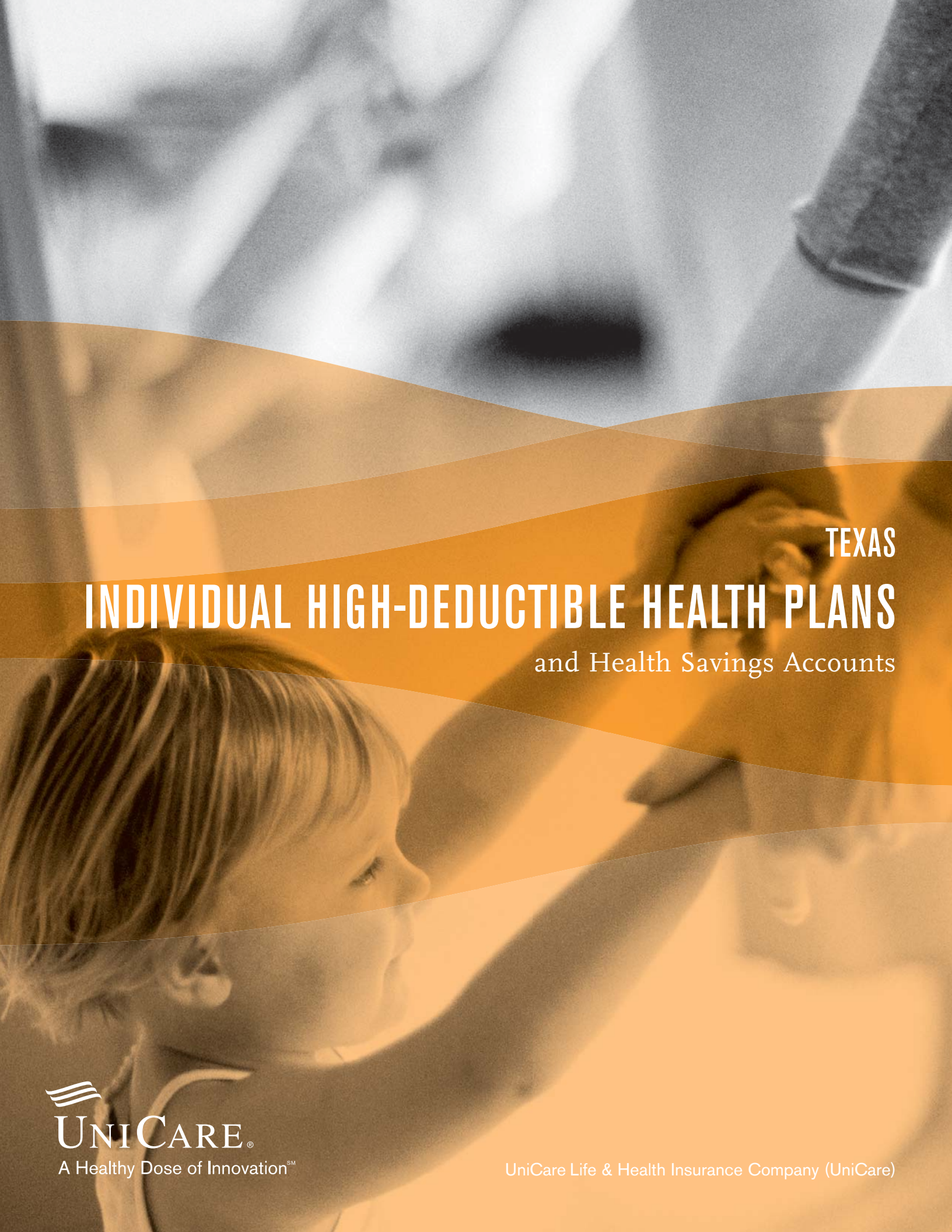

TEXAS

INDIVIDUAL HIGH-DEDUCTIBLE HEALTH PLANS

and Health Savings Accounts

UNICARE®

A Healthy Dose of Innovation℠

UniCare Life & Health Insurance Company (UniCare)

UniCare Life & Health Insurance Company (UniCare) is a WellPoint Company. WellPoint is the largest health benefits company in the nation. WellPoint and its family of companies provide health coverage for over 34 million people.

