



UniCare Life & Health Insurance Company – Arizona

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, F and PrimeChoiceSM Plans

Medicare supplement insurance can be sold in only 12 standard plans plus two high deductible plans. The PrimeChoice, PrimeChoice Plus and PrimeChoice Preferred are approved Medicare 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 begins on Page 10.

Medicare Disclosure: Your right to purchase other plans. You may replace your Medicare plan with any Medicare supplement plan we offer of comparable or lesser benefits. This offer does not require proof of good health.

- Basic Benefits:** Included in Plans A-J.
- **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 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 or offer 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, in Plans F and J, the plan’s separate foreign travel emergency deductible.

Plan G	H	I	J*	K**	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 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 or offer 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, in Plans F and J, the plan's separate foreign travel emergency deductible.

** Plans K and L provide for different cost sharing for items and other services 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.

PREMIUMS FOR MEDICARE SUPPLEMENT PLANS-ARIZONA Effective February 1, 2007

Non-Tobacco

Rate is determined by your age, tobacco usage and ZIP code.

Issue Age	Standard Plan A		Standard Plan F		PrimeChoice Plan		PrimeChoice Preferred Plan	
	Monthly Premium		Monthly Premium		Monthly Premium		Monthly Premium	
	Area 1	Area 2	Area 1	Area 2	Area 1	Area 2	Area 1	Area 2
65	\$ 98	\$ 90	\$ 140	\$ 150	\$ 25	\$ 24	\$ 45	\$ 42
66	100	94	144	155	26	24	46	43
67	104	96	148	159	27	25	48	44
68	107	99	153	164	28	26	49	45
69	110	101	157	168	29	26	51	47
70	113	105	162	174	36	33	64	59
71	117	108	167	179	37	34	66	61
72	121	111	172	185	38	35	68	63
73	124	114	177	190	39	36	70	65
74	128	118	182	195	40	37	72	67
75	131	121	187	201	46	43	81	75
76	134	124	192	206	47	44	83	76
77	138	128	197	211	49	45	85	78
78	142	131	202	217	50	46	87	80
79	145	134	207	222	51	47	89	82
80+	147	136	225	242	60	55	104	97

PrimeChoice Plus Chronic Care Rider - All Areas

Issue Age	65	66	67	68	69	70	71	72	73	74	75
Monthly Premium*	\$39	\$44	\$48	\$53	\$57	\$62	\$70	\$78	\$86	\$94	\$102

Area 1 includes areas with ZIP codes beginning with 850, 852-853, 855-857 and 864.

Area 2 includes all other ZIP codes in Arizona.

Rates for the Chronic Care Rider are based on Issue Age. Your premiums will always be based on the age you are when your policy is issued.

Your PrimeChoice Plus rate is your Chronic Care Rider monthly premium in addition to your PrimeChoice plan premium.

Tobacco

Issue Age	Standard Plan A		Standard Plan F		PrimeChoice Plan		PrimeChoice Preferred Plan	
	Monthly Premium		Monthly Premium		Monthly Premium		Monthly Premium	
	Area 1	Area 2	Area 1	Area 2	Area 1	Area 2	Area 1	Area 2
65	\$ 113	\$ 105	\$ 162	\$ 150	\$ 29	\$ 27	\$ 52	\$ 48
66	117	108	167	155	30	28	54	50
67	121	111	172	159	31	29	55	51
68	124	114	177	164	32	30	57	53
69	128	118	182	168	33	31	59	54
70	132	122	188	174	42	39	74	69
71	136	125	194	179	43	40	77	71
72	140	130	200	185	44	41	79	73
73	144	133	206	190	46	42	81	75
74	148	137	211	196	47	43	84	77
75	153	141	217	201	54	50	93	86
76	156	144	223	206	55	51	96	89
77	160	148	229	211	56	52	98	91
78	165	152	234	217	58	53	101	93
79	168	156	240	222	59	55	103	95
80+	170	158	261	242	69	64	121	112

Area 1 includes areas with ZIP codes beginning with 850, 852-853, 855-857 and 864.

