

# The **CELTICARE II** Health Plan Maryland



Comprehensive, flexible coverage  
For kids, adults and families



Earning Your Trust, Every Day



# The CeltiCare

## Something just right for everyone

The CeltiCare II Health Plan is a major medical plan designed for individuals ages six months to 64½ and their families. Unique in its flexibility, CeltiCare II enables you to customize your coverage to meet your specific health needs and budgets. Celtic offers you the choice of three plans, each covering a wide variety of medical and hospitalization costs as well as some extra benefits everyone needs. Plus, with the CeltiCare II Health Plan, every insured receives a cash-back incentive for participating in the Healthy Lifestyle Program.

Also, when only your children need coverage, CeltiCare II gives you the opportunity to cover a child as the primary insured person, so you can customize a plan specifically designed for a child's needs. And Celtic has created special rates just for children, so you'll have an affordable way to insure your child's health.

## Three major medical plans

The three plans are based on the flexibility of your health care needs and desired premium level. You can choose the plan best for you.

**CeltiCare II Select PPO** - you receive high quality care for the lowest premium by accessing respected network physicians and hospitals. This doctor and hospital PPO offers savings on every visit to any network provider.

**CeltiCare II "Any Doc" PPO** - you don't have to change doctors to realize the advantage of a low office visit copayment. With the Celtic "Any Doc" PPO you have the flexibility to choose your own physician while saving money with the preferred rates of our prominent nationwide hospital network.

**CeltiCare II Managed Indemnity Plan** - offers you comprehensive major medical coverage with the flexibility to select the doctors and hospitals of your choice.

## Additional Options

For a small additional premium, you can take advantage of the CeltiCare II Plus Option or stand alone Prescription Drug Option. The CeltiCare II Plus Option is an economical package of extra health benefits that includes the following:

**Supplemental Accident** - first-dollar coverage up to \$500 per occurrence, per person.

**Prescription Drugs** - generic drugs available with a copay and no deductible.

# II™ Health Insurance Plan

*Comprehensive coverage that lets you choose the plan that suits you best. And saves you more!*

**Preventive Care** - covers routine tests and exams up to \$300 per person per calendar year (after coverage has been in effect 90 days). No deductible or copayment required. Some eligible services include routine physicals, serum cholesterol, breast exams, Pap smears, tetanus and urinalysis.

## Celtic Makes it Easy

**Flexible Payment Options, Guaranteed Rates.** You have the option to pay your initial premium with a credit card, debit card, or by check. On the application you can choose from a variety of premium options, including monthly or quarterly billing or the Monthly Automatic Pay Plan.

Choosing Celtic's Monthly Automatic Pay Plan makes handling payments easy by automatically deducting your premium from your checking or savings account at no additional charge. Both the monthly and quarterly billing options have an \$8 per bill fee.

And Celtic will guarantee your premium rates for the first 12 months of coverage, an offer most insurance companies won't make.

**Easy Claims, Helpful Service.** Celtic makes health insurance easy and worry-free. When submitting a claim, there are no forms to complete, and payments are made quickly.

If you do have a question, just call our Client Service Representatives toll-free at 1-800-477-7870. They are available during regular business hours to help with practically any situation, from claims, billing and pre-certification to a change in coverage.

**Full Credit for Meeting Prior Deductibles.** If you choose to replace your current insurance coverage with the CeltiCare II Health Plan, you'll receive credit for satisfying any portion of the previous carrier's deductible met during the same calendar year.

\*Paper applications also require a \$25 non-refundable application fee.

**Note:** The CeltiCare II Select PPO and The CeltiCare II "Any Doc" PPO plans are available in areas served by the PPO Network. Your agent can supply you with a complete listing to make sure there is a participating hospital and/or physician near you.

## How to Apply for CeltiCare II

### Choose a plan

- A. CeltiCare II Select PPO Plan
- B. CeltiCare II "Any Doc" PPO Plan
- C. CeltiCare II Managed Indemnity Plan

### Choose a deductible and coinsurance level

- A. \$500, \$1,000, \$1,500, \$2,500 or \$5,000 with 80/20 coinsurance
- B. \$2,500 or \$5,000 with 100% coinsurance

### Determine if you want to take advantage of any options

- A. CeltiCare II Plus Option
- B. Stand alone Prescription Drug Option

### Get a QuikQuote™ from your agent

Your agent can receive an up-to-date rate quote in seconds, by calling **1-800-477-7990** or visiting our web site at **www.celtic-net.com**. You'll be quoted Celtic's Preferred rate.

