

ILLINOIS  
**PLAN OVERVIEW**  
Small Group Insurance Plans

# UniCare—Your Trusted Choice in Health Insurance

## UniCare Solutions & Services

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

## More Control & Support

We help give our clients and their associates more control by offering an array of health benefit insurance plans, including our new suite of consumer-driven health plans. By harnessing the power of robust Web opportunities, such as *WebMD*® and the **unicare.com** Web site, we are helping to strengthen the position of our agents and clients alike.

## More Networks & Offerings

In this dynamic market, strength and agility are key. That's why UniCare's nationwide networks offer more than 31,300 independently contracted hospitals and more than 600,000 independently contracted primary care physicians and specialists. Our complete product portfolio—medical, dental, life, Short-Term Disability and Long-Term Disability, and Full Circle Health programs—are what make us different. They are what make UniCare a top choice for health care benefit products.

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

## General Plan Information

UniCare Small Group health insurance plans allow you to choose the plan that best fits your needs. Refer to the charts on the following pages to compare the benefits of all plans.

## 2-3 Plan Rules

Having affordable health insurance is more important than ever. Selecting the right insurance plans for you and your employees is important too. UniCare's new underwriting guidelines will help make selecting the correct coverage for your employees and clients easier and faster.

RULES	DESCRIPTIONS
<b>Premium Differential</b>	The 25% & 35% premium differential is based on total premium for group, regardless of rating methodology.
<b>2 Plans/25% Premium Differential</b>	Combine 2 plans with up to a 25% differential between the lowest and highest premiums.
<b>3 Plans/35% Premium Differential</b>	Combine 3 plans (at least one of the plans must be a UniCare HSA- or HIA-compatible plan) with up to a 35% differential between the lowest and highest premiums.
<b>Riders</b>	If a rider is selected, then the rider must be applied to all medical plans selected.
<b>HMO Plans</b>	Can be combined with any PPO Plans whether or not a Mental Health Rider is elected. The 25% and 35% differential still applies.

# Choose from Plans That Fit Your Needs

## New HMO Plans

UniCare is pleased to introduce three new HMO plans with variable copay and drug card benefit options. You will have the option of selecting from two different HMO networks to offer to their employees—Classic HMO or Performance Select HMO—providing them with additional health benefit choices and increased flexibility.

## Premier Flex Plus/Premier Flex

UniCare offers a variety of Premier Flex Plus/Premier Flex insurance plans with a broad range of valuable benefits, including plans that offer unlimited office visits with a copay. These plans are competitively priced and offer a choice of deductibles.

## Flex Advantage

UniCare's Flex Advantage Plans feature lower price points, important core benefits and components that your employees want such as additional office visits for in-network services and first dollar preventive care benefits.

## Solaura Plans

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

Solaura plans are available in three varying options:

**The Solaura Health Savings Account (HSA) 1 Plan** is funded by your own pre-tax contributions. Others may also contribute money to your HSA on your behalf. You can use money in your HSA to pay for your covered medical care, including covered prescriptions. You can also use the money in your HSA to pay for medical expenses that are not covered by the health plan, like contact lenses, over-the-counter medications, and orthodontic braces.

**The Solaura Health Incentive Account Plan (HIA)** allows you to earn health care dollars for your Health Incentive Account by taking steps that can help you achieve your health potential. The dollars earned in your HIA are available for you to help reduce your out-of-pocket expenses under the plan. You can also use those earned dollars to pay for covered medical care and prescriptions.

**With the Solaura Health Incentive Account Plus Plan (HIA Plus)**, members receive quarterly allocations in a Health Incentive Account that are used to pay for covered health care expenses. You can earn additional reward credits for your account with rewards for healthy behaviors. You can use the health credits for covered medical care and prescriptions, and can lower the amount you have to spend out of your pocket.

## HSA-Compatible Plans

An HSA is a Health Savings Account established exclusively to pay for current and future qualified medical expenses of eligible individuals.<sup>3</sup> In order for individuals or families to qualify for a Health Savings Account (HSA), they must be enrolled in a High Deductible Health Plan (HDHP<sup>2</sup>). UniCare's HDHPs are HSA-compatible, designed to meet certain requirements, annual deductibles and annual out-of-pocket expense maximums.

Through an arrangement with JPMorgan Bank, N.A. (Chase<sup>1</sup>), UniCare can offer the convenience of applying for both an HSA and an HDHP together. Rather than applying for an HDHP, then finding a bank and going through another enrollment process for your HSA, UniCare makes both steps available to you at once.

## Pathways

With Pathways, UniCare has made health insurance more affordable than ever. UniCare's Pathways plans offer the flexibility and benefits sought by active employees, providing them with protection to fit their needs and budget.<sup>1</sup>

## Premium Only Plan (P.O.P.)

The Premium Only Plan<sup>2</sup> allows employees to pay their share of premiums with pre-tax dollars resulting in increased take home pay for them and reduced payroll taxes for you.

The Premium Only Plan (P.O.P.) can help generate immediate, significant tax savings by:

- Reducing FICA, federal, state or local taxes (where applicable), on employees' portions of employer-sponsored insurance plan premiums.
- Defraying part of the cost of employee premiums with associated tax savings.
- Increasing employees' take-home pay.

P.O.P. is offered to you at only \$125 per year.

<sup>1</sup> JPMorgan Chase Bank, N.A. (Chase). Chase is an independent company that is not affiliated with, or owned or controlled, in whole or in part, by UniCare or any of its affiliates, subsidiaries or its parent company. The HSA with Chase is governed by the terms and conditions of the contract that individuals have with Chase regarding those accounts and UniCare has no control, nor does it exercise any control, over the contractual relationship between individuals and Chase. <sup>2</sup> A high-deductible plan is not an HSA. An HSA, which must be established for tax-advantaged treatment, is a separate arrangement between the individual and a bank or other qualified institutions. You must be an eligible individual under IRS regulation to receive the tax benefits of an HSA. Consultation with a tax advisor is recommended. <sup>3</sup> The Health Savings Account is a separate arrangement between you and the bank. UniCare does not establish, administer or maintain the savings account.

<sup>1</sup> Pathways Plans, either in whole or in part, do not provide some state-mandated health benefits normally required in accident and sickness insurance policies in Texas: For groups with no more than 50 eligible employees, state-mandated benefits not included are: a) Serious Mental Illness, b) Oral contraceptives, prescription contraceptive drugs and devices and related services (unless the plan includes maternity benefits); c) Chemical Dependency, d) In Vitro fertilization, and e) Speech and Hearing. For groups with more than 50 eligible employees, state-mandated benefits not included are: a) Telemedicine/Telehealth, b) Chemical Dependency, c) In Vitro fertilization, and d) Speech and Hearing. For groups 51 or more eligible employees, state-mandated benefits not included are: a) Telemedicine/Telehealth, b) Chemical Dependency, c) Offer for coverage of in vitro fertilization, d) Offer of coverage of speech and hearing. <sup>2</sup> The services described for the Premium Only Plan are not insurance services or products. Administrative services for the Premium Only Plan are provided by Ceridian Benefits Services, Inc., an independent company which is not affiliated with UniCare, its affiliates, subsidiaries, or parent company. UniCare does not provide tax advice. Employers should consult their own legal counsel or tax advisor for tax information.

## HMO Plans Comparison Chart

Any medical service to be covered must either be provided or Referred by a Primary Care Physician, except in a medical emergency and must be available within the Service Area.

