UniCare Life & Health Insurance Company – Nevada

Administrative Office: P.O. Box 9063, Oxnard, CA 93031-9063 • Toll Free Telephone Number: 1-800-508-9355

OUTLINE OF MEDICARE SUPPLEMENT COVERAGE COVER PAGE BENEFIT PLANS A, D, F and PrimeChoice℠ Plans

Medicare supplement insurance can be sold in 12 standard plans plus two high deductible plans. This chart shows the benefits included in each plan. Every company must make available Plan "A." Some plans may not be available in your state. Benefit information for the PrimeChoice℠ plans begin on Page 12.

Basic Benefits: Included in All Plans.

- **Hospitalization**: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
- **Medical Expenses**: Part B coinsurance (generally 20% of Medicare-approved expenses) or, in the case of hospital outpatient department services paid under a prospective payment system, applicable copayments.
- **Blood**: First three pints of blood each year.

Plan A	B	C	D	E	F/F*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits
		Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible
					Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-home Recovery		
				Preventive Care NOT covered by Medicare	

* Plans F and J also have an option called a High Deductible Plan F and a High Deductible Plan J. These high deductible plans pay the same benefits as Plans F and J after one has paid a calendar year $1,860 deductible. Benefits from High Deductible Plans F and J will not begin until out-of-pocket expenses are $1,860. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

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Plan G	Plan H	Plan I	Plan J*	Plan K**	Plan L**
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	100% of Part A hospitalization coinsurance plus coverage for 365 days after Medicare benefits end 50% hospice cost sharing 50% of Medicare-eligible expenses for the first three pints of blood 50% Part B coinsurance, except 100% coinsurance for Part B preventive services	100% of Part A hospitalization coinsurance plus coverage for 365 days after Medicare benefits end 75% hospice cost sharing 75% of Medicare-eligible expenses for the first three pints of blood 75% Part B coinsurance, except 100% coinsurance for for Part B preventive services
Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	Skilled Nursing Facility Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	50% Part A Deductible	75% Part A Deductible
			Part B Deductible		
Part B Excess (80%)		Part B Excess (100%)	Part B Excess (100%)		
Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		
At-home Recovery		At-home Recovery	At-home Recovery		
			Preventive Care NOT covered by Medicare	$4,140 Out-of-Pocket Limit***	$2,070 Out-of-Pocket Limit***

* Plans F and J also have an option called a High Deductible Plan F and a High Deductible Plan J. These high deductible plans pay the same benefits as Plans F and J after one has paid a calendar year $1,860 deductible. Benefits from High Deductible Plans F and J will not begin until out-of-pocket expenses are $1,860. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

** Plans K and L provide for different cost sharing for items and services other than Plans A-J. Once you reach the annual limit, the plan pays 100% of the Medicare copayments, coinsurance and deductibles for the rest of the calendar year. The out-of-pocket annual limit does NOT include charges from your provider that exceed Medicare-approved amounts, called "Excess Charges." You will be responsible for paying excess charges.

*** The out-of-pocket annual limit will increase for each year for inflation.

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MEDICARE SUPPLEMENT COVERAGE

Outline of Coverage for Policy Form Series

NVA1001 - Standard Plan A
NVA5005 - Standard Plan D
NVA4004 - Standard Plan F
NV4004H2 - PrimeChoice℠ Plan
NV4004P2 - PrimeChoice Preferred Plan

Retain This Outline For Your Records

Premium Information

Your premium rate increases based upon your Attained Age. We will recalculate your age for each billing and your premium rate will be automatically increased based upon your Attained Age. UniCare can increase your premium if we raise our table of premium rates for all policies like yours in this state. This policy does not contain provisions providing for a refund of premium upon surrender or cancellation of the policy. If termination of this coverage results from the death of the insured, the insured's estate is entitled to a refund of the unused premium.

Disclosures

Use this outline to compare benefits and premiums among policies.

Read Your Policy Very Carefully

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

Right To Return Policy

If you find that you are not satisfied with your policy, you may return it to us at our Administrative Office: P.O. Box 9063, Oxnard, CA 93031-9063. If you send the policy back to us within 30 days after you receive it, we will treat the policy as if it had never been issued and return all of your payments.

Policy Replacement

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

Notice

This policy may not fully cover all of your medical cost. Neither UniCare nor its associates are connected with Medicare. This outline of coverage does not give all the details of Medicare coverage. Contact your local Social Security office or consult *"The Medicare Handbook"* for more details.

