INDIVIDUAL HIGH-DEDUCTIBLE

(HSA-Compatible) Health Insurance Plans

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 and Family PPO coverage

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

Form Numbers TXIHDHP0304   TXIHDHPWP0304   TXIAPL1203

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 these eligible health care expenses, the savings may be tax exempt.

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 the 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 $64^{1/2}$ or younger*
- the applicant's spouse, age $64^{1/2}$ or younger
- the applicant's unmarried child or stepchild who has not yet reached age 25
- the applicant's unmarried grandchild who qualifies as a dependent of the applicant for federal income tax purposes at the time of application and who has not yet reached age 25
- 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 enroll in a UNICARE High-Deductible Health Plan (children-only plan), children are not eligible to have Health Savings Accounts established in their names.

**It is permitted 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

The 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 50% of reasonable charges*	$325
You pay 50% of reasonable charges*	$325
Plus, the difference between the billed charges and the reasonable charges	$350
You pay a total of	**$675**

***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 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 plan booklet. If there are any conflicts between the terms of the plan booklet and the information in this brochure, the terms of the plan booklet will govern.

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

Your Plan Features	High-Deductible (HSA-Compatible) Plan 1			
	Single Party		Family	
	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%	50%	80%	50%
Preventive Care for Babies and Children (through age 6) Exams and lab tests	80%	50%	80%	50%
Immunizations for Babies and Children (through age 6)	100% Deductible(s) Waived		100% Deductible(s) Waived	
Adult Preventive Care Routine PAP smears, annual mammograms, colorectal cancer screenings and PSA screenings	80%	50%	80%	50%
Inpatient Hospital Services [1]	80%	50%	80%	50%
Outpatient Medical Care [2]	80%	50%	80%	50%
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%	50%	80%	50%
Ambulance Service With a maximum covered expense per trip: ground $1,000; air $5,000	80%	50%	80%	50%
Durable Medical Equipment	80%	50%	80%	50%
Initial Care of 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%	50%	80%	50%	100%	70%	100%	70%
80%	50%	80%	50%	100%	70%	100%	70%
100% Deductible(s) Waived		100% Deductible(s) Waived		100% Deductible(s) Waived		100% Deductible(s) Waived	
80%	50%	80%	50%	100%	70%	100%	70%
80%	50%	80%	50%	100%	70%	100%	70%
80%	50%	80%	50%	100%	70%	100%	70%
$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%	50%	80%	50%	100%	70%	100%	70%
80%	50%	80%	50%	100%	70%	100%	70%
80%	50%	80%	50%	100%	70%	100%	70%
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:** 70% of the average wholesale price	**Generic and brand name drugs:** 100%	**Generic and brand name drugs:** 70% 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 50% reduction in benefits 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 plan booklet for additional details on preservice and utilization review, the preauthorization process, penalties, covered services, and limitations and exclusions.

Utilization Management and the authorization program are 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 months to be eligible for benefits concerning all services related to:

- hernia (except strangulated or incarcerated)
- hemorrhoids
- varicose veins
- disorders of the reproductive organs
- sterilization
- disorders of tonsils or adenoids

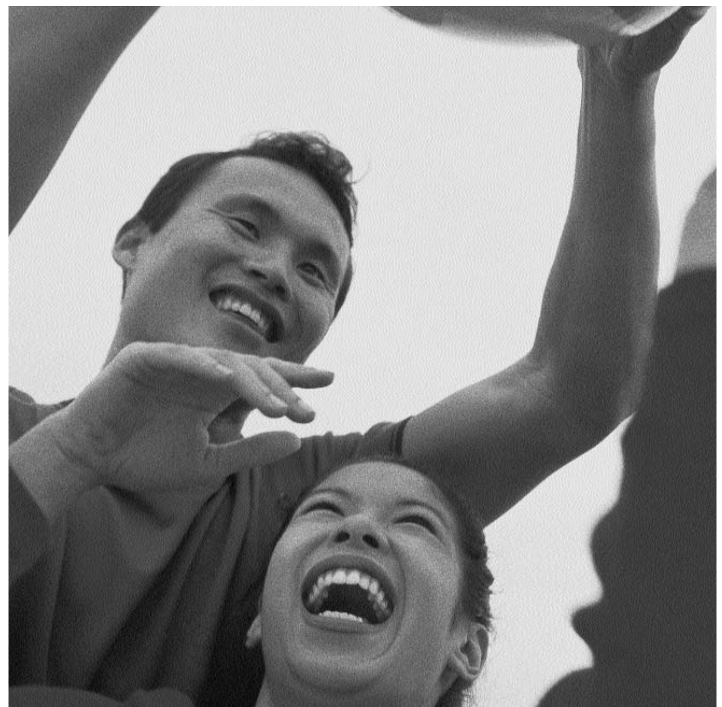
An insured person must be covered by the plan for 30 days prior to the inception of pregnancy to be eligible for any benefits for Complications of Pregnancy.

