Earning Your Trust, Every Day

CELTIC

Benefits effective 9/23/2010

Quality PPO Coverage – Made affordable for kids, individuals and families

Celtic Basic™ Health Plan

Celtic Basic

Adds Up to a Better Low-

Celtic Basic offers what you want:

- A quality, basic health insurance plan
- Affordable rates to fit your budget
- No-hassle PPO coverage with two coinsurance options
- Two $30 copay office visits per year
- Healthy Lifestyle Program
- Prescription Drug Option

The Celtic Network Advantage

The Celtic Basic Health Plan works hard for you by controlling costs through PPO and Pharmacy networks.

HELPFUL DEFINITIONS

Deductible – The dollar amount you spend each year before Celtic begins to make payments for claims.

Copayment – The dollar amount you pay to network providers for a specific medical service or supply.

Coinsurance – The percentage amount you and Celtic will pay for covered medical services after you've met your deductible.

-cost Health Plan

How Does a PPO Work?

PPO stands for Preferred Provider Organization, which is a network of medical care providers, such as physicians, specialists, and hospitals, who have agreed to provide their services at a negotiated discount to Celtic clients.

This means you save two ways. Celtic partners with leading Preferred Provider Organizations in the country — so you pay lower premiums than comparable non-PPO plans. Plus, when you use network providers you pay a lower percentage of the costs based on the Celtic negotiated discount.

Celtic also partners with a leading network of pharmacies to give you prescription drugs at the lowest negotiated prices. And unlike many other plans, Celtic's PPO and pharmacy networks have you covered. So whether you're traveling or relocating to another state, your Celtic Basic plan provides quality, money-saving coverage.

The Right Plan at the Right Time

Today's changing needs and budgets call for a low-cost, high-quality health plan. The Celtic Basic plan offers a basic benefit structure with additional client cost-sharing to keep premiums low. And Celtic guarantees your premium rate for the first 12 months of coverage, an offer many insurance companies won't make.

Plus, with the Healthy Lifestyle Program Celtic covers up to 25% of fees for accredited programs to improve your physical health, such as fitness, weight loss or smoking cessation – $300 maximum per person, per calendar year.

Nobody Makes it Easier than Celtic

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-certification, to a change of address.

Celtic also offers fast Internet services for provider listings, participating pharmacies, billing information and much more. Plus, you can complete an online application today right from your agent's computer.

Earning Your Trust, Every Day

Celtic's commitment to quality benefits, expert service and affordability make the Celtic Basic Health Plan a logical choice for protection against the rising costs of medical services.

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.

How To Get Started

Get a quote

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

Choose your coinsurance level and annual deductible

- 80/20 coinsurance
  - $1,500, $2,500, $5,000 deductible
- 70/30 coinsurance
  - $1,500, $3,500, $5,000, $7,500 deductible

Consider an optional benefit

- Prescription Drug 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.

Celtic Basic Health Plan

Features/Benefits	Specifics						
Eligibility	Ages 19 - 64½ years						
Plan Type	Physician and Hospital PPO						
Coinsurance	80/20 Coverage after deductible of the next $10,000			70/30 Coverage after deductible of the next $10,000			
Annual Deductibles	$1,500	$2,500	$5,000	$1,500	$3,500	$5,000	$7,500
Out-of-Pocket Maximum* (includes annual deductible)	$3,500	$4,500	$7,000	$4,500	$6,500	$8,000	$10,500
Lifetime Maximum	No Maximum						
Non-Preventive office visits to Network Provider	2 visits, $30 copay per person, per calendar year. 3rd and subsequent visits subject to annual deductible and coinsurance						
Labs and x-rays	Subject to annual 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 • $15 copay **Brand (Preferred and Nonpreferred/Specialty drugs)** • $1,000 annual deductible per person, per calendar year • 35% coinsurance for preferred drugs • 50% coinsurance for nonpreferred/specialty drugs						
Emergency Room Deductible	$250 deductible per visit, (waived if admitted to hospital) + annual deductible and coinsurance						
Hospital Confinement/Inpatient Services	$500 deductible per admission + annual deductible and coinsurance. Average semi-private room rate. Intensive care at 4 times the average semi-private room rate.						
Outpatient Hospital Services	$350 deductible per occurrence + annual deductible and coinsurance. Day surgery, major diagnostic procedures and medical services including charges for x-rays, lab tests, EKGs and radiation therapy are eligible expenses.						
Out-of-Network Services **Doctor and Hospital** (in addition to annual plan deductible)	$1,500 annual deductible. Eligible charges reduced additional 20% per occurrence, no cap						
Preventive Care	Eligible expenses for medical services and supplies incurred for preventive care in an asymptomatic individual are covered first dollar.						
Rehabilitation Facility	Inpatient—up to 30 days confinement per person, per calendar year.						
Home Health Care	Up to 20 visits per calendar year.						
Transplants	Covered up to amount negotiated by network if Transplant Network used.						
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.

