

SERFF Tracking Number: CMPL-125943982 State: Arkansas  
Filing Company: American Medical and Life Insurance Company State Tracking Number: 41079  
Company Tracking Number: AMI NCE 11-08  
TOI: H14G Group Health - Hospital Indemnity Sub-TOI: H14G.000 Health - Hospital Indemnity  
Product Name: AMI NCE 11-08  
Project Name/Number: AMI NCE 11-08/AMI NCE 11-08

## Filing at a Glance

Company: American Medical and Life Insurance Company  
Product Name: AMI NCE 11-08 SERFF Tr Num: CMPL-125943982 State: ArkansasLH  
TOI: H14G Group Health - Hospital Indemnity SERFF Status: Closed State Tr Num: 41079  
Sub-TOI: H14G.000 Health - Hospital Indemnity Co Tr Num: AMI NCE 11-08 State Status: Disapproved-Closed  
Filing Type: Form Co Status: Reviewer(s): Rosalind Minor  
Author: Nancy French Disposition Date: 04/15/2009  
Date Submitted: 12/12/2008 Disposition Status: Disapproved  
Implementation Date Requested: On Approval Implementation Date:  
State Filing Description:

## General Information

Project Name: AMI NCE 11-08 Status of Filing in Domicile:  
Project Number: AMI NCE 11-08 Date Approved in Domicile:  
Requested Filing Mode: Review & Approval Domicile Status Comments:  
Explanation for Combination/Other: Market Type: Group  
Submission Type: New Submission Group Market Size: Small and Large  
Overall Rate Impact: Group Market Type: Association  
Filing Status Changed: 04/15/2009 Explanation for Other Group Market Type:  
State Status Changed: 04/15/2009  
Deemer Date: Corresponding Filing Tracking Number:

Filing Description:

Re: American Medical and Life Insurance Company

NAIC #81418 FEIN #13-2562243

Out-of-State Association Filing of Limited Medical Benefit Forms:

- AMLI GRP LM 2007 CERT NY, Certificate of Coverage
- AMLI GRP LM 2007 SCHED, Group Limited Benefits Health Insurance Certificate Schedule
- GRP LM 2007-AE-AR-(11/08), Arkansas Amendatory Endorsement

Dear Commissioner:

SERFF Tracking Number: CMPL-125943982 State: Arkansas  
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Compliance Research Services is pleased to submit the enclosed forms on behalf of American Medical and Life Insurance Company (AMLI). A letter of filing authorization is enclosed.

The purpose of this submission is to allow AMLI to provide limited medical coverage to residents of your state who are members of the National Congress of Employers, a bona fide association based in New York. Coverage will be provided to individual association members. It will not be issued to employers who are affiliated with the association.

The policy provides coverage for accidents, hospital confinement, doctor office visit, preventive care, surgery, urgent care/emergency room, diagnostic tests, mental health and accidental death. Coverage is available to eligible members and their dependents.

Variable areas of the certificate are set off in brackets. These include "John Doe" information, the ranges of benefits that will be offered, and benefit options. The Hospital Intensive Care Unit Confinement Benefit, Hospital Admission Benefit and Preventive Care Test Benefit are optional. The pre-existing condition look back period will be 6 months. The pre-existing condition limitation period will be either 6 or 12 months depending on the benefit options selected.

We have enclosed the certificate of coverage for your review and approval. It includes the mandated benefits required under the laws of the state of New York, the state of issue of the master policy. The enclosed amendatory endorsement adds provisions that are required for certificates issued to association members who are residents of your state. Members will apply for coverage with enrollment form AMLI GRP LM 2007 ENRL approved by your Department on 12/7/2006 under SERFF #AMLI-125043540.

The enclosed forms are new and do not replace any forms currently on file with your Department. They are in final format. AMLI requests the right to change the type style and paper size or to issue the forms in electronic format.

We have included the association bylaws and any transmittals and certifications required by your Department.

If you have questions concerning this filing, please contact me at the phone number or email address shown below.

Sincerely,

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J. David Simon, CLU  
President

## Company and Contact

### Filing Contact Information

(This filing was made by a third party - complianceresearchservicesllc)

Nancy French, Product Manager nrfrench@crssolutionsgroup.com  
10921 Reed Hartman Highway (513) 984-6050 [Phone]  
Cincinnati, OH 45242 (513) 984-7212[FAX]

### Filing Company Information

American Medical and Life Insurance Company CoCode: 81418 State of Domicile: New York  
8 West 38th Street - Suite 1002 Group Code: Company Type:  
New York, NY 10018 Group Name: State ID Number:  
(513) 984-6050 ext. [Phone] FEIN Number: 13-2562243

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## Filing Fees

Fee Required? Yes  
Fee Amount: \$60.00  
Retaliatory? No  
Fee Explanation: 3 forms at \$20.00 each  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American Medical and Life Insurance Company	\$60.00	12/12/2008	24502700

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Disapproved	Rosalind Minor	04/15/2009	04/15/2009

### Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	12/15/2008	12/15/2008	Nancy French	03/13/2009	03/13/2009

### Amendments

Item	Schedule	Created By	Created On	Date Submitted
3-26-2009 Our Response	Supporting Document	Nancy French	03/26/2009	03/26/2009
Group Limited Benefits Health Insurance Certificate Schedule	Form	Nancy French	12/12/2008	12/12/2008
By Laws	Supporting Document	Nancy French	12/12/2008	12/12/2008

### Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
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## Disposition

Disposition Date: 04/15/2009

Implementation Date:

Status: Disapproved

Comment: This submission is being disapproved since I did not receive all of the information/answers to the questions which I sent to you with respect to the association. In my Objection Letter of 12/15/2008, I commented that I needed all information outlined in the attached "Discretionary Group" questionnaire.

