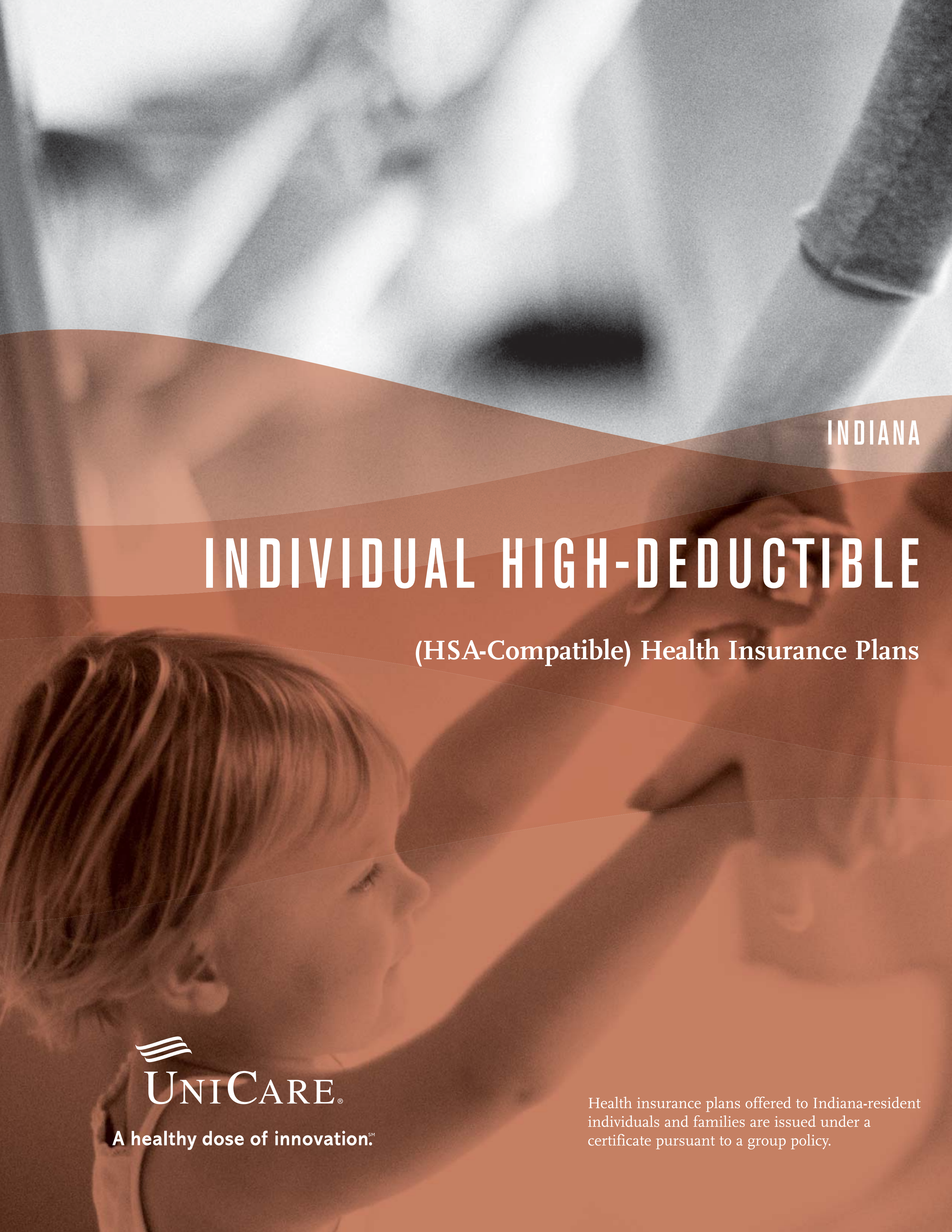


INDIANA

INDIVIDUAL HIGH-DEDUCTIBLE

(HSA-Compatible) Health Insurance Plans

UNICARE®

A healthy dose of innovation.℠

Health insurance plans offered to Indiana-resident individuals and families are issued under a certificate pursuant to a group policy.

UNICARE Life & Health Insurance Company is a separately capitalized and incorporated subsidiary of WellPoint Health Networks Inc. WellPoint Health Networks Inc. is one of the largest managed care companies in the United States. WellPoint and its family of companies provide health coverage for over 15 million people and have over 46 million specialty members. UNICARE's High-Deductible (HSA-Compatible) Plans provide:

– Choice of doctors

– Preventive care for children and adults

– Toll-free dedicated customer service numbers

– NO CLAIM FORMS with Network Providers

– Optional easy-issue Term Life Insurance

– Options of Single Party or Family PPO Coverage

UNICARE offers HSA-Compatible health insurance plans so you can choose the right coverage for you and your family.

What Is a High-Deductible Health Plan?

A High-Deductible Health Plan (HDHP) is a health plan that meets certain requirements in terms of annual deductibles and annual out-of-pocket expense maximums. In order for individuals or families to qualify for a Health Savings Account (HSA), they must be enrolled in an HDHP.

A health plan is an HDHP if the annual deductible for a single party is at least $1,000 and has an out-of-pocket expense maximum that does not exceed $5,000.

A health plan is an HDHP if the annual deductible for a family is at least $2,000 and has an out-of-pocket expense maximum that does not exceed $10,000.

Out-of-pocket expenses include:
- deductibles–the amount you pay for your health care each year before your insurance plan begins to pay
- copayment– a specific dollar amount of a covered service that you pay at the time the service is rendered (for example, prescription drug copays)
- coinsurance– the percentage of a covered service that you pay

What Is a Health Savings Account?

A Health Savings Account (HSA) is a savings account established exclusively to pay for medical expenses of the individual or family who has contributed to the account while covered under a High-Deductible Health Plan.

The HSA provides an avenue to fund your health care expenses now and to save for long-term heath care expenses or to bridge a potential gap between your needs and what funds may become available to you once you become eligible for Medicare. When the funds are used for eligible health care expenses, the savings may be tax deductible.

The High-Deductible (HSA-Compatible) Health Plans are provided by UNICARE Life & Health Insurance Company (UNICARE). The HSA is not administered by UNICARE, but by a qualified bank or financial institution. You may choose any bank or financial institution that is qualified to provide this service. We advise you to consult with your tax advisor for assistance in establishing your HSA.

What is the advantage of an HSA?

Your UNICARE High-Deductible Health Plan works in conjunction with your HSA. The plan provides benefits for covered medical services once applicable deductibles are satisfied. The funds you deposit in your HSA can be used to pay for medical expenses applied to your deductible.

Some medical expenses not covered by your HDHP may still qualify for funding from your HSA without tax penalty. Please refer to section 213d of the IRS code for information regarding what medical expenses can be covered by your HSA.

Please note:
This High-Deductible Health Plan is not a “Health Savings Account” or an “HSA” but is designed as a High-Deductible Health Plan that may allow you, if you are an eligible individual, to take advantage of the income tax benefits available to you when you establish an HSA and use the money you deposit into the HSA to pay for qualified medical expenses subject to the provisions under this plan.

Apply for Your UNICARE High-Deductible Health Plan Now

You must first enroll in a High-Deductible Health Plan (HDHP) before you may establish a Health Savings Account (HSA). You also must continue your enrollment in your HDHP in order to continue to make contributions to your HSA.

High-Deductible Plan Options

You have a choice of three UNICARE High-Deductible Health Plans and the option of a family plan or a plan just for yourself. The annual deductible for each plan and the maximum annual amount you may contribute to your HSA in 2004 are listed in the table below. Additional "catch up" contributions are permitted for those who are between the ages of 55 and 65 by tax year end. Consult your tax advisor for details.

High-Deductible (HSA-Compatible) Plan		Annual Deductible	Amount You May Deposit Into Your HSA Annually
Plan 1	Single Party	$1,000	$1,000
	Family	$2,000	$2,000
Plan 2	Single Party	$2,600	$2,600
	Family	$5,200	$5,150
Plan 3	Single Party	$5,000	$2,600
	Family	$10,000	$5,150

Eligibility for UNICARE High-Deductible (HSA-Compatible) Health Plans

To be eligible for enrollment, you must be:

– age 64½ or younger*

– the applicant's spouse, age 64½ or younger

– the applicant's unmarried child, up to age 19

– the applicant's unmarried child who is a full-time student (12 units per semester), age 19-22

– a resident of the United States for at least 6 months

– able to meet UNICARE's underwriting guidelines

– not eligible for Medicare

– not enrolled in any other group or individual health insurance plan

Eligibility for HSA

To be eligible to establish an HSA:

– you must be covered under a high-deductible health plan (HDHP)

– you may not be covered by any other health plan**

– you may not be entitled to Medicare benefits (generally, this means you are under age 65)

– you may not be claimed as a dependent on another person's tax return

* While children may apply for a UNICARE High-Deductible Health Plan (children-only plan), children are not eligible to have Health Savings Accounts established in their names.

** It is permissible to have insurance under which substantially all of the coverage provided relates to Workers' Compensation laws, tort liabilities, liabilities relating to ownership of property (e.g. automobile insurance), insurance for a specified disease or illness, insurance that pays a fixed amount per day (or other period) of hospitalization, coverage for accidents, disability, dental care, vision care, or long-term care and still be eligible for an HSA.

UNICARE High-Deductible Single Party and Family Plans

Benefit Summary

Amounts shown below are the member's share of costs.

	High-Deductible (HSA-Compatible) Plan 1				High-Deductible (HSA-Compatible) Plan 2				High-Deductible (HSA-Compatible) Plan 3			
	Single Party		Family		Single Party		Family		Single Party		Family	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual Deductible	$1,000	Additional $4,000 out-of-network deductible	$2,000	Additional $8,000 out-of-network deductible	$2,600	Additional $4,000 out-of-network deductible	$5,200	Additional $8,000 out-of-network deductible	$5,000	Additional $4,000 out-of-network deductible	$10,000	Additional $8,000 out-of-network deductible
Annual Out-of-Pocket Maximums (Includes annual deductible and pharmacy copays)	$5,000	$15,000	$10,000	$20,000	$5,000	$15,000	$10,000	$20,000	$5,000	$15,000	$10,000	$20,000

The annual deductible applies to all covered expenses. The out-of-network deductible applies to covered expenses incurred from nonparticipating providers and pharmacies after the annual deductible is satisfied. The in-network out-of-pocket maximum includes the annual deductible, copayments and coinsurance incurred from independently contracted participating providers and pharmacies. The out-of-network out-of-pocket maximum includes the annual deductible, the out-of-network deductible and copayments and coinsurance incurred from nonparticipating providers and pharmacies.

