

Plan Overview

Individual and Family Medical Plans

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 your share of costs for covered expenses after any applicable 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.

All plans with deductibles feature a fourth-quarter carry over for annual deductible. If your annual deductible is not satisfied in a given year, the covered expenses incurred during the months of October through December and applied to your annual deductible for that year will be applied toward your annual deductible for the following calendar year.

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, authorization process, additional deductibles, and penalties that may apply, please refer to the applicable plan booklet. Only the actual plan booklet provisions apply. If there are any conflicts between the terms of the plan booklet and the information in this overview, the terms of the plan booklet will prevail.



**Individual and Family
Plans**

Texas

OVERVIEW OF COVERAGE

Amounts shown below are the member's share of covered expenses after

| Your Plan Features | UNICARE Saver 2000 | | Performance 5000 | | Performance 3000 | |
|--|--|---|---|---|---|---|
| | Participating Provider | Nonparticipating Provider | Participating Provider | Nonparticipating Provider | Participating Provider | Nonparticipating Provider |
| Lifetime Maximum | \$5,000,000/member | | \$5,000,000/member | | \$5,000,000/member | |
| Annual Deductible per Member ¹ | \$2,000, two-member family maximum | | \$5,000, two-member family maximum | | \$3,000, two-member family maximum | |
| Annual Out-of-Pocket Maximum ¹ | \$3,000 plus deductible per member, \$6,000 plus deductible per family | \$10,000 plus deductible per member, \$20,000 plus deductible per family | \$3,000 plus deductible per member, \$6,000 plus deductible per family | \$10,000 plus deductible per member, \$20,000 plus deductible per family | \$3,000 plus deductible per member, \$6,000 plus deductible per family | \$10,000 plus deductible per member, \$20,000 plus deductible per family |
| Office Visits | 2 office visits per member, per year, participating and nonparticipating providers combined. You pay a \$30 copay (deductible is waived) 3+ office visits: You pay 100% of billed charges | 2 office visits per member, per year, participating and nonparticipating providers combined. You pay 50% (deductible is waived) 3+ office visits: You pay 100% of billed charges | First 4 office visits: You pay a \$30 copay (deductible is waived) 5+ office visits: You pay 100% until deductible is met; then you pay 25% (per member, per year) | You pay 50% | First 4 office visits: You pay a \$30 copay (deductible is waived) 5+ office visits: You pay 100% until deductible is met; then you pay 25% (per member, per year) | You pay 50% |
| Preventive Care Office visits, examinations associated with preventive care for babies and children, mammograms, and PSAs | For office visits only, see office visits above. For any lab work or x-rays, see lab work and x-rays below. | | For office visits only, see office visits above. For any lab work or x-rays, see lab work and x-rays below. | | For office visits only, see office visits above. For any lab work or x-rays, see lab work and x-rays below. | |
| Preventive Care for Babies and Children (through age 6) Immunizations | You pay \$0 | You pay \$0 | You pay \$0 | You pay \$0 | You pay \$0 | You pay \$0 |
| Preventive Care for Adults Routine Pap smears, annual mammograms, and PSA for men | You pay 25% | You pay 50% | You pay 25% | You pay 50% | You pay 25% | You pay 50% |
| Lab Work and X-rays | You pay 25% with a maximum covered expense by UNICARE of \$300 per member per year with deductible waived | You pay 50% with a maximum covered expense by UNICARE of \$300 per member per year with deductible waived | You pay 25% | You pay 50% | You pay 25% | You pay 50% |
| Other Preventive Care Services | Not covered | | You pay 25% ² | You pay 50% ² | You pay 25% ² | You pay 50% ² |
