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.**

UNICARE®

A Healthy Dose of Innovation℠

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

7567TX 1/07

Enrolling is Simple.
Just Follow These 3 Easy Steps…

Step 1

COMPLETE THE APPLICATION IN BLUE OR BLACK INK. Be sure you follow the instructions on the application carefully. We have tried to make the instructions easy to follow. If you have any questions, or you are not sure how to answer a question, simply contact our health insurance department at: (818) 654-4548 (818) 776-9865

Step 2

SELECT THE TYPE OF BILLING YOU WANT – monthly (by checking account deduction), or quarterly (every three months).

Step 3

SEND THE COMPLETED APPLICATION TO:

Oleg Skurskiy

18375 Ventura Blvd. #226

Tarzana , CA 91356

Please make your check payable to: UniCare of Texas

We will be in contact with you upon receipt of your completed application. We will also keep you advised of the underwriting status.

If you have questions please contact our office at: (818) 654-4548

UNICARE®

UniCare Health Insurance Company of Texas
APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE

For Seniors with Medicare Parts A and B

UNICARE Texas

Section 1 – Choice of Coverage

Please check the box for your choice of Medicare supplement coverage:

☐ Standard Plan A ☐ Standard Plan G ☐ PrimeChoice℠ Plan (High Deductible Plan F)
☐ Standard Plan F ☐ Standard Plan L ☐ PrimeChoice℠ Preferred Plan (High Deductible Plan F)

Section 2 – Applicant Information

This complete original application will be returned to you, for your records, along with your policy when you are enrolled.

Please copy the information from your Medicare card here ⇩

NAME OF BENEFICIARY (Applicant):	CLAIM NUMBER:	SEX:

IS ENTITLED TO: EFFECTIVE DATE:

HOSPITAL INSURANCE: _____

MEDICAL INSURANCE: _____

Requested effective date or end date of prior Medicare supplement, if replacing: _____ /_____ /_____

Name (as it appears on your Medicare card): _____

Social Security Number: |___|___|___|___|___|___|___|___|___| Date of Birth: _____

Home Address, Apt. No., Suite No.: _____

City: _____ County: _____ State: _____ ZIP: _____

Home Telephone Number: _____

Billing Address (if different from home address): _____

City: _____ County: _____ State: _____ ZIP: _____

Care of/Attention: _____

If transferring from another UniCare Group/Individual or UniCare out-of-state plan, indicate:

Group Number: _____ State: _____ Policy Number: |___|___|___|___|___|___|___|___|___|

Section 3 – Billing Information

❑ Annual ❑ Quarterly ❑ Bimonthly ❑ Monthly (Checking Account Deduction Only)

UniCare Use Only

Broker Number: _____ H/S: ☐ Yes ☐ No

Amount Received: $ _____

Group Number: _____ Policy Number: _____

Effective Date: _____ X Re. Cert. Number: _____

Insert check face up. Please submit one month's premium for your Medicare supplement plan, plus an additional one-time non-refundable $5 processing fee.

Please make check or money order for premium payable to UniCare.

Applicant: Please return application to agent or to the mailing address below.

UniCare Health Insurance Company of Texas,
Administrative Office, P.O. Box 9063, Oxnard, CA 93031-9063

Section 4 – Health History

THIS SECTION MUST BE COMPLETED BY APPLICANT (If you are applying during open enrollment period or if you are eligible for guaranteed issue, you do not need to complete this section.)

Check the box next to any conditions that apply to you.

