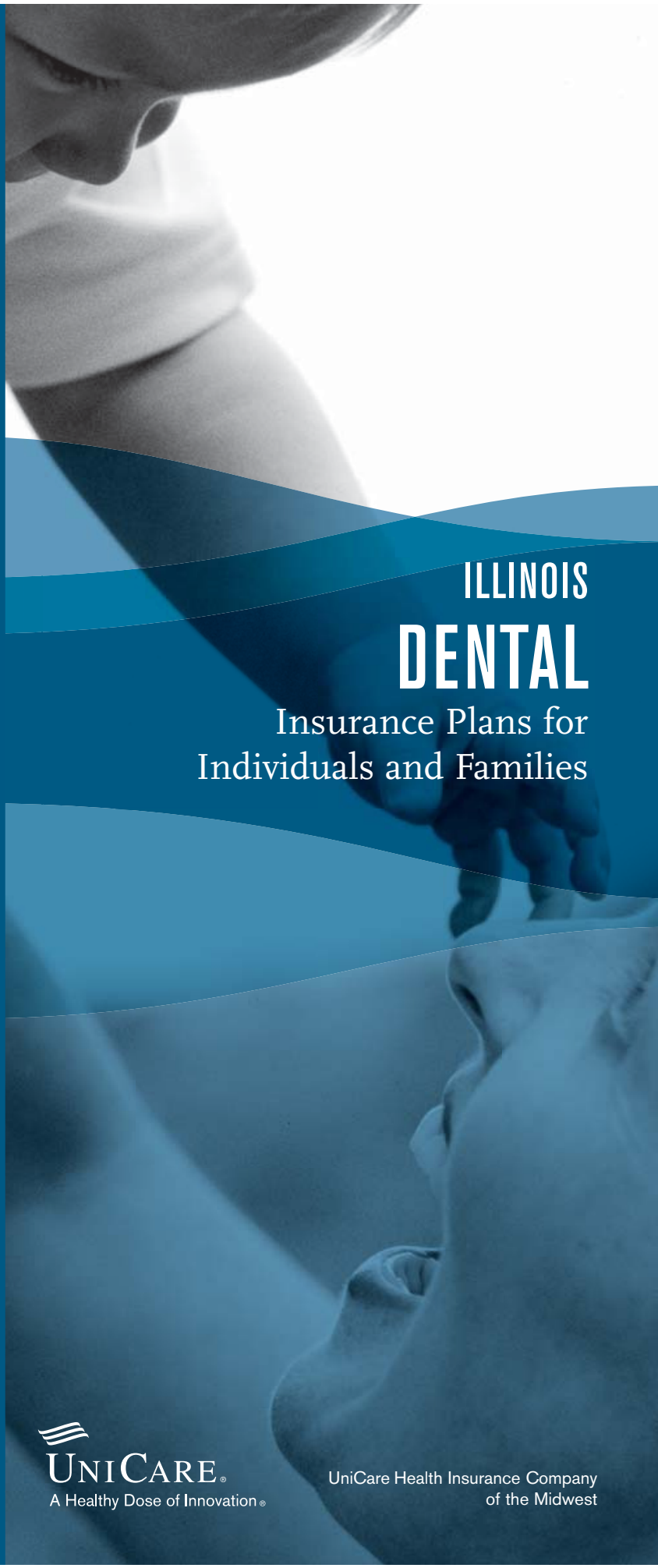
The information in this brochure only provides highlights of the UniCare Individual Dental PPO Plan. For more detailed information, including benefits, limitations, and exclusions, be sure to read the UniCare Individual Dental PPO Plan you will receive once you enroll in the plan. Should there be a conflict between the information provided in this brochure and the terms of the policy, the terms of the policy shall prevail.

