holly Wallack, who is part of a group that works on contingency to reduce patients' bills; she keeps one-third of what she saves clients.

Ms. Wallack began firing off complaints to M.D. Anderson. She said Mrs. Kelly had been billed more than $360 for blood tests that most insurers pay $20 or less for, and up to $120 for saline pouches that cost less than $2 at retail.

On one bill, Mrs. Kelly was charged $20 for a pair of latex gloves. On another itemized bill, Ms. Wallack found this: CTH SIL 2M 7FX 25CM CLAMP A4356, for $314. It turned out to be a penis clamp, used to control incontinence.

M.D. Anderson's prices are reasonable compared with other hospitals, Mr. Tietjen says. The $20 price for the latex gloves, for example, takes into account the costs of acquiring and storing gloves, ones that are ripped and not used and ones used for patients who don't pay at all, he says. The charge for the penis clamp was a "clerical error" he says; a different type of catheter was used, but the hospital waived the charge. The hospital didn't reduce or waive other charges on Mrs. Kelly's bills.

Continuing Treatment

Mrs. Kelly is continuing her treatment at M.D. Anderson. In February, a new, more comprehensive insurance plan from Blue Cross Blue Shield that she has switched to started paying most of her new M.D. Anderson bills. But she is still personally responsible for $145,155.65 in bills incurred before February. She is paying $2,000 a month toward those. Last week, she learned that after being in remission for more than a year, her leukemia has returned.

M.D. Anderson is giving Blue Cross Blue Shield a 25% discount on the new bills. This month, the hospital offered Mrs. Kelly a 10% discount on her balance, but only if she pays $130,640.08 by this Wednesday, April 30. She is still hoping to get a bigger discount, though numerous requests have been denied. The hospital says it gives commercial insurers a bigger discount because they bring volume and they are less risky than people who pay on their own.

The hospital has urged Mrs. Kelly to sell assets. But she worries about losing her family's income and retirement savings. Mrs. Kelly says she wants to pay, but, suspicious of the charges she's seen, she says, "I want to pay what's fair."

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LOW-INCOME & RURAL BENEFICIARIES WITH

MEDIGAP COVERAGE

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LIST OF TABLES AND FIGURES

LOW-INCOME AND RURAL BENEFICIARIES WITH MEDIGAP COVERAGE, 2004

SUMMARY

Medigap supplemental coverage has long helped Medicare beneficiaries fill gaps in their benefits. While policymakers continue to focus on the new Medicare drug benefit, recently released data from the 2004 Medicare Current Beneficiary Survey (MCBS) serve as a reminder of the critical role played by Medigap coverage.

The MCBS data show that Medigap is particularly important to low- and moderate-income beneficiaries, especially those living in rural areas. Here are some key findings:

- Thirty percent of Medigap policyholders resided in rural areas in 2004; by comparison, only 23 percent of all Medicare beneficiaries resided in rural areas.
- Half (50 percent) of rural Medigap policyholders had incomes under $20,000 in 2004, and 43 percent of all Medigap policyholders (living in rural or metropolitan areas) had incomes under $20,000. Nearly three-quarters (74 percent) of rural Medigap policyholders and nearly two-thirds (65 percent) of all Medigap policyholders had incomes below $30,000.
- Overall, 32 percent of Medigap policyholders had incomes ranging from $10,000 to $20,000 in 2004. This income bracket accounted for the highest proportion of Medigap purchasers. In rural areas, 37 percent of Medigap policyholders had incomes in this range.
- Medicare beneficiaries with some form of private coverage — including Medigap, Medicare Advantage, and employer-based plans — reported greater use of preventive care than those with Medicare alone.

The statistics in this report were calculated from the publicly available MCBS Access to Care files. We analyzed a subset of records for non-institutionalized (aged and disabled) beneficiaries. For beneficiaries in the Medicare Advantage and Medicaid categories, June 2004 was the point in time for which beneficiary records were selected for inclusion. We defined "rural" and "metro" areas according to the Office of Management and Budget's (OMB's) classification system.

