

TEXAS

PLAN OVERVIEW

Individual and Family Health Insurance Plans



UNICARE®

A Healthy Dose of Innovation®

UniCare is a WellPoint Company

UniCare – Your Trusted Name in Health Insurance

UniCare Solutions and Services

UniCare strives to deliver quality health care benefit plans and products, and part of our mission is working with our customers and partners alike to create an organization that's easy to do business with. Our dedicated and experienced sales team is striving to create dynamic health care benefit solutions that meet the market's changing needs.

More Control and Support

We help give our clients more control by offering an array of health insurance plans, including our new suite of consumer-driven health plans. By harnessing the power of robust web opportunities on the unicare.com website, we are helping to strengthen the position of our agents and clients alike.

More Networks and Offerings

In this dynamic market, strength and agility are key. That's why UniCare nationwide networks offer more than 4,500 independently contracted hospitals and more than 175,000 independently contracted primary care physicians and specialists. Our complete product portfolio – medical, dental, pharmacy, life, and Full Circle Health® programs – are what make us different. They are what make UniCare a top choice for health care benefit products.

UniCare isn't just a solution for the moment – our goal is to be a trusted partner for the long term. Each company in the UniCare Family of Companies is a separately incorporated and capitalized subsidiary of WellPoint, Inc., which is the largest publicly traded commercial health benefits company in terms of membership in the United States. Now that's the UniCare plan power.

General Plan Information

UniCare Individual health insurance plans allow you to choose the plan that best fit you and your family's needs.

The Enhanced FIT and Saver medical plans offer you a wide variety of benefit options with varying deductible levels, while the Solaura and HSA plans provide you with premium savings, investment opportunities and tax advantages. The UniCare Sound Plans are simplified, comprehensive health insurance plans that were designed to make life a little bit easier for you.

Solaura Health Insurance Plans

UniCare's Solaura® plans give you the ability to help better manage and control your health care dollars. They are designed to help you reduce your out-of-pocket health expenses, while improving your health and well-being. Plus, you have three plan choices and a variety of deductible options, so you can tailor the plan to fit your exact needs and budget.

Solaura plans are available in three varying options:

- The Solaura Health Savings Account (HSA)¹ Plan is funded by your own contributions, which may be tax-deductible. You can use the funds in your health savings account to pay for medical care and prescriptions. You can also use the funds in your HSA to pay for medical expenses that are not covered by the health plan, like contact lenses, over-the-counter medications, and orthodontic braces.
- The Solaura Health Incentive Account Plan (HIA) is funded entirely through reward credits you can earn for healthy behaviors. The plan gives you an account called a Health Incentive Account, or HIA, which you can use to help pay for covered medical care and prescriptions, and can lower the amount you have to spend out of your pocket.
- The Solaura Health Incentive Account Plus Plan (HIA Plus) is funded by quarterly contributions from UniCare. It gives you an account called a Health Incentive Account, or HIA. You can earn additional reward credits for your account with rewards for healthy behaviors. You use the health credits for covered medical care and prescriptions, and can lower the amount you have to spend out of your pocket.

Enhanced FIT and Saver Plans

The Enhanced FIT and Saver plans offer sensible, in-demand benefit features and they come with the support of UniCare dedicated customer service. Each plan suite offers you the choice of a variety of deductibles, plan benefit options and brand-name prescription drug coverage. Take a look at some Enhanced FIT and Saver features:

- All Enhanced FIT plans feature “first-dollar benefits” (coverage with no annual deductible amount) for in-network office visits at a copay of \$30, and certain preventive care screenings with a first-dollar benefit maximum of \$500 per member.
- Enhanced FIT plans are available with annual deductibles of \$1,000, \$1,500, \$2,500, \$3,500, \$5,000, \$10,000, \$15,000 and \$20,000.
- The Saver plans are available with annual deductibles of \$2,000, \$5,000 and \$10,000.
- The Enhanced FIT and Saver plans feature a fourth-quarter carry-over for the annual deductible. If your annual deductible is not satisfied in a given year, the covered expenses incurred during the months of October through December will be applied toward your annual deductible for the following year.

HSA-Compatible Plans

An HSA is a Health Savings Account established exclusively to pay for current and future qualified medical expenses of eligible individuals. In order for individuals or families to qualify for a Health Savings Account (HSA), they must be enrolled in a High Deductible Health Plan (HDHP).¹

UniCare's HDHPs are HSA-compatible, designed to meet certain requirements in terms of annual deductibles and annual out-of-pocket expense maximums.

UniCare offers the convenience of applying for both an HSA and HDHP together, through an arrangement with JPMorgan Bank, N.A. (Chase).² Your HDHP is provided by UniCare. The HSA itself is administered by a financial institution qualified to provide this service. Rather than applying for an HDHP, then finding a bank and going through another enrollment process for your HSA, you can take care of both steps at once.

Individual Consumer Choice Plans

Consumer Choice benefits from UniCare provide you with the benefits you want without the additional cost of benefits you may not need. Take a look at what the Consumer Choice Plans have to offer:

- Three deductible plans with access to emergency care
- Routine health care services
- Preventive and wellness programs to promote good health

The Consumer Choice plans also allow you to use any doctor you choose, but you can save money by using participating (in-network) independently contracted doctors and medical facilities. When you use participating providers, you save money because these providers have agreed to accept lower, negotiated rates for their services. With Consumer Choice Plans from UniCare, you have the peace of mind of knowing that you have the protection you need at a price you can afford.

Sound

We understand that life can be hectic and that health coverage can be a complicated thing. That's why UniCare created the Sound plans. Each plan offers simplified benefits that help make life a little bit easier for you. With Sound, everything is online – simple, quick, painless. Check it out:

- Other features include the ability to choose your annual deductible level - \$1,500, \$3,000, or \$5,000.
- Get immediate coverage for covered office visits, emergency room care, and prescription drugs.³
- The fourth-quarter carry-over: if your annual deductible is not satisfied in a given year, the covered expenses incurred during the months of October through December will be applied toward your annual deductible for the following year.

Finally, the Sound plans also include vision and dental built into each plan, making it three important products all rolled into one.

Refer to the charts on the following pages to compare the benefits of each plan.

To help you make the right choice contact your UniCare agent or your dedicated UniCare Agent Support Team.

¹ A high-deductible plan is not an HSA. An HSA, which must be established for tax-advantaged treatment, is a separate arrangement between the individual and a bank or other qualified institutions. You must be an eligible individual under IRS regulation to receive the tax benefits of an HSA. Consultation with a tax advisor is recommended.

² JP Morgan Chase Bank N.A. (Chase). Chase is an independent company that is not affiliated with, or owned or controlled, in whole or part, by UniCare or any of its affiliates, subsidiaries or its parent company. The HSA with Chase is governed by the terms and conditions of the contract that individuals have with Chase regarding those accounts and UniCare has no control, nor does it exercise any control, over the contractual relationship between individuals and Chase.

³ Brand-name drugs available at higher copays and subject to a separate deductible.

Enhanced FIT Plans Comparison Chart

UniCare's payment for covered expenses after deductible, per member, per year unless otherwise noted.