UNICARE®
A Healthy Dose of Innovation®

UniCare Health Insurance Company
of the Midwest
Chicago, Illinois

BINBR06356U 02/09



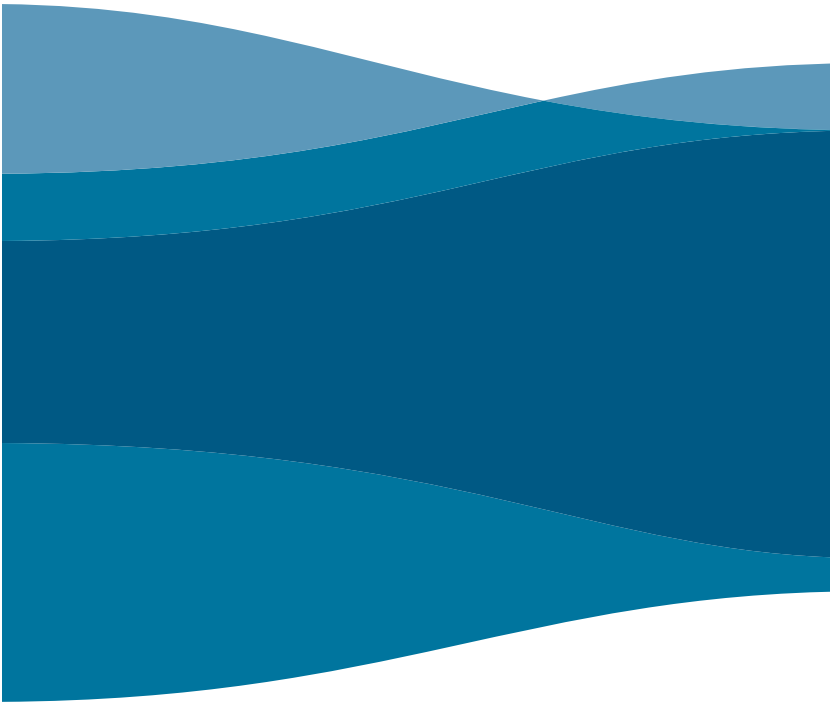
ILLINOIS
DENTAL
Insurance Plans for Individuals and Families

UNICARE®
A Healthy Dose of Innovation®

UniCare Health Insurance Company
of the Midwest

- Freedom to choose any dentist
- Access to quality care at discounted fees
- Wide range of dental services
- Preventive and diagnostic coverage begins on your plan effective date

Only treatments and procedures listed and identified in the benefit schedules are covered.



Individual and Family Dental PPO Plan Coverage

Good oral health is a real quality of life issue, affecting both mental and physical wellness. UniCare Health Insurance Company of the Midwest (UniCare) offers the Individual and Family Dental PPO Plan to help keep your teeth healthy and your smile bright. The UniCare Individual and Family Dental PPO Plan gives you the option of going to any dentist you choose. Hundreds of dedicated independent professionals have contracted with UniCare to provide a wide range of dental services such as routine check-ups, cleanings, fillings, crowns and dental surgery.

The plan was designed with two goals in mind. The first and foremost is to promote good dental hygiene and preventive care, important elements in a total health care package. The second goal is to provide you with the dental care you need in a convenient, cost-conscious manner, thus providing many dental services at reduced costs.

The plan features low-cost preventive and diagnostic care, basic dental care, and a benefit schedule that can help you offset the high cost of major dental care. Please read the following information for details about how the plan works, benefit information and exclusions and limitations that apply.

How the Individual and Family Dental Plan Works

When you choose an independent contracting dentist, you will receive care at negotiated discounted rates—what we term "The UniCare Advantage." Should you choose a noncontracting dentist, the plan still provides benefits, but your out-of-pocket expense may be greater, as the negotiated fees don't apply to noncontracting dentists. You are responsible for any charges in excess of the stated benefit for both contracting and noncontracting dentists.

Your current dentist may be an independent contracting dentist. Before you choose a dentist, be sure to check the Provider Finder on the UniCare Web site at: www.unicare.com or call UniCare Dental Services at (888) 209-7852. It could save you money.