### Select a billing option

Pay monthly or quarterly, whichever is more convenient. To use our Monthly Automatic Pay Plan, just complete the Monthly Automatic Pay Plan agreement on the application. If you choose to receive a monthly or quarterly billing statement, an \$8 per bill fee will be charged.

### Complete the application

Upon submission of your completed application, you'll be required to pay an initial premium equal to your first payment due.\* You can make this initial payment with a credit card (VISA®, MasterCard®, or Discover®), debit card (with the VISA or MasterCard logo), or by check. (Please make the check payable to Celtic Insurance. Agent checks are not accepted.)

### Submit your application for underwriting

Whether applying online or through the mail, consider Celtic's QuikCoverage option, which provides instant coverage for qualified applicants.

# 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.				
Prescription Drugs	<p><b>Prescription Drugs</b> - \$500 annual deductible. Drugs with generic alternatives require the specified copay plus 100% of the cost difference between the drug and the generic alternative. Maintenance Drug prescriptions available by retail and mail order with a 90 day supply.</p> <p><b>Retail:</b></p> <table border="0"> <tr> <td><b>Generic</b></td> <td><b>Brand (Preferred and Nonpreferred/Specialty drugs)</b></td> </tr> <tr> <td> <ul style="list-style-type: none"> <li>\$20 copay</li> </ul> </td> <td> <ul style="list-style-type: none"> <li>\$40 copay for preferred drugs</li> <li>\$75 copay for nonpreferred/specialty drugs</li> </ul> </td> </tr> </table>	<b>Generic</b>	<b>Brand (Preferred and Nonpreferred/Specialty drugs)</b>	<ul style="list-style-type: none"> <li>\$20 copay</li> </ul>	<ul style="list-style-type: none"> <li>\$40 copay for preferred drugs</li> <li>\$75 copay for nonpreferred/specialty drugs</li> </ul>
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Emergency Room Deductible (in addition to annual plan deductible)	\$250 per visit (waived if admitted to hospital).				
Out-of-Network Services <b>Doctor and Hospital</b> (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.				
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)	<p><b>Prescription Drugs</b> - Drugs with generic alternatives require the specified copay plus 100% of the cost difference between the drug and the generic alternative. Maintenance Drug prescriptions available by retail and mail order with a 90 day supply.</p> <p><b>Retail:</b></p> <table border="0"> <tr> <td><b>Generic</b></td> <td><b>Brand (Preferred and Nonpreferred/Specialty drugs)</b></td> </tr> <tr> <td> <ul style="list-style-type: none"> <li>No deductible</li> <li>\$20 copay</li> </ul> </td> <td> <ul style="list-style-type: none"> <li>\$100 annual deductible per person, per calendar year</li> <li>\$40 copay for preferred drugs</li> <li>\$75 copay for nonpreferred/specialty drugs</li> </ul> </td> </tr> </table>	<b>Generic</b>	<b>Brand (Preferred and Nonpreferred/Specialty drugs)</b>	<ul style="list-style-type: none"> <li>No deductible</li> <li>\$20 copay</li> </ul>	<ul style="list-style-type: none"> <li>\$100 annual deductible per person, per calendar year</li> <li>\$40 copay for preferred drugs</li> <li>\$75 copay for nonpreferred/specialty drugs</li> </ul>
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CeltiCare II Plus Option	<p><b>Preventive Care</b> - (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.</p> <p><b>Supplemental Accident</b> - Covered at 100% up to \$500 per person, per occurrence.</p> <p><b>Prescription Drugs</b> - Same benefit structure as stated above for the stand alone Prescription Drug Option.</p>				