Your Plan Features	ENHANCED FIT 1000		ENHANCED FIT 1500/2500		ENHANCED FIT 3500/5000	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible¹ In-network deductible per member, per year with a two-member maximum	\$1,000	\$2,000; additional ded. per member, per year	\$1,500/\$2,500	\$2,000; additional ded. per member, per year	\$3,500/\$5,000;	\$2,000; additional ded. per member, per year
Annual Out-of-Pocket Maximum¹ In addition to deductibles; does not include pharmacy copays	Member: \$3,000 Family: \$6,000	Member: \$10,000 Family: \$20,000	Member: \$3,000 Family: \$6,000	Member: \$10,000 Family: \$20,000	Member: \$3,000 Family: \$6,000	Member: \$10,000 Family: \$20,000
Lifetime Maximum	\$5 million per member		\$5 million per member		\$5 million per member	
Adult Preventive Care Age 18 and over; Includes but not limited to X-rays and lab work for a routine Pap smear, annual mammogram and PSA screening	100%; ded. waived; \$500 max. then 80% after ded.	50%	100%; ded. waived; \$500 max. then 75% after ded.	50%	100%; ded. waived; \$500 max. then 75% after ded.	50%
Adult Office Visits All medical office visits, exams and diagnostic X-rays and lab work performed on the same date and during the same office visit for any covered illness or injury	\$30 copay; unlimited visits; ded. waived	50%; unlimited visits; ded. applies to most services	\$30 copay; unlimited visits; ded. waived	50%; unlimited visits; ded. applies to most services	\$30 copay; unlimited visits; ded. waived	50%; unlimited visits; ded. applies to most services
Child Preventive Care Well baby/children to age 18 Immunizations	100%; ded. waived		100%; ded. waived		100%; ded. waived	
Routine Care Other than immunizations	100%; ded. waived; \$500 max., then 80% after ded.	50%	100%; ded. waived; \$500 max., then 75% after ded.	50%	100%; ded. waived; \$500 max., then 75% after ded.	50%
Child Office Visits	\$30 copay; unlimited visits; ded. waived	50%	\$30 copay; unlimited visits; ded. waived	50%	\$30 copay; unlimited visits; ded. waived	50%
Professional Services Surgery, anesthesia, radiation therapy, in-hospital doctor visits	80%	50%	75%	50%	75%	50%
X-rays and Lab Work	80%	50%	75%	50%	75%	50%
Ambulance Service Maximum covered expense of \$5,000 per trip for air; \$1,000 per trip for ground	80%	50%	75%	50%	75%	50%
Inpatient Medical Emergency²	80%	80% ⁴	75%	75% ⁴	75%	75% ⁴
Inpatient Hospital Services²	80%	50% after \$500 ded. for non- emergency stays	75%	50% after \$500 ded. for non- emergency stays	75%	50% after \$500 ded. for non- emergency stays
Outpatient Hospital² or Surgical Center²	80% ³	50% ³	75% ³	50% ³	75% ³	50% ³
Outpatient Medical Emergency Treatment³ Includes facility charges, staff fees billed by facility or professional services	100%; \$100 copay		100%; \$100 copay		100%; \$100 copay	
Physical/Occupational Therapy and Acupuncture All services combined	\$30 max. per visit 12 visits max. per year		\$30 max. per visit 12 visits max. per year		\$30 max. per visit 12 visits max. per year	
Retail Pharmacy⁵ Per prescription; 30-day supply						
Generic Drugs Deductible waived	\$10 copay	50% of avg. wholesale price	\$10 copay	50% of avg. wholesale price	\$10 copay	50% of avg. wholesale price
Brand-Name Drugs	\$250 ded.; Formulary: \$30 copay; Nonformulary: \$50 copay	\$250 ded.; 50% of avg. wholesale price	\$250 ded.; Formulary: \$30 copay; Nonformulary: \$50 copay	\$250 ded.; 50% of avg. wholesale price	\$500 ded.; Formulary: \$30 copay; Nonformulary: \$50 copay	\$500 ded.; 50% of avg. wholesale price
Self-Injectable Drugs	\$250 ded.; 80%	\$250 ded.; 50% of avg. wholesale price	\$250 ded.; 75%	\$250 ded.; 50% of avg. wholesale price	\$500 ded.; 75%	\$500 ded.; 50% of avg. wholesale price

ENHANCED FIT 10,000		ENHANCED FIT 15,000		ENHANCED FIT 20,000		Your Plan Features
IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	
\$10,000	\$4,000; additional ded. per member, per year	\$15,000	\$4,000; additional ded. per member, per year	\$20,000	\$4,000; additional ded. per member, per year	Annual Deductible ¹ In-network deductible per member, per year with a two-member maximum
Member: \$3,000 Family: \$6,000	Member: \$10,000 Family: \$20,000	Member: \$3,000 Family: \$6,000	Member: \$10,000 Family: \$20,000	Member: \$3,000 Family: \$6,000	Member: \$10,000 Family: \$20,000	Annual Out-of-Pocket Maximum ¹ In addition to deductibles; does not include pharmacy copays
\$5 million per member		\$5 million per member		\$5 million per member		Lifetime Maximum
100%; ded. waived; \$500 max. then 75% after ded.	50%	100%; ded. waived; \$500 max. then 75% after ded.	50%	100%; ded. waived; \$500 max. then 75% after ded.	50%	Adult Preventive Care Age 18 and over; Includes but not limited to X-rays and lab work for a routine Pap smear, annual mammogram and PSA screening
\$30 copay; unlimited visits; ded. waived	50%; unlimited visits; ded. applies to most services	\$30 copay; unlimited visits; ded. waived	50%; unlimited visits; ded. applies to most services	\$30 copay; unlimited visits; ded. waived	50%; unlimited visits; ded. applies to most services	Adult Office Visits All medical office visits, exams and diagnostic X-rays and lab work performed on the same date and during the same office visit for any covered illness or injury
100%; ded. waived		100%; ded. waived		100%; ded. waived		Child Preventive Care Well baby/children to age 18 Immunizations
100%; ded. waived; max. \$500 then 75% after ded.	50%	100%; ded. waived; max. \$500 then 75% after ded.	50%	100%; ded. waived; max. \$500 then 75% after ded.	50%	Routine Care Other than immunizations
\$30 copay; unlimited visits; ded. waived	50%	\$30 copay; unlimited visits; ded. waived	50%	\$30 copay; unlimited visits; ded. waived	50%	Child Office Visits
75%	50%	75%	50%	75%	50%	Professional Services Surgery, anesthesia, radiation therapy, in-hospital doctor visits
75%	50%	75%	50%	75%	50%	X-rays and Lab Work
75%	50%	75%	50%	75%	50%	Ambulance Service Maximum covered expense of \$5,000 per trip for air, \$1,000 per trip for ground
75%	75% ⁴	75%	75% ⁴	75%	75% ⁴	Inpatient Medical Emergency ²
75%	50% after \$500 ded. for non-emergency stays	75%	50% after \$500 ded. for non-emergency stays	75%	50% after \$500 ded. for non-emergency stays	Inpatient Hospital Services ²
75% ³	50% ³	75% ³	50% ³	75% ³	50% ³	Outpatient Hospital ² or Surgical Center ²
100%; \$100 copay		100%; \$100 copay		100%; \$100 copay		Outpatient Medical Emergency Treatment ³ Includes facility charges, staff fees billed by facility or professional services
\$30 max. per visit 12 visits max. per year		\$30 max. per visit 12 visits max. per year		\$30 max. per visit 12 visits max. per year		Physical/Occupational Therapy and Acupuncture All services combined
\$10 copay	50% of average wholesale price	\$10 copay	50% of average wholesale price	\$10 copay	50% of average wholesale price	Retail Pharmacy ⁵ Per prescription; 30-day supply Generic Drugs Deductible waived
\$1,000 ded. Formulary: \$30 copay; Non-formulary: \$50 copay	\$1,000 ded.; 50% of average wholesale price	\$1,000 ded. Formulary: \$30 copay; Non-formulary: \$50 copay	\$1,000 ded.; 50% of average wholesale price	\$1,000 ded. Formulary: \$30 copay; Non-formulary: \$50 copay	\$1,000 ded.; 50% of average wholesale price	Brand-Name Drugs
\$1,000 ded.; 75%	N/A	\$1,000 ded.; 75%	N/A	\$1,000 ded.; 75%	N/A	Self-Injectable Drugs

Please note: when you use nonparticipating (out-of-network) providers, your benefits are based on a maximum allowable amount determined by UniCare as described in your Policy's definition of Reasonable Charge. Using an out-of-network provider may result in higher costs to you because you are responsible for any billed charges in excess of that amount. Please reference your Policy for the full definition of Reasonable Charge.

1 Copays, except pharmacy copays, apply toward your annual out-of-pocket maximum.

2 Services may require preservice review or authorization by UniCare or you will be required to pay an additional penalty. For more details, see Preservice Review section on back cover.

