



# Select Choice™ Series

Consumer-driven major medical insurance plans for individuals and their families



## G·T·L

Guarantee Trust Life Insurance Company

**US Benefit Plan**  
RX AMERICA

Group Insurance for Members of  
US Benefit Plan Rx America (a non-  
profit association)

**AHCP**

Select Choice™ Series is distributed by  
America's Health Care Rx Plan Agency, Inc.

A series of 3 major medical PPO plans that give you the **choice** to **select** a plan that meets your health care needs and budget.

# You have choices with the **Select Choice™** Series!



## **CHOOSE YOUR COVERAGE**

The calendar year deductible, coinsurance and benefit options you select will determine the premium cost for your insurance plan. **The higher the deductible, the lower your premium.** This is because with a higher deductible, you are agreeing to pay more of the routine medical expenses yourself.

By using insurance only for higher-cost expenses, you:

- LOWER YOUR INSURANCE COSTS AND
- ARE ABLE TO BUDGET YOUR MEDICAL/INSURANCE EXPENSES.

### **Our Comprehensive Plan**

provides you the highest benefits and lowest out-of-pocket costs, in exchange for a higher monthly premium.

### **Our Popular Plan**

lowers your monthly premium through higher out-of-pocket costs when you do use medical services.

### **Our Economical Plan**

provides you the lowest premium cost – saving you money every month on your insurance – as you pay covered routine medical costs through your deductible and coinsurance when you use medical services. If you stay healthy and don't use extensive medical services, you'll have premium savings over other insurance plans.

Select Choice™ Series is designed to be a PPO product. Utilizing PPO providers will result in lower out-of-pocket costs to you. Utilizing Non-PPO medical providers will generally result in higher out-of-pocket costs to you and, additionally, you are responsible for the provider's billed charges that exceed the usual, reasonable and customary charge.

## Important features of this series:

### **Calendar Year Deductibles**

- Options from \$1,000 to \$5,000
- Maximum of two deductibles (Comprehensive) or three deductibles (Popular & Economical) per family per calendar year
- Fourth quarter Deductible Carryover Credit
- No separate Non-PPO Deductible

### **Benefits**

- No separate benefit maximum for covered organ transplants
- No calendar year limit on covered outpatient prescriptions (Comprehensive & Popular and, if option elected, on Economical Plan)
- Preventive Care Benefits on all plans
- Emergency Care received outside the U.S.
- Common Accident Deductible
- Spinal Manipulation
- Home Health Care and Hospice Care
- Physician Office Visits
- Optional 24-Hour Occupational Coverage and Optional Supplemental Accident Benefits

### **Premiums**

- Family Premium Discount
- Premiums can not be increased on an individual basis because of claims experience
- Preferred Health Discount for qualified individuals ages 18 through 39

### **PPO Networks**

- Multiple PPO networks to choose from, including a national PPO network
- No balance billing when utilizing a PPO provider
- No claim forms to complete when utilizing a PPO provider
- Medical emergency services, as defined in the policy, paid at PPO level of benefits; limited to usual, reasonable, customary charge
- Medically necessary services not available from a PPO provider and referred to a Non-PPO provider considered for payment at PPO level; limited to usual, reasonable, customary charge

## Covered Expenses\*

- Ambulance Service (maximum benefit per occurrence) - \$1,000 for ground or water, \$5,000 for air
- Anesthetics and their Administration
- Chemotherapy and Radiation Therapy
- Dental Treatment to Sound Natural Teeth resulting from a covered injury
- Dressings, Sutures, Casts, Splints, Trusses, Crutches, Rental of Durable Medical Equipment
- Emergency Treatment Received Outside the U.S.
- Hospital Daily Room and Board (semi-private rate), Hospital Inpatient Miscellaneous Medical Services and Supplies, Hospital Outpatient Services
- Inpatient Psychiatric Care, Chemical Dependency, Substance Abuse, Alcohol and Drug Rehabilitation - Up to maximum benefit of 55 days of active treatment or \$2,000 per calendar year, whichever occurs first
- Outpatient Psychiatric Care - 50% coinsurance up to \$20 per visit with a maximum benefit of 55 visits per calendar year
- Organ Transplants or Replacements (for specific transplants or replacements)
- Oxygen and Rental of Equipment for the Administration of Oxygen
- Physical, Respiratory and Speech Therapy for Rehabilitative Treatment
- Physician Charges - Inpatient and outpatient
- Skilled Nursing Facility for Convalescent Care
- Confinement in an Intensive, Intermediate, Observation or Specialized Care Unit - *Popular and Economical Plans*: Up to 3x semi-private room rate; *Comprehensive Plan*: 3x semi-private room rate maximum is not applicable
- Home Health Care (in lieu of a covered hospital confinement) - Up to \$2,500 maximum benefit per calendar year
- Homeopathic Benefit - When provided by a licensed homeopathist up to \$50 per visit to a maximum benefit of \$500 per calendar year (supplies not covered)
- Hospice Care - *Comprehensive Plan*: Up to a \$5,000 lifetime maximum benefit; *Popular and Economical Plans*: Up to a \$2,000 lifetime maximum benefit
- Hospice Care Bereavement Counseling (not subject to calendar year deductible, service deductible, co-payments or coinsurance) - Covered up to 3 months after covered person's death up to maximum benefit of \$500
- Private Duty Nursing - *Comprehensive Plan*: Up to \$2,000 maximum benefit per covered person per calendar year; *Popular and Economical Plans*: Up to \$1,000 maximum benefit per covered person per calendar year
- Spinal Manipulation and other Manipulative Therapy - Up to \$500 maximum benefit per covered person per calendar year