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 12 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.*

*This does not apply if you had prior creditable 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 plan. 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. Waivers apply for two years, five years, or ten years. Waivers will be reviewed periodically if you request the review in writing and forward the medical records from your attending physician.

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 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 the 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 Texas? 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	$19.50
Two adults	$39.50
Adult with 1 child	$30.00
Adult with 2 children	$40.50
Adult with 3+ children	$56.00
Family (1 child)	$49.50
Family (2 children)	$60.00
Family (3+ children)	$75.50
One child	$10.50
Two children	$20.50
Three+ children	$36.00

*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 plan booklet.

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 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

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. Benefits for eligible inpatient hospital services are paid up to $100 per day, up to a maximum payment of $3,000 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.

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.

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 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 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.

– 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.

– Any services provided by a local, state, or federal government agency, except (a) when payment under the plan is expressly required by federal or state law; or (b)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. 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 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 the patient'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. 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, 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.

– 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. 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 including, but not limited to, all tests, consultations, examinations, medications, and invasive, medical, laboratory, or surgical procedures including sterilization reversals.

– 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, elective cesarean sections, and elective abortions.

– 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.

– 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. (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.

– Any services received on or within twelve 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.

– Growth hormone treatment.

– 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 the services of a standby physician.

– Charges for animal-to-human organ transplants.

– Drugs and medications not requiring a prescription, except insulin.

– 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.

– 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.

Rating Area Definitions-Texas

AREA 1 Residence ZIP Codes	770-772, 77401, 77402, 77411, 77413, 77423, 77429, 77433, 775 (except 77510, 77517, 77518, 77519, 77539, 77545, 77546, 77549-77555, 77563, 77565, 77568, 77573, 77574, 77585, 77590-77592
AREA 2 Residence ZIP Codes	77320, 77336-77349, 77357, 77362, 77365, 77372-77373, 77375, 77396, 77406, 77417, 77441, 77444, 77459, 77461, 77469, 77471, 77476-77479, 77481, 77487, 77489, 77496, 77497, 77510, 77517, 77518, 77519, 77539, 77545, 77546, 77549-77555, 77563, 77565, 77568, 77573, 77574, 77585, 77590-77592, 776, 777
AREA 3 Residence ZIP Codes	752, 753, 773 (except 77320, 77336-77349, 77357, 77362, 77365, 77372-77373, 77375, 77396), 774, (except 77401, 77402, 77406, 77411, 77413, 77417, 77423, 77429, 77433, 77441, 77444, 77459, 77461, 77469, 77471, 77476-77479, 77481, 77487, 77489, 77496, 77497)
AREA 4 Residence ZIP Codes	750 (except 75009, 75020, 75021, 75058, 75069, 75070, 75076, 75090-75092, 75097), 75104, 75106, 75115, 75116, 75123, 75134, 75137, 75138, 75141, 75146, 75149, 75150, 75159, 75172, 75180-75182, 75185, 75187, 760 (except 76023, 76028, 76031-76033, 76041, 76043, 76048-76050, 76055, 76070, 76073, 76077, 76078, 76084, 76086,-76088), 761
AREA 5 Residence ZIP Codes	733, 75009, 75020, 75021, 75058, 75069, 75070, 75076, 75090-75092, 75097, 751 (except those zip codes listed in area 4), 756-759, 76023, 76028, 76031-76033, 76041, 76043, 76048-76050, 76055, 76070, 76073, 76077, 76078, 76084, 76086 - 76088, 762, 778, 779, 782-787, 789, 791
AREA 6 Residence ZIP Codes	754, 755, 763-769, 780, 781, 788, 790, 792-799, 885

Certain Medical Conditions
For certain medical conditions, an applicant may qualify for a plan at a premium that is higher than Level 1 rates.

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 and the nonrefundable $25 application fee 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.

Nonrefundable $25 Application Fee
– Must be submitted with the completed application and first month's premium
– May be paid by a separate credit card transaction
– If paying by check, a separate check is required
– Only one fee is required for families submitting more than one application at the same time, in the same envelope

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 plan booklet.