\* 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 "Any Doc" PPO Plan

Features/Benefits	Specifics								
Eligibility	Ages 6 months - 64½ years								
Plan Type	Any Physician — 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 any doctor	\$35 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.								
Prescription Drugs	<p><b>Prescription Drugs</b> - \$500 annual deductible. Drugs with generic alternatives require the specified copay plus 100% of the cost difference between the drug and the generic alternative. Maintenance Drug prescriptions available by retail and mail order with a 90 day supply.</p> <p><b>Retail:</b></p> <table border="0"> <tr> <td><b>Generic</b></td> <td><b>Brand (Preferred and Nonpreferred/Specialty drugs)</b></td> </tr> <tr> <td>• \$20 copay</td> <td>• \$40 copay for preferred drugs</td> </tr> <tr> <td></td> <td>• \$75 copay for nonpreferred/specialty drugs</td> </tr> </table>	<b>Generic</b>	<b>Brand (Preferred and Nonpreferred/Specialty drugs)</b>	• \$20 copay	• \$40 copay for preferred drugs		• \$75 copay for nonpreferred/specialty drugs		
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	• \$75 copay for nonpreferred/specialty drugs								
Emergency Room Deductible (in addition to annual plan deductible)	\$250 per visit (waived if admitted to hospital).								
Out-of-Network Services <b>Hospital only</b> (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.								
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)	<p><b>Prescription Drugs*</b> - Drugs with generic alternatives require the specified copay plus 100% of the cost difference between the drug and the generic alternative. Maintenance Drug prescriptions available by retail and mail order with a 90 day supply.</p> <p><b>Retail:</b></p> <table border="0"> <tr> <td><b>Generic</b></td> <td><b>Brand (Preferred and Nonpreferred/Specialty drugs)</b></td> </tr> <tr> <td>• No deductible</td> <td>• \$100 annual deductible per person, per calendar year</td> </tr> <tr> <td>• \$20 copay</td> <td>• \$40 copay for preferred drugs</td> </tr> <tr> <td></td> <td>• \$75 copay for nonpreferred/specialty drugs</td> </tr> </table>	<b>Generic</b>	<b>Brand (Preferred and Nonpreferred/Specialty drugs)</b>	• No deductible	• \$100 annual deductible per person, per calendar year	• \$20 copay	• \$40 copay for preferred drugs		• \$75 copay for nonpreferred/specialty drugs
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CeltiCare II Plus Option	<p><b>Preventive Care</b> - (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.</p> <p><b>Supplemental Accident</b> - Covered at 100% up to \$500 per person, per occurrence.</p> <p><b>Prescription Drugs</b> - Same benefit structure as stated above for the stand alone Prescription Drug Option.</p>								

\* 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 Managed Indemnity Plan

Features/Benefits	Specifics				
Eligibility	Ages 6 months - 64½ years				
Plan Type	No network requirements				
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				
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.				
Prescription Drugs	<p><b>Prescription Drugs</b> - \$500 annual deductible. Drugs with generic alternatives require the specified copay plus 100% of the cost difference between the drug and the generic alternative. Maintenance Drug prescriptions available by retail and mail order with a 90 day supply.</p> <p><b>Retail:</b></p> <table border="0"> <tr> <td><b>Generic</b></td> <td><b>Brand (Preferred and Nonpreferred/Specialty drugs)</b></td> </tr> <tr> <td> <ul style="list-style-type: none"> <li>• \$20 copay</li> </ul> </td> <td> <ul style="list-style-type: none"> <li>• \$40 copay for preferred drugs</li> <li>• \$75 copay for nonpreferred/specialty drugs</li> </ul> </td> </tr> </table>	<b>Generic</b>	<b>Brand (Preferred and Nonpreferred/Specialty drugs)</b>	<ul style="list-style-type: none"> <li>• \$20 copay</li> </ul>	<ul style="list-style-type: none"> <li>• \$40 copay for preferred drugs</li> <li>• \$75 copay for nonpreferred/specialty drugs</li> </ul>
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Emergency Room Deductible (in addition to annual plan deductible)	\$250 per visit (waived if admitted to hospital).				
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.				
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)	<p><b>Prescription Drugs*</b> - Drugs with generic alternatives require the specified copay plus 100% of the cost difference between the drug and the generic alternative. Maintenance Drug prescriptions available by retail and mail order with a 90 day supply.</p> <p><b>Retail:</b></p> <table border="0"> <tr> <td><b>Generic</b></td> <td><b>Brand (Preferred and Nonpreferred/Specialty drugs)</b></td> </tr> <tr> <td> <ul style="list-style-type: none"> <li>• No deductible</li> <li>• \$20 copay</li> </ul> </td> <td> <ul style="list-style-type: none"> <li>• \$100 annual deductible per person, per calendar year</li> <li>• \$40 copay for preferred drugs</li> <li>• \$75 copay for nonpreferred/specialty drugs</li> </ul> </td> </tr> </table>	<b>Generic</b>	<b>Brand (Preferred and Nonpreferred/Specialty drugs)</b>	<ul style="list-style-type: none"> <li>• No deductible</li> <li>• \$20 copay</li> </ul>	<ul style="list-style-type: none"> <li>• \$100 annual deductible per person, per calendar year</li> <li>• \$40 copay for preferred drugs</li> <li>• \$75 copay for nonpreferred/specialty drugs</li> </ul>
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CeltiCare II Plus Option	<p><b>Preventive Care</b> - (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.</p> <p><b>Supplemental Accident</b> - Covered at 100% up to \$500 per person, per occurrence.</p> <p><b>Prescription Drugs</b> - Same benefit structure as stated above for the stand alone Prescription Drug Option.</p>				

\* Prescription drugs for psychiatric care not included

**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

The CeliCare 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 CeliCare II Plus option and/or a Preferred Provider Organization (PPO) plan is selected and are identified as such.

