

No Lifetime Plan Maximum

Annual Plan Deductible Options

\$0 • \$100 • \$150 • \$250 • \$500 • \$750 • \$1000 • \$1500 • \$2000 • \$2500 • \$3000 • \$4000

MEDICARE PART A

Hospitalization

Semi-private room and board, general nursing and miscellaneous services and supplies.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
First 60 days	All but \$1,100	\$1,100 - Part A Deductible	\$0 After You Have Satisfied Your Annual Plan Deductible
Days 61 through 90	All but \$275 per day	\$275 per day	
Days 91 through 150 (60 lifetime reserve days)	All but \$550 per day	\$550 per day	
Additional 365 days	\$0	100% of Medicare Eligible Expenses	
<i>Private Duty Nursing Benefits Available with Seniors Choice Optional Plans</i>			

Skilled Nursing Facility

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.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
First 20 days	All approved amounts	\$0	\$0 After You Have Satisfied Your Annual Plan Deductible
Days 21 through 100	All but \$137.50 per day	Up to \$137.50 per day	
Days 101 and after	\$0	\$0	100%
<i>Additional Skilled Nursing Facility Benefits Available with Seniors Choice Optional Plans</i>			

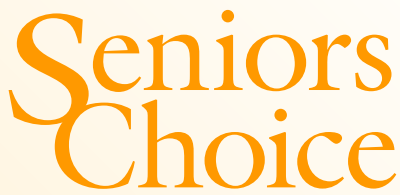
Blood

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
First 3 pints	\$0	100%	\$0 After You Have Satisfied Your Annual Plan Deductible
Additional amounts	100%	\$0	

**All Medicare deductibles are included in plan deductible(s).
 Co-payments apply after the Annual Plan Deductible has been satisfied.**

Medical Coverage Underwritten by Guarantee Trust Life Insurance Company
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For more information, contact Seniors Choice at 1-800-800-6543 or visit www.seniorschoiceplan.com.



2010 Seniors Choice Group Retiree Medical Plan Benefits



MEDICARE PART B

Medical Services

In or Out of the Hospital and Outpatient Hospital Treatment - All Part B Services covered after Annual Plan Deductible has been satisfied and the co-payment amount has been paid. Medicare Part B deductible is included in Annual Plan Deductible.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
First \$155 of Medicare approved amounts	\$0	\$155	*Co-pay After You Have Satisfied Your Annual Plan Deductible
Remainder of Medicare approved amounts	80%	20%	
Part B Excess Charges - above Medicare approved amounts	\$0	100%	
Medical Services Co-payment Amounts by Service			
Doctor's Office Visit per visit			\$10 Co-pay
X-rays or Lab Work in Doctor's Office per visit			\$10 Co-pay
X-rays or Lab Work in Outpatient Facility per visit			\$20 Co-pay
Outpatient Services per visit			\$20 Co-pay
Emergency Room Professional Services per visit (Non-Hospital Admission)			\$100 Co-pay
Durable Medical Equipment			\$10 Co-pay
*Co-payments apply after the Annual Plan Deductible has been satisfied.			

Blood

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
First 3 pints	\$0	100%	\$0 After You Have Satisfied Your Annual Plan Deductible
Additional amounts	80%	20%	

Clinical Laboratory Services

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
Blood tests for Diagnostic Services	80%	20%	\$0 After You Have Satisfied Your Annual Plan Deductible

MEDICARE PARTS A & B

Home Health Services

Covered when provided by a Medicare certified Home Health Agency.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
Limited to reasonable and necessary part-time or intermittent skilled care	100%	\$0	\$0 After You Have Satisfied Your Annual Plan Deductible
Health equipment not limited to hospital beds, oxygen and medical supplies for use at home	80%	20%	

At Home Recovery Benefits Available with Seniors Choice Optional Plans

Foreign Travel Emergency Care

Benefits provided for Medicare approved expenses during first 60 days of a trip outside USA. After a \$250 calendar year deductible, Seniors Choice Plan pays at 80%, up to \$50,000 lifetime maximum.

2010 New Business Group Retiree Medical Monthly Plan Rates

For Groups with effective dates beginning 10/1/09

Monthly Administration Fee is an additional \$8.00 per member per month.