| Professional Services (including surgery, anesthesia, radiation therapy, in-hospital doctor visits, and diagnostic x-ray/lab) | You pay 25%, inpatient only | You pay 50%, inpatient only | You pay 25% for inpatient and outpatient | You pay 50% for inpatient and outpatient | You pay 25% for inpatient and outpatient | You pay 50% for inpatient and outpatient |
| Outpatient Medical Care ³ | You pay 25% | You pay 50% | You pay 25% | You pay 50% | You pay 25% | You pay 50% |
| Physical/Occupational Therapy, Speech Therapy, and Acupuncture/Acupressure | Not covered | | You pay charges over \$30 per visit up to a combined total of 12 visits per year for all of these services ⁴ | | You pay charges over \$30 per visit up to a combined total of 12 visits per year for all of these services ⁴ | |
| Inpatient Hospital Services ⁵ Surgery, x-rays, in-hospital doctor visits, and organ/tissue transplants | You pay 25% | You pay 50% plus a \$500 deductible for nonemergency stays | You pay 25% | You pay 50% plus a \$500 deductible for nonemergency stays | You pay 25% | You pay 50% plus a \$500 deductible for nonemergency stays |
| Inpatient Medical Emergency | You pay 25% | You pay 25% until transferable to a participating hospital, if stay continues thereafter, 50% plus a \$500 deductible | You pay 25% | You pay 25% until transferable to a participating hospital, if stay continues thereafter, 50% plus a \$500 deductible | You pay 25% | You pay 25% until transferable to a participating hospital, if stay continues thereafter, 50% plus a \$500 deductible |
| Ambulatory Surgical Center | You pay 25% | You pay 50% | You pay 25% | You pay 50% | You pay 25% | You pay 50% |
| Ambulance Service ⁶ | You pay 25% | You pay 50% | You pay 25% | You pay 50% | You pay 25% | You pay 50% |
| Hospice ⁷ | You pay 25% | You pay 50% | You pay 25% | You pay 50% | You pay 25% | You pay 50% |
| Prescription Drugs Retail Pharmacies per prescription (up to a 30-day supply) | Generic drugs: You pay \$10 copay Brand name drugs: You pay \$25 copay plus a separate \$200 deductible. Maximum payment by UNICARE of \$500 per member, per year ⁸ | Generic drugs: You pay 50% of the average wholesale price Brand name drugs: You pay 60% of the average wholesale price plus a separate \$200 deductible. Maximum payment by UNICARE of \$500 per member, per year ⁸ | Generic drugs: You pay \$10 copay Brand name drugs: You pay \$25 copay plus a separate \$500 deductible per member, per year | Generic drugs: You pay 50% of the average wholesale price Brand name drugs: You pay 60% of the average wholesale price plus a separate \$500 deductible per member, per year | Generic drugs: You pay \$10 copay Brand name drugs: You pay \$25 copay plus a separate \$300 deductible per member, per year | Generic drugs: You pay 50% of the average wholesale price Brand name drugs: You pay 60% of the average wholesale price plus a separate \$300 deductible per member, per year |
| Mail Service Drugs per prescription; 60-day supply | Generic drugs: You pay \$20 copay Brand name drugs: You pay \$50 copay plus a separate \$200 deductible. Maximum payment by UNICARE of \$500 per member, per year ⁸ | Not available | Generic drugs: You pay \$20 copay Brand name drugs: You pay \$50 copay plus a separate \$500 deductible per member, per year | Not available | Generic drugs: You pay \$20 copay Brand name drugs: You pay \$50 copay plus a separate \$300 deductible per member, per year | Not available |

¹ Copays do not apply toward satisfying any deductible. Copays, except pharmacy copays, apply toward your annual out-of-pocket maximum.

² A maximum covered expense of \$200 per member, per year applies.

³ Emergency room visits that do not result in inpatient admissions will be subject to a \$60 penalty.

⁴ Additional visits for physical, occupational, and speech therapy may be covered following inpatient admission.

⁵ All inpatient care requires preservice review, or you will be subject to a \$500 penalty. This penalty does not apply to emergency care.