More detailed descriptions of the CeliCare II benefits are contained in the 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 40 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;
- 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; Deductible does not apply;
- manipulative therapy coverage;
- 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 40 and over;
- one chlamydia screening test per calendar year;
- treatment of birth defects known as cleft lip or cleft palate or both;
- treatment of temporomandibular joint disorders;
- coverage for treatment of morbid obesity;
- coverage for qualified individuals for bone measurement which is used to identify bone mass or detect bone loss for the prevention, diagnosis, and treatment of osteoporosis.

**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.
- initial prosthetic devices required as a result of a mastectomy performed while an insured person's coverage is in force;
- eligible expenses for medical foods and low protein modified food products for the treatment of inherited metabolic diseases;
- one hair prosthesis up to \$350 for an insured person whose hair loss results from chemotherapy or radiation treatment for cancer. For the hair prosthesis to be covered it must be prescribed by the oncologist;
- hearing aids for minor children up to \$1,400 per hearing aid. Hearing aid must be prescribed, fitted and dispensed by a licensed audiologist.

**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.

**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.

**Prescription Drugs** – \$500 annual deductible. Drugs with generic alternatives require the specified copay plus 100% of the cost difference between the drug and the generic alternative. Maintenance Drug prescriptions available by retail and mail order for a 90 day supply with a copay equal to 3x a one month supply.

**Retail:**

**Generic**

- \$20 copay

**Brand (Preferred and Nonpreferred/Specialty drugs)**

- \$40 copay for preferred drugs
- \$75 copay for nonpreferred/specialty drugs

**Reconstructive Breast Surgery** – As a result of a partial or total mastectomy performed while coverage is in force.

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

**General Anesthesia Dental Coverage** – Coverage for general anesthesia and associated hospital or ambulatory facility charges in conjunction with dental care provided to insured person within certain parameters.

**Mental Illness, Drug and Alcohol Abuse Charges** – Inpatient services are covered as any other sickness. Outpatient services after deductible are covered as 80% for the first 5 visits in any calendar year; 65% for the 6th through 30th visit in any calendar year and 50% for the 31st and any visit after the 31st visit in a calendar year.

**Hospice Care** – Hospice Care charges are covered for the following:

- 30 days of Inpatient Care;
- part-time nursing care by or supervised by a registered nurse;
- counseling, including dietary counseling;
- family counseling;
- bereavement counseling and respite care.

**Maternity Charges** – Coverage for the cost of inpatient hospitalization services for a mother and newborn child for a minimum of 48 hours of inpatient hospitalization care following an uncomplicated vaginal delivery and 96 hours of inpatient hospitalization care following an uncomplicated cesarean section.

**Invitro Fertilization Charges** – Coverage for up to three invitro fertilization attempts per live birth up to a maximum lifetime benefit of \$100,000 for all outpatient expenses arising from invitro fertilization procedures performed on the insured person.

**Wellness Benefit for Children** – Child wellness benefits include:

- all visits for and cost of childhood and adolescent immunizations;
- visits for the collection of adequate samples for hereditary and metabolic newborn screening;
- universal screening of newborns provided by the hospital before discharge;
- all visits for and costs of age appropriate screening tests for tuberculosis, anemia, lead toxicity, hearing and vision as determined by the American Academy of Pediatrics.

**Clinical Trials** – Coverage for clinical trials as a result of treatment provided for a life threatening condition or prevention, early detection, and treatment studies on cancer.

**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 Benefit to be paid.

**The following benefits are only available when the Prescription Drug Option or CeliCare 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. Maintenance Drug prescriptions available by retail and 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**

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;
- 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:**

- 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;
- 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;
- myringotomy or dilation and curettage and surgical treatment of tonsils, adenoids or hernia within first 6 months of coverage;
- outpatient prescription drugs, unless purchased at a participating pharmacy;

**IMPORTANT PLAN INFORMATION**

**Eligibility Requirements** – To qualify for CeltiCare II coverage, a primary applicant must be six months or over and under 64½ 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.

**When Coverage Begins and Ends** – Your effective date will appear on the schedule page of 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;
- you begin living outside the United States;
- you perform an act or practice that constitutes fraud;
- you have made an intentional misrepresentation of material fact under the Policy.

**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 Policy Booklets. In applying for coverage, the primary insured agrees to be bound by the Policy.