

SecureHorizons® Medicare Supplement Plans

North Carolina Outline of Coverage and Premium Information

The following information provides more details about SecureHorizons® Medicare Supplement plans. Please review this information carefully to determine which plan best meets your needs.

- **Plan A**
- **Plan C**
- **Plan F**
- **Plan High Deductible F**
- **Plan G**
- **Plan J**

Underwritten by

PacifiCare®
Life and Health Insurance Company

IMS-OUT-5NC

SecureHorizons®
by UnitedHealthcare

NORTH CAROLINA
NC 4/07

PacifiCare Life and Health Insurance Company
 Outline of Medicare Supplement Insurance Coverage

Benefit Plans A, C, F, High Deductible F, G and J are available (Highlighted Below)

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

See Outline of Coverage sections for details about ALL plans

Basic Benefits:	For Plans A-J
Hospitalization:	Medicare 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 copayments for hospital outpatient services
Blood:	First three pints of blood each year

Plan A	Plan B	Plan C	Plan D	Plan E	Plan F	F*	Plan G	Plan H	Plan I	Plan J	J*
Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	Basic Benefits	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		Skilled Nursing Facility Coinsurance	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 A Deductible	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible
		Part B Deductible			Part B Deductible						Part B Deductible
					Part B Excess (100%)		Part B Excess (80%)		Part B Excess (100%)		Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency
			At-Home Recovery				At-Home Recovery		At-Home Recovery		At-Home Recovery
				Preventive Care (Not covered by Medicare)							Preventive Care (Not covered by Medicare)

Plans Available

* 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 \$2,000 Deductible. Benefits from High Deductible Plans F and J will not begin until out-of-pocket expenses exceed \$2,000. Out-of-pocket expenses for this Deductible are expenses that would ordinarily be paid by the policy. These expenses include the Medicare deductibles for Parts A and B, but do not include the plan's separate foreign travel emergency deductible.

PacifiCare Life and Health Insurance Company
 Outline of Medicare Supplement Insurance Coverage

Benefit Plans K and L

Basic Benefits for Plans K and L include similar services as Plans A–J, but cost-sharing for the Basic Benefits is at different levels.

Plan J	Plan K**	Plan L**
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 Coinsurance	50% Skilled Nursing Facility Coinsurance	75% Skilled Nursing Facility Coinsurance
Part A Deductible	50% Part A Deductible	75% Part A Deductible
Part B Deductible		
Part B Excess (100%)		
Foreign Travel Emergency		
At-Home Recovery		
Preventive Care NOT Covered by Medicare		
	\$4,620 Out-of-Pocket Annual Limit***	\$2,310 Out-of-Pocket Annual Limit***

Plans Available

*** Plans K and L provide for different cost-sharing for items and 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 each year for inflation.*

See Outline of Coverage for details and exceptions.

Medicare Supplement Plan Premium Information

We, PacifiCare Life and Health Insurance Company, can only raise your premium if we raise the premium for all policies like yours in this state (once per twelve month period).

We may change your premium on the renewal date following Medicare deductible and/or coinsurance changes. Your premium will automatically increase when you attain the next higher age bracket.

Premiums for other Medicare supplement policies that are on issue age bases do not increase as the insured ages. Other Medicare supplement policies that are on issue age bases should be compared to policies on attained age bases.

After the first one month's payment, the term of this coverage is for one month, if you have chosen monthly premium payments. If you prepay this coverage on a quarterly, semi-annual or annual basis, the term of the coverage will be the period prepaid. The policy renews automatically, subject to the right of PacifiCare Life and Health Insurance Company to change premium charges.

State of North Carolina. Rates effective 4/1/09.