Your Plan Features	HMO 10-0 PLAN RX 1/RX 2	HMO 20-100 RX 1/RX 2
	IN-NETWORK	IN-NETWORK
Lifetime Maximum	Unlimited	Unlimited
Annual Deductible	None	None
Annual Out-of-Pocket Maximum <sup>1</sup>	Member: \$1,500 Family: \$3,000	Member: \$1,500 Family: \$3,000
Annual Maximum Medical and pharmacy combined	N/A	N/A
Office Visits	\$10 copay	\$20 copay
Preventive Care, Adults/Children Office visits and examinations associated with the preventive care services are subject to copay	\$10 copay	\$20 copay
Annual Pap Smears, Annual Mammograms, PSA Screenings Colorectal Screening, Osteoporosis Screening <sup>2</sup>	100%	100%
Immunizations <sup>3</sup>	100%	100%
Lab Test/X-rays	100%	100%
Outpatient Services	100%	100%
Inpatient Hospital Services	100%	100% after copay of \$100 per day for the first 4 days per admission
Emergency Room Services	\$50 copay; waived if admitted	\$75 copay; waived if admitted
Physical/Occupational/Speech Therapy Maximum of 60 visits for all services; combined per year	\$10 copay per visit	\$20 copay per visit
Ambulance Service Maximum covered expense of \$1,000 per trip for ground; \$5,000 per trip for air	100%	100%
Maternity	100%	100%
Prescription Drugs <sup>4</sup> Retail Pharmacy; per prescription, up to a 30-day supply Generic Drugs	Rx 1: \$10 copay Rx 2: \$15 copay	Rx 1: \$10 copay Rx 2: \$15 copay
Brand Name Formulary Drugs	Rx 1: \$20 copay Rx 2: 35%	Rx 1: \$20 copay Rx 2: 35%
Brand Name Nonformulary Drugs	Rx 1: \$35 copay Rx 2: 50%	Rx 1: \$35 copay Rx 2: 50%
Self-Injectables <sup>4</sup>	50%	50%

Your Plan Features	HMO 30-250 RX 1/RX 2
	IN-NETWORK
Lifetime Maximum	Unlimited
Annual Deductible	None
Annual Out-of-Pocket Maximum <sup>1</sup>	Member: \$1,500 Family: \$3,000
Annual Maximum Medical and pharmacy combined	N/A
Office Visits	\$30 copay
Preventive Care, Adults/Children Office visits and examinations associated with the preventive care services are subject to copay	\$30 copay
Annual Pap Smears, Annual Mammograms, PSA Screenings Colorectal Screening, Osteoporosis Screening <sup>2</sup>	100%
Immunizations <sup>3</sup>	100%
Lab Test/X-rays	100%
Outpatient Services	100%
Inpatient Hospital Services	100% after copay of \$250 per day for the first 4 days per admission
Emergency Room Services	\$150 copay; waived if admitted
Physical/Occupational/Speech Therapy Maximum of 60 visits for all services; combined per year	\$30 copay per visit
Ambulance Service Maximum covered expense of \$1,000 per trip for ground; \$5,000 per trip for air	100%
Maternity	100%
Prescription Drugs <sup>4</sup> Retail Pharmacy; per prescription, up to a 30-day supply Generic Drugs	Rx 1: \$10 copay Rx 2: \$15 copay
Brand Name Formulary Drugs	Rx 1: \$20 copay Rx 2: 35%
Brand Name Nonformulary Drugs	Rx 1: \$35 copay Rx 2: 50%
Self-Injectables <sup>4</sup>	50%

<sup>1</sup> Aggregate copays for basic health care services. <sup>2</sup> Preventive care tests and screenings subject to established medical guidelines. <sup>3</sup> Immunization solely for the purpose of insurance, licensure, employment or travel are not covered. <sup>4</sup> Must be purchased from a Participating Pharmacy.

# Premier Flex Plans Comparison Chart

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

Your Plan Features	PREMIER FLEX PLUS 500-90 PLAN		PREMIER FLEX PLUS 500-80 PLAN	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Lifetime Maximum	\$5 million per member		\$5 million per member	
Annual Deductible Copays do not apply toward satisfying any deductible	\$500; two-ded. family max.		\$500; two-ded. family max.	
Out-of-Network Deductible In addition to annual deductible	N/A	\$1,000	N/A	\$1,000
Annual Out-of-Pocket Maximum Does not include deductible	Member: \$1,500 Family: \$3,000	Member: \$10,000 Family: \$20,000	Member: \$2,000 Family: \$4,000	Member: \$10,000 Family: \$20,000
Annual Maximum Medical and pharmacy combined	N/A	N/A	N/A	N/A
Office Visits <sup>4</sup>	\$20 copay; unlimited visits; ded. waived	70%	\$35 copay; unlimited visits; ded. waived	60%
Preventive Care for Adults/Children Under Age 7 Office visits and examinations associated with the preventive care services listed below	\$20 copay; unlimited visits, ded. waived	70%	\$35 copay; unlimited visits; ded. waived	60%
Annual Pap Smears, Annual Mammograms, PSA Screenings, Colorectal Cancer Screening, Osteoporosis Screenings, Adults only	100%; ded. waived	70%	100%; ded. waived	60%
Immunizations, Children Under Age 7	100%; ded. waived	70%	100%; ded. waived	60%
Lab Work/X-rays, Children Under Age 7	100%; ded. waived	70%	100%; ded. waived	60%
Other Preventive Care Services, Age 7-Adult Routine physical exams, lab, X-rays and immunizations other than indicated above under Preventive Care	100%; \$300 max. in- and out-of-network providers combined; ded. waived	70%; \$300 max in- and out-of-network providers combined	100%; \$300 max. in- and out-of-network providers combined; ded. waived	60%; \$300 max in- and out-of-network providers combined
Outpatient Medical Care <sup>1,2</sup>	90%	70%	80%	60%
Inpatient Hospital Services <sup>3</sup>	90%	70% after \$500 copay	80%	60% after \$500 copay
Inpatient Medical Emergency <sup>3</sup>	90%	90% after \$500 copay until transferable to a participating hospital; if stay continues thereafter, 70%	80%	80% after \$500 copay until transferable to a participating hospital; if stay continues thereafter, 60%
Emergency Room Services <sup>3</sup>	\$150 copay; ded. waived	70%	\$150 copay; ded. waived	60%
Physical/Occupational Therapy, Acupuncture/Acupressure Maximum of 20 visits for all services; in-network and out-of-network providers combined	90%	70%	80%	60%
Ambulance Service Maximum covered expense of \$1,000 per trip for ground; \$5,000 per trip for air	90%	70%	80%	60%
Maternity Optional for groups of 2-14 for the Flex Advantage, Pathways and HSA Compatible Plans	90%	70%	80%	60%
Prescription Drug Deductible Brand Name only	None		None	
Prescription Drugs <sup>5</sup> Retail Pharmacy; per prescription, up to a 30-day supply Generic Drugs	\$15 copay	50% avg. wholesale price	\$15 copay	50% avg. wholesale price
Brand Name Formulary Drugs	\$30 copay	50% avg. wholesale price	\$30 copay	50% avg. wholesale price
Brand Name Nonformulary Drugs	\$45 copay	50% avg. wholesale price	\$45 copay	50% avg. wholesale price
Self-Injectables <sup>5</sup>	10%	30%	20%	40% avg. wholesale price