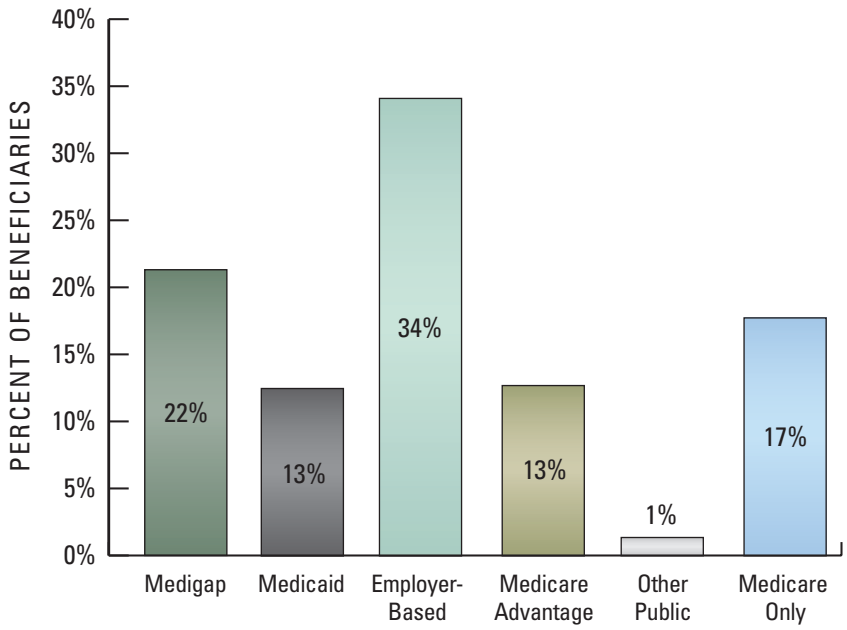
MEDIGAP COVERED MORE THAN TWENTY PERCENT OF MEDICARE BENEFICIARIES IN 2004

Nationwide, 22 percent of all non-institutionalized Medicare beneficiaries chose Medigap policies in 2004 (see Figure 1). Medigap was the second most common form of supplemental insurance, after employer-based coverage (34 percent).

By contrast, 13 percent of Medicare beneficiaries had supplemental coverage through Medicaid, 13 percent chose comprehensive Medicare Advantage plans, and 1 percent had supplemental coverage through public programs other than Medicaid. Another 17 percent of Medicare beneficiaries had no supplemental coverage.

Persons with both employer-based and Medigap coverage were categorized as having employer-based coverage. Approximately 6 percent of Medicare beneficiaries had employer-based plans and Medigap policies.

FIGURE 1.
Coverage Types Of Medicare Beneficiaries (2004)

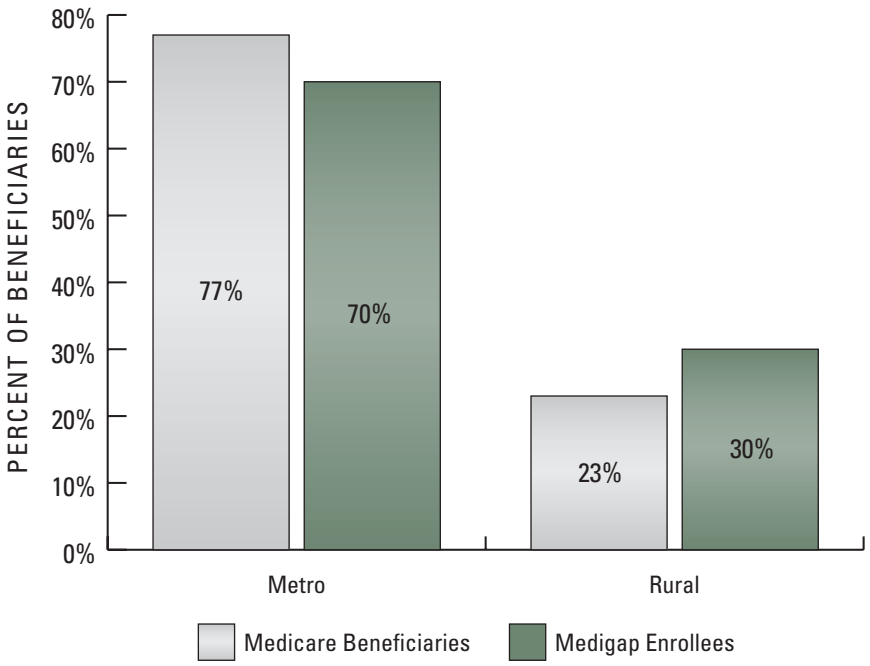


Source: Medicare Current Beneficiary Survey Access to Care files, 2004. (CMS)
Note: Calculations based on responses by non-institutionalized Medicare beneficiaries.

BENEFICIARIES WITH MEDIGAP COVERAGE TEND TO HAVE LOW INCOMES AND LIVE IN RURAL AREAS

A disproportionate number of Medigap policyholders had low incomes and lived in rural areas. Thirty percent of all beneficiaries with Medigap coverage lived in rural (non-metropolitan) areas in 2004. By comparison, 23 percent of all Medicare beneficiaries lived in rural areas (see Figure 2).

