



## Limited Benefit Medical Plan

Limited Benefit Medical Plans are being offered by your employer to help meet the insurance needs of you and your family. For your convenience, premiums are paid through debit or credit card transactions. This brochure is intended to give you a brief overview of the benefits.

**Claims & Customer Service**  
**(877) 685-2432**



**National PPO Network:**

To locate a hospital or physician:

[www.beechstreet.com/beechnplus/lbp](http://www.beechstreet.com/beechnplus/lbp)

or Call (800) 432-1776 for

assistance in English or Spanish



**Pharmaceutical Benefits:**

[www.century.data-rx.com](http://www.century.data-rx.com) or call

Member Help Desk: (800) 454-9399

Pharmacy Help Desk: (888) 714-4422



**24 Hour NurseLine:**

(866) 796-1857; Pin: 1526

**Accident Medical & AD&D Claims:**

To request a claim form, please call

(877) 685-2432

◆Claims Filed By Your Doctor

◆Coverage That Is Easy To Use

◆Guaranteed Issue For Eligible Employees & Their Dependents



**\*There will be an additional \$5.00 administrative fee per billing / credit card transaction charged in addition to the rates shown.**

DESCRIPTION	SELECT	PREMIER
<b>Doctor's Office Visit</b> <sup>1</sup>	\$15 Co-Pay/100% UCR <sup>1</sup> (5 visits)	\$15 Co-Pay/100% UCR <sup>1</sup> (5 visits)
<b>Wellness/Well Child</b> <sup>1</sup>	\$15 Co-Pay/100% UCR <sup>1</sup> Up to \$100 per visit (1 visit)	\$15 Co-Pay/100% UCR <sup>1</sup> Up to \$100 per visit (1 visit)
<b>Outpatient X-Ray &amp; Lab</b> <sup>1</sup>	Up to \$50 per visit (3 visits)	Up to \$50 per visit (3 visits)
<b>Emergency Room Benefit</b> <sup>1</sup>	Up to \$100 per visit (1 sickness)	Up to \$100 per visit (1 sickness)
<b>In-Patient/Out-Patient Surgery &amp; Anesthesia Benefits</b> <sup>1</sup>	Up to \$750/Plan Year 25% of Surgery benefit up to \$188/Plan Year	Up to \$750/Plan Year 25% of Surgery benefit up to \$188/Plan Year
<b>Hospital Confinement</b> <sup>1</sup>	Pays \$200 per day (Maximum of 15 days)	Day 1: Pays \$1,000 Days 2-15: \$500 per day
<b>Maternity</b> <sup>1</sup>	Included	Included
<b>Accident Medical</b> <sup>2</sup> (\$100 deductible per occurrence)	Up to \$5,000 per occurrence	Up to \$5,000 per occurrence
<b>Accidental Death &amp; Dismemberment</b> <sup>2</sup>		
Employee	\$15,000	\$15,000
Spouse	\$7,500	\$7,500
Child	\$3,000	\$3,000
<b>Term Life</b> <sup>3</sup>		
Employee	\$10,000	\$10,000
<b>Pharmaceutical Benefits</b> <sup>4</sup> <b>Discount Drug</b>	Discount Drug	Discount Drug
Employees and their dependents pay the lesser of the pharmacy's usual and customary fee or the contract rate. Discounts are available on both generic and brand name drugs. Contraceptive drugs are included. Savings range from 15% to 80% based on the drug type (brand or generic) and the participating pharmacy filling the claim. No claim forms required. Prescriptions for 30-day supplies can be filled at more than 55,000 participating pharmacies nationwide including all of the national chains and over 90% of independent pharmacies. For additional savings, you may also utilize our mail order pharmacy for 90 day supplies. Please note - this is not insurance.		
<b>Beech Street PPO Network Access</b>	All plan designs provide covered individuals access to a PPO Network that allows them to take advantage of network negotiated rates prior to the above benefits being applied.	
<b>24 Hour NurseLine</b>	All plan designs provide covered individuals 24-hour telephone access to nurses for medical decision support and patient advocacy (available in multiple languages with an audio health information library).	
<b>Employee Cost per Month</b> <sup>5</sup>	<b>Select *</b>	<b>Premier *</b>
Employee	<b>\$80.00</b>	<b>\$100.00</b>
Employee & Spouse	<b>\$158.00</b>	<b>\$202.00</b>
Employee & Child(ren)	<b>\$127.00</b>	<b>\$161.00</b>
Family	<b>\$204.00</b>	<b>\$264.00</b>