⁶ Up to a maximum covered expense of \$750 per trip, air or ground, applies.

any deductibles are met

| 2000 | Performance 2000 | | Performance 1500 | | Performance 1000 | | Performance 600 | |
|---|---|---|---|---|---|---|---|--|
| Participating Provider | Participating Provider | Nonparticipating Provider | Participating Provider | Nonparticipating Provider | Participating Provider | Nonparticipating Provider | Participating Provider | Nonparticipating Provider |
| | \$5,000,000/member | | \$5,000,000/member | | \$5,000,000/member | | \$5,000,000/member | |
| Maximum | \$2,000, two-member family maximum | | \$1,500, two-member family maximum | | \$1,000, two-member family maximum | | \$600, two-member family maximum | |
| Annual deductible \$20,000 plus per family | \$3,000 plus deductible per member, \$6,000 plus deductible per family | \$10,000 plus deductible per member, \$20,000 plus deductible per family | \$3,000 plus deductible per member, \$6,000 plus deductible per family | \$10,000 plus deductible per member, \$20,000 plus deductible per family | \$3,000 plus deductible per member, \$6,000 plus deductible per family | \$10,000 plus deductible per member, \$20,000 plus deductible per family | \$3,000 plus deductible per member, \$6,000 plus deductible per family | \$10,000 plus deductible per member, \$20,000 plus deductible per family |
| Copay 50% | First 4 office visits: You pay a \$30 copay (deductible is waived) 5+ office visits: You pay 100% until deductible is met; then you pay 25% (per member, per year) | You pay 50% | First 4 office visits: You pay a \$30 copay (deductible is waived) 5+ office visits: You pay 100% until deductible is met; then you pay 25% (per member, per year) | You pay 50% | First 4 office visits: You pay a \$30 copay (deductible is waived) 5+ office visits: You pay 100% until deductible is met; then you pay 20% (per member, per year) | You pay 50% | First 4 office visits: You pay a \$30 copay (deductible is waived) 5+ office visits: You pay 100% until deductible is met; then you pay 20% (per member, per year) | You pay 50% |
| Above-network work | For office visits only, see office visits above. For any lab work or x-rays, see lab work and x-rays below. | | For office visits only, see office visits above. For any lab work or x-rays, see lab work and x-rays below. | | For office visits only, see office visits above. For any lab work or x-rays, see lab work and x-rays below. | | For office visits only, see office visits above. For any lab work or x-rays, see lab work and x-rays below. | |
| Copay \$0 | You pay \$0 | You pay \$0 | You pay \$0 | You pay \$0 | You pay \$0 | You pay \$0 | You pay \$0 | You pay \$0 |
| Copay 50% | You pay 25% | You pay 50% | You pay 25% | You pay 50% | You pay 20% | You pay 50% | You pay 20% | You pay 50% |
| Copay 50% | You pay 25% | You pay 50% | You pay 25% | You pay 50% | You pay 20% | You pay 50% | You pay 20% | You pay 50% |
| Copay 50% ² | You pay 25% ² | You pay 50% ² | You pay 25% ² | You pay 50% ² | You pay 20% ² | You pay 50% ² | You pay 20% ² | You pay 50% ² |
| 50% for inpatient and outpatient | You pay 25% for inpatient and outpatient | You pay 50% for inpatient and outpatient | You pay 25% for inpatient and outpatient | You pay 50% for inpatient and outpatient | You pay 20% for inpatient and outpatient | You pay 50% for inpatient and outpatient | You pay 20% for inpatient and outpatient | You pay 50% for inpatient and outpatient |
| Copay 50% | You pay 25% | You pay 50% | You pay 25% | You pay 50% | You pay 20% | You pay 50% | You pay 20% | You pay 50% |
