CeltiCare II Select PPO Plan

Features/Benefits	Specifics	
Eligibility	Ages 6 months - 64½ years	
Plan Type	Physician and Hospital PPO	
Coinsurance	80/20 Coverage after annual plan ded. of the next $10,000	100% Coverage after annual plan ded.
Annual Plan Deductibles	$500, $1,000, $1,500, $2,500, $5,000	$2,500, $5,000
Out-of-Pocket Maximum* (includes annual plan deductible)	$2,500, $3,000, $3,500, $4,500, $7,000	$2,500, $5,000
Lifetime Maximum	$7,000,000	
Non-Preventive office visits to Network Provider	$15 copay/6 visits per person, per calendar year. 7th and subsequent visits subject to annual plan deductible and coinsurance.	
Labs and X-rays	Radiology, pathology and laboratory charges in an outpatient professional setting are paid at 100% up to $200 per person, per calendar year, then subject to annual plan deductible and coinsurance.	
Emergency Room Deductible (in addition to annual plan deductible)	$250 per visit (waived if admitted to hospital).	
Out-of-Network Services **Doctor and Hospital** (in addition to annual plan deductible)	$1,500 annual deductible. Eligible charges reduced additional 20% per occurrence.	
Hospital	Average semi-private room rate. Intensive care at 4 times the average semi-private room rate.	
Transplants	Covered up to amount negotiated by network if Transplant Network used; capped at $100,000 per procedure if insured goes out of network.	
Ambulance	$3,000 maximum per person, per calendar year, for emergency air or ground ambulance service.	

Value-Added Benefits	Specifics
Healthy Lifestyle Program	Pays 25% of fees for eligible programs that improve physical health. $300 maximum per person, per calendar year.
Rx Discounts	Use your Celtic ID card at more than 50,000 participating pharmacies nationwide and receive discounts on prescription drug purchases.
Non-tobacco Rates and Preferred Rates	Applicants and/or their spouses who have not used tobacco in the past 12 months will receive additional premium savings. Plus, Preferred Rates are available for qualifying applicants.

Optional Features/Benefits	Specifics
Prescription Drug Option (stand alone)	**Prescription Drugs -** Drugs with generic alternatives require the specified copay plus 100% of the cost difference between the drug and the generic alternative. Prescriptions available by mail order with a 90 day supply. **Retail:** **Generic** • No deductible • $20 copay **Brand (Preferred and Nonpreferred/Specialty drugs)** • $100 annual deductible per person, per calendar year • $40 copay for preferred drugs • $75 copay for nonpreferred/specialty drugs
CeltiCare II Plus Option	**Preventive Care -** (Eligibility begins after 90 days of coverage) Eligible expenses for medical services and supplies incurred for preventive care in an asymptomatic individual are covered at 100%, up to $300 per person, per calendar year, which includes up to $50 for routine eye exams. **Supplemental Accident -** Covered at 100% up to $500 per person, per occurrence. **Prescription Drugs -** Same benefit structure as stated above for the stand alone Prescription Drug Option.
Term Life Insurance Option (not available in all states)	Ages 6 months-17 years $10,000 Ages 18-64 years $25,000

* Based on In-Network Services

Note: The total family deductible is the amount equal to three times the per-person annual deductible.
Out-of-pocket maximum is three times the per-person maximum, per calendar year, with no carry over.

CELTICARE II HEALTH PLAN BENEFITS **(May vary by state)**

The CeltiCare II Health Plan pays for the benefits highlighted below provided that four simple criteria are met: 1) The treatment is authorized by a physician; 2) the treatment or diagnosis is for a sickness, bodily injury, complication of pregnancy or as part of a covered wellness program; 3) the treatment is medically necessary; and 4) the expense is a reasonable and customary charge incurred while coverage is in force.

Some eligible expenses listed below are only eligible when the CeltiCare II Plus option and/or a Preferred Provider Organization (PPO) plan is selected and are identified as such.

More detailed descriptions of the CeltiCare II benefits are contained in the Certificate Booklet or Policy.

WHAT IS COVERED?

Hospital and Surgical Charges – Charges by a hospital or physician for medical and surgical services and supplies while hospital confined are eligible expenses. The maximum eligible expense for hospital daily room and board charges for normal care is the average semi-private room rate in that hospital. For intensive care, the maximum eligible expense is four times the average semi-private room rate in that hospital.

