



2011 Limited Medical Benefit Enrollment Guide

Prepared For

Delivery Drivers I N C O R P O R A T E D

To Enroll Call: 1-877-385-3601

Date Prepared: 10/05/2011

Issued by:



Marketed by:



DM-C-12exp12/2011-A

COM010710-EH

2011 Enrollment

We are very excited about a new driver benefits package that is being offered to all self employed delivery professionals during this year's Open Enrollment. The plan for this year offers benefits at an affordable cost!

Delivery Drivers, Inc. takes pride in offering a meaningful and competitive benefits package. Our benefits program is designed to be a true value to you. We recognize the importance of offering quality, affordable benefit options.

What is New In 2011?

Effective **11-1-11**, The limited medical plan will be fully insured by "A" rated carrier ; Pan-American Life Insurance Company

Highlights of the Benefits Package

- Guaranteed Issue during open enrollment
- No deductibles or co-pays
- No waiting period for pre-existing conditions*
- \$5,000 Group Term Life Insurance included in medical plans
- Prescription drug card
- Member advocacy services

** Except pregnancy in some states*

What Do I Need To Enroll?

As you prepare to enroll, please make sure you have the following information for you and your dependents:

- Social Security Number
- Date of Birth

How To Enroll

Enrollment is easy and convenient. You simply call the Enrollment Hotline at **1-877-385-3601** and a representative will answer your questions and enroll you over the phone.

The PanaMed limited benefit medical plans are Guaranteed Issue during open enrollment.

IMPORTANT - ANNUAL OPEN ENROLLMENT is the only time you can enroll or make changes to your benefits. Otherwise you will have to wait until next year.
ENROLL TODAY!

Group Limited Benefit Plan Pays



BENEFIT DESCRIPTION	BASIC PLAN	ENHANCED PLAN
<p>GROUP TERM LIFE WITH Accidental Death and Dismemberment</p> <p>AD&D for members only</p>	<p>Member Term Life - \$5,000 Member AD&D - \$5,000 Spouse Term Life - \$2,500 Children Term Life - \$1,250 (6 months to age 19, 26 if fulltime student) Infant Term Life - \$200 (10 days to 6 months)</p>	<p>Member Term Life - \$5,000 Member AD&D - \$5,000 Spouse Term Life - \$2,500 Children Term Life - \$1,250 (6 months to age 19, 26 if fulltime student) Infant Term Life - \$200 (10 days to 6 months)</p>
<p>DAILY HOSPITAL CONFINEMENT BENEFIT</p> <ul style="list-style-type: none"> • 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 	<p>\$100 each day Overall calendar year max subject to 60 days total for any inpatient stay in a hospital except skilled nursing</p>	<p>\$400 each day Overall calendar year max subject to 60 days total for any inpatient stay in a hospital except skilled nursing</p>
<p>Intensive Care Benefit</p> <p>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</p>	<p>\$200 per day Up to 30 days calendar year max (applied to overall calendar year max)</p>	<p>\$800 per day Up to 30 days calendar year max (applied to overall calendar year max)</p>
<p>Substance Abuse</p> <p>Must be diagnosed and admitted as an inpatient in a substance abuse unit</p>	<p>\$50 per day Up to 30 days calendar year max (applied to overall calendar year max)</p>	<p>\$200 per day Up to 30 days calendar year max (applied to overall calendar year max)</p>
<p>Mental Illness</p> <p>Must be diagnosed and admitted as an inpatient into a mental illness unit</p>	<p>\$50 per day Up to 60 days calendar year max (applied to overall calendar year max)</p>	<p>\$200 per day Up to 60 days calendar year max (applied to overall calendar year max)</p>
<p>Skilled Nursing</p> <p>Must be admitted in skilled nursing facility following a covered hospital stay of at least 3 days</p>	<p>\$50 per day Up to 60 days max per stay</p>	<p>\$200 per day Up to 60 days max per stay</p>
<p>PHYSICIAN OFFICE VISIT</p> <p>Primary care visits</p>	<p>\$60 per visit \$360 calendar year max</p>	<p>\$60 per visit \$360 calendar year max</p>

Group Limited Benefit Plan Pays



BENEFIT DESCRIPTION	BASIC PLAN	ENHANCED PLAN
OUTPATIENT DIAGNOSTIC LAB, X-RAY and ADVANCED STUDIES <ul style="list-style-type: none"> • 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
SURGICAL SCHEDULE Inpatient/Outpatient Surgeon Fee; See schedule of operations	N/A	\$1,000 calendar year max
ANESTHESIA BENEFIT 25% of the amount paid under the surgical benefit	N/A	\$250 calendar year max
WELLNESS BENEFIT Routine exams, medical treatment, injections, mammograms, well child care, cancer screening and PSA	\$75 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

Group Medical Accident With Accidental Death & Dismemberment

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

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.