FIGURE 2.
Medicare Beneficiaries, By Area Of Residence (2004)

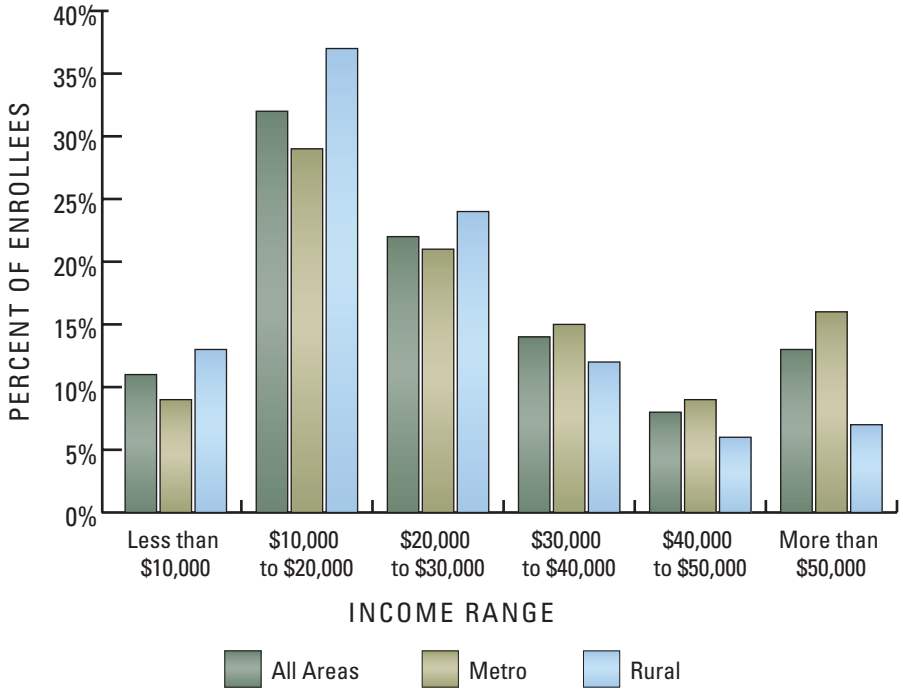


Source: Medicare Current Beneficiary Survey Access to Care files, 2004. (CMS)
Note: Calculations based on responses by non-institutionalized Medicare beneficiaries.

In 2004, the most common income range for Medigap policyholders was $10,000 to $20,000 (see Figure 3). Thirty-two percent of Medigap policyholders overall had incomes within this range, and 37 percent of Medigap policyholders living in rural areas had incomes between $10,000 and $20,000.

The second most common income range for Medigap policyholders was $20,000 to $30,000. Twenty-two percent of all Medigap policyholders had incomes in this range, and 24 percent of rural Medigap policyholders had incomes between $20,000 and $30,000 in 2004.

FIGURE 3.
Medigap Enrollees By Income, Metro And Rural (2004)



Source: Medicare Current Beneficiary Survey Access to Care files, 2004. (CMS)
Note: Calculations based on responses by non-institutionalized Medicare beneficiaries living in areas with at least one Medicare Advantage plan.

A substantial number of Medicare beneficiaries with incomes below $10,000 purchased Medigap coverage. Eleven percent of all Medigap policyholders and 13 percent of rural Medigap policyholders had less than $10,000 in annual income in 2004.

Overall, half (50 percent) of rural Medigap policyholders had incomes under $20,000 in 2004, and 43 percent of all Medigap policyholders (rural or metro) had incomes under $20,000. Similarly, 74 percent of rural Medigap policyholders and 65 percent of all Medigap policyholders had incomes under $30,000.

Across the U.S., 25 percent of Medicare beneficiaries with incomes between $10,000 and $20,000 chose Medigap policies in 2004. Sixteen percent chose Medicare Advantage plans, and 21 percent had Medicare only (see Table 1).

In rural areas, 34 percent of beneficiaries with incomes between $10,000 and $20,000 chose Medigap policies. By contrast, only 23 percent of rural beneficiaries in the $10,000 to $20,000 income range had employer-based coverage. However, employer-based coverage was the most common form of supplemental benefits for Medicare rural beneficiaries in higher income brackets (see Figure 4).

TABLE 1.