Underwritten By:



Guarantee Trust Life Insurance Company

Plan Deductible:	\$0	\$100	\$150	\$250	\$500	\$750	\$1,000	\$1,500	\$2,000	\$2,500	\$3,000	\$4,000
AREA 1 - Washington Zip code 982												
Age - 65	\$125.91	\$116.77	\$112.27	\$106.58	\$93.96	\$83.38	\$73.61	\$58.51	\$46.98	\$38.62	\$32.45	\$25.05
66 - 69	\$137.35	\$127.38	\$122.47	\$116.28	\$102.50	\$90.95	\$80.29	\$63.83	\$51.25	\$42.14	\$35.39	\$27.33
70 - 74	\$169.54	\$159.41	\$154.26	\$147.95	\$133.33	\$120.58	\$108.53	\$89.43	\$74.36	\$63.00	\$54.27	\$43.01
75 - 79	\$200.08	\$189.61	\$184.16	\$177.57	\$161.88	\$147.88	\$134.42	\$112.75	\$95.29	\$81.81	\$71.25	\$57.06
80 - 84	\$244.97	\$233.85	\$227.87	\$220.52	\$202.92	\$186.93	\$171.47	\$145.99	\$125.00	\$108.41	\$95.22	\$76.80
85 +	\$261.96	\$250.54	\$244.34	\$236.51	\$218.00	\$201.20	\$184.98	\$158.06	\$135.72	\$117.96	\$103.80	\$83.81
AREA 2 - Washington Zip codes All Other												
Age - 65	\$144.80	\$134.28	\$129.11	\$122.57	\$108.06	\$95.89	\$84.65	\$67.28	\$54.02	\$44.42	\$37.31	\$28.81
66 - 69	\$157.95	\$146.49	\$140.85	\$133.72	\$117.88	\$104.60	\$92.34	\$73.41	\$58.94	\$48.46	\$40.70	\$31.44
70 - 74	\$194.97	\$183.32	\$177.40	\$170.14	\$153.32	\$138.67	\$124.80	\$102.84	\$85.51	\$72.45	\$62.41	\$49.46
75 - 79	\$230.09	\$218.05	\$211.79	\$204.20	\$186.15	\$170.07	\$154.59	\$129.66	\$109.58	\$94.08	\$81.93	\$65.61
80 - 84	\$281.70	\$268.93	\$262.06	\$253.61	\$233.35	\$214.98	\$197.18	\$167.90	\$143.76	\$124.68	\$109.50	\$88.32
85 +	\$301.26	\$288.12	\$280.98	\$271.99	\$250.70	\$231.38	\$212.72	\$181.77	\$156.07	\$135.65	\$119.37	\$96.39
AREA 3 All of Alaska - Washington Zip Code 994												
Age - 65	\$157.38	\$145.96	\$140.33	\$133.22	\$117.45	\$104.22	\$92.01	\$73.13	\$58.72	\$48.28	\$40.55	\$31.32
66 - 69	\$171.69	\$159.22	\$153.09	\$145.34	\$128.13	\$113.69	\$100.37	\$79.79	\$64.06	\$52.67	\$44.24	\$34.17
70 - 74	\$211.93	\$199.26	\$192.82	\$184.94	\$166.66	\$150.73	\$135.66	\$111.78	\$92.95	\$78.75	\$67.84	\$53.76
75 - 79	\$250.10	\$237.02	\$230.20	\$221.96	\$202.35	\$184.85	\$168.03	\$140.94	\$119.11	\$102.26	\$89.06	\$71.32
80 - 84	\$306.20	\$292.31	\$284.84	\$275.66	\$253.65	\$233.67	\$214.33	\$182.49	\$156.25	\$135.51	\$119.03	\$95.99
85 +	\$327.45	\$313.17	\$305.41	\$295.64	\$272.50	\$251.50	\$231.22	\$197.57	\$169.65	\$147.44	\$129.76	\$104.77
AREA 4												
Age - 65	\$169.97	\$157.64	\$151.56	\$143.88	\$126.85	\$112.56	\$99.37	\$78.98	\$63.41	\$52.14	\$43.80	\$33.83
66 - 69	\$185.42	\$171.96	\$165.33	\$156.96	\$138.38	\$122.79	\$108.40	\$86.17	\$69.18	\$56.88	\$47.78	\$36.90
70 - 74	\$228.89	\$215.20	\$208.25	\$199.73	\$179.99	\$162.78	\$146.52	\$120.73	\$100.38	\$85.05	\$73.27	\$58.07
75 - 79	\$270.11	\$255.98	\$248.62	\$239.72	\$218.54	\$199.64	\$181.47	\$152.22	\$128.65	\$110.44	\$96.19	\$77.02
80 - 84	\$330.70	\$315.69	\$307.63	\$297.71	\$273.95	\$252.36	\$231.47	\$197.09	\$168.75	\$146.35	\$128.55	\$103.67
85 +	\$353.65	\$338.23	\$329.85	\$319.28	\$294.29	\$271.61	\$249.72	\$213.37	\$183.23	\$159.23	\$140.14	\$113.15
AREA 5												
Age - 65	\$188.86	\$175.15	\$168.40	\$159.87	\$140.94	\$125.07	\$110.42	\$87.76	\$70.46	\$57.94	\$48.66	\$37.59
66 - 69	\$206.02	\$191.07	\$183.71	\$174.41	\$153.76	\$136.44	\$120.45	\$95.75	\$76.87	\$63.20	\$53.09	\$41.00
70 - 74	\$254.32	\$239.11	\$231.39	\$221.93	\$199.98	\$180.87	\$162.79	\$134.14	\$111.53	\$94.50	\$81.41	\$64.51
75 - 79	\$300.12	\$284.42	\$276.24	\$266.35	\$242.81	\$221.82	\$201.64	\$169.13	\$142.94	\$122.71	\$106.87	\$85.58
80 - 84	\$367.44	\$350.77	\$341.82	\$330.79	\$304.37	\$280.40	\$257.19	\$218.99	\$187.50	\$162.61	\$142.83	\$115.19
85 +	\$392.94	\$375.81	\$366.49	\$354.76	\$326.99	\$301.79	\$277.46	\$237.08	\$203.57	\$176.93	\$155.72	\$125.73

