Earning Your Trust, Every Day

CELTIC

Savings – Simplicity

Control – Flexibility

CelticSaver HSA Health Plan

The CelticSaver HSA Health

Control – Flexibility –

The CelticSaver HSA Health Plan is a qualified high deductible health plan designed to provide you with major medical coverage including up to $7,000,000 of reliable health insurance protection combined with a Health Savings Account (HSA) option to make your health plan even more affordable.

With the CelticSaver HSA Health Plan you have greater flexibility and control over your health care dollars and receive unique tax advantages that can add-up to significant savings over the years. Plus, you can draw money from your HSA fund to pay for a broad array of qualified medical expenses like contact lenses, dental treatment, long term care insurance and much more.

All Celtic health plans are designed around a solid core of comprehensive insurance benefits. And for a small additional premium, you can take advantage of the CelticSaver HSA Preventive Care Option. This benefit covers routine tests and exams up to $300 per person, per calendar year, including up to $50 for routine eye exams (after coverage has been in effect 90 days). Plus, no deductible or copayment is required. So with the CelticSaver HSA health plan you won't have to sacrifice quality for economy.

Celtic offers two plans to choose from:

The CelticSaver HSA PPO Plan – 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.

The CelticSaver HSA Managed Indemnity Plan – offers you comprehensive coverage with the flexibility to select the doctors and hospitals of your choice.

Value added benefits

The Network Advantage - Physicians and Hospitals
Celtic partners with the leading Preferred Provider Organizations in the country. If you choose the CelticSaver HSA PPO Plan, simply select your doctor and hospital from a network of respected providers, who have agreed to provide health care services at reduced fees. And unlike other plans, you don't need a referral to see a specialist. Plus, Celtic's PPO networks have you covered, even if you're traveling or relocating to another state, you can be assured of quality, money-saving coverage.

The Network Advantage - Participating Pharmacies
Celtic also partners with the largest network of pharmacies in the country to give you prescription drugs at the lowest pre-negotiated rates. Show your Celtic ID card at any of the 50,000 participating pharmacies nationwide and receive substantial savings on your prescription drug purchases.

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. 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.

Note: The CelticSaver HSA PPO plan is available in areas served by the PPO Network.

Plan™

Savings – Simplicity

HSA Tax Advantages

Created under federal legislation, HSAs offer a way to purchase a health policy and save money tax-free.

- Tax Deductible – Contributions to your HSA fund are tax deductible up to the lesser of 100% of your deductible or to the IRS allowed maximums.
- Tax Deferred – Your HSA money earns interest tax deferred and rolls over year after year.
- Tax-Free – Withdrawals from your HSA fund used for qualified medical expenses are tax free.

What you don't spend on health care continues to grow as a tax deferred savings vehicle until you reach age 65 at which point you can use the savings tax-free for medical expenses not covered by Medicare or for non-qualified expenses and only receive normal taxation.

Celtic partners with MSAver® to administer the HSA portion of the plan. MSAver is a nationally recognized provider of HSA administration and offers a portfolio of investment options including access to stocks, bonds and mutual funds. Plus, they make paying for your health care needs easy by providing you with a VISA® check card and checks. As one of the premier experts on HSA implementation they're your number one resource for investment options. Call 1-866-495-9062 for more information.

* You can apply for the CelticSaver HSA Health Insurance Plan without setting up a savings account.

HERE'S AN EXAMPLE OF HOW YOU CAN SAVE WITH CELTICSAVER HSA HEALTH PLAN:

Plan Example for an Individual	Traditional Plan ($1,000 Ded. 100% Coins)	HSA Plan ($2,600 Ded. 100% Coins.)
Monthly Premium Paid	$200	$100
Tax-deductible monthly HSA deposit (optional)	Not allowed	$100
Total Monthly Cost	$200	$200
Annual cost in premium for Health Plan	$2,400	$1,200
Annual cost for HSA		$1,200
Annual cost (premium for Health Plan plus HSA Account)	$2,400	$2,400
Tax Savings (33% of HSA deposit)	None	$400
Total cost of Health Plan and HSA Account	$2,400	$2,000
Your HSA Account Balance after one year (with no medical claims)	None	$1,200*
If $1,000 of medical claims are incurred – out of pocket expenses from the claim	$1,000	None *(claim is covered by the $1,000 in the HSA)*
Annual out-of-pocket expenses	$3,400	$2,000
Annual Savings with the HSA Plan		**=$1,600****

* Does not include interest earned in account.