Your Plan Features	PREMIER FLEX PLUS 1000-80 PLAN		PREMIER FLEX PLUS 2000-80 PLAN	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Lifetime Maximum	\$5 million per member		\$5 million per member	
Annual Deductible Copays do not apply toward satisfying any deductible	\$1,000; two-ded. family max.		\$2,000; two-ded. family max.	
Out-of-Network Deductible In addition to annual deductible	N/A	\$2,000	N/A	\$4,000
Annual Out-of-Pocket Maximum Does not include deductible	Member: \$2,000 Family: \$4,000	Member: \$10,000 Family: \$20,000	Member: \$2,000 Family: \$4,000	Member: \$10,000 Family: \$20,000
Annual Maximum Medical and pharmacy combined	N/A	N/A	N/A	N/A
Office Visits <sup>4</sup>	\$35 copay; unlimited visits; ded. waived	60%	\$35 copay; unlimited visits; ded. waived	60%
Preventive Care for Adults/Children Under Age 7 Office visits and examinations associated with the preventive care services listed below	\$35 copay, unlimited visits, ded. waived	60%	\$35 copay, unlimited visits, ded. waived	60%
Annual Pap Smears, Annual Mammograms, PSA Screenings, Colorectal Cancer Screening, Osteoporosis Screenings, Adults only	100%; ded. waived	60%	100%; ded. waived	60%
Immunizations, Children Under Age 7	100%; ded. waived	60%	100%; ded. waived	60%
Lab Work/X-rays, Children Under Age 7	100%; ded. waived	60%	100%; ded. waived	60%
Other Preventive Care Services, Age 7-Adult Routine physical exams, lab, X-rays and immunizations other than indicated above under Preventive Care	100%; \$300 max. in- and out-of-network providers combined; ded. waived	60%; \$300 max. in- and out-of-network providers combined	100%; \$300 max. in- and out-of-network providers combined; ded. waived	60%; \$300 max. in- and out-of-network providers combined
Outpatient Medical Care <sup>1,2</sup>	80%	60%	80%	60%
Inpatient Hospital Services <sup>3</sup>	80%	60% after \$500 copay	80%	60% after \$500 copay
Inpatient Medical Emergency <sup>3</sup>	80%	80% after \$500 copay until transferable to a participating hospital; if stay continues thereafter, 60%	80%	80% after \$500 copay until transferable to a participating hospital; if stay continues thereafter, 60%
Emergency Room Services <sup>3</sup>	\$150 copay; ded. waived	60%	\$150 copay; ded. waived	60%
Physical/Occupational Therapy, Acupuncture/Acupressure Maximum of 20 visits for all services; in-network and out-of-network providers combined	80%	60%	80%	60%
Ambulance Service Maximum covered expense of \$1,000 per trip for ground; \$5,000 per trip for air	80%	60%	80%	60%
Maternity Optional for groups of 2-14 for the Flex Advantage, Pathways and HSA Compatible Plans	80%	60%	80%	60%
Prescription Drug Deductible Brand Name only	None		None	
Prescription Drugs <sup>5</sup> Retail Pharmacy; per prescription, up to a 30-day supply Generic Drugs	\$15 copay	50% avg. wholesale price	\$15 copay	50% avg. wholesale price
Brand Name Formulary Drugs	\$30 copay	50% avg. wholesale price	\$30 copay	50% avg. wholesale price
Brand Name Nonformulary Drugs	\$45 copay	50% avg. wholesale price	\$45 copay	50% avg. wholesale price
Self-Injectables <sup>5</sup>	20%	40% avg. wholesale price	20%	40% avg. wholesale price

1 In addition to pre-service review, certain services require Authorization to be eligible for maximum benefits. This applies to: Organ/Tissue Transplants, Infusion Therapy, Home Health Services, Skilled Nursing Facilities, and Hospice. Failure to obtain authorization may result in a \$1,000 penalty. 2 All surgical services of an Ambulatory Surgical Center and specified non-Emergency outpatient surgeries and diagnostic procedures regardless of place of service require pre-service review or You pay a \$50 Penalty. Ambulatory Surgical Centers must be licensed and accredited and meet all requirements of state and local laws and agencies. 3 Inpatient medical care has a \$500 Penalty without pre-service review or Authorization. This Penalty is waived on Emergency inpatient admissions, however, Utilization Review is still required. 4 Includes X-rays and lab work billed by physician on the same date of service. 5 Certain Prescription Drugs, including but not limited to Self-Administered Injectable Drugs and injectable Drugs administered in an outpatient setting, may require prior Authorization. Benefits may be denied if You fail to obtain Authorization.

## Premier Flex Plans Comparison Chart *Continued*

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

Your Plan Features	PREMIER FLEX 2500 PLAN		PREMIER FLEX SAVER 1000 PLAN	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Lifetime Maximum	\$5 million per member		\$5 million per member	
Annual Deductible Copays do not apply toward satisfying any deductible	\$2,500, two-ded. family max.		\$1,000, two-ded. family max.	
Out-of-Network Deductible In addition to annual deductible	N/A	\$5,000	N/A	\$2,000
Annual Out-of-Pocket Maximum Does not include deductible	Member: \$3,000 Family: \$6,000	Member: \$10,000 Family: \$20,000	Member: \$3,000 Family: \$6,000	Member: \$10,000 Family: \$20,000
Annual Maximum Medical and pharmacy combined	N/A	N/A	N/A	N/A
Office Visits	\$35 copay for the first 10 visits per year; ded. waived*	60%	\$35 copay for the first 4 visits per year; ded. waived**	60% for the first 4 visits per year; ded. waived**
Preventive Care for Adults/Children Under Age 7 Office visits and examinations associated with the preventive care services listed below	\$35 copay for the first 10 visits per year; ded. waived*	60%	\$35 copay for the first 4 visits per year; ded. waived**	60% for the first 4 visits per year; ded. waived**
Annual Pap Smears, Annual Mammograms, PSA Screenings, Colorectal Cancer Screening, Osteoporosis Screenings, Adults only	70%	60%	70%	60%
Immunizations, Children Under Age 7	70%	60%	70%	60%
Lab Work/X-rays, Children Under Age 7	70%, ded. waived	60%	70%, ded. waived	60%
Other Preventive Care Services, Age 7-Adult Routine physical exams, lab, X-rays and immunizations other than indicated above under Preventive Care	70%; \$200 max. in- and out-of-network providers combined; ded. waived	60%; \$200 max. in- and out-of-network providers combined	70%; \$200 max. in- and out-of-network providers combined; ded. waived	60%; \$200 max. in- and out-of-network providers combined
Outpatient Medical Care <sup>1,2</sup>	70%	60%	70% for X-ray/lab \$300 max. in-network and out-of-network providers combined	60% for X-ray/lab \$300 max. in-network and out-of-network providers combined
Inpatient Hospital Services <sup>3</sup>	70%	60% after \$500 copay	70%	60% after \$500 copay
Inpatient Medical Emergency <sup>3</sup>	70%	70% after \$500 copay until transferable to a participating hospital; if stay continues thereafter, 60%	70%	70% after \$500 copay until transferable to a participating hospital; if stay continues thereafter, 60%
Emergency Room Services <sup>3</sup>	70%	60%	70%	60%
Physical/Occupational Therapy, Acupuncture/Acupressure Maximum of 20 visits for all services; in-network and out-of-network providers combined	Up to \$30 per visit		Not Covered	
Ambulance Service Maximum covered expense of \$1,000 per trip for ground; \$5,000 per trip for air	70%	60%	70%	60%
Maternity Optional for groups of 2-14 for the Flex Advantage, Pathways and HSA Compatible Plans	70%	60%	70%	60%
Prescription Drug Deductible Brand Name only	\$100		\$500	
Prescription Drugs <sup>4</sup> Retail Pharmacy; per prescription, up to a 30-day supply				
Generic Drugs	\$10 copay	50% avg. wholesale price	\$10 copay***	50% avg. wholesale price***
Brand Name Formulary Drugs	\$25 copay	50% avg. wholesale price	\$25 copay***	50% avg. wholesale price***
Brand Name Nonformulary Drugs	\$50 copay	50% avg. wholesale price	\$50 copay***	50% avg. wholesale price***
Self-Injectables <sup>4</sup>	30%	40% avg. wholesale price	Not Covered, except insulin	

1 In addition to pre-service review, certain services require Authorization to be eligible for maximum benefits. This applies to: Organ/Tissue Transplants, Infusion Therapy, Home Health Services, Skilled Nursing Facilities, and Hospice. Failure to obtain authorization may result in a \$1,000 penalty. 2 All surgical services of an Ambulatory Surgical Center and specified non-Emergency outpatient surgeries and diagnostic procedures regardless of place of service require pre-service review or You pay a \$50 Penalty. Ambulatory Surgical Centers must be licensed and accredited and meet all requirements of state and local laws and agencies. 3 Inpatient medical care has a \$500 Penalty without pre-service review or Authorization. This Penalty is waived on Emergency inpatient admissions, however, Utilization Review is still required. 4 Certain Prescription Drugs, including but not limited to Self-Administered Injectable Drugs and injectable Drugs administered in an outpatient setting, may require prior Authorization. Benefits may be denied if You fail to obtain Authorization. \*Includes all office visits combined and those associated with "Other Preventive Care Services." After 10 visits deductible and coinsurance applies. \*\*Includes all office visits participating and non-participating providers combined and those associated with "Other Preventive Care Services." After 4 visits a \$5,000 deductible and coinsurance applies. \*\*\*Maximum payment by UniCare of \$500 for generic, brand name formulary and brand name nonformulary drugs; participating and nonparticipating pharmacies combined.