It Pays to Use a UNICARE Participating Physician or Hospital

Example using the High-Deductible (HSA-Compatible) Plan 2

Participating Providers	
If the billed charges are	$1,000
And UNICARE's negotiated rate is	$650
You get a discount of	$350
UNICARE pays 80% of negotiated fee*	$520
You pay	**$130**

Nonparticipating Providers	
If the billed charges are	$1,000
Amount UNICARE considers reasonable	$650
UNICARE pays 60% of reasonable charges	$390
You pay 40% of reasonable charges*	$260
Plus, the difference between the billed charges and the reasonable charges	$350
You pay a total of	**$610**

***Assuming any deductible has been met and you have not reached your annual out-of-pocket maximum.**

High-Deductible (HSA-Compatible) Single Party and Family Medical Plan Comparison*

All plans feature a $5,000,000 per member lifetime maximum in benefits.

This matrix is intended to help you compare UNICARE plan benefits and reflects UNICARE's payment for covered expenses after the annual and out-of-network deductibles are met.

When you use UNICARE independently contracted in-network (participating) providers, your costs are based on a specially negotiated rate for UNICARE that may often save you money. When you use out-of-network (nonparticipating) providers, your costs are based on charges deemed by UNICARE to be reasonable for that service and area. Reasonable charges may be less than your provider's billed charges and often result in higher costs to you.

Refer to the UNICARE provider directory or to the UNICARE Web site at www.unicare.com to determine which providers in your area are participating providers. Ask your agent to provide you with a UNICARE provider directory before you sign an application for coverage.

*This is only a brief description of various plans available. For a more detailed description of coverage, benefits, limitations and exclusions, preservice and utilization review, the preauthorization process, additional deductibles, and penalties that may apply, please refer to the applicable Certificate of Coverage. If there are any conflicts between the terms of the Certificate of Coverage and the information in this brochure, the terms of the Certificate of Coverage will prevail.

OVERVIEW OF COVERAGE - Amounts below are UNICARE's payment after applicable

	High-Deductible (HSA-Compatible) Plan 1			
	Single Party		Family	
Your Plan Features	Participating	Nonparticipating	Participating	Nonparticipating
Lifetime Maximum	UNICARE pays up to $5,000,000 per member		UNICARE pays up to $5,000,000 per member	
Professional Services Office visits, surgery, anesthesia, radiation therapy, in-hospital doctor visits and diagnostic X-ray/lab	80%	60%	80%	60%
Preventive Care for Babies and Children (through age 6) Exams, immunizations, and lab tests	80%	60%	80%	60%
Adult Preventive Care Routine Pap smears, annual mammograms, colorectal cancer screenings and PSA screenings	80%	60%	80%	60%
Inpatient Hospital Services [1]	80%	60%	80%	60%
Outpatient Medical Care [2]	80%	60%	80%	60%
Physical/Occupational Therapy and Acupuncture/Acupressure	$30 maximum per visit; with a combined maximum of 12 visits per year		$30 maximum per visit; with a combined maximum of 12 visits per year	
Ambulatory Surgical Center [1]	80%	60%	80%	60%
Ambulance Service With a maximum covered expense per trip: ground $1,000; air $5,000	80%	60%	80%	60%
Durable Medical Equipment	80%	60%	80%	60%
Initial Care for a Medical Emergency - Inpatient or Outpatient	80%	80%	80%	80%
Prescription Drugs [3] **Retail Pharmacy** Per prescription (up to 30-day supply)	**Generic drugs:** 100% after member pays a $10 copay **Brand name formulary drugs:** 100% after member pays a $30 copay **Brand name nonformulary drugs:** 100% after member pays a $50 copay	**Generic and brand name drugs:** 50% of the average wholesale price	**Generic drugs:** 100% after member pays a $10 copay **Brand name formulary drugs:** 100% after member pays a $30 copay **Brand name nonformulary drugs:** 100% after member pays a $50 copay	**Generic and brand name drugs:** 50% of the average wholesale price
Prescription Drugs [3] **Mail Service** Per prescription (up to 60-day supply)	**Generic drugs:** 100% after member pays a $20 copay **Brand name formulary drugs:** 100% after member pays a $60 copay **Brand name nonformulary drugs:** 100% after member pays a $100 copay	Not Available	**Generic drugs:** 100% after member pays a $20 copay **Brand name formulary drugs:** 100% after member pays a $60 copay **Brand name nonformulary drugs:** 100% after member pays a $100 copay	Not Available

[1] Services may require preservice review or authorization by UNICARE or you will be required to pay an additional penalty. Please refer to page 6 for specific penalty information.

[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.

deductibles are met.

High-Deductible (HSA-Compatible) Plan 2				High-Deductible (HSA-Compatible) Plan 3			
Single Party		Family		Single Party		Family	
Participating	Nonparticipating	Participating	Nonparticipating	Participating	Nonparticipating	Participating	Nonparticipating
UNICARE pays up to $5,000,000 per member		UNICARE pays up to $5,000,000 per member		UNICARE pays up to $5,000,000 per member		UNICARE pays up to $5,000,000 per member	
80%	60%	80%	60%	100%	60%	100%	60%
80%	60%	80%	60%	100%	60%	100%	60%
80%	60%	80%	60%	100%	60%	100%	60%
80%	60%	80%	60%	100%	60%	100%	60%
80%	60%	80%	60%	100%	60%	100%	60%
$30 maximum per visit; with a combined maximum of 12 visits per year		$30 maximum per visit; with a combined maximum of 12 visits per year		$30 maximum per visit; with a combined maximum of 12 visits per year		$30 maximum per visit; with a combined maximum of 12 visits per year	
80%	60%	80%	60%	100%	60%	100%	60%
80%	60%	80%	60%	100%	60%	100%	60%
80%	60%	80%	60%	100%	60%	100%	60%
80%	80%	80%	80%	100%	100%	100%	100%
Generic drugs: 100% after member pays a $10 copay **Brand name formulary drugs:** 100% after member pays a $30 copay **Brand name nonformulary drugs:** 100% after member pays a $50 copay	**Generic and brand name drugs:** 50% of the average wholesale price	**Generic drugs:** 100% after member pays a $10 copay **Brand name formulary drugs:** 100% after member pays a $30 copay **Brand name nonformulary drugs:** 100% after member pays a $50 copay	**Generic and brand name drugs:** 50% of the average wholesale price	**Generic and brand name drugs:** 100%	**Generic and brand name drugs:** 50% of the average wholesale price	**Generic and brand name drugs:** 100%	**Generic and brand name drugs:** 50% of the average wholesale price
Generic drugs: 100% after member pays a $20 copay **Brand name formulary drugs:** 100% after member pays a $60 copay **Brand name nonformulary drugs:** 100% after member pays a $100 copay	Not Available	**Generic drugs:** 100% after member pays a $20 copay **Brand name formulary drugs:** 100% after member pays a $60 copay **Brand name nonformulary drugs:** 100% after member pays a $100 copay	Not Available	**Generic and brand name drugs:** 100%	Not Available	**Generic and brand name drugs:** 100%	Not Available

Utilization Management

UNICARE uses a process called Utilization Management to help you receive coverage for appropriate treatment in the correct setting and helps you avoid both unexpected out-of-pocket costs and unnecessary procedures.

Preservice review is performed before services are provided. All inpatient medical care requires preservice review or you will be subject to a $500 penalty per continuing hospital confinement. All surgical services of an ambulatory surgical center require preservice review or you will be subject to a $50 penalty. This review must be initiated at least three working days prior to admission to a licensed and accredited hospital or ambulatory surgical center.

Authorization Program

Certain services require prior authorization to be eligible for maximum benefits. There will be a $1,000 penalty for these services unless UNICARE authorizes benefits in advance for: organ/tissue transplants, infusion therapy, home health services, skilled nursing facilities and hospice.

Other services require authorization to be eligible for maximum benefits. Please see your Certificate of Coverage for additional details on preservice and utilization review, the authorization program, penalties, covered services and limitations and exclusions.

Utilization Management and the authorization program is not the practice of medicine or the provision of medical care to you. Remember, only your doctor can provide you with medical advice and care.

Important Additional Information

Waiting Periods

An insured must be covered by the plan for six consecutive months to be eligible for benefits concerning all services related to:

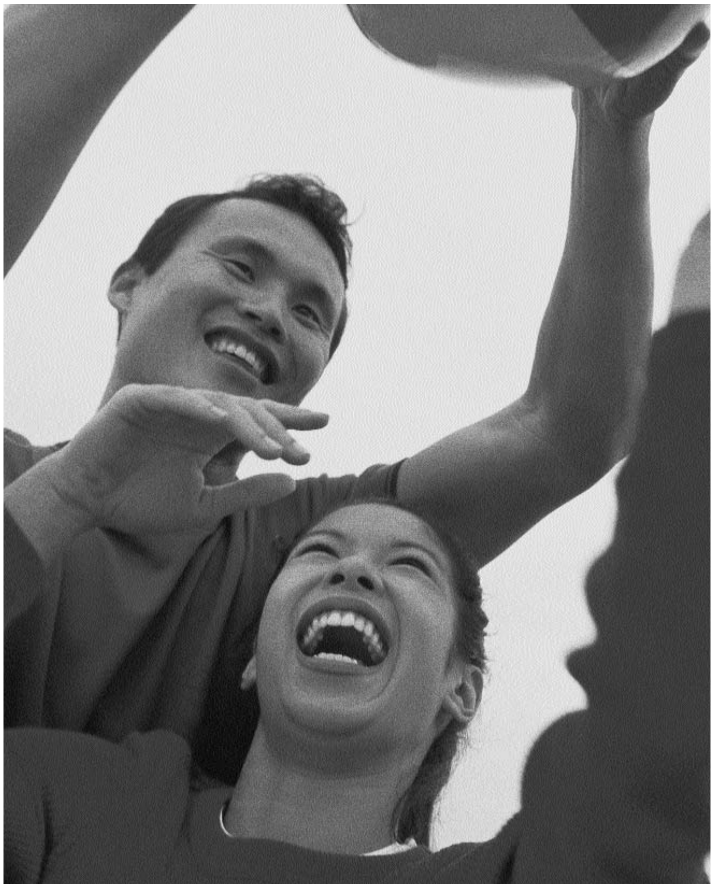
– hernia (except strangulated or incarcerated)

– varicose veins

This includes, but is not limited to, all tests, consultations, examinations, medications and invasive medical, laboratory or surgical procedures that are related to the evaluation or treatment of the above items.

Pre-existing Conditions

For medical conditions that existed six months prior to the effective date of your coverage, there will be no coverage for such conditions for 12 months after the effective date of your coverage.



