

Four New Secure Horizons Medicare Supplement Plans

OUTLINE OF COVERAGE

The following information provides more details about Secure Horizons new Medicare Supplement Plans.

Please review this information carefully to determine which plan best meets your needs.

Plan **A**

Plan **C**

Plan **F**

Plan **G**

Outline of Medicare Supplement Coverage Benefit Plans A, C, F and G are offered

Medicare Supplement insurance can be sold in only ten standard plans. This chart shows the benefits included in each plan. Every insurance company must offer Plan "A". Some plans may not be available.

The Basic Benefits:	Included in ALL plans
Hospitalization:	Medicare Part A coinsurance plus coverage for 365 additional days after Medicare benefits end
Medical Expenses:	Medicare Part B coinsurance (usually 20% of Medicare Approved Amounts)
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
		Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing Coinsurance	Skilled Nursing 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 B Deductible			Part B Deductible				Part B Deductible
					Part B Excess (100%)	Part B Excess (80%)		Part B Excess	Part B Excess
		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
							Basic Drugs (\$1,250 Limit)	Basic Drugs (\$1,250 Limit)	Basic Drugs (\$3,000 Limit)
				Preventive Care					Preventive Care

■ Benefits Offered by Secure Horizons

Please see the premium information insert in the back pocket for monthly plan premium rates in your area.

* 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 \$1,620 deductible. Benefits from high deductible plans F and J will not begin until out-of-pocket expenses are \$1,620. 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 B, but do not include, in Plan J, the plan's separate prescription drug deductible or, in Plans F and J, the plan's separate foreign travel emergency deductible.

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Read Your Policy 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.

Thirty Day Right to Return This Policy

If, after you first sign up for Secure Horizons Medicare Supplement coverage, you find that you are not satisfied with your policy, you may return it to PacifiCare Life & Health Insurance Company, 3100 Lake Center Drive, Santa Ana, CA 92704. 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 your initial payment.

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.

Disclosures

Your policy may not fully cover all of your medical costs.

Neither this 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.

For additional information concerning policy benefits, contact the Health Insurance Counseling and Advocacy Program (HICAP) or your agent. Call the HICAP toll-free telephone number, 1-800-434-0222, for a referral to your local HICAP office. HICAP is a service provided free of charge by the State of California.

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. Secure Horizons 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.

* When physician does not accept Medicare Assignment, the physician cannot bill for more than 115% of the Medicare Approved Charge. In this example, you would pay \$200.

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Example of Policy Coverage

This is a brief description of how Secure Horizons Medicare Supplement Plan A, Plan C, Plan F and Plan G work. Medicare pays the Medicare Approved Amount first, then your Medicare Supplement plan pays as described in the example below.

For this example, assume you have already met your yearly Medicare Part B deductible (\$100) and the physician charge is \$2,000 for a Medicare covered service.

Plan A and Plan C Doctor accepts Medicare Assignment	
Total Charged to You by Your Physician	\$2,000
Medicare Approved Amount	\$1,800
Medicare pays 80% of Approved Amount	\$1,440
Secure Horizons pays	\$ 360
You pay	Nothing

Plan A and Plan C Doctor does not accept Medicare Assignment	
Total Charged to You by Your Physician	\$2,000
Medicare Approved Amount	\$1,800
Medicare pays 80% of Approved Amount	\$1,440
Secure Horizons pays	\$ 360
You pay	\$ 200*

If you enroll in Plan F:

In the example above, you pay nothing for Part B covered services. Plan F pays the difference between the Medicare Approved Amount and the amount charged by the physician.

If you enroll in Plan G:

You pay nothing if the physician provides the service for the Medicare Approved Amount. If your physician does not accept Medicare Assignment, you pay 20% of the difference between the Medicare Approved Amount and your physician's charge. In the example above, you would pay \$40 (\$2,000 - \$1,800 = \$200 x 20% = \$40).