Medical Coverage Underwritten by Guarantee Trust Life Insurance Company
Offered through the Merchants Industry Fund Group Insurance Trust
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These plans offer a 90-day supply from the Pharmacy as well as Mail Order - Through additional cost sharing, incentive to move members with maintenance medication to Mail Order: After you have received the equivalent of a 90 day supply (or 3 refills) within a 180-day period, you will be responsible for the higher co-pays below. After the third refill of maintenance medication, members who have not moved their prescription to Mail Order will pay 40% of the discounted price of the drug at a minimum of \$40. If the discounted cost of the drug is less than \$40, member pays the lower amount.

	SC Choice	SC Preferred	SC Premier
Phase 1: DEDUCTIBLE	\$0	\$0	\$0

Phase 2: INITIAL PERIOD	up to \$2,830		up to \$2,830		up to \$2,830	
<i>30-day supply, you pay</i>						
Generic	\$5		\$5		\$5	
Preferred Brands	\$25		\$25		\$25	
Brands	\$50		\$50		\$50	
Specialty	\$50		\$50		\$50	
<i>90-day supply, you pay</i>						
	Mail Order	Pharmacy	Mail Order	Pharmacy	Mail Order	Pharmacy
Generic	\$10	\$12.50	\$10	\$12.50	\$10	\$12.50
Preferred Brands	\$50	\$62.50	\$50	\$62.50	\$50	\$62.50
Brands	\$100	\$125.00	\$100	\$125.00	\$100	\$125.00
Specialty	\$100	\$125.00	\$100	\$125.00	\$100	\$125.00

Phase 3: COVERAGE GAP	Amount you pay between the Initial Coverage Period and until you reach \$4,550 in out-of-pocket covered prescription drug costs.					
<i>30-day supply, you pay</i>						
Generic	100%		\$5		\$5	
Preferred Brands	100%		100%		\$25	
Brands	100%		100%		\$50	
Specialty	100%		100%		\$50	
<i>90-day supply, you pay</i>						
	Mail Order	Pharmacy	Mail Order	Pharmacy	Mail Order	Pharmacy
Generic	100%	100%	\$10	\$12.50	\$10	\$12.50
Preferred Brands	100%	100%	100%	100%	\$50	\$62.50
Brands	100%	100%	100%	100%	\$100	\$125.00
Specialty	100%	100%	100%	100%	\$100	\$125.00

CATASTROPHIC COVERAGE	After your yearly out-of-pocket drug costs reach \$4,550, you pay the greater of:					
<i>30-day supply, you pay</i>						
Generic (including Brand drugs treated as Generic)	\$2.50		\$2.50		\$2.50	
All Others	\$6.30		\$6.30		\$6.30	
or the greater of:	5% of co-insurance		5% of co-insurance		5% of co-insurance	

MONTHLY PREMIUM	\$59.00	\$86.00	\$221.00
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Additional Skilled Nursing

\$6.83 per month

Covered after SC Plan deductible, from 101 through 365 days; up to \$125 per day

Private Duty Nursing

\$7.88 per month

Covered after SC Plan deductible, \$100 per 8 hour shift; 30 shifts per calendar year

At Home Recovery

\$17.33 per month

Covered after SC Plan deductible, up to \$40/visit and 7 visits per week;
\$1600 per calendar year maximum

Comprehensive Wellness

\$12.60 per month

Subject to a calendar year maximum benefit amount of \$250 (not subject to a plan deductible)

Wellness Care includes, but is not limited to:

- Alternative health care such as massage and acupuncture
- Dental and vision check-ups
- Annual physical examinations
- Chronic disease self-management programs
- Alcohol dependency, substance abuse prevention and violence prevention counseling

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