Rehabilitation Facility – Inpatient up to 30 days confinement per person, per calendar year.

Extended Care Facility – Up to 12 days confinement per person, per calendar year.

Medical Service Charges – Charges for the following medical services are eligible expenses:

- nonsurgical professional services by a physician or nurse;
- up to 30 outpatient visits per person, per calendar year of rehabilitation therapy;
- up to 30 visits per person, per calendar year of home health care by a home health care agency, but only if a hospital, skilled nursing or extended care facility confinement would otherwise be needed and the visit is prescribed by a physician;
- non-surgical treatment for tonsils, adenoids or hernia and surgical treatment for tonsils, adenoids or hernia after coverage is in force for 6 months;
- one screening by low-dose mammography, per calendar year beginning at age 35;
- up to $500 per person, per calendar year of manipulative therapy;
- if a tubal ligation is performed during a pregnancy or complication of pregnancy, then those charges will be considered as eligible expenses. Tubal ligations and vasectomies performed as outpatient surgery are covered after 12 months of continuous coverage;
- one cytologic screening per calendar year for women age 18 and older;
- coverage for one prostate cancer screening per calendar year for an insured person age 50 and over.

Medical Supply Charges – Charges for the following medical supplies are eligible expenses:

- blood, blood plasma, oxygen and anesthesia and their administration;
- initial artificial limbs or eyes needed to replace natural limbs or eyes that are lost while an insured person's coverage is in force (however, no benefit will be paid for repair or replacement of artificial limbs or eyes, or other prosthetic devices);
- casts, splints, surgical dressings, crutches, and the rental of wheelchairs, hospital beds, and other durable medical equipment;
- diabetic equipment and supplies prescribed by a physician.

Dental & Reconstructive Charges – Treatment of sound, natural teeth due to bodily injury that occurs while the insured person's coverage is in force. Reconstructive surgery needed to correct a bodily injury or sickness that occurs while the insured person's coverage is in force is covered. No benefits will be paid for the prevention or correction of teeth irregularities and malocclusion of jaws by removal, replacement, or treatment on or to teeth or any other surrounding tissue. Cosmetic or reconstructive surgery that is not medically necessary will not be covered.

Psychiatric Care Charges – Hospital, medical service and supply charges for psychiatric care while hospital confined are eligible expenses, up to $2,500 per person, per calendar year. Outpatient psychiatric care visits are paid at 50% of eligible expenses up to a $40 maximum and limited to a maximum of $1,000 per insured, per calendar year. This benefit is limited to a $10,000 lifetime maximum per insured for inpatient and outpatient services combined.

Human Organ and Transplant Charges – Hospital, medical service, and medical supply charges for non-experimental human organ and/or tissue transplant charges are eligible expenses. If the insured person uses the Transplant Network, benefits will be paid up to the amount of the charges negotiated by the Network. In addition, there is a limited travel and lodging benefit. If the insured person elects to have the procedure performed outside the Transplant Network, up to $100,000 will be reimbursed per procedure.

Reconstructive Breast Surgery – Including initial prosthetic devices required as a result of a partial or total mastectomy performed while coverage is in force.

Hospice Care – Hospice care, services and supplies, up to $5,000 per an insured person's lifetime.

Complications of Pregnancy – Complications of pregnancy covered as any other illness. No benefits are paid for a normal pregnancy, normal childbirth, elective Cesarean Section, or elective abortion.

Emergency Room – If an insured person is hospital confined immediately following an emergency room visit, the emergency room deductible will not apply.

Healthy Lifestyle Program – 25% of the charges for eligible programs that improve physical health will be covered up to $300 per calendar year, per insured person. Eligible programs include hospital sponsored or accredited smoking cessation, weight loss or weight control programs, as well as fitness or exercise programs that are offered through hospitals, accredited or licensed health clubs, or YMCA/YWCA programs. The annual deductible does not have to be met for Healthy Lifestyle Benefits to be paid.

The following benefits are only available when the Prescription Drug Option or CeltiCare II Plus Option is selected.

Preventive Care Benefit (after 90 day waiting period) – Services for annual physical examinations and routine diagnostic or preventive testing for an asymptomatic insured person are covered at 100% up to $300 per insured person per calendar year. The insured's annual deductible does not have to be met before preventive care benefits are paid.

Charges for care and treatment that are eligible expenses include: low dose mammographies, routine physical examinations, routine gynecologic visits, immunizations, and laboratory testing. Routine eye exams are covered up to $50 per insured person per calendar year.

