2012 Limited Medical Benefit Enrollment Guide

Prepared For

Weiser Security Services, Inc.

To Enroll go to
www.weiserenroll.com
or call
1-877-385-3601

Open enrollment is March 19th thru April 13th

Effective Date of Coverage is May 1, 2012

Presented by:
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Eustis Insurance & Benefits
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Group Limited Benefit Plan Pays

BENEFIT DESCRIPTION	BASIC PLAN	ENHANCED PLAN	PREMIUM PLAN
GROUP TERM LIFE WITH Accidental Death and Dismemberment AD&D for members only	Member Term Life - $5,000 Member AD&D - $5,000 Spouse Term Life - $2,500 Children Term Life - $1,250 (6 months to age 26) Infant Term Life - $200 (10 days to 6 months)	Member Term Life - $5,000 Member AD&D - $5,000 Spouse Term Life - $2,500 Children Term Life - $1,250 (6 months to age 26) Infant Term Life - $200 (10 days to 6 months)	Member Term Life - $5,000 Member AD&D - $5,000 Spouse Term Life - $2,500 Children Term Life - $1,250 (6 months to age 26) Infant Term Life - $200 (10 days to 6 months)
HOSPITAL ADMISSION BENEFIT • Once per admission, once per diagnosis • Pays in addition to Hospital Confinement	$400 first day when admitted as an inpatient into a hospital room	$700 first day when admitted as an inpatient into a hospital room	$700 first day when admitted as an inpatient into a hospital room
DAILY HOSPITAL CONFINEMENT BENEFIT •Must be admitted as an inpatient into a hospital room due to a covered accident or covered sickness •If hospital confinement falls into a category below a different maximum applies	$200 each day Overall calendar year max subject to 60 days total for any inpatient stay in a hospital except skilled nursing	$300 each day Overall calendar year max subject to 60 days total for any inpatient stay in a hospital except skilled nursing	$300 each day Overall calendar year max subject to 60 days total for any inpatient stay in a hospital except skilled nursing
Intensive Care Benefit If the participant is confined in a hospital intensive care unit due to an injury received in a covered accident or because of a covered Sickness	$400 per day Up to 30 days calendar year max (applied to overall calendar year max)	$600 per day Up to 30 days calendar year max (applied to overall calendar year max)	$600 per day Up to 30 days calendar year max (applied to overall calendar year max)
Substance Abuse Must be diagnosed and admitted as an inpatient in a substance abuse unit	$100 per day Up to 30 days calendar year max (applied to overall calendar year max)	$150 per day Up to 30 days calendar year max (applied to overall calendar year max)	$150 per day Up to 30 days calendar year max (applied to overall calendar year max)
Mental Illness Must be diagnosed and admitted as an inpatient into a mental illness unit	$100 per day Up to 60 days calendar year max (applied to overall calendar year max)	$150 per day Up to 60 days calendar year max (applied to overall calendar year max)	$150 per day Up to 60 days calendar year max (applied to overall calendar year max)
Skilled Nursing Must be admitted in skilled nursing facility following a covered hospital stay of at least 3 days	$100 per day Up to 60 days max per stay	$150 per day Up to 60 days max per stay	$150 per day Up to 60 days max per stay
PHYSICIAN OFFICE VISIT Primary care visits	$50 per visit $300 calendar year max	$50 per visit $300 calendar year max	$60 per visit $360 calendar year max