## Preventive Care Benefits\*

- **Child Health Supervision** (includes immunization) - Specific age intervals from birth to 6 years
  - **Pap Smear** - One screening per calendar year
  - **Mammograms** - One baseline age 35-39. Age 40 and over covered yearly
  - **Prostate Cancer Screening (PSA) Tests** - One per calendar year for males age 40 and over
  - **Routine Physical Exams - Comprehensive and Popular Plans** - Covered after insured 90 days; up to \$150 maximum benefit per examination per covered member/spouse per benefit period (every two years), including lab tests (blood/urine) associated with the same routine physical exam. Subject to coinsurance only.  
**Economical Plan** - Covered after insured 12 months; up to \$100 maximum benefit per examination per covered member/spouse per benefit period (every two years), including lab tests (blood/urine) associated with the same routine physical exam. Subject to coinsurance only.
- \* Plan benefits, including Preventive Care Benefits, may be subject to exclusions, limitations and maximum benefits and may vary by state. Complete description of benefits is contained in the Master Policy and outlined in the Certificate. All covered expenses are subject to any applicable calendar year deductible, service deductibles, co-payments, coinsurance and policy maximums, unless otherwise specified.**



# COMPREHENSIVE PLAN

The policy will pay 100% of covered expenses up to the Lifetime Maximum Benefit after you have met your Out-Of-Pocket Expenses<sup>(1)</sup>

<b>Lifetime Maximum Benefit</b>	\$5,000,000										
<b>Calendar Year Deductibles</b>	\$1,000, \$1,500, \$2,500, \$3,500, \$5,000 Maximum <u>two</u> individual calendar year deductibles per family										
<b>Coinsurance/Stop Loss</b> (after the covered person has satisfied the calendar year deductible and any applicable service deductibles and co-pays) PPO and Non-PPO stop loss accumulate separately	<table border="1"> <thead> <tr> <th><u>PPO - Stop Loss</u></th> <th><u>Non-PPO - Stop Loss</u></th> </tr> </thead> <tbody> <tr> <td>100/0%-\$0</td> <td>75/25%-\$15,000</td> </tr> <tr> <td>80/20%-\$5,000</td> <td>60/40%-\$10,000</td> </tr> <tr> <td>80/20%-\$10,000</td> <td>60/40%-\$20,000</td> </tr> <tr> <td>50/50%-\$10,000</td> <td>50/50%-\$20,000</td> </tr> </tbody> </table>	<u>PPO - Stop Loss</u>	<u>Non-PPO - Stop Loss</u>	100/0%-\$0	75/25%-\$15,000	80/20%-\$5,000	60/40%-\$10,000	80/20%-\$10,000	60/40%-\$20,000	50/50%-\$10,000	50/50%-\$20,000
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<b>Physician Office Visits</b> - Co-pay <sup>(2)</sup> applies to physician office visit <u>charge</u> only	<b>\$25 PPO<sup>(3)</sup></b> Additional \$25 <sup>(3)</sup> co-pay for covered lab exams, x-rays and diagnostic tests up to a maximum benefit of \$150 <i>Non-PPO<sup>(3)</sup></i> - Subject to \$25 co-pay plus deductible and Non-PPO coinsurance										
<b>Service Deductibles<sup>(2)</sup></b> *Hospital Emergency Room (per occurrence)	\$100 Waived if admitted as an inpatient immediately following emergency room visit										
*Inpatient Hospital Admission (per admission)	\$0										
*Outpatient Ambulatory Surgical Facility (per visit)	\$0										
*Outpatient Testing (per visit)	\$0										
*Outpatient MRI, CAT Scan, PET Scan and Nuclear Imaging Test (per test)	\$0										
<b>Outpatient Prescription Drugs</b> <b>Rx Co-pay Drug Card</b>	<i>Rx Drug Co-pays:</i> <b>\$15 Generic, \$30 Formulary, \$40 Brand Name</b> Co-pay applies after a separate selected \$100, \$250 or \$500 Rx calendar year deductible per covered person										
<b>Optional Benefits</b>	Supplemental Accident 24-Hour Occupational Coverage										