UniCare's High-Deductible Health Savings Account (HSA) Compatible Insurance Plans provide:

- Choice of doctors
- Preventive care for children and adults
- Toll-free dedicated customer service numbers
- No claim forms with Network Providers
- Optional easy-issue Term Life Insurance
- Options of Single Party or Family Preferred Provider (PPO) Health Insurance Coverage

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UniCare offers High-Deductible Health Savings Account (HSA) compatible health insurance plans so you can choose the right coverage for your family and yourself.

Background

Health Savings Accounts (HSAs) are established to receive tax-favored contributions by or on behalf of eligible individuals. Amounts in an HSA may be accumulated over the years or distributed on a tax-free basis to pay or reimburse qualified medical expenses.

What is a High-Deductible Health Insurance Plan?

A High-Deductible Health Plan (HDHP) is a health plan that meets certain U.S. Treasury Department requirements for annual deductibles and annual out-of-pocket expense maximums, allowing you to qualify for a Health Savings Account (HSA). That is why they are also called "HSA Compatible" health plans.

A health plan is a High-Deductible Health Plan if:

- The annual deductible for a single party is at least $1,050 and the annual out-of-pocket expense maximum does not exceed $5,250; and
- The annual deductible for a family is at least $2,100 and the annual out-of-pocket expense maximum does not exceed $10,500.

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 qualified medical expenses of eligible individuals. The HSA provides a way to fund your health care expenses now, save for long-term health care expenses, or to bridge a potential gap between your needs and funds that may become available once you become eligible for Medicare. When the funds are used for eligible health care expenses, the savings may be tax exempt.

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

Benefits of an HSA/HDHP

The advantages of an HSA can be broken down into two areas — savings benefits and tax benefits:

Savings Benefits

- HSA funds may be used to pay for current, future and post-retirement qualified medical expenses not covered by the HDHP
- Savings can cover your pre-deductible health care costs and other qualified medical expenses
- Money not spent rolls over to following year
- Potential exists to build significant, nest-egg balances after years of tax-advantaged contributions and interest growth

Tax Benefits (subject to IRS Rules)

- Individual HSA contributions are tax-deductible up to the IRS maximum
- Interest earned on HSA funds is tax-advantaged
- HSA withdrawals, if used for qualified medical expenses, are tax-advantaged

Consult a Tax Advisor

This brochure provides general information only and is not intended to be a substitute for the advice of a qualified tax professional. Before you establish an HSA, consult a qualified tax professional, such as a Certified Public Accountant (CPA) who can evaluate your particular needs and circumstances.

Please note: These High-Deductible Health plans are not "Health Savings Accounts" or "HSAs" but are designed as High-Deductible Health plans 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 these plans.

How They Work Together

Health Savings Accounts work in conjunction with UniCare's High-Deductible Health Plans, which are HSA compatible.

The Health Savings Account (HSA) is not a High-Deductible Health Plan – it 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. UniCare does not administer the HSA. Consultation with a tax advisor is recommended before you decide whether applying for an HDHP and opening an HSA is right for you.

Your HDHP provides benefits for covered medical services once any applicable deductibles are satisfied. The funds you deposit into your HSA can then be used to pay for medical expenses applied to your deductible and certain other expenses not covered by the HDHP.

Optional HSA through JPMorgan Bank, N.A. (Chase)

By taking advantage of one of UniCare's HDHPs with an HSA from Chase, you can save time, reduce hassle, enjoy seamless customer service between UniCare and Chase, and establish an HSA with a well respected, nationally-recognized bank. Through an arrangement with Chase, UniCare can offer the convenience of applying for both an HSA and High-Deductible Health Plan together. Rather than applying for an HDHP, then finding a bank and going through another enrollment process for your HSA, you can take care of both steps at once.

- First, fill out an application for one of UniCare's HSA Compatible High-Deductible Health Plans and an application for the Health Savings Account administered by Chase.
- Then, send both applications to UniCare and UniCare coordinates with Chase.
- If you are approved for one of UniCare's HDHPs, your HSA application will be forwarded to Chase. The bank will then send you all other necessary information on the HSA. UniCare does not administer the HSA.

Integrated Enrollment Process

Your agent will assist you to make sure all necessary paperwork is submitted accurately and completely to UniCare.

You complete:
- UniCare Individual Enrollment Application
- Chase HSA Enrollment Form

Application/Enrollment – UniCare processes the health plan application. If approved, enrollment in the HDHP is complete.

Open an HSA – UniCare submits the HSA forms to Chase on your behalf as part of the integrated application process. Chase processes the HSA application.

Your ID Card and Documents –
You receive communications from UniCare and Chase separately once the enrollment process is complete. UniCare will send you an ID card, specifications page and a Plan Booklet. Chase sends a welcome package, debit card and other necessary information.