Group Limited Benefit Plan Pays

BENEFIT DESCRIPTION	BASIC PLAN	ENHANCED PLAN	PREMIUM PLAN
OUTPATIENT DIAGNOSTIC LAB, X-RAY and ADVANCED STUDIES • Per covered person per calendar year • When hospital confinement is not required • Lab (glucose test, urinalysis, CBC) • X-Ray (chest, broken bones) • Advanced Studies (EEG, CT Scan, MRI)	$20 Lab per test (up to 3 tests per calendar year) $70 X-Ray per test (up to 2 tests per calendar year) $1,000 Advanced Studies (Refer to schedule of benefits) $1,200 calendar year max	$20 Lab per test (up to 3 tests per calendar year) $70 X-Ray per test (up to 2 tests per calendar year) $1,000 Advanced Studies (Refer to schedule of benefits) $1,200 calendar year max	$20 Lab per test (up to 3 tests per calendar year) $70 X-Ray per test (up to 2 tests per calendar year) $1,000 Advanced Studies (Refer to schedule of benefits) $1,200 calendar year max
SURGICAL SCHEDULE Inpatient/Outpatient Surgeon Fee; See schedule of operations	$500 calendar year max	$1,000 calendar year max	$2,000 calendar year max
ANESTHESIA BENEFIT 25% of the amount paid under the surgical benefit	$125 calendar year max	$250 calendar year max	$500 calendar year max
WELLNESS BENEFIT Routine exams, medical treatment, injections, mammograms, well child care, cancer screening and PSA	$50 per visit $150 calendar year max	$50 per visit $150 calendar year max	$75 per visit $150 calendar year max
EMERGENCY ROOM SICKNESS VISIT Covers any ER visit as the result of an illness	$75 per visit $300 calendar year max	$75 per visit $300 calendar year max	$75 per visit $300 calendar year max

Group Medical Accident With Accidental Death & Dismemberment

Accident Benefit*	Up to **$2,500** per occurrence
Deductible	**$100** deductible per accident, per insured
Accidental Death	**$5,000**
Accidental Dismemberment	Up to **$5,000**

Initial Treatment Period.. 12 weeks
(Initial treatment must be incurred within 12 weeks of the date of the accident)
Benefit Period.. 52 weeks
(Expenses must be incurred within 52 weeks of the date of the accident)

The insured's loss must occur within one year of the date of the accident

Depending on the state of issue, medical accident insurance is issued by Pan-American Life Insurance Company on policy form number SM-2003 or by Zurich American Insurance Company or Fairmont Specialty.

**Pays "Off the Job" Accident Medical Benefits for Covered Expenses that result directly, and from no other cause, than from a covered accident.*

Discount Prescription Drug Benefit

Save on Your Prescriptions *(Included with Basic & Enhanced Plan)*

The discount prescription benefit is designed to help save on prescription drug costs by giving discounts on prescriptions at **more than 60,000** pharmacies nationwide. Generally, members will pay no more than $10, $25, or $50 for most generics and preferred brand drugs. A fourth tier offers substantial discounts on additional brand-name medications. To maximize savings, ask your doctor to review your generic options and prescribe an appropriate drug within the lowest tier possible. Mail order is also available. **For Drug look-up go to http://pabs.lc.healthtrans.com**

Tier 1. Select Brand and Generic Drugs: *Members pay **$10** or less for the scheduled quantity and dose.*

Tier 2. Select Brand and Generic Drugs: *Members pay **$25** or less for the scheduled quantity and dose.*

Tier 3. Select Brand and Generic Drugs: *Members pay **$50** or less for the scheduled quantity and dose.*

Tier 4. Select Brands and Generics: *Members Pay **100%** of the discounted price.*

No monthly maximum limit per insured.

Discount prescription benefits are not insurance products and are provided by HealthTrans, LLC www.healthtrans.com
Pan-American Life and Healthtrans, LLC are not affiliated.

$15/Co-Pay *(Included with Premium Plan)*

Fully Insured Drug Plan*

Generic - $15 co-pay for 30 day supply
Formulary Brand Name - Discount Only
Monthly Maximum Limit $300 per month per insured
Over 2200 preferred brand drugs included on formulary listing
Mail order available 90 day supply

Using Your Prescription Drug Plan is Easy

Select a convenient pharmacy near you and verify with them that the pharmacy is still in the network. Present your ID card, pay the appropriate amount and you're done.

Nationwide Pharmacy Network and Mail Order Services

The Rx retail pharmacy network consists of **over 62,000** national, regional and local chains and independent pharmacies. The Prescription Drug Plan also offers fully integrated mail order services that provide members the convenience of home delivery. The network currently manages over 2 million members located in all 50 states.