The plan lets you know up front in flat dollar amounts how much the plan pays for covered services. This means that you are able to calculate how much you will have to pay once you have determined your dentist's fee for the specific procedure(s) listed.

If your current dentist is not a contracted dentist and you would like him or her to become one, please notify:

WellPoint Dental
Attn: Network Development
P.O. Box 9069
Oxnard, CA 93031
or call (888) 209-7854

The following is an example of how UniCare's negotiated fees may save you money. Negotiated fees may vary among contracting dentists.

Contracting Dentist	
If the billed charges are	$754
And UniCare's negotiated rate	$500
UniCare will pay the amount specified in the benefit schedule	$215*
Therefore, you pay the difference between the negotiated amount and the scheduled benefit	$285

Noncontracting Dentist	
If the billed charges are	$754
UniCare will pay the amount specified in the benefit schedule	$215*
Therefore, you pay the difference between the billed amount and the scheduled benefit	$539

* This assumes any deductible has been met and you have not reached your annual maximum. Billed charges and negotiated rates in the above table are determined by using an example of contracted and noncontracted fees for dentists in the Chicago, IL area 60601 for ADA procedure code D2750. Negotiated rates may vary by contracted dentists based on their contractual relationship with UniCare.

Calendar Year Deductible

You are responsible for a yearly $50 per person deductible, with a maximum of three deductibles ($150) per family, before your benefits for covered services are available. The calendar year deductible is waived for preventive and diagnostic services when rendered by a contracting dentist.

Calendar Year Maximum Benefit

All dental benefits are limited to a maximum $1,000 payment by UniCare for expenses incurred by each enrolled member during a calendar year.

Waiting Periods

Preventive and diagnostic care begins upon approval of your application. Coverage for basic care begins after six (6) continuous months and for major care after twelve (12) continuous months of coverage.

Customer Service

UniCare's professional dedicated enrollment units are available to assist you and to answer any questions you may have about your plan. The toll-free number is listed on the dental plan identification card you will receive once your enrollment is approved.

Benefit Schedules

To use these schedules, check your dentist's fee and then determine how much the plan pays. You can then easily calculate what you will pay for a specific service after your deductible has been met. The plan pays either the specified amount, or the actual amount charged by your dentist, whichever is lower. You are responsible for any charges in excess of the stated benefit for both contracting and noncontracting dentists.

Preventive and Diagnostic Care

- Begins upon approval of your application.
- Calendar year deductible of $50 per person, with a maximum of three deductibles ($150) per family, is waived **only** when preventive and diagnostic care services are rendered by a contracting dentist.
- Two oral examinations and two dental cleanings per member, per year.
- Total benefit for single and bitewing x-rays not to exceed benefit for full mouth—$43.

Procedure	The Plan Pays	
	Contracting	Non-Contracting
Initial Oral Exam	100%	$15.00
Periodic Oral Exam limited to 2 per member, per year	100%	$15.00
Bitewing X-rays - single film	100%	$11.00
Bitewing X-rays - two films	100%	$14.00
Single (periapical) X-rays - first film	100%	$9.00
Single X-rays - additional films	100%	$9.00
Bitewing X-rays - four films	100%	$20.00
Full mouth X-rays limited to one set every 3 years	100%	$43.00
Routine cleaning limited to 2 per adult per year	100%	$33.00
Routine cleaning limited to 2 per child per year	100%	$21.00
Cleaning with fluoride limited to 2 per child per year	100%	$33.00
Topical fluoride only limited to 2 per child per year	100%	$14.00

- Adult—Any person or dependent 19 years or older covered by this plan.
- Child—Any person or dependent 18 years or younger covered by this plan.

Basic Dental Care

- Coverage begins after the plan has been in effect for six continuous months.
- Calendar year deductible of $50 per person, with a maximum of three deductibles ($150) per family, must be satisfied.
- The benefit schedule is the same for both contracting and noncontracting dentists, but you may have to pay a greater share of the costs if you choose a noncontracting dentist.