HDHP from UniCare with HSA from Chase

Enroll in HDHP → **Open HSA** → **Make HSA Contributions** → **Pay for Qualified Expenses** → **Unused Balances Rollover**

Apply for Your UniCare High-Deductible Health Insurance 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 Health Insurance Plan Options

You have a choice of four UniCare High-Deductible Health Plans and the option of HSA with Chase. The annual deductible for each plan and the maximum annual amount you may contribute to your HSA in 2006 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. Please refer to Appendix B, Question 7 in the back of this brochure.

Please note that the contribution amounts will change each year in accordance with the annual U.S. Treasury announcement made at the end of each year.

Please note that the deductibles for the Variable Deductible Plan and the contribution limits for the Variable Contribution Plan will change each year in accordance with U.S. Treasury guidelines. For example, in 2005 the deductible amounts for the Variable Deductible Plan were $1,000 for Individuals and $2,000 for Families. In 2006, these amounts increased to $1,050 for Individuals and $2,100 for Families.

In 2005, the contribution limits for the Variable Contribution Plan were $2,650 for Individuals and $5,250 for Families. In 2006 these amounts increased to $2,700 for Individuals and $5,450 for Families.

The U.S. Treasury makes its annual announcement toward the end of each year. The new deductible amounts then become effective on January 1 following the announcement.

High-Deductible Health Plan		Annual Deductible	Amount You May Deposit Into Your HSA Annually
Variable Deductible Plan[1]	Single Party	$1,050[1]	$1,050
	Family	$2,100[1]	$2,100
Plan 2	Single Party	$2,600	$2,600
	Family	$5,200	$5,200
Variable Contribution Plan[2]	Single Party	$2,700[2]	$2,700
	Family	$5,450[2]	$5,450
Plan 3	Single Party	$5,000	$2,650
	Family	$10,000	$5,250

Who Can Apply for UniCare High-Deductible (HSA Compatible) Insurance Health Plans?

To be eligible for enrollment, you must be:

- Age 64½ or younger*
- The applicant's spouse, age 64½ or younger
- The applicant's unmarried child, 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

* 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.

[1] The annual deductible is subject to change annually to continue to meet the U.S. Treasury's minimum deductible requirements.

[2] The annual deductible is subject to change annually to continue to meet the U.S. Treasury's maximum annual contribution limits.

Individual High-Deductible (HSA Compatible) Health Insurance Plans Comparison*

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

The matrix on page 6 is intended to help you compare UniCare health insurance plan benefits and reflects UniCare's payment for covered expenses after applicable deductibles are met.

When you use UniCare independently contracted participating (in-network) providers, your costs are based on a specially negotiated rate for UniCare that may often save you money.

When you use nonparticipating (out-of-network) 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. The amount of benefits provided depends upon the plan selected. Your premium will vary with the amount of benefits selected.

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

Note: These plans utilize a Medicare level out-of-network fee schedule.

* 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 prevail.

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

Overview of Coverage-–Amounts shown are for UniCare's payment for covered expenses after applicable deductibles are met, unless otherwise noted. In this chart, "Par" represents Participating Provider and "Nonpar" represents Nonparticipating Provider.