# Flex Advantage Plans Comparison Chart

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

Your Plan Features	FLEX ADVANTAGE 1000 PLAN		FLEX ADVANTAGE 2000 PLAN	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Lifetime Maximum	\$5 million per member		\$5 million per member	
Annual Deductible Copays do not apply toward satisfying any deductible	\$1,000, two-ded. family max.		\$2,000, two-ded. family max.	
Out-of-Network Deductible In addition to annual deductible	N/A	\$2,000	N/A	\$4,000
Annual Out-of-Pocket Maximum Does not include deductible	Member: \$3,000 Family: \$6,000	Member: \$30,000 Family: \$60,000	Member: \$3,000 Family: \$6,000	Member: \$30,000 Family: \$60,000
Annual Maximum Medical and pharmacy combined	N/A	N/A	N/A	N/A
Office Visits	\$35 copay; unlimited visits; ded. waived	60%	\$35 copay; unlimited visits; ded. waived	60%
Preventive Care for Adults/Children Under Age 7 Office visits and examinations associated with the preventive care services listed below	\$35 copay; unlimited visits; ded. waived	60%	\$35 copay; unlimited visits; ded. waived	60%
Annual Pap Smears, Annual Mammograms, PSA Screenings, Colorectal Cancer Screening, Osteoporosis Screenings, Adults only	80%	60%	80%	60%
Immunizations, Children Under Age 7	80%	60%	80%	60%
Lab Work/X-rays, Children Under Age 7	80%	60%	80%	60%
Other Preventive Care Services, Age 7-Adult Routine physical exams, lab, X-rays and immunizations other than indicated above under Preventive Care	80%; \$200 max. in- and out-of-network providers combined; ded. waived	60%; \$200 max. in- and out-of-network providers combined	80%; \$200 max. in- and out-of-network providers combined; ded. waived	60%; \$200 max. in- and out-of-network providers combined
Outpatient Medical Care <sup>1,2,4</sup>	80%	60%	80%	60%
Inpatient Hospital Services <sup>3</sup>	80% after \$500 copay	60% after \$500 copay per admission and less an additional \$500 copay per Continuing Hospital Confinement for non-emergency stays	80% after \$500 copay	60% after \$500 copay per admission and less an additional \$500 copay per Continuing Hospital Confinement for non-emergency stays
Inpatient Medical Emergency <sup>3</sup>	80% after \$500 copay	80% after \$500 copay until transferable to a participating hospital; if stay continues thereafter, 60% of covered expense after additional \$500 penalty	80% after \$500 copay	80% after \$500 copay until transferable to a participating hospital; if stay continues thereafter, 60% of covered expense after additional \$500 copay
Emergency Room Services <sup>4</sup>	80%	60%	80%	60%
Physical/Occupational Therapy, Acupuncture/Acupressure Maximum of 20 visits for all services; in-network and out-of-network providers combined	Up to \$30 per visit		Up to \$30 per visit	
Ambulance Service Maximum covered expense of \$1,000 per trip for ground; \$5,000 per trip for air	80%	60%	80%	60%
Maternity Optional for groups of 2-14 for the Flex Advantage, Pathways and HSA Compatible Plans	80%	60%	80%	60%
Prescription Drug Deductible Brand Name only	\$500		\$500	
Prescription Drugs <sup>5</sup> Retail Pharmacy; per prescription, up to a 30-day supply	\$15 copay	50% avg. wholesale price	\$15 copay	50% avg. wholesale price
Generic Drugs				
Brand Name Formulary Drugs	\$35 copay	50% avg. wholesale price	\$35 copay	50% avg. wholesale price
Brand Name Nonformulary Drugs	\$60 copay	50% avg. wholesale price	\$60 copay	50% avg. wholesale price
Self-Injectables <sup>5</sup>	20%	40% avg. wholesale price	20%	40% avg. wholesale price

Your Plan Features	FLEX ADVANTAGE 2500 PLAN		FLEX ADVANTAGE SAVER 2000 PLAN	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Lifetime Maximum	\$5 million per member		\$5 million per member	
Annual Deductible Copays do not apply toward satisfying any deductible	\$2,500, two-ded. family max.		\$2,000, two-ded. family max.	
Out-of-Network Deductible In addition to annual deductible	N/A	\$5,000	N/A	\$4,000
Annual Out-of-Pocket Maximum Does not include deductible	Member: \$3,000 Family: \$6,000	Member: \$30,000 Family: \$60,000	Member: \$3,000 Family: \$6,000	Member: \$30,000 Family: \$60,000
Annual Maximum Medical and pharmacy combined	N/A	N/A	N/A	N/A
Office Visits	\$35 copay for first 10 visits per year; ded. waived*	60%	\$35 copay for first 4 visits per year; ded. waived**	60% for first 4 visits per year; ded. waived**
Preventive Care for Adults/Children Under Age 7 Office visits and examinations associated with the preventive care services listed below	\$35 copay for first 10 visits per year; ded. waived*	60%	\$35 copay for first 4 visits per year; ded. waived**	60% for first 4 visits per year; ded. waived**
Annual Pap Smears, Annual Mammograms, PSA Screenings, Colorectal Cancer Screening, Osteoporosis Screenings, Adults only	70%	60%	70%	60%
Immunizations, Children Under Age 7	70%	60%	70%	60%
Lab Work/X-rays, Children Under Age 7	70%	60%	70%	60%
Other Preventive Care Services, Age 7-Adult Routine physical exams, lab, X-rays and immunizations other than indicated above under Preventive Care	70%; \$200 max. in- and out-of-network providers combined; ded. waived	60%; \$200 max. in- and out-of-network providers combined	70%; \$200 max. in- and out-of-network providers combined; ded. waived	60%; \$200 max. in- and out-of-network providers combined
Outpatient Medical Care <sup>1,2,4</sup>	70%	60%	70% for X-ray/lab \$300 max. in- and out-of-network providers combined	70% for X-ray/lab \$300 max. in- and out-of-network providers combined
Inpatient Hospital Services <sup>3</sup>	70% after \$500 copay	60% after \$500 copay per admission and less an additional \$500 copay per Continuing Hospital Confinement for non-emergency stays	70%	60% after \$500 copay per admission and less an additional \$500 copay per Continuing Hospital Confinement for non-emergency stays
Inpatient Medical Emergency <sup>3</sup>	70% after \$500 copay	70% after \$500 copay until transferable to a participating hospital; if stay continues thereafter, 60% of covered expense after additional \$500 copay	70%	70% after \$500 copay until transferable to a participating hospital; if stay continues thereafter, 60% of covered expense after additional \$500 copay
Emergency Room Services <sup>4</sup>	70%	60%	70%	60%
Physical/Occupational Therapy, Acupuncture/Acupressure Maximum of 20 visits for all services; in-network and out-of-network providers combined	Up to \$30 per visit		Up to \$30 per visit	
Ambulance Service Maximum covered expense of \$1,000 per trip for ground; \$5,000 per trip for air	70%	60%	70%	60%
Maternity Optional for groups of 2-14 for the Flex Advantage, Pathways and HSA Compatible Plans	70%	60%	70%	60%
Prescription Drug Deductible Brand Name only	\$500		\$500	
Prescription Drugs <sup>5</sup> Retail Pharmacy; per prescription, up to a 30-day supply	\$15 copay	50% avg. wholesale price	\$15 copay***	50% avg. wholesale price
Generic Drugs				
Brand Name Formulary Drugs	\$35 copay	50% avg. wholesale price	\$35 copay***	50% avg. wholesale price***
Brand Name Nonformulary Drugs	\$60 copay	50% avg. wholesale price	\$60 copay***	50% avg. wholesale price***
Self-Injectables <sup>5</sup>	30%	40%	Not covered, except insulin	

1 In addition to pre-service review, certain services require Authorization to be eligible for maximum benefits. This applies to: Organ/Tissue Transplants, Infusion Therapy, Home Health Services, Skilled Nursing Facilities, and Hospice. Failure to obtain authorization may result in a \$1,000 penalty. 2 All surgical services of an Ambulatory Surgical Center require pre-service review or You pay a \$50 Penalty. Ambulatory Surgical Centers must be licensed and accredited and meet all requirements of state and local laws and agencies. 3 Inpatient medical care has a \$500 Penalty without pre-service review or Authorization. This Penalty is waived on Emergency inpatient admissions, however, Utilization Review is still required. 4 Outpatient Emergency Room visits for a Medical Emergency/Emergency Medical Condition that do not result in admission to the Hospital are subject to a \$60 penalty. 5 Certain Prescription Drugs, including but not limited to Self-Administered Injectable Drugs and injectable Drugs administered in an outpatient setting, may require prior Authorization. Benefits may be denied if You fail to obtain Authorization. Refer to the Prescription Drug Utilization Review & Authorization Program in the Prescription Drugs benefits section of this Plan for additional details.