**All benefits, except Accident Medical Expense, AD&D and Term Life, are subject to Plan Year maximums as shown above. Plan Year means the 12 consecutive months from the group's original effective date.**

**See Important Notices Page**



## Enrollment Form for Group Limited Accident & Sickness Insurance

<b>Employer - Please complete this section:</b>	<b>Indicate one of the following:</b>	<b>Is this:</b>
<b>Requested Effective Date:</b> _____	<input type="checkbox"/> Initial Enrollment	<input type="checkbox"/> New Coverage
<b>Date of Hire:</b> _____	<input type="checkbox"/> Open Enrollment	<input type="checkbox"/> Change in Coverage
	<input type="checkbox"/> New Hire	
	<input type="checkbox"/> Life Status Change	

**EMPLOYER'S NAME:** Lakeshore Consortium, Inc.

**CHC GROUP NO. CHC2184**

### EMPLOYEE INFORMATION:

_____ Your Last Name	_____ First Name	_____ Middle Initial	_____ Social Security No.	
_____ Mailing Address		_____ City	_____ State	_____ Zip Code
_____ Home Phone	_____ Date of Birth	<b>Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	<b>Marital Status:</b> <input type="checkbox"/> Single <input type="checkbox"/> Legally Separated <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
_____ Your Email Address				
_____ Location of Employment				

### BENEFIT PLAN SELECTION INFORMATION:

<b>Limited Accident &amp; Sickness Plan Option:</b> <input type="checkbox"/> Select Plan <input type="checkbox"/> Premier Plan	<b>Coverage Type:</b> <input type="checkbox"/> Employee Only <input type="checkbox"/> Employee & Child(ren) <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & Family	<b>Payment Method*:</b> <input type="checkbox"/> Visa <input type="checkbox"/> MasterCard
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**\*Complete authorization section on back. A \$5 administrative fee per transaction will be charged.**

### DEPENDENT INFORMATION:

***If you are enrolling any of your dependents (spouse or child(ren)), please be sure to include their information below; otherwise, their enrollment may be delayed or coverage declined.***

Do you have an eligible spouse?  Yes  No      How many eligible children do you have? \_\_\_\_\_

Please provide the following information for all eligible dependents to be insured under the plan:

If age 19-25, is child a full-time college student?

_____ Spouse's Full Name	_____ Social Security No.	_____ Date of Birth	<input type="checkbox"/> M <input type="checkbox"/> F	_____ Age	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____ Child's Full Name	_____ Social Security No.	_____ Date of Birth	<input type="checkbox"/> M <input type="checkbox"/> F	_____ Age	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____ Child's Full Name	_____ Social Security No.	_____ Date of Birth	<input type="checkbox"/> M <input type="checkbox"/> F	_____ Age	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____ Child's Full Name	_____ Social Security No.	_____ Date of Birth	<input type="checkbox"/> M <input type="checkbox"/> F	_____ Age	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Refusal of Coverage (check the box below if you are not enrolling in the plan; you do not need to sign/date the form):**

I choose not to enroll in the **Limited Accident & Sickness Insurance Plan(s)** offered by my employer. I understand that, if at a later date, I wish to enroll in this plan, I will not be able to do so unless there is another open enrollment period or a life status event.

I have read the Limited Accident & Sickness Insurance Plan enrollment material and accept the terms and conditions of the coverage outlined in it. I understand the Limited Accident & Sickness Insurance Plan does not provide Major Medical or Comprehensive Medical coverage. I have read the enrollment material and understand my coverage is subject to the terms and conditions of the policy issued to my employer. I understand my coverage will go into effect on the date stated in the material only if I am in active service with my employer on that date. If I am not in active service on that date, my coverage will go into effect on the date I return to active service. If I have elected coverage for my dependents, their coverage will not go into effect prior to my effective date. I understand that hospital, surgery and/or disability benefits available under the plan may not be payable for any pre-existing condition until after coverage has been in effect for six months.

To the best of my knowledge and belief, all information I have provided is true and complete. I understand my information is protected by privacy laws and will be released only in accordance with these laws. The only people who have access to this information are employees of the Insurance Company who service my policy or claim and other third parties authorized by the Insurance Company. Information may be disclosed to those who have an insurance-related regulatory or legal need for the information. In other situations, the Insurance Company will ask me for written authorization to disclosed information about me.

**WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.**

\_\_\_\_\_  
Employee's Signature

\_\_\_\_\_  
Date Signed

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## CREDIT CARD AUTHORIZATION

(Please Print)

Name \_\_\_\_\_

Address \_\_\_\_\_

Street

City

State

Zip Code

Mailing Address

(If different than above)

Street or P.O. Box

City

State

Zip Code

Visa     MasterCard    Name on Credit Card \_\_\_\_\_

Credit Card Number \_\_\_\_\_

Expiration Date \_\_\_\_\_

Telephone Number \_\_\_\_\_

Fax Number \_\_\_\_\_

I authorize Affinity Group Underwriters / Towers Affinity Benefit Services\* to bill my Visa / MasterCard for insurance plan(s) provided by ACE American Insurance Company.

This authorization is to remain in force until Affinity Group Underwriters / Towers Affinity Services has received written notification from me of its termination in such time and in such manner as to afford Affinity Group Underwriters / Towers Affinity Benefit Services reasonable opportunity to act upon it.

*\*Century Healthcare utilizes Affinity Group Underwriters / Towers Affinity Benefit Services to administer billing and premium collection for Credit/Debit transactions.*



**Description**

**Silver Dental Plan**

\$1,000 / Plan Year Maximum  
 \$500 maximum for periodontics  
 \$500 maximum for orthodontia

CATEGORY	PLAN PAYS	CATEGORY	PLAN PAYS
<b>Type 1: Preventive &amp; Diagnostic</b>		<b>Type 5: Periodontics (\$500 Lifetime Maximum)</b>	
a. Oral exams, including prophylaxis	\$36.00	a. Tissue grafts or bone surgery	\$96.00
b. Bitewings, per film	\$4.80	b. Gingivectomy (per quadrant), periodontal scaling, periodontal splinting, root planing	\$60.00
c. X-ray, panoramic or cephalometric	\$36.00	c. Gingival curettage (per quadrant)	\$36.00
d. Sealants / topical fluoride	\$10.20	d. Gingivectomy (per tooth)	\$24.00
e. Space maintainers	\$108.00		
<b>Type 2: Major Restorative</b>		<b>Type 6: Oral Surgery</b>	
a. Crowns, bridges & dentures	\$180.00	a. Surgeries Level 1 (ex. Removal of exostosis)	\$120.00
b. Pre-fabricated crowns	\$60.00	b. Surgeries Level 2 (ex. Removal of impacted tooth)	\$66.00
c. Crown build-up procedures	\$48.00	c. Surgeries Level 3 (ex. Simple extraction)	\$36.00
<b>Type 3: Minor Restorative</b>		<b>Type 7: General Anesthesia and IV</b>	
a. Fillings	\$42.00	a. IV, first half hour general, each additional 1/4 hour general	\$72.00
b. Crown, bridge and denture repairs	\$24.00		
c. Relining or rebasing dentures	\$60.00		
<b>Type 4: Endodontics</b>		<b>Type 8: Orthodontia</b>	
a. Root canals, apicoectomies	\$192.00		\$500.00
b. Root amputation	\$96.00		
c. Therapeutic pulpotomy, retrograde fillings, apexification, hemisection	\$48.00		

**Types 1 through 7 subject to annual maximum of: \$1,000.00**  
**Types 2, 5, 6a, 7 and 8 are subject to 12 month waiting period**

**VSP Free Exam**

- Over 25,000 private practice optometrists and ophthalmologist nationwide.
- One free WellVision Exam per person per calendar year
- 20% discount off complete pair of lenses and frames
- 15% discount off contact lens fitting & evaluation exam.
- 15% average discount off the regular price or 5% off promotional price for Laser Vision Correction from contracted facilities.

To find doctors in your neighborhood visit:  
[www.vsp.com](http://www.vsp.com) or call (800) 877-7195

**Careington Dental PPO Network**

To access a Careington Dental PPO provider:  
<https://www.careington.com/search/search.aspx?gpId=PPO&agentcode=CENTURYPP056042P>

<b>Monthly Premium</b>	
Employee	\$21.63
Employee & Spouse	\$37.63
Employee & Children	\$50.63
Family	\$66.63



## Your Coverage from a VSP Doctor

**\$25 copay** ..... *every plan year*

**WellVision Exam**® focuses on your eye health and overall wellness ..... *every plan year*

### Prescription Glasses

**Lenses** ..... *every plan year*

- Single vision, lined bifocal, and lined trifocal lenses.
- Polycarbonate lenses for dependent children.

**Frame** ..... *every other plan year*

- \$120 allowance for frame of your choice
- 20% off the amount over your allowance

~OR~

**Contact Lens Care** ..... *every plan year*

\$120 allowance for contacts and the contact lens exam (fitting and evaluation). This additional exam ensures proper fit of contacts.