Sample Prescription Drugs	Generic	Formulary Brand
ANTIBIOTIC	Rimatadine	Augmentin
BLOOD PRESSURE	Lisinopril	Mavik
CHOLESTEROL LOWERING	Lovastatin	Lipitor

Please refer to your benefit materials for Limitations and Exclusions; Quantity Limits per co-pay may apply to certain medications.

Fully Insured Rx benefits are provided by RxEDO, Inc. www.rxedo.com
Pan-American Life and RxEDO, Inc. are not affiliated.

Pharmacy Network

Some of the participating pharmacies include:

Costco
CVS Pharmacy
K Mart
Target
Walgreens
Walmart
And many more…

PPO Provider Network

First Health Network

First Health is more than a PPO Network, it is a full service Managed Care Organization offering savings opportunities on a national, directly contracted basis. It provides access to more than 5,000 Hospitals and 550,000 Physicians and health care professionals nationwide.

First Health is committed to patient safety at a high level by exercising care in the selection and evaluation of providers for our network. Thorough credentialing and recredentialing processes minimize unfavorable risks, which in turn, impacts clinical and cost outcomes.

In addition to the First Health Network, our members also have access to a secondary or Wrap Network that provides them and their covered dependants a broader access to Physicians and health care professionals in urban, suburban, and rural areas.

For provider look-up www.firsthealth.com or call 1-800-236-3609

PPO Provider services are provided by Competitive Health, Inc.
Pan-American Life and Competitive Health are not affiliated.

Global Repatriation

Peace of Mind for You and Your Family

Global Repatriation is a worldwide benefit designed to help families when a member or a covered dependent suffers a loss of life due to a covered accident or illness while traveling 100 miles or more away from their permanent residence. Travel within the United States and abroad is included.

Our Global Repatriation benefit makes all the necessary arrangements for the transportation of a covered member's remains to anywhere in the United States and includes repatriation of foreign nationals to their home countries. Arrangements must be coordinated with the member service center and covers up to $20,000 in expenses.

We recognize travel may be an important part of your family's lifestyle. Have peace of mind knowing your family is protected.

Global Repatriation benefit is provided by AXA Assistance USA. www.axa-assistance.us
Pan-American Life and AXA Assistance USA are not affiliated. See policy for exclusions and limitations.

Telehealth Services

24/7 Physician Care when you need it!

AmeriDoc provides member access to services from participating physicians in a national network of U.S. licensed and based physicians, many of whom are board-certified, who use electronic health records, telephone consultations and online video consultations to diagnose, recommend treatment and write short term prescription for non DEA-controlled medications when appropriate*. Physicians are available 24 hours a day, 365 days a year, allowing members to conveniently access healthcare for their families from their home, work or on-the-go, as opposed to more expensive and time consuming alternatives like the doctor's office or emergency room.

Benefits

- Physicians available anytime, 24/7/365
- Convenience of obtaining medical care at work, home, or on-the-go
- Save money by avoiding in-office doctor's visits
- Quality care from physicians who can provide consultations, diagnose, recommend treatment and write short term prescriptions for non DEA-controlled medications when appropriate*
- Speak to a physician in most cases less than 30 minutes, but within 3 hours guaranteed
- Physician reviews and updates on-line health record when performing a medical consultation
- Secure, personal and portable electronic health records
- Consultations are included in your plan at no additional cost

Ideal to use…

- When you don't have the time to go the doctor's office
- When your primary care physician is not available
- After normal hours of operation
- For non-emergent medical care
- When on vacation or out of town

For common conditions like…

- Sinus Infections
- Respiratory Conditions
- Urinary Tract Infections
- Allergies
- Bronchitis
- Poison Ivy
- Pink Eye
- Cold or Flu & more…

For more information visit www.ameridoc.com or call 1-877-263-7409

*Network physicians are medical doctors (M.D.s) in all states except OK, where they are doctors of osteopathy (D.O.s)
Online video consultations not available in TX.