\*Includes all office visits combined and those associated with "Other Preventive Care Services." After 10 visits deductible and coinsurance applies. \*\*Includes all office visits participating and non-participating providers combined and those associated with "Other Preventive Care Services." After 4 visits a \$5,000 deductible and coinsurance applies. \*\*\*Maximum payment by UniCare of \$500 for generic, brand name formulary and brand name nonformulary drugs; participating and nonparticipating pharmacies combined.

## Solaura Plans Comparison Chart

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

Your Plan Features	SOLAURA HSA PLAN E		SOLAURA HSA PLAN F	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Lifetime Maximum	\$5 million per member		\$5 million per member	
Annual Deductible per Member Copays do not apply toward satisfying any deductible	Member: \$1,500 Family: \$3,000		Member: \$1,500 Family: \$3,000	
Annual Out-of-Pocket Maximum In addition to annual deductible	Member: \$1,500 Family: \$3,000	Member: \$3,000 Family: \$6,000	Member: \$5,000 Family: \$10,000	Member: \$10,000 Family: \$20,000
Health Account Contribution by UniCare	N/A		N/A	
Office Visits and Professional Services That support surgery, anesthesia, radiation therapy, in-hospital doctor visits, diagnostic radiology and lab	100%	70%	80%	60%
Preventive Care for Adults: Including, but not limited to lab/X-ray for a routine Pap smear, annual mammogram, PSA screening and Colorectal cancer screening	100%; ded. waived	70%	100%; ded. waived	60%
Preventive Care for Babies <sup>1</sup> Birth through age 6	100%; ded. waived	70%	100%; ded. waived	60%
Preventive Care for Children <sup>1</sup> Ages 7 through 18	100%; ded. waived	70%	100%; ded. waived	60%
Inpatient Hospital Services Includes surgery, organ/tissue transplants	100%	70%	80%	60%
Inpatient Medical Emergency	100%	100% until transferable to a par hospital; if stay continues thereafter, 70%	80%	80% until transferable to a par hospital; if stay continues thereafter, 60%
Outpatient Hospital/Ambulatory Surgical Center Includes outpatient emergency room services, diagnostic and radiological procedures	100%	70%	80%	60%
Ambulance	100%	70%	80%	60%
Maternity	100%	70%	80%	60%
Physical/Occupational Therapy, Acupuncture/Acupressure	\$30 per visit; up to 20 visits/year		\$30 per visit; up to 20 visits/year	
Prescription Drug Deductible Generic and Brand Name	Included in plan deductible		Included in plan deductible	
Prescription Drugs Retail Pharmacy; per prescription, up to a 30-day supply Generic Drugs	100%	70%	80%	60%
Brand Name Formulary Drugs	100%	70%	80%	60%
Brand Name Nonformulary Drugs	100%	70%	80%	60%
Self-Injectibles, Except Insulin	100%	70%	80%	60%

Your Plan Features	SOLAURA HSA PLAN G		SOLAURA HSA PLAN H		SOLAURA HSA PLAN I	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Lifetime Maximum	\$5 million per member		\$5 million per member		\$5 million per member	
Annual Deductible per Member Copays do not apply toward satisfying any deductible	Member: \$2,500 Family: \$5,000		Member: \$2,500 Family: \$5,000		Member: \$5,000 Family: \$10,000	
Annual Out-of-Pocket Maximum In addition to annual deductible	Member: \$2,500 Family: \$5,000	Member: \$5,000 Family: \$10,000	Member: \$5,000 Family: \$10,000	Member: \$10,000 Family: \$20,000	Member: \$5,000 Family: \$10,000	Member: \$10,000 Family: \$20,000
Health Account Contribution by UniCare	N/A		N/A		N/A	
Office Visits and Professional Services That support surgery, anesthesia, radiation therapy, in-hospital doctor visits, diagnostic radiology and lab	100%	70%	80%	60%	100%	70%
Preventive Care for Adults: Including, but not limited to lab/X-ray for a routine Pap smear, annual mammogram, PSA screening and Colorectal cancer screening	100%; ded. waived	70%	100%; ded. waived	60%	100%; ded. waived	70%
Preventive Care for Babies <sup>1</sup> Birth through age 6	100%; ded. waived	70%	100%; ded. waived	60%	100%; ded. waived	70%
Preventive Care for Children <sup>1</sup> Ages 7 through 18	100%; ded. waived	70%	100%; ded. waived	60%	100%; ded. waived	70%
Inpatient Hospital Services Includes surgery, organ/tissue transplants	100%	70%	80%	60%	100%	70%
Inpatient Medical Emergency	100%	100% until transferable to a par hospital; if stay continues thereafter, 70%	80%	80% until transferable to a par hospital; if stay continues thereafter, 60%	100%	100% until transferable to a par hospital; if stay continues thereafter, 70%
Outpatient Hospital/Ambulatory Surgical Center Includes outpatient emergency room services, diagnostic and radiological procedures	100%	70%	80%	60%	100%	70%
Ambulance	100%	70%	80%	60%	100%	70%
Maternity	100%	70%	80%	60%	100%	70%
Physical/Occupational Therapy, Acupuncture/Acupressure	\$30 per visit; up to 20 visits/year		\$30 per visit; up to 20 visits/year		\$30 per visit; up to 20 visits/year	
Prescription Drug Deductible Generic and Brand Name	Included in plan deductible		Included in plan deductible		Included in plan deductible	
Prescription Drugs Retail Pharmacy; per prescription, up to a 30-day supply Generic Drugs	100%	70%	80%	60%	100%	70%
Brand Name Formulary Drugs	100%	70%	80%	60%	100%	70%
Brand Name Nonformulary Drugs	100%	70%	80%	60%	100%	70%
Self-Injectibles, Except Insulin	100%	70%	80%	60%	100%	70%

<sup>1</sup> Includes routine physical exam, lab and X-ray along with immunizations (includes diphtheria, haemophilus influenza type b, hepatitis B, measles, mumps, pertussis, polio, rubella, tetanus, varicella & immunizations required by law)