Texas 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	Area 5	Area 6
Single Male						
Under 30	123	117	121	107	103	98
30-34	134	127	132	117	113	107
35-39	148	140	145	129	125	118
40-44	181	172	178	158	152	144
45-49	221	210	217	193	186	176
50-54	251	238	246	219	211	200
55-59	340	322	334	297	286	271
60-64	447	424	439	390	376	357
Single Female						
Under 30	144	137	141	126	121	115
30-34	166	157	163	145	140	133
35-39	193	183	189	168	162	154
40-44	225	213	221	196	189	180
45-49	257	244	252	224	216	205
50-54	313	297	307	273	263	250
55-59	348	330	342	304	293	278
60-64	411	390	404	359	346	328
Applicant & Spouse						
Under 30	230	218	226	201	194	184
30-34	243	230	239	212	204	194
35-39	272	258	267	237	229	217
40-44	325	308	319	284	273	259
45-49	390	370	383	340	328	311
50-54	443	420	435	387	373	354
55-59	576	546	566	503	485	460
60-64	710	673	697	620	597	567
Applicant & 1 Child						
Under 30	169	160	166	148	142	135
30-34	187	177	184	163	157	149
35-39	208	197	204	182	175	166
40-44	232	220	228	203	195	185
45-49	257	244	252	224	216	205
50-54	300	285	295	262	252	239
55-59	327	310	321	285	275	261
60-64	413	392	405	361	348	330
Applicant & 2 Children						
Under 30	239	227	235	209	201	191
30-34	258	245	253	225	217	206
35-39	280	266	275	244	236	223
40-44	305	289	299	266	257	243
45-49	333	316	327	291	280	266
50-54	377	358	370	329	317	301
55-59	406	385	399	354	342	324
60-64	494	469	485	431	416	394
Applicant & 3+ Children						
Under 30	315	299	309	275	265	251
30-34	334	317	328	292	281	267
35-39	357	339	350	312	300	285
40-44	384	364	377	335	323	307
45-49	413	392	405	361	348	330
50-54	459	435	451	401	386	366
55-59	490	465	481	428	412	391
60-64	582	552	571	508	490	465
Family w/ 1 Child						
Under 30	306	290	300	267	257	244
30-34	319	303	313	278	268	255
35-39	348	330	342	304	293	278
40-44	402	381	395	351	338	321
45-49	467	443	458	408	393	373
50-54	520	493	511	454	438	415
55-59	653	619	641	570	549	521
60-64	787	746	773	687	662	628
Family w/ 2 Children						
Under 30	387	367	380	338	326	309
30-34	400	379	393	349	337	319
35-39	429	407	421	374	361	342
40-44	483	458	474	422	406	386
45-49	550	522	540	480	463	439
50-54	604	573	593	527	508	482
55-59	736	698	723	642	619	587
60-64	873	828	857	762	735	697
Family w/ 3+ Children						
Under 30	471	447	462	411	396	376
30-34	484	459	475	423	407	386
35-39	514	487	505	449	432	410
40-44	569	540	559	497	479	454
45-49	637	604	625	556	536	508
50-54	691	655	678	603	581	552
55-59	826	783	811	721	695	659
60-64	965	915	947	842	812	770
* Child Under 1	115	109	113	100	97	92
* Child 1-17	73	69	72	64	61	58
* 2 Children	117	111	115	102	98	93
* 3+ Children	184	175	181	161	155	147