Some of the information was provided such as the tax returns, a list of Arkansas members, the by-laws, etc.

You also sent information on a Handbook from Cinergy Health. Cinergy Health is not the association group and I could not use this to determine whether the association provided other benefits other than insurance.

I am still concerned about the brochure. Even though the underwriter is listed on Page 3, this information is not prominent and the consumer would assume that Cinergy Health is an insurance company which is properly licensed in Arkansas (which it is not). There should be prominent disclaimers on the brochure stating that Cenergy Health is not licensed as an insurance company in Arkansas.

Your attention is called to the following areas of our Rule and Regulation 11 which is guideline for advertisement material for Accident and Health Insurance in Arkansas. Many areas of the brochure is not in compliance with our Rule and Regulation 11, some of which I have outlined below.

1. Rule and Regulation 11, Section 7 A which states...."The format and content of an advertisement of an accident and health insurance policy shall be sufficiently complete and clear to avoid deception or the capacity or tendency to mislead or deceive. Whether an advertisement has a capacity or tendency to mislead or deceive shall be determined by the Commissioner of Insurance from the overall impression that the advertisement may be reasonably expected to create upon a person of average education or intelligence, within the segment of the public to which it is directed.
2. Rule and Regulation 11, Section 15 A which states...."The name of the actual insurer shall be stated in all of its advertisements. The form number or numbers of the policy advertised shall be stated in an advertisement which is an invitation to contract. An advertisement shall not use a trade name, any insurance group designation, name of the parent company of the insurer, name of a particular division of the insurer, service mark, slogan, symbol or other device which, without disclosing the name of the actual insurer, would have the capacity and tendency to mislead or deceive as to the true identity of the insurer.
3. Rule and Regulation 11, Section 15 I which states...."The use of the name of an agency or "Underwriters" or "Plan" in



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Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Disapproved	Yes
Supporting Document	Application	Disapproved	Yes
Supporting Document	Filing Authorization	Disapproved	Yes
Supporting Document	Readability	Disapproved	Yes
Supporting Document	By Laws	Disapproved	Yes
Supporting Document	Arkansas Census	Disapproved	Yes
Supporting Document	Handbook	Disapproved	Yes
Supporting Document	Tax Returns	Disapproved	Yes
Supporting Document	3-26-2009 Our Response	Disapproved	Yes
Form	Certificate of Coverage	Disapproved	Yes
Form (revised)	Group Limited Benefits Health Insurance Certificate Schedule	Disapproved	Yes
Form	Arkansas Amendatory Endorsement	Disapproved	Yes
Form	Group Limited Benefits Health Insurance Certificate Schedule	Replaced	Yes

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## Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 12/15/2008

Submitted Date 12/15/2008

Respond By Date

Dear Nancy French,

This will acknowledge receipt of the captioned filing.

### Objection 1

- Certificate of Coverage (Form)

Comment: With respect to the Association, I need all information outlined in the attached.

### Objection 2

- Certificate of Coverage (Form)

Comment: The conversion language is not in compliance with ACA 23-86-115. The three-month period is a limitation which is not allowed.

### Objection 3

- Certificate of Coverage (Form)

Comment: Benefits must be provided for Children's Preventive Health Care as outlined under ACA 23-79-141.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor



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## Response Letter

Response Letter Status Submitted to State  
Response Letter Date 03/13/2009  
Submitted Date 03/13/2009

Dear Rosalind Minor,

### Comments:

This is in response to your Objection Letter of December 15, 2008 concerning this submission.

### Response 1

Comments: 1. The information you requested from the National Congress of Employers is located in the supporting information tab.

### Related Objection 1

Applies To:

- Certificate of Coverage (Form)

Comment:

With respect to the Association, I need all information outlined in the attached.

### Changed Items:

#### Supporting Document Schedule Item Changes

Satisfied -Name: Arkansas Cencus

Comment:

Satisfied -Name: Handbook

Comment:

Satisfied -Name: Tax Returns

Comment:

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

### Response 2

Comments:

2. You stated that the conversion language is not in compliance with ACA 23-86-115 in that a three-month period is a

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limitation which is not allowed. Our review of ACA 23-86-115 (a)(1) shows that the conversion requirements only apply to a certificate delivered or issued for delivery in Arkansas that provides coverage on an expense incurred basis. As this coverage is provided on an indemnity basis, we respectfully request that you reconsider your position that the conversion requirements contained in ACA 23-86-115 apply.

### **Related Objection 1**

Applies To:

- Certificate of Coverage (Form)

Comment:

The conversion language is not in compliance with ACA 23-86-115. The three-month period is a limitation which is not allowed.

### **Changed Items:**

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

### **Response 3**

Comments: 3. You stated that benefits must be provided for Children's Preventive Health Care as outlined under ACA 23-79-141. Our review of ACA 23-79-141 (d) shows that the requirement to provided Children's Preventive Health Care benefits only apply to a certificate delivered or issued for delivery in Arkansas that provides coverage on an expense incurred basis. As this coverage is provided on an indemnity basis, we respectfully request that you reconsider your position that the requirements contained in ACA 23-79-141 apply.

### **Related Objection 1**

Applies To:

- Certificate of Coverage (Form)

Comment:

Benefits must be provided for Children's Preventive Health Care as outlined under ACA 23-79-141.

### **Changed Items:**

No Supporting Documents changed.