Area 1

*MONTHLY PREMIUM TABLE – NON-TOBACCO						
ATTAINED AGE	PLAN A	PLAN C	PLAN F	PLAN F+	PLAN G	PLAN J
Under 65	\$257.32	\$328.01	N/A	N/A	N/A	\$326.29
65	\$108.35	\$139.23	\$141.59	\$ 53.30	\$121.72	\$138.82
66	\$108.35	\$139.23	\$141.59	\$ 53.30	\$121.72	\$138.82
67	\$113.99	\$145.13	\$147.49	\$ 57.83	\$126.68	\$144.59
68	\$119.63	\$151.03	\$153.39	\$ 62.37	\$131.65	\$150.38
69	\$124.15	\$159.29	\$160.47	\$ 66.91	\$136.62	\$157.33
70	\$128.66	\$165.19	\$167.55	\$ 71.44	\$144.07	\$164.26
71	\$135.43	\$171.09	\$173.44	\$ 77.11	\$149.04	\$170.05
72	\$139.95	\$179.34	\$181.70	\$ 81.65	\$155.25	\$178.14
73	\$145.59	\$185.24	\$187.60	\$ 87.32	\$160.22	\$183.93
74	\$147.85	\$188.78	\$191.14	\$ 89.59	\$162.70	\$187.40
75	\$151.23	\$192.32	\$194.68	\$ 92.99	\$166.43	\$190.87
76	\$153.49	\$194.68	\$197.04	\$ 95.26	\$170.15	\$193.19
77	\$155.75	\$199.40	\$201.76	\$ 97.52	\$172.64	\$197.81
78	\$159.13	\$202.94	\$205.30	\$100.93	\$175.12	\$201.28
79	\$161.39	\$206.48	\$208.84	\$103.19	\$178.85	\$204.75
80	\$173.80	\$221.82	\$224.18	\$115.67	\$192.51	\$219.79
81	\$177.19	\$225.36	\$227.72	\$119.07	\$194.99	\$223.26
82	\$179.45	\$228.90	\$232.44	\$122.47	\$198.72	\$227.88
83	\$182.83	\$232.44	\$235.98	\$125.87	\$201.20	\$231.35
84	\$186.22	\$237.16	\$240.70	\$129.28	\$204.93	\$235.98
85+	\$188.48	\$241.88	\$245.42	\$132.68	\$209.90	\$240.61

*To obtain quarterly, semi-annual or annual premium, multiply the monthly premium by 3, 6 or 12, respectively.

State of North Carolina. Rates effective 4/1/09.

Area 1

*MONTHLY PREMIUM TABLE – TOBACCO						
ATTAINED AGE	PLAN A	PLAN C	PLAN F	PLAN F+	PLAN G	PLAN J
Under 65	\$295.92	\$377.21	N/A	N/A	N/A	\$375.23
65	\$124.60	\$160.11	\$162.83	\$ 61.30	\$139.98	\$159.64
66	\$124.60	\$160.11	\$162.83	\$ 61.30	\$139.98	\$159.64
67	\$131.09	\$166.90	\$169.61	\$ 66.50	\$145.68	\$166.28
68	\$137.57	\$173.68	\$176.40	\$ 71.73	\$151.40	\$172.94
69	\$142.77	\$183.18	\$184.54	\$ 76.95	\$157.11	\$180.93
70	\$147.96	\$189.97	\$192.68	\$ 82.16	\$165.68	\$188.90
71	\$155.74	\$196.75	\$199.46	\$ 88.68	\$171.40	\$195.56
72	\$160.94	\$206.24	\$208.96	\$ 93.90	\$178.54	\$204.86
73	\$167.43	\$213.03	\$215.74	\$100.42	\$184.25	\$211.52
74	\$170.03	\$217.10	\$219.81	\$103.03	\$187.11	\$215.51
75	\$173.91	\$221.17	\$223.88	\$106.94	\$191.39	\$219.50
76	\$176.51	\$223.88	\$226.60	\$109.55	\$195.67	\$222.17
77	\$179.11	\$229.31	\$232.02	\$112.15	\$198.54	\$227.48
78	\$183.00	\$233.38	\$236.10	\$116.07	\$201.39	\$231.47
79	\$185.60	\$237.45	\$240.17	\$118.67	\$205.68	\$235.46
80	\$199.87	\$255.09	\$257.81	\$133.02	\$221.39	\$252.76
81	\$203.77	\$259.16	\$261.88	\$136.93	\$224.24	\$256.75
82	\$206.37	\$263.24	\$267.31	\$140.84	\$228.53	\$262.06
83	\$210.25	\$267.31	\$271.38	\$144.75	\$231.38	\$266.05
84	\$214.15	\$272.73	\$276.81	\$148.67	\$235.67	\$271.38
85+	\$216.75	\$278.16	\$282.23	\$152.58	\$241.39	\$276.70

*To obtain quarterly, semi-annual or annual premium, multiply the monthly premium by 3, 6 or 12, respectively.

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 your insurance company.

Right to Return Policy

If you find that you are not satisfied with your policy, you may return it to our home office, P.O. Box 12466, Pensacola, FL 32591-2466, or to our administrator. 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 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 PacifiCare Life and Health Insurance Company nor any of its agents 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 a new policy, be sure to answer truthfully and completely all questions about your medical and health history. The Company may have the right to 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.