(1) Out-of-pocket expenses include any applicable deductibles, co-pays, coinsurance, amounts in excess of usual, reasonable and customary charges and non-covered expenses.

(2) Co-pay and service deductibles, if applicable, are in addition to the chosen calendar year deductible/coinsurance and do not apply to the calendar year deductible.

(3) After your PPO co-pay, balance of PPO office visit charge paid at 100%. Covered x-rays, lab exams and diagnostic tests performed in the PPO Physician Office and billed by the PPO Physician are subject to a separate additional \$25 co-pay, then paid at 100% up to a maximum benefit of \$150. Covered expenses in excess of the \$150, expenses performed and/or billed by an outside lab, and all other covered services performed during the PPO office visit are subject to calendar year deductible and coinsurance. Non-PPO - After \$25 co-pay all covered services, including lab and testing, are subject to the calendar year deductible and Non-PPO coinsurance.

# POPULAR PLAN



The policy will pay 100% of covered expenses up to the Lifetime Maximum Benefit after you have met your Out-Of-Pocket Expenses<sup>(1)</sup>

<b>Lifetime Maximum Benefit</b>	\$5,000,000								
<b>Calendar Year Deductibles</b>	\$1,000, \$1,500, \$2,500, \$3,500, \$5,000 Maximum <u>three</u> individual calendar year deductibles per family								
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<b>Physician Office Visits</b> - Co-pay <sup>(2)</sup> applies to physician office visit <u>charge</u> only	<b>\$45 PPO<sup>(3)</sup></b> Non-PPO <sup>(3)</sup> - Subject to \$45 co-pay plus deductible and Non-PPO coinsurance								
<b>Service Deductibles<sup>(2)(5)</sup></b> *Hospital Emergency Room (per occurrence)  *Inpatient Hospital Admission (per admission) *Outpatient Ambulatory Surgical Facility (per visit) *Outpatient Testing <sup>(4)</sup> (per visit) *Outpatient MRI, CAT Scan, PET Scan and Nuclear Imaging Test (per test)	<table border="1"> <tbody> <tr> <td>\$100</td> </tr> <tr> <td>Waived if admitted as an inpatient immediately following emergency room visit</td> </tr> <tr> <td>\$200</td> </tr> <tr> <td>\$200</td> </tr> <tr> <td>\$200</td> </tr> <tr> <td>\$200</td> </tr> </tbody> </table>	\$100	Waived if admitted as an inpatient immediately following emergency room visit	\$200	\$200	\$200	\$200		
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<b>Optional Benefits</b>	Supplemental Accident 24-Hour Occupational Coverage								

- (1) Out-of-pocket expenses include any applicable deductibles, co-pays, coinsurance, amounts in excess of usual, reasonable and customary charges and non-covered expenses.
- (2) Co-pay and service deductibles, if applicable, are in addition to the chosen calendar year deductible/coinsurance and do not apply to the calendar year deductible.
- (3) After co-pay, balance of PPO office visit charge is paid at 100%. All other covered services performed during the office visit (including x-rays and testing) are subject to the calendar year deductible and coinsurance. Non-PPO visits, after co-pay, balance of all covered expenses subject to calendar year deductible and Non-PPO coinsurance.
- (4) Applies to outpatient x-rays, laboratory and diagnostic testing not performed in a physician's office. Additionally, this service deductible does not apply to charges subject to the Outpatient MRI, CAT Scan, PET Scan, Nuclear Imaging Test Service Deductible.
- (5) Service Deductibles' family maximum of \$2,400 per calendar year. Once the calendar year Family Maximum is met, no further service deductibles will apply for the balance of that calendar year.