| For a combined total of 12 visits per year for all of these services ⁴ | You pay charges over \$30 per visit up to a combined total of 12 visits per year for all of these services ⁴ | | You pay charges over \$30 per visit up to a combined total of 12 visits per year for all of these services ⁴ | | You pay charges over \$30 per visit up to a combined total of 12 visits per year for all of these services ⁴ | | You pay charges over \$30 per visit up to a combined total of 12 visits per year for all of these services ⁴ | |
| 50% plus a deductible for emergency stays | You pay 25% | You pay 50% plus a \$500 deductible for nonemergency stays | You pay 25% | You pay 50% plus a \$500 deductible for nonemergency stays | You pay 20% | You pay 50% plus a \$500 deductible for nonemergency stays | You pay 20% | You pay 50% plus a \$500 deductible for nonemergency stays |
| 5% until deductible is met; thereafter, 50% deductible | You pay 25% | You pay 25% until transferable to a participating hospital, if stay continues thereafter, 50% plus a \$500 deductible | You pay 25% | You pay 25% until transferable to a participating hospital, if stay continues thereafter, 50% plus a \$500 deductible | You pay 20% | You pay 20% until transferable to a participating hospital, if stay continues thereafter, 50% plus a \$500 deductible | You pay 20% | You pay 20% until transferable to a participating hospital, if stay continues thereafter, 50% plus a \$500 deductible |
| Copay 50% | You pay 25% | You pay 50% | You pay 25% | You pay 50% | You pay 20% | You pay 50% | You pay 20% | You pay 50% |
| Copay 50% | You pay 25% | You pay 50% | You pay 25% | You pay 50% | You pay 20% | You pay 50% | You pay 20% | You pay 50% |
| Copay 50% | You pay 25% | You pay 50% | You pay 25% | You pay 50% | You pay 20% | You pay 50% | You pay 20% | You pay 50% |
| Generic drugs: 50% of the wholesale price | Generic drugs: You pay \$10 copay | Generic drugs: You pay 50% of the average wholesale price | Generic drugs: You pay \$10 copay | Generic drugs: You pay 50% of the average wholesale price | Generic drugs: You pay \$10 copay | Generic drugs: You pay 50% of the average wholesale price | Generic drugs: You pay \$10 copay | Generic drugs: You pay 50% of the average wholesale price |
| Brand name drugs: 60% of the wholesale price plus a separate deductible per member, per year | Brand name drugs: You pay \$25 copay plus a separate \$200 deductible per member, per year | Brand name drugs: You pay 60% of the average wholesale price plus a separate \$200 deductible per member, per year | Brand name drugs: You pay \$25 copay plus a separate \$150 deductible per member, per year | Brand name drugs: You pay 60% of the average wholesale price plus a separate \$150 deductible per member, per year | Brand name drugs: You pay \$25 copay plus a separate \$100 deductible per member, per year | Brand name drugs: You pay 60% of the average wholesale price plus a separate \$100 deductible per member, per year | Brand name drugs: You pay \$25 copay plus a separate \$60 deductible per member, per year | Brand name drugs: You pay 60% of the average wholesale price plus a separate \$60 deductible per member, per year |
| Not available | Generic drugs: You pay \$20 copay Brand name drugs: You pay \$50 copay plus a separate \$200 deductible per member, per year | Not available | Generic drugs: You pay \$20 copay Brand name drugs: You pay \$50 copay plus a separate \$150 deductible per member, per year | Not available | Generic drugs: You pay \$20 copay Brand name drugs: You pay \$50 copay plus a separate \$100 deductible per member, per year | Not available | Generic drugs: You pay \$20 copay Brand name drugs: You pay \$50 copay plus a separate \$60 deductible per member, per year | Not available |