Plan 2 – Level 1

Single Party $2,600
Family $5,200

	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6
Single Male						
Under 30	76	72	75	66	64	61
30-34	83	79	81	72	70	66
35-39	91	86	89	79	77	73
40-44	112	106	110	98	94	89
45-49	137	130	135	120	115	109
50-54	155	147	152	135	130	124
55-59	210	199	206	183	177	168
60-64	276	262	271	241	232	220
Single Female						
Under 30	87	83	85	76	73	69
30-34	100	95	98	87	84	80
35-39	117	111	115	102	98	93
40-44	136	129	134	119	114	109
45-49	155	147	152	135	130	124
50-54	189	179	186	165	159	151
55-59	210	199	206	183	177	168
60-64	247	234	243	216	208	197
Applicant & Spouse						
Under 30	121	115	119	106	102	97
30-34	128	121	126	112	108	102
35-39	144	137	141	126	121	115
40-44	172	163	169	150	145	137
45-49	206	195	202	180	173	164
50-54	234	222	230	204	197	187
55-59	304	288	298	265	256	243
60-64	375	356	368	327	316	299
Applicant & 1 Child						
Under 30	86	82	84	75	72	69
30-34	95	90	93	83	80	76
35-39	106	101	104	93	89	85
40-44	118	112	116	103	99	94
45-49	131	124	129	114	110	105
50-54	153	145	150	134	129	122
55-59	167	158	164	146	141	133
60-64	210	199	206	183	177	168
Applicant & 2 Children						
Under 30	120	114	118	105	101	96
30-34	129	122	127	113	109	103
35-39	140	133	137	122	118	112
40-44	153	145	150	134	129	122
45-49	166	157	163	145	140	133
50-54	188	178	185	164	158	150
55-59	203	193	199	177	171	162
60-64	247	234	243	216	208	197
Applicant & 3+ Children						
Under 30	157	149	154	137	132	125
30-34	166	157	163	145	140	133
35-39	178	169	175	155	150	142
40-44	191	181	188	167	161	152
45-49	205	194	201	179	172	164
50-54	228	216	224	199	192	182
55-59	244	231	240	213	205	195
60-64	290	275	285	253	244	231
Family w/ 1 Child						
Under 30	160	152	157	140	135	128
30-34	166	157	163	145	140	133
35-39	182	173	179	159	153	145
40-44	210	199	206	183	177	168
45-49	243	230	239	212	204	194
50-54	271	257	266	237	228	216
55-59	340	322	334	297	286	271
60-64	411	390	404	359	346	328
Family w/ 2 Children						
Under 30	201	191	197	175	169	160
30-34	208	197	204	182	175	166
35-39	223	211	219	195	188	178
40-44	251	238	246	219	211	200
45-49	286	271	281	250	241	228
50-54	314	298	308	274	264	251
55-59	382	362	375	333	321	305
60-64	453	430	445	395	381	362
Family w/ 3+ Children						
Under 30	245	232	241	214	206	196
30-34	252	239	247	220	212	201
35-39	267	253	262	233	225	213
40-44	296	281	291	258	249	236
45-49	331	314	325	289	279	264
50-54	359	340	352	313	302	287
55-59	429	407	421	374	361	342
60-64	502	476	493	438	422	401
* Child Under 1	71	67	70	62	60	57
* Child 1-17	45	43	44	39	38	36
* 2 Children	60	57	59	52	50	48
* 3+ Children	92	87	90	80	77	73

Plan 3 – Level 1

Single Party $5,000
Family $10,000

	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6
Single Male						
Under 30	69	65	68	60	58	55
30-34	75	71	74	65	63	60
35-39	83	79	81	72	70	66
40-44	102	97	100	89	86	81
45-49	125	119	123	109	105	100
50-54	141	134	138	123	119	113
55-59	191	181	188	167	161	152
60-64	252	239	247	220	212	201
Single Female						
Under 30	79	75	78	69	66	63
30-34	91	86	89	79	77	73
35-39	106	101	104	93	89	85
40-44	123	117	121	107	103	98
45-49	141	134	138	123	119	113
50-54	171	162	168	149	144	136
55-59	190	180	187	166	160	152
60-64	224	212	220	196	188	179
Applicant & Spouse						
Under 30	99	94	97	86	83	79
30-34	105	100	103	92	88	84
35-39	118	112	116	103	99	94
40-44	141	134	138	123	119	113
45-49	169	160	166	148	142	135
50-54	192	182	189	168	162	153
55-59	249	236	244	217	210	199
60-64	307	291	301	268	258	245
Applicant & 1 Child						
Under 30	70	66	69	61	59	56
30-34	78	74	77	68	66	62
35-39	86	82	84	75	72	69
40-44	97	92	95	85	82	77
45-49	107	101	105	93	90	85
50-54	125	119	123	109	105	100
55-59	136	129	134	119	114	109
60-64	172	163	169	150	145	137
Applicant & 2 Children						
Under 30	96	91	94	84	81	77
30-34	103	98	101	90	87	82
35-39	112	106	110	98	94	89
40-44	122	116	120	107	103	97
45-49	133	126	131	116	112	106
50-54	151	143	148	132	127	121
55-59	163	155	160	142	137	130
60-64	198	188	194	173	167	158
Applicant & 3+ Children						
Under 30	124	118	122	108	104	99
30-34	131	124	129	114	110	105
35-39	140	133	137	122	118	112
40-44	151	143	148	132	127	121
45-49	162	154	159	141	136	129
50-54	180	171	177	157	151	144
55-59	193	183	189	168	162	154
60-64	229	217	225	200	193	183
Family w/ 1 Child						
Under 30	129	122	127	113	109	103
30-34	134	127	132	117	113	107
35-39	147	139	144	128	124	117
40-44	169	160	166	148	142	135
45-49	197	187	193	172	166	157
50-54	219	208	215	191	184	175
55-59	275	261	270	240	231	220
60-64	332	315	326	290	279	265
Family w/ 2 Children						
Under 30	161	153	158	141	135	129
30-34	166	157	163	145	140	133
35-39	179	170	176	156	151	143
40-44	201	191	197	175	169	160
45-49	229	217	225	200	193	183
50-54	251	238	246	219	211	200
55-59	306	290	300	267	257	244
60-64	363	344	356	317	305	290
Family w/ 3+ Children						
Under 30	195	185	191	170	164	156
30-34	201	191	197	175	169	160
35-39	213	202	209	186	179	170
40-44	236	224	232	206	199	188
45-49	264	250	259	230	222	211
50-54	287	272	282	251	241	229
55-59	343	325	337	299	289	274
60-64	400	379	393	349	337	319
* Child Under 1	65	62	64	57	55	52
* Child 1-17	41	39	40	36	34	33
* 2 Children	49	46	48	43	41	39
* 3+ Children	74	70	73	65	62	59