Area 2 includes all other ZIP codes in Arizona.

Please Note: A one-time non-refundable \$5 processing fee will be added to your initial premium.

Your initial premium is for one month's payment and will be due upon enrollment. We will bill you bimonthly (every two months) thereafter, unless you return your Monthly Checking Account Deduction Authorization with your application, in which case we will deduct the amount automatically from your account.

Note: These plans are intended only for people age 65 or older who are enrolled in both Parts A and B of Medicare.

Methods of payment: Annual premiums are 12 times the monthly premiums stated.

Quarterly premiums are three times the monthly premiums stated.

Bimonthly premiums are two times the monthly premiums stated.

Please refer to the policy for a complete list of coverage, conditions, restrictions, limitations and exclusions.

MEDICARE SUPPLEMENT COVERAGE

Outline of Coverage for Policy Form Series

AZ0002A - Standard Plan A

AZ0002F - Standard Plan F

**AZ0002H - PrimeChoiceSM Plan
(High Deductible Plan F)**

AZ0002HP - PrimeChoiceSM Preferred Plan
Retain This Outline For Your Records

Premium Information

UniCare can increase your premium if we raise premium rates for all policies like yours in this state. Your premium rate is based upon your age at the time of application.

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 costs. 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 "*Medicare and You*" 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.

Limitations and Exclusions

We will not duplicate any benefits paid by Medicare, or pay for services which are not allowed by Medicare. There is no preexisting condition limitation. Benefits are only provided beginning after your effective date with the plan and while the policy is in force.

Refund of Premium

If you die while coverage under this policy is in effect, UniCare will refund the unearned portion of premium paid on a pro rata basis. However, if you choose to cancel, surrender or terminate your policy after the Free Look Period as noted in your policy, no refund will be paid for the unearned premium previously paid.

Complaints

We are certain that you will be completely satisfied with your UniCare plan, but if you should ever have a complaint or problem, please follow the Insured Grievance Procedure: Contact UniCare.

You can call us at 1-800-508-WELL.

You can write to us at:

P.O. Box 9063, Oxnard, CA 93031-9063.

Your grievance will be reviewed and you will receive a response within 30 days.

After you receive your policy, please feel free to contact your UniCare Authorized Agent or call us toll-free at 1-800-508-WELL.

**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 days in a row.

	Services	Medicare Pays	Standard Plan A Pays	You Pay
Part A Services	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 ¹
	91st day and after:			
	• While using 60 lifetime reserve days	All but \$496 a day	\$496 a day	\$0 ¹
	• Once lifetime reserve days are used:			
	— Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0 ^{1,2}
	— 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 ¹	
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 ¹	
Additional amounts	100%	\$0	\$0 ¹	
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	

¹ \$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

² NOTICE: When your Medicare Plan A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**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.

Services	Medicare Pays	Standard Plan A Pays	You Pay
Part B Services			
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 ¹
Part B Excess Charges (Above Medicare-approved amounts)	\$0	\$0	All Costs
Blood			
First three pints	\$0	All costs	\$0 ¹
Next \$131 of Medicare-approved amounts*	\$0	\$0	\$131 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0 ¹
Clinical Laboratory Services — Blood Tests for Diagnostic Services			
	100%	\$0	\$0 ¹

¹ \$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

**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.

Services	Medicare Pays	Standard Plan A Pays	You Pay	
Part A+B Services	Home Healthcare Medicare-approved Services			
	• Medically-necessary skilled care services and medical supplies	100%	\$0	\$0 ¹
	• Durable medical equipment			
	First \$131 of Medicare-approved amounts*	\$0	\$0	\$131 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	\$0 ¹	