Enrollment and Review Process

Each individual and family member who applies for coverage in any of the UNICARE plans must submit an application for UNICARE underwriting review. If any applicant does not qualify based on UNICARE's underwriting standards, the application will not be approved. Certain conditions, subject to UNICARE's underwriting guidelines, may qualify an applicant for the plan at a premium that is higher than the level I (preferred) premium and/or coverage for a particular medical condition may be excluded for coverage by a waiver. Please follow the instructions on the Individual and Family Plans application form.

If you are accepted, please carefully read your UNICARE Certificate of Coverage. This document lists, in more detail, all the benefits, conditions, limitations, exclusions, and requirements of your plan.

Waivers of Coverage

If you have a condition, illness, or injury that can be identified as one that does not necessarily affect your overall good health but could affect the risk balance of all insureds, we will waive that condition from coverage. This means that expenses for treatment of that condition or any other condition related to it will not be covered for a specified period of time.

Waived conditions will be clearly identified on your plan specification page. The period for which coverage is waived will also be stated.

Terms of Coverage

Coverage under this plan remains in force as long as the required premiums are paid on time and as long as the insured remains eligible for coverage. Coverage ceases when an insured no longer lives in the service area or becomes ineligible because of divorce or a change in dependent status. (In the case of divorce and over-age dependents, UNICARE may offer a similar plan.) UNICARE may change the premiums of this plan after 30 days' written notice to the insured. 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 plan as you.

Rates

Medical rates are calculated based on the age of the applicant or spouse, whoever is older, and the residence address. Rates are recalculated at each billing period based on age and the residence address. See pages 15-16 for medical coverage rates.

UNICARE high-deductible plans are not HSAs. The HSA account, which you must establish before you can enjoy tax-advantaged treatment, is a separate arrangement between you and a bank or other qualified institution. You must be an eligible individual under IRS regulations to receive the tax benefits of an HSA. Consultation with a tax advisor is recommended.

UNICARE has designed these plans to meet government requirements for High-Deductible Health Plans to be used in conjunction with establishing eligibility for HSA tax benefits. Although UNICARE believes that these plans meet these requirements, the Internal Revenue Service has not ruled on whether these plans are qualified as High-Deductible Health Plans.

Should you purchase one of these plans in order to obtain the income tax benefits associated with an HSA, and the Internal Revenue Service were to rule that this plan does not qualify as a High-Deductible Health Plan, you may not be eligible for the income tax benefits associated with an HSA. In this instance, you may have adverse income tax consequences with respect to your HSA for all years in which you were not eligible. However, if there were such a ruling, or if government requirements for a High-Deductible Health Plan change, UNICARE intends to amend the High-Deductible Health Plans prospectively, if necessary, to meet the requirements of a qualified plan. Any changes made to the plans to meet Internal Revenue Service requirements will not be effective until such changes are filed and approved with the appropriate regulatory authorities, as appropriate. A change in the plans' premiums may also be required as a result of a change in the plans.

HealthyExtensions℠

The Key to a Healthy Life — HealthyExtensions*

HealthyExtensions is an innovative program that gives you discounts on health and wellness products and services.

As a UNICARE member, you can take advantage of discounts from 5 up to 50 percent off a variety of alternative health care and wellness products and services offered by independent vendors.

Examples of products and services that are available:

- Vitamins
- Nutrition and fitness programs
- Health clubs
- Hearing aids
- Eyeglasses and contact lenses
- Skin care products
- Educational materials
- Online resources
- Alternative health practitioners

MedCall® — 24/7 Telephone Access to Health Care Professionals

You have access to nurse counselors 24 hours a day, seven days a week who can provide you with medical information whenever you need it. At no additional cost to you, this telephone hotline provides answers to many health questions about:

- Symptoms or procedures and alternatives
- Medications and side effects
- A diagnosis
- Referrals for doctors and medical facilities
- Referrals for local, state and national self-help agencies

In addition to personalized calls, MedCall provides you with recorded information on more than 200 health topics so you can learn more about your health care concerns at your convenience.

*This program is provided as a service to our members. These are not insurance benefits and are subject to change or cancellation without notice. Services and products provided by independent vendors that are not affiliated with UNICARE, its affiliates, subsidiaries, or parent company.

Vision Care Services — A Featured Discount Program for You

As a part of the HealthyExtensions program, you will receive discounts from participating optometrists and ophthalmologists for your vision care needs. Discounts of 10 up to 50 percent are available for eye exams, frames, lenses and contacts at participating providers.

If you wear contact lenses, you may purchase them from your favorite eye care professional or you might take advantage of additional savings and convenience by ordering via phone or Internet to have your contacts delivered directly to your home.

In addition, LASIK vision correction surgery is available to you at significant savings through TruVision™ and Cole Managed Vision.

Platinum Network Travel Access — Peace-of-Mind While You Travel

What happens if you or one of your family members get sick while traveling outside of Indiana? The Travel Access program helps you take advantage of your health plan benefits while traveling outside of your local independently contracted provider network, but within the continental United States. After all, you and your family deserve the same great benefits when you travel.

With Travel Access:

– There are no additional premium costs
– Your health care benefits are not changed by the addition of Travel Access
– The provider will submit the claim forms to UNICARE on your behalf

All you have to do is call your Travel Access representative, should a medical need arise, and you will be provided with the name, address and phone number of an independently contracted network provider or providers in the immediate area in which you are traveling that can help address your health concern. It's that simple.

Individual and Family Dental PPO Plan Coverage

Keep Your Teeth Healthy and Your Smile Bright.

Good oral health is a quality of life issue, affecting both your mental and physical wellness. UNICARE offers the Individual and Family Dental PPO Plan to provide affordable coverage for regular dental care.

With UNICARE's dental coverage you have:

– access to quality care at discounted fees
– a wide range of services for preventive, diagnostic, basic and major dental care
– no waiting period for preventive and diagnostic care
– freedom to choose any dentist
– additional savings for visiting an independently contracted, in-network dentist
– an annual deductible of $50 per person or $150 per family, waived for preventive and diagnostic services performed by a contracted dentist

For more information about the Individual and Family Dental PPO Plan, please call your UNICARE agent or visit the UNICARE Web site at www.unicare.com.

UNICARE Individual Dental Fee for Service Plan Monthly Rates*	
One adult	$25.00
Two adults	$50.00
Adult with 1 child	$37.50
Adult with 2 children	$50.50
Adult with 3+ children	$69.50
Family (1 child)	$62.50
Family (2 children)	$75.50
Family (3+ children)	$94.50
One child	$12.50
Two children	$25.50
Three+ children	$44.50

*Rates are current as of May 2004. Rates are subject to change without notice. Please contact your agent or UNICARE for the most current rates.

Individual Term Life Insurance

Is Your Family Prepared for the Unexpected?

For just cents per day, you can enjoy the security and peace of mind of knowing you can help meet your family's financial needs even if you're not there to provide for them.

There are some great reasons to add life insurance to your UNICARE Individual medical coverage:

- Life insurance provides a financial safeguard for your family
- No additional forms to fill out
- No medical exams
- One bill for medical and life coverage
- Available with all UNICARE medical plans, subject to underwriting
- You may choose life insurance for all of your eligible family members
- Child coverage for as little as $1.50 per month
- Adult coverage for as little as $2.80 per month*

To apply for enrollment, check the Life box in Section 2 and complete the Term Life portion in Section 5 on the Individual Enrollment Application.

Monthly Rates*

Age	$15,000	$25,000	$50,000
Under 1	Not Available	Not Available	Not Available
1-18	$1.50	$2.50	Not Available
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

**The rates for term life insurance will change based on the applicant's age. The age categories are shown in the chart above. The policy is issued for a one-year term, renewable at the policyholder's option. The rate schedule may be changed at the beginning of any annual term. The rates shown in the matrix above are accurate as of May 2004. Rates are subject to change without notice. Please contact your agent or UNICARE for the most current rates.*

The term life insurance coverage is subject to the written provisions of the policy issued by UNICARE. You should consult with your UNICARE agent regarding the specific terms and provisions of the policy. Each family member who has elected the term life insurance option will be sent a separate policy.

The policy will be canceled automatically on the first of the month of the policyholder's 65th birthday. If that birthday falls on the first of the month, the policy will be canceled on the first day of the month prior to the birth month.

Insurance coverage is underwritten by UNICARE Life & Health Insurance Company.

Limitations and Exclusions

The primary limitations and exclusions for the plans described in this brochure are listed below. Please take a few moments to review this information. 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.

Limitations

The following are the primary limitations that apply to these plans:

Infusion Therapy

Covered Expenses will not exceed: total parenteral nutrition (with or without lipids), $250 per day; antibiotics, average wholesale price (AWP)+$125 per day; chemotherapy, AWP + $150 per day, pain management $125 per day; aerosol therapy, AWP + $70 per day; tocolytic therapy, $250 per day; special Items, AWP; intravenous hydration, $75 per day.

Ambulance Service

UNICARE pays a maximum covered expense of $5,000 per trip for air transport or $1,000 per trip for ground transport.

Home Health

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.

Physical, Occupational Therapy/Medicine and Acupuncture/Acupressure

Benefits are payable up to $30 per visit with a combined maximum of 12 visits per year.

Hospice

Limited to a lifetime maximum payment of $10,000.

Smoking Cessation

Benefits for any smoking cessation program designed to end the dependency on nicotine are payable up to a maximum of $50 per lifetime.

Diabetes

Covered expenses for diabetes equipment and diabetes supplies are subject to a maximum of $500 per year.

Exclusions

This Plan does **not** provide benefits for:

– 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 UNICARE considers to be experimental or investigative procedures.

– Services received before the effective date of coverage or during an inpatient stay that began before the 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 recovered or can be recovered, either by adjudication, settlement, or otherwise, under any Workers' Compensation, employer's liability law, or occupational disease law, even if you do not claim those benefits.

– Any intentionally self-inflicted injury or illness.

– Conditions caused by (a) an act of war; (b) the inadvertent release of nuclear energy when government funds are available for treatment of illness or injury arising from such release of nuclear energy; (c) an insured person participating in the military service of any country; (d) an insured person participating in an insurrection, rebellion, or riot; (e) services received as a direct result of an insured person's commission of, or attempt to commit a felony or as a direct result of the insured person being engaged in an illegal occupation; (f) an insured person, being under the influence of illegal narcotics or nonprescribed controlled substances unless administered on the advice of a physician.

– Any services provided by a local, state, or federal government agency except when payment under this plan is expressly required by federal or state law.

– If you are eligible for Medicare, any services covered by Medicare under Part A and B are excluded from consideration of payment regardless of actual enrollment in Medicare or payment by Medicare for those services.

