UNICARE
A Healthy Dose of Innovation℠

UniCare Health Insurance Company of Texas

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, G, L and PrimeChoice℠ (High Deductible Plan F) 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℠ (High Deductible Plan F) plans begin on Page 15.

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 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 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 the plan's separate foreign travel emergency deductible.

Plan G	Plan H	Plan I	Plan J/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 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 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

TXPLANA - Standard Plan A
TXPLANF - Standard Plan F
TXPLANG 2/06 - Standard Plan G
TXPLANL 2/06 - Standard Plan L
TXPLANPC2 - PrimeChoice℠ Plan (High Deductible Plan F)
TX4004HP2 - PrimeChoice Preferred Plan (High Deductible Plan F)

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. Please refer to the enclosed premium reference sheet entitled "Premiums for Medicare Supplement Plans – Texas" for actual plan premiums, including information about when your premiums maybe increased.

Disclosures

Use this outline to compare benefits and premiums among policies.

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.

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.

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. If you choose to cancel, surrender or terminate your policy, any plan premiums received by UniCare for periods occurring after the effective date of that termination, less any amounts due to UniCare, will be refunded to you.

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.

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

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

† 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.

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

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

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

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.

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

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 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.

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

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

† 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.

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.

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

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.

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

	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**
	• Durable medical equipment			
	First $131 of Medicare-approved amounts*	$0	$131 (Part B Deductible)	$0**
	Remainder of Medicare-approved amounts	80%	20%	$0**
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 G
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.

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

Part A Services

Services	Medicare Pays	Standard Plan G 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

† 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.

STANDARD PLAN G
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.

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

Part B Services

Services	Medicare Pays	Standard Plan G 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	80%	20%
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 G
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.

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

	Services	Medicare Pays	Standard Plan G Pays	You Pay
Part A+B Services	**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**
Other Benefits **Not covered by Medicare**	**At-home Recovery Services–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 to $40 a visit	Balance
	• Number of visits covered (Must be received within eight weeks of last Medicare-approved visit)	$0	Up to the number of Medicare-approved visits, not to exceed seven each week	Balance
	• Calendar year maximum	$0	$1,600	Balance
	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 L
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* You will pay one-fourth of the cost sharing of some covered services until you reach the annual out-of-pocket limit of $2,070 each calendar year. The amounts that count toward your annual limit are noted with diamonds(◆) in chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **Howerver, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

** 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.

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

Part A Services

Services	Medicare Pays	Standard Plan L Pays	You Pay*
Hospitalization** Semiprivate room and board, general nursing and miscellaneous hospital services and supplies:			
First 60 days	All but $992	$744 (75% of Part A Deductible)	$248 (25% of 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 • Once lifetime reserve days are used:	All but $496 a day	$496 a day	$0***
— Additional 365 days	$0	100% of Medicare-eligible expenses	$0***†
— Beyond the additional 365 days	$0	$0	All costs

† 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.

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

* You will pay one-fourth of the cost sharing of some covered services until you reach the annual out-of-pocket limit of $2,070 each calendar year. The amounts that count toward your annual limit are noted with diamonds(◆) in chart below. Once you reach the annual limit, the plan pays 100% of your Medicare copayment and coinsurance for the rest of the calendar year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

** 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.

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

Part A Services

Services	Medicare Pays	Standard Plan L Pays	You Pay*
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 $93 a day	Up to $31 a day◆
101st day and after	$0	$0	All costs
Blood			
First three pints	$0	75%	25%◆
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	Generally, most Medicare-eligible expenses for outpatient drugs and inpatient respite care	75% of coinsurance or copayments	25% of coinsurance or copayments◆

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

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

**** 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 L 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)****◆
Preventive Benefits for Medicare	Generally 75% or more of Medicare-approved amounts	Remainder of Medicare-approved amounts	All costs above Medicare-approved amounts
Remainder of Medicare-approved amount	Generally 80%	Generally 15%	Generally 5%◆
Part B Excess Charges (Above Medicare-approved amounts)	$0	$0	All costs (and they do not count toward annual out-of-pocket limit of $2,070)*
Blood			
First three pints	$0	75%	25%◆
Next $131 of Medicare-approved amounts****	$0	$0	$131 (Part B Deductible)◆
Remainder of Medicare-approved amounts	Generally 80%	Generally 15%	Generally 5%◆
Clinical Laboratory Services — Tests for Diagnostic Services	100%	$0	$0***

* This plan limits your annual out-of-pocket payments for Medicare-approved amounts to $2,070 per year. **However, this limit does NOT include charges from your provider that exceed Medicare-approved amounts (these are called "Excess Charges") and you will be responsible for paying this difference in the amount charged by your provider and the amount paid by Medicare for the item or service.**

STANDARD PLAN L
PARTS A & B

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

**** 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 L 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%	15%	5%◆

Part A Services

PrimeChoice℠ Plan (High Deductible 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.

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

	Services	Medicare Pays	After You Pay $1,860 Deductible‡, Plan Pays	In Addition To $1,860 Deductible‡, You Pay
Hospitalization[1]	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 • Once lifetime reserve days are used:	All but $496 a day	$496 a day	$0**
	— 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

† 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.

‡ **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 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.

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

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**

‡ **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 Plan (High Deductible 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.

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

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**

‡ **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 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

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 (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 Preferred Plan (High Deductible Plan F) – 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	**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.
‡ **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.**

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