Plan Features	High-Deductible (HSA Compatible) Variable Deductible Plan	High-Deductible (HSA Compatible) Plan 2	High-Deductible (HSA Compatible) Variable Contribution Plan**	High-Deductible (HSA Compatible) Plan 3
Annual Deductible (Medical and pharmacy combined)	For 2006 $1,050 for single party, $2,100 for family The annual deductible will reflect the U.S. Treasury's minimum deductible requirements for HSA qualified high-deductible health plans. The amount is subject to change annually.	$2,600 for single party, $5,200 for family	For 2006 $2,700 for single party, $5,450 for family The annual deductible will reflect the U.S. Treasury's maximum annual contribution limits for Health Savings Accounts. The amount is subject to change annually.	$5,000 for single party, $10,000 for family
Additional Out-of-Network Deductible	$4,000 for single party, $8,000 for family			
Annual Out-of-Pocket Maximum[1] (includes annual deductible and pharmacy copays)	**Par:** $5,000 (Single Party), $10,000 (Family) **Nonpar:** $15,000 (Single Party), $20,000 (Family)			
Lifetime Maximum Benefit	UniCare pays up to $5,000,000 per member			
Office Visits Exam only for any covered illness, injury or certain preventive care services for adults and children through age 6.	**Par:** 80% **Nonpar:** 50%		**Par:** 100% **Nonpar:** 70%	
Preventive Care for Babies and Children (through age 6) Immunizations	**Par/Nonpar:** 100%, deductible(s) waived			
Adult Preventive Care Screenings Lab work and x-rays for routine Pap smears, annual mammograms, colorectal cancer screening or PSA screenings	**Par:** 80% **Nonpar:** 50%		**Par:** 100% **Nonpar:** 70%	
Professional Services Such as surgery, anesthesia, radiation therapy, in-hospital doctor visits and diagnostic x-ray/lab	**Par:** 80% **Nonpar:** 50%		**Par:** 100% **Nonpar:** 70%	
Ambulance Service	**Par:** 80% **Nonpar:** 50%		**Par:** 100% **Nonpar:** 70%	
Initial Care of a Medical Emergency[2, 3] Inpatient or outpatient	With a maximum covered expense of $1,000 per trip for Ground; $5,000 per trip for Air **Par:** 80% **Nonpar:** 80%[4]		**Par:** 100% **Nonpar:** 100%[4]	
Inpatient Hospital Services[2]	**Par:** 80% **Nonpar:** 50%		**Par:** 100% **Nonpar:** 70%	
Outpatient Hospital[2, 3] **or Surgical Center**[3]	**Par:** 80% **Nonpar:** 50%		**Par:** 100% **Nonpar:** 70%	
Physical Therapy, Occupational Therapy and Acupuncture/Acupressure	Maximum payment of $30 per visit, up to 12 visits per member, per year, for all of these services combined			
Durable Medical Equipment	**Par:** 80% **Nonpar:** 50%		**Par:** 100% **Nonpar:** 70%	
Retail Pharmacy[5] Per prescription, up to a 30-day supply. Deductibles apply Generic Drugs	**Par:** You pay a $10 copay **Nonpar:** UniCare pays 50% of the average wholesale price		**Par:** You pay a $10 copay **Nonpar:** UniCare pays 70% of the average wholesale price	**Par:** UniCare pays 100% **Nonpar:** UniCare pays 70% of the average wholesale price
Brand Name Formulary Drugs	**Par:** You pay a $30 copay **Nonpar:** UniCare pays 50% of the average wholesale price		**Par:** You pay a $30 copay **Nonpar:** UniCare pays 70% of the average wholesale price	**Par:** UniCare pays 100% **Nonpar:** UniCare pays 70% of the average wholesale price
Brand Name Nonformulary Drugs	**Par:** You pay a $50 copay **Nonpar:** UniCare pays 50% of the average wholesale price		**Par:** You pay a $50 copay **Nonpar:** UniCare pays 70% of the average wholesale price	**Par:** UniCare pays 100% **Nonpar:** UniCare pays 70% of the average wholesale price
Self Injectable Drugs	**Par:** UniCare pays 80% **Nonpar:** UniCare pays 50% of the average wholesale price		**Par:** UniCare pays 80% **Nonpar:** UniCare pays 70% of the average wholesale price	**Par:** UniCare pays 100% **Nonpar:** UniCare pays 70% of the average wholesale price

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

[2] Services may require preservice review or authorization by UniCare or you will be required to pay an additional penalty. See page 11 for specific penalty amounts.

[3] Emergency room visits that do not result in an inpatient admission will be subject to a $60 charge.

[4] Until transferable to a participating hospital; then 50% subject to a $500 deductible per continuing hospital confinement once transferable.

[5] Certain prescription drugs require prior authorization by UniCare.

** This UniCare High-Deductible Variable Contribution plan offers prescription drug coverage. Once your annual deductible is satisfied, you only have to pay the appropriate copay for your prescriptions. Once your out-of-pocket maximum is met, you have 100% pharmacy coverage. See the pharmacy benefit for details on the copay amounts.

Platinum Network Travel Access – for peace of mind when you travel

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

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

Plan members can order prescriptions by mail, phone, or online with **Mail Service Prescription Drugs**

In addition to filling your prescriptions at a retail pharmacy, you may opt for the convenience of filling your prescription through **PrecisionRx**[1] by mail, phone, or online.

One of the advantages of using this program is that you can order a 60-day mail order supply instead of the 30-day supply at retail pharmacies. When you order a 60-day mail order supply, your copay is double that of your retail 30-day supply copay. Just as with retail pharmacy, annual deductibles will apply.

