CELTICARE PREFERRED
Health Plan

Comprehensive, flexible coverage
For kids, adults and families

Benefits effective 9/23/2010

Earning Your Trust, Every Day

Something just right for everyone

The CeltiCare Preferred Health Plan lets you customize your coverage to meet your specific health needs and budgets. Celtic offers you the choice of three plans, each covering important medical and hospitalization costs as well as some extra benefits to fit your lifestyle. Plus, with the CeltiCare Preferred plan, you receive annual first-dollar preventive care coverage and a cash-back incentive for participating in the Healthy Lifestyle Program.

And for a small additional premium, everyone can take advantage of the Prescription Drug option and the Supplemental Accident option for first-dollar coverage up to $500 per person, per occurrence. Unique in its flexibility, CeltiCare Preferred has just the right amount of coverage for you.

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 Preferred 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 Preferred "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 hospital network.

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

Preferred™ Health Insurance Plan

Coverage that lets you choose the plan that suits you best. And saves you more!

Celtic makes it easy

12-month rate guarantee
Celtic guarantees your premium rates for the first 12 months of coverage, an offer most insurance companies won't make.

Need live, personal assistance
Call **(800) 779-7989** to speak with a Consumer Sales Representative Monday-Friday during regular business hours (CST).

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

- Find physicians and hospitals in your PPO network
- Check billing information
- Look for pharmacies or refill prescriptions
- Email a client Service Rep your question
- Understand your plan with the online learning center

Earning your trust, every day
For over 25 years, Celtic Insurance Company has been providing quality health coverage to children, individuals and families nationwide. We have always protected our customers with a conservative investment strategy and reliable products. And today, we are one of the leading individual health carriers in the marketplace known for our financial strength and stability.

Note: The CeltiCare Preferred Select PPO and The CeltiCare Preferred "Any Doc" PPO plans are available in areas served by the PPO Network. The Managed Indemnity Plan is not available in all states.

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.

How to Apply Online for CeltiCare Preferred

Get a quote
Get a rate quote in seconds by going to www.celtic-net.com and clicking on the Get A Quote Now button. Or, use the link provided by your insurance agent. From the quote screen you can compare up to four plans, find a doctor and view plan details and optional benefits.

Choose your deductible, coinsurance level and plan type

- CeltiCare Preferred Select PPO Plan
- CeltiCare Preferred "Any Doc" PPO Plan
- CeltiCare Preferred Managed Indemnity Plan

Consider any optional benefits

- Prescription Drug Option
- Supplemental Accident Option
- Term Life Insurance Option

Apply
Click the Apply button to complete an online application*. Upon submission of your completed application, you'll be required to pay an initial premium equal to your first payment due. Then, for continued convenience choose the Monthly Automatic Pay Plan by completing the agreement on the application. If you choose to receive a monthly or quarterly billing statement, a $10 per bill fee will be charged.

*Paper applications also require a $25 non-refundable application fee that may vary by state.

Plan features, benefits and fees may vary by state.

CeltiCare Preferred Select PPO Plan Profile

Features/Benefits	Specifics	
Eligibility	Ages 19 - 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	No Maximum	
Non-Preventive office visits to Network Provider	$15 copay/2 visits per person, per calendar year. 3rd and subsequent visits subject to annual plan deductible and coinsurance.	
Preventive Care	Eligible expenses for medical services and supplies incurred for preventive care in an asymptomatic individual are covered first-dollar at 100%.	
Labs and x-rays	Subject to annual plan deductible and coinsurance, except for preventive care.	
Prescription Drugs	**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 for 2½ times the retail cost. **Retail:** **Generic** • No deductible • $10 copay **Brand (Preferred and Nonpreferred/Specialty drugs)** • $500 annual deductible per person, per calendar year • $40 copay for preferred drugs • 30% coinsurance for nonpreferred/specialty drugs	
Psychiatric Care**	Subject to annual plan deductible and coinsurance.	
Emergency Room Deductible (in addition to annual plan deductible)	$250 deductible 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.	
Ambulance	$5,000 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	**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 • $5 copay **Brand (Preferred and Nonpreferred/Specialty drugs)** • $100 annual deductible per person, per calendar year • $40 copay for preferred drugs • 30% coinsurance for nonpreferred/specialty drugs
Supplemental Accident Option	Covered at 100% up to $500 per person, per occurrence.
Term Life Insurance Option (not available in all states)	Ages 19-64 years $25,000

* Based on In-Network Services
** Benefit will vary by state

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 Preferred "Any Doc" PPO Plan Profile

