

PERSONAL PLAN

HEALTHCARE FOR INDIVIDUALS



HMO



**An individual Health Plan that You
and Your Family can feel good about.**



Universal Care®
Healthcare you can feel good about.

THE PERSONAL PLAN

ADVANTAGES

Why is the Universal Care Personal Plan the **Right** health plan choice for You?

- **Choice of two benefit plans.**
- **Affordable rates**
- **An outstanding network of contracted doctors and hospitals throughout Los Angeles, Orange, San Bernardino, Riverside, San Diego, Kern, and Ventura Counties.**
- *Champion*HEALTH Network is made up of **Universal Care Medical** group locations located in **Los Angeles and Orange Counties.**
- **Prescription drug benefits and a prescription mail order service to provide additional savings.**
- **Manageable, monthly premiums that can be transferred directly from your checking account.**
- **Nurse AdviceLine** staffed by qualified medical personnel who are here to assist you 24-hours a day, 365 days a year.
- **Annual Well-Woman Exams** including: direct access to an **OB/GYN** (no referral needed!), an annual **Pap Smear** and breast/pelvic exam.
- **Maternity coverage*.**
- **Well-baby care.**
- **Affordable Youth Rates** – our youth rates are often lower than dependent rates in other group plans.
- **Dental Plan option.**

*waiting periods may apply.

At Universal Care, we are committed to:

- **Keeping you and your family healthy**
- **Listening to your ideas and comments**
- **Offering you affordable rates and comprehensive benefits**
- **Providing a courteous, helpful and knowledgeable Member Services staff**
- **Selecting qualified doctors and distinguished hospitals**

We invite you to join the thousands who have already joined Universal Care... because we give you a lot to feel good about.

WITH THIS BROCHURE YOU WILL FIND:

- **Summary of Plan Benefits** (*enclosed*)
- **Application and Enrollment Form** (*enclosed*)
- **Medical Benefits Rate Schedule** (*enclosed*)
- **Dental Option** (*enclosed*)
- **Electronic/Automatic Payment Form** (*enclosed*)
- **Return Envelope** (*enclosed*)
- **Provider Directory** (*attached*)

CHOOSING THE PLAN

THAT'S RIGHT FOR YOU

CHOOSING YOUR BENEFIT PLAN

We're pleased to offer two benefit plan options for individuals and their families – Personal Plan 10 and Personal Plan 20. Both offer the same excellent benefits, but you have the freedom to choose the level of copayment that best fits your budget. You'll find a Summary of Plan Benefits on the following pages and rates in the back pocket.

PRESCRIPTION DRUG BENEFIT

Universal Care covers prescription drugs on a formulary basis (including birth control pills and prescriptions for confirmed diagnosis of Schizophrenia, Schizoaffective disorder, Bipolar disorder, Major depressive disorders, Panic disorder, Obsessive-Compulsive disorder, Anorexia Nervosa, Bulimia Nervosa, Autism and Serious Emotional Disturbances in children) prescribed by a Universal Care physician if and only if they are dispensed at a contracting pharmacy.

PRIMARY CARE PHYSICIAN

All of your medical care will be coordinated and managed through the Universal Care contracted physician of your choice, known as your Primary Care Physician. And, each covered family member can select his or her own Primary Care Physician from a Contracting Medical Group. These doctors become familiar with your specific medical needs, thereby offering you quality care and appropriate referrals to specialists whenever needed.

If you have any questions about which plan is best for you and your family, please call your agent or call Universal Care at **800-380-2522**. We'll be happy to assist you.

ENROLLING IN UNIVERSAL CARE IS EASY

- 1) Once you've selected the benefit plan for you and your family members, Complete the Application and Enrollment Form that follows.
- 2) On the Application and Enrollment Form, you are asked to select a Primary Care Physician for each applicant from a contracting IPA or Medical Group or the Champion Network. To make your selection, just follow the simple directions in the Provider Directory which is enclosed with this brochure.
- 3) You may also want to take a moment to review the Dental Plan Option Information located in the back pocket of this brochure. If you choose to enroll, just check the appropriate box on the Application and Enrollment Form, and then fill out the Dental Plan Enrollment Form.
- 4) Use the Rate Schedules in the back pocket of this brochure to calculate your first month's premium. Please note there are premium differences depending on Network selection. (If you choose the Dental Option, make sure you add your dental premium amount to your first month's medical premium.)
- 5) Write a check for the total monthly premium amount, payable to Universal Care, and enclose it with your Application and Enrollment Forms in the envelope provided.
- 6) If you elect the convenience of pre-authorized payment from your checking account, fill out the enclosed Electronic/Automatic Payment Form, and return it with your application.

In the event you have any questions, feel free to call us at **800-380-2522**.



BENEFITS AND COVERAGE

Copayment Requirements

This matrix is intended to be used to help you compare coverage benefits and is a summary only. The evidence of coverage and plan contract should be consulted for a detailed description of coverage benefits, limitations and exclusions.

DEDUCTIBLES

LIFETIME MAXIMUMS

PROFESSIONAL SERVICES

Physician Services

Preventive Care:

Periodic physical examination

Annual Well-Woman examination (direct access to OB/GYN in member's selected Universal Care medical group or IPA; examination includes pap smear, manual breast examination and pelvic examination)

Well baby care

Adult and Pediatric Immunizations

Venereal disease tests

Allergy testing and treatment

Vision screening through age 18

Hearing screening through age 18

Testing of PKU

OUTPATIENT SERVICES

Diagnostic x-ray and laboratory procedures

Short-term physical, speech & occupational therapy (session limitations apply)

Radiation, radioisotope therapy & chemotherapy

Outpatient Surgery

HOSPITALIZATION SERVICES

(also refer to maternity, mental health, and chemical dependency sections)

Room and Board

Additional Inpatient Services:

Diagnostic x-ray and laboratory procedures

Operating room and related facilities

Drugs, medications, biologicals, anesthesia, oxygen

Hemodialysis and administration of blood

Inpatient Rehabilitation/Subacute Care

Physical and respiratory therapy

Diagnostic, therapeutic and rehabilitative services

Radiation, radioisotope therapy & chemotherapy

Miscellaneous charges for necessary care/treatment

Coordinated discharge planning

Mental Health Hospitalization for members with confirmed diagnosis of Schizophrenia, Schizoaffective disorder, Bipolar disorder, Major depressive disorders, Panic disorder, Obsessive-Compulsive disorder, Anorexia Nervosa, Bulimia Nervosa, Autism and Serious Emotional Disturbances of Children

Physician Visits in Hospital

Surgical Benefits (Surgeon, assistant surgeon, and anesthesiologist)