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

Individual and Family Dental Fee-For-Service Insurance Plan

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 Fee-For-Service Plan to provide affordable coverage for regular dental care. Research continues to establish links between peridontal disease and serious health conditions including heart disease, stroke, osteoporosis, low birth weight pregnancy, diabetes and respiratory infection*.

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 Fee-For-Service Plan, please call your UniCare agent or visit the UniCare Web site at www.unicare.com.

For complete details including benefits, limitations and exclusions, please refer to the Dental Fee-For-Service Plan booklet.

UniCare Individual Dental Fee-For-Service Plan Monthly Rates**	
One adult	$20.50
Two adults	$41.50
Adult with 1 child	$31.50
Adult with 2 children	$42.50
Adult with 3+ children	$58.50
Family (1 child)	$51.50
Family (2 children)	$62.50
Family (3+ children)	$79.00
One child	$11.00
Two children	$21.50
Three+ children	$37.50

*Oral Health in America: A Report of the Surgeon General, May 25, 2003.

**Rates are current as of October 1, 2006. 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?

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 health insurance coverage:

- Life insurance provides a financial safeguard for your family
- No additional forms to fill out
- 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 July 2006. 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.

Appendix A — Important Information About UniCare's High-Deductible Health Plans

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.

Note: Penalties are not counted toward any deductible or out-of-pocket maximum.

Important Additional Information

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

- Hernia (except strangulated or incarcerated)
- 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.

Appendix A — Important Information About UniCare's High-Deductible Health Plans (cont.)

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 1 (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 Plan 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 you. However, UniCare will not change the premium schedule for this plan on an individual basis, but only for all insureds in the same class and covered under the same 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 the UniCare Texas High-Deductible Health Plans Monthly Rates Guide for medical coverage rates.

10-Day Free Look

Once your Plan Booklet arrives, you have 10 full days to examine and either accept or decline coverage by returning the plan.

Limitations and Exclusions

The primary limitations and exclusions for the medical 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. Only the actual plan provisions apply. If there are any conflicts between the terms of the plan and the information in this brochure, the terms of the plan will prevail.

Limitations

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

Ambulance Service

Limited to 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 inpatient 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

These plans do 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.

Limitations and Exclusions (cont.)

- 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 (including but not limited to drug samples), medications, or other substances dispensed or administered in any outpatient setting, unless otherwise covered under the plan.
- Cosmetic surgery or other services for beautification. This exclusion does not apply to medically necessary reconstructive surgery to restore a bodily function, to correct a deformity caused by injury or congenital defect of a newborn child, or by breast reconstruction performed to restore or achieve breast symmetry incident to a mastectomy.
- Procedures or treatments to change characteristics of the body to those of the opposite sex. This includes any medical, surgical, or psychiatric treatment or study related to sex change.
- Treatment of sexual dysfunction, impotence and/or inadequacy.
- All services related to the evaluation or treatment of fertility and/or infertility 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.

Dental Insurance Limitations & Exclusions

The UniCare Individual Dental Fee-For-Service Plan does not provide benefits for:

- Services not specifically listed in the benefit schedule of the policy.
- Any amounts in excess of the maximum amount stated in the "yearly maximum benefit" section or listed in the benefit schedule.
- Services or supplies that UniCare considers to be not medically necessary, experimental, or investigative.
- Services received before your effective date or after your coverage ends.
- Services for which no charge would be made to you in the absence of insurance coverage or services for which you are not legally obligated to pay.
- Any condition for which benefits could 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.
- Disease contracted or injuries sustained as a result of declared or undeclared war and/or conditions caused by the inadvertent release of nuclear energy when government funds are available for treatment of illness or injury arising from such release of nuclear energy.
- Any services provided by a local, state, county, or federal government agency including any foreign government.
- Professional services received from a person who lives in the insured person's home or who is related to the insured person by blood, marriage, or adoption.
- Any services performed for cosmetic purposes unless they are for the correction of functional disorders or as a result of an accidental injury occurring while you were covered under the policy.
- Charges for treatment by other than a licensed dentist or physician, except charges for dental prophylaxis performed by a licensed dental hygienist, under the supervision and direction of a dentist.
- Replacement of an existing prosthesis which has been lost, stolen, or which, in the opinion of the dentist is or can be made satisfactory.
- Replacement of a fixed or removable prosthesis if such replacement occurs within five years of the original placement.
- Orthodontic services, braces, appliances, and all related services.
- Diagnosis or treatment of the joint of the jaw and/or occlusion services, supplies, or appliances provided in connection with:

  (a) any treatment to alter, correct, fix, improve, remove, replace, reposition, restore, or otherwise treat the joint of the jaw (temporomandibular joint).