Procedure	The Plan Pays
Filling - one surface	$32.00
Filling - two surfaces	$41.00
Filling - three surfaces	$47.00
Filling - four or more surfaces	$55.00
Extraction - erupted tooth or root	$36.00
Surgical - removal of erupted tooth	$65.00
Removal of impacted tooth - soft tissue	$90.00
Removal of impacted tooth - partial bony	$110.00
Removal of impacted tooth - complete bony	$135.00

Major Dental Care

- Coverage begins after the plan has been in effect for twelve continuous months.
- Calendar year deductible of $50 per person, with a maximum of three deductibles ($150) per family, must be satisfied.
- The benefit schedule is the same for both contracting and noncontracting dentists, but you may have to pay a greater share of the costs if you choose a noncontracting dentist.

Procedure	The Plan Pays
Scaling/root planing per quadrant	$41.00
Gingivectomy - per tooth	$36.00
Gingivectomy - per quadrant	$125.00
Root canal - 1 canal	$135.00
Root canal - 2 canals	$160.00
Root canal - 3 canals	$205.00
Crown (except stainless steel)	$215.00
Stainless steel crown	$55.00
Pontic	$215.00
Complete denture (upper or lower)	$275.00
Partial denture (upper or lower)	$255.00
Denture reline (chairside)	$65.00
Denture reline (lab)	$85.00

This is a brief summary of the plan. Please refer to the Certificate of Coverage for more complete details including benefits, limitations and exclusions.

Eligibility and Enrollment

To be eligible for enrollment, you must be:

- A resident of the State of Illinois who properly applies for coverage and is accepted by UniCare
- A resident of the United States for at least six months, age 64 1/2 or younger
- The applicant's lawful spouse of the opposite sex, age 64 1/2 or younger
- The applicant's unmarried child up to age 19
- The applicant's unmarried child who is a full-time student (12 units per semester), age 19 through 22
- Not enrolled under any other UniCare individual or group dental plan
- Unmarried stepchildren who reside with the applicant up to age 19 or if a full-time student (12 units), age 19 through 22

Date Coverage Begins

The effective date of your coverage is printed on your identification card. Your coverage will stay in effect with our consent, on a three-month basis if you have chosen quarterly coverage, or on a monthly basis if you have chosen the monthly checking account deduction program.

Premium Rates

The rates listed are monthly rates. Monthly payment is available only through the monthly checking account deduction program. If you prefer to pay quarterly, multiply the monthly rate by three.

UniCare Individual and Family Dental PPO Plan Monthly Rates	
One adult	$31.00
Two adults	$62.00
Adult with 1 child	$47.00
Adult with 2 children	$63.00
Adult with 3+ children	$87.50
Family (1 child)	$78.00
Family (2 children)	$94.50
Family (3+ children)	$118.50
One child	$16.50
Two children	$32.50
Three+ children	$57.00

UniCare reserves the right to change rates. Please contact UniCare for the most current rates.

Counties with strong network access:

Clinton	Kanakakee	Ogle
Cook	Kendall	Peoria
DeKalb	Lake	St. Clair
DuPage	Livingston	Will
Jackson	Madison	Winnebago
Kane	McHenry	

Counties without strong network access: A fewer number of independently contracted dentists are available in other areas. UniCare plan members are entitled to the benefits of the negotiated amounts if they choose one of those independently contracted dentists. Benefits are still available for noncontracting dentists, as specified by the plan. If you would like your dentist to become an independently contracted dentist, please have him or her contact us.