Feature/Benefit Option	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 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 • 35% coinsurance for preferred drugs • 50% coinsurance for nonpreferred/specialty drugs

*Based in In-Network Services

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

CELTIC BASIC PLAN BENEFITS (May vary by state)

The Celtic Basic 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; 3) The treatment is medically necessary and medically appropriate; 4) The expense is a reasonable and customary charge incurred while coverage is in force.

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

WHAT IS COVERED?

For each insured person all benefits are subject to deductibles and coinsurance as indicated on the Celtic Basic Health Plan Benefits Chart.

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.

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

- nonsurgical professional services by a physician or nurse;
- radiologist or laboratory charges for X-ray or radiation therapy, diagnosis or treatment;
- inpatient rehabilitation facility charges, up to 30 days confinement per calendar year;
- screening by low-dose mammography, beginning at age 35;
- emergency ground or air transportation in an ambulance to the nearest hospital, up to $3,000 per calendar year;
- if a tubal ligation is performed during a pregnancy or complication of pregnancy, then those charges will be considered as eligible expenses. Tubal ligation and vasectomies performed as outpatient surgery are covered after 12 months of continuous coverage;
- one cytological 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, or one screening per calendar year for an insured person who is at unusual risk, as determined by a physician;
- pre-admission testing;
- home health care - up to 20 visits per calendar year.

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);
- braces, casts, splints or surgical dressings;
- diabetic equipment and supplies prescribed by a physician and self-management training and education, including nutritional counseling when supervised by a licensed health care provider with expertise in diabetes.

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.

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.

Reconstructive Breast Surgery—as a result of a partial or total mastectomy.

Preventive Care Benefit – Services for 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.

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
- $15 copay

Brand (Preferred and Nonpreferred/Specialty drugs)

- $1,000 annual deductible per person, per calendar year
- 35% coinsurance for preferred drugs
- 50% coinsurance for nonpreferred/specialty drugs

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
- $10 copay

Brand (Preferred and Nonpreferred/Specialty drugs)

- $500 annual deductible per person, per calendar year
- 35% coinsurance for preferred drugs
- 50% coinsurance for nonpreferred/specialty drugs

PPO NETWORK CHARGES FOR CELTIC BASIC PLAN

Network Physician Office Visits—A $30 copayment for non wellness office visits performed by a network physician for a symptomatic insured person in an office setting are covered, with a limit of two copay visits per calendar year. Three or more non wellness office visits are eligible expenses subject to the deductible and coinsurance.

Other than for preventive care, all lab and x-ray charges are subject to the plan deductible and coinsurance.

Non-network Services—Each time an out-of-network provider (physician and/or hospital) is used, eligible charges are reduced by an additional 20%, which does not apply to the out-of-pocket maximum. The office visit copay does not apply when non-network physicians are used.