Complete Answers Are Very Important

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

STANDARD PLAN A
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

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

** **The plan pays all the costs that Medicare does not pay.**

Part A Services

Services	Medicare Pays	Standard Plan A Pays**	You Pay
Hospitalization*			
Semiprivate room and board, general nursing and miscellaneous hospital services and supplies:			
First 60 days	All but $992	$0	$992 (Part A Deductible)
61st through 90th day	All but $248 a day	$248 a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but $496 a day	$496 a day	$0
• Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare-eligible expenses	$0
— Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care*			
You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $124 a day	$0	Up to $124 a day
101st day and after	$0	$0	All costs
Blood			
First three pints	$0	three pints	$0
Additional amounts	100%	$0	$0
Hospice Care			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

STANDARD PLAN A
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $131 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Part B Services

Services	Medicare Pays	Standard Plan A Pays	You Pay
Medical Expenses — In or Out of the Hospital and Outpatient Hospital Treatment such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests and durable medical equipment			
First $131 of Medicare-approved amounts*	$0	$0	$131 (Part B Deductible)
Remainder of Medicare-approved amount	generally 80%	generally 20%	$0
Part B Excess Charges (Above Medicare-approved amounts)	$0	$0	All Costs
Blood			
First three pints	$0	All costs	$0
Next $131 of Medicare-approved amounts*	$0	$0	$131 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services — Tests for Diagnostic Services	100%	$0	$0

STANDARD PLAN A
PARTS A & B

*Once you have been billed $131 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Part A+B Services

Services	Medicare Pays	Standard Plan A Pays	You Pay
Home Healthcare Medicare-approved Services			
• Medically-necessary skilled care services and medical supplies	100%	$0	$0
• Durable medical equipment			
First $131 of Medicare-approved amounts*	$0	$0	$131 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0

STANDARD PLAN D
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

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

** **The plan pays all the costs that Medicare does not pay.**

Part A Services

Services	Medicare Pays**	Standard Plan D Pays**	You Pay
Hospitalization*			
Semiprivate room and board, general nursing and miscellaneous hospital services and supplies:			
First 60 days	All but $992	$992 (Part A Deductible)	$0
61st through 90th day	All but $248 a day	$248 a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but $496 a day	$496 a day	$0
• Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare-eligible expenses	$0
— Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care*			
You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $124 a day	Up to $124 a day	$0
101st day and after	$0	$0	All costs
Blood			
First three pints	$0	three pints	$0
Additional amounts	100%	$0	$0
Hospice Care			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

STANDARD PLAN D
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $131 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Part B Services

Services	Medicare Pays	Standard Plan D Pays	You Pay
Medical Expenses — In or Out of the Hospital and Outpatient Hospital Treatment such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests and durable medical equipment			
First $131 of Medicare-approved amounts*	$0	$0	$131 (Part B Deductible)
Remainder of Medicare-approved amount	generally 80%	generally 20%	$0
Part B Excess Charges (Above Medicare-approved amounts)	$0	$0	All Costs
Blood			
First three pints	$0	All costs	$0
Next $131 of Medicare-approved amounts*	$0	$0	$131 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services — Tests for Diagnostic Services	100%	$0	$0

STANDARD PLAN D
PARTS A & B

*Once you have been billed $131 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Part A+B Services

Services	Medicare Pays	Standard Plan D Pays	You Pay
Home Healthcare Medicare-approved Services			
• Medically-necessary skilled care services and medical supplies	100%	$0	$0
• Durable medical equipment			
First $131 of Medicare-approved amounts*	$0	$0	$131 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
At-home Recovery — Not Covered by Medicare Home care certified by your doctor, for personal care during recovery from an injury or sickness for which Medicare-approved a Home Care Treatment Plan:			
Benefit for each visit	$0	Actual charges up to $40 per visit	Balance
Number of visits covered (must be received within eight weeks of last Medicare-approved visits)	$0	Up to the number of Medicare-approved visits, not to exceed seven each week	Balance
Calendar year maximum	$0	$1,600	Balance

Other Benefits
Not covered by Medicare

Foreign Travel — Not Covered by Medicare Medically-necessary emergency care services beginning during the first 60 days of each trip outside the United States			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