⁷ Inpatient hospitalization for spinal injury or stroke, with prior authorization from UNICARE. Penalty is waived on emergency admissions, however utilization review is still required.

⁸ Up to a maximum covered expense of \$10,000 per lifetime for participating and nonparticipating providers. Includes generic and brand, both in- and out-of-network for retail pharmacy and mail services.

| | Performance 500 | | Performance Plus No Deductible | |
|-------------------------------------|---|--|---|--|
| Participating Provider | Participating Provider | Nonparticipating Provider | Participating Provider | Nonparticipating Provider |
| | \$5,000,000/member | | \$5,000,000/member | |
| Maximum | \$500, two-member family maximum | | None | |
| Deductible (20,000 plus per family) | \$3,000 plus deductible per member, \$6,000 plus deductible per family | \$10,000 plus deductible per member, \$20,000 plus deductible per family | \$3,000 per member, \$6,000 per family | \$10,000 per member, \$20,000 per family |
| Office visits | First 4 office visits: You pay a \$30 copay (deductible is waived) 5+ office visits: You pay 100% until deductible is met; then you pay 20% (per member, per year) | You pay 50% | You pay \$30 copay, unlimited visits | You pay 50% |
| Lab work | For office visits only, see office visits above. For any lab work or x-rays, see lab work and x-rays below. | | You pay \$30 copay | |
| Outpatient | You pay \$0 | You pay \$0 | You pay \$0 | You pay \$0 |
| Outpatient | You pay 20% | You pay 50% | You pay 20% | You pay 50% |
| Outpatient | You pay 20% | You pay 50% | You pay 20% | You pay 50% |
| Outpatient | You pay 20% ² | You pay 50% ² | You pay 20% ² | You pay 50% ² |
| Outpatient | You pay 20% for inpatient and outpatient | You pay 50% for inpatient and outpatient | You pay 20% for inpatient and outpatient | You pay 50% for inpatient and outpatient |
| Outpatient | You pay 20% | You pay 50% | You pay 20% | You pay 50% |
| Outpatient | You pay charges over \$30 per visit up to a combined total of 12 visits per year for all of these services ¹ | | You pay charges over \$30 per visit up to a combined total of 12 visits per year for all of these services ¹ | |
| Outpatient | You pay 20% | You pay 50% plus a \$500 deductible for nonemergency stays | You pay 20% | You pay 50% plus a \$500 penalty for nonemergency stays |
| Outpatient | You pay 20% | You pay 20% until transferable to a participating hospital, if stay continues thereafter, 50% plus a \$500 deductible | You pay 20% | You pay 20% until transferable to a participating hospital, if stay continues thereafter, 50% plus a \$500 penalty |
| Outpatient | You pay 20% | You pay 50% | You pay 20% | You pay 50% |
| Outpatient | You pay 20% | You pay 50% | You pay 20% | You pay 50% |
| Outpatient | You pay 20% | You pay 50% | You pay 20% | You pay 50% |
| Outpatient | Generic drugs: You pay \$10 copay | Generic drugs: You pay 50% of the average wholesale price | Generic drugs: You pay \$10 copay | Generic drugs: You pay 50% of the average wholesale price |
| Outpatient | Brand name drugs: You pay \$25 copay plus a separate \$50 deductible per member, per year | Brand name drugs: You pay 60% of the average wholesale price plus a separate \$50 deductible per member, per year | Brand name drugs: You pay \$25 copay | Brand name drugs: You pay 60% of the average wholesale price |
| Outpatient | Generic drugs: You pay \$20 copay Brand name drugs: You pay \$50 copay plus a separate \$50 deductible per member, per year | Not available | Generic drugs: You pay \$20 copay Brand name drugs: You pay \$50 copay | Not available |

¹Participating providers combined.
²Rate combined.

Medical Plans Limitations & Exclusions

Some of the limitations and exclusions for each of the plans described in this brochure are listed in the overview below. Please take a few moments to review them. A more comprehensive list of each plan's limitations and exclusions can be found in the plan booklet.

The Performance 5000, 3000, 2000, 1500, 1000, 600, and 500, and Performance Plus No Deductible and UNICARE Saver 2000 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 stated in this plan.
- Services not specifically listed in the plan as covered services.
- Services or supplies that are not medically necessary, experimental, or investigative as determined by UNICARE.
- 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 a health plan or insurance coverage.
- Any condition covered by workers' compensation or similar laws.
- Any intentionally self-inflicted injury or illness.
- Services received for any condition caused by or contributed by:
 - (a) an act of war, invasion, armed aggression, or release of nuclear energy
 - (b) the inadvertent release of nuclear energy when government funds are available for treatment,
 - (c) an insured person's participation in the military of any country; participation in an insurrection, rebellion, or riot; commission of or attempt to commit a felony, or