Personal Plan 10

\$0

None

\$10 Copayment

\$10 Copayment

\$10 Copayment

\$10 Copayment

\$10 Copayment

\$10 Copayment

\$10 Copayment

\$10 Copayment

\$10 Copayment

\$10 Copayment

\$10 Copayment

\$10 Copayment

\$10 Copayment

No Charge

No Charge

No Charge

No Charge

No Charge

No Charge

Personal Plan 20

\$0

None

\$20 Copayment

\$20 Copayment

\$20 Copayment

\$20 Copayment

\$20 Copayment

\$20 Copayment

\$20 Copayment

\$20 Copayment

\$20 Copayment

\$20 Copayment

\$20 Copayment

\$20 Copayment

\$20 Copayment

20% of Charges

20% of Charges

20% of Charges

20% of Charges

No Charge

No Charge

HOSPITALIZATION SERVICES continued

Mastectomy/Breast Reconstruction After Mastectomy

Surgery to perform a Medically Necessary mastectomy and lymph node dissection is covered, including prosthetic devices or reconstructive surgery to restore and achieve symmetry for the Member incident to the mastectomy. The length of a hospital stay is determined by the attending physician and surgeon in consultation with the Member, consistent with sound clinical principles and processes. Coverage includes any initial and subsequent reconstructive surgeries or prosthetic devices for the diseased breast on which the mastectomy was performed and for a healthy breast if, in the opinion of the attending physician and surgeon, this surgery is necessary to achieve normal symmetrical appearance.

Reconstructive Surgery

Inpatient Reconstructive Surgery is covered when performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following:

To improve function; or

To create a normal appearance, to the extent possible.

Examples include repair of congenital defects, such as port wine stain, or developmental abnormalities which are disfiguring, and for which surgical repair leads to improvement of the defect and/or appearance of the enrollee, such as cleft lip or cleft palate.

Reconstructive procedures require utilization review in accordance with standards of care as practiced by physicians specializing in reconstructive surgery and prior authorization by a Universal Care Medical Director or designee.

Skilled Nursing Facility

EMERGENCY HEALTH COVERAGE

Emergency Facility

Physician Visits in Hospital

AMBULANCE SERVICES

Ambulance

HOSPICE SERVICES

BREAST CANCER SCREENING, DIAGNOSIS AND TREATMENT

Personal Plan 10

No Charge
(Outpatient or
Inpatient)

No Charge
(Outpatient or
Inpatient)

No Charge
(60 days per
benefit year)

\$75 Copayment
No Charge

\$50 Copayment

Inpatient Services:
No Charge
Outpatient Services:
\$10 Copayment

\$10 Copayment

Personal Plan 20

20% of Charges
(Outpatient or
Inpatient)

20% of Charges
(Outpatient or
Inpatient)

No Charge
(60 days per
benefit year)

\$75 Copayment
No Charge

\$50 Copayment

Inpatient Services:
No Charge
Outpatient Services:
No Charge

\$20 Copayment

PRESCRIPTION DRUG COVERAGE

Generic drugs on the Formulary or generic drugs not on the Formulary but pre-authorized by Universal Care;

Brand-name drugs on the Formulary when no generic is available; or brand name drugs not on the Formulary, but pre-authorized by Universal Care; or

Certain Medically Necessary brand name or generic drugs not on the Formulary and not pre-authorized by Universal Care. Selected non-formulary drugs will have limitations consistent with guidelines developed by Universal Care Pharmacy & Therapeutics Committee. Some non-Formulary drugs may also be excluded from coverage. See Exclusions and Limitations Related to the Outpatient Prescription Drug Benefit in this Evidence of Coverage (EOC). (This service is not available for mail order drugs unless pre-authorized by Universal Care.)

Maximum prescription benefit is \$3,000 per Benefit Year per Member.

Mail Order Prescriptions

Three month's supply of generic maintenance drugs and medications.

Three month's supply of brand maintenance drugs and medications.

Treatment of PKU

Treatment will include those formulas and special food products that are part of a diet prescribed by a Contracting Physician and managed by a health care professional in consultation with a Physician who specializes in the treatment of metabolic disease and who contracts with or is authorized by Universal Care, provided that the diet is deemed Medically Necessary to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU.

DURABLE MEDICAL EQUIPMENT

Crutches, wheelchairs, prosthetic devices, canes, braces

Personal Plan 10

\$15 Copayment

\$25 Copayment

\$40 Copayment

\$22.50 Copayment
per prescription

\$37.50 Copayment
per prescription

Subject to Brand Drug
Copayment after the
treatment has been
prior approved by
Universal Care for a
30 day supply.

No Charge
Up to a maximum
benefit of \$1,000
per benefit year.

Personal Plan 20

\$15 Copayment

\$25 Copayment

\$40 Copayment

\$22.50 Copayment
per prescription

\$37.50 Copayment
per prescription

Subject to Brand Drug
Copayment after the
treatment has been
prior approved by
Universal Care for a
30 day supply.

20% of Charges
Up to a maximum
benefit of \$1,000
per benefit year.

MENTAL HEALTH SERVICES

Mental health care is provided when referred by a Universal Care contracted physician. Initial Evaluation by a licensed Mental Health Provider (Psychiatrists, Psychologists, MFCC, MFT, or Therapist with a Masters Degree) upon referral by a PCP is covered, subject to office visit copayment equal to the medical office visit copayment.

1. Mental Health assessment, diagnosis, and referral by PCP
2. Initial evaluation by a licensed mental health practitioner or provider, if required
3. Conditions covered with the same limitations as medical coverage. Confirmed diagnosis of Schizophrenia, Schizoaffective disorder, Bipolar disorder, Major depressive disorders, Panic disorder, Obsessive-Compulsive disorder, Anorexia Nervosa, Bulimia Nervosa, and Autism and Serious Emotional Disturbances of children.
4. For conditions not covered under Section 3 above: Up to fifty (50) minutes with psychologist (Ph.D) or therapist with Master's degree office visit or by telephone.

CHEMICAL DEPENDENCY SERVICES

Alcohol and Drug Use Services: (Detoxification Only)

- Outpatient (limited to 20 visits per benefit year)
- Inpatient (limited to 72 hours per occurrence and a maximum of 18 days per benefit year)

HOME HEALTH SERVICES

Home Health Care

FAMILY PLANNING

Family Planning Services:

- Norplant, IUD, diaphragm, cervical cap (insertion only, device not covered)
- Depo-Provera Injection
- Vasectomy (male sterilization)
- Tubal ligation (female sterilization)
- Information and instruction on methods of birth control
- Interruption of pregnancy: Medically Necessary
- Interruption of pregnancy: not Medically Necessary and under twenty (20) weeks of gestation.
- Infertility studies and treatment

Personal Plan 10

Subject to office visit copayment

Subject to office visit copayment

Outpatient services:
Copayment is equal to medical office visit.

