

# mPowerMed

Your empowered health insurance options

## L1 PPO Plan

Plan Specifics	L1																				
Lifetime Maximum	\$1,000,000																				
Critical Illness Primary insured only	No benefit																				
Calendar Year Maximum	\$100,000, \$20,000 for outpatient treatment, \$1,000 for outpatient prescription drugs																				
Physician Office Visit Copay Out-of-network physician office visits subject to the out-of-network deductible and coinsurance.	\$40 copay per in-network physician office visit, after copay plan pays 100% of the balance of the office visit charge; other covered services performed during the office visit are subject to the deductible and coinsurance. Limit of 3 covered office visits per covered person per calendar year; additional visits will not be covered expenses and will not apply toward deductible or coinsurance																				
Calendar Year Deductible, In-Network In-network and out-of-network deductibles accumulate separately. When the out-of-network deductible is satisfied, the in-network deductible will be considered satisfied for the remainder of the calendar year.	<ul style="list-style-type: none"> <li>• \$0</li> <li>• \$1,500</li> <li>• \$5,000</li> <li>• \$500</li> <li>• \$2,500</li> </ul> <p><u>Out-of-network deductible:</u> 3 times the in-network deductible for deductibles of \$500 and above; \$750 for the \$0 deductible <u>Family deductible:</u> 3 times the individual deductible amount</p>																				
Coinsurance & Out-of-Pocket Maximum Out-of-pocket limits shown are in excess of the deductible. In-network and out-of-network out-of-pocket amounts accumulate separately. When the out-of-network out-of-pocket is satisfied, the in-network out-of-pocket will be considered satisfied for the remainder of the calendar year.	<table border="0"> <thead> <tr> <th colspan="2"><u>In-network</u></th> <th colspan="2"><u>Out-of-network</u></th> </tr> <tr> <th><u>Coinsurance</u></th> <th><u>Out-of-pocket</u></th> <th><u>Coinsurance</u></th> <th><u>Out-of-pocket</u></th> </tr> </thead> <tbody> <tr> <td>• 100%</td> <td>\$0</td> <td>70%</td> <td>\$3,000</td> </tr> <tr> <td>• 70%</td> <td>\$5,000</td> <td>50%</td> <td>\$10,000</td> </tr> <tr> <td>• 50%</td> <td>\$6,000</td> <td>50%</td> <td>\$12,000</td> </tr> </tbody> </table> <p><u>Family out-of-pocket:</u> 2 times the individual out-of-pocket amount</p>	<u>In-network</u>		<u>Out-of-network</u>		<u>Coinsurance</u>	<u>Out-of-pocket</u>	<u>Coinsurance</u>	<u>Out-of-pocket</u>	• 100%	\$0	70%	\$3,000	• 70%	\$5,000	50%	\$10,000	• 50%	\$6,000	50%	\$12,000
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Outpatient Prescription Drugs <i>*If you can find a generic drug for less than the copay amount, you pay that cost, not the full copay!</i>	<ul style="list-style-type: none"> <li>• Generic: \$20 copay*</li> <li>All other covered outpatient prescription drugs: Same as any other illness; subject to deductible and coinsurance and \$1,000 calendar year maximum prescription benefit per person</li> <li>OR</li> <li>• Discount only; prescription drugs will not be covered expenses and will not apply toward the deductible or coinsurance. (The discount is not an insurance benefit.)</li> </ul>																				
Wellness Routine Physical Exams, Well Child Exams, PSA Test, Digital Screening and Colorectal Cancer Examination	<p><u>In-network:</u> \$40 copay, then 100% up to a combined maximum benefit of \$200 per covered person per calendar year; covered charges exceeding \$200 are subject to deductible and coinsurance</p> <p><u>Out-of-network:</u> Subject to the out-of-network deductible and coinsurance</p>																				
ER Copay Waived if admitted inpatient immediately following emergency room visit	\$100, then subject to in-network deductible and coinsurance																				
Outpatient Surgical Services Copay	\$250, then subject to deductible and coinsurance																				
Inpatient Hospital Confinement Copay	\$500, then subject to deductible and coinsurance																				

For agent use only; this plan overview is not for consumer use or distribution.