Nonrefundable $25 Application Fee Required: A separate, nonrefundable $25 application fee must be submitted with each application and the first month's premium. The fee may be paid by separate check or credit card charge. Only one fee is required for families submitting separate applications at the same time, in the same envelope.

*While children may enroll in a UNICARE High-Deductible Health Plan (children-only plan), children are not eligible to have a Health Savings Account established in their name.

Texas 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	Area 5	Area 6
Single Male						
Under 30	172	164	169	150	144	137
30-34	188	178	185	164	158	150
35-39	207	196	203	181	175	165
40-44	253	241	249	221	213	202
45-49	309	294	304	270	260	246
50-54	351	333	344	307	295	280
55-59	476	451	468	416	400	379
60-64	626	594	615	546	526	500
Single Female						
Under 30	202	192	197	176	169	161
30-34	232	220	228	203	196	186
35-39	270	256	265	235	227	216
40-44	315	298	309	274	265	252
45-49	360	342	353	314	302	287
50-54	438	416	430	382	368	350
55-59	487	462	479	426	410	389
60-64	575	546	566	503	484	459
Applicant & Spouse						
Under 30	322	305	316	281	272	258
30-34	340	322	335	297	286	272
35-39	381	361	374	332	321	304
40-44	455	431	447	398	382	363
45-49	546	518	536	476	459	435
50-54	620	588	609	542	522	496
55-59	806	764	792	704	679	644
60-64	994	942	976	868	836	794
Applicant & 1 Child						
Under 30	237	224	232	207	199	189
30-34	262	248	258	228	220	209
35-39	291	276	286	255	245	232
40-44	325	308	319	284	273	259
45-49	360	342	353	314	302	287
50-54	420	399	413	367	353	335
55-59	458	434	449	399	385	365
60-64	578	549	567	505	487	462
Applicant & 2 Children						
Under 30	335	318	329	293	281	267
30-34	361	343	354	315	304	288
35-39	392	372	385	342	330	312
40-44	427	405	419	372	360	340
45-49	466	442	458	407	392	372
50-54	528	501	518	461	444	421
55-59	568	539	559	496	479	454
60-64	692	657	679	603	582	552
Applicant & 3+ Children						
Under 30	441	419	433	385	371	351
30-34	468	444	459	409	393	374
35-39	500	475	490	437	420	399
40-44	538	510	528	469	452	430
45-49	578	549	567	505	487	462
50-54	643	609	631	561	540	512
55-59	686	651	673	599	577	547
60-64	815	773	799	711	686	651
Family w/ 1 Child						
Under 30	428	406	420	374	360	342
30-34	447	424	438	389	375	357
35-39	487	462	479	426	410	389
40-44	563	533	553	491	473	449
45-49	654	620	641	571	550	522
50-54	728	690	715	636	613	581
55-59	914	867	897	798	769	729
60-64	1102	1044	1082	962	927	879
Family w/ 2 Children						
Under 30	542	514	532	473	456	433
30-34	560	531	550	489	472	447
35-39	601	570	589	524	505	479
40-44	676	641	664	591	568	540
45-49	770	731	756	672	648	615
50-54	846	802	830	738	711	675
55-59	1030	977	1012	899	867	822
60-64	1222	1159	1200	1067	1029	976
Family w/ 3+ Children						
Under 30	659	626	647	575	554	526
30-34	678	643	665	592	570	540
35-39	720	682	707	629	605	574
40-44	797	756	783	696	671	636
45-49	892	846	875	778	750	711
50-54	967	917	949	844	813	773
55-59	1156	1096	1135	1009	973	923
60-64	1351	1281	1326	1179	1137	1078
* Child Under 1	161	153	158	140	136	129
* Child 1-17	102	97	101	90	85	81
* 2 Children	164	155	161	143	137	130
* 3+ Children	258	245	253	225	217	206