Inpatient services:
Copayment is equal to inpatient hospital benefit.

\$40 Copayment
(20 visits per 12 month period)

\$20 Copayment

\$250 Copayment per admission, additional Inpatient Hospital Care benefits as set forth under "Benefits While Hospitalized as an Inpatient."

\$10 Copayment

\$10 Copayment

\$30 Copayment

\$150 Copayment

\$150 Copayment

No Charge

No Charge

\$150 Copayment

No Benefit

Personal Plan 20

Subject to office visit copayment

Subject to office visit copayment

Outpatient services:
Copayment is equal to medical office visit.

Inpatient services:
Copayment is equal to inpatient hospital benefit.

\$40 Copayment
(20 visits per 12 month period)

\$20 Copayment

\$500 Copayment per admission, additional Inpatient Hospital Care benefits as set forth under "Benefits While Hospitalized as an Inpatient."

\$20 Copayment

\$20 Copayment

\$30 Copayment

\$150 Copayment

\$150 Copayment

No Charge

No Charge

\$150 Copayment

No Benefit

HEALTH EDUCATION

General Health Education Services

DENTAL TREATMENT ANESTHESIA

DIABETES MANAGEMENT AND TREATMENT

MATERNITY CARE

The Health Plan will exclude coverage for twelve (12) months following the effective date of coverage, for any services or expenses related to a pregnancy, including complications of pregnancy and delivery, for which medical advice, diagnosis or care of treatment was recommended or received during the twelve (12) months immediately preceding the effective date of coverage.

The exclusion of coverage period is reduced for periods of Qualifying Prior Coverage maintained by persons applying for coverage under this Health Plan within thirty (30) days of termination of the prior coverage.

Prenatal and Postnatal Care

Normal Delivery, Cesarean Section, Complications of Pregnancy

OUT-OF-POCKET MAXIMUM

The maximum that a Member or family will be required to pay in Copayments each year. After maximum Copayments have been paid, Universal Care will pay 100% of covered services provided.

This Summary of Benefits is not a contract. The Individual Subscriber Agreement must be consulted for the exact terms and conditions of coverage. The benefits described in this matrix are effective July 1, 2003, and supercede any other forms.

Personal Plan 10

No Charge for regular plan programs. Reasonable Charges for special programs made available to Plan Members.

\$10 Copayment

\$10 Copayment

\$10 Copayment
No Charge

\$2,500/Member/year
\$7,500/family/year
(does not include Prescription Drugs or DME)

Personal Plan 20

No Charge for regular plan programs. Reasonable Charges for special programs made available to Plan Members.

\$20 Copayment

\$20 Copayment

\$20 Copayment
20% of Charges

\$2,500/Member/year
\$7,500/family/year
(does not include Prescription Drugs or DME)

PRINCIPAL EXCLUSIONS AND LIMITATIONS OF BENEFITS

- A. All services which are obtained without authorization from Member's Contracting Medical Group or Universal Care's Medical Director (except for Emergency or Urgently Needed Services) and except for obstetrical and gynecological physician services obtained directly from an OB/GYN or Primary Care Physician affiliated with your Contracting Medical Group.
- B. Any service obtained prior to Member's start date of coverage or subsequent to the date coverage terminates, except as specified in the Evidence of Coverage and Disclosure Form with respect to certain Members who have become totally disabled.
- C. Services provided by non-Contracting Providers when the Member has refused treatment provided or authorized by Member's Contracting Medical Group.
- D. Services which, in the judgment of Universal Care or Your Contracting Medical Group, are not Medically Necessary.
- E. Services which are part of a plan of treatment for a non-Covered Service and which are the sole, direct and predictable consequence of such Non-Covered Service; provided, however, that Universal Care will not exclude coverage for Medically Necessary services required to treat an illness or injury that may be a consequence of Non-Covered Services but are not predictable in advance, such as unexpected complications of surgery.

OTHER EXCLUSIONS AND LIMITATIONS

- A. Cosmetic or reconstructive surgery, used to alter or reshape normal structures of the body in order to improve appearance, is not covered, except as provided under the reconstructive surgery benefit above. When services are determined to be cosmetic, all services to be provided as part of the cosmetic treatment plan are also excluded, including hospital, physician, medical supplies and medications (injectable, intravenous or taken by mouth).
- B. Inpatient mental health care services are not covered, other than the diagnosis and Medically Necessary treatment of serious emotional disturbances of a child and the following severe mental illnesses: schizophrenia, schizoaffective disorder, bipolar disorder-manic-depressive illness, major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa.
- C. Rehabilitative programs, including treatment for chronic alcoholism, drug addiction, or other substance abuse are not covered.
- D. Services (including educational programs) that are primarily oriented towards treating a social, developmental or learning problem rather than a medical problem, including dyslexia and behavioral modification therapy are not covered.
- E. Custodial or domiciliary care, extended care, homemaker services, respite care, convalescent care or extended care not requiring skilled nursing care are not covered.
- F. Experimental or investigational treatments are not covered unless required by an external, independent review panel pursuant to California Health and Safety Code Section 1370.4. Please refer to the section of this document titled, "Independent Review of Experimental or Investigational Treatment".
- G. Personal or comfort items, including diapers that are prescribed or recommended by a physician, are not covered unless Medically Necessary.
- H. Private hospital rooms during inpatient hospitalization are not covered unless: (1) semi-private room is not available; or (2) it is determined to be Medically Necessary.
- I. Whole blood that has not been replaced, plasma and any specially processed derivative are not covered. Only the administration of blood products is covered.
- J. Blood bank fees are not covered.
- K. Hearing aids and implantable hearing devices are not covered. Audiology services (other than screening for acuity) are not covered. Hearing aid supplies are not covered. Implantable hearing devices are not covered, except that cochlear devices for bilateral, profoundly hearing impaired individuals not benefited from conventional amplification (hearing aids) are covered.
- L. Personal or home-based artificial kidney equipment is not covered.
- M. Specialized footwear, including foot orthotics, custom made orthopedic shoes or customized footwear, that is not permanently attached to an orthopedic brace is not covered.
- N. House calls by a Physician are not covered, unless authorized by the Member's Contracting Medical Group.
- O. Routine foot care, including, but not limited to, removal and reduction of corns and calluses, clipping of toenails, treatment for flat feet, fallen arches and chronic foot strain, is not covered, except when determined to be Medically Necessary.
- P. Chiropractic and Acupuncture services are not covered.
- Q. Procedures, services, medications and supplies related to sex transformations are not covered.
- R. Eye examinations by an optometrist, as well as any eyeglass appliance, including, but not limited to, corrective lenses and frames, contact lenses, contact lens fitting, and measurements, are not covered. Keratotomy procedures and other refractive surgical procedures are not covered unless a specialized vision supplemental benefit is purchased.
- S. Dental care is not covered. Dental care includes all services required for prevention and treatment of diseases and disorders of the teeth and gums, including but not limited to: x-rays, routine fluoride treatment, plaque removal, tooth decay, dental embryonal tissue disorders, periodontal disease, tooth extraction, replacement of missing teeth, dental implants, dentures and other oral prosthetic devices unless a specialized dental supplemental benefit is purchased.
- T. Treatment for disabilities connected to military services for which the Member is legally entitled to services through a federal government agency and to which the Member has reasonable accessibility.
- U. Universal care does not provide coverage for infertility diagnosis, treatment or services for this plan. This includes all forms of in-vitro fertilization (IVF) and zygote intrafallopian transfer (ZIFT), as well as procedures related to IVF or ZIFT; ovum transplants; ovum or ovum bank charges; and the Medical or Hospital Services incurred by surrogate mothers who are not Universal Care Members are not covered. Medication for the diagnosis and treatment of infertility is not covered. Male infertility treatment is not covered. Any and all procedures that manipulate the human ova, as well as all services that support the carrying out of these procedures are not covered. Sperm, sperm bank and ovum bank charges are not covered.
- V. Marriage or family counseling is not covered, except for outpatient crisis intervention.
- W. Family Planning Services:
 - Norplant, Intra-uterine device (IUD), diaphragm, and cervical cap devices are not covered.
 - Depo-Provera medication is not covered.
 - Voluntary interruption of pregnancy when not Medically Necessary only covered through twenty