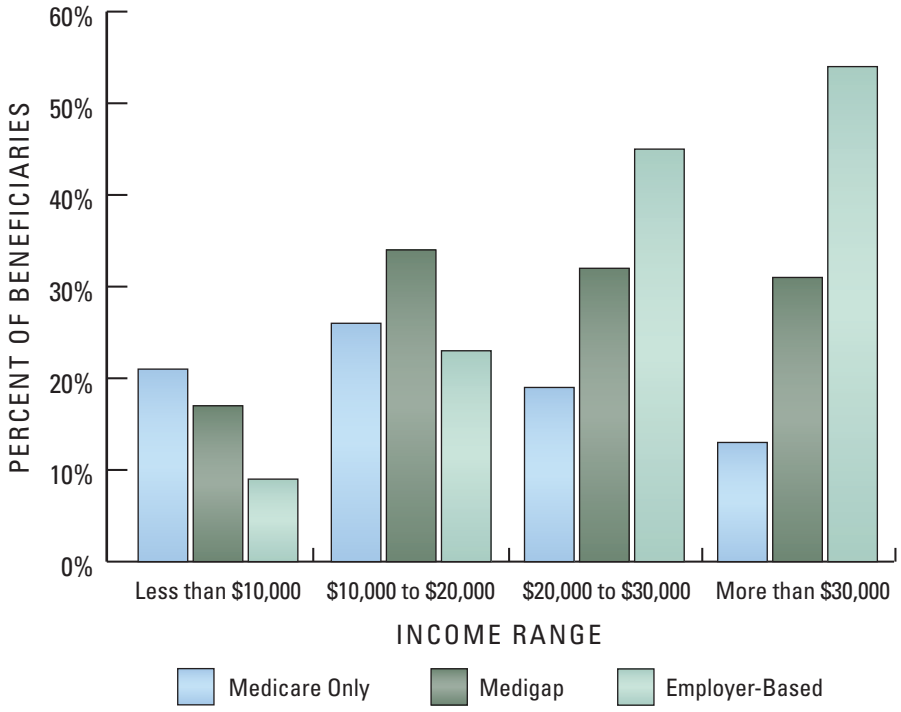
Income Range Of Medicare Beneficiaries, By Coverage Type (2004)
All Geographic Areas

	Less than $10,000	$10,000 to $20,000	$20,000 to $30,000	$30,000 to $40,000	$40,000 to $50,000	More than $50,000
MEDIGAP	11%	25%	24%	24%	23%	26%
MEDICAID	48%	13%	1%	1%	**	**
EMPLOYER-BASED	8%	22%	43%	49%	54%	56%
MEDICARE ADVANTAGE	10%	16%	15%	14%	12%	9%
OTHER PUBLIC	2%	3%	1%	1%	**	**
MEDICARE ONLY	20%	21%	16%	11%	11%	9%
TOTAL	100%	100%	100%	100%	100%	100%

Source: Medicare Current Beneficiary Survey Access to Care files, 2004 (CMS).
Note: Calculations based on responses by non-institutionalized Medicare beneficiaries.
** Less than 1 percent
The percentages in this table may not sum to 100 due to rounding.

FIGURE 4.

Income Level Of Medicare Beneficiaries In Rural Areas, By Private Supplemental Coverage Type (2004)



Source: Medicare Current Beneficiary Survey Access to Care files, 2004. (CMS)
Note: Calculations based on responses by non-institutionalized Medicare beneficiaries who lived in rural areas.

MEDIGAP POLICYHOLDERS REPORTED USING MORE PREVENTIVE CARE

Medicare beneficiaries with private coverage reported more use of preventive care than beneficiaries without private coverage.

Medigap policyholders and Medicare Advantage enrollees reported rates of preventive services that were about equal to those reported by beneficiaries with employer-based coverage. This is notable because beneficiaries with employer-based coverage have considerably higher average incomes and therefore would reasonably be expected to have a greater likelihood of receiving preventive care.

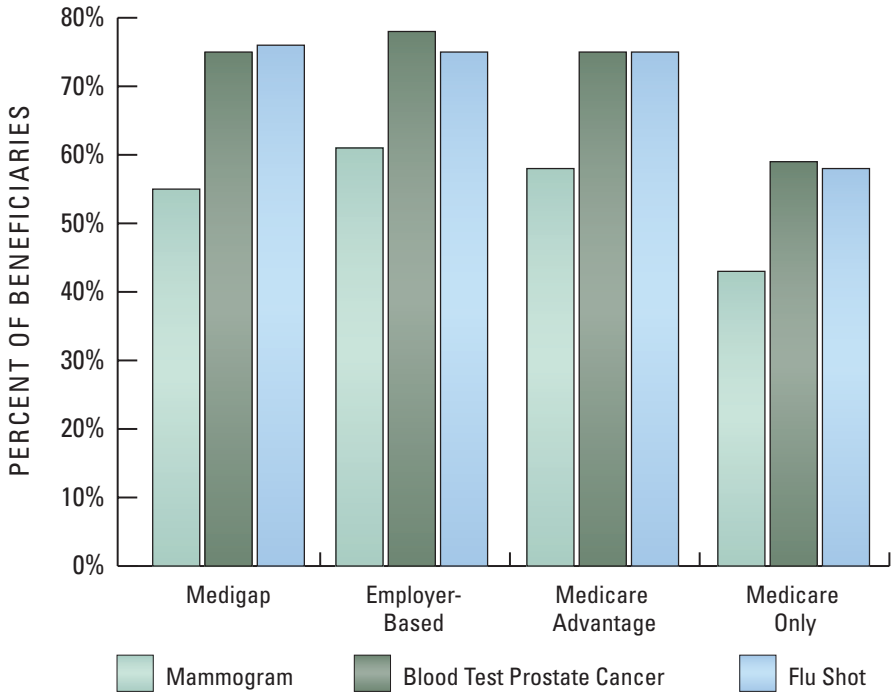
However, Medicare beneficiaries with Medicare alone reported lower rates of preventive care use than beneficiaries with some form of private coverage.