3 If emergency room visit results in admission, inpatient deductible and coinsurance apply.

4 Until transferable to a participating hospital; if stay continues thereafter, then 50% subject to a \$500 deductible.

5 Certain prescription drugs may require prior authorization by UniCare.

Individual Consumer Choice Plans Comparison Chart

UniCare's payment for covered expenses after deductible, per member, per year unless otherwise noted.

Your Plan Features	CONSUMER CHOICE PPO 1000		CONSUMER CHOICE PPO 2000		CONSUMER CHOICE PPO 5000	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible Per member, per year with a two-member maximum	\$1,000		\$2,000		\$5,000	
Annual Out-of-Pocket Maximum In addition to deductible	Member: \$3,000 Family: \$6,000	No out-of-pocket maximum	Member: \$3,000 Family: \$6,000	No out-of-pocket maximum	Member: \$3,000 Family: \$6,000	No out-of-pocket maximum
Lifetime Maximum	\$5 million per member		\$5 million per member		\$5 million per member	
Adult Preventive Care X-rays and lab work for routine Pap smear, annual mammogram and PSA screening	80%	50%	75%	50%	75%	50%
Office Visits Exam only for any covered illness or injury, and certain preventive care services for adults	\$30 copay; ded. waived; after 4th visit subject to coinsurance and ded.	50%	\$30 copay; ded. waived; after 4th visit subject to coinsurance and ded.	50%	\$30 copay; ded. waived; after 4th visit subject to coinsurance and ded.	50%
Child Preventive Care Well baby/children through age 6 Immunizations	100%; ded. waived	100%; ded. waived	100%; ded. waived	100%; ded. waived	100%; ded. waived	100%; ded. waived
Other Preventive Care Services Such as flu shots or routine physical exams/ tests; maximum covered expense of \$200 per member per year	80%	50%	75%	50%	75%	50%
Colorectal Cancer Screening	80%	50%	75%	50%	75%	50%
Professional Services surgery, anesthesia, radiation therapy, in-hospital doctor visits	80%	50%	75%	50%	75%	50%
X-rays and Lab Work	80%	50%	75%	50%	75%	50%
Ambulance Service Maximum covered expense of \$750 per trip for ground, \$2,000 per trip for air	80%	50%	75%	50%	75%	50%
Initial Care of a Medical Emergency¹ Inpatient or Outpatient	80%	80% until transferable to a participating hospital; 50% thereafter	75%	75% until transferable to a participating hospital; 50% thereafter	75%	75% until transferable to a participating hospital; 50% thereafter
Inpatient Hospital Services¹	80%	50% less a \$500 ded. for non-emergency stays	75%	50% less a \$500 ded. for non-emergency stays	75%	50% less a \$500 ded. for non-emergency stays
Outpatient Hospital or Surgical Center^{1,2}	80%	50%	75%	50%	75%	50%
Physical/Occupational Therapy and Acupuncture⁴ All services combined	\$30 max. per visit; 12 visits max. per year		\$30 max. per visit; 12 visits max. per year		\$30 max. per visit; 12 visits max. per year	
Retail Pharmacy³ Per prescription; 30-day supply Generic Drugs Deductible waived	\$10 copay	50% of average wholesale price	\$10 copay	50% of average wholesale price	\$10 copay	50% of average wholesale price
Brand-Name Drugs	\$1,000 ded. Formulary: \$30 copay; Nonformulary: \$50 copay	\$1,000 ded.; 50% of average wholesale price	\$1,000 ded. Formulary: \$30 copay; Nonformulary: \$50 copay	\$1,000 ded.; 50% of average wholesale price	\$1,000 ded. Formulary: \$30 copay; Nonformulary: \$50 copay	\$1,000 ded.; 50% of average wholesale price
Self-Injectable Drugs	50% of negotiated rate	50% of average wholesale price	50% of negotiated rate	50% of average wholesale price	50% of negotiated rate	50% of average wholesale price

Please note: when you use nonparticipating (out-of-network) providers, your benefits are based on a maximum allowable amount determined by UniCare as described in your Policy's definition of Reasonable Charge. Using an out-of-network provider may result in higher costs to you because you are responsible for any billed charges in excess of that amount. Please reference your Policy for the full definition of Reasonable Charge.

Please note: You may have the option to choose a Consumer Choice benefits health insurance plan, that either in whole or in part, does not provide state-mandated health benefits normally required in accident and sickness insurance policies in Texas. A standard health benefit plan may provide a more affordable health insurance policy for you although at the same time, it may provide you with fewer health benefits than those normally included as state-mandated health benefits in policies in Texas. If you choose a standard health benefit plan, please consult with your insurance agent to discover which state-mandated health benefits are excluded from the plan.

1 Services may require preservice review or authorization by UniCare or you will be required to pay an additional penalty.

2 Emergency room visits that do not result in an inpatient admission will be subject to a \$60 penalty.

3 Certain prescription drugs may require prior authorization by UniCare.

4 Additional visits for physical/occupational and speech therapy may be covered following inpatient hospitalization for severe trauma with prior authorization from UniCare.

Solaura® Plans Comparison Chart

UniCare's payment for covered expenses after deductible, per member, per year unless otherwise noted.

Your Plan Features	HSA PLAN 1A		HSA PLAN 2A		HSA PLAN 3A	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible¹ Per member, per year; shared in- and out-of-network	Member: \$3,000 Family: \$6,000		Member: \$5,000 Family: \$10,000		Member: \$3,000 Family: \$6,000	Member: \$6,000 Family: \$12,000
Annual Out-of-Pocket Maximum Both out-of-pockets include the deductible and coinsurance	Member: \$5,000 Family: \$10,000	Member: \$10,000 Family: \$20,000	Member: \$5,000 Family: \$10,000	Member: \$10,000 Family: \$20,000	Member: \$3,000 Family: \$6,000	Member: \$9,000 Family: \$18,000
Lifetime Maximum	\$5 million per member		\$5 million per member		\$5 million per member	
Health Account Contribution by UniCare² Unlimited rollover	N/A		N/A		N/A	N/A
Adult Preventive Care Including but not limited to X-rays and lab work for a routine Pap smear, annual mammogram, PSA screening and colorectal cancer screening; includes office visits related to preventive care and routine physical exams	100%; ded. waived	60%	100%; ded. waived	70%	100%; ded. Waived	70%
Office Visits Diagnostic radiology and lab work	80%	60%	100%	70%	100%	70%
Baby Preventive Care and Immunizations Through age 6; includes office visits related to preventive care	100%; ded. waived		100%; ded. waived		100%; ded. waived	
Child Preventive Care and Immunizations Well child age 7 through 18; includes office visits related to preventive care	100%; ded. waived	60%	100%; ded. waived	70%	100%; ded. waived	70%
Professional Services Surgery, anesthesia, radiation therapy, in-hospital doctor visits	80%	60%	100%	70%	100%	70%
Ambulance Service	80%	60%	100%	70%	100%	70%
Inpatient Medical Emergency	80%	80% until transferable to a participating hospital; 60% thereafter	100%	100% until transferable to a participating hospital; 70% thereafter	100%	100% until transferable to a participating hospital; 70% thereafter
Inpatient Hospital Services	80%	60%	100%	70%	100%	70%
Outpatient Hospital or Surgical Center	80%	60%	100%	70%	100%	70%
Physical/Occupational Therapy and Acupuncture All services combined	\$30 max. per visit; 12 visits max. per year		\$30 max. per visit; 12 visits max. per year		\$30 max. per visit; 12 visits max. per year	
Retail Pharmacy Administered by NextRx SM ; 30-day supply	80%	60%	100%	70%	100%	70%

Please note: when you use nonparticipating (out-of-network) providers, your benefits are based on a maximum allowable amount determined by UniCare as described in your Policy's definition of Reasonable Charge. Using an out-of-network provider may result in higher costs to you because you are responsible for any billed charges in excess of that amount. Please reference your Policy for the full definition of Reasonable Charge.

1 Once the participating out-of-pocket maximum has been met, covered services obtained from an in-network provider, including prescription drugs, will be covered at 100%. Once the nonparticipating out-of-pocket maximum has been met, covered services obtained from an out-of-network provider will be covered at the maximum allowable amount.