– Any services for which payment may be obtained from any local, state, or federal government agency (except Medicaid). Veterans Administration hospitals and military treatment facilities will be considered for payment according to current law.

– Professional services received, or supplies purchased, from yourself, a person who lives in the insured person's home or who is related to the insured person by blood, marriage or adoption, or the insured person's employer.

– Inpatient or outpatient 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; services provided by a rest home, a home for the aged, a nursing home, or any similar facility service.

– Inpatient room and board charges in connection with a hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.

– Treatment of drug or other substance addiction or abuse, except for treatment of alcoholism as specifically provided in the plan.

– Dental services.

– Orthodontic services.

– Dental implants or any associated procedure.

– Hearing aids.

– Routine hearing tests except as provided under

Well Baby and Well Child Care.

– Optometric services, eye exercises including orthoptics, eyeglasses, contact lenses, routine eye exams, and routine eye refractions, except as specifically stated in the plan.
– An eye surgery solely for the purpose of correcting refractive defects of the eye.
– Outpatient speech therapy.
– Any drugs, medications, or other substances dispensed or administered in any outpatient setting except as specifically stated in the plan. This includes, but is not limited to, items dispensed by a physician.
– Cosmetic surgery or other services for beautification, including any medical complications that are generally predictable and associated with such services by the organized medical community. This exclusion does not apply to reconstructive surgery to restore a bodily function or to correct a deformity caused by injury or congenital defect of a newborn child or to medically necessary reconstructive surgery performed to restore 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 including, but not limited to, all tests, consultations, examinations, medications, and invasive medical, laboratory, or surgical procedures including sterilization reversals and in vitro fertilization.
– Cryopreservation of sperm or eggs.
– All nonprescription contraceptive drugs, devices, and/or supplies that are available over-the-counter or without a prescription and non-FDA-approved prescription contraceptive drugs, devices, and/or supplies.
– Orthopedic shoes (except when joined to braces) or shoe inserts, including orthotics.
– Services primarily for weight reduction or treatment of obesity or any care which involves weight reduction as a main method for treatment except as specifically stated in the plan.
– Routine physical exams or tests that do not directly treat an actual illness, injury or condition, including those required by employment or government authority.
– Charges by a provider for telephone consultations.
– Items which are furnished primarily for your personal comfort or convenience (air purifiers, air conditioners, humidifiers, exercise equipment, treadmills, spas, elevators and supplies for hygiene or beautification, including wigs, etc.).
– Educational services except for diabetes self-management training and as specifically provided or arranged by UNICARE.
– Nutritional counseling or food supplements.
– Any services received on or within 12 months after the effective date of coverage if they are related to a pre-existing condition.
– Incidental supplies used by a provider in the administration of infusion therapy.
– Foreign country provider charges except as specifically stated in the plan.
– Growth hormone treatment except when such treatment is medically proven to be effective for the treatment of documented growth retardation due to deficiency of growth hormones, growth retardation secondary to chronic renal failure before or during dialysis, or for patients with AIDS wasting syndrome. Services must also be clinically proven to be effective for such use and such treatment must be likely to result in a significant improvement of the insured's condition.
– Routine foot care.
– Charges for which we are unable to determine our liability because you or an insured person failed, within 60 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 animal to human organ transplants.
– Charges for normal pregnancy or maternity care, including normal delivery, elective abortions and elective nonemergency cesarean sections, as long as the service is not related to Complications of Pregnancy.
– Drugs and medications not requiring a prescription, except insulin.
– Drugs and medications to induce nonspontaneous abortions.
– Dietary supplements, cosmetics, health or beauty aids.
– Any vitamin, mineral, herb or botanical product that does not have an FDA- (Food and Drug Administration) approved indication to treat, diagnose or cure a medical condition, even if it is thought to have health benefits.
– 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.
– 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 nonprescription (over-the-counter) chemical and dose equivalent.
– Lost or stolen prescriptions.

This is only a brief description of the plans. For more complete details, including benefits, limitations and exclusions, please refer to the applicable Certificate of Coverage.

Rating Area Definitions – Indiana

AREA 1	46303, 46307, 46308, 46311, 46312, 46319-46324, 46342, 46356, 46373, 46375, 46394, 464
AREA 2	All ZIP codes beginning with 463 that are not listed in Area 1
AREA 3	All ZIP codes beginning with 462, 465, and 466
AREA 4	Rest of State

Certain Medical Conditions

For certain medical conditions, an applicant may qualify for a plan at a premium that is higher than Level 1 rates and/or have such medical conditions excluded from coverage by application of a waiver.

Tobacco Users

Tobacco users pay an additional 40 percent premium. If any family member who is to be insured uses tobacco, see the Level 1+40 percent rates.

Additional Information

– An application must be completed to apply for coverage. Payment for the first month's premium must accompany the application.
– Rates are based on the age of the applicant or spouse, whoever is older, and the residence address. Rates are recalculated at each billing period based on age and the residence address.
– Payment methods are
  1) monthly by checking account deduction on the first of each month or
  2) 3-month (quarterly) billing.

See application instructions for specifics.

These rates are for the products described in this brochure and are intended for use only with this brochure. For a more detailed description of coverage, benefits, limitations and exclusions, preservice and utilization reviews, authorization process, additional deductibles and penalties that may apply, please refer to the applicable Certificate of Coverage.

Indiana Individual High-Deductible (HSA-Compatible) Monthly Rates, Effective 6/1/04

Plan 1 – Level 1

Single Party $1,000
Family $2,000

	Area 1	Area 2	Area 3	Area 4
Single Male				
Under 30	89	82	75	68
30-34	103	95	87	78
35-39	126	116	106	96
40-44	158	145	133	120
45-49	209	192	176	159
50-54	258	237	217	196
55-59	353	325	297	268
60-64	432	397	363	328
Single Female				
Under 30	101	93	85	77
30-34	126	116	106	96
35-39	163	150	137	124
40-44	199	183	167	151
45-49	231	213	194	176
50-54	279	257	234	212
55-59	315	290	265	239
60-64	361	332	303	274
Applicant & Spouse				
Under 30	178	164	150	135
30-34	190	175	160	144
35-39	230	212	193	175
40-44	277	255	233	211
45-49	354	326	297	269
50-54	427	393	359	325
55-59	555	511	466	422
60-64	662	609	556	503
Applicant & 1 Child				
Under 30	126	116	106	96
30-34	146	134	123	111
35-39	173	159	145	131
40-44	200	184	168	152
45-49	224	206	188	170
50-54	259	238	218	197
55-59	309	284	260	235
60-64	367	338	308	279
Applicant & 2 Children				
Under 30	187	172	157	142
30-34	207	190	174	157
35-39	236	217	198	179
40-44	265	244	223	201
45-49	291	268	244	221
50-54	329	303	276	250
55-59	381	351	320	290
60-64	443	408	372	337
Applicant & 3+ Children				
Under 30	252	232	212	192
30-34	273	251	229	207
35-39	304	280	255	231
40-44	334	307	281	254
45-49	361	332	303	274
50-54	401	369	337	305
55-59	456	420	383	347
60-64	521	479	438	396
Family w/ 1 Child				
Under 30	238	219	200	181
30-34	250	230	210	190
35-39	290	267	244	220
40-44	344	316	289	261
45-49	423	389	355	321
50-54	495	455	416	376
55-59	624	574	524	474
60-64	730	672	613	555
Family w/ 2 Children				
Under 30	302	278	254	230
30-34	317	292	266	241
35-39	359	330	302	273
40-44	417	384	350	317
45-49	496	456	417	377
50-54	570	524	479	433
55-59	700	644	588	532
60-64	808	743	679	614
Family w/ 3+ Children				
Under 30	376	346	316	286
30-34	391	360	328	297
35-39	433	398	364	329
40-44	492	453	413	374
45-49	572	526	480	435
50-54	647	595	543	492
55-59	778	716	654	591
60-64	887	816	745	674
*Child Under 1	106	98	89	81
*Child 1-17	69	63	58	52
*2 Children	99	91	83	75
*3+ Children	159	146	134	121

Plan 2 – Level 1

Single Party $2,600
Family $5,200

	Area 1	Area 2	Area 3	Area 4
Single Male				
Under 30	61	56	51	46
30-34	71	65	60	54
35-39	87	80	73	66
40-44	109	100	92	83
45-49	144	132	121	109
50-54	178	164	150	135
55-59	243	224	204	185
60-64	297	273	249	226
Single Female				
Under 30	69	63	58	52
30-34	87	80	73	66
35-39	111	102	93	84
40-44	136	125	114	103
45-49	158	145	133	120
50-54	191	176	160	145
55-59	216	199	181	164
60-64	248	228	208	188
Applicant & Spouse				
Under 30	103	95	87	78
30-34	110	101	92	84
35-39	133	122	112	101
40-44	160	147	134	122
45-49	205	189	172	156
50-54	247	227	207	188
55-59	321	295	270	244
60-64	382	351	321	290
Applicant & 1 Child				
Under 30	72	66	60	55
30-34	83	76	70	63
35-39	98	90	82	74
40-44	113	104	95	86
45-49	127	117	107	97
50-54	147	135	123	112
55-59	175	161	147	133
60-64	208	191	175	158
Applicant & 2 Children				
Under 30	104	96	87	79
30-34	115	106	97	87
35-39	131	121	110	100
40-44	147	135	123	112
45-49	162	149	136	123
50-54	183	168	154	139
55-59	212	195	178	161
60-64	246	226	207	187
Applicant & 3+ Children				
Under 30	139	128	117	106
30-34	151	139	127	115
35-39	167	154	140	127
40-44	184	169	155	140
45-49	199	183	167	151
50-54	221	203	186	168
55-59	251	231	211	191
60-64	287	264	241	218
Family w/ 1 Child				
Under 30	136	125	114	103
30-34	143	132	120	109
35-39	166	153	139	126
40-44	197	181	165	150
45-49	242	223	203	184
50-54	283	260	238	215
55-59	357	328	300	271
60-64	418	385	351	318
Family w/ 2 Children				
Under 30	172	158	144	131
30-34	181	167	152	138
35-39	205	189	172	156
40-44	238	219	200	181
45-49	283	260	238	215
50-54	325	299	273	247
55-59	399	367	335	303
60-64	461	424	387	350
Family w/ 3+ Children				
Under 30	215	198	181	163
30-34	223	205	187	169
35-39	247	227	207	188
40-44	281	259	236	214
45-49	327	301	275	249
50-54	369	339	310	280
55-59	444	408	373	337
60-64	506	466	425	385
*Child Under 1	73	67	61	55
*Child 1-17	47	43	39	36
*2 Children	56	52	47	43
*3+ Children	89	82	75	68