Fifty-five percent of women with Medigap coverage, 61 percent of women with employer-based coverage, and 58 percent of women with Medicare Advantage coverage said they had mammograms in the previous year. However, only 43 percent of women without any private coverage said they had received mammograms during that time frame.

Seventy-five percent of men with Medigap coverage, 78 percent of men with employer-based coverage, and 75 percent of men with Medicare Advantage plans reported having blood tests for prostate cancer in the previous year. However, only 59 percent of men with Medicare alone said they had received the tests during that period.

Finally, 76 percent of beneficiaries with Medigap coverage received flu shots. The percentage of beneficiaries who received flu shots was 75 percent for both beneficiaries with employer-based coverage and for Medicare Advantage enrollees. However, only 58 percent of beneficiaries without private coverage were immunized against the flu (see Figure 5).

FIGURE 5.
Medicare Beneficiaries Reporting Having Received Specific Services During Previous Year, By Coverage Type (2004)



Source: Medicare Current Beneficiary Survey Access to Care files, 2004. (CMS)
Note: Calculations based on responses by non-institutionalized Medicare beneficiaries.

MOST POPULAR MEDIGAP POLICIES

Under the Omnibus Budget Reconciliation Act (OBRA) of 1990, Medigap policies must conform to a standardized set of benefit models developed by the National Association of Insurance Commissioners (NAIC). The NAIC initially developed 10 models, labeled A through J, and two additional models (K and L) were created through the Medicare Modernization Act (MMA) of 2003. Table 2 lists enrollment in the Medigap policies available in 2004.

The Medigap policies labeled "C" and "F," which cover nearly all of Medicare's deductibles and coinsurance, were the most popular.

TABLE 2.
Description Of Medigap Policy Types, And Percent Of Medigap Policyholders With Each Type (2004)

	TYPES OF MEDIGAP POLICIES: PLANS A THROUGH J									
	A	B	C	D	E	F	G	H	I	J
BASIC BENEFITS	✔	✔	✔	✔	✔	✔	✔	✔	✔	✔
SKILLED NURSING COINSURANCE			✔	✔	✔	✔	✔	✔	✔	✔
MEDICARE PART A DEDUCTIBLE		✔	✔	✔	✔	✔	✔	✔	✔	✔
MEDICARE PART B DEDUCTIBLE			✔			✔				✔
MEDICARE PART B EXCESS CHARGE (100%)						✔			✔	✔
MEDICARE PART B EXCESS CHARGE (80%)							✔			
FOREIGN TRAVEL EMERGENCY			✔	✔	✔	✔	✔	✔	✔	✔
AT-HOME RECOVERY				✔			✔		✔	✔
BASIC DRUG BENEFIT*								✔	✔	✔
PERCENT OF MEDIGAP PURCHASERS WITH TYPE OF MEDIGAP POLICY	6%	6%	19%	7%	2%	41%	5%	3%	2%	10%

* Basic drug benefit limit for Plans H and I was $1,250 in 2004; for Plan J, it was $3,000.

Source for Medigap policy description: *2004, Choosing A Medigap Policy, A Guide To Health Insurance For People With Medicare*, April 2004, Centers for Medicare & Medicaid Services.

Source for Medigap purchasers' policy types: Medicare Current Beneficiary Survey Access to Care files, 2004 (CMS).

Note: Calculations based on responses by non-institutionalized Medicare beneficiaries.

ADDITIONAL INFORMATION

This overview is based on a report by Karen Heath, Policy Analyst. The full report, including all tables and a description of methodology, is available at www.ahipresearch.org. The data cited in the report and overview provide an update to AHIP's 2005 publication, *Low-Income and Rural Beneficiaries with Medigap Coverage, 2002*, authored by Teresa Chovan, Director, and Jeff Lemieux, Senior Vice President, of AHIP's Center for Policy and Research.

APPENDIX A
TABLES

Table 1A.
Geographic Location Of Medicare Beneficiaries, By Coverage Type (2004)

Coverage Type	Geographic Location		
	Rural	Metro	Total
ALL MEDICARE BENEFICIARIES	23%	77%	100%
MEDIGAP	30%	70%	100%
MEDICAID	28%	72%	100%
EMPLOYER-BASED	23%	77%	100%
MEDICARE ADVANTAGE	2%	98%	100%
OTHER PUBLIC	29%	71%	100%
MEDICARE ONLY	29%	71%	100%

Source: Medicare Current Beneficiary Survey Access to Care files, 2004 (CMS).
Note: Calculations based on responses by non-institutionalized Medicare beneficiaries.
The percentages in this table may not sum to 100 due to rounding.