Plan 2 – Level 1+40

Single Party $2,600
Family $5,200

	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6
Single Male						
Under 30	106	101	105	92	90	85
30-34	116	111	113	101	98	92
35-39	127	120	125	111	108	102
40-44	157	148	154	137	132	125
45-49	192	182	189	168	161	153
50-54	217	206	213	189	182	174
55-59	294	279	288	256	248	235
60-64	386	367	379	337	325	308
Single Female						
Under 30	122	116	119	106	102	97
30-34	140	133	137	122	118	112
35-39	164	155	161	143	137	130
40-44	190	181	188	167	160	153
45-49	217	206	213	189	182	174
50-54	265	251	260	231	223	211
55-59	294	279	288	256	248	235
60-64	346	328	340	302	291	276
Applicant & Spouse						
Under 30	169	161	167	148	143	136
30-34	179	169	176	157	151	143
35-39	202	192	197	176	169	161
40-44	241	228	237	210	203	192
45-49	288	273	283	252	242	230
50-54	328	311	322	286	276	262
55-59	426	403	417	371	358	340
60-64	525	498	515	458	442	419
Applicant & 1 Child						
Under 30	120	115	118	105	101	97
30-34	133	126	130	116	112	106
35-39	148	141	146	130	125	119
40-44	165	157	162	144	139	132
45-49	183	174	181	160	154	147
50-54	214	203	210	188	181	171
55-59	234	221	230	204	197	186
60-64	294	279	288	256	248	235
Applicant & 2 Children						
Under 30	168	160	165	147	141	134
30-34	181	171	178	158	153	144
35-39	196	186	192	171	165	157
40-44	214	203	210	188	181	171
45-49	232	220	228	203	196	186
50-54	263	249	259	230	221	210
55-59	284	270	279	248	239	227
60-64	346	328	340	302	291	276
Applicant & 3+ Children						
Under 30	220	209	216	192	185	175
30-34	232	220	228	203	196	186
35-39	249	237	245	217	210	199
40-44	267	253	263	234	225	213
45-49	287	272	281	251	241	230
50-54	319	302	314	279	269	255
55-59	342	323	336	298	287	273
60-64	406	385	399	354	342	323
Family w/ 1 Child						
Under 30	224	213	220	196	189	179
30-34	232	220	228	203	196	186
35-39	255	242	251	223	214	203
40-44	294	279	288	256	248	235
45-49	340	322	335	297	286	272
50-54	379	360	372	332	319	302
55-59	476	451	468	416	400	379
60-64	575	546	566	503	484	459
Family w/ 2 Children						
Under 30	281	267	276	245	237	224
30-34	291	276	286	255	245	232
35-39	312	295	307	273	263	249
40-44	351	333	344	307	295	280
45-49	400	379	393	350	337	319
50-54	440	417	431	384	370	351
55-59	535	507	525	466	449	427
60-64	634	602	623	553	533	507
Family w/ 3+ Children						
Under 30	343	325	337	300	288	274
30-34	353	335	346	308	297	281
35-39	374	354	367	326	315	298
40-44	414	393	407	361	349	330
45-49	463	440	455	405	391	370
50-54	503	476	493	438	423	402
55-59	601	570	589	524	505	479
60-64	703	666	690	613	591	561
* Child Under 1	99	94	98	87	84	80
* Child 1-17	63	60	62	55	53	50
* 2 Children	84	80	83	73	70	67
* 3+ Children	129	122	126	112	108	102