## Solaura Plans Comparison Chart *Continued*

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

Your Plan Features	SOLAURA HIA+A		SOLAURA HIA+B	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Lifetime Maximum	\$5 million per member		\$5 million per member	
Annual Deductible per Member <i>Copays do not apply toward satisfying any deductible</i>	Member: \$1,000 Family: \$2,000		Member: \$1,500 Family: \$3,000	
Annual Out-of-Pocket Maximum <i>In addition to annual deductible</i>	Member: \$5,000 Family: \$10,000	Member: \$10,000 Family: \$20,000	Member: \$5,000 Family: \$10,000	Member: \$10,000 Family: \$20,000
Health Account Contribution by UniCare	Member: \$500 Family: \$1,000		Member: \$500 Family: \$1,000	
Office Visits and Professional Services <i>That support surgery, anesthesia, radiation therapy, in-hospital doctor visits, diagnostic radiology and lab</i>	80%	60%	80%	60%
Preventive Care for Adults: <i>Including, but not limited to lab/X-ray for a routine Pap smear, annual mammogram, PSA screening and Colorectal cancer screening</i>	100%; ded. waived	60%	100%; ded. waived	60%
Preventive Care for Babies <sup>1</sup> <i>Birth through age 6</i>	100%; ded. waived	60%	100%; ded. waived	60%
Preventive Care for Children <sup>1</sup> <i>Ages 7 through 18</i>	100%; ded. waived	60%	100%; ded. waived	60%
Inpatient Hospital Services <i>Includes surgery, organ/tissue transplants</i>	80%	60%	80%	60%
Inpatient Medical Emergency	80%	80% until transferable to a par hospital; if stay continues thereafter, 60%	80%	80% until transferable to a par hospital; if stay continues thereafter, 60%
Outpatient Hospital/Ambulatory Surgical Center <i>Includes outpatient emergency room services, diagnostic and radiological procedures</i>	80%	60%	80%	60%
Ambulance	80%	60%	80%	60%
Maternity	80%	60%	80%	60%
Physical/Occupational Therapy, Acupuncture/Acupressure	\$30 per visit; up to 20 visits/year		\$30 per visit; up to 20 visits/year	
Prescription Drug Deductible <i>Generic and Brand Name</i>	Included in plan deductible		Included in plan deductible	
Prescription Drugs <i>Retail Pharmacy; per prescription, up to a 30-day supply</i>	80%	60%	80%	60%
Generic Drugs	80%	60%	80%	60%
Brand Name Formulary Drugs	80%	60%	80%	60%
Brand Name Nonformulary Drugs	80%	60%	80%	60%
Self-Injectibles, Except Insulin	80%	60%	80%	60%
Mail Order Prescription <i>Per prescription, up to a 90-day supply</i>	80%	N/A	80%	N/A
Generic Drugs	80%	N/A	80%	N/A
Brand Name Formulary Drugs	80%	N/A	80%	N/A
Brand Name Nonformulary Drugs	80%	N/A	80%	N/A

SOLAURA HIA+C		SOLAURA HIA+D		SOLAURA HIA	
IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
\$5 million per member		\$5 million per member		\$5 million per member	
Member: \$2,500 Family: \$5,000		Member: \$5,000 Family: \$10,000		Member: \$1,000 Family: \$2,000	
Member: \$5,000 Family: \$10,000	Member: \$10,000 Family: \$20,000	Member: \$5,000 Family: \$10,000	Member: \$10,000 Family: \$20,000	Member: \$4,000 Family: \$8,000	Member: \$8,000 Family: \$16,000
Member: \$750 Family: \$1,500		Member: \$1,000 Family: \$2,000		N/A	
80%	60%	100%	70%	80%	60%
100%; ded. waived	60%	100%; ded. waived	70%	100%; ded. waived	60%
100%; ded. waived	60%	100%; ded. waived	70%	100%; ded. waived	60%
100%; ded. waived	60%	100%; ded. waived	70%	100%; ded. waived	60%
80%	60%	100%	70%	80%	60%
80%	80% until transferable to a par hospital; if stay continues thereafter, 60%	100%	100% until transferable to a par hospital; if stay continues thereafter, 70%	80%	80% until transferable to a par hospital; if stay continues thereafter, 60%
80%	60%	100%	70%	80%	60%
80%	60%	100%	70%	80%	60%
80%	60%	100%	70%	80%	60%
\$30 per visit; up to 20 visits/year		\$30 per visit; up to 20 visits/year		\$30 per visit; up to 20 visits/year	
Included in plan deductible		Included in plan deductible		Included in plan deductible	
70%	50%	100%	70%	80%	60%
70%	50%	100%	70%	80%	60%
70%	50%	100%	70%	80%	60%
70%	50%	100%	70%	80%	60%
70%	N/A	100%	N/A	80%	N/A
70%	N/A	100%	N/A	80%	N/A
70%	N/A	100%	N/A	80%	N/A

<sup>1</sup> Includes routine physical exam, lab and X-ray along with immunizations (includes diphtheria, haemophilus influenza type b, hepatitis B, measles, mumps, pertussis, polio, rubella, tetanus, varicella & immunizations required by law)

# HSA Comparison Chart

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

Your Plan Features	UNICARE HSA COMPATIBLE PLAN A****		UNICARE HSA COMPATIBLE PLAN B	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Lifetime Maximum	\$5 million per member		\$5 million per member	
Annual Deductible Copays do not apply toward satisfying any deductible	Member: \$1,150**** Family: \$2,300****		Member: \$2,600 Family: \$5,200	
Out-of-Network Deductible In addition to annual deductible	N/A	Member: \$2,000 Family: \$4,000	N/A	Member: \$5,200 Family: \$10,400
Annual Out-of-Pocket Maximum Does not include deductible	Member: \$2,000 Family: \$4,000	Member: \$15,000 Family: \$30,000	Member: \$2,000 Family: \$4,000	Member: \$15,000 Family: \$30,000
Annual Maximum Medical and pharmacy combined	N/A	N/A	N/A	N/A
Office Visits	80%	60%	80%	60%
Preventive Care for Adults/Children Under Age 7 Office visits and examinations associated with the preventive care services listed below	80%	60%	80%	60%
Annual Pap Smears, Annual Mammograms, PSA Screenings Colorectal Cancer Screening, Osteoporosis Screenings, Adults only	80%	60%	80%	60%
Immunizations, Children Under Age 7	80%	60%	80%	60%
Lab Work/X-rays, Children Under Age 7	80%	60%	80%	60%
Other Preventive Care Services, Age 7-Adult Routine physical exams, lab, X-rays and immunizations other than indicated above under Preventive Care	80%; \$200 max. in- and out-of-network providers combined	60%; \$200 max. in- and out-of-network providers combined	80%; \$200 max. in- and out-of-network providers combined	60%; \$200 max. in- and out-of-network providers combined
Outpatient Medical Services <sup>1,2</sup>	80%	60%	80%	60%
Inpatient Hospital Services <sup>3</sup>	80%	80% after \$500 copay	80%	80% after \$500 copay
Inpatient Medical Emergency <sup>3</sup>	80%	80% after \$500 copay until transferable to a participating hospital; if stay continues thereafter, 60%	80%	80% after \$500 copay until transferable to a participating hospital; if stay continues thereafter, 60%
Emergency Room Services <sup>4</sup>	80%	60%	80%	60%
Physical/Occupational Therapy, Acupuncture/Acupressure Maximum of 20 visits for all services; in-network and out-of-network	Up to \$30 per visit		Up to \$30 per visit	
Ambulance Service Maximum covered expense of \$1,000 per trip for ground; \$5,000 per trip for air	80%	60%	80%	60%
Maternity Optional for groups of 2-14 for the Flex Advantage, Pathways and HSA Compatible Plans	80%	60%	80%	60%
Prescription Drug Deductible Brand Name only	Included in plan deductible		Included in plan deductible	
Prescription Drugs <sup>5</sup> Retail Pharmacy; per prescription, up to a 30-day supply Generic Drugs	\$10 copay	50% avg. wholesale price	\$10 copay	50% avg. wholesale price
Brand Name Formulary Drugs	\$25 copay	50% avg. wholesale price	\$25 copay	50% avg. wholesale price
Brand Name Nonformulary Drugs	\$50 copay	50% avg. wholesale price	\$50 copay	50% avg. wholesale price
Self-Injectables <sup>5</sup>	20%	40% avg. wholesale price	20%	40% avg. wholesale price