2 The annual account contribution only applies to the HIA Plus Plans.

Solaura® Plans Comparison Chart, continued

UniCare's payment for covered expenses after deductible, per member, per year unless otherwise noted.

Your Plan Features	HIA 1		HIA 2		HIA PLUS 1	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible¹ Per member, per year; shared in- and out-of-network	Member: \$2,500 Family: \$5,000		Member: \$5,000 Family: \$10,000		Member: \$5,000 Family: \$10,000	
Annual Out-of-Pocket Maximum Both out-of-pockets include the deductible and coinsurance	Member: \$5,000 Family: \$10,000	Member: \$10,000 Family: \$20,000	Member: \$5,000 Family: \$10,000	Member: \$10,000 Family: \$20,000	Member: \$5,000 Family: \$10,000	Member: \$10,000 Family: \$20,000
Lifetime Maximum	\$5 million per member		\$5 million per member		\$5 million per member	
Health Account Contribution by UniCare² Unlimited rollover	N/A		N/A		Member: \$200 Family: \$400	
Adult Preventive Care Including but not limited to X-rays and lab work for a routine Pap smear, annual mammogram, PSA screening and colorectal cancer screening; includes office visits related to preventive care and routine physical exams	100%; ded. waived	60%	100%; ded. waived	70%	100%; ded. waived	80%
Office Visits Diagnostic radiology and lab work	80%	60%	100%	70%	100%	80%
Baby Preventive Care and Immunizations Through age 6; includes office visits related to preventive care	100%; ded. waived		100%; ded. waived		100%; ded. waived	
Child Preventive Care and Immunizations Well child age 7 through 18; includes office visits related to preventive care	100%; ded. waived	60%	100%; ded. waived	70%	100%; ded. waived	80% ²
Professional Services Surgery, anesthesia, radiation therapy, in-hospital doctor visits	80%	60%	100%	70%	100%	80%
Ambulance Service	80%	60%	100%	70%	100%	80%
Inpatient Medical Emergency	80%	80% until transferable to a participating hospital; 60% thereafter	100%	100% until transferable to a participating hospital; 70% thereafter	100%	100% until transferable to a participating hospital; 80% thereafter
Inpatient Hospital Services	80%	60%	100%	70%	100%	80%
Outpatient Hospital or Surgical Center	80%	60%	100%	70%	100%	80%
Physical/Occupational Therapy and Acupuncture All services combined	\$30 max. per visit; 12 visits max. per year		\$30 max. per visit; 12 visits max. per year		\$30 max. per visit; 12 visits max. per year	
Retail Pharmacy Administered by NextRx SM ; 30-day supply	80%	60%	100%	70%	100%	80%

HIA PLUS 2		HIA PLUS 3		Your Plan Features
IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	
Member: \$5,000 Family: \$10,000		Member: \$10,000 Family: \$20,000		Annual Deductible ¹ Per member, per year; shared in- and out-of-network
Member: \$5,000 Family: \$10,000	Member: \$10,000 Family: \$20,000	Member: \$10,000 Family: \$20,000	Member: \$20,000 Family: \$40,000	Annual Out-of-Pocket Maximum Both out-of-pockets include the deductible and coinsurance
\$5 million per member		\$5 million per member		Lifetime Maximum
Member: \$500 Family: \$1,000		Member: \$200 Family: \$400		Health Account Contribution by UniCare ² Unlimited rollover
100%; ded. waived	70%	100%; ded. waived	70%	Adult Preventive Care Including but not limited to X-rays and lab work for a routine Pap smear, annual mammogram, PSA screening and colorectal cancer screening; includes office visits related to preventive care and routine physical exams
100%	70%	100%	70%	Office Visits Diagnostic radiology and lab work
100%; ded. waived		100%; ded. waived		Baby Preventive Care and Immunizations Through age 6; includes office visits related to preventive care
100%; ded. waived	70% ²	100%; ded. waived	70% ²	Child Preventive Care and Immunizations Well child age 7 through 18; includes office visits related to preventive care
100%	70%	100%	70%	Professional Services Surgery, anesthesia, radiation therapy, in-hospital doctor visits
100%	70%	100%	70%	Ambulance Service
100%	100% until transferable to a participating hospital; 70% thereafter	100%	100% until transferable to a participating hospital; 70% thereafter	Inpatient Medical Emergency
100%	70%	100%	70%	Inpatient Hospital Services
100%	70%	100%	70%	Outpatient Hospital or Surgical Center
\$30 max. per visit; 12 visits max. per year		\$30 max. per visit; 12 visits max. per year		Physical/Occupational Therapy and Acupuncture All services combined
100%	70%	100%	70%	Retail Pharmacy Administered by NextRx SM ; 30-day supply

Please note: when you use nonparticipating (out-of-network) providers, your benefits are based on a maximum allowable amount determined by UniCare as described in your Policy's definition of Reasonable Charge. Using an out-of-network provider may result in higher costs to you because you are responsible for any billed charges in excess of that amount. Please reference your Policy for the full definition of Reasonable Charge.

¹ Once the participating out-of-pocket maximum has been met, covered services obtained from an in-network provider, including prescription drugs, will be covered at 100%. Once the nonparticipating out-of-pocket maximum has been met, covered services obtained from an out-of-network provider will be covered at the maximum allowable amount.

² The annual account contribution only applies to the HIA Plus Plans.

HSA-Compatible Health Insurance Plans Comparison Chart

UniCare's payment for covered expenses after deductible, per member, per year unless otherwise noted.

Your Plan Features	HIGH DEDUCTIBLE VARIABLE DEDUCTIBLE PLAN		HIGH DEDUCTIBLE PLAN 2 ⁷		HIGH DEDUCTIBLE VARIABLE CONTRIBUTION PLAN	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible Per member, per year; medical and pharmacy combined	Member: \$1,150 ⁶ Family: \$2,300	Member: \$5,150 ⁶ Family: \$10,300	Member: \$2,600 Family: \$5,200	Member: \$6,600 Family: \$13,200	Member: \$3,000 ⁶ Family: \$5,950	Member: \$7,000 ⁶ Family: \$13,950
Annual Out-of-Pocket Maximum¹ Includes annual deductible pharmacy copays and coinsurance	Member: \$5,000 Family: \$10,000	Member: \$15,000 Family: \$20,000	Member: \$5,000 Family: \$10,000	Member: \$15,000 Family: \$20,000	Member: \$5,000 Family: \$10,000	Member: \$15,000 Family: \$20,000
Lifetime Maximum	\$5 million per member		\$5 million per member		\$5 million per member	
Child Preventive Care Immunization; well baby/children through age 6	100%; ded. waived		100%; ded. waived		100%; ded. waived	
Child Office Visits Office visits/examinations related to preventive care and labs	80%	50%	80%	50%	100%	70%
Adult Preventive Care Routine Pap smear, annual mammogram and PSA screening and colorectal cancer screening	80%	50%	80%	50%	100%	70%
Adult Office Visits Exam only for any covered illness or injury, and certain preventive care services for adults	80%	50%	80%	50%	100%	70%
Professional Services Surgery, anesthesia, radiation therapy, in-hospital doctor visits and diagnostic X-rays and lab work	80%	50%	80%	50%	100%	70%
Ambulance Service Maximum covered expense of \$1,000 per trip for ground, \$5,000 per trip for air	80%	50%	80%	50%	100%	70%
Initial Care of a Medical Emergency^{2,3} Inpatient or Outpatient	80%	80% ⁴	80%	80% ⁴	100%	100% ⁴
Inpatient Hospital Services²	80%	50%	80%	50%	100%	70%
Outpatient Hospital^{2,3} or Surgical Center²	80%	50%	80%	50%	100%	70%
Durable Medical Equipment	80%	50%	80%	50%	100%	70%
Physical/Occupational Therapy and Acupuncture/Acupressure All services combined	\$30 max. per visit; 12 visits max.		\$30 max. per visit; 12 visits max.		\$30 max. per visit; 12 visits max.	
Retail Pharmacy⁵ Per prescription; 30-day supply; deductibles apply Generic Drugs	\$10 copay ⁷	50% of avg. wholesale price ⁷	\$10 copay	50% of avg. wholesale price	\$10 copay ⁷	70% of avg. wholesale price ⁷
Brand-Name Formulary Drugs	\$30 copay ⁷	50% of avg. wholesale price ⁷	\$30 copay	50% of avg. wholesale price	\$30 copay ⁷	70% of avg. wholesale price ⁷
Brand-Name Nonformulary Drugs	\$50 copay ⁷	50% of avg. wholesale price ⁷	\$50 copay	50% of avg. wholesale price	\$50 copay ⁷	70% of avg. wholesale price ⁷
Self-Injectable Drugs	80% ⁷	50% of avg. wholesale price ⁷	80%	50% of avg. wholesale price	80% ⁷	70% of avg. wholesale price ⁷