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**Amendment Letter**

Amendment Date:

Submitted Date: 03/26/2009

**Comments:**

Please see our response in the supporting documentation tab.

**Changed Items:**

**Supporting Document Schedule Item Changes:**

**User Added -Name: 3-26-2009 Our Response**

Comment: Dear Ms. Minor:

Thank you for your note of March 19 concerning this submission.

You asked about proper identification of American Medical as the insurer of the plan that is marketed by Cinergy Health. The association does not have a separate marketing brochure. However, we note that the Cinergy brochure at the bottom of page 3 does identify American Medical as the underwriter. On page 6, the question "Is Cinergy Health an Insurance Carrier?" explains that Cinergy is not an insurer but that it is an agency that works with insurers to develop and implement insurance plans. The Liability provision on page 11 of the brochure also explains that Cinergy is not an insurer, HMO or underwriter.

Considering the above, we believe the language in the brochure takes care to avoid the impression that Cinergy is the insurer of the plan. If you have questions or would like to discuss, please call me at 513-984-6050 and I will be happy to discuss.

Thank you for your consideration.

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**Note To Filer**

**Created By:**

Rosalind Minor on 03/19/2009 10:47 AM

**Last Edited By:**

Rosalind Minor

**Submitted On:**

04/15/2009 09:53 AM

**Subject:**

Brochure

**Comments:**

The brochure that you attached is for Cinergy Health which appears to be an insurance company/plan. Does the association have a marketing brochure?

If the certificate holder is given this brochure, they might assume that their insurance is with Cinergy Life (which is not licensed in Arkansas). Your certificate/policy is underwritten by American Medical and Life Insurance Company.

Please comment.

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**Amendment Letter**

Amendment Date:  
 Submitted Date: 12/12/2008

**Comments:**

Schedule

**Changed Items:**

**Form Schedule Item Changes:**

**Form Schedule Item Changes:**

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
AMLI GRP LM 2007 SCHED	Schedule Pages	Group Limited Benefits Health Insurance Certificate Schedule	Initial				53	AMLI GRP LM 2007 SCHED NCE-NY Cert Schedule-AR,.pdf

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**Amendment Letter**

Amendment Date:

Submitted Date: 12/12/2008

**Comments:**

By Laws Attached

**Changed Items:**

**Supporting Document Schedule Item Changes:**

**User Added -Name: By Laws**

Comment:

NCE-AMENDED CONSTITUTION AND BYLAWSNCERS5 07.pdf

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## Form Schedule

**Lead Form Number:** AMLI GRP LM 2007 CERT NY

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Disapproved	AMLI GRP LM 2007 CERT NY	Certificate	Certificate of Coverage	Initial		41	AMLI GRP LM 2007 CERT NY NCE-NY Certificate.pdf
Disapproved	AMLI GRP LM 2007 SCHED	Schedule Pages	Group Limited Benefits Health Insurance Certificate Schedule	Initial		53	AMLI GRP LM 2007 SCHED NCE-NY Cert Schedule-AR,.pdf
Disapproved	GRP LM 2007-AE-AR-(11/08)	Certificate Amendment, Insert Page, Endorsement or Rider	Arkansas Amendatory Endorsement	Initial		47	AR AE.pdf

**American Medical and Life Insurance Company**  
New York, New York

**GROUP LIMITED BENEFITS ACCIDENT AND SICKNESS HEALTH INSURANCE**

**THIS IS A LIMITED BENEFIT COVERAGE PROVIDING BENEFITS DUE TO ACCIDENT AND SICKNESS. THIS CERTIFICATE EXPLAINS THE LIMITED BENEFITS PROVIDED UNDER THE GROUP SUPPLEMENTAL HEALTH INSURANCE POLICY. BENEFITS PROVIDED ARE SUPPLEMENTAL AND NOT INTENDED TO COVER ALL MEDICAL EXPENSES. THIS IS NOT A SUBSTITUTE FOR COMPREHENSIVE HEALTH INSURANCE.**

**CERTIFICATE OF COVERAGE**

Issued under the terms of

**Group Insurance Policy Number: 50001**

**Issued to: National Congress of Employers  
(herein called the Holder)**

**Policy Date: December 1, 2006**

American Medical and Life Insurance Company hereby certifies that members of the class(es) eligible for insurance are insured under the above Policy as determined by the Eligibility and Effective Date provisions. Class is defined in the Certificate Schedule.

This Certificate is evidence of insurance provided under the Policy. All benefits are paid according to the terms of the Policy. This Certificate describes the essential features of the insurance coverage.

In this Certificate, the words "Named Insured" or "You" means a member of an eligible class as described on the Certificate Schedule, who is insured under the Policy and for whom premiums are remitted. The words Covered Person refer to any person covered under the Policy as described on the Certificate Schedule. The words We, Us, Our or Company refer to American Medical and Life Insurance Company. Policy means the Group Supplemental Health Insurance contract owned by the Policy Holder and available for review by You. If the terms of Your Certificate of coverage and the Policy differ, the Policy will govern.

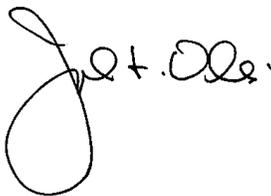
The Policy and this Certificate may be changed in whole or in part or cancelled as stated in the Policy. Such action may be taken without the consent of or notice to any Covered Person. Only an authorized officer at Our home office can approve a change. The approval must be in writing and endorsed on or attached to the Policy. No other person, including an agent, may change the Policy or Certificate or waive any of its provisions. Premiums are subject to periodic changes.