Plan 3 – Level 1+40

Single Party $5,000
Family $10,000

	Area 1	Area 2	Area 3	Area 4	Area 5	Area 6
Single Male						
Under 30	97	91	95	84	81	77
30-34	105	99	104	91	88	84
35-39	116	111	113	101	98	92
40-44	143	136	140	125	120	113
45-49	175	167	172	153	147	140
50-54	197	188	193	172	167	158
55-59	267	253	263	234	225	213
60-64	353	335	346	308	297	281
Single Female						
Under 30	111	105	109	97	92	88
30-34	127	120	125	111	108	102
35-39	148	141	146	130	125	119
40-44	172	164	169	150	144	137
45-49	197	188	193	172	167	158
50-54	239	227	235	209	202	190
55-59	266	252	262	232	224	213
60-64	314	297	308	274	263	251
Applicant & Spouse						
Under 30	139	132	136	120	116	111
30-34	147	140	144	129	123	118
35-39	165	157	162	144	139	132
40-44	197	188	193	172	167	158
45-49	237	224	232	207	199	189
50-54	269	255	265	235	227	214
55-59	349	330	342	304	294	279
60-64	430	407	421	375	361	343
Applicant & 1 Child						
Under 30	98	92	97	85	83	78
30-34	109	104	108	95	92	87
35-39	120	115	118	105	101	97
40-44	136	129	133	119	115	108
45-49	150	141	147	130	126	119
50-54	175	167	172	153	147	140
55-59	190	181	188	167	160	153
60-64	241	228	237	210	203	192
Applicant & 2 Children						
Under 30	134	127	132	118	113	108
30-34	144	137	141	126	122	115
35-39	157	148	154	137	132	125
40-44	171	162	168	150	144	136
45-49	186	176	183	162	157	148
50-54	211	200	207	185	178	169
55-59	228	217	224	199	192	182
60-64	277	263	272	242	234	221
Applicant & 3+ Children						
Under 30	174	165	171	151	146	139
30-34	183	174	181	160	154	147
35-39	196	186	192	171	165	157
40-44	211	200	207	185	178	169
45-49	227	216	223	197	190	181
50-54	252	239	248	220	211	202
55-59	270	256	265	235	227	216
60-64	321	304	315	280	270	256
Family w/ 1 Child						
Under 30	181	171	178	158	153	144
30-34	188	178	185	164	158	150
35-39	206	195	202	179	174	164
40-44	237	224	232	207	199	189
45-49	276	262	270	241	232	220
50-54	307	291	301	267	258	245
55-59	385	365	378	336	323	308
60-64	465	441	456	406	391	371
Family w/ 2 Children						
Under 30	225	214	221	197	189	181
30-34	232	220	228	203	196	186
35-39	251	238	246	218	211	200
40-44	281	267	276	245	237	224
45-49	321	304	315	280	270	256
50-54	351	333	344	307	295	280
55-59	428	406	420	374	360	342
60-64	508	482	498	444	427	406
Family w/ 3+ Children						
Under 30	273	259	267	238	230	218
30-34	281	267	276	245	237	224
35-39	298	283	293	260	251	238
40-44	330	314	325	288	279	263
45-49	370	350	363	322	311	295
50-54	402	381	395	351	337	321
55-59	480	455	472	419	405	384
60-64	560	531	550	489	472	447
* Child Under 1	91	87	90	80	77	73
* Child 1-17	57	55	56	50	48	46
* 2 Children	69	64	67	60	57	55
* 3+ Children	104	98	102	91	87	83

Nonrefundable $25 Application Fee Required: A separate, nonrefundable $25 application fee must be submitted with each application and the first month's premium. The fee may be paid by separate check or credit card charge. Only one fee is required for families submitting separate applications at the same time, in the same envelope.

*While children may enroll in a UNICARE High-Deductible Health Plan (children-only plan), children are not eligible to have a Health Savings Account established in their name.

A healthy dose of innovation.℠

Individual & Family PPO Health Insurance Plans

UNICARE Performance Plans
UNICARE Consumer Choice Plans
UNICARE High-Deductible (HSA-Compatible) Plans
UNICARE Life and Dental Plans

Application

Thank you for applying with UNICARE.

If you are electing a UNICARE Consumer Choice PPO plan, please note: Some of the plans offered do not include all of the STATE-MANDATED HEALTH BENEFITS NORMALLY REQUIRED IN ACCIDENT AND SICKNESS INSURANCE POLICIES IN TEXAS. These standard health benefit plans 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 benefits plan, please consult with your insurance agent to discover which state-mandated health benefits are excluded in the policy.

- **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 intentional 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 below.
- **Also please include a separate $25 nonrefundable application fee.** Only one application fee is required for families submitting more than one application at the same time in the same envelope. The application fee is waived for all applications submitted online.

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.
- Failure to include a **separate** $25 nonrefundable application fee check.

Mailing Address

- **Applicant:** Please return this application to the agent.
- **Agent:** Please mail this application to the address below.

UNICARE Life & Health Insurance Company
Attn: Individual Services - Texas
P.O. Box 5030
Bolingbrook, IL 60440-5030

Insurance coverage underwritten by UNICARE Life & Health Insurance Company, a separately capitalized and incorporated subsidiary of WellPoint Health Networks Inc.

® Registered Mark and SM Service Mark of WellPoint Health Networks Inc.

Individual Enrollment Application - Texas

Applicant's Social Security No.

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)
Employer			Maiden Name of Applicant / Spouse (If applicable)	
Occupation	Title		Business Phone ( )	

Billing Type: ☐ Monthly Bank Draft ☐ Quarterly Billing ☐ Summary Bill (Please attach Summary Bill cover sheet.)