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

CELTIC BASIC 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 used as prescribed by a physician;
- suicide or attempted suicide, or self-inflicted bodily injury while sane or insane;

No benefits are paid for services 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;
- treatment or surgical procedure relating to fertility, including diagnosis or treatment of infertility;
- tubal ligations and vasectomies 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;
- smoking cessation or weight loss programs;
- birth control (except where state mandated);
- outpatient prescription drugs, unless purchased at a participating pharmacy;
- treatment of psychiatric or psychological disorders or mental nervous disorders of any kind, unless required by state law;
- gender reassignment (sex change or reassignment) or treatment for sexual dysfunction or sexual inadequacy;
- treatment 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;
- speech exams;
- chronic pain disorder, acupuncture or biofeedback, or treatment including manipulation, for dislocations and subluxation of the vertebrae or spinal column;
- eye refractions, fitting of glasses or hearing aids, glasses, contact lenses, radial keratotomy, or treatment to correct refractive eye disorders;
- treatment or medication that is experimental or investigational;
- custodial care;
- hospice care;
- outpatient rehabilitation therapy, not related to home health care;
- treatment of drug addiction, substance abuse or chemical dependency, or alcoholism, unless required by state law;
- myringotomy or dilation and curettage and surgical treatment of tonsils, adenoids or hernia within first six months of coverage, unless due to emergency;
- allergy tests and injections;
- hearing aids, exams or fittings, or surgical or non-surgical treatment or procedure to correct hearing loss;
- durable medical equipment not specifically listed under the medical supply charges.

IMPORTANT PLAN INFORMATION

Eligibility Requirements—To qualify for Celtic Basic coverage, a primary applicant must be at least 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 Celtic Basic Health Plan application is individually underwritten based on the health history of you and your covered dependents. 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.

Creditable Coverage—Time spent under the Celtic Basic 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 Celtic Basic 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.

For an insured person, aged 19 and over, CelticSaver HSA 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 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 Celtic Basic 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 event of a non-certification, there is an appeal process available.

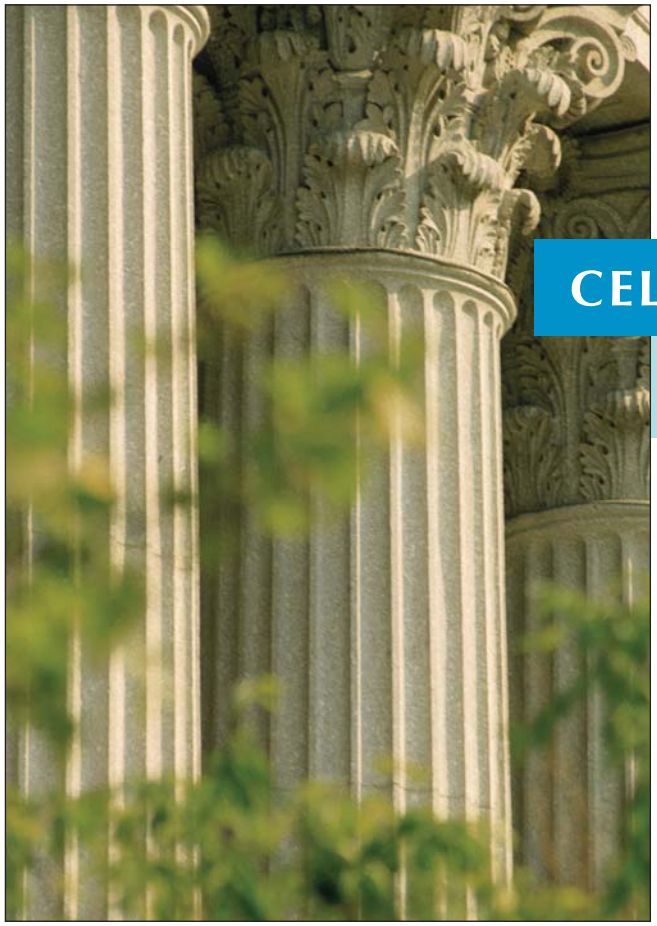
Remember, the final decision for medical treatment is always the right and responsibility of you and your doctor.

What if I don't notify Celtic before treatment?—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.



CELTIC INSURANCE COMPANY

SOLID, STRONG, COMMITTED...

these are the characteristics that have shaped Celtic Insurance Company. And they are representative of the way in which we conduct business. Celtic is a company known for financial stability. We have always protected our customers with a conservative investment strategy and reliable products. We also believe our quality products should be backed by superior service. So you can count on our well trained personnel to administer your policy efficiently and without delay.

CELTIC

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