

**BENEFIT SELECTION INSERT
FOR GROUPS OF 51 OR MORE ELIGIBLE EMPLOYEES**



Group Name _____

Group # _____ Effective Date _____

1. MEDICAL PLAN CHOICES

Plan <i>(circle those that apply)</i>	Preferred Plan 100/80/60	Preferred Plan 80/80/50	Preferred Plan Asuris Advance SM 80/80/50	Preferred Plan Asuris Advance SM 70/70/50	HSA-Qualified Preferred Plan 80/80/60
Deductible <i>(check one)</i> For Preferred Plan 100/80/60, deductible is waived for office visits when a copay applies and for outpatient diagnostic lab and x-ray services.	<input type="checkbox"/> \$200	<input type="checkbox"/> \$500	<input type="checkbox"/> \$750	<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$1,500 Member / \$3,000 Family <input type="checkbox"/> \$2,500 Member / \$5,000 Family <input type="checkbox"/> \$3,500 Member / \$7,000 Family
Office Visit Copay <i>(check one)</i>	<input type="checkbox"/> \$15 <input type="checkbox"/> \$20 <input type="checkbox"/> \$25	Not Applicable	<input type="checkbox"/> \$20 <input type="checkbox"/> \$25 <input type="checkbox"/> \$30	<input type="checkbox"/> \$20 <input type="checkbox"/> \$25 <input type="checkbox"/> \$30	Not Applicable
Out-of-Pocket Coinsurance Maximum <i>(check one)</i>	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000		<input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000	<input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000	\$5,000 Member / \$10,000 Family

2. OPTIONAL BENEFITS for all plans

Mental Disorders <i>(check one)</i> 8 days inpatient/12 visits outpatient per calendar year are included in base PPO Plans – Option 12	<input type="checkbox"/> Mental Disorders Option 13 (15 days inpatient/25 visits outpatient per calendar year) (Not available to HSA-Qualified Preferred Plan)
Spinal Manipulations 10 spinal manipulations are included in base medical plans.	<input type="checkbox"/> Spinal Manipulations #1A - (no specific spinal manipulation limit)
Vision Care <i>(check one)</i>	<input type="checkbox"/> Exam and Schedule Hardware Benefit – Option 11 (Not available to HSA-Qualified Preferred Plan) <input type="checkbox"/> Exam and 80% to \$200 Hardware Benefit – Option 7 (\$200 maximum benefit every two calendar years beginning with the initial date of service) <input type="checkbox"/> None
TMJ	Standard – included in rates quoted (\$1,000 per calendar year / \$5,000 per lifetime maximum benefit)
Traditional Dental Plans Refer to Group Master Application for participation requirements. <i>(check those that apply)</i>	<input type="checkbox"/> Indicate Traditional Dental Plan # _____ <input type="checkbox"/> Orthodontia (50% to \$1,000) <input type="checkbox"/> None
Columbia Dental Plans (for Groups of 100+ employees only) Refer to Group Master Application for participation requirements. <i>(check those that apply)</i>	<input type="checkbox"/> Indicate CD Plan # _____ <input type="checkbox"/> Orthodontia <input type="checkbox"/> None

3. OPTIONAL BENEFITS for all plans except the HSA-Qualified Preferred Plan

Prescription Drugs <i>(check those that apply)</i>	Tiered – Open Formulary <input type="checkbox"/> \$7 generic formulary/30% brand-name formulary/50% non-formulary copay <input type="checkbox"/> \$12 generic formulary/30% brand-name formulary/50% non-formulary copay <input type="checkbox"/> \$10 generic formulary/\$20 brand-name formulary/\$40 non-formulary copay	Closed Formulary <input type="checkbox"/> \$15 Copay <input type="checkbox"/> \$20 Copay <input type="checkbox"/> 50% Copay to \$2,000 maximum benefit per calendar year (only available for renewing groups that currently have this Rx option) <input type="checkbox"/> 20% Copay with \$500 prescription drugs deductible per calendar year	<input type="checkbox"/> None
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“OPTIONAL BENEFITS” continued on reverse side

3. OPTIONAL BENEFITS for all plans except the HSA-Qualified Preferred Plan - continued

Preventive Care	<i>(check one)</i>	<input type="checkbox"/> Preventive Care Option #7 (no specific benefit maximum per calendar year)
		<input type="checkbox"/> Preventive Care Option #8 (deductible waived; subject to any applicable per-visit copay; benefit limited to \$300 per person, per calendar year)
		<input type="checkbox"/> None
		Preferred Plan Asuris Advance groups must choose one of the following options:
		<input type="checkbox"/> Preventive Care Option #9 (deductible waived; subject to any applicable per-visit copay; benefit limited to \$300 per person, per calendar year)
		<input type="checkbox"/> Preventive Care Option #10 (deductible waived: no specific benefit maximum per calendar year)

4. NOTES – For groups of 100+ eligible employees currently enrolled on and renewing on a product or benefit option not included on this insert, please list any products/benefits not listed above

5. ACCOUNTABLE OFFICER'S CERTIFICATION

I certify that the information on this Benefit Selection Insert is complete and accurate.

X _____
Accountable Officer's Signature & Title Date