# ECONOMICAL PLAN

The policy will pay 100% of covered expenses up to the Lifetime Maximum Benefit after you have met your Out-Of-Pocket Expenses<sup>(1)</sup>

<b>Lifetime Maximum Benefit</b>	\$2,000,000												
<b>Calendar Year Deductibles</b>	\$1,000, \$1,500, \$2,500, \$3,500, \$5,000 Maximum <u>three</u> individual calendar year deductibles per family												
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<b>Service Deductibles<sup>(2)(5)</sup></b> *Hospital Emergency Room (per occurrence)  *Inpatient Hospital Admission (per admission) *Outpatient Ambulatory Surgical Facility (per visit) *Outpatient Testing <sup>(4)</sup> (per visit) *Outpatient MRI, CAT Scan, PET Scan and Nuclear Imaging Test (per test)	<table border="1"> <tbody> <tr> <td>\$100 Waived if admitted as an inpatient immediately following emergency room visit</td> </tr> <tr> <td>\$300</td> </tr> <tr> <td>\$300</td> </tr> <tr> <td>\$300</td> </tr> <tr> <td>\$300</td> </tr> </tbody> </table>	\$100 Waived if admitted as an inpatient immediately following emergency room visit	\$300	\$300	\$300	\$300							
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- (1) Out-of-pocket expenses include any applicable deductibles, co-pays, coinsurance, amounts in excess of usual, reasonable and customary charges and non-covered expenses.
- (2) Co-pay and service deductibles, if applicable, are in addition to the chosen calendar year deductible/coinsurance and do not apply to the calendar year deductible.
- (3) After co-pay, balance of PPO office visit charge is paid at 100%. All other covered services performed during the office visit (including x-rays and testing) are subject to the calendar year deductible and coinsurance. Non-PPO visits, after co-pay, balance of all covered expenses subject to calendar year deductible and Non-PPO coinsurance.
- (4) Applies to outpatient x-rays, laboratory and diagnostic testing not performed in a physician's office. Additionally, this Service Deductible does not apply to charges subject to the Outpatient MRI, CAT Scan, PET Scan, Nuclear Imaging Tests Service Deductible.
- (5) Service Deductibles' family maximum of \$3,600 per calendar year. Once the calendar year Family Maximum is met, no further service deductibles will apply for the balance of that calendar year.

## Rx Co-pay Drug Card

(optional on the Economical Plan)

After your selected separate Prescription Drug (Rx) calendar year deductible, outpatient covered prescription drugs are subject to the following co-pays:

**\$15 generic, \$30 formulary, \$40 brand name.** After co-pay, the balance of the cost of the drug is paid at 100% at participating pharmacies. Mail order (most states) included with 2x applicable co-pay for a 90-day supply.

For all plans, a reduced benefit may be offered (or, on the Economical Plan, the benefit eliminated) if any proposed insured is on maintenance medications.

*To determine an affiliated participating network pharmacy, call Express Scripts at 800-234-7345. Express Scripts has over 50,000 affiliated pharmacies nationwide. Simply present your Rx Co-pay Drug Card and pay the deductible and applicable co-pay. Charges for covered Rx drugs purchased from non-affiliated pharmacies will be paid to the covered person up to the amount that would be paid if purchased through an affiliated participating pharmacy, less the covered person's drug co-payment and Rx deductible.*

*Prescription Co-pay Drug Card benefits are not payable for drugs purchased without a prescription; contraceptive drugs, devices or supplies; immunization agents or therapeutic devices. A complete listing of the Rx exclusions is listed in the Prescription Drug Card Benefit Rider.*

## Rx Discount Card

(included on all plans)

While you are meeting your Rx Co-pay Drug Card deductible, if applicable, and for drugs not covered under the Rx benefit rider, simply present your Rx Discount Card at an affiliated network pharmacy to receive a discount on drug purchases. While the cost of the drug is your responsibility, you can enjoy the valuable discount when you utilize the affiliated pharmacy(ies). **The Rx discount is not an insurance benefit.** The Rx discount is not available for drugs purchased at pharmacies not affiliated with Express Scripts.



## Optional Benefits

**Supplemental Accident - Benefits paid at 100% up to \$500 maximum benefit per occurrence with NO calendar year deductible.** Charges for the covered injury must be incurred within 90 days of the date of the injury, provided initial treatment was received within 72 hours of the injury. Covered expenses in excess of \$500 will be payable as any other covered expense.