Plan A

Medicare (Part A) – Hospital Services – Per Benefit Period

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

Services	Medicare Pays	SecureHorizons Plan A Pays	You Pay
Hospitalization*			
Semi-private room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but \$1,068	\$0	\$1,068 (Part A Deductible)
61st through 90th day	All but \$267 a day	\$267 a day	\$0
91st day and after: <i>While using 60 lifetime reserve days</i>	All but \$534 a day	\$534 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 3 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 \$133.50 a day	\$0	Up to \$133.50 a day
101st day and after	\$0	\$0	All costs
Blood			
First three pints	\$0	3 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.

Plan A

Medicare (Part B) – Medical Services – Per Calendar Year

* Once you have been billed \$135 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	SecureHorizons 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 \$135 of Medicare Approved Amounts*	\$0	\$0	\$135 (Part B Deductible)
Remainder of Medicare Approved Amounts	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 \$135 of Medicare Approved Amounts*	\$0	\$0	\$135 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
Clinical Laboratory Services			
Tests for diagnostic services	100%	\$0	\$0
Parts A and B			
Home Health Care – Medicare Approved Services			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment First \$135 of Medicare Approved Amounts*	\$0	\$0	\$135 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

Plan C

Medicare (Part A) – Hospital Services – Per Benefit Period

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

Services	Medicare Pays	SecureHorizons Plan C Pays	You Pay
Hospitalization*			
Semi-private room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but \$1,068	\$1,068 (Part A Deductible)	\$0
61st through 90th day	All but \$267 a day	\$267 a day	\$0
91st day and after: <i>While using 60 lifetime reserve days</i>	All but \$534 a day	\$534 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 3 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 \$133.50 a day	Up to \$133.50 a day	\$0
101st day and after	\$0	\$0	All costs
Blood			
First three pints	\$0	3 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.

Plan C

Medicare (Part B) – Medical Services – Per Calendar Year

* Once you have been billed \$135 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	SecureHorizons Plan C 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 \$135 of Medicare Approved Amounts*	\$0	\$135 (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	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 \$135 of Medicare Approved Amounts*	\$0	\$135 (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0
Clinical Laboratory Services			
Tests for diagnostic services	100%	\$0	\$0
Parts A and B			
Home Health Care – Medicare Approved Services			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment First \$135 of Medicare Approved Amounts*	\$0	\$135 (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 U.S.A.			
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

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.

Services	Medicare Pays	SecureHorizons Plan F Pays	You Pay
Hospitalization*			
Semi-private room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but \$1,068	\$1,068 (Part A Deductible)	\$0
61st through 90th day	All but \$267 a day	\$267 a day	\$0
91st day and after: <i>While using 60 lifetime reserve days</i>	All but \$534 a day	\$534 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 3 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 \$133.50 a day	Up to \$133.50 a day	\$0
101st day and after	\$0	\$0	All costs
Blood			
First three pints	\$0	3 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.

Plan F

Medicare (Part B) – Medical Services – Per Calendar Year

* Once you have been billed \$135 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	SecureHorizons 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 \$135 of Medicare Approved Amounts*	\$0	\$135 (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	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 \$135 of Medicare Approved Amounts*	\$0	\$135 (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0
Clinical Laboratory Services			
Tests for diagnostic services	100%	\$0	\$0
Parts A and B			
Home Health Care – Medicare Approved Services			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment First \$135 of Medicare Approved Amounts*	\$0	\$135 (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 U.S.A.			
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

Plan F High Deductible

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 benefits as Plan F after one has paid a calendar year \$2,000 Deductible. Benefits from the High Deductible Plan F will not begin until out-of-pocket expenses are \$2,000. 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 \$2,000 Deductible** SecureHorizons Plan F Pays	In Addition To \$2,000 Deductible** You Pay
Hospitalization*			
Semi-private room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but \$1,068	\$1,068 (Part A Deductible)	\$0
61st through 90th day	All but \$267 a day	\$267 a day	\$0
91st day and after: <i>While using 60 lifetime reserve days</i>	All but \$534 a day	\$534 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 3 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 \$133.50 a day	Up to \$133.50 a day	\$0
101st day and after	\$0	\$0	All costs
Blood			
First three pints	\$0	3 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.