Supplemental Accident Benefit – Eligible expenses for the necessary treatment of a bodily injury of the insured person are covered at 100% up to $500 per occurrence if treatment is received within 90 days after the accident causing the bodily injury. The treatment must be ordered or given by a physician. For treatment received after 90 days or for any amount in excess of the $500 benefit maximum per occurrence, the annual deductible and coinsurance will apply. Drugs and medicines that are received after the first day of treatment for this bodily injury shall not be covered under this benefit.

Prescription Drug Option – Drugs with generic alternatives require the specified copay plus 100% of the cost difference between the drug and the generic alternative. Prescriptions available by mail order for a 90 day supply with a copay equal to 3x a one month supply.

Retail:

Generic

- No deductible
- $20 copay

Brand (Preferred and Nonpreferred/Specialty drugs)

- $100 annual deductible per person, per calendar year
- $40 copay for preferred drugs
- $75 copay for nonpreferred/specialty drugs

The following benefits are only available when a Preferred Provider Organization (PPO) plan is selected.

CELTICARE II SELECT PPO PLAN

Network Physician Office Visits – Services performed by a network physician for a symptomatic insured person in an office setting are covered, subject to a $15 per visit copayment amount, up to six visits per person, per calendar year. The office visit covers only management and evaluation services and does not include labs and x-rays.

Non-network Services – The annual deductible is increased by $1,500 and an additional 20% coinsurance applies for all services received from an out-of-network provider (physician and/or hospital). This amount does not apply to the out-of-pocket maximum. Also, the office visit copay does not apply when non-network physicians are used.

CELTICARE II "ANY DOC" PPO PLAN

Physician Office Visits – Services performed by a physician for a symptomatic insured person in an office setting are covered, subject to a $35 per

visit copayment amount, up to six visits per person, per calendar year. The office visit covers only management and evaluation services and does not include labs and x-rays.

Non-network Services – The annual deductible is increased by $1,500 and an additional 20% coinsurance applies for all services received from an out-of-network hospital. This amount does not apply to the out-of-pocket maximum.

If charges by a non-network hospital are incurred by an insured person due to a medical emergency, the annual deductible and coinsurance will be the same as if provided by a network hospital.

CELTICARE II HEALTH PLAN EXCLUSIONS (May vary by state)

Benefits are not paid under any plan for a sickness or bodily injury resulting from:

- any act of war, declared or undeclared, or service in the military forces of any country, including non-military units supporting such forces;
- participation in a riot, felony, or other illegal act or being under the influence of alcohol, drugs or narcotics unless taken as prescribed by a physician;
- suicide or attempted suicide, or self-inflicted bodily injury while sane or insane;

No benefits are paid that are provided:

- free of charge in lieu of this insurance;
- by a government-operated hospital unless the insured person is required to pay;
- for treatment received outside the United States except for a medical emergency while traveling for up to a maximum of 90 consecutive days;

Additionally, no benefits are paid for:

- sickness or bodily injury that arises out of, or as a result of, any work if the insured person is required to be covered under Worker's Compensation or similar legislation.

Other exclusions include:

- normal pregnancy and delivery, elective or repeat cesarean section;
- routine physical examinations and "well-baby" care of a dependent child unless CeltiCare II Plus option is chosen. "Well-baby" care is defined as charges not related to a sickness or bodily injury;
- treatment or surgical procedure relating to fertility, including diagnosis or treatment of infertility;
- birth control (except where state mandated);
- tubal ligations and vasectomies performed while hospital confined are not covered. The reversal of a tubal ligation or vasectomy is not covered at any time;
- treatment or surgery for exogenous, endogenous, or morbid obesity;
- gender reassignment (sex change or reassignment);
- eye refractions, vision therapy, glasses or fitting of glasses, contact lenses, surgical or non-surgical treatment to correct refractive eye disorders, or any treatment or procedure to correct vision loss;
- hearing aids, exams or fittings, or surgical or non-surgical treatment or procedure to correct hearing loss;
- treatment or medication that is experimental or investigational;
- custodial care;
- treatment of drug addiction or chemical dependency;
- myringotomy or dilation and curettage and surgical treatment of tonsils, adenoids or hernia within first 6 months of coverage;
- outpatient prescription drugs.