** Annual savings is calculated by subtracting the annual out-of-pocket expenses of the traditional plan ($3,400) from the annual out-of-pocket expenses of the HSA plan ($2,000) plus adding the remaining $200 in the HSA Fund, which can rollover into the next year if unused by claims. Please note if you are self-employed you can deduct your health insurance premium.

Celtic Insurance Company does not provide tax, investment or legal advice. Federal and state tax laws may change and are subject to interpretation. If tax, investment or legal advice is requested, consumers should seek the services of a licensed professional.

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 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

- CelticSaver HSA PPO
- CelticSaver HSA Managed Indemnity

Consider an optional benefit

- Preventive Care 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, which may vary by state.

Plan features, benefits and fees may vary by state.

CelticSaver HSA Health Plan Profile

Features/Benefits	Specifics	
Eligibility	Ages 18 - 64½ years*	
Plan Options	PPO** or Managed Indemnity	
Annual Plan Deductibles & Coinsurance	**Individual** $1,500 (80/20 of the next $18,000) $2,600 (80/20 of the next $12,000) $1,500 (100%) $2,600 (100%) $5,000 (100%)	**Family** $3,000 (80/20 of the next $36,000) $5,150 (80/20 of the next $24,000) $3,000 (100%) $5,150 (100%) $10,000 (100%)
Lifetime Maximum	$7,000,000 per person	
Non-Preventive office visits	Covered after deductible subject to coinsurance.	
Emergency Room Deductible (in addition to annual plan deductible)	$250 per visit (waived if admitted to hospital)	
Prescription Drugs	Covered after deductible subject to coinsurance.	
Preventive Care	(Eligibility begins after 90 days of coverage) Eligible expenses for medical services and supplies incurred for preventive care in an asymptomatic individual are covered up to $300 per person, per calendar year, which includes up to $50 for routine eye exams.	
Psychiatric Care***	Inpatient annual maximum of $2,500 per person, per calendar year. Outpatient annual maximum of $1,000, which includes visits and prescription drugs per person, per calendar year. Lifetime maximum of $10,000 per person for inpatient and outpatient combined.	
Manipulative Therapy***	$500 maximum per person, per calendar year.	
Hospital	Average semi-private room rate. Intensive care at four times the average semi-private room rate.	
Home Health Care	30 visits per person, per calendar year.	
Rehabilitation Facility	Inpatient—up to 30 days confinement per person, per calendar year.	
Rehabilitation Therapy	Outpatient—up to 30 visits per person, per calendar year.	
Extended Care Facility	Up to 12 days of confinement per person, 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**	
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.	
Rx Discount	Use your Celtic ID card at more than 50,000 participating pharmacies nationwide and receive discounts on prescription drug purchases.	
Optional Benefit	**Specifics**	
Preventive Care	(Eligibility begins after 90 days of coverage) Eligible expenses for medical services and supplies incurred for preventive care in an asymptomatic individual are covered first-dollar at 100%, up to $300 per person, per calendar year, which includes up to $50 for routine eye exams.	

* The Primary Applicant cannot be claimed as a dependent on any tax return.
** If PPO plan is chosen, out-of-network eligible charges reduced additional 20%.
*** Benefit will vary by state.

CELTICSAVER HSA HEALTH PLAN BENEFITS

(May vary by state)

The CelticSaver HSA Health Plan pays for the benefits highlighted below provided that four simple criteria are met: 1) The treatment is authorized by a physician; 2) the treatment or diagnosis is for a sickness, bodily injury, complication of pregnancy or as part of a covered wellness program; 3) the treatment is medically necessary; and 4) the expense is a reasonable and customary charge incurred while coverage is in force.

More detailed descriptions of the CelticSaver HSA 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;
- 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;
- emergency air or ground transportation in an ambulance to the nearest hospital up to $3,000;
- 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:

- prescription drugs;
- 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;
- 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 & Cosmetic Charges – Treatment of sound, natural teeth due to bodily injury that occurs while the insured person's coverage is in force. No benefits will be paid for the prevention or correction of teeth irregularities and malocclusion of jaws by removal, replacement, or treatment on or to teeth or any other surrounding tissue. 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.

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

Psychiatric Care Charges – Hospital, medical service and supply charges for psychiatric care while hospital confined are eligible expenses, up to $2,500 per insured person, per calendar year. Outpatient psychiatric care visits and prescription drugs are limited to a maximum of $1,000 per insured person per calendar year. $10,000 lifetime maximum benefit per insured for inpatient and outpatient combined.