- (d) an insured person age 19 or older being under the influence of illegal narcotics or nonprescribed controlled substances.
- Any services for which payment may be obtained from any local, state, or federal government agency except:
 - (a) when payment under this 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 for which you are entitled to receive Medicare benefits. Veterans Administration hospitals and military treatment facilities will be considered for payment according to current law.
- Professional services received from or supplies purchased from a person who lives in your home, who is related to you by blood, marriage, or adoption, or is the insured person's employer.
- Services of a private duty nurse.
- Inpatient room and board charges in connection with a hospital stay primarily for environmental change, physical therapy, or treatment of chronic pain; custodial care or rest cures, or for diagnostic tests which could have been performed safely on an outpatient basis.
- Services provided by a rest home, a home for the aged, a nursing home, or any similar facility service.
- Treatment of drug, alcohol, or other substance addiction or abuse, except as stated in the plan booklet.
- Treatment of mental, emotional, or functional nervous disorders (including a smoking cessation program), or psychological testing, except as specifically stated in the plan.
- Dental services.
- Orthodontic services, braces, and other orthodontic appliances
- Dental implants or any associated procedures.
- Hearing aids.
- Routine hearing tests, except as provided under well baby, well child care, and newborn hearing benefits.
- Optometric services, eye exercises including orthoptics, eyeglasses, contact lenses, routine eye exams, and routine eye refractions.
- Certain eye surgeries, including those solely for the purpose of correcting refractive defects.
- Outpatient speech therapy, except as specifically provided in the plan.
- Any drugs, medications, or other substances dispensed or administered in any outpatient setting, except as specifically stated in 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, abnormal craniofacial structure caused by congenital defects, or to breast reconstruction performed to restore or achieve breast symmetry incident to a mastectomy.
- Sex change operations or related treatment and study.
- Treatment of sexual dysfunction, impotence, and/or inadequacy.
- All services related to the evaluation or treatment of fertility and/or infertility.
- Cryopreservation of sperm or eggs.
- Orthopedic shoes (except when joined to braces) or shoe inserts, including orthotics.
- Routine foot care.
- Services primarily for weight reduction or treatment of obesity.
- Routine physical exams or tests, including those required by employment or government authority, except as specifically stated under the plan.
- Charges by a provider for telephone consultations. (Note: a Telemedicine Medical Service or Telehealth Service will not be excluded solely because the service is not provided through a face-to-face consultation.)

- Items which are furnished primarily for your personal comfort or convenience.
- Educational services, except for diabetes self-management training programs, and as specifically provided or arranged by UNICARE.
- Nutritional counseling or food supplements, except for formulas necessary for the treatment of phenylketonuria.
- Any services received on or within 12 months after the effective date of coverage if they are related to a preexisting condition.
- Foreign country provider charges, except as specified in the plan.
- Services for which a third party may be liable or legally responsible to pay.
- Growth hormone treatment.
- Charges of a standby physician.
- Charges for animal to human organ transplants.
- All nonprescription contraceptive drugs, devices, and supplies and non-FDA approved prescription contraceptive drugs, devices, and supplies. (Oral contraceptives and some contraceptive devices are covered under all plans' prescription benefits).
- Charges for pregnancy or maternity care, including normal delivery, elective abortions, and cesarean sections.
- All incidental supplies used by a provider in the administration of infusion therapy, except as specifically provided by the plan.

Additional Limitations & Exclusions for the UNICARE Saver 2000 Plan

- Any services of a physician, except as specifically stated under limited professional and other services.
- Surgical procedures for sterilization.
- Physical and/or occupational therapy/medicine, except when provided during an inpatient hospital confinement.
- Acupuncture/acupressure.
- Durable medical equipment.



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Insurance coverage underwritten by UNICARE Life & Health Insurance Company

Sales Office
Houston, Texas