HIGH DEDUCTIBLE PLAN 3 ⁷		
IN-NETWORK	OUT-OF-NETWORK	Your Plan Features
Member: \$5,000 Family: \$10,000	Member: \$9,000 Family: \$18,000	Annual Deductible Per member, per year; medical and pharmacy combined
Member: \$5,000 Family: \$10,000	Member: \$15,000 Family: \$20,000	Annual Out-of-Pocket Maximum¹ Includes annual deductible pharmacy copays and coinsurance
\$5 million per member		Lifetime Maximum
100%; ded. waived		Child Preventive Care Immunization; well baby/children through age 6
100%	70%	Child Office Visits Office visits/examinations related to preventive care and labs
100%	70%	Adult Preventive Care Routine Pap smear, annual mammogram and PSA screening and colorectal cancer screening
100%	70%	Adult Office Visits Exam only for any covered illness or injury, and certain preventive care services for adults
100%	70%	Professional Services Surgery, anesthesia, radiation therapy, in-hospital doctor visits and diagnostic X-rays and lab work
100%	70%	Ambulance Service Maximum covered expense of \$1,000 per trip for ground, \$5,000 per trip for air
100%	100% ⁴	Initial Care of a Medical Emergency^{2,3} Inpatient or Outpatient
100%	70%	Inpatient Hospital Services²
100%	70%	Outpatient Hospital^{2,3} or Surgical Center²
100%	70%	Durable Medical Equipment
\$30 max. per visit; 12 visits max.		Physical/Occupational Therapy and Acupuncture/Acupressure All services combined
100%	70% of avg. wholesale price	Retail Pharmacy⁵ Per prescription; 30-day supply; deductibles apply Generic Drugs
100%	70% of avg. wholesale price	Brand-Name Formulary Drugs
100%	70% of avg. wholesale price	Brand-Name Nonformulary Drugs
100%	70% of avg. wholesale price	Self-Injectable Drugs

Please note: when you use nonparticipating (out-of-network) providers, your benefits are based on a maximum allowable amount determined by UniCare as described in your Policy's definition of Reasonable Charge. Using an out-of-network provider may result in higher costs to you because you are responsible for any billed charges in excess of that amount. Please reference your Policy for the full definition of Reasonable Charge.

Please note: The Variable Deductible Plans have been issued new deductible amounts for individual and family coverage. The new deductible amounts are effective January 1, 2009.

- 1 Once the participating out-of-pocket maximum has been met, covered services obtained from an in-network provider, including prescription drugs, will be covered at 100%. Once the nonparticipating out-of-pocket maximum has been met, covered services obtained from an out-of-network provider, will be covered at the maximum allowable amount.
- 2 Services may require preservice review or authorization by UniCare or you will be required to pay an additional deductible penalty.
- 3 Emergency room visits that do not result in an inpatient admission will be subject to an additional \$60 charge.
- 4 Until transferable to a participating hospital; if stay continues thereafter, then 50% or 70%, depending on the plan; subject to applicable deductibles.
- 5 Certain prescription drugs may require prior authorization by UniCare.
- 6 The annual deductible will reflect the U.S. Treasury's minimum deductible requirements for HSA-qualified high deductible health plans. The amount is subject to change annually.
- 7 The High Deductible Variable Contribution plan offers prescription drug coverage. Once your annual deductible is satisfied, you only have to pay the appropriate copay for your prescriptions. Once your out-of-pocket maximum is met, you have 100% pharmacy coverage. See the pharmacy benefit for details on the copay amounts.

Sound Plans Comparison Chart

UniCare's payment for covered expenses after deductible, per member, per year unless otherwise noted.

Your Plan Features	THE CRUISER 1500 DEDUCTIBLE		CURB JUMPER 3000 DEDUCTIBLE		GRAVITY BENDER 5000 DEDUCTIBLE	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible Per calendar year	\$1,500	\$1,500	\$3,000	\$3,000	\$5,000	\$5,000
Annual Out-of-Pocket Per member, per year	\$1,500	\$15,000; plus ded.	\$3,000	\$15,000; plus ded.	\$5,000	\$15,000; plus ded.
Lifetime Maximum	\$5 million per member		\$5 million per member		\$5 million per member	
Adult Preventive Care Routine Pap smears, annual mammograms, colorectal cancer screenings and PSA test for men	100%	50%	100%	50%	100%	50%
Adult Office Visits Includes any lab/X-ray related to preventive care performed in physician's office and billed by physician on the same date of service	\$40 copay; ded. waived	50%	\$40 copay; ded. waived	50%	\$40 copay; ded. waived	50%
Child Preventive Care and Immunizations⁶ Preventive care services for babies/children through age 6; includes immunizations and lab work	\$40 copay; ded. waived	50%	\$40 copay; ded. waived	50%	\$40 copay; ded. waived	50%
Child Office Visits Includes immunizations and lab work related to preventive care performed in physician's office and billed by physician on the same date of service	\$40 copay; ded. waived	50%	\$40 copay; ded. waived	50%	\$40 copay; ded. waived	50%
Professional Services Surgery, anesthesia, radiation therapy, in-hospital doctor visits, diagnostic X-rays and lab work	100%	50%	100%	50%	100%	50%
Ambulance Service Maximum covered expense of \$1,000 per trip for ground, \$5,000 per trip for air	100%	50%	100%	50%	100%	50%
Initial Care of a Medical Emergency^{1, 2} Annual deductible waived	\$150 copay per visit; annual ded. waived	\$150 copay per visit; annual ded. waived	\$150 copay per visit; annual ded. waived	\$150 copay per visit; annual ded. waived	\$150 copay per visit; annual ded. waived	\$150 copay per visit; annual ded. waived
Inpatient Hospital Services¹	100%	50% ^{1, 5}	100%	50% ^{1, 5}	100%	50% ^{1, 5}
Outpatient Hospital or Surgical Center	100%	50%	100%	50%	100%	50%
Physical/Occupational Therapy and Acupuncture All services combined	12 visit max per year		12 visit max per year		12 visit max per year	
Retail Pharmacy³ Per prescription; 30 day supply Generic	\$10 copay	50%	\$10 copay	50%	\$10 copay	50%
Brand-Name Drugs All brand-name prescription drugs are subject to a separate \$2000 deductible per year	Formulary: \$30 copay; Nonformulary: \$50 copay	50%	Formulary: \$30 copay; Nonformulary: \$50 copay	50%	Formulary: \$30 copay; Nonformulary: \$50 copay	50%
Self-Injectable Drugs⁴ Does not include insulin; brand-name self-injectable drugs subject to the brand-name prescription drug deductible	80%	50%	80%	50%	80%	50%
Mail Service Up to 60-day supply; Some prescription drugs and/or medicines not available through the mail service Generic	\$20 copay	N/A	\$20 copay	N/A	\$20 copay	N/A
Brand-Name Drugs Per prescription; subject to a separate \$2000 deductible per year	\$60 copay	N/A	\$60 copay	N/A	\$60 copay	N/A
Self-Injectable Drugs^{3, 4} Does not include insulin; brand-name self-injectable drugs subject to brand-name prescription drug deductible	80%	N/A	80%	N/A	80%	N/A

Please note: when you use nonparticipating (out-of-network) providers, your benefits are based on a maximum allowable amount determined by UniCare as described in your Policy's definition of Reasonable Charge. Using an out-of-network provider may result in higher costs to you because you are responsible for any billed charges in excess of that amount. Please reference your Policy for the full definition of Reasonable Charge.

