

# Health Insurance Plans



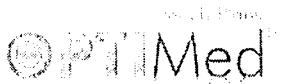
BENEFITS	OptiMed Med-Choice Plus Open Access Plan	OptiMed Value Care Open Access Plan	OptiMed Select Care Open Access Plan
<b>Overall Per Person Calendar Year Maximum</b>	\$100,000	\$100,000	\$100,000
<b>Physician Office Visits</b> General Office Visits- 6 Visit Per Person Calendar Year Maximum	\$40 Per Visit	\$50 Per Visit	\$75 Per Visit
<b>Emergency Room - Sickness - Included in Office Visit Maximum</b>	\$40 Per Visit	\$50 Per Visit	\$75 Per Visit
<b>Wellness Benefit</b> Maximum of \$150 Per Person Per Calendar Year	\$50 Per Visit	\$50 Per Visit	\$75 Per Visit
<b>Outpatient X-Ray and Lab - 5 Calendar Year Maximum</b>	PPO Discounts Apply	\$20 Per Day \$300 Max Per Person Per Calendar Year	\$40 Per Day \$300 Max Per Person Per Calendar Year
<b>Emergency Room - Accident</b> For treatment in an emergency room if performed within 72 hours of the accident	\$300 Per Visit	\$500 Per Visit	\$1,000 Per Visit
<b>Surgery and Anesthesia - Scheduled Benefit Indemnity</b> Inpatient - Calendar Year Maximum Per Person			\$2,000 Procedure Max
Outpatient - Calendar Year Maximum Per Person	PPO Discounts Apply	PPO Discounts Apply	50% of Inpatient
Anesthesiology			20% of Surgical Benefit
<b>Hospital Confinement Indemnity for Bodily Sickness &amp; Injuries</b> Requires 24 hours stay. Payable from first day of confinement.	\$100 Per Day	\$200 Per Day	\$800 Per Day
<b>Intensive Care Confinement Indemnity</b> Paid in addition to Daily Hospital Confinement Benefit Calendar year Maximum is 30 days per person	\$100 Per Day	\$200 Per Day	\$800 Per Day
<b>Hospital Confinement Benefit for Mental &amp; Nervous and Substance Abuse</b> Mental & Nervous	\$100 Per Day	\$200 Per Day	\$800 Per Day
Substance Abuse	\$100 Per Day	\$200 Per Day	\$800 Per Day
<b>Confinement Benefit for Skilled Nursing</b>	\$50 Per Day	\$100 Per Day	\$400 Per Day
<b>Life/AD&amp;D \$5,000</b>	Included	Included	Included
<b>Outpatient Prescription Drug Benefit</b> Member pays 100% of discounted price for drugs not on formulary	Prescription Drug Card with \$10/\$20/\$40 Tiered Formulary Discount Card	\$10 Generic Formulary Copay (\$15 Copay for Oral Formulary Contraceptives)	\$10 Generic Formulary Copay with \$50 Brand Formulary Copay (\$15 Copay for Oral Formulary Contraceptives)
<b>Catastrophic Care Services</b>	Included	Included	Included
<b>Disease Management</b>	Included	Included	Included
<b>Maternity Care</b>	Included	Included	Included
<b>PPO Network</b>	Included	Included	Included
<b>Free Online Doctor's Office Visits</b>	Included	Included	Included
<b>National Dental &amp; Vision Network</b>	Included	Included	Included
<b>National Lab Program</b>	Included	Included	Included
<b>Free Cobra Administration</b>	Included	Included	Included
<b>24 Hour Nurse Line</b>	Included	Included	Included
<b>Free Section 125 - Premium Only Plans (POP)</b>	Included	Included	Included

\*This is only a brief summary benefit description and not a complete description of benefits, and/or limitations. Each benefit has benefit limits and maximums. Please see brochure and SPD for complete benefit descriptions. Some provisions, benefits, exclusions or limitations listed herein may vary depending on state of residence.

\*Coverage will continue as long as long as the premiums are paid, the master policy remains in effect, the employee remains eligible for coverage and remains employed by the Policyholder. Riders terminate concurrently with the Policy and Certificate to which they are attached.

**Disclosures:**

Certain Group Reform states require a minimum of 51+ eligible employees. Before any presentation of a proposal, please check with your OptiMed sales representative to be certain that the program being proposed is appropriate for the state intended. This is not an offer of sale. No offering of this material should be given without the expressed approval of OptiMed, and any offering will be based upon state availability, underwriting guidelines, agent guide, and minimum group size and participation requirements being met.