**24-Hour Occupational Coverage** - To be eligible for this optional Rider, the applicant and/or spouse must be: (1) a sole proprietor, partner, owner or other individual gainfully employed in an occupation eligible for the Rider; and (2) eligible to opt out of Workers' Compensation by their state law and have done so. This optional Rider provides benefits for injuries or sicknesses, that arise out of or in the course of employment, on the same basis as any other covered illness. **Benefits are payable provided** the covered person is not insured or required to be covered under any Workers' Compensation or similar law, the expenses are incurred while the Rider is in force **and** the covered person's occupation and employment status as listed on the application for this benefit has not changed after the covered person's effective date under the Rider. If the covered person's occupation changes, the covered person is required to provide notification within 30 days of the date of the change in occupation. **The covered person should request that the Rider be terminated;** however, the individual can request to the plan administrator to add this Rider to their certificate under their new occupation if gainfully employed in an eligible occupation and is eligible to opt out of Workers' Compensation and has done so. If this Rider is not elected, there is no on the job coverage.



## Additional Plan Features

### Calendar Year Deductible Carryover -

Covered expenses incurred during the last three months of a calendar year that are applied to the medical plan's calendar year deductible will also apply toward the following year's calendar year deductible. This does not apply to the separate Rx Drug Card deductible.

**Common Accident Deductible** - If two or more covered persons sustain an injury in the same accident, only one calendar year deductible will be applied to all covered medical expenses arising out of that accident.

**Initial 12 Month Rate Guarantee** - Initial premium rates, excluding fees, are guaranteed for 12 months. Initial premium rates may change if you move, change your plan or add/delete covered dependents.

**Medical Emergencies** - Medical benefits for emergency (as defined in the policy) services will be considered for payment at participating provider benefit level, limited to the usual, reasonable and customary charge. Emergency services must be provided within 72 hours following the onset of the injury or illness.

**Medically Necessary Covered Services Not Available From A PPO Provider** - and referred to a Non-PPO provider will be considered for payment at PPO level; limited to the usual, reasonable and customary charge.

## Discounts

- Family premium discount of 10% applies when a certificate is issued with two or more eligible family members applying together.
- Preferred Health discount of 20% applies to qualified individuals ages 18 through 39.

## General Information

- Available effective dates are the 1st or 15th of a month contingent on underwriting approval.
- 10 Day Right To Examine Provision.

### Eligibility:

- Members can apply for coverage if they are a dues paying member of USBenefit Plan Rx America between the ages of 18 through 64.
- Member's dependents can apply for coverage if they are a legally married spouse of the opposite gender through age 64, and unmarried dependent children under age 19 (under age 25 if enrolled full time in an accredited two-year or four-year college or university).
- Children only coverage available for infant through 18 (24 if full-time student). Parent must be enrolled as a member of USBenefit Plan Rx America.

### Termination of Insurance:

Insurance will remain in force until:

- The date there is fraud or material misrepresentation with regard to the policy or its benefits.
- The date the member's premium is due if not received by the end of the grace period.
- The premium due date following the date the policy terminates.
- The date of death of the covered member.
- The premium due date following the date the insurer terminates all certificates in a specific state.
- Spouse coverage terminates on the premium due date following the date of the member's and spouse's divorce.
- Dependent child's coverage terminates on the premium due date following: the date of the covered dependent's marriage; the date the covered dependent reaches age 19 (or 25 if a full-time student). (Termination of covered member's insurance will also result in dependent termination.)

Dependents may be eligible to convert under the Policy's Health Insurance Conversion Provision.

**In the absence of fraud or misrepresentation, insureds can not be singled out for a rate increase nor can their certificate be cancelled due to claims on an individual basis.**

**Failure to fully disclose health information can result in rescission (voiding) or reformation of coverage and the denial of a claim. Please refer to the Application and the Certificate of Insurance for further details.**

## Precertification of Care

Hospital admissions and certain outpatient procedures, services or supplies, as outlined in the Policy, require precertification before a covered person receives them. PRECERTIFICATION IS NOT PREAUTHORIZATION AND DOES NOT GUARANTEE THAT AN ADMISSION, SERVICE OR PROCEDURE IS COVERED UNDER THE POLICY.

**Non-Precertification Penalty**  
Failure to precertify when required will result in a \$500 non-precertification penalty.



## Pre-Existing Conditions - Definition and Limitation

An illness or injury of a covered person for which the covered person has received medical advice, treatment, services, diagnostic tests, consultation or medication during the twelve (12) months prior to the covered person's effective date of coverage under the policy. Benefits will be payable for a pre-existing condition, unless the condition is specifically excluded under the policy or excluded by endorsement or rider attached to the policy or certificate, if at the end of a continuous 12-month period commencing on or after the effective date of the covered person's coverage, the person has not received medical advice, treatment, services, diagnostic tests, consultation or medication in connection with such illness or injury; or, at the end of the two (2) year period commencing on the effective date of the covered person's coverage, the person has been covered under the policy.