The male pronoun includes the female whenever used.

This Policy is delivered in and governed by the laws of the governing jurisdiction and to the extent applicable by the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments.

**TO OBTAIN INFORMATION YOU MAY CALL OUR TOLL FREE NUMBER: 1-800-847-1148**

For American Medical and Life Insurance Company:



President



Chief Compliance Officer

**The Policy is a limited Policy. Please read this Certificate carefully.**

**THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.**

**If You are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the Company.**

## TABLE OF CONTENTS

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## **CERTIFICATE SCHEDULE**

The benefit specifications are shown on the following attachment(s) which are hereby made a part of this Certificate:

AML I GRP LM 2007-SCHED Certificate Schedule

## **GENERAL DEFINITIONS**

Additional definitions may be contained in other Certificate benefit provision or any endorsement or rider.

### **Accident**

*Accident* means an unintended or unforeseen bodily injury sustained by a Covered Person, wholly independent of disease, bodily infirmity, illness, infection, or any other abnormal physical condition.

### **Confined or Confinement**

*Confined or Confinement* means the assignment to a bed as a resident inpatient in a Hospital or a licensed Skilled Nursing Facility on the advice of a Physician or Confinement in an Observation Unit within a Hospital for a period of no less than 20 continuous hours on the advice of a Physician.

### **Covered Accident**

A *Covered Accident* is an Accident which:

- occurs after the effective date shown on the Certificate Schedule;
- occurs while this Certificate is in force; and
- is not excluded by name or specific description in this Certificate.

**Covered Person(s).** You and Your Dependents who are insured under the Group Policy.

### **Covered Sickness**

A *Covered Sickness* means a Sickness which:

- occurs after the effective date shown on the Certificate Schedule;
- occurs while this Certificate is in force; and
- is not excluded by name or specific description in this Certificate.

### **Doctor or Physician**

A *Doctor or Physician* means a legally qualified practitioner of the healing arts acting within the scope of his or her license and is not an Immediate Family Member.

For purposes of this definition, Immediate Family Member means a Covered Person's Spouse, son, daughter, mother, father, sister, or brother.

### **Experimental/Investigational**

A drug, device or medical care or treatment will be considered experimental/investigational if:

- The drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;

- The informed consent document utilized with the drug, device, medical care or treatment states or indicates that the drug, device, medical care or treatment is part of a clinical trial, experimental phase or investigational phase or if such a consent document is required by law;
- The drug, device, medical care or treatment or the patient informed consent document utilized with the drug, device or medical care or treatment was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal or state law requires such review and approval;
- Reliable evidence shows that the drug, device or medical care or treatment is the subject of ongoing Phase I or Phase II clinical trials, is the research, experimental study or investigational arm of ongoing Phase III clinical trials, or is otherwise under study to determine the maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable evidence means only: published reports and articles in authoritative medical and scientific literature; written protocol or protocols by the treating facility studying substantially the same drug, device or medical care or treatment; or the written informed consent used by the treating facility or other facility studying substantially the same drug, device, medical care or treatment. Benefits will be considered in accordance with the drug or device at the time it is given or when medical care is received.

### **Hospital**

A *Hospital* means a short-term, acute general hospital that is:

- primarily engaged in providing, by or under continuous supervision of physicians, to inpatients diagnostic and therapeutic services for diagnosis, treatment and care of injured or sick persons;
- has organized departments of medicine and major surgery;
- has a requirement that every patient must be under the care of a physician or dentist;
- provides 24 hour nursing care by or under the supervision of RNs;
- has in effect a hospital review plan applicable to all patients which meets at least the standards set forth in Section 1861(k) of the United States Public Law 89-97 (42 USCA 1395x[k]);
- is duly licensed by the agency responsible for licensing such hospitals; and
- is not, other than incidentally, a place of rest, a place primarily for the treatment of tuberculosis, a place for the aged, a place for drug addicts, alcoholics, or a place for convalescent, custodial, educational or rehabilitatory care.

## **Hospital Intensive Care Unit**

A *Hospital Intensive Care Unit* means a place which:

- is a specifically designated area of the Hospital called an Intensive Care Unit that is restricted to patients who are critically ill or injured and who require intensive, comprehensive observation and care;
- is separate and apart from the surgical recovery room and from rooms, beds and wards customarily used for patient Confinement
- is permanently equipped with special lifesaving equipment for the care of the critically ill or injured;
- is under constant and continuous observation by a specially trained nursing staff assigned exclusively to the Intensive Care Unit on a 24-hour basis; and
- has a Physician assigned to the Intensive Care Unit on a full-time basis.

A Hospital Intensive Care Unit that meets the definition above may include Hospital units with the following names:

- Intensive Care Unit;
- Coronary Care Unit;
- Neonatal Intensive Care Unit;
- Pulmonary Care Unit;
- Burn Unit;
- Transplant Unit.

A Hospital Intensive Care Unit is not any of the following step-down units:

- a progressive care unit;
- an intermediate care unit;
- a private monitored room;
- a sub-acute Intensive Care Unit;
- an Observation Unit; or
- any facility not meeting the definition of a Hospital Intensive Care Unit as defined in this Certificate.

## **Medically Necessary**

*Medically Necessary* means a service or supply that is necessary and appropriate for the diagnosis or treatment of an Injury or Sickness based on generally accepted current medical practice. A service or supply will not be considered Medically Necessary if:

- it is provided only as a convenience to the Covered Person or provider;
- it is not appropriate treatment for the Covered Person's diagnosis or symptoms;
- it exceeds in scope, duration or intensity that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment; or
- it is experimental/investigational treatment.