Terms of Coverage

Coverage under this plan remains in force as long as the required premiums are paid on time and as long as the insured remains eligible for coverage. In addition, when an insured becomes ineligible because of divorce or a change in dependent status, coverage ceases. (In the case of divorce and over-age dependents, UniCare may offer a similar plan.) UniCare may refuse to renew or may change the premiums of this plan after 30 days written notice to the policyholder. However, UniCare will not refuse to renew or change the premium schedule for this plan on an individual basis, but only for all policyholders in the same class and covered under the same plan as you.

Other Insurance in This Company

Insurance effective at any one time on the insured under a like plan or plans in this company is limited to the one such plan elected by the insured, his beneficiary or his estate, as the case may be, and the company will return all premiums paid for all other such plans.

Exclusions and Limitations

The UniCare Individual and Family Dental PPO Plan does not provide benefits for:

- Unlisted services: Services not specifically listed in the benefit schedule of this policy.
- Excess amounts: Any amounts in excess of the maximum amount stated in the "calendar year maximum benefit" section or listed in the benefit schedule.
- Experimental or investigative procedures: Services or supplies that are mainly limited to laboratory and/or animal research, but which are not generally accepted as proven and effective procedures and are considered experimental within the organized medical community.
- Expenses before coverage begins: Services received before your effective date.
- End of coverage: Services received after your coverage ends.
- Services for which you are not legally obligated to pay: Services for which no charge would be made to you in the absence of insurance coverage.
- Workers' compensation: Any condition for which benefits could be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, even if you do not claim those benefits.
- War: Disease contracted or injuries sustained as result of war declared or undeclared, conditions caused by the inadvertent release of nuclear energy when government funds are available for treatment of illness or injury arising from such release of nuclear energy.
- Government services: Any services provided by a local, state, county or federal government agency including any foreign government.
- Services from relatives: Professional services received from a person who lives in the insured person's home or who is related to the insured person by blood, marriage or adoption.
- Cosmetic dentistry: Any services performed for cosmetic purposes are not covered under this plan, unless they are for the correction of functional disorders or as a result of an accidental injury occurring while you were covered under this policy.
- Charges for treatment by other than a licensed dentist or physician, except charges for dental prophylaxis performed by a licensed dental hygienist, under the supervision and direction of a dentist.
- Replacement of an existing prosthesis which has been lost or stolen; or which in the opinion of the dentist is or can be made satisfactory.
- Replacement of a fixed or removable prosthesis if such replacement occurs within five years of the original placement, unless the denture is a stayplate used during the healing period for recently extracted anterior teeth.
- Orthodontic services, braces, appliances and all related services.
- Diagnosis or treatment of the joint of the jaw and/or occlusion (the way upper and lower teeth meet) services, supplies or appliances provided in connection with: (a) any treatment to alter, correct, fix, improve, remove, replace, reposition, restore or otherwise treat the joint of the jaw (temporo mandibular joint) or associated musculature, nerves and other tissues for any reason or by any means; or (b) any treatment, including crowns, caps and/or bridges to change the way the upper and lower teeth meet (occlusion); or (c) treatment to change vertical dimension (the space between the upper and lower jaw) for any reason or by any means including the restoration of vertical dimension because teeth have worn down.

- Procedures requiring appliances or restorations (other than those for replacement of structure loss from caries) that are necessary to alter, restore or maintain occlusions. These include but are not limited to: (a) changing the vertical dimension; (b) replacing or stabilizing lost tooth structure by attrition, abrasion, or erosion; (c) realignment of teeth; (d) gnathological recording; (e) occlusal equilibration; (f) periodontal splinting.
- Oral examinations exceeding two visits per insured per year.
- Prophylaxis treatments, exceeding two treatments per insured per year.
- Fluoride applications for patients over eighteen (18) years of age. Fluoride applications exceeding two visits per year.
- More than one set of full-mouth x-rays or its equivalent per insured in a three year period.
- Correction of congenital or development malformation for an insured person including but not limited to cleft palate, maxillary or mandibular (upper and lower jaw) malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth), and anodontia (congenitally missing teeth). This exclusion does not apply to otherwise eligible charges incurred for the treatment of a congenital defect or defects in a dependent child who is eligible to be covered under this Policy and who has been so covered continuously from the date of her or his birth until the date the expense is incurred.
- Adjustment, repairs or relines to prosthesis except following 6 months from initial placement and if the prosthesis was paid for under this plan.
- Fixed bridges, removable cast partials and/or cast crown with or without veneers for patients under sixteen years of age.