**Health conditions duly disclosed in the application for coverage of the covered person and otherwise covered by this policy, unless the condition is specifically excluded by endorsement or rider attached to the policy or certificate, are covered from the effective date of coverage under the policy.**

**Coverage under the plan may be uniformly modified prospectively subject to HIPAA and state law.**

**Applicants should not cancel any existing medical insurance plan until they have been notified in writing by the insurance company or its designated plan administrator that their new insurance is in effect.**



## Exclusions & Limitations

Except as specifically provided for in the policy, the policy does not cover:

- Pre-existing conditions.
- **Charges incurred prior to the date the covered person has been covered under the policy for six consecutive calendar months for the care or treatment of: hernia; tonsils; adenoiditis; any disease or disorder of the reproductive system; any rectal disease or disorder; gall bladder; varicose veins; or laminectomy, discectomy or spinal fusion. Any such condition may also be excluded as a pre-existing condition. This limitation shall not apply to services provided for an emergency where such condition is not excluded as a pre-existing condition. This exclusion will not apply to a covered person receiving treatment due to a malignancy, provided such treatment is not being rendered to a pre-existing condition.**
- Expenses incurred before the effective date.
- Expenses incurred after coverage under the policy terminates, regardless of when the condition originated.
- Any conditions specifically excluded by riders or exclusions attached to the policy.
- Expenses incurred to treat complications resulting from treatment, drugs, supplies, devices, procedures or conditions which are not covered under the policy.
- Experimental, investigational services.
- Expenses determined to be educational.
- Amounts in excess of the usual, reasonable and customary charges.
- Expenses the covered person is not required to pay, which are covered by other insurance, except Medicaid, or which would not have been billed if no insurance existed.
- Charges determined by us to be unbundled charges.
- Care in government institutions unless the covered person is obligated to pay for such care.
- Charges incurred for illness or injury that arises out of, as a result of, or in the course of employment.
- Non-emergency treatment received outside of the United States.
- Charges incurred by a covered person while on active duty in the Armed Services.
- Expenses resulting from a declared or undeclared war, or from voluntary participation in a riot or insurrection.
- Expenses incurred or expense related thereto, while engaging in an illegal act or occupation or during the commission, or the attempted commission, of a felony.
- Pregnancy or childbirth, except for complications of pregnancy.
- Charges incurred for voluntary termination of pregnancy.
- Any drug (including birth control pills), implants or injections, supply, treatment, device or procedure that prevents or terminates conception and/or childbirth.
- Diagnosis and treatment of infertility, including but not limited to any attempt to induce fertilization by any method other than by natural means; in vitro fertilization, artificial insemination or similar procedures whether the covered person is the donor, recipient or surrogate.
- Any drugs, supplies, treatments, devices or procedures related to sex transformation or reversal thereof, sexual dysfunctions, penile implants or sexual inadequacies.
- Sterilization or reversal of sterilization.
- Physical exams or other services or supplies not needed for medical treatment.
- Prophylactic treatment, including surgery or diagnostic testing.
- Outpatient treatment of alcoholism.
- Outpatient treatment of chemical dependency, substance abuse and/or drug addiction.
- Programs, treatment, supplies, or procedures for tobacco use cessation or nicotine addiction.
- Expenses resulting from intentional self-inflicted injury, suicide or attempted suicide, whether sane or insane.
- Charges incurred for illness or injury resulting either directly or indirectly from the covered person's: (a) voluntary taking of poison; (b) voluntary inhaling of gas; (c) being intoxicated or under the influence of alcohol, drugs, controlled substances, or any other substances capable of mental or physical impairment, unless it has been administered or prescribed by a physician.
- Dental treatment or care, orthodontia or other treatment involving the teeth and supporting structures.
- Treatment by any method for jaw joint problems including temporomandibular joint dysfunction (TMJ), TMJ pain syndromes, craniomandibular disorders, myofascial pain dysfunction or other conditions of the joint linking the jaw bone (mandible) and skull and the complex of muscles, nerves and other tissues related to the joint.
- Surgical or non-surgical correction of refractive error; vision therapy; routine vision exams to assess the initial need for or changes to prescription eyeglasses or contact lenses; the purchase, fitting or adjustment of eyeglasses or contact lenses; eyeglasses or contact lenses for the treatment of aphakia.
- Routine hearing exams to assess the need for or change to hearing aids; the purchase, fittings or adjustments of hearing aids; and/or the surgical or non-surgical treatment for the improvement of hearing including the insertion of hearing aids or implants.
- Cosmetic or reconstructive procedures, services or supplies.
- Charges for breast reduction unless medically necessary.
- Charges for breast augmentation.
- Removal of breast implants.
- **Outpatient prescription medications on the Economical Plan (unless covered under the Optional Rx Co-pay Drug Card, if elected).**
- Medications and drugs, including vitamins and vitamin-mineral supplements, available over-the-counter (OTC) whether or not by a physician's prescription order.
- Any expense related to the treatment of hair loss.
- Treatment of weak, strained, flat, unstable, or unbalanced feet, fallen arches, metatarsalgia, bunions or the removal of one or more corns, calluses or toenails; chronic foot strain or symptomatic complaint of the feet.
- Charges for blood or blood plasma that has been replaced.
- Treatment of autism.
- Treatment of developmental delays, learning disabilities, attitudinal disorders, attention deficit disorders, disciplinary problems, testing and training for education or vocation.
- Treatment of acne.
- Weight loss programs, diets, or treatment of obesity, extreme obesity or morbid obesity, including surgery for reconstruction, repair or reversal of a gastric bypass.
- Transportation charges.
- Rest and/or recuperation cures or care in a skilled nursing facility, convalescent nursing home or facility, extended care facility, or home for the aged, whether or not part of a hospital.
- Services or supplies for personal comfort or convenience, including custodial care or homemaker services.
- Services and/or supplies furnished and/or provided by an immediate family member or a person who ordinarily resides in the home of the covered person or by the employer of an immediate family member, except for covered expenses rendered while hospital confined.
- Any charges incurred in connection with a hospital admission on Friday or Saturday unless the attending physician states in writing that the admission was an emergency.
- Immunizations not necessary for the treatment of an illness or injury.
- Expenses incurred for occupational therapy.
- Acupuncture unless the charges incurred are in lieu of anesthesia.
- Marriage or family counseling.
- Sex therapy.
- Stand - by availability of a physician when no treatment was rendered.
- Genetic testing, counseling or services.
- Expenses which are not medically necessary to the care or treatment of an injury or illness.