	Yes	No
1. Are you currently confined or has confinement been recommended to a bed, hospital, nursing facility or other care facility, or do you need the assistance of a wheelchair for any daily activity?	❑	❑
2. Within the past two years, have you been hospitalized two or more times or been confined to a nursing home for a total of two weeks or longer?	❑	❑
3. Within the past two years, have you been advised to have surgery which has not yet been done?	❑	❑
4. Within the past five years, have you been told you had, consulted for treatment, sought treatment, had treatment recommended, received treatment, been hospitalized for, or taken or been advised by a physician to take prescription drugs (excluding drugs for high blood pressure) for the following conditions:		
a. Heart conditions including, but not limited to, heart attack, open heart surgery, placement of pacemaker, heart valve replacement, angioplasty, aneurysm, congestive heart failure, enlarged heart, cardiovascular heart disease, coronary artery disease or stroke?	❑	❑
b. Alzheimer's disease, Parkinson's disease, senile dementia, organic brain disorder or other senility disorders?	❑	❑
c. Any respiratory condition including, but not limited, to Chronic Obstructive Pulmonary Disease (COPD) or emphysema (excluding allergies and asthma)?	❑	❑
d. Internal cancer, leukemia, Hodgkin's disease, insulin dependent diabetes, chronic kidney disease, kidney/renal failure, kidney/renal dialysis, cirrhosis of the liver, organ transplant (except cornea), amputation or joint replacement due to disease?	❑	❑
5. Have you ever been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)?	❑	❑

List all prescription drugs currently prescribed for your use: (If none, write "none.") _____

_____

List name, address and telephone number of prescribing physician, if different from below:_____

_____

_____

Applicant's Initials: _____

Section 5 – Medical Information

Name of Primary Care Physician: _____ Telephone: (_____)_____

Address: _____

Section 6 – General Information

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. **PLEASE ANSWER ALL QUESTIONS.** Please mark "Yes" or "No" below with an "X" to the best of your knowledge.

Did you turn age 65 in the last six months? ❑ Yes ❑ No

Did you enroll in Medicare Part B in the last six months? ❑ Yes ❑ No

If yes, what is the effective date? _____

Are you covered for medical assistance through the state Medicaid program? ❑ Yes ❑ No
(NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer "NO" to this question.)

If "YES:"

Will Medicaid pay your premiums for this Medicare supplement policy? ❑ Yes ❑ No

Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium? ❑ Yes ❑ No

Are you covered as a Specified Low-Income Medicare Beneficiary (SLMB)? ❑ Yes ❑ No

Are you covered as a Qualified Medicare Beneficiary (QMB)? ❑ Yes ❑ No

If you had coverage from any Medicare plan other than Original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank. START: ____/____/____ END: ____/____/____

If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? ❑ Yes ❑ No

Was this your first type of Medicare plan? ❑ Yes ❑ No

Did you drop a Medicare supplement policy to enroll in the Medicare plan? ❑ Yes ❑ No

Do you have another Medicare supplement policy in force? ❑ Yes ❑ No

If so, with what company and what plan do you have?_____

If so, do you intend to replace your current Medicare supplement policy with this policy? ❑ Yes ❑ No

---

Receipt for funds received

Date: _____ Amount: _____

Name: _____

Social Security Number:_____

Account: _____ Check Number: _____

Policy Description: _____

Received By: _____

This is a receipt for cash received only. This receipt does not guarantee insurance coverage.

Section 6 – General Information (continued)

Have you had coverage under any health insurance within the past 63 days? (For example, an employer, union or individual plan.) ❑ Yes ❑ No

If so, with what company and what kind of policy?_____

What are your dates of coverage under the other policy?
START: ____/____/____ END: ____/____/____
(If you are still covered under the other policy, leave "END" blank.)

Do you now or have you during the past five years used any tobacco products, including cigarettes, pipes, cigars or chewing tobacco? ❑ Yes ❑ No

Section 7 – Eligible Persons for Guaranteed Issue

The following describes the conditions for guaranteed issue. Please note that specific time frames and evidence of term or disenrollment from a previous health plan may be required.

1. The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare and the plan terminates or ceases to provide all such supplemental health benefits to the individual or the individual is enrolled under an employee welfare benefit plan that is primary to Medicare and the plan terminates or ceases to provide all health benefits to the individual because the individual leaves the plan.