Telehealth services are not insurance products and access to them is provided by AmeriDoc, LLC. www.ameridoc.com
Pan-American Life and AmeriDoc, LLC are not affiliated.

Telehealth services do not replace the primary care physician. AmericDoc, LLC does not guarantee that a prescription will be written and network physicians operate subject to state regulations. Network physicians do not prescribe DEA-controlled substances and reserve the right to deny care for potential misuse of services..

Member Advocacy

Members Can Have Personalized Advocacy Services

Pan-American Benefits Solutions understand the "ins and outs" of the healthcare and insurance worlds.

We make healthcare work for the insureds. No more hassles. No more frustrations. Member Advocacy makes it easy and simple to get help. Members just need to make one call to Pan-American Benefits Solutions and talk with an advocacy service representative.

Member Advocacy Helps…

- Review and help resolve insurance claims
- Negotiate billing and payment arrangements with providers
- Contact local programs which can reduce out-of-pocket medical expenses
- Find low or no cost prescription drug programs
- Mitigate billing issues so members can focus on getting better

And…much more!

Member Services

Member Services

Our member service representatives are responsible for ensuring that customers receive the best assistance with their questions and concerns. Pan-American Benefits Solutions customer service representatives interact with customers to provide information in response to inquiries about products and services. They communicate with administrators and members through a variety of means; by telephone, by e-mail, fax or mail.

We can assist members, companies and providers with:

- Member Advocacy
- ID Cards
- Policy Information
- Member Eligibility
- Verification of Benefits
- Prescription Benefits
- Annual Adult Wellness Test
- PPO Network Information
- Account Management
- Claims
- And more!

Monday through Friday, 8:00 AM – 5:00 PM, Central Time.

1-877-569-3075

Frequently Asked Questions

Q: Is PanaMed Major Medical coverage?

A: No. PanaMed is a fixed indemnity plan. This is not basic health insurance or major medical coverage and is not designed as a substitute for either coverage. PanaMed is a limited benefit plan that pays a fixed benefit amount to help cover the cost of common medical services. The plan is not designed to cover the costs of serious or chronic illnesses. It contains specific dollar limits that will be paid for medical services which may not be exceeded. Specific dollar limits are listed in the summary of benefits.

Q: Does PanaMed have any exclusions or limitations?

A: Benefits are subject to certain exclusions, limitations, and terms for keeping the benefits in force. For example the following services are not covered by this plan: infertility treatments, cosmetic surgery, counseling for mental illness or substance abuse, obesity, weight reduction or dietetic control, physical therapy, spinal manipulation, acupuncture. This is a partial list of services that are generally not covered. Members should refer to their certificate to determine which services are covered and to what extent. Additional information can be found at www.panamericanbenefits.com.

Q: Will the PanaMed plan provide an indemnity benefit to any Physician or Hospital?

A: Yes. The member is free to seek the services of any licensed Physician or accredited Hospital. There is no requirement that the Physician or Hospital belong to a PPO network to receive benefits.

Q: **What is a PPO and the advantage for using?**

A: PPO is the abbreviation for Preferred Provider Organization. This organization of providers (referred to as a "network") has agreed to provide their services as a negotiated discount, reducing your out of pocket cost. While PanaMed may be used at any hospital or physician's office, members are encouraged to utilize the PPO network for discounted provider prices.

Q: How does a member determine which providers participate in the network?

A: PPO participation may be verified by calling the PPO company directly or by accessing the PPO company's website. The PPO company's contact information can be found on the member's ID card or by selecting the PPO information tab via the Pan-American Life Web Portal. The insured is responsible for verifying the current PPO participation of their provider.

Q: Is there a pre-existing condition exclusion on the plan?

A: Because this is a limited medical plan there are no pre-existing condition exclusions. However there are certain circumstances where pregnancy is not covered if conception occurred prior to the insured's effective date of coverage. This exclusion does not apply to residents of California, Montana, and Texas, or to North Carolina groups.

Q: Can dependents be insured by PanaMed?