STANDARD PLAN F
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

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

** **The plan pays all the costs that Medicare does not pay.**

Part A Services

Services	Medicare Pays**	Standard Plan F Pays***	You Pay
Hospitalization* Semiprivate room and board, general nursing and miscellaneous hospital services and supplies:			
First 60 days	All but $992	$992 (Part A Deductible)	$0
61st through 90th day	All but $248 a day	$248 a day	$0
91st day and after: • While using 60 lifetime reserve days	All but $496 a day	$496 a day	$0
• Once lifetime reserve days are used: — Additional 365 days	$0	100% of Medicare-eligible expenses	$0
— Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care* You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $124 a day	Up to $124 a day	$0
101st day and after	$0	$0	All costs
Blood			
First three pints	$0	three pints	$0
Additional amounts	100%	$0	$0
Hospice Care Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

STANDARD PLAN F
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

*Once you have been billed $131 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Part B Services

Services	Medicare Pays	Standard Plan F Pays	You Pay
Medical Expenses — In or Out of the Hospital and Outpatient Hospital Treatment such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests and durable medical equipment			
First $131 of Medicare-approved amounts*	$0	$131 (Part B Deductible)	$0
Remainder of Medicare-approved amount	generally 80%	generally 20%	$0
Part B Excess Charges (Above Medicare-approved amounts)	$0	100%	$0
Blood			
First three pints	$0	All costs	$0
Next $131 of Medicare-approved amounts*	$0	$131 (Part B Deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services — Tests for Diagnostic Services	100%	$0	$0

STANDARD PLAN F
PARTS A & B

*Once you have been billed $131 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Part A+B Services

Services	Medicare Pays	Standard Plan F Pays	You Pay
Home Healthcare Medicare-approved Services			
• Medically-necessary skilled care services and medical supplies	100%	$0	$0
• Durable medical equipment			
First $131 of Medicare-approved amounts*	$0	$131 (Part B Deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0

STANDARD PLAN F
OTHER BENEFITS — NOT COVERED BY MEDICARE

*Once you have been billed $131 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year.

Services	Medicare Pays	Standard Plan F Pays	You Pay
Other Benefits			
Foreign Travel — Not Covered by Medicare Medically-necessary emergency care services beginning during the first 60 days of each trip outside the United States			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PrimeChoice℠ Plan
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

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

** The plan pays the costs that Medicare does not pay after you pay the deductible.

*** This high deductible plan pays the same or offers the same benefits as Plan F after one has paid a calendar year $1,860 deductible. Benefits from the High Deductible Plan F will not begin until out-of-pocket expenses are $1,860. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

Part A Services

Services	Medicare Pays**	After You Pay $1,860 Deductible,* Plan Pays**	In Addition To $1,860 Deductible,* You Pay***
Hospitalization*			
Semiprivate room and board, general nursing and miscellaneous hospital services and supplies:			
First 60 days	All but $992	$992 (Part A Deductible)	$0
61st through 90th day	All but $248 a day	$248 a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but $496 a day	$496 a day	$0
• Once lifetime reserve days are used:			
— Additional 365 days	$0	100% of Medicare-eligible expenses	$0
— Beyond the additional 365 days	$0	$0	All costs
Skilled Nursing Facility Care*			
You must meet Medicare's requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	$0	$0
21st through 100th day	All but $124 a day	Up to $124 a day	$0
101st day and after	$0	$0	All costs
Blood			
First three pints	$0	three pints	$0
Additional amounts	100%	$0	$0
Hospice Care			
Available as long as your doctor certifies you are terminally ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and inpatient respite care	$0	Balance

PrimeChoice Plan
MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

* Once you have been billed $131 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B deductible will have been met for the calendar year. The $131 Part B deductible will be applied toward the annual deductible for the calendar year set forth in NAC 687B.311.