# Things you need to know about Health Insurance Coverage\*

**What are Covered Expenses?** The expenses payable under the policy for the medically necessary services or supplies for treatment of a covered illness or injury. The amount payable will vary depending upon whether the services were provided by a PPO Provider (In Network) or Non-PPO Provider (out of Network). See PPO below.

**Calendar Year Deductible:** The amount of covered expenses each covered person must pay before the policy pays. This does not include any separate co-payments, separate service deductibles, prescription drug card deductible or non-covered expenses.

**Coinsurance:** The percentage of a covered expense that is paid by each covered person after the person has paid their calendar year deductible and any applicable service deductibles and co-payments. You select the amount of coinsurance desired at time of application.

**Coinsurance Stop Loss:** The maximum amount of money the covered person will be required to pay for covered expenses each calendar year. It does not include calendar year deductibles, service deductibles, co-payments or expenses not covered under the policy. As an example; you purchase an "80%/20% PPO to \$5,000; 60%/40% Non-PPO to \$10,000" coinsurance plan, with a \$1,500 calendar year deductible. After the covered person pays the \$1,500 calendar year deductible and any applicable service deductibles or co-payments, the policy pays 80% of the next \$5,000 of covered expenses and the covered person would be responsible for 20% or \$1,000. If the covered person used a Non-PPO provider, the policy pays 60% of the next \$10,000 of covered expenses and the covered person would be responsible for 40% or \$4,000. After the coinsurance maximum is met, the policy pays 100% of additional covered expenses incurred during the balance of the calendar year.

**PPO Network:** "Preferred Provider Organization (PPO)". A PPO is comprised of doctors, physicians, surgeons, hospitals, clinics and other health care service providers who have contracted with the Network to provide their services at negotiated prices and agree not to bill more than the negotiated fee. The highest level of benefits are available under the policy when a PPO provider is used for covered services. The policy will pay a lower level of benefits when a Non-PPO provider is used, because these providers have not signed contracts with the Network and do not provide services at agreed upon prices. When Non-PPO providers are used for services covered under the policy, covered expenses are limited to the usual, reasonable and customary charge and the covered person is responsible for any amount of billed charges that exceed the usual, reasonable and customary charge.

**Physician/Doctor's Office Visit Co-payments:** The PPO Physician's office visit co-pay is the amount each covered person pays at the time of service for each visit and covers the office visit charge. After the co-pay, the balance of the office visit charge is paid at 100%. **All other covered expenses incurred during the PPO provider visit, including charges for x-rays, labs and diagnostic tests, are not covered under the co-payment and will be subject to the calendar year deductible and coinsurance.** For Non-PPO physicians, after the co-pay, the balance of the office visit charge and all other covered expenses incurred during the Non-PPO provider visit are subject to the calendar year deductible and Non-PPO coinsurance.