(20) weeks. Voluntary interruption of pregnancy after the twentieth (20th) week is covered only when the mother's life is in jeopardy.

- X. Reports, evaluations, examinations or hospitalizations required for employment, insurance examinations, licensing, camp or school, including sports physicals, or other organizational activities, are not covered.
- Y. Medical Services or Hospital Services for which a Contracting Provider or a Non-Contracting Provider is paid under the Medicare program are not covered.
- Z. Medical Services or Hospital Services for which a Contracting Provider or a Non-Contracting Provider is paid under the Workers' Compensation payer (including, but not limited to, any Workers' Compensation carrier, self-funded employer or employer association, or the State uninsured employers' fund) are not covered.
- AA. Reversal of voluntary, surgically induced sterilization is not covered.
- BB. Medical and Hospital Services of an organ donor or prospective organ donor are not covered when the recipient of an organ transplant is not a Member.
- CC. Organ transplants not Medically Necessary and organ transplants considered Experimental or Investigational are not covered, unless required by an external, independent review panel pursuant to California Health and Safety Code Section 1370.4. Please refer to the section of this document titled, "Independent Review of Denied Experimental or Investigational Treatment". Organ transplants must be performed at a Universal Care designated transplant center.
- DD. The following items of durable medical equipment are not covered: deluxe equipment, such as motor driven wheelchairs and beds; items that are not primarily medical in nature or that are for the Member's comfort and convenience, such as bedboards, bathtub lifts, overbed tables, adjust-a-beds, ramps, telephone arm and air conditioners; replacement, repair or routine periodic maintenance of durable medical appliances purchased or leased by the Health Plan; physicians' equipment such as stethoscopes and blood pressure monitoring devices; exercise and hygienic equipment, such as exercycles; Moore Wheels, bidet toilet seats and bathtub seats; self-help devices that are not primarily medical in nature, such as humidifiers, sauna baths and elevators; and items deemed, in the opinion of the Universal Care Medical Director, to be experimental or research equipment. Corrective appliances, prosthetics and durable medical equipment purchase or rental is limited to initial placement, repair or adjustment, and replacement due to normal wear and tear or because of a significant change in the Member's physical condition (as determined by Member's Contracting Medical Group).
- EE. Acupressure, biofeedback, hypnotherapy, sleep therapy and behavioral training are not covered.
- FF. Bone-marrow transplants are not covered when they are Experimental or Investigational, unless required by an external, independent review panel pursuant to California Health and Safety Code Section 1370.4. Please refer to the section of this document titled, "Independent Review of Denied Experimental or Investigational Treatment".
- GG. Eating disorder programs (inpatient or outpatient) for dietary control and weight loss surgery or other treatment of obesity, including but not limited to food and food supplements, laboratory tests in association with weight reduction programs, or vitamins are not covered.
- HH. Care for conditions for which state or local law requires treatment in a public facility are not covered. Emergency or Urgently Needed Services required after participating in a criminal act are covered only until the Member is stabilized and placed on a police hold. Notwithstanding the foregoing, and in compliance with California Health & Safety Code Section 1374.12, this provision shall not restrict Universal Care's liability for Covered Services solely because such services were provided while the Member was in a state hospital.
- II. Universal Care is not responsible for unusual circumstances, such as complete or partial destruction of facilities, war, riot, labor disputes, disability of a significant number of personnel, or similar events which result in delay in providing services in or ability to provide services. The Health Plan will make alternative arrangements, as it is able and as necessary and appropriate.
- JJ. Except for the diagnosis and Medically Necessary treatment of the following severe mental illness (including schizophrenia, schizoaffective disorder, bipolar disorder-manic-depressive illness, major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa) and/or serious emotional disturbances of a child, mental health services are limited to outpatient short term or crisis intervention services, up to a maximum of twenty (20) sessions per Benefit Year.
- KK. Any travel immunization's not recommended and approved by the Center for Disease Control are not covered.
- LL. Circumcision without medical necessity is not a covered benefit.
- MM. Infertility diagnosis, treatment and services are not covered.
- NN. Artificial insemination is not covered.
- OO. Conception by artificial means, including surrogate maternity services are not covered.
- PP. The number of visits of inpatient rehabilitation/subacute care is limited by a demonstration of significant improvement within the total number of days allowed by your participating benefit schedule.
- QQ. The maximum outpatient pharmacy benefit is \$3000 per Benefit Year.
- RR. Physical therapy, speech therapy, occupational therapy and other outpatient rehabilitative treatments are limited to thirty (30) sessions for any injury, illness or congenital abnormality. An additional thirty (30) sessions, up to a maximum of sixty (60) sessions total, will be covered if, in the opinion of the participating physician and Medical Director of Universal Care or Contracting Medical Group, significant improvement will result from such treatment.
- SS. The maximum Durable Medical Equipment benefit is \$1,000 per Benefit Year.
- TT. Skilled Nursing Care is limited to care received in a Skilled Nursing Facility for up to sixty (60) days per benefit year when Medically Necessary.
- UU. Vision care other than for the determination of the need for vision correction for members through age eighteen (18).
- VV. Hearing examinations other than for the determination of the need for hearing correction for members through age eighteen (18).
- WW. The annual copayment maximum excludes prescription drugs and DME.
- XX. Upon referral to a clinical cancer trial by the member's treating physician, Universal Care will cover the routine patient care costs for member's participation in a cancer clinical trial, subject to the specific requirements of Section 1370.6 of the California Health and Safety Code.