** The High Deductible Plan F offers benefits similar to the benefits offered by the Standard Plan F except that the high deductible plan requires the insured to pay a higher annual deductible. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $1,860 deductible. Benefits from the High Deductible Plan F will not begin until out-of-pocket expenses are $1,860. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

Part B Services

Services	Medicare Pays	After You Pay $1,860 Deductible,** Plan Pays	In Addition To $1,860 Deductible,** You Pay
Medical Expenses — In or Out of the Hospital and Outpatient Hospital Treatment such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests and durable medical equipment			
First $131 of Medicare-approved amounts*	$0	$131 (Part B Deductible)	$0
Remainder of Medicare-approved amount	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-approved amounts)	$0	100%	$0
Blood			
First three pints	$0	All costs	$0
Next $131 of Medicare-approved amounts*	$0	$131 (Part B Deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
Clinical Laboratory Services — Tests for Diagnostic Services	100%	$0	$0

PrimeChoice Plan
PARTS A & B

* Once you have been billed $131 of Medicare-approved amounts for covered services (which are noted with an asterisk), your Part B Deductible will have been met for the calendar year. The $131 Part B deductible will be applied toward the annual deductible for the calendar year set forth in NAC 687B.311.

** The High Deductible Plan F offers benefits similar to the benefits offered by the Standard Plan F except that the high deductible plan requires the insured to pay a higher annual deductible. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $1,860 deductible. Benefits from the High Deductible Plan F will not begin until out-of-pocket expenses are $1,860. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible.

Part A+B Services

Services	Medicare Pays	After You Pay $1,860 Deductible,** Plan Pays	In Addition To $1,860 Deductible,** You Pay
Home Healthcare Medicare-approved Services			
• Medically-necessary skilled care services and medical supplies	100%	$0	$0
• Durable medical equipment			
First $131 of Medicare-approved amounts*	$0	$131 (Part B Deductible)	$0
Remainder of Medicare-approved amounts	80%	20%	$0

PrimeChoice Plan
OTHER BENEFITS – NOT COVERED BY MEDICARE

Services	Medicare Pays	After You Pay $1,860 Deductible,* Plan Pays	In Addition To $1,860 Deductible,* You Pay
Foreign Travel – Not Covered By Medicare Medically-necessary emergency care services beginning during the first 60 days of each trip outside the United States			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

* This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $1,860 deductible. Benefits from the High Deductible Plan F will not begin until out-of-pocket expenses are $1,860. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. This includes the Medicare deductibles for Part A and Part B, but does not include the plan's separate foreign travel emergency deductible. (See Page 17 for additional information.)

PrimeChoice Preferred Plan – ADDITIONAL BENEFITS

In addition to the services covered under the PrimeChoice plan, your PrimeChoice Preferred plan also provides coverage for the following services, which are not subject to the calendar year plan deductible (unless otherwise noted).

Services	Medicare Pays	After You Pay $1,860 Deductible, Plan Pays	In Addition To $1,860 Deductible, You Pay
Medical Expenses – In or Out of the Hospital and Outpatient Hospital Treatment such as physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests and durable medical equipment			
First $131 of Medicare-approved amounts	$0	$131 (not subject to plan deductible)	$0
Remainder of Medicare-approved amount	generally 80%	generally 20%[1]	$0
Part B Excess Charges (Above Medicare-approved amounts)	$0	100%[1]	$0

Services	Medicare Pays	Plan Pays	You Pay
Physician Office Visits Unlimited Medicare-covered physician office visits. Copayment applies to specific procedural codes and charges for the physician office visits only. Services not considered part of an "office visit" include, but are not limited to, x-rays, laboratory work, surgery and any other medical service performed in the office. These services are subject to the calendar year deductible.	generally 80% after the $131 Part B deductible	generally 20% (less the $5 copayment)	$5 copayment for physician office visit[4]
Medicare-covered Chiropractic Services Manual manipulation of the spine to correct subluxation[2]	generally 80%	generally 20% (less the $10 copayment)	$10 copayment[4]
Vision Care Benefits–Not Covered by Medicare (Basic Vision Care through Vision Service Plan [VSP])	$0	100% coverage for one pair of standard eyeglass lenses and up to $75 for one pair of frames OR up to $95 for one pair of contact lenses per 24-month period. Remainder of eye exam.	$20 copayment for eye exam and remainder of frames or contact lenses[3]

[1] After you pay the required annual plan deductible.
[2] Provided such treatment is legal in the state where performed. Chiropractic Maintenance Therapy is not covered by this policy.
[3] There may be an additional charge if you select cosmetic lens options such as progressive multifocal lenses, lens coating and lens tinting.
[4] Once the plan deductible has been met, the copayment is waived.

UniCare is not connected with or endorsed by the U.S. Government or the federal Medicare program. Medical coverage is provided by UniCare Life & Health Insurance Company, a separately incorporated and capitalized subsidiary of WellPoint Inc.

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