  (b) any treatment, including crowns, caps, and/or bridges to change the way the upper and lower teeth meet (occlusion);

  (c) treatment to change vertical dimension (the space between the upper and lower jaw).
- Procedures requiring appliances or restorations (other than those for replacement of structure loss from caries) that are necessary to alter, restore, or maintain occlusions.
- Oral examinations exceeding two visits per insured per year.
- Prophylaxis treatments exceeding two treatments per insured per year.
- Fluoride applications for patients over 18 years of age or applications exceeding two visits per year.
- More than one set of full-mouth x-rays or its equivalent per insured in a three-year period.
- Correction of congenital or developmental malformation.
- Adjustment, repairs, or relines to prosthesis, except following six months from initial placement and if the prosthesis was paid for under this plan.
- Fixed bridges, removable cast partials, and/or cast crown with or without veneers for patients under 16 years of age.
- Replacement of crowns and cast restorations, including porcelain crowns, if such replacement occurs within five years of the original placement.
- If a policyholder transfers from the care of one dentist to that of another dentist during the course of treatment or if more than one dentist renders services for one dental procedure, UniCare shall be liable only for the amount it would have been liable for had one dentist rendered the services.
- Prescribed drugs, premedication, or analgesia.
- Oral hygiene instruction.
- Services for treatment of malignancies and neoplasms.
- All hospital costs and any additional fees charged by the dentist for hospital treatment.
- Implants (materials implanted into or on bone or soft tissue) or the removal of implants.
- Replacement of teeth missing prior to the effective date of coverage.
- Services for periodontics and fixed or removable prosthodontics within the first 12 months of the insured person's effective date.

Appendix B — Important Information About Health Savings Accounts

Answers to Your Questions

Q1. What is an HSA Compatible High-Deductible Health Plan (HDHP)?

An HSA Compatible HDHP is a health plan that meets certain requirements in terms of annual deductibles and annual out-of-pocket expense maximums. In order to qualify for a Health Savings Account (HSA), you must be enrolled in a qualified HDHP. To qualify as an HSA Compatible HDHP in 2006, the plan must:

- Have a minimum deductible of $1,050 and annual out-of-pocket maximum not exceeding $5,250 for individuals
- Have a minimum deductible of $2,100 and annual out-of-pocket maximum not exceeding $10,500 for family coverage
- Not provide benefits (except for certain preventive care benefits) until the deductible for that year has been met
- Include a combined medical and prescription deductible and out-of-pocket maximum

HSA statutes indicate that minimum deductible and out-of-pocket expense maximums and contribution limits may be revised annually for cost of living adjustments.

Q2. Who owns and administers an HSA?

The individual owns the HSA. It is a personal, portable savings account that the individual retains even if they are no longer enrolled in an HDHP. HSAs are opened and maintained at an HSA-qualified bank or financial institution.

Q3. Who is eligible to establish an HSA?

An eligible individual is anyone who:

- Is covered under a qualified high-deductible health plan on the first day of the month the HDHP is effective
- Does not have coverage through an additional plan that is not a qualified HDHP*
- Is not enrolled in Medicare (generally, has not reached age 65)
- May not be claimed as a dependent on another person's tax return.

Q4. What are the advantages of combining a UniCare HDHP with a JPMorgan Bank, N.A. (Chase) HSA?

- Ease and convenience: Instead of dealing with two separate enrollment processes at different times, you can apply for both a qualified HDHP and a Chase HSA at the same time through UniCare.
- Streamlined customer support: Individuals will benefit from seamless customer service between UniCare and Chase.
- More control: If an individual has a qualified HDHP and an HSA, the individual will have more control over how they save for and manage their health care expenses.

Q5. Who may contribute to the HSA?

Any individual may contribute to an HSA on behalf of an eligible individual. Individual contributions are tax deductible from gross income up to the annual contribution maximum.

Q6. How can I contribute to the Chase HSA?

You may contribute by:

- Automatic electronic funds transfer withdrawal from your designated account
- Sending a check with a deposit slip directly to Chase

Please note that direct ATM deposits will not be accepted.

*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.

Appendix B — Important Information About Health Savings Accounts (cont.)

Q7. How much may be contributed to the HSA?

