

**This plan features a \$5,000,000 per member lifetime maximum in benefits.**

This matrix provides a brief description of plan features and reflects UniCare's share of costs for covered expenses after the annual and out-of-network deductibles are met. When you use UniCare independently contracted participating (in-network) providers, your costs are based on a specially negotiated rate for UniCare that may often save you money. When you use nonparticipating (out-of-network) providers, your costs are based on charges deemed by UniCare to be reasonable for that service and area. Reasonable charges may be less than your provider's billed charges and often result in higher costs to you. Refer to the UniCare provider directory or to the UniCare Web site at [www.unicare.com](http://www.unicare.com) to determine which providers in your area are participating (in-network) providers. Ask your agent to provide you with a UniCare provider directory before you sign an application for coverage.

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

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

| Plan Features                                                                                  | Participating Provider                                        | Nonparticipating Provider                                         |
|------------------------------------------------------------------------------------------------|---------------------------------------------------------------|-------------------------------------------------------------------|
| <b>Annual Deductible<sup>1</sup></b>                                                           | \$5,000 per member, per year with a two-member family maximum |                                                                   |
| <b>Out-of-Network Deductible<sup>1</sup></b>                                                   | Does Not Apply                                                | Additional \$2,000 out-of-network deductible per member, per year |
| <b>Annual Out-of-Pocket Maximum<sup>1</sup></b><br>(Amounts shown plus applicable deductibles) | \$3,000 per member,<br>\$6,000 per family                     | \$10,000 per member,<br>\$20,000 per family                       |

Amounts shown below are UniCare's payment after applicable deductibles are met, unless otherwise noted.

| Plan Features                                                                                                                                | Participating Provider                                                                                                                       | Nonparticipating Provider                            |
|----------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|
| <b>Lifetime Maximum</b>                                                                                                                      | UniCare pays up to \$5,000,000 per member                                                                                                    |                                                      |
| <b>Office Visits</b><br>Exam only for any covered illness, injury or certain preventive care services for adults and children through age 6. | \$30 copay, unlimited visits<br>deductible waived                                                                                            | 60%, unlimited visits<br>deductible applies          |
| <b>Preventive Care</b><br>Immunizations for babies and children (through age 6)                                                              | 100%, deductible waived<br>Maximum payment of \$300 per member, per year.<br>After maximum payment has been met, 70% and deductible applies. | 60%, deductible applies                              |
| <b>Adult Preventive Care Screenings</b><br>Lab work and x-rays for routine Pap smears, annual mammograms and PSA screenings                  | 100%, deductible waived<br>Maximum payment of \$300 per member, per year.<br>After maximum payment has been met, 70% and deductible applies. | 60%, deductible applies                              |
| <b>Colorectal Cancer Screening</b>                                                                                                           | 70%                                                                                                                                          | 60%                                                  |
| <b>Professional Services</b><br>Surgery, anesthesia, radiation therapy, and in-hospital doctor visits                                        | 70%                                                                                                                                          | 60%                                                  |
| <b>Lab Work and X-rays</b>                                                                                                                   | 70%                                                                                                                                          | 60%                                                  |
| <b>Inpatient Hospital Services<sup>2</sup></b>                                                                                               | 70%                                                                                                                                          | 60%, less a \$500 deductible for non-emergency stays |
| <b>Outpatient Hospital<sup>2,3</sup><br/>or Surgical Center<sup>2</sup></b>                                                                  | 70%                                                                                                                                          | 60%                                                  |
| <b>Initial Care of a Medical Emergency<sup>2,3</sup></b><br>Inpatient or Outpatient Hospital Services                                        | 70%                                                                                                                                          | 70% <sup>4</sup>                                     |
| <b>Physical/Occupational Therapy and Acupuncture</b>                                                                                         | \$30 maximum payment per visit with a combined maximum of 12 visits per year for all of these services combined                              |                                                      |

## Illinois FIT 5000 Health Insurance Plan (cont'd)

Amounts shown below are UniCare's payment after applicable deductibles are met, unless otherwise noted.

| Plan Features                                                                                                                                                                                                        | Participating Provider                                                                                                                                                                                                                                 | Nonparticipating Provider                                                                      |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------|
| <b>Ambulance Service</b>                                                                                                                                                                                             | 70%<br>With a maximum covered expense of \$1,000 per trip for Ground; \$5,000 per trip for Air                                                                                                                                                         | 60%<br>With a maximum covered expense of \$1,000 per trip for Ground; \$5,000 per trip for Air |
| <b>Durable Medical Equipment</b>                                                                                                                                                                                     | 70%                                                                                                                                                                                                                                                    | 60%                                                                                            |
| <b>Prescription Drugs<sup>5</sup></b>                                                                                                                                                                                |                                                                                                                                                                                                                                                        |                                                                                                |
| <b>Retail Pharmacy</b><br>Per prescription<br>(up to a 30-day supply)                                                                                                                                                |                                                                                                                                                                                                                                                        |                                                                                                |
| <b>Generic Drugs</b><br>Not subject to deductible(s)                                                                                                                                                                 | You pay a \$10 copay                                                                                                                                                                                                                                   | UniCare pays 50% of the average wholesale price                                                |
| <b>Brand Name Drugs</b><br>\$500 Brand Name Deductible applies                                                                                                                                                       | You pay a \$30 copay for formulary drugs, or a \$50 copay for nonformulary drugs                                                                                                                                                                       | UniCare pays 50% of the average wholesale price                                                |
| <b>Self Injectable Drugs</b><br>Brand Name Deductible applies to brand name self-administered injectable drugs                                                                                                       | You pay 30%                                                                                                                                                                                                                                            | UniCare pays 50% of the average wholesale price                                                |
| <b>Mail Service</b><br>Per prescription<br>(up to a 60-day supply)<br><br>Brand name drugs are subject to a separate \$500 deductible per member, per year, including Brand name Self-administered Injectable Drugs. | <b>Generic Drugs:</b><br>You pay a \$20 copay<br><br><b>Brand Name Formulary Drugs:</b><br>You pay a \$60 copay<br><br><b>Brand Name Nonformulary Drugs:</b><br>You pay a \$100 copay<br><br><b>Self-administered Injectable Drugs:</b><br>You pay 30% | Not available                                                                                  |

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

<sup>2</sup>Services may require preservice review or authorization by UniCare or you will be required to pay an additional penalty.

<sup>3</sup>Emergency room visits that do not result in an inpatient admission will be subject to a \$60 deductible.

<sup>4</sup>Until transferable to a participating hospital; then 60% subject to a \$500 deductible per continuing hospital confinement once transferable.

<sup>5</sup>Certain prescription drugs may require prior authorization by UniCare.