

**BENEFIT SELECTION INSERT
FOR GROUPS OF 100 OR MORE ENROLLED EMPLOYEES**



Group Name _____

Group # _____ Effective Date _____

1. MEDICAL PLAN CHOICES

Plan (check those that apply)	<input type="checkbox"/> Preferred Plan 100/80/60	<input type="checkbox"/> Preferred Plan 80/80/50	<input type="checkbox"/> Preferred Plan Asuris Advance SM 80/80/50	<input type="checkbox"/> Preferred Plan Asuris Advance SM 70/70/50
Deductible (check one) 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
Office Visit Copay (check one)	<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
Out-of-Pocket Coinsurance Maximum (check one)	<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

Plan (check one)	<input type="checkbox"/> HSA-Qualified Preferred Plan 80/80/60 (only available for renewing groups that currently have one of these options)	<input type="checkbox"/> Asuris HSA Healthplan
Deductible (check one)	<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	<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 <input type="checkbox"/> \$3,000 Member / \$5,000 Family (embedded deductible) <input type="checkbox"/> \$3,000 Member / \$7,000 Family (embedded deductible)
Out-of-Pocket Coinsurance Maximum	\$5,000 Member / \$10,000 Family	

2. OPTIONAL BENEFITS

Mental Disorders (check one) 8 days inpatient/12 visits outpatient per calendar year are included in base Preferred Plans – Option 12 (Please check box to the right if upgrade is purchased.)	<input type="checkbox"/> Mental Disorders Option 13 (15 days inpatient/25 visits outpatient per calendar year) (Available with Preferred 100/90/60, Preferred 80/80/50, and Asuris Advance plans)
Spinal Manipulations 10 spinal manipulations are included in each base medical plan.	<input type="checkbox"/> Spinal Manipulations #1A - (no specific spinal manipulation limit)
Vision Care (check one)	<input type="checkbox"/> Exam and Schedule Hardware Benefit – Option 11 (Not available to HSA-Qualified Preferred Plan or Asuris HSA Healthplan) <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. (check those that apply)	<input type="checkbox"/> Indicate Traditional Dental Plan # _____ <input type="checkbox"/> Orthodontia (50% to \$1,000) <input type="checkbox"/> None
Columbia Dental Plans Refer to Group Master Application for participation requirements. (check those that apply)	<input type="checkbox"/> Indicate CD Plan # _____ <input type="checkbox"/> Orthodontia <input type="checkbox"/> None

“OPTIONAL BENEFITS” continued on reverse side

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

<p>Prescription Drugs <i>(check one)</i></p>	<p>Tiered – Open Formulary</p> <p><input type="checkbox"/> \$7 generic formulary/30% brand-name formulary/50% non-formulary copay</p> <p><input type="checkbox"/> \$12 generic formulary/30% brand-name formulary/50% non-formulary copay</p> <p><input type="checkbox"/> \$10 generic formulary/\$20 brand-name formulary/\$40 non-formulary copay</p>	<p>Closed Formulary</p> <p><input type="checkbox"/> \$15 Copay</p> <p><input type="checkbox"/> \$20 Copay</p> <p><input type="checkbox"/> 50% Copay to \$2,000 maximum benefit per calendar year</p> <p><input type="checkbox"/> 20% Copay with \$500 prescription drugs deductible per calendar year</p>
<p>Preventive Care <i>(check one)</i></p>	<p><input type="checkbox"/> Preventive Care Option #14 (no specific benefit maximum per calendar year)</p> <p><input type="checkbox"/> Preventive Care Option #15 (deductible waived; subject to any applicable per-visit copay; benefit limited to \$300 per person, per calendar year)</p> <p><input type="checkbox"/> None</p> <p>Preferred Plan Asuris Advance groups must choose one of the following options:</p> <p><input type="checkbox"/> Preventive Care Option #17 (deductible waived; subject to any applicable per-visit copay; benefit limited to \$300 per person, per calendar year)</p> <p><input type="checkbox"/> Preventive Care Option #18 (deductible waived: no specific benefit maximum per calendar year)</p>	

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

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