Contribution guidelines vary for singles and families:

- Singles: In 2006, the annual contribution maximum for members enrolled in an eligible HDHP for the full 12 months is $2,700 or the full amount of the HDHP deductible, whichever is less. For members enrolled for less than 12 months, their annual maximum contribution is a prorated portion of the $2,700 or a prorated portion of their deductible, whichever is less, depending on the number of full months they have been enrolled in the eligible HDHP that year.
- Families: In 2006, the annual contribution maximum for members enrolled in an eligible HDHP for the full 12 months is $5,450 or the full amount of the HDHP deductible, whichever is less. For members enrolled for less than 12 months, their annual maximum contribution is a prorated portion of the $5,450 or a prorated portion of their deductible, whichever is less, depending on the number of full months they have been enrolled in the eligible HDHP that year.
- Individuals between the ages 55-65 can make additional catch-up contributions of $700 in 2006, increasing $100 per year until 2009 when it becomes $1,000.

Q8. What are the fees associated with the Chase HSA?

The fees for this account are similar to the fees for other checking/savings accounts. Chase Bank will deduct the following fees from your HSA:

- $20 account opening fee for singles and families
- $3 monthly maintenance fee
- $.95 per month for monthly printed statements only if a member requests them (transaction history is available on-line free of charge)
- $1 fee per ATM transaction (cash withdrawals)
- $.25 per check processed
- $20 for stop check service
- $10 for duplicate check
- $20 for non-sufficient funds
- $10.50 for returned deposit check or electronic funds transfer
- $12 to replace lost or stolen card
- $20 for closing account
- $9.95 per book of 25 checks (optional)

Please note: There is no fee for point-of-payment debit card transactions. The fees shown in the column on the left above are accurate as of December 2005. Fees are subject to change. Please contact HSA customer service at (888) 854-0537 for the most current fees.

Q9. What is the minimum amount that can be contributed monthly to the Chase HSA?

There is an initial contribution requirement of $50. There is no minimum monthly contribution or balance requirement at this time. However, maintenance and transaction fees will be deducted from the account. You are responsible for ensuring that there are sufficient funds in the account to cover those fees.

Q10. When can I contribute to the Chase HSA?

You can contribute to your HSA the first day of the month after your UniCare HDHP is effective. For example, if your medical plan is effective on July 15, you can begin to contribute to the HSA on August 1. Contributions for the current year must be made by April 15 of the following year. For example, all contributions for 2006 must be made by April 15, 2007.

Q11. When can I withdraw funds from my HSA?

You are permitted to withdraw money from your HSA any time after your HSA is established, even if you are not currently enrolled in a qualified HDHP. Tax penalties apply if funds are not used for a qualified medical expense.

Q12. How will I be able to monitor my account balance and transactions?

Chase will have transaction history available online that will be accessible 24 hours a day, seven days a week. You can print your electronic statement or you can request monthly paper statements for an additional fee of $.95 per month. You may also call the HSA customer service number to speak with a representative about account balances and transactions. Upon enrollment in your HSA, if you will be monitoring your account online, you must set up a login ID and password for access.

Q13. How do I report the interest from the HSA on my taxes?

Chase will send you appropriate annual reporting on the interest earned in the HSA.

Appendix B — Important Information About Health Savings Accounts (cont.)

Q14. What are "qualified medical expenses" that are eligible for tax-free distribution?

A qualified medical expense is any health care cost as defined in the Internal Revenue Code (IRC Section 213 [d]), but only to the extent the expenses are not reimbursed by insurance. For examples of qualified medical expenses, refer to the next page. Qualified medical expenses eligible for reimbursement from the HSA must be incurred after the HSA has been established.

Q15. Are health insurance premiums qualified expenses?

Generally, no, except in the following instances:

- Qualified long-term care insurance
- COBRA health care continuation coverage
- Health care coverage while an individual is receiving unemployment compensation

Q16. How can I access my Chase HSA funds to pay for qualified medical expenses?

You may either:

- Use your Chase HSA debit card at the point-of-payment location (such as a doctor's office); the card works like a regular bank debit card
- Write a check from the HSA account
- Use your Chase debit card at an ATM to withdraw money from your HSA. (Chase HSA debit cards are accepted at ATMs that display logos for Chase, Bank One, NYCE, Pulse, Interlink and Visa.)