United Group Programs, Inc.  
 Crystal Corporate Center  
 2500 North Military Trail, Suite 450  
 Boca Raton, FL 33431  
 (800) 603-5006

**OptiMed Health Plans Limited Medical Indemnity Coverage Employee Enrollment Form**

Information (Please print in ink)

Policy Number: LM-108

Plan Selected:	<input type="checkbox"/> Med Choice	<input type="checkbox"/> Value Care	<input type="checkbox"/> Value Care Plus	<input type="checkbox"/> Preferred Care	<input type="checkbox"/> Select Care	<input type="checkbox"/> Premier Care
Name: (Last) (First) (Middle Initial)			Social Security Number:		Home Telephone Number:	
Home Address: (Street) (City) (State) (Zip Code)				Best Time for Company to Call: (Home) (Work)		
Status: <input type="checkbox"/> Male <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Female <input type="checkbox"/> Married <input type="checkbox"/> Widowed				Place of Birth:		Date of Birth: / /
Occupation: (Title and Industry)			Age:	Work Telephone Number:		Email Address:
Beneficiary: (Last) (First) (Middle Initial)			Relationship:		Date of Hire: / /	

**Dependent Information** (Complete only for Dependents to be covered under this plan)

Dependents Name: (First and Last)	Sex:	Date of Birth:	Social Security Number:	Full-Time Student:
Spouse:		/ /		
Child:		/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No
Child:		/ /		<input type="checkbox"/> Yes <input type="checkbox"/> No

(Attach a separate sheet for additional children)

**Requested Effective Date (check one):**

- I request an effective date of \_\_\_\_\_ (must be the 1<sup>st</sup> of the month) I understand I cannot change this date.  
 None, since I am declining coverage.

**Declination of Coverage:**

This section must be completed if you are declining coverage for yourself and/or your Dependents. I have been given the opportunity to apply for group insurance provided through Fidelity Security Life Insurance Company. The reason I am not applying for coverage is: \_\_\_\_\_  
 I understand the Effective Date of Coverage for myself and/or my Dependents may not be available until the next Open Enrollment Period should I desire to apply at a later date unless I am not included as a Late Entrant as defined in the Policy, or unless I apply for coverage during the Annual Open Enrollment Period

**Coverage (check one):**

- Insured/Employee Only  Insured/Employee and Spouse  
 Insured/Employee and Children  Family  
 Insured/Employee Plus 1 Dependent  Insured/Employee Plus 2 or more Dependents

FIDELITY SECURITY LIFE INSURANCE COMPANY  
 Kansas City, Missouri 64111

I have reviewed this form and represent the information provided is true and complete.

I acknowledge and agree that the insurance product presented and applied for is not a major medical policy; the insurance benefits included in the plan are limited; I am not an independent contractor or self-employed worker, my dependents (for whom I am applying for coverage) and I are not covered under any other limited medical or major medical plan and that if at any time I or my dependents obtain other limited medical or major medical coverage, then my dependents and/or I are no longer eligible under this plan.

I hereby represent that I have reviewed the fraud warning notice (if applicable) included with this application for my state of residence.

Dated at \_\_\_\_\_ on the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_  
 City State Month Year

Signature (Parent if under age 18) – ENROLLER SIGNATURE – PRINTED NAME

Date

Health Insurance Enrollment

Optimized Program

Bi-Weekly Rates	Optimized Med-Choice	Optimized Value Care	Optimized Select Care
Employee	\$15.00	\$23.79	\$63.94
Employee & Spouse	\$32.88	\$51.34	\$128.72
Employee & Children	\$30.71	\$48.47	\$122.05
Family	\$43.91	\$66.83	\$175.81