Current soft contact lens wearers may qualify for a special program that includes a contact lens evaluation and initial supply of replacement lenses. Effective January 1, 2009

**Diabetic Eyecare Program** – Allows you to obtain medical Eyecare services related to Type 1 diabetes. There is a \$5 copay for medical eyecare exams.

## Extra Discounts and Savings

### Glasses and Sunglasses

- Average 30% savings on lens options like progressives and scratch-resistant and anti-reflective coatings
- 20% off additional glasses and sunglasses, including lens options\*

### Contacts\*

- 15% off cost of contact lens exam (fitting and evaluation)

### Laser Vision Correction

- Average 15% off the regular price or 5% off the promotional price from contracted facilities.
- After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor

\* Available from any VSP doctor within 12 months of your last eye exam

## Your Monthly Contribution

Employee Only .....	\$10.05
Employee + Spouse .....	\$16.42
Employee + Child(ren) .....	\$16.38
Employee + Family .....	\$26.43

You get the best value from your benefit when you see a VSP doctor. If you see a non-VSP provider, you'll typically pay more out-of-pocket. You'll pay the provider in full and have 6 months to submit a claim to VSP for partial reimbursement less copays. Before seeing a non-VSP provider, call us at 800.877.7195.

### Out-of-Network Reimbursement Amounts:

Exam .....	Up to \$45
Single vision lenses .....	Up to \$45
Lined bifocal lenses .....	Up to \$65
Lined trifocal lenses .....	Up to \$85
Frame .....	Up to \$47
Contacts .....	Up to \$105

\*Dependent Spouse benefit level can not exceed the insured's coverage amount.

Child(ren)'s benefit is in family units, the price is the same if there are more than one child.

## Hospital Supplement Plan

<b>Lump Sum Benefit:</b>	\$1,000
<b>Hospital Confinement:</b>	Pays \$100 per day (Maximum of 100 days)
<b>Monthly Cost</b>	
Employee Only .....	\$10.05
Employee + Spouse .....	\$16.42
Employee + Child(ren) .....	\$16.38
Employee + Family .....	\$50.00
<b>IMPORTANT:</b> Employee must purchase the limited medical plan in order to elect the HI Supplement. The same family members must be covered under all plan options – limited medical, HI supplement and dental, if offered. The HI Supplement is NOT available as a stand alone product.	

## Optional Term Life

Optional Life Insurance helps provide financial protection by promising to pay a benefit in the event of an eligible employee's covered death.

	Option I	Option II	Option III
<b>Benefit Schedule</b>	<b>\$10,000</b>	<b>\$25,000</b>	<b>\$50,000</b>
<b>Guarantee Issue</b>	All Amounts Guaranteed		
<b>Age Reduction</b>	65% at age 65–69 35% at age 75–79 20% at age 85–89 10% at age 95+	50% at age 70–74 25% at age 80–84 15% at age 90–94	
<b>Monthly Cost</b>			
<b>Age &lt;=44</b>	<b>\$1.80</b>	<b>\$4.50</b>	<b>\$9.00</b>
<b>45-59</b>	<b>\$7.10</b>	<b>\$17.75</b>	<b>\$35.50</b>
<b>60+</b>	<b>\$33.80</b>	<b>\$84.50</b>	<b>\$169.00</b>

## Dependent Life\*

Dependent Life Insurance allows insured members to provide life insurance for their spouse and/or child(ren). This provides additional financial security for employees and their families.

	Option I	Option II
<b>Spouse Benefit</b>	<b>\$10,000</b>	<b>\$25,000</b>
<b>Monthly Cost</b>	<b>\$5.28</b>	<b>\$13.20</b>
<b>Option I</b>		
<b>Child(ren) Benefit</b>	<b>\$2,000</b>	<b>\$10,000</b>
<b>Monthly Cost</b>	<b>\$0.36</b>	<b>\$1.80</b>

## Short Term Disability

Short Term Disability provides financial protection for eligible employees by promising to pay a percentage of weekly pre-disability earnings in the event of a covered disability.

	Option I	Option II
<b>Weekly Benefit</b>	50% up to \$125	50% up to \$250
<b>Elimination Period (Accident / Sickness)</b>	15 days	15 days
<b>Maximum Benefit Period</b>	13 weeks	13 weeks
<b>Monthly Cost</b>	<b>\$9.38</b>	<b>\$18.75</b>