**Service Deductibles:** The payment which must be made by a covered person at the time of service for certain procedures or service. Service Deductibles do not apply toward the calendar year deductible or coinsurance.

\*These may vary by policy and the plan of coverage selected.

# Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act (HIPAA) and related state laws require insurance carriers to offer coverage to Eligible Individuals on a guaranteed-issue basis and without a pre-existing condition exclusion. Such coverage is not required in states that have enacted alternative mechanisms. Where required by law, Guarantee Trust Life will offer coverage to Eligible Individuals. Your agent can tell you the type of coverage available to Eligible Individuals in your area. In general, Eligible Individuals are individuals who satisfy the following requirements:

- Have been insured under Creditable Coverage for at least 18 months (with no more than a 63-day gap in coverage), the most recent being under an employer-sponsored, governmental or church plan;
- Are not eligible for coverage under an employer-sponsored plan, Medicare or Medicaid;
- Do not have other health insurance coverage;
- Whose most recent coverage was not terminated for nonpayment or fraud; and
- Who have elected and exhausted any COBRA or state continuation coverage.

Creditable Coverage means: employer-sponsored coverage; health insurance coverage; Medicare; Medicaid; CHAMPUS; tribal organization programs; public health plans; or Peace Corps plans.

## LabOne\*

LabOne is another cost containment program. It does not replace existing lab benefits. **LabOne is a fully accredited and certified laboratory which offers significant savings over other labs.** At the time of service, simply request that lab work be sent to LabOne for processing. LabOne will submit claims for services directly to Guarantee Trust Life or the plan administrator. If a provider is unable to collect the specimen, LabOne has contracted draw sites available.

**You will receive LabOne discounts when your lab specimens are sent to LabOne for testing.** Covered expenses are subject to calendar year deductible, coinsurance and any applicable service deductibles.

Client Services: 1-800-750-1253  
www.laboneselect.com

\*Not available in all states.

# Our Commitment

## Please Note:

This brochure is a brief description of the features of the Master Group Policy; this brochure is not a contract. Not all policy provisions, exclusions and limitations are listed in this brochure. The insurance certificate is issued upon approval of coverage, and will contain a summary of the coverage with a complete list of covered expenses, exclusions and limitations. To review a specimen copy of the insurance certificate, just ask your agent.

Your state laws may mandate that the benefits described in this brochure be different. Please refer to the state specific benefits page (brochure insert) for a description of these differences, if any.

This plan is not being sold as an employee benefit plan and the member's employer may not be responsible, either directly or indirectly, for paying the premiums; therefore, any state or federal laws pertaining to employer-sponsored health insurance plans do not apply to these plans.

No agent has the authority to change any benefits, to bind coverage with Guarantee Trust Life or to promise a specific coverage date.

**Applicants should not cancel any existing medical insurance until they have been notified in writing by Guarantee Trust Life or the Plan Administrator that their new insurance is in effect.**

*Guarantee Trust Life and USBenefit Plan Rx America (a non-profit association) are unaffiliated entities. Guarantee Trust Life does not receive any compensation or sales or promotional fees from the Association. AHCP and its agents may receive compensation from the association for sales promotion.*



Details on the membership benefits included in the membership package(s) can be found on the USBenefit website at [www.usbenefitplan.com](http://www.usbenefitplan.com)



Marketed by: America's Health Care/Rx Plan Agency, Inc., 777 Main Street, Fort Worth, TX 76102  
www.ameri-choice.com  
EMAIL: [marketing@ameri-choice.com](mailto:marketing@ameri-choice.com)  
PHONE: 877-228-8773



Guarantee Trust Life Insurance Company  
Glenview, IL

Policy Form: #GR0591  
Policy Form in FL: #GR0591(FL)  
Master Group Policy: #GTL-SCS-01/06  
Master Group Policy in FL: #GTL-SCS(FL)-01/06

The Master Group Policy is issued to USBenefit Plan Rx America in the state of Illinois. Benefits, exclusions, limitations and availability may vary by state. Insurance premiums vary by age, sex, occupation, state, zip code, plan deductibles and coinsurance selected, effective date and underwriting decision. Premiums may also vary based on selected PPO network.

Insurance Plan is underwritten by Guarantee Trust Life Insurance Company, Glenview, IL.