Plan A

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

SERVICES	MEDICARE PAYS	SECURE HORIZONS PLAN A PAYS	YOU PAY
HOSPITALIZATION*			
Semi-private room and board, general nursing and miscellaneous services and supplies			
▪ First 60 days	All but \$840	\$0	\$840 (Part A Deductible)
▪ 61st through 90th day	All but \$210 a day	\$210 a day	\$0**
▪ 91st day and after: <i>While using 60 lifetime reserve days</i>	All but \$420 a day	\$420 a day	\$0**
▪ Once lifetime reserve days are used: <i>Additional 365 days</i>	\$0	100% of Medicare Eligible Expenses	Any Additional Costs
▪ <i>Beyond the Additional 365 days</i>	\$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 \$105 a day	\$0	Up to \$105 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 ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and respite care	\$0	Balance

*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.

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

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Plan A

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

SERVICES	MEDICARE PAYS	SECURE HORIZONS 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 \$100 of Medicare Approved Amounts [†] (the Part B Deductible)	\$0	\$0	\$100 (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 \$100 of Medicare Approved Amounts [†]	\$0	\$0	\$100 (Part B Deductible)
▪ Remainder of Medicare Approved Amounts	80%	20%	\$0**
CLINICAL LABORATORY SERVICES			
▪ Blood tests for diagnostic services	100%	\$0	\$0**
Parts A & B			
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
▪ Medically necessary skilled care services and medical supplies	100%	\$0	\$0**
▪ Durable medical equipment <i>First \$100 of Medicare Approved Amounts[†]</i>	\$0	\$0	\$100 (Part B Deductible)
▪ Remainder of Medicare Approved Amounts	80%	20%	\$0**

[†] Once you have been billed \$100 of Medicare Approved Amounts for covered services (which are noted with a cross[†]), your Part B Deductible will have been met for the calendar year.

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

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Plan C

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

SERVICES	MEDICARE PAYS	SECURE HORIZONS PLAN C PAYS	YOU PAY
HOSPITALIZATION*			
Semi-private room and board, general nursing and miscellaneous services and supplies			
▪ First 60 days	All but \$840	\$840 (Part A Deductible)	\$0**
▪ 61st through 90th day	All but \$210 a day	\$210 a day	\$0**
▪ 91st day and after: <i>While using 60 lifetime reserve days</i>	All but \$420 a day	\$420 a day	\$0**
▪ Once lifetime reserve days are used: <i>Additional 365 days</i>	\$0	100% of Medicare Eligible Expenses	Any Additional Costs
▪ <i>Beyond the Additional 365 days</i>	\$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 \$105 a day	Up to \$105 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 ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and respice care	\$0	Balance

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

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 \$100 of Medicare Approved Amounts [†] (the Part B Deductible)	\$0	\$100 (Part B Deductible)	\$0**
▪ Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0**

*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.

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

[†] Once you have been billed \$100 of Medicare Approved Amounts for covered services (which are noted with a cross[†]), your Part B Deductible will have been met for the calendar year.

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Plan C

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

SERVICES	MEDICARE PAYS	SECURE HORIZONS PLAN C PAYS	YOU PAY
▪ Part B Excess Charges (Above Medicare Approved Amounts)	\$0	\$0	All Cost
BLOOD			
▪ First three pints	\$0	All Costs	\$0**
▪ Next \$100 of Medicare Approved Amounts [†]	\$0	\$100 (Part B Deductible)	\$0**
▪ Remainder of Medicare Approved Amounts	80%	20%	\$0**
CLINICAL LABORATORY SERVICES			
▪ Blood tests for diagnostic services	100%	\$0	\$0**
Parts A & B			
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
▪ Medically necessary skilled care services and medical supplies	100%	\$0	\$0**
▪ Durable medical equipment <i>First \$100 of Medicare Approved Amounts[†]</i>	\$0	\$100 (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 during the first 60 days of each trip outside the USA			
▪ 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

[†] Once you have been billed \$100 of Medicare Approved Amounts for covered services (which are noted with a cross[†]), your Part B Deductible will have been met for the calendar year.