Plan 3 – Level 1

Single Party $5,000
Family $10,000

	Area 1	Area 2	Area 3	Area 4
Single Male				
Under 30	56	52	47	43
30-34	65	60	55	49
35-39	80	74	67	61
40-44	100	92	84	76
45-49	132	121	111	100
50-54	163	150	137	124
55-59	223	205	187	169
60-64	273	251	229	207
Single Female				
Under 30	63	58	53	48
30-34	79	73	66	60
35-39	101	93	85	77
40-44	124	114	104	94
45-49	144	132	121	109
50-54	173	159	145	131
55-59	196	180	165	149
60-64	225	207	189	171
Applicant & Spouse				
Under 30	87	80	73	66
30-34	92	85	77	70
35-39	112	103	94	85
40-44	135	124	113	103
45-49	172	158	144	131
50-54	208	191	175	158
55-59	270	248	227	205
60-64	321	295	270	244
Applicant & 1 Child				
Under 30	60	55	50	46
30-34	69	63	58	52
35-39	82	75	69	62
40-44	95	87	80	72
45-49	106	98	89	81
50-54	123	113	103	93
55-59	146	134	123	111
60-64	174	160	146	132
Applicant & 2 Children				
Under 30	85	78	71	65
30-34	93	86	78	71
35-39	107	98	90	81
40-44	120	110	101	91
45-49	131	121	110	100
50-54	149	137	125	113
55-59	172	158	144	131
60-64	200	184	168	152
Applicant & 3+ Children				
Under 30	111	102	93	84
30-34	121	111	102	92
35-39	134	123	113	102
40-44	148	136	124	112
45-49	160	147	134	122
50-54	177	163	149	135
55-59	201	185	169	153
60-64	230	212	193	175
Family w/ 1 Child				
Under 30	113	104	95	86
30-34	118	109	99	90
35-39	137	126	115	104
40-44	163	150	137	124
45-49	200	184	168	152
50-54	234	215	197	178
55-59	296	272	249	225
60-64	346	318	291	263
Family w/ 2 Children				
Under 30	141	130	118	107
30-34	148	136	124	112
35-39	167	154	140	127
40-44	194	178	163	147
45-49	231	213	194	176
50-54	266	245	223	202
55-59	326	300	274	248
60-64	376	346	316	286
Family w/ 3+ Children				
Under 30	175	161	147	133
30-34	182	167	153	138
35-39	201	185	169	153
40-44	228	210	192	173
45-49	266	245	223	202
50-54	300	276	252	228
55-59	361	332	303	274
60-64	412	379	346	313
*Child Under 1	67	62	56	51
*Child 1-17	44	40	37	33
*2 Children	47	43	39	36
*3+ Children	72	66	60	55

*While children may apply for a UNICARE High-Deductible Health Plan (children-only plan), children are not eligible to have Health Savings Accounts established in their names.

Indiana Individual High-Deductible (HSA-Compatible) Monthly Rates, Effective 6/1/04

Plan 1 – Level 1+40

Single Party $1,000
Family $2,000

	Area 1	Area 2	Area 3	Area 4
Single Male				
Under 30	125	115	105	95
30-34	144	133	122	109
35-39	176	162	148	134
40-44	221	203	186	168
45-49	293	269	246	223
50-54	361	332	304	274
55-59	494	455	416	375
60-64	605	556	508	459
Single Female				
Under 30	141	130	119	108
30-34	176	162	148	134
35-39	228	210	192	174
40-44	279	256	234	211
45-49	323	298	272	246
50-54	391	360	328	297
55-59	441	406	371	335
60-64	505	465	424	384
Applicant & Spouse				
Under 30	249	230	210	189
30-34	266	245	224	202
35-39	322	297	270	245
40-44	388	357	326	295
45-49	496	456	416	377
50-54	598	550	503	455
55-59	777	715	652	591
60-64	927	853	778	704
Applicant & 1 Child				
Under 30	176	162	148	134
30-34	204	188	172	155
35-39	242	223	203	183
40-44	280	258	235	213
45-49	314	288	263	238
50-54	363	333	305	276
55-59	433	398	364	329
60-64	514	473	431	391
Applicant & 2 Children				
Under 30	262	241	220	199
30-34	290	266	244	220
35-39	330	304	277	251
40-44	371	342	312	281
45-49	407	375	342	309
50-54	461	424	386	350
55-59	533	491	448	406
60-64	620	571	521	472
Applicant & 3+ Children				
Under 30	353	325	297	269
30-34	382	351	321	290
35-39	426	392	357	323
40-44	468	430	393	356
45-49	505	465	424	384
50-54	561	517	472	427
55-59	638	588	536	486
60-64	729	671	613	554
Family w/ 1 Child				
Under 30	333	307	280	253
30-34	350	322	294	266
35-39	406	374	342	308
40-44	482	442	405	365
45-49	592	545	497	449
50-54	693	637	582	526
55-59	874	804	734	664
60-64	1022	941	858	777
Family w/ 2 Children				
Under 30	423	389	356	322
30-34	444	409	372	337
35-39	503	462	423	382
40-44	584	538	490	444
45-49	694	638	584	528
50-54	798	734	671	606
55-59	980	902	823	745
60-64	1131	1040	951	860
Family w/ 3+ Children				
Under 30	526	484	442	400
30-34	547	504	459	416
35-39	606	557	510	461
40-44	689	634	578	524
45-49	801	736	672	609
50-54	906	833	760	689
55-59	1089	1002	916	827
60-64	1242	1142	1043	944
*Child Under 1	148	137	125	113
*Child 1-17	97	88	81	73
*2 Children	139	127	116	105
*3+ Children	223	204	188	169

Plan 2 – Level 1+40

Single Party $2,600
Family $5,200

	Area 1	Area 2	Area 3	Area 4
Single Male				
Under 30	85	78	71	64
30-34	99	91	84	76
35-39	122	112	102	92
40-44	153	140	129	116
45-49	202	185	169	153
50-54	249	230	210	189
55-59	340	314	286	259
60-64	416	382	349	316
Single Female				
Under 30	97	88	81	73
30-34	122	112	102	92
35-39	155	143	130	118
40-44	190	175	160	144
45-49	221	203	186	168
50-54	267	246	224	203
55-59	302	279	253	230
60-64	347	319	291	263
Applicant & Spouse				
Under 30	144	133	122	109
30-34	154	141	129	118
35-39	186	171	157	141
40-44	224	206	188	171
45-49	287	265	241	218
50-54	346	318	290	263
55-59	449	413	378	342
60-64	535	491	449	406
Applicant & 1 Child				
Under 30	101	92	84	77
30-34	116	106	98	88
35-39	137	126	115	104
40-44	158	146	133	120
45-49	178	164	150	136
50-54	206	189	172	157
55-59	245	225	206	186
60-64	291	267	245	221
Applicant & 2 Children				
Under 30	146	134	122	111
30-34	161	148	136	122
35-39	183	169	154	140
40-44	206	189	172	157
45-49	227	209	190	172
50-54	256	235	216	195
55-59	297	273	249	225
60-64	344	316	290	262
Applicant & 3+ Children				
Under 30	195	179	164	148
30-34	211	195	178	161
35-39	234	216	196	178
40-44	258	237	217	196
45-49	279	256	234	211
50-54	309	284	260	235
55-59	351	323	295	267
60-64	402	370	337	305
Family w/ 1 Child				
Under 30	190	175	160	144
30-34	200	185	168	153
35-39	232	214	195	176
40-44	276	253	231	210
45-49	339	312	284	258
50-54	396	364	333	301
55-59	500	459	420	379
60-64	585	539	491	445
Family w/ 2 Children				
Under 30	241	221	202	183
30-34	253	234	213	193
35-39	287	265	241	218
40-44	333	307	280	253
45-49	396	364	333	301
50-54	455	419	382	346
55-59	559	514	469	424
60-64	645	594	542	490
Family w/ 3+ Children				
Under 30	301	277	253	228
30-34	312	287	262	237
35-39	346	318	290	263
40-44	393	363	330	300
45-49	458	421	385	349
50-54	517	475	434	392
55-59	622	571	522	472
60-64	708	652	595	539
*Child Under 1	102	94	85	77
*Child 1-17	66	60	55	50
*2 Children	78	73	66	60
*3+ Children	125	115	105	95

Plan 3 – Level 1+40

Single Party $5,000
Family $10,000

	Area 1	Area 2	Area 3	Area 4
Single Male				
Under 30	78	73	66	60
30-34	91	84	77	69
35-39	112	104	94	85
40-44	140	129	118	106
45-49	185	169	155	140
50-54	228	210	192	174
55-59	312	287	262	237
60-64	382	351	321	290
Single Female				
Under 30	88	81	74	67
30-34	111	102	92	84
35-39	141	130	119	108
40-44	174	160	146	132
45-49	202	185	169	153
50-54	242	223	203	183
55-59	274	252	231	209
60-64	315	290	265	239
Applicant & Spouse				
Under 30	122	112	102	92
30-34	129	119	108	98
35-39	157	144	132	119
40-44	189	174	158	144
45-49	241	221	202	183
50-54	291	267	245	221
55-59	378	347	318	287
60-64	449	413	378	342
Applicant & 1 Child				
Under 30	84	77	70	64
30-34	97	88	81	73
35-39	115	105	97	87
40-44	133	122	112	101
45-49	148	137	125	113
50-54	172	158	144	130
55-59	204	188	172	155
60-64	244	224	204	185
Applicant & 2 Children				
Under 30	119	109	99	91
30-34	130	120	109	99
35-39	150	137	126	113
40-44	168	154	141	127
45-49	183	169	154	140
50-54	209	192	175	158
55-59	241	221	202	183
60-64	280	258	235	213
Applicant & 3+ Children				
Under 30	155	143	130	118
30-34	169	155	143	129
35-39	188	172	158	143
40-44	207	190	174	157
45-49	224	206	188	171
50-54	248	228	209	189
55-59	281	259	237	214
60-64	322	297	270	245
Family w/ 1 Child				
Under 30	158	146	133	120
30-34	165	153	139	126
35-39	192	176	161	146
40-44	228	210	192	174
45-49	280	258	235	213
50-54	328	301	276	249
55-59	414	381	349	315
60-64	484	445	407	368
Family w/ 2 Children				
Under 30	197	182	165	150
30-34	207	190	174	157
35-39	234	216	196	178
40-44	272	249	228	206
45-49	323	298	272	246
50-54	372	343	312	283
55-59	456	420	384	347
60-64	526	484	442	400
Family w/ 3+ Children				
Under 30	245	225	206	186
30-34	255	234	214	193
35-39	281	259	237	214
40-44	319	294	269	242
45-49	372	343	312	283
50-54	420	386	353	319
55-59	505	465	424	384
60-64	577	531	484	438
*Child Under 1	94	87	78	71
*Child 1-17	62	56	52	46
*2 Children	66	60	55	50
*3+ Children	101	92	84	77

*While children may apply for a UNICARE High-Deductible Health Plan (children-only plan), children are not eligible to have Health Savings Accounts established in their names.