Your Plan Features	UNICARE HSA COMPATIBLE PLAN C		UNICARE HSA COMPATIBLE PLAN D	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Lifetime Maximum	\$5 million per member		\$5 million per member	
Annual Deductible Copays do not apply toward satisfying any deductible	Member: \$5,000 Family: \$10,000		Member: \$2,600 Family: \$5,200	
Out-of-Network Deductible In addition to annual deductible	N/A	Member: \$10,000 Family: \$20,000	N/A	Member: \$5,200 Family: \$10,400
Annual Out-of-Pocket Maximum Does not include deductible	Once annual deductible is met, member pays nothing	Member: \$15,000 Family: \$30,000	Once annual deductible is met: Medical: member pays nothing; Pharmacy: Member: \$2,000 Family: \$4,000	Member: \$15,000 Family: \$30,000
Annual Maximum Medical and pharmacy combined	N/A	N/A	N/A	N/A
Office Visits	100%	60%	100%	60%
Preventive Care for Adults/Children Under Age 7 Office visits and examinations associated with the preventive care services listed below	100%	60%	100%	60%
Annual Pap Smears, Annual Mammograms, PSA Screenings Colorectal Cancer Screening, Osteoporosis Screenings, Adults only	100%	60%	100%	60%
Immunizations, Children Under Age 7	100%	60%	100%	60%
Lab Work/X-rays, Children Under Age 7	100%	60%	100%	60%
Other Preventive Care Services, Age 7-Adult Routine physical exams, lab, X-rays and immunizations other than indicated above under Preventive Care	100%; \$200 max. in- and out-of-network providers combined	60%; \$200 max. in- and out-of-network providers combined	100%; \$200 max. in- and out-of-network providers combined	60%; \$200 max. in- and out-of-network providers combined
Outpatient Medical Services <sup>1,2</sup>	100%	60%	100%	60%
Inpatient Hospital Services <sup>3</sup>	100%	100% after \$500 copay	100%	100% after \$500 copay
Inpatient Medical Emergency <sup>3</sup>	100%	100% after \$500 copay until transferable to a participating hospital; if stay continues thereafter, 60%	100%	100% after \$500 copay until transferable to a participating hospital; if stay continues thereafter, 60%
Emergency Room Services <sup>4</sup>	100%	60%	100%	60%
Physical/Occupational Therapy, Acupuncture/Acupressure Maximum of 20 visits for all services; in-network and out-of-network	Up to \$30 per visit		Up to \$30 per visit	
Ambulance Service Maximum covered expense of \$1,000 per trip for ground; \$5,000 per trip for air	100%	60%	100%	60%
Maternity Optional for groups of 2-14 for the Flex Advantage, Pathways and HSA Compatible Plans	100%	60%	100%	60%
Prescription Drug Deductible Brand Name only	Included in plan deductible		Included in plan deductible	
Prescription Drugs <sup>5</sup> Retail Pharmacy; per prescription, up to a 30-day supply Generic Drugs	Member does not pay anything	50% avg. wholesale price	\$10 copay	50% avg. wholesale price
Brand Name Formulary Drugs	Member does not pay anything	50% avg. wholesale price	\$25 copay	50% avg. wholesale price
Brand Name Nonformulary Drugs	Member does not pay anything	50% avg. wholesale price	\$50 copay	50% avg. wholesale price
Self-Injectables <sup>5</sup>	Member does not pay anything	40% avg. wholesale price	20%	40% avg. wholesale price

1 In addition to pre-service review, certain services require Authorization by UniCare to be eligible for maximum benefits. This applies to: Organ/Tissue Transplants, Infusion Therapy, Home Health Services, Skilled Nursing Facilities, and Hospice. Failure to obtain authorization may result in a \$1,000 penalty. 2 All surgical services provided in an Ambulatory Surgical Center require pre-service review or You pay a \$50 Penalty. Ambulatory Surgical Centers must be licensed and accredited and meet all requirements of state and local laws and agencies. 3 Inpatient medical care has a \$500 Penalty without pre-service review or Authorization. This Penalty is waived on Emergency inpatient admissions, however, Utilization Review is still required. 4 Non-Emergency Outpatient Hospital Emergency room visits that do not result in inpatient admissions will require a \$60 Penalty. 5 Certain Prescription Drugs, including but not limited to Self-Administered Injectable Drugs and injectable Drugs administered in an outpatient setting, may require prior Authorization. Benefits may be denied if You fail to obtain Authorization.

\*\*\*\*The annual deductible will reflect the U.S. Treasury minimum deductible requirements for HSA qualified high-deductible plans. The amount is subject to change annually.

# Pathways Plans Comparison Chart

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

Your Plan Features	PATHWAYS ADVANTAGE PLAN		PATHWAYS PLUS PLAN	
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK
Lifetime Maximum	\$5 million per member		\$5 million per member	
Annual Deductible Copays do not apply toward satisfying any deductible	\$1,000; two ded. family max.		\$1,000; two ded. family max.	
Out-of-Network Deductible In addition to annual deductible	N/A	\$2,000	N/A	\$2,000
Annual Out-of-Pocket Maximum Does not include deductible	Member: \$5,000 Family: \$10,000	Member: \$30,000 Family: \$60,000	N/A	
Annual Maximum Medical and pharmacy combined	N/A		\$50,000	
Office Visits	\$40 copay; unlimited visits; ded. waived	60%	\$40 copay; unlimited visits; ded. waived	50%
Preventive Care for Adults/Children Under Age 7 Office visits and examinations associated with the preventive care services listed below	100% up to \$200; ded. waived; after \$200 ded. and coinsurance apply	60%	100% up to \$200; ded. waived; after \$200 ded. and coinsurance apply	50%
Annual Pap Smears, Annual Mammograms, PSA Screenings Colorectal Cancer Screening, Osteoporosis Screenings, Adults Only	100% up to \$200; ded. waived; after \$200 ded. and coinsurance apply	60%	100% up to \$200; ded. waived; after \$200 ded. applies	50%
Immunizations, Children Under Age 7	100% up to \$200; ded. waived; after \$200 ded. and coinsurance apply	60%	100% up to \$200; ded. waived; after \$200 ded. and coinsurance apply	50%
Lab Work/X-rays, Children Under Age 7	100% up to \$200; ded. waived; after \$200, ded. and coinsurance apply	60%	100% up to \$200; ded. waived; after \$200 ded. and coinsurance apply	50%
Other Preventive Care Services, Age 7-Adult Routine physical exams, lab, X-rays and immunizations other than indicated above under Preventive Care	Not Covered		Not Covered	
Outpatient Medical Services <sup>1,2</sup>	60%; X-ray/lab only; \$300 max. in- and out-of-network providers combined	60%; X-ray/lab only; \$300 max. in- and out-of-network providers combined	60%; X-ray/lab only; \$300 max. in- and out-of-network providers combined	50%; X-ray/lab only; \$300 max. in- and out-of-network providers combined
Inpatient Hospital Services <sup>3</sup>	60%	60% after \$500 copay	60%	50% after \$500 copay
Inpatient Medical Emergency <sup>3</sup>	60%	60% after \$500 copay until transferable to a participating hospital; if stay continues thereafter, 60%	60%	60% after \$500 copay until transferable to a participating hospital; if stay continues thereafter, 50%
Emergency Room Services <sup>4</sup>	60%	60%	60%	50%
Physical/Occupational Therapy, Acupuncture/Acupressure Maximum of 20 visits for all services; in-network and out-of-network providers combined	Up to \$30 per visit		Up to \$30 per visit	
Ambulance Service Maximum covered expense of \$1,000 per trip for ground; \$5,000 per trip for air	60%	60%	60%	50%
Maternity Optional for groups of 2-14 for the Flex Advantage, Pathways and HSA Compatible Plans	60%	60%	60%	50%
Prescription Drug Deductible Brand Name only	\$2,000		\$2,000	
Prescription Drugs <sup>5</sup> Retail Pharmacy; per prescription, up to a 30-day supply Generic Drugs	\$20 copay	50% avg. wholesale price	\$20 copay	50% avg. wholesale price
Brand Name Formulary Drugs	50%	50% avg. wholesale price	50%	50% avg. wholesale price
Brand Name Nonformulary Drugs	50%	50% avg. wholesale price	50%	50% avg. wholesale price
Self-Injectables	Not covered, except Insulin		Not Covered, except insulin	

