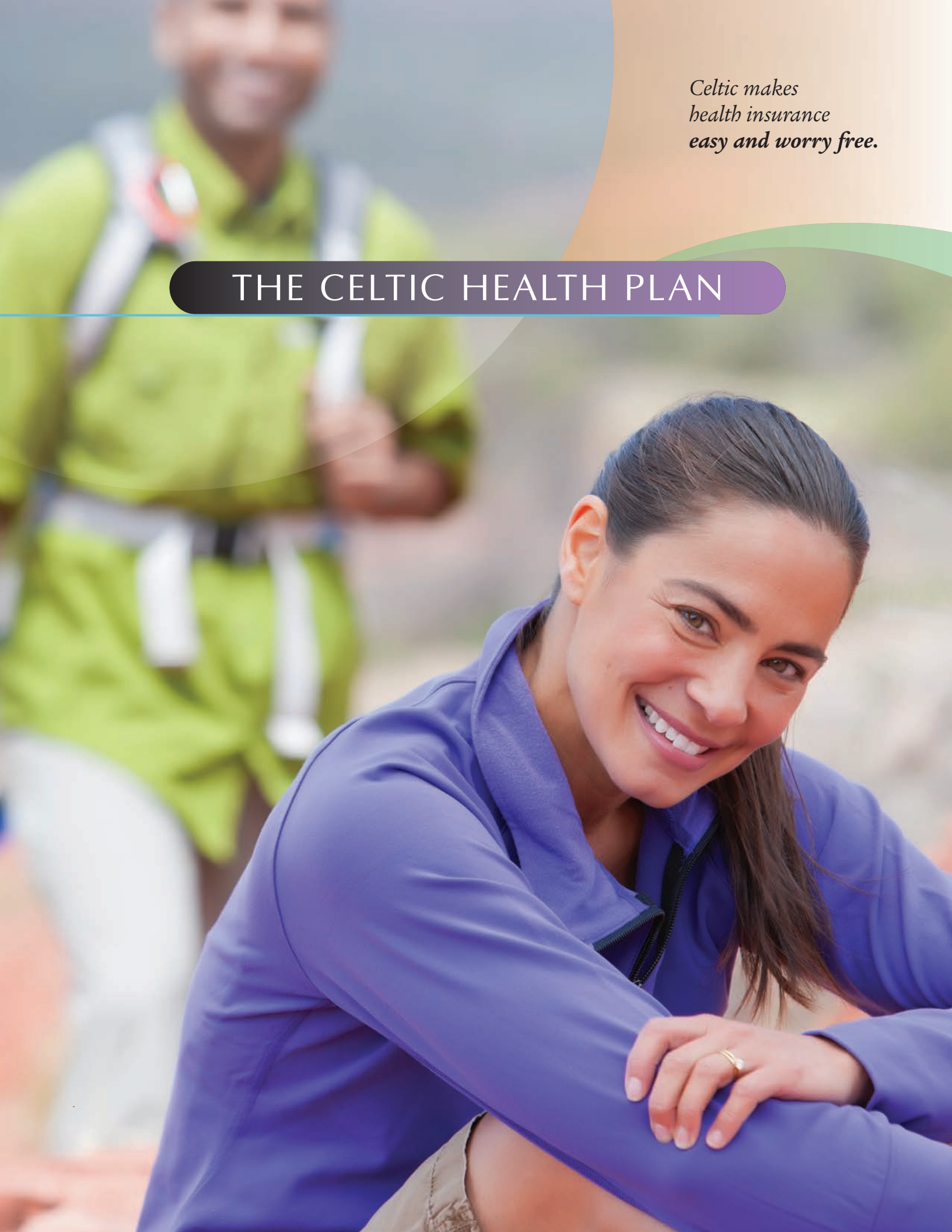
Celtic makes
health insurance
easy and worry free.

THE CELTIC HEALTH PLAN



CELTIC MAKES IT EASY

For information at your fingertips, go to **www.celtic-net.com:**

- Most up-to-date listing of network doctors and hospitals
- Locate a US Script® participating pharmacy near you

GET A QUOTE AND APPLY

Call **1-800-779-7989** to speak with a Consumer Sales Representative to receive a quote or to have an application to apply for a Celtic individual health plan emailed to you. To download an application, go to https://www.celtic-net.com/QuikForms_State_Selection.aspx and select your state from the drop-down menu.

QUESTIONS ABOUT YOUR PLAN?

Celtic makes health insurance easy and worry-free. If you have a question, just call our Client Service Representatives at **1–800-477-7870.** They are available during regular business hours to help with any situation, from claims, billing and pre-authorization, to a change of address. Celtic also offers fast internet services for provider listings and participating pharmacies.

NEED LIVE, PERSONAL ASSISTANCE?

Call **1-800-779-7989** to speak with a Consumer Sales Representative Monday-Friday during regular business hours (CST).

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 Policy Booklets and set forth in the applicable insurance policy. In applying for coverage, the primary insured agrees to be bound by the Policy. The benefits described in this brochure and any accompanying literature are the standard benefits offered by Celtic. Policy provisions vary in some states.