The fact that a Physician may prescribe, order, recommend or approve a service or supply does not, of itself, make the service or supply Medically Necessary.

## **Named Insured**

A *Named Insured* is a person who is a member of an eligible class and holds a certificate of coverage.

## **Observation Unit**

An *Observation Unit* is a specified area within a Hospital, apart from the emergency room, where a patient can be monitored following outpatient surgery or treatment in the emergency room by a Physician; and which

- is under the direct supervision of a Physician or registered nurse; and
- is staffed by nurses assigned specifically to that unit; and
- provides care seven days per week, 24 hours per day.

## **Policy Year**

*Policy Year* means a consecutive 12-month period or any part of such period, beginning on the Certificate Effective Date and ending on the Certificate Anniversary Date as shown on the Certificate Schedule.

## **Pre-existing Condition**

*Pre-existing condition* means a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received from a physician within a 6 month period preceding the effective date of coverage of the Covered Person.

## **Resource Based Relative Value System, referred to as RBRVS.**

The methodology used by the federal government to determine benefits payable under Medicare. Medicare assigns a "Relative Value Unit" or RVU to thousands of procedure codes used to bill physician and other services. The total RVU is the sum of three component RVUs including the Work RVU, the Practice Expense RVU and the Malpractice RVU. The Work RVU takes into account factors such as the amount of time required to perform the service and the degree of skill required to perform it. The Practice Expense RVU takes into account the location of the service, e.g., office setting, outpatient setting, etc. The Malpractice RVU takes into account the malpractice cost associated with a particular practice. We will base benefits payable on RBRVS.

## **Sickness**

*Sickness* means an illness, infection, disease or any other abnormal physical condition not caused by an Accident.

## **Skilled Nursing Facility**

*Skilled Nursing Facility* means a facility that is operated pursuant to law and is primarily engaged in providing

room and board accommodations and skilled nursing care under the supervision of a duly licensed Physician.

### **Waiting Period**

*Waiting period* means the period of time during which benefits are not paid. The waiting period for this policy is 0 days

### **ELIGIBILITY AND EFFECTIVE DATE**

#### **Effective Dates of Coverage**

Your coverage under the Policy will start at 12:01 a.m. Standard Time on the effective date of coverage shown on Your Certificate Schedule.

#### **Eligibility**

To be eligible to enroll in the coverage, an individual must:

- be a member of an eligible class as defined on the Certificate Schedule; and
- satisfy the waiting period shown on the Certificate Schedule, if applicable.

#### **Enrollment**

An individual who is a member of an eligible class may enroll for coverage during the eligibility period, as shown on the Certificate Schedule that follows the later of:

- the Certificate Effective Date;
- the date the individual first becomes a member of an eligible class;
- the date the individual completes the waiting period shown on the Certificate Schedule, if applicable.

An individual who fails to enroll during the eligibility period may enroll only during the annual Open Enrollment Period shown on the Certificate Schedule.

#### **Delayed Effective Date of Coverage**

The effective date of any Named Insured's coverage will be delayed for any Named Insured if they are not a member of an eligible class on the effective date shown on the Certificate Schedule. The coverage will be effective on the date that the Named Insured returns to status as a member of an eligible class. If this is Named Insured and Spouse coverage or family coverage, coverage on the Spouse and/or Dependent children will be effective on the date that the Named Insured returns to status as a member of an eligible class.

#### **Who is Covered By This Certificate**

If this is Named Insured coverage as shown on the Certificate Schedule, We insure You, the Named Insured.

If this is Named Insured and Spouse coverage as shown on the Certificate Schedule, We insure You and Your Spouse.

If this family coverage, as shown on the Certificate Schedule, We insure You, Your Spouse (if applicable), and Your Dependent children.

*Spouse* means the person married to You on the day We issue Your Certificate.

*Dependent children* means:

- any unmarried natural children, step-children, legally adopted children or children placed into Your custody for adoption who is under the age of 19 years of age; and
- any unmarried children who are 19 years of age to age 26 years of age if the child:
  - a. is attending an accredited school full-time; and
  - b. chiefly dependent upon you for support and maintenance.

Adopted children and step children will be eligible for coverage on the same basis as natural children.

Coverage on a Dependent child will continue for a covered student who takes a leave of absence from school due to illness for a period of 12 months from the last day of attendance in school. However, coverage will not continue beyond the age at which coverage would otherwise terminate. In order to qualify for this continuation, the medical necessity of a leave of absence from school must be certified to by the student's attending Physician. Written documentation of the illness must be submitted to Us.

Coverage for the Named Insured's newborn children:

A child born to You or Your insured Spouse will automatically become insured as a Dependent. The child must be born to the Named Insured or to his Spouse while this Policy is in force. We will cover each newborn child from the moment of live birth. Such coverage includes:

- the necessary care and treatment of medically diagnosed congenital defects;
- birth abnormalities;
- prematurity'
- routine nursery care.

#### **Coverage for the Named Insured's adopted child(ren):**

We will cover the Named Insured's adopted child(ren) from the moment of birth if You take physical custody of the infant upon the infant's release from the hospital and file a petition pursuant to Section 115-c of the Domestic Relations Law within thirty days of birth provided that no notice of revocation to the adoption has been filed pursuant to Section 115-b of the Domestic Relations Law and consent to the adoption has not been revoked. However, coverage of the initial hospital stay shall not be required where a natural parent has insurance coverage available for the infant's care.