1 All Inpatient medical care requires pre-service review or you will be subject to a \$500 penalty per continuing hospital confinement without pre-service review. This penalty is waived on emergency admissions, however, hospital confinement without pre-service review. This penalty is waived on emergency admissions, however, utilization review is still required.

2 Copayment waived if the emergency room visit results in an inpatient admission immediately following the emergency room visit.

3 Certain Prescription Drugs may require prior authorization.

4 Insulin is covered under the generic or brand-name prescription drug benefit.

5 Immunizations and preventive lab work for babies and children thru age 6 are covered at 100%, deductible waived for both in and out of network providers.

6 Emergency Stays: 100% until transferable to a Participating hospital. 60% subject to a additional \$500 deductible once transferable per continuing hospital confinement.

Saver Plan Comparison Chart

UniCare's payment for covered expenses after deductible, per member, per year unless otherwise noted.

Your Plan Features	UNICARE SAVER 2000		UNICARE SAVER 5000		UNICARE SAVER 10,000	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Annual Deductible Per member, per year with a two-member family maximum	\$2,000		\$5,000		\$10,000	
Annual Out-of-Pocket Maximum In addition to deductibles; does not include pharmacy copay	Member: \$3,000 Family: \$6,000	Member: \$10,000 Family: \$20,000	Member: \$3,000 Family: \$6,000	Member: \$10,000 Family: \$20,000	Member: \$3,000 Family: \$6,000	Member: \$10,000 Family: \$20,000
Lifetime Maximum	\$5 million per member		\$5 million per member		\$5 million per member	
Office Visit Exam only for any covered illness, injury or certain preventive care services; adults and children through age 6	\$30 copay; deductible waived ¹	50%; deductible waived ¹	\$30 copay; deductible waived ¹	50%; deductible waived ¹	\$30 copay; deductible waived ¹	50%; deductible waived ¹
Adult Preventive Care Routine Pap smears, annual mammograms, colorectal cancer screenings, PSA screenings	75%	50%	75%	50%	75%	50%
Other Routine Care Services Includes flu shot or routine physical exams and lab work	Not Covered		Not Covered		Not Covered	
Preventive Care for Babies and Children through age 6 Examinations and lab tests	For office visits: see Office Visits; For lab work: see Lab Work and X-rays	For office visits: see Office Visits; For lab work: see Lab Work and X-rays	For office visits: see Office Visits; For lab work: see Lab Work and X-rays	For office visits: see Office Visits; For lab work: see Lab Work and X-rays	For office visits: see Office Visits; For lab work: see Lab Work and X-rays	For office visits: see Office Visits; For lab work: see Lab Work and X-rays
Immunizations for Babies and Children through age 6	100%; deductible waived		100%; deductible waived		100%; deductible waived	
Limited Professional Services Surgery, anesthesia, radiation therapy, in-hospital doctor visits	75% for limited services only	50% for limited services only	75% for limited services only	50% for limited services only	75% for limited services only	50% for limited services only
X-rays and Lab Work	75%; deductible waived ²	50%; deductible waived ²	75%; deductible waived ²	50%; deductible waived ²	75%; deductible waived ²	50%; deductible waived ²
Ambulance Service Maximum covered expense of \$750 per trip for ground or air	75%	50%	75%	50%	75%	50%
Initial Care of Medical Emergency^{3,4} Inpatient or Outpatient	75%	75% ⁵	75%	75% ⁵	75%	75% ⁵
Inpatient Hospital Services³	75%	50% less \$500 deductible for non-emergency stays	75%	50% less \$500 deductible for non-emergency stays	75%	50% less \$500 deductible for non-emergency stays
Outpatient Medical Care³	75%	50%	75%	50%	75%	50%
Physical/Occupational Therapy and Acupuncture/Acupressure All services combined	Not Covered		Not Covered		Not Covered	
Retail Pharmacy⁶ Per prescription; 30-day supply ⁷ Generic Drugs Deductible waived	\$10 copay	50% of the average wholesale price	\$10 copay	50% of the average wholesale price	\$10 copay	50% of the average wholesale price
Brand-Name Drugs \$200 brand-name deductible applies per member, per year	\$25 copay	50% of average wholesale price	\$25 copay	50% of average wholesale price	\$25 copay	50% of average wholesale price
Mail Service⁸ Per prescription ⁷ Generic Drugs Deductible waived	\$20 copay	N/A	\$20 copay	N/A	\$20 copay	N/A
Brand-Name Drugs \$200 brand-name deductible applies	\$50 copay	N/A	\$50 copay	N/A	\$50 copay	N/A

Please note: when you use nonparticipating (out-of-network) providers, your benefits are based on a maximum allowable amount determined by UniCare as described in your Policy's definition of Reasonable Charge. Using an out-of-network provider may result in higher costs to you because you are responsible for any billed charges in excess of that amount. Please reference your Policy for the full definition of Reasonable Charge.

- Two office visits per member, per year, participating and nonparticipating providers combined. 3+ office visits: member pays 100 percent of billed charges
- Maximum payment of \$300 per member, per year with deductible waived; participating and nonparticipating providers combined.
- Services may require preservice review or authorization by UniCare or you will be required to pay an additional penalty.
- Emergency room visits that do not result in an inpatient admission will be subject to an additional \$60 penalty.
- Until transferable to a participating hospital, then 50 percent subject to a \$500 deductible per continuing hospital confinement once transferable.
- Certain prescription drugs may require prior authorization by UniCare.
- Maximum payment by UniCare of \$500 per member, per year; includes generics and brand, participating and nonparticipating retail and mail service combined.
- Saver 2000 Plan - 60-day mail order supply; Saver 5000 and 10,000 Plans - 90-day mail order supply.

Specialty Offerings

How to turn your health plan into the ultimate security package.

One application, one premium bill and two great insurance options make it easy to create a complete benefit solution for you and your family.

Health. Dental. Term Life. One application to help fit all of your needs.

Dental

According to the American Dental Hygienist Association, gum and tooth disease have been linked to a number of major health conditions like heart disease, stroke, respiratory disease and diabetes.¹ That's why it's important to take good care of your oral health. Enroll in dental coverage from UniCare and appreciate the convenience of:

- Day one coverage for diagnostic and preventive care – no waiting periods for cleanings and X-rays
- Quality dental benefits up to \$1,000 per member per year
- In and out-of-network coverage (But you get the greatest savings when you choose a dentist from our broad network. To find a provider, visit unicare.com and click Find a Doctor.)

MONTHLY DENTAL RATES*

UNICARE INDIVIDUAL & FAMILY DENTAL FEE-FOR-SERVICE PLAN	FEE-FOR-SERVICE RATES
1 Adult	\$20.50
2 Adults	\$41.50
Adult with 1 child	\$31.50
Adult with 2 children	\$42.50
Adult with 3+ children	\$58.50
Family – 1 child	\$51.50
Family – 2 children	\$62.50
Family – 3+ children	\$79.00
1 Child	\$11.00
2 Children	\$21.50
3+ Children	\$37.50

*Rates subject to change. The rates listed are monthly rates. Monthly payment is available only through the monthly checking account deduction program. If you prefer to pay quarterly, multiply the monthly rate by three.

SAMPLE BENEFITS FOR DIAGNOSTIC AND PREVENTIVE CARE

PROCEDURE	UNICARE DENTAL PAYS*
Periodic Oral Exam, limited to 2 exams per member per year	\$13
Bitewing X-rays, single film	\$6
Bitewing X-rays, two films	\$11
Single (periapical) X-rays, first film	\$7
Single X-rays, additional films	\$7
Bitewing X-rays, four films	\$16
Full mouth X-rays, limited to one set every 3 years	\$31
Routine Cleaning, limited to 2 per adult** per year	\$28
Routine Cleaning, limited to 2 per child** per year	\$21
Cleaning with Fluoride, limited to 2 per child per year	\$28
Topical Fluoride Only, limited to 2 per child per year	\$9

Coverage begins on your effective date. The plan deductible is \$50 per member/\$150 per family member. The annual plan maximum is \$1,000. Two oral examinations and two dental cleanings per member, per year. Includes single and bitewing X-rays not to exceed benefit for full-mouth X-rays \$31.