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.

Please call 1-877-569-3075, Monday through Friday, 8AM-5PM (CST).

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

Health Advocacy

Participants Can Have Personalized Advocacy Services

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

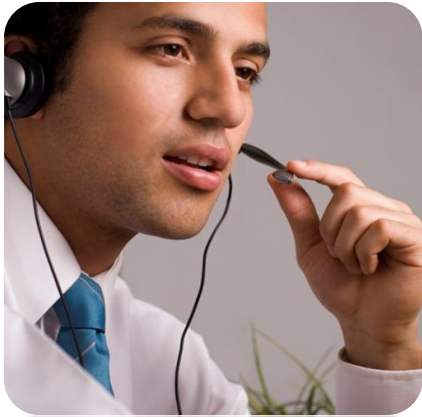
Pan-American Benefits Solutions understand the “ins and outs” of the healthcare and insurance worlds. And we know how to get things done. Health Advocacy makes it easy and simple to get help.

Pan-American Benefits Solutions help participants...

- Find some of the best doctors, hospitals and providers anywhere in the country
- Resolve insurance claims
- Negotiate billing and payment arrangements
- Schedule appointments with providers, including hard to reach specialists
- Assist in the transfer of medical records, x-rays and lab results
- Identify renowned “best-class” medical institutions regarding serious illness or injury

And...much more!

The Quality Leader in the PPO Industry



PanaMed members can benefit from discounted provider prices through our partnership with several leading Preferred Provider Organizations (PPO). Our Preferred Provider Organizations consist of more than **550,000** physicians, **4,100** hospitals and more than **67,000** ancillary care facilities throughout the United States.

Their accreditations are tangible evidence of the quality and consistency of the services they offer to our customers, providers and more than 16 million members who use the Networks. As external review becomes a more critical element in the PPO evaluation process, you can be confident that when you choose our networks, you are choosing recognized leaders that meet the highest national standards.

Our PPOs are widely regarded as leaders in the industry.

PPO Provider services are provided by MultiPlan, Inc. www.multiplan.com

For provider look-up www.multiplan.com or call 1-866-755-7427

Telehealth Services

24/7 Physician Care when you need it!

Telehealth provides a national network of U.S. board-certified physicians who use electronic health records, telephone consultations and online video consultations to diagnose, recommend treatment and write short term, non-DEA controlled prescriptions*, when appropriate. Physicians are available 24 hours a day, 365 days a year, allowing members of any age to conveniently access quality care 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 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 FREE!

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

*Prescriptions not available to OK residents, informational calls only

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

Adult Wellness & Lab Tests

Comprehensive Wellness Profile.

Once each calendar year, you and your spouse are eligible to receive a no-cost Annual Wellness Test **valued at over \$500**. Every year you have a new opportunity to detect heart disease, diabetes and other conditions that could threaten your health. Take advantage with the Comprehensive Wellness Profile (CWP), our most complete general wellness panel.

*Included in the Comprehensive Wellness Profile**

- Complete Blood Count (CBC)
- Thyroid Profile w/TSH
- Kidney Panel
- Liver Panel
- Lipid Profile (cholesterol, HDL, LDL, the risk ratio, triglycerides)
- Minerals and Bone
- Fluids and Electrolytes
- Glucose (Diabetes)

**Wellness Profile does not include urinalysis*

Please call 1-877-569-3075 to schedule your tests

Lab Testing Benefit

The Lab Program provides access to amazing savings, averaging between 40%-70% of the usual price. The vast nationwide network of Lab centers contains over 8,000 accredited laboratory sites across the country. All major laboratories are represented in the Direct Labs network. Anytime your doctor orders a test, you simply call your member scheduling department and they will advise you of the most convenient location and ensure that you only pay the reduced Member's only Rate.

Adult Wellness and Lab services are not insurance products and are provided by Direct Laboratory Services, Inc. www.directlabs.com. Pan-American Life and Direct Laboratory Services, Inc. are not affiliated.

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:

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

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



1-877-569-3075

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 keratotomy.
- 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, anesthesiologists, 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.

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.