¹ \$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

**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 days in a row.

Services	Medicare Pays	Standard Plan F Pays	You Pay	
Part A Services	Hospitalization*			
	Semiprivate room and board, general nursing and miscellaneous hospital services and supplies:			
	First 60 days	All but \$992	\$992 (Part A Deductible)	\$0 ¹
	61st through 90th day	All but \$248 a day	\$248 a day	\$0 ¹
	91st day and after:			
	• While using 60 lifetime reserve days	All but \$496 a day	\$496 a day	\$0 ¹
	• Once lifetime reserve days are used:			
	— Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0 ^{1,2}
	— 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 ¹
21st through 100th day	All but \$124 a day	Up to \$124 a day	\$0 ¹	
101st day and after	\$0	\$0	All costs	
Blood				
First three pints	\$0	three pints	\$0 ¹	
Additional amounts	100%	\$0	\$0 ¹	
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	

¹ \$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

² NOTICE: When your Medicare Plan A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy’s “Core Benefits.” During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid.

**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.

Services	Medicare Pays	Standard Plan F Pays	You Pay	
Part B Services 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 ¹
	Remainder of Medicare-approved amount	generally 80%	generally 20%	\$0 ¹
	Part B Excess Charges (Above Medicare-approved amounts)	\$0	100%	\$0 ¹
	Blood			
First three pints	\$0	All costs	\$0 ¹	
Next \$131 of Medicare-approved amounts*	\$0	\$131 (Part B Deductible)	\$0 ¹	
Remainder of Medicare-approved amounts	80%	20%	\$0 ¹	
Clinical Laboratory Services — Blood Tests for Diagnostic Services	100%	\$0	\$0 ¹	

¹ \$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

**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.

Services	Medicare Pays	Standard Plan F Pays	You Pay
Part A+B Services			
Home Healthcare Medicare-Approved Services			
• Medically-necessary skilled care services and medical supplies	100%	\$0	\$0 ¹
• Durable medical equipment			
First \$131 of Medicare-approved amounts*	\$0	\$131 (Part B Deductible)	\$0 ¹
Remainder of Medicare-approved amounts	80%	20%	\$0 ¹
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

¹ \$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

Part

A

Services

**PrimeChoiceSM Plan (High Deductible Plan F)
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**

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

Services	Medicare Pays	After You Pay \$1,860 Deductible,** Plan Pays	In Addition To \$1,860 Deductible,** You Pay
Hospitalization¹			
Semiprivate room and board, general nursing and miscellaneous hospital services and supplies:			
First 60 days	All but \$992	\$992 (Part A Deductible)	\$0 for covered expenses
61st through 90th day	All but \$248 a day	\$248 a day	\$0 for covered expenses
91st day and after:			
• While using 60 lifetime reserve days	All but \$496 a day	\$496 a day	\$0 for covered expenses
• Once lifetime reserve days are used:			
— Additional 365 days	\$0	100% of Medicare-eligible expenses	\$0 for covered expenses ²
— Beyond the additional 365 days	\$0	\$0	All costs
Skilled Nursing Facility Care¹			
You must meet Medicare’s requirements, including having been in a hospital for at least three days and entered a Medicare-approved facility within 30 days after leaving the hospital			
First 20 days	All approved amounts	\$0	\$0 for covered expenses
21st through 100th day	All but \$124 a day	Up to \$124 a day	\$0 for covered expenses
101st day and after	\$0	\$0	All costs
Blood			
First three pints	\$0	three pints	\$0 for covered expenses
Additional amounts	100%	\$0	\$0 for covered expenses
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

¹ 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 days in a row.