UNICARE
A healthy dose of innovation.℠

Indiana

Individual & Family PPO Health Insurance Plans

UNICARE Premier No Deductible Plan
UNICARE 500, 1000, 1500, 2000, 3000, 5000 Plans
UNICARE Saver Plan
UNICARE High-Deductible (HSA-Compatible) Plans
UNICARE Life and Dental Plans

Application

Thank you for applying with UNICARE.

PLEASE NOTE:

– **Coverage is not available if:**
  - any family member is currently pregnant (whether or not listed on the application) or in the process of adoption; or
  - the applicant has not resided in the U.S. for the last six (6) consecutive months.

– **Coverage is not guaranteed until approved in writing by UNICARE. Do not cancel your current insurance coverage until you have been notified of approval by UNICARE and your UNICARE coverage is effective.**

Instructions

Do not complete this application until you have read the current product brochure.

Please follow these instructions to allow us to better process your application.

– For your own protection, **you, the applicant,** must complete this application. You are solely responsible for its accuracy and completeness.

– All information must be stated accurately.

– All questions must be answered in full or the application may be returned to you resulting in a delay in processing.

– For additional information or explanations attach extra sheets, if necessary. **All attachments must be signed and dated.**

– Print clearly using blue or black ink. No correction fluid, please. **Sorry, but typed applications will not be accepted.**

– This application must be received by UNICARE Medical Underwriting within thirty (30) days from the signature date.

– UNICARE Health and Dental Plans are available only in areas where the UNICARE Network exists. Please see Provider Directories for more details.

– Even if this application is approved, any misstatements or omissions may result in future claims being denied and the plan being rescinded.

– Your insurance will become effective only if this application is approved as applied for, the appropriate premium is enclosed, and other specific conditions are met. **(See details under Section 7 – Conditions of Application).**

– Please return this application and your check to your agent OR mail to the address listed at right.

Billing Information

Carefully read the instructions accompanying each billing type and make sure that your check is attached to the application.

– **Monthly billing (with monthly bank draft authorization only):** Submit the one (1)-month premium, complete the Monthly Bank Draft Authorization.

– **Quarterly billing:** Submit the three (3)-month (quarterly) premium.

Most common causes for delay in underwriting

– Missing, inaccurate or incomplete information such as:
  - Weight AND Height
  - Spouse's social security number
  - Dependent's social security number
  - Date of birth
  - Date of last pelvic examination
  - Results of last pelvic examination
  - Physician address, phone number and fax number

– Incomplete or illegible information such as the mailing address does not include city, state, and ZIP code.

– ALL questions are not answered in Sections 4 and 6. If it does not apply to you, the answer should be "No." Do not leave any answers blank.

– The application is not signed and dated by the applicant and/or all dependents over age 18.

– Agent portion of application is not completed, signed, or dated with a date on or after applicant's signature date.

– Additional documentation or information is required.

Mailing Address

– **Applicant:** Please return this application to the agent.

– **Agent:** Please mail this application to the address below.

UNICARE Individual Services
P.O. Box 5030
Bolingbrook, IL 60440-5030

UNICARE
A healthy dose of innovation.℠

Applicant's Social Security No.

Individual Enrollment Application - Indiana

UNICARE Life & Health Insurance Company

- *Application must be completed by the applicant in blue or black ink.*
- *Any family member currently pregnant (whether or not listed on the application) or in the process of adoption is not eligible.*

1. Applicant Information *(Please Print)*

Primary Applicant's Last Name	First Name	M.I.
Home Address *(Residence address required; P.O. Box not acceptable)*		
City	State	ZIP Code

Reason for Application *(Check one)*

☐ New Enrollment(s)
☐ Child only *(Please use youngest child for primary applicant)*
☐ Add dependent(s) to I.D. No: ____
To change existing UNICARE plan, please enter I.D. No: ____

For Summary Bill (existing), I.D. No: ____

Mailing Address *(If different than above)* (P.O. Box or Personal Mail Box No.)		Home Phone No. ( )	E-mail Address *(Optional)*
City	State ZIP Code	Daytime Phone No. ( )	Fax No. ( )
In care of:		Marital Status ☐ Single ☐ Married	Spouse's Social Security No. *(Required)*
Billing Type: ☐ Monthly Bank Draft ☐ Quarterly Billing ☐ Summary Bill *(Please attach Summary Bill cover sheet.)*		Maiden Name of Applicant/Spouse *(If applicable)*	
Has any person listed on this application resided outside the U.S. for the past six (6) consecutive months? ☐ Yes ☐ No If yes, please provide name and explain:			
Language preference *(Optional)* ☐ English ☐ Spanish ☐ Korean ☐ Chinese ☐ Polish ☐ Other *(Specify)*:			

Ethnic Code *(Optional)*

1 ☐ Caucasian	3 ☐ Black/African American	5a ☐ Native American Indian	A ☐ Amerasian	J ☐ Japanese	N ☐ Asian Indian	T ☐ Laotian
2 ☐ Hispanic	4 ☐ Asian	5b ☐ Alaskan Native	C ☐ Chinese	K ☐ Korean	P ☐ Hawaiian	V ☐ Vietnamese
		7 ☐ Filipino	H ☐ Cambodian	M ☐ Samoan	R ☐ Guamanian	Z ☐ Other

2. Choice of UNICARE Individual Coverage

Plan Choice:

☐ HSA-Compatible Plan 1 (T085)	☐ UNICARE Saver 2000 (G852)	☐ UNICARE 2000 (G851)	☐ UNICARE 500 (G848)	
☐ HSA-Compatible Plan 2 (T086)	☐ UNICARE 5000 (PE33)	☐ UNICARE 1500 (G850)	☐ Premier No Deductible Plan (G847)	
☐ HSA-Compatible Plan 3 (T087)	☐ UNICARE 3000 (PE32)	☐ UNICARE 1000 (G849)	☐ Life	☐ Dental

3. Applicants for Coverage

Check one: ☐ Insure all eligible applicants ☐ Insure no one unless all are accepted for coverage
Please list *all* applicants applying for coverage. ***(List children youngest to oldest)***
If a family member's last name is different than yours, please attach explanation to application.

Relation	Last Name First Name M.I.	MUST BE ACCURATE Height	MUST BE ACCURATE Weight	Date of Birth	Social Security No.	✓ Full Time Student	FamilyFlex List Medical Plan code number(s) from Section 2	✓ Dental	UNICARE USE ONLY WVR	UNICARE USE ONLY WVR
☐ Male ☐ Female	Yourself									
☐ Husband ☐ Wife	Spouse									
☐ Son ☐ Daughter										
☐ Son ☐ Daughter										
☐ Son ☐ Daughter										
☐ Son ☐ Daughter										
☐ Son ☐ Daughter										

FOR UNICARE USE ONLY – DO NOT WRITE BELOW

Group No.	Certificate No.	Agent I.D. No.	Effective Date	X Ref. Cert. No.	☐ AA ☐ AR
By	Date				

Applicant's Social Security No.

4. Other Coverage - *Please answer **all** of the following questions.*

A. Do you currently have, or has anyone to be insured had continuous coverage in the last 18 months?. . . . . ☐ Yes ☐ No
If Yes, please provide the following information:

Name of insured(s)	Insurance carrier(s)	Effective date	End date

Do you agree to discontinue your current coverage if this application is accepted? . . . . ☐ Yes ☐ No
If No, please explain:

B. Has anyone on this application been insured by UNICARE in the last 5 years? . . . . ☐ Yes ☐ No
If Yes, please provide the following information.

Name of Insured(s)	Plan/I.D. No.	Group No.	
Name of Plan	City	State	Date cancelled

C. If any applicant has/had UNICARE group coverage, please complete the following:

I certify that my UNICARE group coverage will end/ended on (date):

☐ **I do not wish to enroll in any available Conversion Agreement.** I understand that with the coverage for which I am applying with this application there may be a lapse in coverage. If accepted with or without lapse in coverage, each person will be subject to new waiting periods and deductibles.

D. Has anyone identified on this application ever been declined, postponed, had a waiver applied, or charged an extra premium for life, disability, or health insurance, or had such insurance rescinded?. . . . . ☐ Yes ☐ No
If Yes, please provide the following information.

1. Name of applicant	Name of Insurance Company	Explain
2. Name of applicant	Name of Insurance Company	Explain

E. Are any persons applying for coverage on this application eligible for Medicare benefits? . . . . ☐ Yes ☐ No
If Yes, please list all eligible person(s). Note: Any applicant eligible for Medicare Part A or B is **not** eligible for this coverage.

Eligible person(s)

F. Has anyone applying for coverage on this application filed a claim for disability or Workers' Compensation within the past 18 months? . . . . ☐ Yes ☐ No
If Yes, please provide the following information.

Name of applicant	Effective date	End date

5. Term Life Insurance

Applicants must meet UNICARE'S Underwriting Guidelines to qualify for Term Life Insurance Coverage. Applicants under the age of one year are not eligible for Life Insurance. **Submit Premium with application.**

Name of Family Member	✓ Amount of Coverage			Name of Beneficiary**	Relationship	Beneficiary Street Address City/State/ZIP Code
	$15,000	$25,000	$50,000*			
Primary Applicant						
Spouse						
Dependent						

*The $50,000 amount is not available to applicants under the age of 19. If selected by an approved applicant under age 19, the selection will default to $25,000.
****If a beneficiary is not listed** and a policy is issued, death benefits will be paid in accordance with the Beneficiary Provision of the Policy.

I have discussed Life Insurance with my agent and decline to apply – Initial: __________

6. Health History – Include information on *all* family members you wish to enroll.

Applicant's Social Security No.

6A. Health History Questionnaire – *ALL* QUESTIONS MUST BE ANSWERED OR THE APPLICATION MAY BE RETURNED AND/OR REJECTED. If you answer "Yes" to any question in Section 6A, you must give complete details in Section 6B.