PRESCRIPTION PROGRAM

DEFINITIONS:

Formulary: a continually updated list of prescription medications that are approved by the Universal Care Pharmacy and Therapeutics ("P&T") Committee, which is comprised of physicians and pharmacists. The formulary contains both brand-name drugs and generic drugs, all of which have Food and Drug Administration ("FDA") approval. Members who would like additional information about the Formulary should contact Universal Care's Contracted Medical Group Pharmacy Services Department at 1-800-635-6668 x4100.

Contracting Pharmacy: a pharmacy that has contracted with Universal Care to provide outpatient prescription drugs to Members at negotiated costs.

Non-Contracting Pharmacy: a pharmacy that has not contracted with Universal Care.

Pre-Authorization: the review process whereby Universal Care determines the Medical necessity of a prescription drug prior to the Member receiving such prescription drug from a pharmacy.

COVERED PRESCRIPTION DRUGS

The drug benefit will be provided for the following prescription drugs contained on the Formulary, and for non-Formulary drugs and selected Formulary drugs when pre-authorized under the procedure described below, when Medically Necessary and ordered by a Universal Care Contracting Physician and filled at a Contracting Pharmacy:

1. Federal Legend Drugs: Any medicinal substance which bears the legend: "Caution: Federal law prohibits dispensing without a prescription".
2. State Restricted Drug: Any medicinal substance, which may be dispensed by prescription only according to State law.
3. Compounded Medication: Any medicinal substance, which has at least one ingredient that is Federal Legend or State Restricted in a therapeutic amount.
4. Generic Drugs: For brand-name drugs that have FDA-approved generic equivalents, prescriptions will be filled with a generic drug unless a brand-name drug is Medically Necessary and pre-authorized by Universal Care. Notwithstanding the foregoing, Member may request that a prescription be filled with a brand-name drug that has one or more FDA-approved generic equivalents and is not included on the Formulary by paying the non-Formulary copayment amount. Please refer to the schedule of Copayment Requirements in the "Prescription Drug Benefit" section of this EOC for further information on generic drug benefits.

PRE-AUTHORIZATION FOR ALL NON-FORMULARY DRUGS AND SELECTED FORMULARY DRUGS – All non-Formulary drugs and selected Formulary drugs must be Pre-authorized as Medically Necessary by Universal Care in order to be covered. Pre-authorization requests may be initiated by Member's Universal Care Contracting Physician. Universal Care's pre-authorization review process for selected Formulary drugs is to ensure that the drugs are Medically Necessary and being utilized according to treatment guidelines consistent with good professional practice. Non-Formulary drugs, which are not a benefit exclusion, may be Pre-authorized in any of the following instances:

1. No Formulary alternative is appropriate and the drug is Medically Necessary for patient care, as determined by Universal Care, consistent with professional practice.
2. The Formulary alternative has failed after a therapeutic trial. Member's Universal Care Contracting Physician will be asked to provide a copy of the medical chart notes, pharmacy history, lab results, etc. specifically stating treatment failure with the Formulary alternative.
3. The Formulary alternative is not medically appropriate as determined by a clinical review of Physician chart notes or other requested information.
4. The Member has been under treatment of a Universal Care Plan and remains stable on a non-Formulary prescription drug and conversion to a Formulary drug would be medically inappropriate.
5. The Member experiences a typical allergic reaction or established adverse effects relating to the pharmacological properties of the Formulary drug which are attributed to formulations or differences in absorption, distribution or elimination.

EXCLUSIONS AND LIMITATIONS RELATED TO THE OUTPATIENT PRESCRIPTION DRUG BENEFIT – Prescription drug benefits will not be covered for any prescription covering or prescribing the following:

1. Non-Formulary drugs and Formulary drugs that require Pre-Authorization and are not Pre-Authorized by Universal Care.
2. Drugs or medicines purchased and received prior to the Member's effective date or subsequent to the Member's termination.
3. Therapeutic devices or appliances including hypodermic needles, syringes (except insulin syringes), support garments and other non-medicinal substances (except as noted above).
4. Non-FDA approved contraceptive devices and supplies, however Universal Care Health Plan covers a variety of FDA-approved prescription contraceptive methods as described under Family Planning, above.
5. Medications to be taken or administered to the eligible Member while he or she is receiving Covered Services in a hospital, rest home, nursing home, Skilled Nursing Facility or other similar facility, since such medications are covered under the inpatient benefit.
6. Drugs or medicines delivered or administered to the Member by the Contracting Provider or the Contracting Provider's staff.
7. Dietary supplements, including, but not limited to, vitamins (except prenats), fluoride supplements, health or beauty aids, diet pills, formulas (except PKU), liquid nutrition products, and antioxidants.
8. Medications prescribed for experimental or investigational therapies, unless required by an independent medical review organization pursuant to the section titled "Independent Review of Denied Experimental or Investigational Treatment".

9. Non-FDA approved indications unless the drug is prescribed by a Contracting Physician for the treatment of a life-threatening condition; or the drug is prescribed by a Contracting Physician for the treatment of a chronic and seriously debilitating condition, the drug is Medically Necessary to treat that condition, and the drug is on the Health Plan Formulary. If the drug is not on the Health Plan Formulary, the drug shall be subject to pre-authorization by Universal Care. All non-FDA approved indications must be recognized for treatment of the indicated condition by one of the following: the American Medical Association Drug Evaluations; the American Hospital Formulary Services edition of Drug Information; the United States Pharmacopoeia Dispensing Information, Volume I "Drug Information for the Health Care Professional"; two articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal.
10. Medications available without a prescription (over the counter) or for which there is a non-prescription equivalent available, even if ordered by a Contracting Physician.
11. Drugs or medicines prescribed for cosmetic purposes.
12. Medications prescribed by non-Contracting Physicians, except for prescriptions required as a result of Emergency or Urgently Needed services.
13. Smoking cessation products including, but not limited to, nicotine gum and nicotine nasal spray.
14. Injectable drugs, except insulin.
15. Drugs purchased at a non-Contracting Pharmacy.
16. Anabolic steroids unless Medically Necessary.
17. Medication which may be properly received without charge under local, state or federal programs or which is reimbursable under other insurance programs including workers' compensation.
18. Medication for the diagnosis and treatment of infertility is not covered.
19. The maximum outpatient pharmacy benefit is \$3,000 per Benefit Year.