A child adopted by You or Your insured Spouse will automatically become insured as a dependent. The effective date of the coverage will be the earlier of:

- the date of placement for the purpose of adoption; or
- the date on which You assume a legal obligation for total or partial support of the child.

Coverage for adopted children will be to the same extent as is provided for other covered dependent children and will include the necessary care and treatment of pre-existing medical conditions.

Coverage will continue for the adopted child unless the placement is disrupted prior to the final adoption; and

- the child is permanently removed from placement;
- the legal obligation terminates; or
- You rescind, in writing, the agreement of adoption or agreement assuming financial responsibility.

For each newborn, step child and/or adopted child, You must:

- notify Us of his birth or placement in Your residence within 31 days of this occurrence;
- complete the required application for him; and
- pay the required premium for him, if any.

If a newborn is not enrolled within 31 days of birth coverage will be provided from the date that notice is given. Any Additional premium required should be made to the Holder within 31 days of notification of birth or placement for the purposes of a step child and/ or adoption.

## **DESCRIPTION OF BENEFITS**

### **ACCIDENT MEDICAL BENEFIT**

We will pay the Accidental Medical Benefit, shown on the Certificate Schedule, if any Covered Person incurs charges due to injuries received in a Covered Accident. Covered charges are subject to:

- Accident Medical Benefit Deductible;
- The Accident Medical Benefit percent;
- Accident Medical Maximum Benefit amount; and
- the provisions of this Policy.

The Deductible, Accident Medical Benefit percent and Maximum Benefit for the Accident Medical Benefit are shown in the Certificate Schedule.

Covered charges for this benefit are:

- Hospital room and board and general nursing services;
- Hospital miscellaneous expense for medical services and supplies including emergency services;
- operating and recovery room;

- Physician charges for medical treatment including performing a surgical procedure;
- diagnostic tests performed by a Physician including laboratory fees and x-rays;
- the cost of giving an anesthetic;
- a private duty nurse;
- prescription drugs;
- rental of durable medical equipment (if the purchase price is less than the rental, the maximum amount payable will be the purchase price);
- artificial limbs, eyes and other prosthetic devices, except replacement;
- casts, splints, trusses, crutches and braces, except dental braces;
- oxygen and rental of equipment for the administration of oxygen;
- physiotherapy given by a licensed physical therapist acting within the scope of their license.

If a Covered Person is injured in a Covered Accident, this Accident Medical Benefit will cover any remaining expenses, not covered by the group policy according to the Schedule of Benefits and Policy Provisions.

The Accident Medical Benefit will be paid after other Benefits available under the Group Limited Benefits Accident and Sickness Health Insurance has been exhausted.

### **HOSPITAL CONFINEMENT BENEFITS**

#### **Hospital Confinement Benefit**

We will pay the Hospital Confinement Benefit, shown on the Certificate Schedule, if any Covered Person incurs charges for and is Confined in a Hospital due to injuries received in a Covered Accident or due to a Covered Sickness. The Confinement to a Hospital must begin while the coverage is in force.

We will pay the amount shown on the Certificate Schedule for each day the Covered Person is confined, up to the Hospital Confinement Maximum Benefit shown on the Certificate Schedule.

We will not pay this benefit for:

- emergency room treatment;
- outpatient treatment; or
- Confinement of less than 20 hours to an Observation Unit.

We will not pay the Hospital Confinement benefit and the Hospital Intensive Care Unit Confinement benefit concurrently.

We will not pay for any Hospital Confinement of a newborn child of a covered person following birth unless the child is injured or sick.

Written proof of loss should include a Hospital bill verifying the patient's name, the dates of Hospital Confinement, the diagnosis and the charges incurred.

#### **[Hospital Intensive Care Unit Confinement Benefit**

We will pay the Hospital Intensive Care Unit Confinement Benefit, shown on the Certificate Schedule, if any Covered Person incurs charges for and is Confined to a Hospital Intensive Care Unit as the result of injuries received in a Covered Accident or due to a Covered Sickness. The Confinement to a Hospital Intensive Care Unit must begin while the coverage is in force.

We will pay the Hospital Intensive Care Unit benefit amount shown on the Certificate Schedule for each day the Covered Person is Confined, up to the Hospital Intensive Care Unit Maximum Benefit shown on the Certificate Schedule.

If any Covered Person is Confined to a Hospital care unit that does not meet the definition in this Policy of a Hospital Intensive Care Unit, We will pay the Hospital Confinement benefit up to the maximum benefit period shown on the Certificate Schedule. We will not pay the Hospital Intensive Care Unit Confinement benefit and the Hospital Confinement benefit concurrently.

We will not pay for any Hospital Confinement of a newborn child of a covered person following birth unless the child is injured or sick.

Written proof of loss should include a Hospital bill verifying the patient's name, the dates of Hospital Confinement, the diagnosis and the charges incurred.]

#### **Surgery With Anesthesia Benefit**

We will pay the Surgery Benefit, shown on the Certificate Schedule, if any Covered Person undergoes a surgical procedure due to a Covered Accident or Covered Sickness. The procedure must be performed by a Physician using anesthesia administered by a licensed anesthesiologist or certified registered nurse anesthetist (CRNA). We will pay this benefit once per covered surgical procedure. If a Covered Person has more than one surgical procedure performed at the same time, We will pay only one surgical procedure benefit, even if caused by more than one Accident or Sickness. We will pay the benefit that has the highest dollar value. The surgical procedure must occur while the coverage is in force.

The Anesthesia Benefit is the surgery benefit times the percentage shown in the Certificate Schedule.