Features/Benefits	Specifics	
Eligibility	Ages 19 - 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	No Maximum	
Non-Preventive office visits to any doctor	$35 copay/2 visits per person, per calendar year. 3rd and subsequent visits subject to annual plan deductible and coinsurance.	
Preventive Care	Eligible expenses for medical services and supplies incurred for preventive care in an asymptomatic individual are covered first-dollar at 100%.	
Labs and x-rays	Subject to annual plan deductible and coinsurance, except for preventive care.	
Prescription Drugs	**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 for 2½ times the retail cost. **Retail:** **Generic** • No deductible • $10 copay **Brand (Preferred and Nonpreferred/Specialty drugs)** • $500 annual deductible per person, per calendar year • $40 copay for preferred drugs • 30% coinsurance for nonpreferred/specialty drugs	
Psychiatric Care**	Subject to annual plan deductible and coinsurance.	
Emergency Room Deductible (in addition to annual plan deductible)	$250 deductible per visit (waived if admitted to hospital).	
Out-of-Network Services **Hospital only** (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.	
Ambulance	$5,000 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	**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 • $5 copay **Brand (Preferred and Nonpreferred/Specialty drugs)** • $100 annual deductible per person, per calendar year • $40 copay for preferred drugs • 30% coinsurance for nonpreferred/specialty drugs
Supplemental Accident Option	Covered at 100% up to $500 per person, per occurrence.
Term Life Insurance Option (not available in all states)	Ages 19-64 years $25,000

* Based on In-Network Services
** Benefit will vary by state

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 Preferred Managed Indemnity Plan Profile

Features/Benefits	Specifics	
Eligibility	Ages 19 - 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	No Maximum	
Preventive Care	Eligible expenses for medical services and supplies incurred for preventive care in an asymptomatic individual are covered first-dollar at 100%.	
Labs and x-rays	Subject to annual plan deductible and coinsurance, except for preventive care.	
Prescription Drugs	**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 for 2½ times the retail cost. **Retail:** **Generic** • No deductible • $10 copay **Brand (Preferred and Nonpreferred/Specialty drugs)** • $500 annual deductible per person, per calendar year • $40 copay for preferred drugs • 30% coinsurance for nonpreferred/specialty drugs	
Psychiatric Care*	Subject to annual plan deductible and coinsurance.	
Emergency Room Deductible (in addition to annual plan deductible)	$250 deductible 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.	
Ambulance	$5,000 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	**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 • $5 copay **Brand (Preferred and Nonpreferred/Specialty drugs)** • $100 annual deductible per person, per calendar year • $40 copay for preferred drugs • 30% coinsurance for nonpreferred/specialty drugs
Supplemental Accident Option	Covered at 100% up to $500 per person, per occurrence.
Term Life Insurance Option (not available in all states)	Ages 19-64 years $25,000

* Benefit will vary by state

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 PREFERRED HEALTH PLAN BENEFITS

(May vary by state)

The CeltiCare Preferred 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 or bodily injury, 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 Preferred Supplemental Accident option or Prescription Drug option and/or a Preferred Provider Organization (PPO) plan is selected and are identified as such.

More detailed descriptions of the CeltiCare Preferred 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;
- 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.

Health Screening Charges

- **Mammogram** - Coverage for one mammogram per calendar year for an insured person or more often as recommended by a physician. Eligible expenses for a mammogram shall include radiologist and facility charges;
- **Cytology - Cervix -** One cytologic screening per calendar year or more often if recommended by a physician;
- **Prostate Cancer** - Coverage for an annual prostate-specific antigen (PSA) test or equivalent test for the presence of prostate cancer shall be provided when recommended by a physician; and.
- **Colorectal Cancer Screening** with colonoscopy or fecal occult blood testing for:
  - an insured person age 50 or over every three years; or
  - an insured person age 30 or older who may be classified as high risk for colorectal cancer, because the insured person or a first-degree family member has a history of colorectal cancer.

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 Charges – Treatment of sound, natural teeth due to bodily injury that occurs while the insured person's coverage is in force.

Reconstructive Charges – Reconstructive surgery needed to correct a bodily injury or sickness that occurs while the insured person's coverage is in force is covered.

Psychiatric Care Charges – Subject to annual plan deductible and coinsurance.

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 travel and lodging benefit.

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 for a 90 day supply with a copay equal to 2½ x a one month supply.

Retail:
Generic

- No deductible
- $10 copay

Brand (Preferred and Nonpreferred/Specialty drugs)

- $500 annual deductible per person, per calendar year
- $40 copay for preferred drugs
- 30% coinsurance for nonpreferred/specialty drugs

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

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.

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

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

Preventive Care Benefit – Services for immunizations, annual physical examinations and routine diagnostic or preventive testing for an asymptomatic insured person are covered at 100%. The insured's annual deductible does not have to be met before preventive care benefits are paid.

The following benefits are only available if the options are chosen.

Supplemental Accident Benefit Option – 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 2½ x a one month supply.

Retail:
Generic

- No deductible
- $5 copay

Brand (Preferred and Nonpreferred/Specialty drugs)

- $100 annual deductible per person, per calendar year
- $40 copay for preferred drugs
- 30% coinsurance for nonpreferred/specialty drugs

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

CELTICARE PREFERRED 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 two 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 PREFERRED "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 two 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.

Note: Celtic Insurance Company contracts with Preferred Provider Organizations (PPO) to utilize their network of health care providers and hospitals for Celtic's PPO health benefit plans. The Preferred Provider Organizations support their clients by developing standards to determine network adequacy and accessibility. These standards are contained in an Access Plan, which is available upon request.

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

IMPORTANT PLAN INFORMATION (May vary by state)

Eligibility Requirements – To qualify for CeltiCare Preferred coverage, a primary applicant must be 19 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.