Dispensing Quantity Limitations - The amount of drug that may be dispensed per prescription or refill will be one Prescription Unit as consistent with good professional practice, not to exceed more than thirty (30) days or as noted in the Universal Care Formulary. Maintenance medications as noted in the Universal Care formulary may be dispensed up to a three (3) month supply and available only from Universal Care's contracted mail order vendor.

If a Universal Care Contracting Pharmacy Is Not Available - The Outpatient Prescription Drug Benefit is honored ONLY at Contracting Pharmacies. Members are eligible for direct reimbursement only if a Contracting Pharmacy was not available or accessible. In this situation the Member will be required to pay the price of the prescription and should file for reimbursement. For direct reimbursement, the Member must send to Universal Care the following information:

1. Copies of the receipts, etc., showing the name of the drug, date filled, pharmacy name, name of Member for whom the prescription was written, and proof of payment.
2. A statement describing why a Contracting pharmacy was not available to the Member.
3. The above information should be sent to the following address:
Universal Care Claims Department
ATTN: Pharmacy Claims
P.O. Box 16420
Signal Hill, CA 90755-3682.

If request for reimbursement is determined to be appropriate, payment will be forwarded to the Member.

UNIVERSAL CARE'S FORMULARY

Universal Care uses a comprehensive Formulary as a method of evaluating various drug products available to treat illnesses. The Formulary is a list of covered and preferred medications that are:

- FDA approved for specified indications;
- Reviewed by Universal Care with participation by practicing Physicians;
- Safe and effective as well as Medically Necessary for the treatment or maintenance of a medical condition; and
- Cost effective for the treatment of the medical condition.

Universal Care's Pharmacy and Therapeutics Committee, which is comprised of Physicians and pharmacists, meets on a bi-monthly basis to review and update medications for inclusion or exclusion from the Formulary. Results from these meetings are published and distributed to Contracting Physicians via newsletters and updates.

The Formulary is available upon request. Simply contact your Member Services Representative at 1-800-673-4666. Please be advised that your Physician will determine when you require a particular medication along with the correct dosage.

A Physician or pharmacist must request an exception process for those drugs not listed on the Universal Care Formulary should he/she believe that a particular medication is required by an enrollee. This provider must obtain Pre-authorization from Universal Care via a medical exception review process. This means that he/she must complete a non-Formulary drug request form and submit it to Universal Care for review. Either a pharmacist or Physician will review the request within two (2) days of receipt from the Health Plan Physician. Once the determination for the non-Formulary request is complete, written notification will be forwarded to the Health Plan Physician. Written notification will also be forwarded to the Member only for those requests that have been modified or denied.

PERSONAL PLAN

APPLICATION AND ENROLLMENT FORM

Benefit Plan (check appropriate choice)

- Personal Plan 10 Personal Plan 20
 Dental Plan Other

Check Desired Network:

- Universal Care Network
 ChampionHEALTH Network



1600 East Hill Street
 Signal Hill, CA 90755-3682
800-380-2522
 www.universalcare.com

Requested Effective Date

Month	Date	Year

- New Enrollment Addition of Dependent Change of CMG/IPA Physician

Actual effective date will be assigned by the Underwriting Department of Universal Care upon acceptance. Please allow 30 days for processing.

Individual / Family

The Applicant Certifies the following Information:

(Indicate the younger spouse as the applicant)

Last Name		First Name		M.I.	Home Phone No. ()	
Home Address <small>Must be complete – P.O. Box not acceptable</small>				E-Mail Address		
City		County		State	Zip Code	Work Phone No. ()
Employer				Occupation		Date of Hire Month Day Year
Applicant's Employer Address				City	State	Zip Code
Spouse's Occupation		Spouse's Employer		Work Phone No. ()		
Spouse's Employer Address				City	State	Zip Code

Applicant / Family Information

List *yourself* and all eligible family members to be enrolled. If a listed family member's name is different from yours, please explain below. *Height and weight must be stated accurately.*

Provider Selection:

For Universal Care Network, please select a Contracting Medical Group (CMG) or a physician from an Independent Practice Association (IPA) for each family member.

For ChampionHEALTH Network, please select a location for each family member.

Last Name	First Name	M.I.	Height/Weight	Date of Birth	Social Security #	CMG/IPA Physician / Champion Location	Physician No.	Check if current patient
Applicant <input type="checkbox"/> M <input type="checkbox"/> F				Month Day Year				
Applicant <input type="checkbox"/> M <input type="checkbox"/> F				Month Day Year				
Applicant <input type="checkbox"/> M <input type="checkbox"/> F				Month Day Year				
Applicant <input type="checkbox"/> M <input type="checkbox"/> F				Month Day Year				
Applicant <input type="checkbox"/> M <input type="checkbox"/> F				Month Day Year				

Different last name explanation:

If Available, I would prefer to receive materials in the following language. _____.

The following information is voluntary and will help us to better serve your needs. Please check the ethnicity with which you most closely identify.

- Alaskan/Native American African American Asian/Pacific Islander
 Caucasian Hispanic Other

Health Questionnaire

Has any person listed in this application ever had any signs or symptoms, been consulted for, received advice, sought treatment, had treatment recommended, received treatment or been hospitalized for any of the following conditions? All questions must be checked *Yes* or *No*, circle the conditions applicable and provide the information requested below.