If a Covered Person has more than one surgery for the same Covered Accident or Covered Sickness in a 90-day time period, We will pay the benefit that has the highest dollar value. If We have already paid a lower benefit amount for the same Covered Accident or

Covered Sickness, We will deduct the amount paid from the higher benefit amount and pay the difference.

Written proof of loss should include the surgeon's and the anesthesiologist's or certified registered nurse anesthetist's (CRNA's) itemized statement(s) verifying the patient's name, the surgical procedure code(s), the date of treatment, the diagnosis and the charges incurred.

This benefit is subject to the Surgery Maximum Benefit shown on the Certificate Schedule.

This benefit will not be paid for surgeries performed without anesthesia.

#### **[HOSPITAL ADMISSION BENEFIT**

We will pay the Hospital Admission Benefit, shown on the Certificate Schedule, if any Covered Person incurs charges and is admitted to a Hospital as the result of injuries received in a Covered Accident or Covered Sickness while this coverage is in force. If admission is due to a Covered Accident the Covered Person must be admitted within six months after the Covered Accident.

If a Covered Person is admitted to a Hospital and is discharged and admitted again for the same or related condition within 90 days, We will treat this later Hospital admission as a continuation of the previous Confinement. If more than 90 days have passed between the periods of Hospital Confinement, We will treat this later admission as a new and separate admission.

We will not pay this benefit for:

- emergency room treatment;
- outpatient treatment; or
- A stay of less than 20 hours in an Observation Unit.

This benefit is subject to the Hospital Admission Benefit Maximum Benefit, shown on the Certificate Schedule.]

#### **DOCTOR'S OFFICE VISIT BENEFITS**

##### **Doctor's Office Visit**

We will pay the Doctor's Office Visit Benefit, shown on the Certificate Schedule, if any Covered Person incurs charges for and requires a Doctor's office visit due to injuries received in a Covered Accident or due to a Covered Sickness. The visit must occur:

- while the coverage is in force; and
- after the waiting period. No benefits will be paid for visits during the waiting period.

For a visit due to injuries received in a Covered Accident, the visit must occur within 72 hours after the date of the Covered Accident.

Services must be rendered by a licensed Physician acting within the scope of their license.

We will pay the Doctor's Office Visit benefit amount per visit shown on the Certificate Schedule, up to the Doctor's Office Visit Benefit Maximum Benefit, shown on the Certificate Schedule.

Written proof of loss should include bills verifying the patient name, the date of treatment, the diagnosis and the charges incurred.

#### **[PREVENTIVE CARE TEST BENEFIT**

We will pay the Preventive Care Test Benefit, shown on the Certificate Schedule, if any Covered Person incurs charges for and has one of the preventive care tests listed below performed:

- while the coverage is in force; and
- after the waiting period. No benefits will be paid for a Preventive Care Test performed during the waiting period.

This benefit is not subject to the limitations and exclusions listed in the Limitations and Exclusions section of this Policy.

We will pay the Preventive Care Test Benefit listed on the Certificate Schedule for one of only the following Preventive Care Tests (also referred to as "Tests" or "Test")

- Blood test for triglycerides
- Bone marrow testing
- Breast ultrasound
- CA 15-3 (blood test for breast cancer)
- CA 125 (blood test for ovarian cancer)
- CEA (blood test for colon cancer)
- Chest X-ray
- Colonoscopy or virtual colonoscopy
- Eye exam performed by a licensed optometrist or ophthalmologist
- Fasting blood glucose test
- Flexible sigmoidoscopy
- Hemocult stool analysis
- Mammography
- PSA (blood test for prostate cancer)
- Pap smear or Thin Prep Pap Test
- Serum Protein Electrophoresis (blood test for myeloma)
- Stress test on a bicycle or treadmill
- Thermography

This benefit is subject to the Preventive Care Test Benefit Maximum Benefit shown on the Certificate Schedule.

Written proof of loss should include a billing statement from the medical provider conducting the test, verifying the patient's name, the type of Preventive Test performed and the date of treatment.]

#### **URGENT CARE/EMERGENCY ROOM VISIT BENEFIT**

We will pay the Urgent Care/Emergency Room Benefit, shown on the Certificate Schedule, if any Covered Person incurs charges for and requires medical care from an urgent care facility or emergency room due to injuries received in a Covered Accident or due to a Covered Sickness. The visit must occur:

- while the coverage is in force; and
- after the waiting period. No benefits will be paid for visits during the waiting period.

For a visit due to injuries received in a Covered Accident, the visit must occur within 72 hours after the date of the Covered Accident.

Services must be rendered by a Physician including.

We will pay the Urgent Care/Emergency Room benefit amount shown on the Certificate Schedule, up to the Urgent Care/Emergency Room Benefit Maximum Benefit, shown on the Certificate Schedule.

Written proof of loss should include bills verifying the patient name, the date of treatment, the diagnosis and the charges incurred

#### **DIAGNOSTIC, X-RAY AND LABORATORY TESTS BENEFIT**

We will pay the Diagnostic Test Benefit shown on the Certificate Schedule when any Covered Person incurs charges for diagnostic, x-ray and/or laboratory testing caused by a Covered Accident or Covered Sickness.

Benefits are payable on a per day basis and are subject to:

- the Diagnostic Test Benefit amount per day;
- the maximum number of testing days per Policy Year, per Covered Person; and
- the definitions, limitations, exclusions and other provisions of the policy and certificate.

The Diagnostic Test must be performed:

- while the coverage is in force;
- in a Hospital, ambulatory surgical center or Doctor's office; and
- after the waiting period. No benefits will be paid for a diagnostic test performed during the waiting period.

