Earning Your Trust, Every Day

CELTIC

Quality PPO Coverage – Made affordable

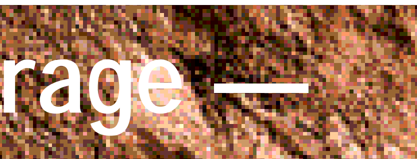
for kids, individuals and families

Celtic ValueOne Health Plan

Quality PPO Cove

Made affordable for kids,

People's lives are often changing. And today's economy calls for smart planning when it comes to choosing health insurance coverage that's right for you and your family. The Celtic ValueOne™ Health Plan is the economical solution for protection against costly health care procedures that are often unforeseen and unbudgeted. So whether you're an entrepreneur, a consultant, work for an employer that doesn't offer a group plan, or just between jobs, Celtic designed the ValueOne plan around a solid core of comprehensive insurance benefits that cover your needs.



individuals and families

The Network Advantage

The Celtic ValueOne plan works hard for you by controlling costs. Celtic partners with Private HealthCare Systems and Advance PCS - one of the leading Preferred Provider Organizations and the largest network of pharmacies in the country – to give you optimal access to health care providers and prescription drugs at competitive rates. And unlike many PPO plans, Celtic's PPO network and pharmacy network are nationwide. So whether you're traveling or relocating to another state, you can be assured of quality, money-saving coverage.

Fast Coverage, Made Simple

Applying for the Celtic ValueOne plan is easy. There are no complicated forms to complete and no waiting periods before coverage takes effect. For even faster processing, you can complete an online ValueOne application today right from your agent's computer. And with Celtic QuikCoverage, eligible applicants can be covered immediately.*

Flexible Payment Options, Guaranteed Rates

With the Celtic ValueOne plan you have the option to pay your initial premium by credit card (Visa®, MasterCard®, or Discover®), debit card (with the VISA or MasterCard logo), or by check. You also have a choice 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.*

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

Earning Your Trust, Every Day

Celtic's commitment to quality benefits, expert service and affordability make the Celtic ValueOne Plan a logical choice for protection against the rising costs of health care.

For 25 years, Celtic Insurance Company has been providing quality health coverage to children, individuals and families nationwide. Celtic has earned A.M. Best's "Excellent" rating (currently A-) since 1986. And today, we are one of the leading individual health carriers in the marketplace known for our financial strength and stability.

The Reliable Solution

With the Celtic ValueOne Health Plan you receive:

- Affordable premiums
- High-quality care and coverage
- Timely claims service
- Trustworthy service

*Plan features, benefits, rates and fees may vary by state.

Note: The Celtic ValueOne Health Plan is available in areas served by the PPO Network. Your agent can supply you with a complete listing to make sure there is a participating physician and hospital near you.

How to Apply for Celtic ValueOne

Choose a Deductible and Coinsurance

- 70/30 coinsurance
- $2,000, $3,500, $6,000 or $10,000 deductible

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.**

Plus, you may qualify for Celtic's Preferred non-tobacco user rate.

Complete the application

Upon submission of your completed application, you'll be required to pay an initial premium equal to your first payment due, either monthly or quarterly, and a nonrefundable application fee. 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.)

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.

Submit your application for underwriting

If you answered "No" to the five health questions on the application, are within the Company's height, weight, and age guidelines, and have acceptable occupations/avocations, your agent can get coverage instantly with QuikCoverage. Whether applying online or through the mail, consider Celtic's QuikCoverage option.