Table 1A shows the geographic location (rural or metro) of Medicare beneficiaries by coverage type. For example, 30 percent of Medigap policyholders lived in rural areas in 2004.

Table 2A.
Geographic Location Of Medigap Policyholders, By Income (2004)

Income Range	Geographic Location		
	Rural	Metro	All Areas
Less than $10,000	13%	9%	11%
$10,000 to $20,000	37%	29%	32%
$20,000 to $30,000	24%	21%	22%
$30,000 to $40,000	12%	15%	14%
$40,000 to $50,000	6%	9%	8%
More than $50,000	7%	16%	13%
Total	100%	100%	100%

Source: Medicare Current Beneficiary Survey Access to Care files, 2004 (CMS).
Note: Calculations based on responses by non-institutionalized Medicare beneficiaries.
The percentages in this table may not sum to 100 due to rounding.

Table 2A shows the geographic location (rural, metro, all areas) of Medigap policyholders, by income range. For example, 37 percent of rural Medigap policyholders had incomes between $10,000 and $20,000 in 2004.

Table 3A.
Income Range Of Medicare Beneficiaries, By Coverage Type (2004)
All Geographic Areas

Coverage Type	Income Range					
	Less than $10,000	$10,000 to $20,000	$20,000 to $30,000	$30,000 to $40,000	$40,000 to $50,000	More than $50,000
MEDIGAP	11%	25%	24%	24%	23%	26%
MEDICAID	48%	13%	1%	1%	**	**
EMPLOYER-BASED	8%	22%	43%	49%	54%	56%
MEDICARE ADVANTAGE	10%	16%	15%	14%	12%	9%
OTHER PUBLIC	2%	3%	1%	1%	**	**
MEDICARE ONLY	20%	21%	16%	11%	11%	9%
Total	100%	100%	100%	100%	100%	100%

Source: Medicare Current Beneficiary Survey Access to Care files, 2004 (CMS).
Note: Calculations based on responses by non-institutionalized Medicare beneficiaries.
** Less than 1 percent
The percentages in this table may not sum to 100 due to rounding.

Table 3A shows the income range of all Medicare beneficiaries, by coverage type, in all geographic areas. For example, 25 percent of all Medicare beneficiaries with incomes between $10,000 and $20,000 in 2004 had Medigap policies.

Table 4A.
Income Range Of Medicare Beneficiaries, By Coverage Type (2004)
Metro Areas

Coverage Type	Income Range					
	Less than $10,000	$10,000 to $20,000	$20,000 to $30,000	$30,000 to $40,000	$40,000 to $50,000	More than $50,000
MEDIGAP	10%	22%	21%	23%	22%	24%
MEDICAID	47%	13%	1%	**	**	**
EMPLOYER-BASED	8%	22%	42%	48%	54%	56%
MEDICARE ADVANTAGE	14%	21%	19%	18%	14%	10%
OTHER PUBLIC	2%	3%	**	1%	**	**
MEDICARE ONLY	20%	19%	16%	10%	10%	9%
Total	100%	100%	100%	100%	100%	100%

Source: Medicare Current Beneficiary Survey Access to Care files, 2004 (CMS).
Note: Calculations based on responses by non-institutionalized Medicare beneficiaries.
** Less than 1 percent
The percentages in this table may not sum to 100 due to rounding.

Table 4A shows the income range of Medicare beneficiaries, by coverage type, who lived in metro areas in 2004. For example, 22 percent of Medicare beneficiaries who lived in metro areas in 2004 and had incomes between $10,000 and $20,000 had Medigap policies.

Table 5A.
Income Range Of Medicare Beneficiaries, By Coverage Type (2004)
Rural Areas

Coverage Type	Income Range					
	Less than $10,000	$10,000 to $20,000	$20,000 to $30,000	$30,000 to $40,000	$40,000 to $50,000	More than $50,000
MEDIGAP	17%	34%	32%	30%	29%	34%
MEDICAID	51%	14%	1%	1%	1%	1%
EMPLOYER-BASED	9%	23%	45%	52%	58%	53%
MEDICARE ADVANTAGE	0%	1%	1%	2%	1%	3%
OTHER PUBLIC	2%	2%	2%	1%	0%	**
MEDICARE ONLY	21%	26%	19%	15%	11%	10%
Total	100%	100%	100%	100%	100%	100%

Source: Medicare Current Beneficiary Survey Access to Care files, 2004 (CMS).
Note: Calculations based on responses by non-institutionalized Medicare beneficiaries.
** Less than 1 percent
The percentages in this table may not sum to 100 due to rounding.