IMPORTANT PLAN INFORMATION

Eligibility Requirements – To qualify for CeltiCare II coverage, a primary applicant must be six months or over and under 64 1/2 years of age and must not be covered under any other health insurance plan. Applicant must be a United States citizen or a foreign resident who has been living in the United States for at least two years under a permanent visa. Dependents must be 6 weeks or older.

Underwriting – Your CeltiCare II application is individually underwritten based on the health history of you and your dependents to be covered. To effectively underwrite your application, Celtic must obtain as much medical information about you as possible. This is accomplished through the use of health questions on the application form and, in some instances, a follow-up medical questionnaire and/or telephone verification of information. In addition, Celtic may request medical records as necessary. If you answered "NO" to the five health questions on the application, have acceptable occupations/avocations, and are within the Company's height, weight, and age guidelines, your agent can get coverage instantly with QuikCoverage, if available in your state. Otherwise, please mail your application for underwriting.

Credit for Prior Deductibles – If you choose to replace current insurance coverage with the CeltiCare II Health Plan, you will receive credit for satisfying any portion of the previous carrier's deductible in the same calendar year. Copies of EOBs (Explanation of Benefits) are required for proof of deductible.

PLEASE NOTE: Creditable Coverage - Time spent under the CeltiCare II Health Plan may or may not count towards "creditable coverage" as defined in the Health Insurance Portability and Accountability Act, Public Law 104-191. Your individual circumstances, as well as state and federal law, will determine how much, if any, of your coverage under the CeltiCare II Health Plan is creditable coverage.

Pre-existing Conditions – A pre-existing condition is a sickness or bodily injury for which an insured person received a diagnosis, medical advice, consultation, or treatment during the 12 months prior to the effective date, or for which an insured person had symptoms 12 months before the effective date which would cause an ordinarily prudent person to seek medical care or treatment.

CeltiCare II will provide full coverage of pre-existing medical conditions if certain specific guidelines are met. The applicant must fully disclose all pre-existing medical conditions on the application. Then, if they pass our underwriting guidelines, on a standard basis, we'll provide full coverage. Benefits are not paid for an insured person's undisclosed pre-existing condition until coverage has been in force 12 months from the effective date provided coverage was issued on a standard basis.

Term Life Insurance Option - If available in your state, you may elect the Term Life Insurance option, which pays a benefit to the beneficiary if the primary insured person dies. The maximum benefit amount is $25,000 for individuals ages 18-64 years and $10,000 for individuals ages 6 months through 17 years.

When Coverage Begins and Ends – Your effective date will appear on the schedule page of your Certificate Booklet or Policy, provided that you mail in your premium payment with your application and are accepted for coverage. Coverage ends when:

- you fail to make the required premium payments;
- you cease to be an eligible dependent;
- you begin living outside the United States;

Celtic's Health Care Certification Program – Health Care Certification is a benefit which is automatically included in the CeltiCare II Health Plan. The Health Care Certification Program promotes high-quality medical care, and can help you better understand and evaluate your treatment options.

How does it work? – You need to contact the Celtic Health Care Certification Program at 1-800-477-7870 to certify medical treatment. The review team is made up of medical advisors with backgrounds in the medical, surgical, and psychiatric fields. If you have concerns about your proposed treatment, they can help you develop appropriate questions to ask your physician. The medical advisor may also discuss possible alternatives with your doctor if there are any questions regarding the necessity of your treatment. Celtic recommended second surgical opinions are always paid at 100%. Also, in the event of a non-certification there is an appeal process available.

Remember, the final decision for medical treatment is always the right and responsibility of you and your doctor.

What if I don't notify Celtic before treatment? – For all plans non-notification results in an exclusion from eligible expenses of 20% of all charges related to the treatment, if you did not notify the Celtic Health Care Certification Program before treatment.

What if my treatment is considered not medically appropriate and/or not medically necessary? – A "Notice of Non-Certification" is issued to you and your doctor. If you decide to receive the non-certified treatment, no benefits are paid.

IMPORTANT NOTE

The information shown in this brochure and in any accompanying literature is not intended to provide full details of Celtic plans and may change at the discretion of Celtic Insurance Company. Complete terms of coverage are outlined in the individual Certificate Booklets and set forth in the applicable insurance policy. In applying for coverage, the primary insured agrees to be bound by the Certificate or Policy. The benefits described in this brochure and any accompanying literature are the standard benefits offered by Celtic. Policy provisions vary in some states.

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