- Replacement of crowns and cast restorations including porcelain crowns, if such replacement occurs within five years of the original placement.
- Transfer of care: If a policyholder transfers from the care of one dentist to that of another dentist during the course of treatment, or if more than one dentist renders services for one dental procedure, UniCare shall be liable only for the amount it would have been liable for had one dentist rendered the services.
- Prescribed drugs, pre-medication or analgesia.
- Oral hygiene instruction.
- Malignancies and neoplasms: Services for treatment of malignancies and neoplasms are not covered services.
- All hospital costs and any additional fees charged by the dentist for hospital treatment.
- Implants: (materials implanted into or on bone or soft tissue), or the removal of implants are not benefits under the policy. However, if implants are provided in association with a covered prosthetic appliance, UniCare will allow the benefit for a standard complete or partial denture or a bridge toward the cost of implants and the prosthetic appliances.
- Services or supplies that are not medically necessary.
- Replacement of teeth missing prior to the effective date of coverage.
- Services for periodontics, fixed or removable prosthodontics within the first 12 months of the insured person's effective date.

This is a brief summary of the plan. Please refer to the Certificate of Coverage for more complete details, including benefits, limitations and exclusions.

How to enroll

If you are a new member and want dental coverage **only**:

- Complete and sign the attached application.
- Determine your premium rate (see page 10) and your initial premium (see page 17).
- Send the application and payment to your agent or to the UniCare address below.

If you are applying for UniCare medical coverage and dental coverage:

- See instructions on the Individual & Family PPO Plan Application.

If you are a UniCare member and want to **add** dental coverage:

- Complete the attached application.
- Determine your premium rate (see page 10).
- Determine your initial premium—it should be the same type of billing as your medical coverage. If you are using monthly checking account deduction, you must still send the first month's premium with the application
- Write a check payable to UniCare.
- Send the application to your agent or to the UniCare address below.

Send your application and payment to:

UniCare Life & Health Insurance Company
Attn: Individual Membership Department
P.O. Box 5061
Bolingbrook, IL 60440-5061

To determine your initial premium*:

- If you want to pay your bill monthly, submit the one-month premium, complete the Monthly Bank Draft Authorization and attach a blank check marked "VOID" to the form.
- If you want to pay your bill quarterly, submit the three-month (quarterly) premium.

Applicants who are approved for enrollment will receive a UniCare Individual Dental PPO Plan. Please review it carefully as it contains specific details about your coverage, exclusions and limitations. This brochure only provides highlights of the UniCare Individual Dental PPO Plan. This is not the insurance contract and only the actual plan provisions will apply.

*If you are a UniCare member, you must select the same payment plan you have for your health plan.

UNICARE®

ATTACH CHECK HERE

UNICARE INDIVIDUAL PPO DENTAL PLAN ENROLLMENT APPLICATION

UniCare Health Insurance Company of the Midwest

Once completed, fax both sides of this form to UniCare–Attention: Individual Membership FAX (866) 868-8846

If UniCare approves my application, please assign an effective date of the

☐ 1st of the month following approval.

☐ _____ (mm/dd/yy).

If you are a UniCare subscriber, please enter your current UniCare group number and certificate number.

GROUP NO.	CERTIFICATE NO.

Applicant Information – Applicant must complete this section. Please print

Last Name	First Name	MI	Social Security No.