*Plan pays lesser of amounts shown or actual fee charged by the dentist.

**Adult – any person or dependent 19 years or older covered by this plan.

Child – any person or dependent 18 years or younger covered by this plan.

SAMPLE BENEFITS FOR BASIC DENTAL CARE

Coverage begins after your Plan has been in effect for 6 continuous months.

PROCEDURE	UNICARE DENTAL PAYS*
Filling – one surface	\$28
Filling – two surfaces	\$38
Filling – three surfaces	\$45
Filling – four or more surfaces	\$55
Extraction – erupted tooth or root	\$31
Surgical – removal of erupted tooth	\$55
Removal of Impacted Tooth – soft tissue	\$75
Removal of Impacted Tooth – partial bony	\$95
Removal of Impacted Tooth – complete bony	\$115

*Plan pays lesser of amounts shown or actual fee charged by the dentist.

SAMPLE BENEFITS FOR MAJOR DENTAL CARE

Coverage begins after your Plan has been in effect for 12 continuous months.

PROCEDURE	UNICARE DENTAL PAYS*
Scaling/Root Planing per Quadrant	\$37
Gingivectomy – per tooth	\$27
Gingivectomy – per quadrant	\$100
Root Canal – 1 canal	\$110
Root Canal – 2 canals	\$135
Root Canal – 3 canals	\$170
Crown (except stainless steel)	\$170
Pontic	\$170
Complete Denture (upper or lower)	\$205
Partial Denture (upper or lower)	\$205
Denture Reline (chair-side)	\$44
Denture Reline (lab)	\$60

*Plan pays lesser of amounts shown or actual fee charged by the dentist.

Term life insurance

Losing a loved one is painful enough without having to worry about finances. So why not give your family the extra support they’ll need with term life insurance from UniCare.

It’s affordable. Just pennies a day.

It’s easy. No medical exam or additional enrollment forms needed.

UNICARE INDIVIDUAL

AGE	\$15,000	\$25,000	\$50,000
1–18	\$1.50	\$2.50	N/A
19–29	\$2.80	\$4.65	\$9.30
30–39	\$3.25	\$5.40	\$10.80
40–49	\$7.50	\$12.50	\$25.00
50–59	\$20.90	\$34.80	\$69.60
60–64	\$29.40	\$49.00	\$98.00

Health Extras

Full Circle Health®

Your health – and the health of your family – is important to us. That's why we have introduced UniCare Full Circle Health, a comprehensive suite of health care management programs that help keep our members become engaged and empowered to take control of their health.¹ UniCare Full Circle Health surrounds you with services in four areas:

Health Resources: Healthy Living is our online location for health and wellness resources that are designed to help you and your family do what's most important, make smart decisions and live healthier lives. And if you need assistance, we are only a phone call away.

Health Extras: HealthyExtensionsSM gives you access to a large selection of discounted health and fitness materials, services and products, including fitness memberships, massage therapy, exercise programs and more.

Health Guidance: Our MedCall® 24/7 Nurse Information Line offers answers to many of your questions when you need them. Registered nurses will answer general health and wellness questions and also provide guidance.

Health Management: If you or a family member is living with a chronic condition, Condition Management is designed to help you achieve a better level of health. And, there are additional support resources, to help you stay motivated such as our website featuring the latest health news and educational mailings specific to your health needs.

WellPoint NextRxSM – the UniCare Mail Service Program

Many UniCare plans include a mail service drug benefit. If you or a covered family member takes maintenance medications, we offer more convenience in filling your prescriptions. With NextRx you can order maintenance medications and refills from the comfort of your own home – and your medication will be delivered right to your door.² NextRx saves you the time and energy of a trip to the pharmacy. To learn more visit our website wellpointnextrx.com.

10-Day Free Look

Once your plan booklet arrives, you have 10 full days to examine and either accept or decline coverage. By returning the plan booklet with a written request to cancel, you are notifying UniCare of your request to discontinue coverage. We will proceed to cancel your coverage as of the original effective date and refund any premium you have paid. After 10 days, you may cancel by sending UniCare a written notice. Upon receipt of the request, UniCare will cancel your policy the first of the following month or a later date specified in the notice. UniCare shall cancel and refund the excess of paid premium.

Travel Access – Peace of Mind While You Travel

Travel Access is available to UniCare plan members at no additional premium cost. When you or one of your family members needs medical care while traveling outside of your local provider network, but within the continental United States, Travel Access can help you get connected.

When you call your Travel Access representative, you will be provided with the name, address and phone number of an independently contracted doctor or hospital that is within the UniCare expanded provider network. The doctor will help address your health concern(s) and submit the claim forms to UniCare on your behalf so that your health care benefits are applied.

Pharmacy benefit management services provided by Professional Claim Services, Inc. dba WellPoint Pharmacy Management.

¹ The UniCare Full Circle Health program availability varies from plan to plan. Please refer to your Certificate of Coverage for more complete information.

² Due to state laws, certain medications require a signature at the time of delivery and certain drugs require a hardcopy prescription be mailed in by you or your physician. Pharmacy law requires that prescriptions for controlled substances be mailed in only. WellPoint NextRx cannot accept faxed or phoned-in prescriptions for these medications. Call WellPoint NextRx toll-free at (866) 274-6825 for further information.

Limitations

The following limitations are specific to the medical plans listed in this brochure.

Ambulance Services: For the Enhanced FIT Plans and the UniCare HSA Compatible Plans only, ambulance services are limited to a maximum covered expense of \$5,000 per trip for air transport or \$1,000 per trip for ground transport. For the UniCare Saver Plans, ambulance services are limited to a maximum covered expense of \$750 per trip (air or ground).

Home Health Care: Limited to a combined maximum of 60 visits each year.

Skilled Nursing Facilities: Limited to a maximum covered expense of \$400 per day, and 100 days per year.

Services for Mental, Emotional or Functional Nervous Disorders:

- Inpatient: Benefits for eligible inpatient hospital services are paid up to \$100 per day, up to a maximum payment of \$3,000 per year;
- Outpatient: Benefits for eligible treatment are payable up to \$30 per visit up to a maximum of 12 visits per year for in or outpatient professional charges.

Physical, Occupational Therapy/Medicine, Speech Therapy and Acupuncture/ Acupressure: Benefits are payable up to \$30 per visit with a combined total maximum of 12 visits per year.

Hospice For Enhanced FIT, Saver and UniCare HSA Compatible Plans: Limited to a lifetime maximum payment of \$10,000.

AIDS/ARC: Benefits for Acquired Immune Deficiency Syndrome (AIDS) and/or AIDS Related Complex (ARC) are limited to a maximum of \$10,000 per year with a lifetime maximum of \$50,000.

Additional Limitations for the UniCare Saver Plans

Office Visits: Limited to two visits per member per year.

Lab and X-ray (non hospital based): Limited to a maximum payment of \$300 per member per year.

Prescription Drugs: Limited to a maximum payment of \$500 per member per year. Includes generic and brand, participating and nonparticipating retail and mail order combined.

Exclusions

The following exclusions are specific to the medical plans listed in this brochure.