Celtic Health Plan Indemnity

Benefit	In-network
Annual Deductible per calendar year	**Individual:** $6,000; **Family:** $12,000
Coinsurance for eligible expenses	80/20% after Annual Deductible
Out-of-pocket Maximum per calendar year	**Individual:** $6,350; **Family:** $12,700
Physician Office Services	
Primary Care Physician Office Visit	20% Coinsurance after Annual Deductible
Specialist Physician Office Visit	20% Coinsurance after Annual Deductible
Other Practitioner Office Visit	20% Coinsurance after Annual Deductible
Preventive Care (including screenings & immunizations)	No charge
Diagnostic Tests (X-rays & lab work)	20% Coinsurance after Annual Deductible
Imaging Test (CT/PET scans, MRI)	20% Coinsurance after Annual Deductible
Prescription Drugs	
Generic Drugs	20% Coinsurance after Annual Deductible
Preferred Brand Drugs	20% Coinsurance after Annual Deductible
Non-preferred Brand Drugs	20% Coinsurance after Annual Deductible
Specialty Drugs	20% Coinsurance after Annual Deductible
Mail Order (limited to 90 day supply)	20% Coinsurance after Annual Deductible
Outpatient Services	
Outpatient Facility	
Outpatient Surgery Physician & Surgical Services	20% Coinsurance after Annual Deductible
Outpatient Laboratory & Professional Services	20% Coinsurance after Annual Deductible
Emergency & Urgent Care Services	
Emergency Room	20% Coinsurance after Annual Deductible
Emergency Transportation/Ambulance (air or ground)	20% Coinsurance after Annual Deductible
Urgent Care	20% Coinsurance after Annual Deductible
Inpatient Hospital Services	
Inpatient Hospital Facility	20% Coinsurance after Annual Deductible
Inpatient Hospital Physician & Surgical Services	20% Coinsurance after Annual Deductible
Mental/Behavioral Health & Substance Abuse Disorder Services	
Mental/Behavioral Health Inpatient Services	20% Coinsurance after Annual Deductible
Mental/Behavioral Health Outpatient Services	20% Coinsurance after Annual Deductible
Substance Abuse Disorder Inpatient Services	20% Coinsurance after Annual Deductible
Substance Abuse Disorder Outpatient Services	20% Coinsurance after Annual Deductible
Maternity Services	
Prenatal & Postnatal Care	20% Coinsurance after Annual Deductible
Delivery & Inpatient Services	20% Coinsurance after Annual Deductible
Other Covered Services	
Chiropractic Care/Durable Medical Equipment/Home Health Care Services/Hospice Services/Skilled Nursing Facility/	20% Coinsurance after Annual Deductible
Habilitation Services/Rehabilitation Services (including Speech, Occupational & Physical Therapy)	20% Coinsurance after Annual Deductible
Pediatric Services (up to 19 years of age)	
Eye Exam (1 treatment per calendar year)	20% Coinsurance after Annual Deductible
Glasses ($150 hardware per year, including contacts)	20% Coinsurance after Annual Deductible
Dental Check-up (2 visits per calendar year)	20% Coinsurance after Annual Deductible

Benefits may very by state.

GENERAL LIMITATIONS AND EXCLUSIONS (May vary by state)

No benefits will be paid for:

1. Any service or supply that would be provided without cost to you or your covered dependent in the absence of insurance covering the charge;
2. Expenses/surcharges imposed on you or your covered dependent by a provider, including a hospital, but that are actually the responsibility of the provider to pay;
3. Any services performed by a member of a covered person's immediate family; and
4. Any services not identified and included as covered expenses under the policy. You will be fully responsible for payment for any services that are not covered expenses.

Even if not specifically excluded by this policy, no benefit will be paid for a service or supply unless it is:

1. Administered or ordered by a physician; and
2. Medically necessary to the diagnosis or treatment of an injury or illness, or covered under the Preventive Care Expense Benefits provision.

Covered expenses will not include, and no benefits will be paid for any charges that are incurred:

1. For any portion of the charges that are in excess of the eligible expense;
2. For weight modification, or for surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass surgery;
3. For breast reduction or augmentation;
4. For vasectomies, and reversal of sterilization and vasectomies;
5. For treatment of malocclusions, disorders of the temporomandibular joint, or craniomandibular disorders, except as described in covered expenses of the Medical Benefits provision;
6. For dental expenses, including braces for any medical or dental condition, surgery and treatment for oral surgery, except as expressly provided for under Medical Benefits;
7. For cosmetic treatment, except for reconstructive surgery that is incidental to or follows surgery or an injury that was covered under the policy or is performed to correct a birth defect in a child who has been a covered person from its birth until the date surgery is performed;
8. For eye refractive surgery, when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism;
9. While confined primarily to receive rehabilitation, custodial care, educational care, or nursing services unless expressly provided for by the policy;
10. For eyeglasses, contact lenses, hearing aids, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as specifically provided under the policy;
11. For maternity expenses due to pregnancy of an eligible child except for complications of pregnancy;
12. For experimental or investigational treatment(s) or unproven services;
13. For treatment received outside the United States, except for a medical emergency while traveling for up to a maximum of 90 consecutive days. If travel extends beyond 90 consecutive days, no coverage is provided for medical emergencies for the entire period of travel including the first 90 days;
14. As a result of an injury or illness arising out of, or in the course of, employment for wage or profit, if the covered person is insured, or is required to be insured, by workers' compensation insurance pursuant to applicable state or federal law;
15. As a result of:
    a. Intentionally self-inflicted bodily harm whether the covered person is sane or insane;
    b. An injury or illness caused by any act of declared or undeclared war;
    c. The covered person taking part in a riot; or
    d. The covered person's commission of a felony, whether or not charged;
16. For or related to durable medical equipment or for its fitting, implantation, adjustment, or removal, or for complications there from, except as expressly provided for under the Medical Benefits.

When Coverage Begins and Ends – Your effective date will appear on the schedule page with your 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.

Celtic's Prior Authorization Program – Health Care Pre-authorization is a benefit which is automatically included in the health plan. The Prior Authorization 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 Celtic's Prior Authorization 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-authorization 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 (Prior Authorization) results in an exclusion from eligible expenses of 20% of all charges related to the treatment, if you did not notify Celtic's Prior Authorization Program before treatment.

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