Health Insurance Rates

Dental

**GroupLink Dental Program Madison National Life**

Dental	Option 1	Option 2
<b>Preventive Care (Type 1)</b> Oral Exams and Prophylaxis (one per 6 months) Flouride	100% No Deductible	100% No Deductible
<b>Diagnostic Care (Type 11)</b> Bitewing X-ray (1 per 12 mos.) Full Mouth X-ray (1 per 36 mos.)	100%	100%
<b>Basic Care (Type 111)</b> Emergency - Palliative Endodontics, Fillings, Periodontics, Simple Extraction <b>Waiting Period</b>	100%   6 Months	100%   6 Months
<b>Major Care (Type 1V)</b> Bridges, Dentures, Implants, Inlays, and Crowns, Other  Prosthetics, Oral Surgery, Repair, Surgical Extractions <b>Waiting Period</b>	40%   12 Months	60%   12 Months
<b>Orthodontia Services</b> Waiting Period Annual Maximum Lifetime Maximum	NA	50% 12 Months \$500 \$1,000
<b>Bi Weekly Rates</b>		
<b>KY Rates</b>		
Employee	\$ 7.69	\$ 9.79
Employee + Spouse	\$ 15.43	\$ 19.57
Employee + Children	\$ 15.86	\$ 20.18
Family	\$ 25.99	\$ 30.07
<b>IL Rates</b>		
Employee	\$ <del>8.26</del> 8.63	\$ <del>10.45</del> 11.63
Employee + Spouse	\$ <del>16.52</del> 17.25	\$ <del>20.90</del> 23.26
Employee + Children	\$ <del>17.04</del> 17.78	\$ <del>21.55</del> 23.98
Family	\$ <del>27.91</del> 29.14	\$ <del>35.31</del> 39.30
<b>MO Rates</b>		
Employee	\$ 7.14	\$ 9.13
Employee + Spouse	\$ 14.27	\$ 18.27
Employee + Children	\$ 14.71	\$ 18.84
Family	\$ 24.11	\$ 30.86

# Dental Enrollment

## MADISON NATIONAL LIFE INSURANCE COMPANY, INC. - P.O. Box 20593, Indianapolis, Indiana EMPLOYEE DENTAL INSURANCE APPLICATION

PLEASE PRINT IN SPACE PROVIDED

EMPLOYER NAME		LOCATION		GROUP NO.	
LAST NAME		FIRST NAME		M.I.	
STREET ADDRESS		CITY		STATE	ZIP
SOCIAL SECURITY NUMBER		TELEPHONE NUMBER ( )		BIRTH DATE / /	
SEX MALE FEMALE <input type="checkbox"/> <input type="checkbox"/>	EMPLOYMENT DATE MM DD YY / /	MARITAL STATUS SINGLE MARRIED <input type="checkbox"/> <input type="checkbox"/>	OCCUPATION/TITLE	EMPLOYMENT STATUS ACTIVE INACTIVE <input type="checkbox"/> <input type="checkbox"/>	

### Dental Insurance

EMPLOYEE       SPOUSE       CHILDREN      REQUESTED EFFECTIVE DATE: \_\_\_\_\_

SPOUSE NAME		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	BIRTH DATE (MM-DD-YY) / /	
CHILD NAME		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	BIRTH DATE (MM-DD-YY) / /	STUDENT (Over Age 19) <input type="checkbox"/> Yes <input type="checkbox"/> No
CHILD NAME		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	BIRTH DATE (MM-DD-YY) / /	STUDENT (Over Age 19) <input type="checkbox"/> Yes <input type="checkbox"/> No
CHILD NAME		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	BIRTH DATE (MM-DD-YY) / /	STUDENT (Over Age 19) <input type="checkbox"/> Yes <input type="checkbox"/> No
CHILD NAME		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	BIRTH DATE (MM-DD-YY) / /	STUDENT (Over Age 19) <input type="checkbox"/> Yes <input type="checkbox"/> No

WILL YOU OR ANY DEPENDENT HAVE OTHER DENTAL INSURANCE COVERAGE? \_\_\_\_\_  
IF YES, PLEASE LIST THE NAME OF THE OTHER INSURANCE COMPANY AND PHONE NUMBER:  
\_\_\_\_\_

I DECLINE DENTAL COVERAGE FOR:  MYSELF     MY SPOUSE     MY CHILDREN

REASON FOR REFUSAL: \_\_\_\_\_

I hereby request coverage as outlined above under the Madison National Life Insurance Company, Inc. of Wisconsin group plan offered by my employer. I authorize my employer to deduct from my earnings, including any future adjustments, any required contributions. I reserve the right to revoke or change this authorization by written notice. I understand that if I have declined any coverage on myself or eligible dependents and wish to enroll at a later date, coverage will be deferred in accordance with the Policy provisions. I declare all answers are true and complete.

WARNING: Any person who knowingly and with intent to defraud an insurer files an application or statement of claim containing any false, incomplete or misleading information may be guilty of insurance fraud which is a crime.

DATE	CITY AND STATE
SIGNATURE OF EMPLOYEE	