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

☐ Saver 2000 (G859)
☐ Performance 5000 (PE29)
☐ Performance 3000 (PE28)
☐ Performance 2000 (G858)
☐ Life
☐ Performance 1500 (G857)
☐ Performance 1000 (G856)
☐ Performance 600 (G855)
☐ Performance 500 (G854)
☐ Dental
☐ Performance Plus No Deductible (G853)
☐ Consumer Choice $5000 (R414)
☐ Consumer Choice $2000 (R413)
☐ Consumer Choice $1000 (R412)
☐ HSA-Compatible Plan 1 (T765)
☐ HSA-Compatible Plan 2 (T766)
☐ HSA-Compatible Plan 3 (T767)

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	Weight	Date of Birth	Social Security No.	FamilyFlex List Medical Plan code number(s) from Section 2	✓ Dental	UNICARE USE ONLY WVR	WVR
☐ Male ☐ Female	Yourself								
☐ Husband ☐ Wife	Spouse								
☐ 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 coverage in the last 18 months? . . . . . ☐ Yes ☐ No
If Yes, please provide the following information and attach the Certificate of Creditable Coverage from your prior health insurance carrier.

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
3. 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: __________

Applicant's Social Security No.

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

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 or consultation recommended, received treatment, or been hospitalized for any of the following conditions listed in questions 1 through 24 **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

Has any person listed on this application **ever:**

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 as having 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.

Applicant's Social Security No.

6B. Professional Services

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 ever 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 ever 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 nonparticipating 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 10, 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 DOES NOT GUARANTEE UNDERWRITING TO BE COMPLETED BEFORE THE DATE REQUESTED. I UNDERSTAND THAT IF I SELECT AN EFFECTIVE DATE, ONLY UNICARE CAN CHANGE THIS DATE, HOWEVER, UNICARE CANNOT CHANGE THIS DATE UNDER ANY CIRCUMSTANCES ONCE THE PLAN 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 a non-refundable application fee of $25 to be paid on a separate check or through a separate credit card deduction and to pay the premium amount required with this application. If my application is denied, UNICARE will return only the premium payment. If my application is accepted, this premium amount will be applied to the premium charges.
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, and/or cashing of my nonrefundable application fee check or cashing of my premium check or charging either of these amounts to 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 intentional misstatements or omissions.

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

    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/Disclosure Statement

Some of the plans offered do not include all of the state-mandated health benefits. The Consumer Choice PPO Plans do not provide some of the state-mandated health benefits. State-mandated benefits not included are: 1) mental or nervous disorders including those with organic disease; 2) off-label drugs; 3) prescription contraceptive drugs and devices and related services; 4) telemedicine/telehealth. In addition, coinsurance differentials between participating and nonparticipating providers may be greater than 30%. Purchase of this plan may limit your future coverage options in the event your health changes and needed benefits are not available under this plan. Coverage for pregnancy is not available under any UNICARE Individual and Family PPO Plan.

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 a period not longer than 2 years 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 the above disclosure statement. I have read and understand this Application in its entirety. I have received a written plan description.

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

Signature	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 AND SEPARATE CHECK FOR APPLICATION FEE HERE. DO NOT TAPE.

Applicant's Social Security No.

8. Payment Method – Submit nonrefundable application fee and premium payment with application (required).

8A. Nonrefundable $25 Application Fee Payment

Only one application fee is required for families submitting more than one application at the same time. No application fee is required for applications submitted online.

☐ Please charge the separate, non-refundable application fee to my credit card. ☐ I am attaching a separate check for the non-refundable application fee.

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 (First payment will be credited to approved applicants only.)

☐ **Monthly Billing** (Available with Monthly Checking Account Deduction).
- Submit the one (1) month premium.
- Complete section 8C, **Monthly Checking Account Deduction Authorization.**
- 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.

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.

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 next page)

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 funds collected:

  Total Medical premium . . . . $ ....

  Total Dental premium. . . . . $ ....

  Total Life premium . . . . $ ....

  Nonrefundable application fee . . . . $ $25

  Total funds 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)			Writing 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 of Writing	
Agent 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 X____ ________________________

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 nonrefundable application fee payable to UNICARE;

$____________ as a premium, 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 PREMIUM 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____ ________________________

TXIMFAPLCR0903 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.

A healthy dose of innovation.[SM]

UNICARE Life & Health Insurance Company
Sales Office
Houston, Texas

Insurance coverage is underwritten by UNICARE Life & Health Insurance Company.
® Registered Mark and SM Service Mark of WellPoint Health Networks Inc.

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
0010104TX 4/04