mPower 2010 0309

# L1 Traditional Plan

Plan Specifics	L1								
Lifetime Maximum	\$1,000,000								
Critical Illness Primary insured only	No benefit								
Calendar Year Maximum	\$100,000, \$20,000 for outpatient treatment, \$1,000 for outpatient prescription drugs								
Physician Office Visit Copay	\$40 copay per physician office visit, after copay plan pays 100% of the balance of the office visit charge; other covered services performed during the office visit are subject to the deductible and coinsurance. Limit of 3 covered office visits per covered person per calendar year; additional visits will not be covered expenses and will not apply toward deductible or coinsurance								
Calendar Year Deductible	<ul style="list-style-type: none"> <li>• \$0</li> <li>• \$1,500</li> <li>• \$5,000</li> <li>• \$500</li> <li>• \$2,500</li> </ul> Family deductible: 3 times the individual deductible amount								
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# L1 Optional Benefits

## Life Insurance

Each mPowerMed plan offers a minimum of \$10,000 term life insurance benefit for the primary insured. If the client elects life insurance coverage, he or she may select up to a total of \$100,000, in increments of \$10,000. The life insurance benefit is payable as long as the mPowerMed health plan is in force on the date of the primary insured's death.\*

## Supplemental Accident

Our Supplemental Accident benefit pays 100 percent up to the selected per-accident maximum of \$500, \$1,000 or \$2,500 and applies to covered charges incurred for treatment of an accidental bodily injury. This benefit also covers subsequent follow-up care received within 3 months from the date of the accident and is available for an unlimited number of accidents while coverage under the rider is in force. Covered charges incurred after the maximum benefit is paid, or 3 months after the accident, are subject to the plan deductible and coinsurance.

## Maternity Coverage

The mPowerMed plan offers optional coverage for routine pregnancy and delivery with a maximum benefit of \$2,500. Covered charges are first subject to a \$2,500 maternity deductible. Additional charges are subject to the selected plan coinsurance up to the maximum benefit of \$2,500. If a PPO plan is selected, this optional benefit also provides access to network provider discounts, which could save hundreds of dollars! If elected, coverage for routine pregnancy and delivery will begin after a 12-month waiting period. In order for the pregnancy to be considered a covered expense, delivery cannot occur until the waiting period has expired.

\* Term life insurance benefits are subject to a reduction schedule based on age. The selected life benefit amount is reduced as follows: Age 65-69: 65%, Age 70-74: 40%, Age 75-79: 25%, Age 80-84: 15%, Age 85+: 10%. Death by suicide, while sane or insane, is not covered if the death occurs within 12 months of the effective date of coverage under this rider.

## Benefit Limitations

(limitations apply to PPO and Traditional Plans)

### L1

Skilled Nursing Facility Care After the deductible has been satisfied, covered charges will be paid at the selected coinsurance level.	Maximum of \$100 per day and 25 days per calendar year per covered person
Home Health Care After the deductible has been satisfied, covered charges will be paid at the selected coinsurance level.	Maximum of 15 visits per calendar year per covered person
Ground, Water and Air Ambulance Services	Covered charges are paid the same as any other illness with a maximum of \$1,000 per covered person per calendar year
Physical, Speech and Occupational Therapies After the deductible has been satisfied, covered charges will be paid at the selected coinsurance level.	Maximum of 15 treatments for one type of therapy and up to 30 treatments for any combination of therapies per calendar year per covered person
Organ Transplant If a Center of Excellence is utilized, a travel expense allowance is included for up to \$5,000 for one companion or two companions if the insured is a minor.	Subject to the policy's calendar year maximum of \$100,000 and lifetime maximum of \$1,000,000
Outpatient X-Ray, Lab and Diagnostic Testing	Maximum of \$250 per covered person per calendar year
Outpatient Diagnostic Imaging (including but not limited to MRI, CAT Scan and PET Scan)	Maximum of \$250 per covered person per calendar year

Mental or Nervous Disorders and Chemical Dependency Disorders Benefits are not provided for inpatient chemical dependency treatment.	Combined lifetime maximum of \$10,000 per covered person while insured
Outpatient Mental or Nervous Disorders and Chemical Dependency Disorders	Maximum of \$25 per visit, up to a maximum of \$1,250 per calendar year, subject to the medical plan deductible and coinsurance
Inpatient Mental or Nervous Disorders	Maximum of up to \$2,500 per calendar year, subject to the medical plan deductible and coinsurance
Non-Surgical Back Treatment (Including but not limited to Chiropractic Care)	Maximum of \$500 per calendar year per covered person, subject to the medical plan deductible and coinsurance
Hospice Care	The plan will pay covered expenses for hospice care for up to 6 months, not subject to any copays, deductible and coinsurance

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For complete details, refer to the certificate of coverage MNL GC 107 and Master Policy MNL 2008-CA-MP, underwritten by Madison National Life Insurance Company, Inc., Madison, Wisconsin.

This is intended as a summary only. Provisions may vary by state. For complete details, see the certificate of coverage. Benefits are subject to usual, reasonable and customary amounts.