- Have you been terminated from or voluntarily disenrolled from an employee welfare benefit plan? ❑ Yes ❑ No

2. The individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare and any of the following circumstances apply or the individual is 65 years of age or older and is enrolled with a Program of All-Inclusive Care for the Elderly (PACE) provider under section 1894 of the Social Security Act and there are circumstances similar to the following that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a Medicare Advantage plan:

A. The certification of the organization or plan has been terminated; or

B. The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides; or

C. The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in section 1851(g)(3)(B) of the Social Security Act (where the individual has not paid premiums on a timely basis or has engaged in disruptive behavior as specified in standards under section 1856) or the plan is terminated for all individuals within a residence area; or

D. The individual demonstrates, in accordance with guidelines established by the Secretary, that:

(i) The organization offering the plan substantially violated a material provision of the organization's contract under U.S.C. Title 42, Chapter 7, Subchapter XVIII, Part D in relation to the individual, including the failure to provide an individual on a timely basis medically-necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards; or

(ii) The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or

E. The individual meets such other exceptional conditions as the Secretary may provide.

- Have you been terminated from or voluntarily disenrolled from a Medicare Advantage plan or a Program of All-Inclusive Care for the Elderly (PACE)? ❑ Yes ❑ No

3. The individual is enrolled with an entity listed below and enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under Paragraph (2):

A. An eligible organization under a contract under section 1876 of the Social Security Act (Medicare cost); or

B. A similar organization operating under demonstration project authority, effective for periods before April 1, 1999; or

C. An organization under an agreement under section 1833(a)(1)(A) of the Social Security Act (healthcare prepayment plan); or

D. An organization under a Medicare Select policy.

- Have you been terminated from or voluntarily disenrolled from an eligible organization under a contract under section 1876 of the Social Security Act (Medicare cost) or a similar organization operating under demonstration project authority or an organization under an agreement under section 1833(a)(1)(A) of the Social Security Act (healthcare prepayment plan) or an organization under a Medicare Select policy? ❑ Yes ❑ No

4. The individual is enrolled under a Medicare supplement policy and the enrollment ceases because:

A. Of the insolvency of the issuer or bankruptcy of the non-issuer organization or of other involuntary termination of coverage or enrollment under the policy; or

B. The issuer of the policy substantially violated a material provision of the policy; or

C. The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual; or

- Did your Medicare supplement policy enrollment cease due to involuntary termination of coverage by the issuer or the issuer substantially violated a material provision of the policy or the issuer materially misrepresented the policy's provisions? ❑ Yes ❑ No

5. The individual was enrolled under a Medicare supplement policy, and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, any eligible organization under a contract under section 1876 of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under section 1894 of the Social Security Act or a Medicare Select policy and the subsequent enrollment is terminated by the individual during any period within the first 12 months of such subsequent enrollment (during which the individual is permitted to terminate such subsequent enrollment under section 1851(e) of the Social Security Act); or

- Have you disenrolled from a Medicare supplement policy and subsequently disenrolled from a Medicare Advantage plan within 12 months of enrollment, for the first time? ❑ Yes ❑ No

6. The individual, upon first becoming enrolled in Medicare Part B for benefits at age 65 or older, enrolls in a Medicare Advantage plan under Part C of Medicare or with a PACE provider under section 1894 of the Social Security Act and disenrolls from the plan or program no later than 12 months after the effective date of enrollment.

- Have you disenrolled from a Medicare Advantage plan within 12 months of enrollment, for the first time? ❑ Yes ❑ No

Section 7 – Eligible Persons for Guaranteed Issue (continued)

7. The individual enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that covers outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D, along with the application for a policy described in subsection (c)(4) of this section.
8. The individual loses eligibility for health benefits under Title XIX of the Social Security Act (Medicaid).

Section 8 – Conditions of Application

Please read the following carefully.