Has any person listed on this application had a clear, distinct symptom that would cause an ordinarily prudent person to seek advice or treatment, or had treatment recommended, received treatment, or been hospitalized for any of the following conditions listed in questions 1 through 28 **within the last 10 years:**

1. Frequent and/or severe headaches, migraines, seizures, epilepsy, multiple sclerosis, or any other neurological or central nervous system disorder(s) ☐ Yes ☐ No
2. Dizziness, weakness, fainting, numbness/tingling, head injury, paralysis, stroke, confusion, memory loss, loss of consciousness, narcolepsy, or any similar symptoms ☐ Yes ☐ No
3. Chest pain, high or low blood pressure, heart disease, heart attack, heart murmur, palpitations, pacemaker, or any other heart disorder or condition ☐ Yes ☐ No
4. Poor circulation, blood clot, varicose veins, enlarged lymph nodes, blood/bleeding disorder, anemia, rheumatic fever, or any other circulatory condition ☐ Yes ☐ No
5. Allergies, difficulty breathing, shortness of breath, asthma, chronic cough, spitting/coughing up blood, respiratory/lung infections, sinusitis, bronchitis, pneumonia, reactive airway disease (RAD), pneumocystis carinii pneumonia (PCP), tuberculosis, emphysema, or any other respiratory disorder or condition ☐ Yes ☐ No
6. Diseases or problems of the nose, nosebleeds, polyps, deviated nasal septum, excessive snoring, or use of a sleep monitoring device ☐ Yes ☐ No
7. Diseases or problems of the mouth/gums, throat/swallowing, tonsils, adenoids, jaw/chewing problems or TMJ ☐ Yes ☐ No
8. Gastric reflux, ulcers, hernia, intestinal problems, diverticulitis, colitis, diarrhea, rectal problems/bleeding, polyps, hemorrhoids, or any other digestive disorder or condition ☐ Yes ☐ No
9. Gallbladder, spleen, pancreatitis, liver disease, jaundice, unexplained weight loss/gain, or hepatitis (indicate type:_______) ☐ Yes ☐ No
10. Kidney/bladder/urinary tract infections, stones, incontinence, blood in urine or any other disease or disorders of the kidneys or urinary system ☐ Yes ☐ No
11. Bone, joint and/or muscle pain, injury or disorder of joint/tendon/ligament/disc, weakness of back/spine/neck/joint, fracture, sprain/strain, fibromyalgia, arthritis, gout, polio, or any other musculoskeletal disorder ☐ Yes ☐ No
12. Physical handicap, joint replacement, hardware (pins, plates, screws, etc.), amputation, or prosthesis ☐ Yes ☐ No
13. Diabetes, thyroid, pituitary, adrenal, or any other endocrine disorders ☐ Yes ☐ No
14. Immune disorders, lupus, scleroderma, mononucleosis, chronic fatigue syndrome ☐ Yes ☐ No
15. Is any applicant a candidate for, or a recipient of an organ or bone marrow transplant? ☐ Yes ☐ No
16. Skin infections, cancer, melanoma, lesion, psoriasis, keratosis, warts, ulcers, birthmarks, severe burns, acne, fungal infections, Kaposi's sarcoma, eczema, dermatitis, hyperhidrosis, herpes, scars/keloids, cosmetic or reconstructive surgery, or any other skin conditions ☐ Yes ☐ No
17. Sexually transmitted disease, such as herpes, genital warts, etc. ☐ Yes ☐ No
18. Male applicant(s)
    a) Prostate, undescended testes, infertility, low sperm count, impotence, sexual dysfunction, or implant ☐ Yes ☐ No
    b) Is any male listed on this application expecting a child or in the process of adoption or surrogate pregnancy with anyone, whether or not the mother is listed on this application? ☐ Yes ☐ No
19. Female applicant(s)
    a) Breast disorder/cyst, lump, fibroid tumors, silicone injections, or implants ☐ Yes ☐ No
    b) Pelvic pain, menstruation disorders, abnormal pelvic exam/PAP smear, endometriosis, uterine fibroids, ovarian cysts, infertility or miscarriages ☐ Yes ☐ No
    c) Date and result of last pelvic exam/Pap smear for each female over 16:

       Name:______________ Mo/Day/Yr:_____ ☐ Normal ☐ Abnormal

       Name:______________ Mo/Day/Yr:_____ ☐ Normal ☐ Abnormal

       Name:______________ Mo/Day/Yr:_____ ☐ Normal ☐ Abnormal
    d) Is the applicant, spouse or any female dependent, whether or not listed on the application, currently pregnant, or in the process of adoption or surrogate pregnancy? ☐ Yes ☐ No
20. Diseases or problems of the eyes or sight, crossed eyes, glaucoma, cataracts, detached retina or blurred vision ☐ Yes ☐ No
21. Diseases or problems of the ears or hearing, implant, or hearing aid ☐ Yes ☐ No
22. Eating disorder, depression, anxiety, counseling, member of a support group, bi-polar, chemical imbalance, attention deficit disorder, schizophrenia, obsessive-compulsive, panic disorder, etc. ☐ Yes ☐ No
23. Mental or physical impairment or deformity, congenital abnormalities or birth defects Specify:________________________________ ☐ Yes ☐ No
24. Has any applicant consulted a provider for any condition or symptom(s) for which a diagnosis has not been established? ☐ Yes ☐ No
25. Had cancer, tumor/growth, leukemia, or cyst? ☐ Yes ☐ No
26. Had an abnormal physical exam, laboratory results, x-rays, EKG, MRI, CT scan or been advised to undergo further testing surgery, or treatment? ☐ Yes ☐ No
27. Seen, been a patient in a hospital, clinic, or other medical facility, received treatment from or consulted any doctor, or other person providing health care services for any other condition or symptom(s) (excluding childbirth) not listed on this application? ☐ Yes ☐ No
28. Been diagnosed or received treatment by a physician or health care professional for AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), or tested positive for HIV (Human Immunodeficiency Virus)? ☐ Yes ☐ No

IMPORTANT: ***Applicant's medical conditions, which occur after the signature date and before the approval date that come to UNICARE's attention, may be considered in the final underwriting decision.***

6B. Professional Services

Applicant's Social Security No.

Give COMPLETE details of any "Yes" answers to the questions in 6A. (Use additional sheets if necessary.)

Question #	Name of Family Member	Date of Onset	Name of Physician/Hospital/Other Facility			Date of Visit
Name of Condition/Illness		Date Ended	Address			Phone No.
Treatment (X-ray, lab, surgery, etc.)		Degree of Recovery	City	State	ZIP	Fax No.
Results ☐ Normal ☐ Abnormal	☐ Still under treatment		Medications			Frequency
If abnormal, please explain:			Dosage	Date Prescribed		Date Discontinued

Question #	Name of Family Member	Date of Onset	Name of Physician/Hospital/Other Facility			Date of Visit
Name of Condition/Illness		Date Ended	Address			Phone No.
Treatment (X-ray, lab, surgery, etc.)		Degree of Recovery	City	State	ZIP	Fax No.
Results ☐ Normal ☐ Abnormal	☐ Still under treatment		Medications			Frequency
If abnormal, please explain:			Dosage	Date Prescribed		Date Discontinued

Question #	Name of Family Member	Date of Onset	Name of Physician/Hospital/Other Facility			Date of Visit
Name of Condition/Illness		Date Ended	Address			Phone No.
Treatment (X-ray, lab, surgery, etc.)		Degree of Recovery	City	State	ZIP	Fax No.
Results ☐ Normal ☐ Abnormal	☐ Still under treatment		Medications			Frequency
If abnormal, please explain:			Dosage	Date Prescribed		Date Discontinued

6C. Prescription Medications –

List all medications not noted above taken within the last 12 months by any family member listed on this application.

Family Member	Medication and Dosage	Illness for which Medication is Prescribed	Date Prescribed	Date Discontinued	Name, Phone No. & FAX No. of Physician or Hospital Address/City/State/ZIP Code

6D. Other Health Questions

Question					
1. Has any applicant in the past 10 years smoked or used any tobacco products, such as: cigarettes, cigars, pipe, snuff, or chewing tobacco? ☐ Yes ☐ No	1. Family member	Amount per day	2. Family member	Amount per day
	Type of product	Date Discontinued	Type of product	Date Discontinued
2. Has any applicant used illegal or controlled drugs, or substances such as marijuana, cocaine, methamphetamines, in the last 10 years, or been diagnosed as chemically or alcohol dependent? ☐ Yes ☐ No	1. Family member		2. Family member	
	Type of product	Date Discontinued	Type of product	Date Discontinued
3. Has any applicant in the past 10 years used any illegal or controlled I.V. drugs? ☐ Yes ☐ No	1. Family member		2. Family member	
	Type of product	Date Discontinued	Type of product	Date Discontinued
4. Has any applicant consumed any alcoholic beverages in the last 6 months? ☐ Yes ☐ No	1. Family member		2. Family member	
Amount: A drink is 12 oz. of beer, 6 oz. of wine, or 1 oz. of liquor.	Amount ________ per ☐ day ☐ week ☐ month		Amount ________ per ☐ day ☐ week ☐ month	
	Type of Product		Type of Product	
5. Has any applicant been advised to reduce alcohol intake within the past 10 years? ☐ Yes ☐ No	1. Family member	Date Discontinued	2. Family member	Date Discontinued

To provide further information, please use additional sheets if necessary. List the page number, section name, and question number you are explaining. Also, please identify the applicable family member. All additional sheets must be signed by the applicant. ☐ **No. of sheets attached**

7. Conditions of Application

It is important that you carefully read and fully understand the following.

Applicant's Social Security No.

I, the undersigned, understand that under the UNICARE plan for which I am applying, I may be entitled to lesser benefits if I use a non-participating hospital, physician, or other provider, than if I use a UNICARE independently contracted participating hospital, physician, or other provider.

All applicants age 18 and over must personally read, agree to, and sign the following. If an applicant does not read English, the translator must sign and submit the Statement of Accountability, Section 11, for translating this entire application.

Effective Date

If you currently have health coverage, we strongly recommend that you maintain your current coverage, and allow us to assign your effective date FOLLOWING APPROVAL. If, however, you would like to request a specific effective date, we strongly recommend you allow 60-75 days for underwriting. This will help ensure that your application is processed before you surrender your present insurance, and will prevent you from being required to pay for two policies.

NOTE: If you are adding a dependent, the effective date will always be the first of the month after approval.

- ☐ I request that UNICARE assign my effective date if my application is approved. My effective date will be assigned as either the 1st or the 15th of the month following the approval date of my application.
- ☐ If UNICARE approves my application, please assign an effective date of the
  - ☐ 1st of the month following approval.
  - ☐ 15th of the month following approval.
  - ☐ 1st of ____________________.
  - ☐ 15th of ____________________.

This date must be AFTER the signature date but not greater than 75 days from the signature date on this application.