Table 5A shows the income range of Medicare beneficiaries, by coverage type, who lived in rural areas in 2004. For example, 34 percent of Medicare beneficiaries who lived in rural areas in 2004 and had incomes between $10,000 and $20,000 had Medigap policies.

Table 6A.
United States - Active Choosers (2004)

	Medicare Only	Medicare Advantage	Medigap
All	29%	37%	34%
Geographic Location			
Rural Areas	38%	15%	47%
Metro Areas	29%	38%	33%
Race/Ethnicity			
Non-White	42%	43%	15%
White	36%	27%	37%
Education			
Less Than High School	34%	40%	26%
High School	26%	38%	36%
Some College / College Degree	28%	35%	37%
Income Range			
Less than $10,000	43%	36%	21%
$10,000 to $20,000	30%	40%	30%
$20,000 to $30,000	26%	40%	34%
$30,000 to $40,000	20%	41%	39%
$40,000 to $50,000	23%	37%	39%
More than $50,000	22%	28%	50%

Source: Medicare Current Beneficiary Survey Access to Care files, 2004 (CMS).
Note: Calculations based on responses by non-institutionalized Medicare beneficiaries who lived in areas with at least one Medicare Advantage plan. The percentages in this table may not sum to 100 due to rounding.

Table 6A shows the coverage choices made by "active choosers," which we define as Medicare beneficiaries who do not have employer-based coverage, do not qualify for Medicaid, and live in areas with at least one Medicare Advantage plan. These beneficiaries can choose among Medicare Advantage, Medigap, or Medicare alone. The table lists the distribution of coverage types by geographic location, race/ethnicity, education, and income range. For example, 47 percent of active choosers who lived in rural areas in 2004 had Medigap policies.

Table 7A.
Geographic Location Of Medigap Policyholders, By Type of Medigap Plan (2004)

Medigap Plan Type	Geographic Location		
	Rural	Metro	All Areas
Plan A	6%	6%	6%
Plan B	5%	6%	6%
Plan C	13%	21%	19%
Plan D	5%	7%	7%
Plan E	2%	2%	2%
Plan F	47%	39%	41%
Plan G	7%	4%	5%
Plan H	3%	3%	3%
Plan I	1%	2%	2%
Plan J	11%	10%	10%
Total	100%	100%	100%

Source: Medicare Current Beneficiary Survey Access to Care files, 2004 (CMS).
Note: Calculations based on responses by non-institutionalized Medicare beneficiaries.
The percentages in this table may not sum to 100 due to rounding.

Table 7A shows the geographic location of Medigap policyholders, by type of Medigap plan. For example, 47 percent of Medigap policyholders who lived in rural areas in 2004 had Medigap Plan F. Nationwide, 41 percent of Medigap policyholders had Medigap Plan F in 2004.

Table 8A.
Income Range Of Medigap Policyholders, By Medigap Plan Type (2004)

Medigap Plan Type	Income Range					
	Less than $10,000	$10,000 to $20,000	$20,000 to $30,000	$30,000 to $40,000	$40,000 to $50,000	More than $50,000
Plan A	6%	5%	7%	6%	2%	6%
Plan B	8%	7%	7%	2%	4%	3%
Plan C	26%	20%	19%	16%	13%	15%
Plan D	7%	7%	9%	4%	7%	4%
Plan E	0%	2%	1%	5%	1%	1%
Plan F	37%	40%	38%	45%	51%	42%
Plan G	2%	5%	5%	5%	9%	5%
Plan H	0%	4%	3%	2%	1%	4%
Plan I	0%	1%	3%	1%	4%	5%
Plan J	13%	9%	7%	13%	8%	16%
Total	100%	100%	100%	100%	100%	100%

Source: Medicare Current Beneficiary Survey Access to Care files, 2004 (CMS).
Note: Calculations based on responses by non-institutionalized Medicare beneficiaries.
The percentages in this table may not sum to 100 due to rounding.

Table 8A shows the income range of Medigap policyholders by type of Medigap plan. For example, 40 percent of Medigap policyholders with incomes between $10,000 and $20,000 in 2004 had Medigap Plan F.

Table 9A.
Medicare Beneficiaries Who Reported Receiving Specific Preventive Services In The Last Year, By Coverage Type (2004)

Coverage Type	Percent of Medicare Beneficiaries Who Reported Receiving These Preventive Services		
	Mammogram	Blood test for prostate cancer	Flu shot
MEDICARE ADVANTAGE	58%	75%	75%
MEDICAID	43%	45%	56%
EMPLOYER-BASED	61%	78%	75%
MEDIGAP	55%	75%	76%
OTHER PUBLIC	38%	59%	64%
MEDICARE ONLY	43%	59%	58%

Source: Medicare Current Beneficiary Survey Access to Care files, 2004 (CMS).
Note: Calculations based on responses by non-institutionalized Medicare beneficiaries.