Celtic ValueOne Health Plan

Features/Benefits	Specifics			
Eligibility	Ages 6 months - 64½ years			
Coinsurance	70/30 Coverage after deductible of the next $10,000			
Annual Deductibles	$2,000	$3,500	$6,000	$10,000
Out-of-Pocket Maximum*	$5,000	$6,500	$9,000	$13,000
Lifetime Maximum	$5,000,000			
Non-Preventive office visits to Network Provider	Subject to annual deductible and coinsurance			
Emergency Room Deductible (in addition to annual deductible)	$150 deductible per visit, (waived if admitted to hospital)			
Out-of-Network Services **Doctor and Hospital** per occurrence	Eligible charges reduced additional 20%, no cap			
Hospital Confinement/Inpatient Services (in addition to annual deductible)	$500 deductible per admission. Average semi-private room rate. Intensive care at 4 times the average semi-private room rate.			
Outpatient Hospital Services (in addition to annual deductible)	$250 deductible per occurrence. Day surgery, major diagnostic procedures and medical services including charges for x-rays, lab tests, EKGs and radiation therapy are eligible expenses.			
Rehabilitation Facility	Inpatient—up to 30 days confinement per person, per calendar year.			
Home Health Care	Up to 30 visits per calendar year.			
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
Free Rx Discount Card**	Use this card at more than 40,000 participating pharmacies nationwide and receive discounts on prescription drug purchases.
Preferred Rates	Preferred rates are available for non-tobacco users. Applicants and/or their spouses who have not used tobacco in the past 12 months will receive premium savings.

Feature/Benefit Option	Specifics	
Rx Drug Card***	$500 annual deductible **Retail:** • $15 copay for generic drugs • $35 copay and a 20% coinsurance for brand-name drugs with no generic substitutes • $35 copay and a 20% coinsurance for brand-name drugs with an available generic substitute along with 100% of the cost difference between the brand-name drug and the generic copy.	**Mail order:** (90 day supply) • $30 copay for generic drugs • $70 copay and a 20% coinsurance for brand-name drugs with no generic substitutes • $70 copay and a 20% coinsurance for brand-name drugs with an available generic substitute along with 100% of the cost difference between the brand-name drug and the generic copy.

* Based on In-Network Services
** The Rx Discount Card is a value-added feature and not part of the insurance contract.
*** When the Prescription Drug Card Option is chosen, it replaces the Rx Discount Card. Prescription drugs for psychiatric care not included, except where required by state law.

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 VALUEONE PLAN BENEFITS **(May vary by state)**

The Celtic ValueOne 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 ValueOne 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.

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 the first year of 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 30 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);
- initial prosthetic devices required as a result of a mastectomy performed while an insured person's coverage is in force;
- 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 & Cosmetic 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. 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. Maximum of two transplants per lifetime.

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

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

PPO NETWORK CHARGES FOR CELTIC VALUEONE PLAN

Network Physician Office Visits—Services performed by a network physician for a symptomatic insured person in an office setting are covered subject to the 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. Also, the eligible expenses are subject to the plan deductible and coinsurance.

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 VALUEONE 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;

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;
- routine physical examinations;
- immunizations, newborn nursery charges, and routine "well baby" care of a dependent child, unless required by state law;
- treatment or surgical procedure relating to fertility, including diagnosis or treatment of infertility;
- outpatient prescription drugs (unless outpatient prescription drug card option is chosen);
- 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);
- 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;
- 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 6 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 ValueOne coverage, applicant must be at least 6 months and under 64 1/2 years of age and must not be covered under any other health insurance plan. Applicant must be a United States citizen or a foreign resident who has been living in the United States for at least two years under a permanent visa. Dependents must be 6 weeks or older.

Underwriting—Your Celtic ValueOne 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.

If you answer "NO" to all of the health questions on the application, you can have your agent bind coverage for you immediately, over the phone or online, via QuikCoverage. Height, weight, age and occupation/avocation must be within Celtic's guidelines. Otherwise, please mail your application for underwriting. QuikCoverage is not available in all states.

Credit for Prior Deductibles—If you choose to replace current insurance coverage with the Celtic ValueOne 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.

Creditable Coverage—Time spent under the Celtic ValueOne 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 ValueOne 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 of coverage, 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.

Celtic 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:

- the lifetime maximum benefit has been paid;
- you fail to make the required premium payments;
- you cease to be an eligible dependent;
- you begin living outside the United States;
- the Master Policy is terminated. Celtic may cancel the Policy on the first of any month by giving 90 days prior written notice.

Celtic's Health Care Certification Program—Health Care Certification is a benefit which is automatically included in the Celtic ValueOne 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.

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 have earned an "A-" Excellent rating from A.M. Best Company. 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 **Earning Your Trust, Every Day**

© 2003 Celtic Insurance Company,
A Celtic Group Company