REQUESTING AN EFFECTIVE DATE <u>DOES NOT GUARANTEE</u> UNDERWRITING TO BE COMPLETED BEFORE THE DATE REQUESTED. I UNDERSTAND THAT IF I SELECT AN EFFECTIVE DATE, UNICARE CANNOT CHANGE THIS DATE UNDER ANY CIRCUMSTANCES ONCE THE CERTIFICATE OF COVERAGE IS ISSUED. Initial X__________

Billing Date

UNICARE premiums are due on the 1st of each month. Insureds with a mid-month premium effective date will be billed on a pro-rated basis to bring future due dates to the first of a month.

Agreement *(All applicants)*

I, the undersigned, agree to the following:

1. I understand and agree to pay the premium required with this application. This payment is a deposit which will be returned if my application is denied, or applied to the premium charges if my application is accepted.
2. If my application for UNICARE coverage is accepted as applied for, the coverage date will be as specified above, but I agree I have no coverage under this application until I am notified in writing by UNICARE that my application is approved.
3. I understand that UNICARE has the right to deny my application, and if it does so, I will be notified in writing and the premium I submitted will be returned.
4. **MINOR CHILDREN:** I represent that I have made such investigations as are necessary to assure the truth and accuracy of all statements made in this application regarding minor children.
5. **CONCERNING DEPENDENTS AGE 18 AND OVER:** I represent that my dependents age 18 and over (1) have read this application, and have provided such full and accurate information necessary to complete this application, (2) I have discussed all provisions of this application, especially Sections 6A, 6B, 6C and 6D with them, and (3) all information contained in this application regarding them is complete and accurate.
6. I understand and agree that if UNICARE rejects my application, under no circumstance will any benefits be payable for any person listed on this application. Receipt of money, cashing of my check or charging my credit card by UNICARE does not constitute approval of my application or create UNICARE coverage.
7. If I am accepted, this application will become part of the agreement between UNICARE and myself.
8. UNICARE may request additional information, and this may delay processing of this application. If the health care provider charges a fee for these services, UNICARE will determine payment, and I will be responsible for any difference.
9. The selling agent has no authority to promise me coverage or to modify UNICARE underwriting policy or terms of any UNICARE coverage.
10. I have personally read and completed this application. Nothing has been left off regarding the past or present health of anyone listed on this application. I understand that no one listed is eligible for benefits if any information on this application is false, incomplete or omitted. UNICARE may void all coverage from the original effective date of the agreement for such material misstatements or omissions.

    If the family member is a minor, I accept full legal and financial responsibility for the coverage and information provided.

    PLEASE NOTE: If the listed minor dependent does not reside with the applicant purchasing this plan, the custodial parent or guardian must complete the Health History Section and sign the Conditions of Application accepting legal responsibility for full and complete disclosure of the minor applicant, including any history of substance abuse. Also, if the responsible adult is not the natural parent, please submit court papers authorizing guardianship.
11. My UNICARE agent may receive copies of any correspondence about my medical history when correspondence is required.

Authorization

I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy or pharmacy benefit manager, medical facility, or other health care provider ("My Providers") that has provided payment, treatment or services to me or any of my dependents who are also applying for coverage to disclose entire medical records, prescription history, medications prescribed and any other protected health information concerning me or any of my dependents who are also applying for coverage with UNICARE, including UNICARE or its designated agent. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

By signing below, I acknowledge that any agreements made to restrict protected health information does not apply to this authorization and I instruct any physician, health care professional, hospital, clinic, medical facility, or other health care provider to release and disclose entire medical records without restriction.

This protected health information is to be disclosed under this Authorization so that UNICARE may: 1) underwrite my application for coverage, make eligibility, risk rating, policy issuance and enrollment determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with UNICARE.

This authorization shall remain in force for 36 months following the date of signature below, and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to the entity identified above, I understand that a revocation is not effective to the extent that any of My Providers has already relied on this Authorization to disclose information about me or any of my dependents who are also applying for coverage or to the extent that UNICARE has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but it will not be redisclosed by UNICARE except as authorized by me or as required by law.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this authorization. I further understand that if I refuse to sign this authorization to release complete medical records, UNICARE may not be able to process my application, or if coverage has been issued may not be able to make any benefit payments. I understand that any authorized representative, UNICARE designated agent or I will receive a copy of this authorization upon request.

I understand and agree to all the Conditions of Application (Section 7). I understand that coverage is subject to the provisions in the Conditional Receipt (Section 12). I have read and understand this Application in its entirety.

Signatures (Required) – All applicants over age 18 must sign and date.

1. Applicant/parent or legal guardian	Today's date
2. Applicant's Spouse *(required if applying for coverage)*	Today's date
3. Applicant age 18 or over	Today's date
4. Applicant age 18 or over	Today's date
5. Applicant age 18 or over	Today's date
6. Applicant age 18 or over	Today's date

ATTACH INITIAL PREMIUM CHECK HERE. DO NOT TAPE.

Applicant's Social Security No.

8. Payment Method – Submit premium payment with application *(required)*.

8A. Initial Premium Payment by Credit Card

New members only. Not available to make a coverage change.

Select one: ☐ 1 month ☐ 3 months		Initial Premium Amount $
Credit Card: ☐ VISA ☐ MasterCard		
Credit Card No.		Expiration Date
Cardholder's Name		Cardholder's ZIP Code
Authorized Signature *(as it appears on the credit card)* X		Today's Date

8B. Payment Type

☐ **Monthly Billing** *(Available with Monthly Checking Account Deduction).*

1. Submit the one (1) month premium.
2. Complete section 8C, **Monthly Checking Account Deduction Authorization**.
3. If your application is approved, the premium for all products selected, including dental and/or life, will be deducted from your checking account on the first of the month ONLY.

☐ **Quarterly Billing** – Submit the three (3)-month premium.

Please note: First payment will be credited to approved applicants only.

8C. Monthly Checking Account Deduction Authorization

Attach a check for one (1) month's premium above where indicated. If the account listed below is a joint account, both account holders' signatures are required. **UNICARE must be notified of any changes to your bank account no later than the 20th of the month preceding the change.**

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

NOTE: Should your withdrawal not be honored by your bank, you will automatically be removed from Monthly Checking Account Deduction and be billed quarterly. After 12 months, you may re-apply for the monthly checking account deduction option.

You will incur a $25 service charge for any withdrawal not honored.

Applicant Name	Applicant Social Security No.	Name on Checking Account			
Name of Bank or Financial Institution	Address	City		State	ZIP Code
Checking Account No.	Bank Routing No.	Federal Credit Union Routing No.			
Authorized Signature *(as it appears in the financial institution's records)*	Date	Authorized Signature *(as it appears in the financial institution's records)*	Date		

(Continued on reverse)

DO NOT WRITE BELOW

Applicant's Social Security No.

9. **Are you applying for UNICARE medical coverage through a UNICARE-appointed agent?** ☐Yes ☐No

10. To be completed by your UNICARE-Appointed Agent

- Are you aware of any information not disclosed on this application relating to the health, habits or reputation of any person listed on this application which might have a bearing on the risk? ☐ Yes ☐ No
- Did you see the proposed subscriber (and spouse, if applying) at the time this application was executed? ☐ Yes ☐ No

  If no, please explain: ______________________________

  ____
- I verify that this application was completed by the applicant unless the Statement of Accountability (Section 11) was completed. ☐ Yes ☐ No

- Breakdown of premium collected:

  Total Medical premium $ ____________

  Total Dental premium $ ____________

  Total Life premium $ ____________

  Total premium collected **$** ____________
- Was the Monthly Checking Account Deduction Authorization (Section 8C) completed? *(only if applicable)* ☐ Yes ☐ No
- Was a Conditional Receipt given? ☐ Yes ☐ No

Name of Writing Agent *(Print Name)*			Agent's Street Address/Suite or Personal Mail Box No.	
Agent/Agency I.D. No.	Sub-Agent I.D. No.		City/State/ZIP Code	Location No.
Phone No. ( )	Fax No. ( )		E-mail Address	
Signature of Writing Agent *(Required)*		Date *(Required)*	RSM Name	

Mail Plan to: ☐ **Agent** ☐ **Primary Applicant**

PLEASE NOTE: If neither box is checked, the Plan will be mailed directly to the primary applicant.

Mailing address: Agent, please mail this application to: **UNICARE, P.O. Box 5030, Bolingbrook, IL 60440-5030**

11. Statement of Accountability – To be completed when the applicant cannot complete the application.

I, ______________________________, personally read and completed this Individual Enrollment Application for the applicant named below because:

☐ Applicant does not read English ☐ Applicant does not speak English ☐ Applicant does not write English

☐ Other *(explain)*: ______________________________

I translated the contents of this form and to the best of my knowledge, obtained and listed all the requested personal and medical history disclosed by: ______________________________

I also translated and fully explained the "Conditions of Application (Section 7)."

By ______________________________ ____________________

Signature of Translator Today's Date *(Required)*

12. Conditional Receipt – To be completed by the agent and given to the applicant.

Received from ______________________________ $ ____________ as a premium amount, payable to UNICARE.

Subject to the following:

IN NO EVENT SHALL UNICARE HAVE ANY LIABILITY TO THE APPLICANT IF THE APPLICATION IS NOT APPROVED, EXCEPT FOR THE OBLIGATION TO RETURN THE MONEY SUBMITTED WITH THIS APPLICATION IF THIS APPLICATION IS NOT APPROVED, AND NEITHER SHALL ANY COVERAGE EXIST NOR SHALL THE APPLICANT BE ENTITLED TO ANY BENEFITS UNLESS AND UNTIL THIS APPLICATION IS APPROVED BY UNICARE.

Dated this ____________ **day of** ____________ **, 20** ______**.**

Agent acknowledges receipt of money and delivery of Conditional Receipt.

By X ______________________________ ____________________

Signature of Agent Agent I.D. Number

Notice of Information Practices

If you apply for or are covered by a UNICARE health care plan, UNICARE may collect personal information about you in order to evaluate your application or to administer benefits. This information is normally limited to the condition of your health. For example, UNICARE may provide information to a hospital in order to verify benefits. Upon your request, UNICARE will provide details of the nature of personal information that may be collected, the circumstances under which it may be disclosed without authorization, and your right to access and correction if you believe it to be inaccurate. UNICARE can choose to furnish the medical record information either directly to you or to a medical professional designated by you.

UNICARE®

A healthy dose of innovation.℠

UNICARE Life & Health Insurance Company
Sales Office
Bolingbrook, Illinois

Insurance coverage is underwritten by UNICARE Life & Health Insurance Company.

An application is required to be completed to apply for coverage and is subject to approval by UNICARE.

Rates and benefits effective 6/1/04
0010123IN 4/04