Table 9A shows the percent of Medicare beneficiaries, by coverage type, who reported receiving certain preventive services in 2004. For example, 76 percent of Medigap policyholders received flu shots in 2004.

Table 10A.
Geographic Location Of Medigap Policyholders, By Marital Status (2004)

Marital Status	Geographic Location		
	Rural	Metro	All Areas
Married	57%	56%	57%
Widowed	35%	32%	33%
Divorced	6%	8%	7%
Separated	**	**	**
Never married	1%	4%	3%
Total	100%	100%	100%

Source: Medicare Current Beneficiary Survey Access to Care files, 2004 (CMS).
Note: Calculations based on responses by non-institutionalized Medicare beneficiaries.
** Less than one percent
The percentages in this table may not sum to 100 due to rounding.

Table 10A shows the percent of Medigap policyholders, by marital status, who resided in rural and metro areas in 2004. For example, 35 percent of Medigap policyholders who lived in rural areas in 2004 were widowed.

APPENDIX B
METHODOLOGY

This study's purpose was two-fold: (1) to describe the characteristics of Medicare beneficiaries with Medigap supplemental coverage; and (2) to compare Medigap policyholders' characteristics to those of Medicare beneficiaries with other types of supplemental coverage or no supplemental coverage. We describe Medicare beneficiaries by income range, geographic location (rural versus metro), education, and marital status. In addition, we describe the demographic characteristics of Medicare beneficiaries who purchased Medigap policies in 2004.

Data for this study came from the 2004 Medicare Current Beneficiary Survey (MCBS), Access to Care files, Centers for Medicare & Medicaid Services (CMS).

We selected a subset of the data, which included records of beneficiaries who were not institutionalized.

Each beneficiary record in the subset was categorized according to a hierarchy of six coverage types, as follows:

1. Enrolled in Medicare Advantage
2. Enrolled in Medicaid
3. Has employer-based insurance, or employer-based insurance and self-purchased insurance (Medigap)
4. Has self-purchased insurance only (Medigap)
5. Has other public coverage
6. Has Medicare only (Medicare fee-for-service only)

For example, the first coverage type included beneficiaries with Medicare Advantage, the second coverage type included beneficiaries with Medicaid, excluding beneficiaries who were also enrolled in Medicare Advantage, and so on. For beneficiaries categorized in the Medicare Advantage and Medicaid hierarchies, June 2004 was the point in time for which beneficiary records were selected for inclusion. It is worth noting that interviews for the Access to Care files occur once a year, while the MCBS Cost and Use files are based on responses to interviews that are conducted three times annually. Hence, the MCBS Access to Care files are more likely to be influenced by beneficiaries' gaps in care, and would therefore tend to show fewer beneficiaries with supplemental coverage than the MCBS Cost and Use files.

Category 3 includes beneficiaries with employer-based supplemental coverage and those with both employer-based coverage and Medigap plans. Category 4 contains beneficiaries with Medigap only. The "other public coverage" category (category 5) contains beneficiaries with supplemental health benefits through military or veterans' coverage, such as TRICARE. Beneficiaries in category 6 were found to have Medicare fee-for-service only, with no supplemental coverage.

The study also included an analysis of Medicare beneficiaries across the U.S. who did not have employer-based coverage, did not qualify for Medicaid, and resided in areas with at least one Medicare Advantage plan. These beneficiaries, called "active choosers," essentially had a clear-choice among Medicare Advantage, Medigap, or no supplemental coverage. We analyzed active choosers' selections of Medicare supplemental coverage by geographic location, race/ethnicity, educational level, and income range. Results of our analysis of active choosers in 2004 showed a basic consistency with the analysis conducted for our previous report, based on 2002 data.

In the MCBS dataset, Medicare beneficiaries were classified as residing in either rural (non-metropolitan) or metropolitan areas in 2004 based on CMS administrative data. CMS used information from the Office of Management and Budget to define a metropolitan statistical area (MSA), which is used to define the "metro" category in this report.[1]

The six race/ethnicity descriptions of beneficiaries provided in the MCBS dataset were re-grouped into two categories. The Non-White category was comprised of individuals who were identified via administrative records as being African-American, Asian, Hispanic, North American Natives or those designated as "Other." The White category contained only the race/ethnicity designation of "White."

As a general rule, all records in the MCBS dataset containing data values such as "unknown" or "refused" were dropped from the respective analyses.

[1] OMB Bulletin No. 05-02, Appendix, November 2004. Statistical and Science Policy Branch, Office of Information and Regulatory Affairs, Office of Management and Budget. MSAs … "have at least one urbanized area of 50,000 or more population, plus adjacent territory that has a high degree of social and economic integration with the core as measured by commuting ties."

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