1. I agree to pay an application fee equal to the premiums required for the plan requested on this application and that this payment will be returned to me if my application is rejected or will be applied to the premiums if my application is accepted.
2. UniCare will not reject my application if it is submitted during the six-month period beginning in the first month after I first enrolled in Medicare Part B or during the period which I am an eligible person for guaranteed issue. If my application is not received during the open enrollment or guaranteed issue period, UniCare has the right to reject my application. If UniCare rejects my application, I will be notified in writing and any application fees submitted with this application will be refunded. I understand and agree that if UniCare rejects my application, under no circumstances will any UniCare benefits be payable. **Cashing of my check by UniCare does not constitute approval of my application.**
3. If my application is accepted, this application will become part of the agreement between UniCare and myself.
4. The selling agent has no authority to promise me coverage or to modify UniCare underwriting policies or terms of any UniCare coverage.
5. I alone am responsible for reading and accurately completing this application. I have left nothing out regarding my past or present health. I understand that I am not eligible for any benefits if any information requested on this application, **even information about my Medicare coverage**, is false, incomplete or omitted and that UniCare may void all coverage from the original effective date of the policy for material misstatements or omissions.

Notice to Applicant

1. You do not need more than one Medicare supplement policy.
2. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need more than one type of coverage in addition to your Medicare benefits.
3. You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
4. If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient drug coverage but will otherwise be substantially equivalent to your coverage before the date of the suspension.

5. If you are eligible for and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage but will otherwise be substantially equivalent to your coverage before the date of suspension.
6. Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

Section 9 – Authorization and Agreements

CONDITIONED AUTHORIZATION TO USE OR OBTAIN MEDICAL INFORMATION FOR ENROLLMENT OR TO PAY CLAIMS

Name	ID Number	Phone

Address (Street, City, State, ZIP)

Protected Health Information (PHI) to be Used and/or Disclosed: Any and all information or records relating to the medical history, medical examinations, services rendered or treatment given, including treatment for alcohol abuse, substance abuse, mental or emotional disorders, AIDS (Acquired Immune Deficiency Syndrome) or ARC (AIDS-related complex).

Entities or Persons Authorized to Use or Disclose: The United States Department of Health and Human Services (including the Centers for Medicare & Medicaid Services and any contractors or agents, including Medicare intermediaries), any physician or other healthcare professional, hospital or other healthcare facility, counselor, therapist or any other medical or medically-related facility or professional.

Entities or Persons Authorized to Receive: UniCare Health Insurance Company of Texas or affiliate ("UniCare"), its agents, employees, designees or representatives, including my UniCare agent or broker.

***Purpose of this Authorization:** By signing this form, you will authorize us to use and/or disclose your Protected Health Information (PHI) to determine if you will be enrolled in our health plan or are eligible for benefits, or for underwriting or risk rating your enrollment or eligibility. This authorization is a condition of your enrollment in our health plan or your eligibility for benefits.

Obtain your Protected Health Information (PHI) from other covered entities so that we may determine payment of a claim for specified benefits involving you.

***Effect of Declining**: If you decide not to sign this authorization, we may decline to enroll you in our health plan or to give you the benefits. This PHI used or disclosed may be subject to redisclosure by the recipient, in which case it would no longer be protected under the HIPAA Privacy Rule.

*Not applicable during open enrollment or guaranteed issue periods.

Section 9 – Authorization and Agreements (continued)

This authorization is a condition of our paying the claim.

Effect of Granting this Authorization: The PHI used or disclosed may be subject to redisclosure by the recipient, in which case it would no longer be protected under the HIPAA Privacy Rule.

Expiration: This authorization will expire upon the termination of any UniCare coverage that may be in effect.

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to:

UniCare Health Insurance Company of Texas
PO. Box 9063
Oxnard, CA 93031-9063
Telephone 800-508-9355, Fax 805-375-0361

I understand that revocation of this authorization will not effect any action you took in reliance on this authorization before you received my written notice of revocation.