		YES	NO			YES	NO
1.	Brain/nervous system - dizziness, headaches, seizure disorder, loss of consciousness, epilepsy, paralysis, any neuromuscular disease such as: muscular dystrophy, multiple sclerosis, stroke, ALS, cerebral palsy, polio, mental retardation, history of malignant or nonmalignant tumor?	<input type="checkbox"/>	<input type="checkbox"/>	9.	Skin conditions - skin cancer, melanoma, psoriasis, keratosis, herpes, warts, birthmarks, burns, Erythema Nodosum, caposi sarcoma, hemangioma, port wine birth marks?	<input type="checkbox"/>	<input type="checkbox"/>
2.	Cardiovascular system - heart or valve problems, coronary artery disease, heart attack, congestive heart failure, heart murmur, pericarditis, mitral valve prolapse, mitral regurgitation, rheumatic fever, palpitations, high blood pressure, shortness of breath, chest pain, previous open heart surgery, congenital heart disease, palpitations, fainting spells?	<input type="checkbox"/>	<input type="checkbox"/>	10.	Metabolic system - diabetes, gout, thyroid or adrenal disorders, hormone or growth hormone deficiencies, immune system disorders, lupus, erthematosis, Raynaud's disease, acquired immune deficiency syndrome (AIDS), AIDS-related complex (ARC), including evaluation for treatment with AZT or Pentamidine therapy? (CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH CARE SERVICE PLANS AS A CONDITION OF OBTAINING COVERAGE)	<input type="checkbox"/>	<input type="checkbox"/>
3.	Circulatory system - varicose veins, peripheral vascular disease, phlebitis, blood clots, stroke, bleeding problems, blood disorder; anemia, enlarged lymph nodes, white blood cell problems; red blood cell problems, platelet disorder?	<input type="checkbox"/>	<input type="checkbox"/>	11.	Diseases or problems of the eyes or sight, ears or hearing, nose or breathing, throat or swallowing - such as: any infections, crossed eyes, cataracts, detached retina, polyps, deviated nasal septum, nose bleeds, hoarseness, ringing in the ears, growths in the ears, nose, mouth or eyes, excessive smoking, neoplasm of the eye, previous trauma to the eyes, ears, nose or throat?	<input type="checkbox"/>	<input type="checkbox"/>
4.	Respiratory tract - asthma, reactive airway disease, bronchitis, hay fever, allergies, sinusitis, lung/chest problems of any kind, emphysema, tuberculosis, spitting or coughing up blood, shortness of breath, pneumonia, cystic fibrosis, pulmonary fibrosis, chronic obstructive pulmonary disease, lung tumor benign or malignant, fungal disease of the lung, sarcoidosis?	<input type="checkbox"/>	<input type="checkbox"/>	12.	History of cancer, tumor, cysts in any location or organ of the body?	<input type="checkbox"/>	<input type="checkbox"/>
5.	Digestive system - mouth, tongue, esophagus or stomach problems, ulcer, gall bladder disorder, liver disease, cirrhosis, jaundice, ascites, hepatitis, pancreatis, colon, intestinal or rectal problems, colitis, chronic diarrhea, hemorrhoids, hernia, weight or eating problems, Hirschsprungs Disease, Crohns, ulcerative colitis, blood in stool, vomiting of blood?	<input type="checkbox"/>	<input type="checkbox"/>	13.	Alcoholism, drug dependency or substance abuse?	<input type="checkbox"/>	<input type="checkbox"/>
6.	Urinary tract - renal colic, gravel or stone, urethra, bladder or kidney problems, infections, stricture, pyelonephritis, kidney tumor; blood in urine, tumor of the ureter or urethra or bladder, previous trauma to the bladder or genitals?	<input type="checkbox"/>	<input type="checkbox"/>	14.	Presently a member of a support group? How long?	<input type="checkbox"/>	<input type="checkbox"/>
7.	Male reproductive system - prostate problems, infertility, impotency, infections, herpes, syphilis, gonorrhea, or other venereal disease, infection or inflammation of the testicle, born with only one or no testicles, or history of undescended testicles, cancer of the testicles, cancer of the prostate, cancer of the penis?	<input type="checkbox"/>	<input type="checkbox"/>	15.	Congenital anomaly of any organ, birth defects - Down's syndrome, Cerebral Palsy, cleft lip or palate, clubfoot, development delay, mental retardation, or other neurological or physical abnormalities?	<input type="checkbox"/>	<input type="checkbox"/>
8.	Female reproductive system - breast problems including implants, adhesions, abnormal bleeding, endometriosis, fibroid tumors, abnormal Pap tests, problems of the ovaries, uterus and associated female organs, infertility, infections, genital warts, herpes, syphilis or other venereal disease, excessive bleeding during menses, abnormal menses, excessive hair on face or abdomen, Turner's syndrome, Stein-Leventhal syndrome?	<input type="checkbox"/>	<input type="checkbox"/>	16.	Is any applying family member expecting to be a mother or father (expecting a child)? Expected delivery or adoption date: _____	<input type="checkbox"/>	<input type="checkbox"/>
				17.	Musculo-Skeletal system - neck, spine/back sprain, pain, injury, or problems; sciatica, curvature of the spine, scoliosis; any pain, injuries, or problems of the joints, bones, or muscles; arthritis; rheumatoid arthritis, temporal/mandibular joint syndrome (TMJ), Lyme disease, fractures/residual hardware, dislocations, bunions, hammertoe, carpal tunnel syndrome, physically handicapped, polio, any amputation, plantar warts, chronic heel pain, chronic muscle pain or cramping?	<input type="checkbox"/>	<input type="checkbox"/>

Please explain and provide us with FULL DETAILS for each "Yes" answer to any condition(s) checked in the preceding boxes. Include name of family member, nature of illness, dates and duration of treatment. In addition, please give details below of last doctor visit and/or physical examination for all family members listed regardless of the date or reason.



Attach additional sheets if necessary.

Condition No.	Family Member Name (Name used on doctor's record)	Name of hospital, full name of every physician or clinic (include zip code)	Name of condition(s) or illness(es) treated	Indicate treatment rendered such as check-ups, x-rays, lab and surgical procedures, etc.
<input type="checkbox"/>	Name Medical Record Number (if known) Date Began: Mo. _____ Yr. _____ Still under treatment: <input type="checkbox"/> Yes <input type="checkbox"/> No Date Ended: / /	Name Address City State Zip Phone ()		Medication Taken: Date Prescribed: Dosage:
<input type="checkbox"/>	Name Medical Record Number (if known) Date Began: Mo. _____ Yr. _____ Still under treatment: <input type="checkbox"/> Yes <input type="checkbox"/> No Date Ended: / /	Name Address City State Zip Phone ()		Medication Taken: Date Prescribed: Dosage:
<input type="checkbox"/>	Name Medical Record Number (if known) Date Began: Mo. _____ Yr. _____ Still under treatment: <input type="checkbox"/> Yes <input type="checkbox"/> No Date Ended: / /	Name Address City State Zip Phone ()		Medication Taken: Date Prescribed: Dosage:

Health Questionnaire continued

	YES	NO	Please answer each question. If yes, please provide details in the space provided.	
• Have any applying persons ever smoked cigarettes, cigars or pipes, or used chewing tobacco products. If yes, how many per 24 hours and for what period of time?	<input type="checkbox"/>	<input type="checkbox"/>	Person:	Packs per day:
			How many years:	When did you/they stop:
• Do any applying persons drink alcoholic beverages?	<input type="checkbox"/>	<input type="checkbox"/>	Person:	Type:
			Drinks per week:	
• Have any applying persons ever had any application for health or life insurance declined, postponed or restricted in any way?	<input type="checkbox"/>	<input type="checkbox"/>	Person:	Please explain:
• Have any applying persons ever requested or received a pension, benefits or payment because of an injury, sickness or disability?	<input type="checkbox"/>	<input type="checkbox"/>	Person:	Please explain:
• Has any applying person had other health coverage (insurance) within the last 6 months? Type of coverage: Single/Family Group HMO Disability Medicare Short Term or Interim Other	<input type="checkbox"/>	<input type="checkbox"/>	Person:	Please explain:
• Have any applying persons ever received any counseling or treatment for symptoms of depression, manic depression, anxiety, panic attacks, nervousness, mental or emotional disorders, schizophrenia, behavior problems, hyperactivity, attention deficit disorder, eating disorders, bulimia, anorexia, alcohol or substance abuse, or for any other reason?	<input type="checkbox"/>	<input type="checkbox"/>	Person:	Please explain:
• Have any applying persons ever been a patient in a hospital, clinic, sanatorium, or other medical facility? For how long and how many years ago?	<input type="checkbox"/>	<input type="checkbox"/>	Person:	Please explain:
• Have any applying persons ever had any surgery including cosmetic/reconstructive surgery?	<input type="checkbox"/>	<input type="checkbox"/>	Person:	Please explain:
• Have any applying persons ever had abnormal laboratory results, blood work, X-rays, EKG's, EMG's, nerve conduction or blood flow studies, CT Scans, MRIs or PET Scans or angiograms?	<input type="checkbox"/>	<input type="checkbox"/>	Person:	Please explain:
• Do any applying persons have a prosthesis, implant, or retained hardware?	<input type="checkbox"/>	<input type="checkbox"/>	Person:	Please explain:
• Have any applying persons been advised to undergo further testing, treatment or surgery which has not yet been performed by a physician, dentist, or other provider?	<input type="checkbox"/>	<input type="checkbox"/>	Person:	Please explain:
• Have any applying persons had any pain or difficulty breathing, chewing, swallowing, jaw problems either medical or dental?	<input type="checkbox"/>	<input type="checkbox"/>	Person:	Please explain:
• Has anyone had treatment in the last 10 years, contacted or seen a physician, psychologist, chiropractor, counselor, therapist or any other person providing health care services?	<input type="checkbox"/>	<input type="checkbox"/>	Person:	Please explain:
• Do any applying persons presently have any condition or illness not mentioned elsewhere on this application or complications or residuals remaining following any treatment?	<input type="checkbox"/>	<input type="checkbox"/>	Person:	Please explain:

Please provide information regarding the last doctor visit and/or physical examinations for ALL persons applying.

Name of Family Member	Date of Visit	Reason For Visit and Results	Name and Address of Attending Physician/Clinic

List all medications taken currently or within the last year by any persons listed on this application.

Name of Family Member	Name and Address of Attending Physician				

List Medication(s)	Date Prescribed	Date Discontinued	List Medication(s)	Date Prescribed	Date Discontinued

Please attach additional sheets of paper to provide further information for the application, if necessary. List the page number, section name and condition you are explaining. Also, please identify the applicable family member.



Attach additional sheets if necessary.

Conditions of Membership and Signature

I, the undersigned, represent that: All information on this application is true and complete to the best of my knowledge, and that no material information has been withheld or omitted concerning the past and present state of the applicant's or any family member's health.

I, the undersigned, understand that: I give my consent to all doctors, hospitals and providers of health services to furnish any and all records pertaining to my family's or my own medical history, including dates of treatment, nature of accident or sickness and record of surgery, patient records of members and any information concerning AIDS (Acquired Immune Deficiency Syndrome) or ARC (Aids Related Complex), which Universal Care requires, to a representative of Universal Care for review and keeping. A photocopy of this request is as valid as the original.

Universal Care will rely upon the accuracy and completeness of the application information, for contracting with or for rejecting the applicant, and the discovery of additional material facts, known by the applicant but not disclosed herein, may result in the rescission or modification of any contract entered into. It is my responsibility to report any changes in my eligibility or that of my dependents.

I AGREE AND UNDERSTAND THAT ANY AND ALL DISPUTES, INCLUDING CLAIMS RELATING TO THE DELIVERY OF SERVICES UNDER THE PLAN AND CLAIMS OF MEDICAL MALPRACTICE (THAT IS AS TO WHETHER ANY MEDICAL SERVICES RENDERED UNDER THE HEALTH PLAN WERE UNNECESSARY OR UNAUTHORIZED OR WERE IMPROPERLY, NEGLIGENTLY OR INCOMPETENTLY RENDERED), EXCEPT FOR CLAIMS SUBJECT TO ERISA, BETWEEN MYSELF AND MY DEPENDENTS ENROLLED IN THE PLAN (INCLUDING ANY HEIRS OR ASSIGNS) AND UNIVERSAL CARE OR

ANY OF ITS PARENTS, SUBSIDIARIES OR AFFILIATES SHALL BE DETERMINED BY SUBMISSION TO BINDING ARBITRATION, ANY SUCH DISPUTE WILL NOT BE RESOLVED BY A LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS THE FEDERAL PROCEEDINGS. ALL PARTIES TO THIS AGREEMENT ARE GIVING UP THEIR CONSTITUTIONAL RIGHT TO HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION.

If the sole Applicant under this application is under 18 years of age, Applicant's parent or legal guardian must sign below as such. In such event, the parent or legal guardian does hereby agree to be legally responsible for the accuracy of information in this Application and for payment of fees. If such responsible party is not the natural parent of the Applicant, copies of the court papers authorizing guardianship must be submitted with this application.

I understand and agree that by enrolling or accepting services under this Health Plan, I and any enrolled dependents are obligated to understand and abide by all terms, conditions and provisions of the Universal Care Subscriber Agreement.

I have read and understand the terms of this Application and my signature below indicates my acceptance of these terms and that the information entered in this Application is complete, true and correct.

Please see the Combined Evidence of Coverage and Disclosure Form, as well as the Individual Subscriber Agreement for additional information on benefit exclusions and limitations.

By my signature below, I acknowledge that I have received a copy of Universal Care's Notice of Privacy Practice.

Attached is my personal check or money order in an amount equal to one month's dues as my deposit. It will be refunded if my application is not approved. If I am accepted, this application will become part of the agreement between Universal Care and myself and enrolled dependents. Coverage is effective upon approval by Universal Care and Notification to Applicant.

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

• **IMPORTANT – ALL SIGNATURES MUST INCLUDE TODAY'S DATE** •

Agent's Certification

I hereby certify that I am not aware of any information not disclosed in this application or enrollment form by my client which may have a bearing on this risk.

I hereby certify that I have advised my client not to terminate any existing coverage until receiving notice that the coverage being applied for by the applicant is accepted.

Writing Agent's Name	Agent #	Telephone Number
Agent's Address		Tax I.D. Number
Agent's Signature		Date
		Month Day Year

 **For Company Use Only**

Reviewed By	Date	Effective Date	Subscriber#	SA#
Approved By	Date		UCR#	GA#

Please make sure you –

- ✓ Completely filled out the Application & Enrollment Form
- ✓ Identified the options you want
- ✓ Identified the Network Selection
- ✓ Completed the Automatic Payment Form
- ✓ Included your first month's premium with the application

Incomplete Applications will be returned to the Applicant.

Call your Agent or Universal Care Representative at **800-380-2522** if you have any questions.

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