A: Yes. If the member is covered by PanaMed, dependents are also eligible for coverage.

Q: Are Medicare and Medicaid recipients eligible for PanaMed?

A: Yes. However, under Medicare and Medicaid policies, PanaMed is considered primary coverage. As a result, with PanaMed, Medicare and/or Medicaid coverage may be reduced or discontinued.

Q: Can the PanaMed plan be used if the insured has separate health insurance?

A: Yes. The specified benefits pay irrespective of any other private group coverage.

Q: Is the member allowed to assign benefits to his or her healthcare provider?

A: Yes. Benefits are automatically assigned to the member's healthcare provider. If the member would like to receive the benefit payment directly, complete the medical claim form and sign the authorization of payment section.

Q: Are chiropractor visits covered under the PanaMed plan?

A: Only charges billed as a physician office visit are covered. Charges billed as treatment and/or manipulations are not covered.

Q: How is the payment for a surgical procedure determined?

A: Any payment for covered services is subject to the insured's eligibility at the time of service, limitations/exclusions set forth in the policy provisions and the information submitted with your claim by your medical provider. For benefit information on a specific surgical procedure please contact our member service department. You will need to provide the CPT code for the surgery from your physician.

Q: Is PanaMed COBRA eligible?

A: Yes. PanaMed is COBRA eligible for employer groups with 20 or more employees.

Exclusions and Limitations

Additional Exclusions and Limitations can be found at www.panamericanbenefits.com. Exclusions and Limitations may be affected by state law.

Benefits are not provided for Loss, Injury or Illness of a Covered Person which results directly or indirectly, wholly or partly from:

A. Insurrection, rebellion, participation in a riot, commission of or attempting to commit an assault, battery, felony, or act of aggression.
B. Declared or undeclared war or acts thereof, including terrorist acts.
C. Accidental Bodily Injury occurring while serving on full-time active duty in any Armed Forces of any country or international authority (any premium paid will be returned by Us pro-rata for any period of active-full time duty).
D. Any Injury or Illness arising out of or in the course of work for wage or profit.
E. Any Injury or Illness covered by any Worker's Compensation Act, Occupational Disease Law or similar law.
F. Except in regard to Medical benefits, bodily injuries received while the Covered Person was operating a motor vehicle under the influence of alcohol as evidenced by a blood alcohol level in excess of the state legal intoxication limit.
G. Charges for which: (1) there is no legal obligation to pay, or (2) no charge is made, or (3) in the absence of coverage, no charge would be made.
H. Charges incurred after Termination of Coverage.
I. Charges for care or services furnished by any agency or program funded by federal, state or local government. This does not apply to Medicaid or where prohibited by law.
J. Charges which are not Medically Necessary (as defined) for treatment of Illness or Injury.
K. Charges for services which are not related to and consistent with the treatment of any Injury or Illness of the Covered Person.
L. Unless specifically provided for in the plan, charges for routine physicals or general health exams, unless they are necessary for the diagnosis and treatment of an Illness.
M. Charges for medical care, services, or supplies which are not furnished or prescribed by a Doctor (as defined).
N. Charges for experimental or investigational treatment, procedures for research purposes, or practices when not generally recognized as accepted medical practices.
O. Charges for care, treatment, services or supplies that are not approved or accepted as essential to the treatment of an Injury or Illness by any of the following: The American Medical Association; The U.S. Surgeon General; The U.S. Department of Public Health; The National Institute of Health; or the professional review organization(s) which administer the Utilization Review Program.
P. Charges related to cosmetic surgery or Dental Care done to beautify a person without medical or dental indication of Injury or Illness.
Q. Unless specifically provided in the Plan, charges for Dental treatment or Oral Surgery.
R. Unless specifically provided in the Plan, charges for treatment of Substance Abuse Disorders or Mental Illness Disorders.
S. Unless specifically provided in the Plan, charges for refractions, eyeglasses or hearing aids or their fitting.
T. Unless specifically provided in the Plan, charges in connection with obesity, weight reduction, or dietetic control, except for morbid obesity or disease etiology.
U. Unless specifically provided in the Plan, charges for treatment or services for temporomandibular joint dysfunction or TMJ pain syndrome, orofacial, or myofascial syndrome whether medical or dental in scope.
V. Charges for reversal procedures in connection with previous male or female sterilization.
W. Unless specifically provided in the Plan, charges for routine immunizations and vaccinations, including but not limited to polio, mumps, measles, small pox, DPT, or tine tests.
X. Charges for services in the nature of educational or vocational testing or training.
Y. Any charges for elective abortions.
Z. Radial keratotomies.
AA. Any charges in excess of the Plan maximums for Organ or Tissue Transplants as shown in the Summary of Benefits.
BB. Charges for treatment of male or female infertility; in vitro and in vivo fertilization of an ovum; or artificial insemination.
CC. Charges for stand-by surgeons, pediatricians, anesthesiologists, anesthetists, or other Doctor as defined by the Plan; or stand-by supplies, equipment, rooms, or any other service, supply or treatment not actually used in the care or treatment of an Illness or Injury.
DD. Charges made by; durable medical equipment recommended by; or drugs dispensed by; a physician, surgeon, nurse or other Doctor (as defined) who: 1. Normally lives with the Plan Participant; or 2. Is a member of the Plan Participant's family; or 3. Is the Plan Participant's Plan Sponsor.
EE. Charges for Custodial Care.
FF. Charges related to smoking cessation.
GG. Charges for the treatment of the following: Codependency; Social, occupational, or religious maladjustments; Compulsive gambling; Chronic marital or family problems when not related to the primary focus of treatment which must be a diagnosable mental disorder.
HH. Pregnancy will not be covered if conception was before the Effective Date of the Plan. Pregnancy will be covered as any other sickness when date of conception is after your Effective Date of coverage.