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

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Plan F

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

SERVICES	MEDICARE PAYS	SECURE HORIZONS PLAN F PAYS	YOU PAY
HOSPITALIZATION*			
Semi-private room and board, general nursing and miscellaneous services and supplies			
▪ First 60 days	All but \$840	\$840 (Part A Deductible)	\$0**
▪ 61st through 90th day	All but \$210 a day	\$210 a day	\$0**
▪ 91st day and after: <i>While using 60 lifetime reserve days</i>	All but \$420 a day	\$420 a day	\$0**
▪ Once lifetime reserve days are used: <i>Additional 365 days</i>	\$0	100% of Medicare Eligible Expenses	Any Additional Costs
▪ <i>Beyond the Additional 365 days</i>	\$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 \$105 a day	Up to \$105 a day	\$0**
▪ 101st day and after	\$0	\$0	All Cost
BLOOD			
▪ First three pints	\$0	3 pints	\$0**
▪ Additional amounts	100%	\$0	\$0**
HOSPICE CARE			
Available as long as your doctor certifies you are ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and respite care	\$0	Balance

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

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 \$100 of Medicare Approved Amounts [†] (the Part B Deductible)	\$0	\$100 (Part B Deductible)	\$0**

*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.

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

[†] Once you have been billed \$100 of Medicare Approved Amounts for covered services (which are noted with a cross[†]), your Part B Deductible will have been met for the calendar year.

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Plan F

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

SERVICES	MEDICARE PAYS	SECURE HORIZONS PLAN F PAYS	YOU PAY
▪ 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 \$100 of Medicare Approved Amounts [†]	\$0	\$100 (Part B Deductible)	\$0**
▪ Remainder of Medicare Approved Amounts	80%	20%	\$0**
CLINICAL LABORATORY SERVICES			
▪ Blood tests for diagnostic services	100%	\$0	\$0**
Parts A & B			
HOME HEALTH CARE MEDICARE APPROVED SERVICES			
▪ Medically necessary skilled care services and medical supplies	100%	\$0	\$0**
▪ Durable medical equipment <i>First \$100 of Medicare Approved Amounts[†]</i>	\$0	\$100 (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 during the first 60 days of each trip outside the USA			
▪ 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

[†] Once you have been billed \$100 of Medicare Approved Amounts for covered services (which are noted with a cross[†]), your Part B Deductible will have been met for the calendar year.

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

IMS-OUT

Plan G

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

SERVICES	MEDICARE PAYS	SECURE HORIZONS PLAN G PAYS	YOU PAY
HOSPITALIZATION*			
Semi-private room and board, general nursing and miscellaneous services and supplies			
▪ First 60 days	All but \$840	\$840 (Part A Deductible)	\$0**
▪ 61st through 90th day	All but \$210 a day	\$210 a day	\$0**
▪ 91st day and after: <i>While using 60 lifetime reserve days</i>	All but \$420 a day	\$420 a day	\$0**
▪ Once lifetime reserve days are used: <i>Additional 365 days Beyond the Additional 365 days</i>	\$0	100% of Medicare Eligible Expenses	Any Additional Costs
	\$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 \$105 a day	Up to \$105 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 ill and you elect to receive these services	All but very limited coinsurance for outpatient drugs and respite care	\$0	Balance

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

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 \$100 of Medicare Approved Amounts [†] (the Part B Deductible)	\$0	\$0	\$100 (Part B Deductible)
▪ Remainder of Medicare Approved Amounts	Generally 80%	Generally 20%	\$0**

*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.

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

[†] Once you have been billed \$100 of Medicare Approved Amounts for covered services (which are noted with a cross[†]), your Part B Deductible will have been met for the calendar year.

IMS-OUT

Plan G

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

SERVICES	MEDICARE PAYS	SECURE HORIZONS PLAN G PAYS	YOU PAY
▪ Part B Excess Charges (Above Medicare Approved Amounts)	\$0	80% Part B Excess Charges	20%
BLOOD			
▪ First three pints	\$0	All Costs	\$0**
▪ Next \$100 of Medicare Approved Amounts [†]	\$0	\$0	\$100 (Part B Deductible)
▪ Remainder of Medicare Approved Amounts	80%	20%	\$0**
CLINICAL LABORATORY SERVICES			
▪ Blood tests for diagnostic services	100%	\$0	\$0**

Parts A & B

HOME HEALTH CARE MEDICARE APPROVED SERVICES			
▪ Medically necessary skilled care services and medical supplies	100%	\$0	\$0**
▪ Durable medical equipment <i>First \$100 of Medicare Approved Amounts[†]</i>	\$0	\$0	\$100 (Part B Deductible)
▪ 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 during the first 60 days of each trip outside the USA			
▪ 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

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

[†] Once you have been billed \$100 of Medicare Approved Amounts for covered services (which are noted with a cross[†]), your Part B Deductible will have been met for the calendar year.

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

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