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.

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

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

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.

Preventive Care Benefit (after 90 day waiting period) – Services for annual physical examinations and routine diagnostic or preventive testing for an asymptomatic insured person are eligible expenses subject to deductible and coinsurance up to $300 per person, per calendar year.

Charges for care and treatment that are eligible expenses include: low dose mammographies, routine physical examinations, routine gynecologic visits, immunizations, and laboratory testing. Routine eye exams are covered up to $50 per insured person per calendar year.

THE FOLLOWING BENEFIT IS ONLY AVAILABLE IF THE OPTION IS CHOSEN.

Preventive Care Benefit (after 90 day waiting period) – Services for annual physical examinations and routine diagnostic or preventive testing for an asymptomatic insured person are covered first-dollar at 100% up to $300 per insured person per calendar year. The insured's annual deductible does not have to be met before preventive care benefits are paid.

Charges for care and treatment that are eligible expenses include: low dose mammographies, routine physical examinations, routine gynecologic visits, immunizations, and laboratory testing. Routine eye exams are covered up to $50 per insured person per calendar year.

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

CELTICSAVER HSA PPO PLAN

Network Services – To maximize the benefits received under the CelticSaver HSA PPO Plan an insured person must receive services from a network provider.

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. 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.

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.

CELTICSAVER HSA 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;
- treatment of drug addiction or chemical dependency;
- myringotomy or dilation and curettage and surgical treatment of tonsils, adenoids or hernia within first 6 months of coverage;
- newborn nursery charges, unless required by state law.

IMPORTANT PLAN INFORMATION

Eligibility Requirements – To qualify for CelticSaver HSA coverage, a primary applicant must be 18 years of age or over and under 64½ years of age and must not be covered under any other health insurance plan or be claimed as a dependent on any tax return. 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 CelticSaver HSA 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 CelticSaver HSA 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 CelticSaver HSA 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.

Benefits are paid for an insured person's pre-existing condition once coverage is in force for 12 continuous months after the effective date, unless specifically excluded from coverage under this certificate.

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.

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;
- 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 (Pre-authorizaion) Program – Health Care Certification (Pre-authorization) is a benefit which is automatically included in the CelticSaver HSA 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 there is an appeal process available.

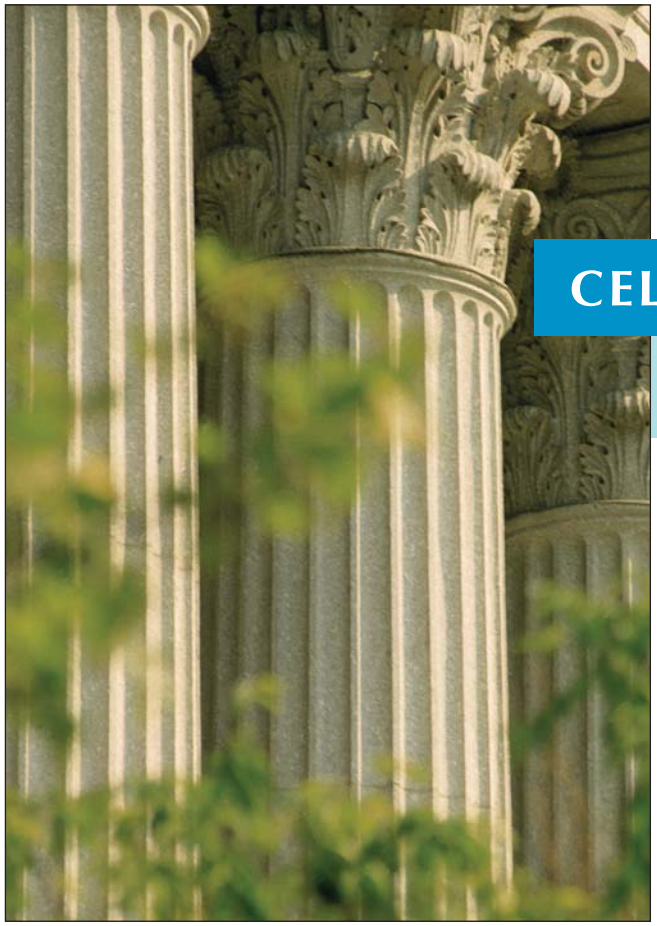
Remember, the final decision for medical treatment is always the right and responsibility of you and your doctor.

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.

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 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