- Services for any condition for which benefits are excluded by a waiver.
- Any amounts in excess of maximum amounts of covered expenses.
- Services not specifically listed in the plan as covered services.
- Services or supplies that are not medically necessary.
- Services or supplies that are experimental or investigative.
- Services received before the effective date of coverage or during an inpatient stay that began before that effective date.
- Services received after coverage ends.
- Services for which you have no legal obligation to pay or for which no charge would be made if you did not have health insurance coverage.
- Any condition for which benefits are covered under any workers compensation or similar laws.
- Services received for any intentionally self-inflicted injury or illness.
- Services received for any condition caused by, or contributed by: (a) an act of war; (b) the inadvertent release of nuclear energy when government funds are available for treatment; (c) an insured person participating in the military service of any country; (d) an insured person participating in an insurrection, rebellion, or riot; (e) an insured person's commission of or attempt to commit a felony; (f) an insured person, age 19 or older, being under the influence of illegal narcotics, alcohol or nonprescribed controlled substances.
- Smoking cessation programs, except those specifically provided or arranged by UniCare.
- Any services for which payment may be obtained from any local, state, or federal government agency except Medicaid and when payment under this Plan is expressly required by federal or state law; or services provided for the treatment of mental or nervous disorders by a tax supported institution of the State of Texas.
- Any services to the extent that you are entitled to receive Medicare benefits for those services, whether or not Medicare benefits are actually paid. Veterans Administration hospitals, and military treatment facilities will be considered for payment according to current legislation.
- Professional services received, or supplies purchased from, an insured person, a person who lives in the insured person's home or who is related to the insured person by blood, marriage, or adoption, or is the insured person's employer.
- Services of a private duty nurse.
- Inpatient room and board charges in connection with a hospital stay primarily for: environmental change, physical therapy, or treatment of chronic pain; custodial care, or rest cures; diagnostic tests which could have been performed safely on an outpatient basis.
- Services provided by a rest home, a home for the aged, a nursing home, or any similar facility service.
- Treatment of drug, alcohol, or other substance addiction or abuse.
- Dental services.
- Orthodontic services.
- Dental implants or any associated procedures.
- Hearing aids.
- Optometric services, eye exercises including orthoptics, eyeglasses, contact lenses, routine eye exams, and routine eye refractions.
- An eye surgery solely for the purpose of correcting refractive defects of the eye.
- Outpatient speech therapy except as specifically provided in the plan.
- Any drugs (including but not limited to drug samples), medications, or other substances dispensed or administered in any outpatient setting unless otherwise covered by plan.
- Cosmetic surgery or other services for beautification. This exclusion does not apply to medically necessary reconstructive surgery to restore a bodily function, to correct a deformity caused by injury or congenital defect of a newborn child, or by breast reconstruction performed to restore or achieve breast symmetry incident to a mastectomy.
- Procedures or treatments to change characteristics of the body to those of the opposite sex. This includes any medical, surgical, or psychiatric treatment or study related to sex change.
- Treatment of sexual dysfunction, impotence and/or inadequacy.
- All services related to the evaluation or treatment of fertility and/or infertility.
- All nonprescription contraceptive drugs, devices and supplies and non-FDA-approved prescription contraceptive drugs, devices, and supplies. Prescription contraceptive drugs or devices are covered under the prescription drug benefit of the plan.
- Charges for pregnancy and maternity care, including but not limited to, normal delivery, cesarean sections, and elective abortions, except as specifically provided in the plan.
- Cryopreservation of sperm or eggs.

- Orthopedic shoes (except when joined to braces) or shoe inserts, including orthotics.
- Services primarily for weight reduction or treatment of obesity including morbid obesity, or any care which involves weight reduction as a main method for treatment. This includes morbid obesity surgery, even if the insured person has other health conditions that might be helped by a reduction of obesity or weight, or any program, product or medical treatment for weight reduction or any expenses of any kind to treat obesity, weight control or weight reduction.
- Routine physical exams or tests that do not directly treat an actual illness, injury, or condition, including those required by employment or government authority except as specifically stated under the adult preventive care and well baby and well child care sections of this plan.
- Charges by a provider for telephone consultations. (Note: a Telemedicine Medical Service or Telehealth Service will not be excluded solely because the service is not provided through a face-to-face consultation.)
- Items which are furnished primarily for your personal comfort or convenience.
- Educational services except for a diabetes self-management training program and as specifically provided or arranged by UniCare.
- Nutritional counseling or food supplements except for formulas necessary for the treatment of phenylketonuria.
- Any services received on or within 12 months after the effective date of coverage if they are related to a pre-existing condition.
- All incidental supplies used by a provider in the administration of infusion therapy.
- Foreign country provider charges, except as specifically stated in the plan.
- Service for which a third party may be liable or legally responsible to pay.
- Growth hormone treatment.
- Routine foot care.
- Charges for which we are unable to determine our liability because you or an insured person failed within 90 days or as soon as reasonably possible to (a) authorize us to receive all the medical records and information we requested or, (b) provide us with information we requested regarding the circumstances of the claim or other insurance coverage.
- Charges for the services of a standby physician.
- Charges for animal-to-human organ transplants.

Additional Exclusions for the UniCare Saver Plans

- Any services of a physician, except as specifically stated in the plan.
- Surgical procedures for sterilization.
- Physical and/or occupational therapy/medicine, except when provided during an inpatient hospital confinement.
- Outpatient speech therapy.
- Acupuncture/Acupressure.
- Durable medical equipment.
- Professional services for any care for mental or nervous disorders and substance abuse, whether the care is provided in an inpatient hospital setting or as an outpatient.

Prescription Drug Exclusions

- Drugs and medications not requiring a prescription, except insulin.
- Nonmedical substances or items.
- Drugs and medications used to induce non-spontaneous abortions.
- Dietary supplements, cosmetics, and health or beauty aids.
- Any vitamin, mineral, herb or botanical product.
- Any expense incurred in excess of the UniCare negotiated rate.
- Any drug labeled “Caution, limited by federal law to investigational use” or non-FDA-approved investigational drugs.
- Any drug or medication prescribed for experimental indications.
- Drugs used for cosmetic purposes.
- Select classes of drugs where non-preferred medications, which have therapeutic alternatives have shown no benefit regarding efficacy or side effects over preferred drugs. However, this will not apply if the prescriber denotes, “dispense as written” or do not substitute.”
- Drugs used for the primary purpose of treating infertility or promoting fertility.
- Anorexiants or drugs associated with weight loss.
- Drugs obtained outside the United States.
- Drugs for treatment of a condition, illness, or injury for which benefits are excluded or limited by a waiver, pre-existing condition, or other contract limitation.

- Prescription drugs with a non-prescription (over-the-counter) chemical and dose equivalent.
- Lost or stolen prescriptions.
- Waiting Period: An insured person must be insured for 6 months under the plan to be eligible for benefits related to:
 - Hernia except for strangulated or incarcerated hernia
 - Any disorder of reproductive organs
 - Sterilization
 - Varicose veins
 - Hemorrhoids
 - Disorder of tonsils or adenoids

An insured person must also be insured for 30 days under the plan prior to the inception of pregnancy to be eligible for any benefits for Complications of Pregnancy.

Terms of Coverage

Coverage under the health insurance plan remains in force as long as the required premiums are paid on time and as long as you remain eligible for coverage. Coverage ceases when you become ineligible because of divorce or a change in dependent status. (In the case of divorce and coverage dependents, UniCare will offer a similar plan.) UniCare may change the premiums of this plan with 30 days advance written notice to you. However, UniCare will not change the premium schedule for this plan on an individual basis, but only for all insureds in the same class and covered under the same benefit plan as you.

Pre-Existing Conditions

Coverage will not be provided for 12 months following the effective date of this plan for medical conditions that existed in the 12 months prior to the effective date. UniCare will, however, give you credit for the time you were covered by other creditable coverage if the coverage under the plan ended less than 63 days from the date of application for the UniCare plan.

Preservice Review

Services may require preservice review or authorization by UniCare or you will be required to pay an additional penalty. Inpatient medical care requires preservice review or you will pay a \$500 penalty per continuing hospital confinement. This penalty is waived on emergency admissions, however, utilization review is still required. Surgical services of an ambulatory surgical center and specified outpatient surgeries and diagnostic procedures, regardless of place of service, require preservice review or you will pay a \$50 penalty. Organ/tissue transplants, infusion therapy, home health services, skilled nursing facilities and hospice services require prior authorization from UniCare or there will be a 50 percent reduction in benefits.

These listings are an overview only. A more detailed list of each plan's limitations and exclusions can be found in the applicable Certificate of Coverage. Only the actual Certificate of Coverage provisions apply. If there are conflicts between the terms of the Certificate of Coverage and this Plan Overview, the terms of the Certificate of Coverage will prevail.



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