² NOTICE: When your Medicare Part A hospital benefits are exhausted, the insurer stands in the place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy’s “Core Benefits.” During this time, the hospital is prohibited from billing you for the balance based on any difference between its billed charges and the amount Medicare would have paid

**PrimeChoice Plan (High Deductible 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.
- ** 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
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 ¹	\$0	\$131 (Part B Deductible)	\$0 ²
Remainder of Medicare-approved amount	Generally 80%	Generally 20%	\$0 ²
Part B Excess Charges (Above Medicare-approved amounts)	\$0	100%	\$0 ²
Blood			
First three pints	\$0	All costs	\$0 ²
Next \$131 of Medicare-approved amounts ¹	\$0	\$131 (Part B Deductible)	\$0 ²
Remainder of Medicare-approved amounts	80%	20%	\$0 ²
Clinical Laboratory Services — Blood Tests for Diagnostic Services			
	100%	\$0	\$0 ²

¹ If Medicare Part B deductible has not already been met as part of the annual plan deductible, you pay the \$131 annual Medicare Part B deductible.

² \$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

PrimeChoice Plan (High Deductible Plan F)

PARTS A & B

* 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+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 ²
• Durable medical equipment			
First \$131 of Medicare-approved amounts ¹	\$0	\$131 (Part B Deductible)	\$0 ²
Remainder of Medicare-approved amounts	80%	20%	\$0 ²

¹ If Medicare Part B deductible has not already been met as part of the annual plan deductible, you pay the \$131 annual Medicare Part B deductible.

² \$0 indicates your liability for covered charges. You are responsible for all other non-covered charges.

PrimeChoice Plan (High Deductible Plan F)
OTHER BENEFITS — NOT COVERED BY MEDICARE

All benefits, except the foreign travel emergency deductible (a separate \$250 deductible), are subject to an annual \$1,860 deductible. This means that you pay applicable deductible and copayment amounts for Medicare-covered services until you have reached the policy \$1,860 deductible.

Expenses that would not satisfy the \$1,860 annual plan deductible include:

- Services not covered by Medicare
- Foreign Travel Emergency \$250 deductible

Foreign Travel – Not Covered By Medicare	Services	Medicare Pays	After You Pay \$1,860 Deductible,* Plan Pays	In Addition To \$1,860 Deductible,* You Pay
	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 (separate from the annual \$1,860 plan deductible)
	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 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.

**PrimeChoice Plus Plan (High Deductible Plan F)
CHRONIC CARE RIDER BENEFITS — NOT COVERED BY MEDICARE**

In addition to the services covered under the PrimeChoice plan, your PrimeChoice Plus plan also provides coverage for the following services. All Rider services are subject to the Combined Daily Benefit Amount of \$100. The same Combined Daily Benefit Amount applies to any combination of Rider services.

Services	Medicare Pays	PrimeChoice Plus Plan Pays	You Pay
Skilled Nursing Facility Care¹ Beyond first 100 days of Medicare-covered services and/or supplies	\$0	100% of covered charges (up to \$100 per day) for Skilled Nursing Facility Care*	All costs incurred beyond the covered maximum
Non-Skilled Nursing Facility Care¹ Non-skilled or custodial care in Skilled Nursing or Residential Facility	\$0	100% of covered charges (up to \$100 per day) for Non-Skilled Nursing and Residential Facility Care*	All costs incurred beyond the covered maximum
Home Healthcare Licensed home health services not covered by Medicare	\$0	100% of covered charges (up to \$100 per day)*	All costs incurred beyond the covered maximum
Home Support Care Home support and custodial care in the home	\$0	100% of covered charges (up to \$100 per day)*	All costs incurred beyond the covered maximum

- * Pays up to a lifetime maximum of \$36,500 after Rider Waiting Period (six months) and applicable Facility Elimination Period (100 days)** and/or Home Care Service deductible (\$1,000)*** has been met.
- ** Facility Elimination Period (100 days) must be met in addition to the Rider Waiting Period. Coordinated with Medicare-covered benefits. Needs to be met once over the lifetime of the policy.
- *** Home Care Service deductible (\$1,000) must be paid, in addition to meeting the Rider Waiting Period. Needs to be met once over the lifetime of the policy.

PrimeChoice Preferred Plan – ADDITIONAL BENEFITS

In addition to the services covered under the High Deductible Plan F, 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	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
Chiropractic Services	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	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.



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