I have had full opportunity to read and consider the contents of this authorization and I understand that by signing this authorization I am confirming my authorization of the use and/or disclosure of my Protected Health Information, as described in this authorization.

x _____ x _____ _____

Print Name | Signature | Date

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

_____ _____

Personal Representative: Print Name | Relationship to Individual

x _____ _____

Signature | Date

A photocopy of this authorization is as valid as the original and my UniCare agent or broker and I are entitled to receive a copy of this form. YOU ARE ENTITLED TO A COPY OF THIS AUTHORIZATION AFTER YOU SIGN IT.

■ I understand and agree to the Replacement Notification, the Disclosure Statement (only for Medicare SELECT applicants), Conditions of Application and the Authorization. I acknowledge receipt of the "Guide to Health Insurance for People with Medicare" and "Outline of Medicare Supplement Coverage and Premium Information" as required. I understand that receipt of money with this application does not create UniCare Health Insurance Company of Texas coverage. Coverage will come into effect only if this application is approved by UniCare Health Insurance Company of Texas.

■ I, the applicant, acknowledge that I have read and understand this application in its entirety and realize that any false statement or misrepresentation in the application may result in loss of coverage under the policy.

x _____ x _____

Applicant's Signature | Date of Signature

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to the information you have furnished, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by UniCare. Your new policy will provide 30 days within which you may decide without cost whether you desire to keep the policy. For your own information and protection you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT, BROKER OR OTHER REPRESENTATIVE:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason (check one):

❑ Additional benefits.
❑ Fewer benefits and lower premiums.
❑ My plan has outpatient prescription drug coverage and I am enrolling in Medicare Part D.
❑ Other. (Please specify.) _____

❑ No change in benefits, but lower premiums.
❑ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.
_____

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____
Typed Name and Address of Agent

_____

_____ _____ _____ _____
Signature of Agent | Date | Applicant's Signature | Date

For Agent Only

Please list any other health insurance policies or coverages you have sold to the applicant which are still in force and any other health insurance policies or coverages you have sold to the applicant in the past five years which are no longer in force. Please submit with the application, as required:

Date:	Name of Policy:	Name and Address of Insurance Company:
From: _____ Mo./Yr.	_____	Name: _____
To: _____ Mo./Yr.		Address: _____
		City/State: _____

(Attach additional sheets, if necessary.)

I have read and understand the application. I additionally certify that I have given the "Guide to Health Insurance for People with Medicare," an outline of coverage for the policy applied for and that the applicant has both Parts A and B of Medicare. The applied for policy will not duplicate any health insurance coverage. I have requested and received documentation that indicates that the applied for policy will not duplicate any coverage. I have verified the information in the Replacement Notification Section.

Agent's Signature	Date of Signature	(City and State)
OLEG SKURSKIY	BCLNGNPVMZ	
Print Agent's Name		Agent Number
18375 VENTURA BLVD 226		818-654-4548
Street Address		Telephone Number
TARZANA, CA 91356		
City	State	ZIP

Premium Amount: $_____

Send Policy and ID Card To: ❑ Agent ☒ Insured

The ID card will be sent to the insured in a separate mailing.

Optional Monthly Checking Account Deduction Authorization

As a convenience to me, I request and authorize you to pay and charge to my account checks drawn on that account by and payable to the order of UniCare Health Insurance Company of Texas, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such debt shall be the same as if it were a check drawn on you and signed personally by me. I authorize UniCare to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my UniCare premiums. This authority is to remain in effect until revoked by me in writing or verbally and until you actually receive such notice, I agree that you shall be fully protected in honoring any such debt. I further agree that if any such debt be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance.

Please attach a blank check marked "VOID."

Insured:	Social Security Number:
	Bank Name:
x Date:	x Date:

Authorized signature(s) as it/they appear in the financial institution's records. All authorized persons must sign.