Underwriting – Your CeltiCare Preferred 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.

PLEASE NOTE: Creditable Coverage - Time spent under the CeltiCare Preferred 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 Preferred 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.

For an insured person, age 19 and over, benefits are paid for pre-existing conditions once coverage is in force for 12 continuous months after the effective date, unless specifically excluded from coverage under this certificate. For dependents under 19, no pre-existing limitations apply.

Any treatment or service for an excluded pre-existing condition, including any complications or conditions resulting from treatment of a pre-existing condition are not eligible expenses.

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 19-64 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 (Pre-authorization) Program – Health Care Certification (Pre-authorization) is a benefit which is automatically included in the CeltiCare Preferred Health Plan. The Health Care Certification (Pre-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 the Celtic Health Care Certification (Pre-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-certification (Pre-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 (Pre-authorization) 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 (Pre-authorization) Program before treatment.

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

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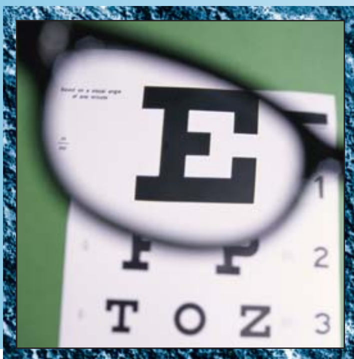

CELTIC®

Celtic Value-Added
VISION BENEFIT

Extra benefits to fit your lifestyle

Celtic's vision benefit provides you extra coverage for your eyecare needs at no extra charge to you. What's more, a deductible does not have to be met for vision benefits to be paid. For individuals and for families, each insured member receives the money-saving services outlined below.

Routine Vision Member Benefits Include:

- **Vision Exam** comprehensive eye exam from our network of optometrists & ophthalmologists
- **Frames** any frame up to the retail allowance. If the frame exceeds plan limits, one simply pays the difference less a 20% discount (except at Wal-Mart, where member is responsible for frame charges above $87.50)
- **Lenses** plastic single vision, flat top bifocal, and flat top trifocal lenses are covered in full
- **Contact Lenses** In lieu of spectacles, benefits may be used for the fitting, follow-up and/or purchase of contact lenses
- **LASIK Surgery** $300 & 15% off LASIK procedures at LasikPlus Centers – **http://www.opticarelasik.com/** or **1-866-293-1414**

How to Use Your Benefits

- Locate a network provider by calling **1-800-477-7870 choosing Option 2, then Option 4** or visiting **http://www.Opticare.com/CelticVision/**
- Make an appointment
- Contact OptiCare's Concierge Service at **1-800-477-7870 choosing Option 2, then Option 4** and provide your appointment information
- OptiCare communicates with your provider, making certain you receive the maximum benefit for which you are entitled
- Present your Celtic ID at your appointment
- The OptiCare network provider takes care of the rest

Celtic Health Plan
Vision Benefits Administered by OptiCare

Plan Frequencies	Exam every 12 months Lenses every 12 months Frames every 24 months Contacts every 12 months	
Copay	Exam $10.00/Hardware $20.00	
Benefits	**Network Doctor (after copay)**	**Non-Network (copays apply)**
Eye Exam	Paid in Full	Up to $38.50
Lenses (per pair)		
Single	Paid in full	$37.50
Bifocal	Paid in full	$55.00
Trifocal	Paid in full	$90.00
Lenticular	Paid in full	$90.00
Frame-Retail Value	$125.00	$87.50
Contact Lenses (in lieu of glasses)	$80.00*	$56.00
Standard Contact Lens Fitting**	Covered	$26.60
LASIK	15% off at LasikPlus	No benefit

*except at Wal-Mart, where contact lens allowance is $56.
**current wearers of disposable, daily wear or extended wear lenses.
For specialty fits (new wearers, toric, RGP, multi-focal, etc.), the member is responsible for any charges over $75, less a 20% discount.

CELTIC®

Celtic Value-Added
VISION BENEFIT *continued...*

Limitations

Vision Exam and Vision Materials – Fees charged by a provider for services other than Vision Exam or Covered Vision Materials must be paid in full by the Covered Person to the provider. Such fees or materials are not covered under this policy.

Exclusions

- No benefits will be paid for services or materials connected with or charges arising from orthoptic or vision training, subnormal vision aids, and any associated supplemental testing.
- Any eye or Vision Examination, or any corrective eye wear, required by an employer as a condition of employment.
- Services provided as a result of Worker's Compensation law, or similar legislation, or required by any governmental agency or program whether Federal, state or subdivisions thereof.
- Lens options such as progressive lens, polycarbonate lens, high index tints and lens with UV and anti-reflective coating.
- Non-prescription lenses, non-prescription sunglasses (except for declared discounts) or two pair of glasses in lieu of bifocals.
- Lost or broken lenses, frames, glasses or contact lenses will not be replaced except in the next benefit period when vision materials next become available.

Most providers do not allow insurance to be combined with discounts, specials or other insurance plans.

Celtic Vision Benefit is administered by
OptiCare Managed Vision

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