Plan F High Deductible

Medicare (Part B) – Medical Services – Per Calendar Year

* Once you have been billed \$135 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 benefits as Plan F after one has paid a calendar year \$2,000 Deductible. Benefits from the High Deductible Plan F will not begin until out-of-pocket expenses are \$2,000. 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 \$2,000 Deductible** SecureHorizons Plan F Pays	In Addition To \$2,000 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 \$135 of Medicare Approved Amounts*	\$0	\$135 (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	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 \$135 of Medicare Approved Amounts*	\$0	\$135 (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0
Clinical Laboratory Services			
Tests for diagnostic services	100%	\$0	\$0
Parts A and B			
Home Health Care – Medicare Approved Services			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment First \$135 of Medicare Approved Amounts*	\$0	\$135 (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 U.S.A.			
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

Plan G

Medicare (Part A) – Hospital Services – Per Benefit Period

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

Services	Medicare Pays	SecureHorizons Plan G Pays	You Pay
Hospitalization*			
Semi-private room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but \$1,068	\$1,068 (Part A Deductible)	\$0
61st through 90th day	All but \$267 a day	\$267 a day	\$0
91st day and after: <i>While using 60 lifetime reserve days</i>	All but \$534 a day	\$534 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 3 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 \$133.50 a day	Up to \$133.50 a day	\$0
101st day and after	\$0	\$0	All costs
Blood			
First three pints	\$0	3 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.

Plan G

Medicare (Part B) – Medical Services – Per Calendar Year

* Once you have been billed \$135 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	SecureHorizons 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 \$135 of Medicare Approved Amounts*	\$0	\$0	\$135 (Part B Deductible)
Remainder of Medicare Approved Amounts	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 \$135 of Medicare Approved Amounts*	\$0	\$0	\$135 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0
Clinical Laboratory Services			
Tests for diagnostic services	100%	\$0	\$0
Parts A and B			
Home Health Care – Medicare Approved Services			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment First \$135 of Medicare Approved Amounts*	\$0	\$0	\$135 (Part B Deductible)
Remainder of Medicare Approved Amounts	80%	20%	\$0

Plan G

Medicare (Part B) – Medical Services – Per Calendar Year

Services	Medicare Pays	SecureHorizons Plan G Pays	You Pay
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 up to \$40 a visit	Balance
Number of visits covered (must be received within 8 weeks of last Medicare-approved visit)	\$0	Up to the number of Medicare-approved visits, not to exceed 7 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 U.S.A.			
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

Plan J

Medicare (Part A) – Hospital Services – Per Benefit Period

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

Services	Medicare Pays	SecureHorizons Plan J Pays	You Pay
Hospitalization*			
Semi-private room and board, general nursing, and miscellaneous services and supplies			
First 60 days	All but \$1,068	\$1,068 (Part A Deductible)	\$0
61st through 90th day	All but \$267 a day	\$267 a day	\$0
91st day and after: <i>While using 60 lifetime reserve days</i>	All but \$534 a day	\$534 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 3 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 \$133.50 a day	Up to \$133.50 a day	\$0
101st day and after	\$0	\$0	All costs
Blood			
First three pints	\$0	3 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.

Plan J

Medicare (Part B) – Medical Services – Per Calendar Year

* Once you have been billed \$135 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	SecureHorizons Plan J 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 \$135 of Medicare Approved Amounts*	\$0	\$135 (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	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 \$135 of Medicare Approved Amounts*	\$0	\$135 (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0
Clinical Laboratory Services			
Tests for diagnostic services	100%	\$0	\$0
Parts A and B			
Home Health Care – Medicare Approved Services			
Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable medical equipment First \$135 of Medicare Approved Amounts*	\$0	\$135 (Part B Deductible)	\$0
Remainder of Medicare Approved Amounts	80%	20%	\$0

Plan J

Medicare (Part B) – Medical Services – Per Calendar Year

Services	Medicare Pays	SecureHorizons Plan J Pays	You Pay
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 up to \$40 a visit	Balance
Number of visits covered (must be received within 8 weeks of last Medicare-approved visit)	\$0	Up to the number of Medicare-approved visits, not to exceed 7 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 U.S.A.			
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
Preventive Medical Care Benefit – Not Covered by Medicare			
Some annual physical and preventive tests and services administered or ordered by your doctor when not covered by Medicare			
First \$120 each calendar year	\$0	\$120	\$0
Additional charges	\$0	\$0	All costs

Notes

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