PATHWAYS ESSENTIALS PLANS		Your Plan Features
IN-NETWORK	OUT-OF-NETWORK	
\$5 million per member		Lifetime Maximum
\$2,500; two ded. family max.		Annual Deductible Copays do not apply toward satisfying any deductible
N/A	\$5,000	Out-of-Network Deductible In addition to annual deductible
N/A		Annual Out-of-Pocket Maximum Does not include deductible
\$25,000		Annual Maximum Medical and pharmacy combined
\$40 copay; unlimited visits; ded. waived	50%	Office Visits
100% up to \$200, ded. waived; after \$200 ded. applies	50%	Preventive Care for Adults/Children Under Age 7 Office visits and examinations associated with the preventive care services listed below
100% up to \$200; ded. waived; after \$200 ded. applies	50%	Annual Pap Smears, Annual Mammograms, PSA Screenings Colorectal Cancer Screening, Osteoporosis Screenings, Adults Only
100% up to \$200; ded. waived; after \$200 ded. and coinsurance apply	50%	Immunizations, Children Under Age 7
100% up to \$200; ded. waived; after \$200 ded. and coinsurance apply	50%	Lab Work/X-rays, Children Under Age 7
Not Covered		Other Preventive Care Services, Age 7-Adult Routine physical exams, lab, X-rays and immunizations other than indicated above under Preventive Care
60%; X-ray/lab only; \$300 max. in- and out-of-network providers combined	50%; X-ray/lab only; \$300 max. in- and out-of-network providers combined	Outpatient Medical Services <sup>1,2</sup>
60%	50% after \$500 copay	Inpatient Hospital Services <sup>3</sup>
60%	60% after \$500 copay until transferable to a participating hospital; if stay continues thereafter, 50%	Inpatient Medical Emergency <sup>3</sup>
60%	50%	Emergency Room Services <sup>4</sup>
Up to \$30 per visit		Physical/Occupational Therapy, Acupuncture/Acupressure Maximum of 20 visits for all services; in-network and out-of-network providers combined
60%	50%	Ambulance Service Maximum covered expense of \$1,000 per trip for ground; \$5,000 per trip for air
60%	50%	Maternity Optional for groups of 2-14 for the Flex Advantage, Pathways and HSA Compatible Plans
\$2,000		Prescription Drug Deductible Brand Name only
\$20 copay	50% avg. wholesale price	Prescription Drugs <sup>5</sup> Retail Pharmacy; per prescription, up to a 30-day supply Generic Drugs
50%	50% avg. wholesale price	Brand Name Formulary Drugs
50%	50% avg. wholesale price	Brand Name Nonformulary Drugs
Not Covered, except insulin		Self-Injectables

1 In addition to pre-service review, certain services require Authorization by UniCare to be eligible for maximum benefits. This applies to: Organ/Tissue Transplants, Infusion Therapy, Home Health Services, Skilled Nursing Facilities, and Hospice. Failure to obtain authorization may result in a \$1,000 penalty. 2 All surgical services provided in an Ambulatory Surgical Center require pre-service review or You pay a \$50 penalty. Ambulatory Surgical Centers must be licensed and accredited and meet all requirements of state and local laws and agencies. 3 Inpatient medical care has a \$500 penalty without pre-service review or Authorization. This Penalty is waived on Emergency inpatient admissions, however, Utilization Review is still required. 4 Non-Emergency Outpatient Hospital Emergency room visits that do not result in inpatient admissions will require a \$60 Penalty. 5 Certain Prescription Drugs, including but not limited to injectable Drugs administered in an outpatient setting, may require prior Authorization. Benefits may be denied if You fail to obtain prior Authorization. Refer to the Prescription Drug Utilization Review & Authorization Program in the Prescription Drugs benefits section of this Plan for additional details.

# Specialty Offerings

## Group Term Life Insurance Options

Affordable Term Life, Accidental Death & Dismemberment, Supplemental Life and Dependent Life plans from UniCare provide important financial safeguards for you, your employees and the people who depend on them.

## Comprehensive Dental Insurance Coverage

UniCare offers comprehensive dental plans to help you attract and retain the best employees. UniCare offers a wide variety of PPO, Fee-For-Service and Voluntary dental plan options to provide you and your employees with choices in benefit levels and cost.

## Save When You Purchase Life and Dental Together

You can save up to 6 percent on your Life and Dental insurance premiums when you purchase \$25,000 or more of Group Life insurance along with Non-Voluntary Dental insurance Plans.

## Short Term Disability (STD) and Long Term Disability (LTD)

Short Term Disability insurance provides income replacement to employees who are unable to work for a short period of time Long Term Disability is a critical benefit that helps attract and retain quality employees because it provides them with the security of replacement income in the event of an injury or illness. UniCare's Short Term Disability and Long Term Disability plans offer the flexibility to choose plans that best meet the needs of both you and your employees.

Note: Only Long Term Disability can be sold as a stand-alone product.

## Secure Pack

Secure Pack from UniCare empowers small businesses with big business benefits—all in one convenient package. The package includes Group Term Life Insurance, Accidental Death and Dismemberment (AD&D), Dependent Life Insurance and Group Short Term Disability and/or Group Long Term Disability.

## Health and Wellness Solutions

**UniCare Full Circle Health** offers your employees access to a comprehensive suite of health care management programs to help them become more engaged and empower them to take control of their health. UniCare takes a proactive approach to help members get healthy, stay healthy and live better—surrounding them with resources, tools, guidance and support to help them make the right health care decisions.

UniCare Full Circle Health is packed with some of the most advanced and exciting care management tools available, including:

- **Health Assessment:** Helps members identify many health risks, including family history and lifestyle behaviors; compare health status to the national average and become more actively engaged in their health and wellness.
- **Healthy Living:** Gives members access to a variety of health-related reference materials, including: drug interactions, alternative medicine as well as children's, women's and men's health information.
- **MaterniCall®:** MaterniCall encourages expectant women to become more active in health-related decisions during their pregnancy. The goal of the program is to increase healthy pregnancies and reduce the risk of premature births.
- **MedCall®:** Provides members with a toll-free, 24 hours/7 days a week, health information line with confidential access to nurse counselors for many general health care questions.

- **HealthyExtensions<sup>SM1</sup>:** Gives members access to a large selection of discounted health and fitness materials, services and products.
- **Condition Management:** Provides members with personalized support tools tailored to their health improvement needs, including condition-specific materials, periodic reminders and access to a registered nurse 24 hours a day.
- **MyHealth Record:** Provides members with a secure, confidential online resource to create their own personal electronic health record, which they can print and share with physicians at their convenience.
- **Comprehensive Medical Management:** Works with members, their doctor and other health care providers to help ensure they receive the support they need and the appropriate benefit coverage for their specific treatment plan.
- **Healthcare Advisor<sup>SM</sup>:** Provides members with information they may need when they are preparing for certain medical procedures or conditions, including a hospital's credentials, drug alternatives, and various treatment options.

## Defined Contributions

UniCare offers Defined Contribution options that give you the power to control benefit costs, help your business to grow, and allow you to choose how much to contribute to your employees' medical and dental coverage.

### Medical Insurance

You have the flexibility to choose their preferred approach for contributing towards employee health care premiums. Employers must contribute either:

- A minimum of 50% of the employee's monthly health premium (Tradition Contribution) or
- 100% of the employee's monthly health premium
- \$100 per employee per month or the employee's actual premium for the month (whichever is less) for the employee's health premium (Defined Contribution 100)

- \$80 per employee per month or the employee's actual premium for the month (whichever is less) for the employee's health premium (Defined Contribution 80)
- Any fixed dollar amount (in \$5.00 increments) selected by the employer greater than \$100 per employee per month or the employee's actual premium for the month (whichever is less) for the employee's health premium (Defined Contribution Select)

### Defined Contributions: Pathway Plans

If you choose to only offer the Pathways Plans then they have the flexibility to choose from:

- A minimum of 50% of your employee's monthly health premium (Tradition Contribution) or
- \$30 per employee per month, or your employee's actual premium for the month (whichever is less) for your employee's health premium (Defined Contribution 30)

### Dental Insurance

- A minimum of 50% of your employee's monthly Dental premium (Tradition Contribution) or
- \$15 per employee per month. Or your employee's actual premium for the month (whichever is less) for the employee's dental premium (Define Contribution 15)
- Any fixed dollar amount in \$5.00 increments selected by you greater than \$15 per employee per month or your employee's actual premium for the month (whichever is less) for your employee's dental premium (Defined Contribution Select)
- Voluntary Contribution: You select contribution amount of 49% or less per employee, per month.

### Life & Disability Insurance

- A minimum of 50% of your employee's monthly Life premium

Note: Payroll Deduction is a requirement if contributory

1 Full Circle Health materials, services and products are not insurance and are ineligible for benefits under a member's benefits plan. Members are fully responsible for the charges associated with these materials, services and products, all of which are provided by independent vendors and practitioners not affiliated with the Plan. Services and/or products are subject to change or withdrawal without notice.