Bi-Weekly Rates

Voluntary Rates*	BASIC PLAN	ENHANCED PLAN	PREMIUM PLAN
Member	**$29.51**	**$37.51**	**$50.42**
Member + Spouse	**$55.25**	**$72.45**	**$99.83**
Member + Child(ren)	**$45.41**	**$58.96**	**$82.39**
Family	**$74.31**	**$98.56**	**$137.80**

**Non-Voluntary Rates are based on Employer Paid (50% or greater employer contributions). Rates include insurance and non-insurance products. For the cost of the insurance product offered by Pan-American Life, contact your Pan-American agent.*

Special enrollment rules apply in the states of Connecticut, Minnesota, New Hampshire, New Jersey, New York, Utah, Vermont and Washington. Please ask for details.

The PanaMed plan is not available for groups located in Connecticut, Hawaii, Kansas, Maine, Massachusetts, Minnesota, New Hampshire, New Jersey, New York, North Dakota, Utah or Vermont.

For groups located in an approved state, coverage is not available for employees residing in Hawaii, Kansas, Maine, Massachusetts and New Hampshire. Please note that certain benefits are not available in all states. Groups and residents of Oklahoma must include certain mandated benefits.

To Enroll go to
www.weiserenroll.com
or call
1-877-385-3601

Proposal is based on information provided and subject to underwriting and Home Office approval.
This Group is domiciled in the state of LOUISIANA.

PanaMed is issued by Pan-American Life Insurance Company on policy form number GER-1991-1, GER-2004-1, GER-2007-1, PA-102401-POL, GER-2006-1, PA-102401-POL-FL, PA-102401-POL-IN, PA-102401-POL-IA , GER-2010-I(LA), GER-2007-I(OR), GER-2007-1(WA) or PA-102401-POL-WY. There are no exclusions for pre-existing conditions except for pregnancy in most states. The plan will not pay benefits for any care provided prior to the coverage effective date or if the insured is confined in a hospital at the time the coverage is effective. Hospital does not include a nursing home, convalescent home or extended care facility. Coverage is not available in all states. Like most group benefit programs, our products have exclusions, limitations, waiting periods and terms for keeping them in force. Rates subject to change.