Home Phone No.	Business Phone No.	Sex	Marital Status	Age	Date of Birth
( )	( )	☐ M ☐ F	☐ Single ☐ Married		

Home Address (Must be complete. P.O. Box not acceptable)			Billing Address (If different or P.O. Box)		
City	State	ZIP Code	City	State	ZIP Code

Spouse to be Insured – Signature required below.

Last Name of Spouse	First Name	Sex	Date of Birth (mo/Day/Yr)	Social Security No.
		☐ M ☐ F		

Children to be Insured

NAME (First and Last Name)	SEX	BIRTHDATE Mo Day Yr	SOCIAL SECURITY NO.
1	☐ M ☐ F		
2	☐ M ☐ F		
3	☐ M ☐ F		
4	☐ M ☐ F		

Signatures (Required)

If the family member is a minor, I accept full legal and financial responsibility for the coverage and information provided on this application. If the responsible adult is not the natural parent, please submit court papers authorizing guardianship. I understand that coverage is subject to all conditions and provisions specified in the Policy. I understand that receipt of money with this application does not create UniCare coverage. Coverage will come into effect only on approval by UniCare.

Signature of Applicant / Parent or Legal Guardian	Today's Date	Signature of Applicant's Spouse	Today's Date
X		X	
Signature of Applicant's Dependent Age 18 or over	Today's Date	Signature of Applicant's Dependent Age 18 or over	Today's Date
X		X	

Agent Information

Name of Agent (Print)	Phone	Agent Tax I.D. Number	Check one	Signature of Agent	Today's Date
Andrew Carver	815-609-6715	DFHNRPNKSY	☐ EIN ☐ SS#	X	

FOR UNICARE USE ONLY

Group No.	Certificate No.	Agent Tax I.D. No.	Effective Date	Area		By	Date

(Continued on reverse side)

Once completed, fax both sides of this form to UniCare– Attention: Individual Membership FAX (866) 868-8846

Select Billing Type

☐ Monthly (By checking account deduction only.) ☐ Quarterly

Please choose the draft date on which you would like your premium debited from your checking account:

☐ 1st ☐ 8th ☐ 15th ☐ 22nd of the month

Monthly Bank Draft Authorization

INSTRUCTIONS:

1. Complete this section.
2. Submit a check for one- (1) month's premium made out to UniCare.

All funds are drawn on the first of each month. Premiums may be prorated in order to adjust the initial paid to date or in the event of membership changes.

OPTIONAL MONTHLY BANK DRAFT AUTHORIZATION. As a convenience to me, I request and authorize YOU to pay and charge to my account checks drawn on that account by and payable to the order of UniCare provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such debit shall be the same as if it were a check drawn on you and signed personally by me. I authorize UniCare to initiate debits (and/or corrections to previous debits) from my account with the financial institution indicated for payment of my UniCare premium. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such debit. I further agree that if any such debit be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in forfeiture of insurance.

NOTE TO APPLICANT: Should your withdrawal not be honored by your bank, you will automatically be removed from Monthly Checking Account Deduction and be billed quarterly. After 12 months, you may re-apply for the Monthly Checking Account Deduction option.

You will incur a service charge for any withdrawal not honored. UniCare must be notified of any changes to your bank account.

Applicant's Name

Applicant's Social Security No.

Name on Checking Account (If different than above)

Routing No.

Checking Account No.

Name of Bank

Authorized Signature (as it appears in the financial institution's records)

X

Date

Initial Premium Payment by Electronic Check

Select one: ☐ 1 month ☐ 3 months

Check No. Initial Premium Amount Electronic Check $

Bank/Credit Union Routing No.

Checking Account No. (as it appears on your check)

Name on Account

Initial Premium Payment by Credit Card
New members only. Not available to make a coverage change.

Select one: ☐ 1 month ☐ 3 months	Initial Premium Amount Credit Card: $	Credit Card ☐ VISA ☐ MasterCard
Credit Card No.		Expiration Date
Cardholder's Name		Cardholder's ZIP Code
Authorized Signature **(as it appears on the credit card)**		Today's Date