When a provider sends a claim to UniCare after a visit, you will receive an explanation of benefits (EOB) in the mail outlining what discounts, if any, have been applied for the services rendered and the provider will mail you a bill for any remaining charges. You may then either call the provider's office to have a portion of the claim charged using your HSA debit card number or you may mail a check to the provider from your HSA checkbook. (Debit card option is only applicable in offices with debit card functionality.)

Q17. Can HSA funds be used for unqualified expenses?

HSA funds can be withdrawn for any purpose. However, funds withdrawn to pay for unqualified expenses of the member or dependents will be subject to applicable income taxes and penalties. You should consult your tax advisor for regulations regarding distributions from HSAs.

Q18. Who is responsible to ensure that funds are being used for qualified medical expenses?

It is your responsibility to ensure that the funds from your account are being used for qualified medical expenses. Chase nor UniCare will audit or restrict the use of these funds. On your annual tax returns or in the event of an audit, it will be your responsibility to maintain your receipts and to document and demonstrate the appropriate use of these funds for the IRS.

Q19. What happens if I change from a UniCare HDHP to another medical plan?

As long as you are enrolled in a qualified HDHP, you may contribute to your HSA. If you change your coverage and enroll in a non-qualified HDHP, it is your responsibility to discontinue any further contributions to your account. You will no longer be eligible to contribute to your HSA if you disenroll from a qualified HDHP. However, you will still own your account and can continue to earn interest and make withdrawals to pay for qualified medical expenses.

Q20. Must I sign up for an HSA in order to apply for one of UniCare's HDHPs?

No. You can apply for a UniCare HDHP without the HSA.

Q21. Can IRA funds be rolled into an HSA?

No. Rollovers from an IRA to an HSA are not permitted.

Q22. Can MSA funds be rolled into an HSA?

MSAs established on or before 12/31/03 can be either "grandfathered" or rolled into HSAs on a tax-free basis. Rollover contributions need not be in cash. Consult with your tax advisor for details or restrictions that may apply.

Examples of Qualified Medical Expenses

Eligible Qualified Medical Expenses

A qualified medical expense is any health care cost as defined in the Internal Revenue Code (IRC section 213[d]), but only to the extent the expenses are not reimbursed by insurance. Qualified medical expenses eligible for reimbursement from the HSA must be incurred after the HSA has been established. The individual account holder is responsible for determining whether expenditures are for qualified medical expenses. See the list below for examples of qualified medical expenses, and always consult your tax advisor.

- Prescription drugs, including birth control pills
- Doctor visits, lab, X-ray and other diagnostic and treatment services
- Car controls for the physically challenged
- Christian Science practitioner services
- Coinsurance costs for health care, prescription drug and dental plans
- Dental X-ray, fillings, extraction and dentures
- Orthodontia (such as braces)
- Specially installed equipment if primary purpose is health care
- Eyeglasses, contact lenses, and solution
- Guide dog or other animal, including its maintenance
- Hearing aids and batteries
- In-vitro fertilization
- Remedial reading lessons for a child with a severe learning disability
- Laser eye surgery
- Routine physical exams
- Stop-smoking programs
- Special school costs, including tutoring fees and tuition, for physically challenged or mentally impaired
- Transportation to and from health care providers
- Vitamin and mineral supplements that can be obtained only by prescription
- Qualified long-term care services and long-term care insurance

Please note these are examples only and may be subject to change. Please refer to the Qualified Medical Expenses as defined in the Internal Revenue Code (IRC Section 213 [d]).

Have More Questions?

If you have additional questions about the Chase HSAs in general, contact your UniCare Agent or HSA Customer Service at (888) 854-0537. Tax-related questions should be answered by your personal tax advisor only.

The following are resources located on the internet that provide detailed information about Health Savings Accounts:

- Treasury: http://www.treas.gov/offices/public-affairs/hsa includes frequently asked questions, official guidance and contact information.
- The HSA Insider: http://www.hsainsider.com
- The National Association of Health Underwriters (NAHU): http://www.nahu.org/consumer/HSAGuide.htm

UniCare is not responsible for the content or maintenance of these Web sites.

Helpful Information

If you are applying for a UniCare High-Deductible Health Plan and a Health Savings Account (HSA) from Chase Bank, please attach your JPMorgan Bank, N.A. (Chase) enrollment form to your UniCare health plan application and mail them to:

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

If you have an established High-Deductible Health Plan please mail the completed Chase Bank HSA enrollment form to:

UniCare Individual Services
P.O. Box 5061
Bolingbrook, IL 60440-5061

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Notes:

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