The Diagnostic Test must be ordered by a Physician because of a Covered Accident or Covered Sickness.

Benefits are payable subject to the Maximum Number of Testing days per Policy Year for each Covered Person shown in the Certificate Schedule.

This benefit is subject to the Diagnostic Tests, X-ray and Laboratory Benefit Maximum Benefit shown on the Certificate Schedule.

We will not pay the Preventive Care Test Benefit and the Diagnostic Test Benefit concurrently.

Benefits for Colonoscopy Test are limited to one test per Policy Year per Covered Person.

If any Covered Person has a procedure for which a benefit would be payable under the Surgery With Anesthesia benefit, We will pay only the Surgery With Anesthesia benefit.

Written proof of loss should include a billing statement from the medical provider conducting the Diagnostic Test, verifying the patient's name, the type of Diagnostic Test performed, the diagnosis and the charges incurred and the date of treatment.

### **MENTAL HEALTH BENEFITS**

Coverage for the following benefits will be paid the same as other benefits available under the policy. However, these benefits will only be provided when the benefits are required as a result of an accident:

#### **Inpatient Benefits**

For Inpatient Benefits, we will pay the Mental Health Inpatient Benefit, shown on the Certificate Schedule, for each day of confinement if any Covered Person is confined to a Hospital or licensed institution to provide treatment for Mental Illness.

Benefits are subject to the Mental Health Inpatient Benefit Maximum Benefit shown on the Certificate Schedule.

#### **Outpatient Benefits**

For Outpatient Benefit, we will pay the Mental Health Outpatient Benefit, shown on the Certificate Schedule, for Covered Persons receiving treatment as a result of Mental Illness.

Benefits are subject to the Mental Health Outpatient Benefit Maximum shown on the Certificate Schedule.

*Mental Illness* means any mental condition including but not limited to affective disorders, neuroses, anxiety, stress, adjustment reactions, Alzheimer's disease and other organic senile dementias.

We will not pay any benefit for stays in a Half-Way house or other place that is not a licensed facility offering treatment for Mental Illness.

### **ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT**

#### **Accidental Death Benefit**

We will pay the Accidental Death Benefit, shown on the Certificate Schedule if any Covered Person is injured as

the result of a Covered Accident, and the injury causes the Covered Person to die within 90 days after the Covered Accident.

#### **Dismemberment Benefit**

We will pay the Dismemberment Benefit amount shown on the Rider Schedule if any Covered Person is injured as the result of a Covered Accident. Loss must occur within 90 days after the Covered Accident.

Only one amount will be paid for all losses resulting from one Accident. We will pay the largest benefit amount to which the Covered Person is entitled. Payment will be made to the Covered Person, or in the event of his death, to the named beneficiary.

#### **Proof of Loss**

We must be given written proof of loss within 90 days after the covered loss occurs. If an authorized representative is not able to give Us written proof of loss within 90 days, it will not have a bearing on the claim if proof is given to Us as soon as it is reasonably possible except in the absence of legal capacity. Written proof of loss must include a claim form and if loss is due to death of a covered person, a certified copy of the death certificate.

#### **Beneficiary**

In the event of a benefit payable due to the Named Insured's death, the Accidental Death benefit will be paid to the Named Insured's beneficiary. The beneficiary is the person the Named Insured designated in the enrollment form as the beneficiary, unless it was changed at a later date. If a beneficiary was not named or if the person named is not living at the Named Insured's death, any Accidental Death benefit due will be paid in this order to:

the Insured's Spouse; or children; or parents; or brothers and sisters; or estate. In the event of a benefit payable due to the death of a Spouse or Dependent child, the Accidental Death benefit will be paid to the Named Insured, if living, otherwise to the estate of the insured Spouse or Dependent child.

If benefits are payable to a Covered Person's estate, We can pay benefits up to \$1,000 to someone related to the Covered Person by blood or marriage who We feel is fairly entitled to them. If We do this, We will have no responsibility for this payment because We made it in good faith.

#### **Change of Beneficiary**

The Named Insured can ask Us to change their beneficiary at any time. The Insured should notify Us, and We will send him the form to complete. The request must be witnessed by someone other than his present beneficiary or his proposed beneficiary and returned to Us at Our home office. The change must be approved by Us. If approved, it will go into effect the day he signed the request. The change will not have a bearing on any payment We make before We receive it.

**NEW YORK MANDATES:** Under New York Law, certain mandated benefits are required to be provided under a medical expense policy. We will pay benefits as applicable to this program for such mandates.

**MATERNITY CARE.** Charges incurred for maternity care, including hospital, surgical or medical care to the same extent that coverage is provided for sickness under the policy. Such maternity care coverage, other than coverage for perinatal complications, will include inpatient hospital coverage for the mother and newborn for:

- a. at least 48 hours after childbirth for any delivery other than a caesarean section; and
- b. at least 96 hours after a caesarean section.

Such coverage for maternity care includes the services of a licensed nurse midwife practicing consistent with a written agreement and affiliated or practicing in conjunction with a licensed facility. We will not pay for duplicative routine services actually provided by both a licensed nurse midwife and a physician.

Maternity care coverage also includes, at minimum, parent education, assistance and training in breast or bottle feeding and the performance of any necessary maternal and newborn clinical assessments.

The mother will have the option to be discharged earlier than the time periods established above. In such case, the hospital coverage will include at least one home care visit which will be in addition to, rather than in lieu of, any home health care coverage available under the policy. The policy covers the home care visit, which may be requested at any time within 48 hours of the time of delivery (96 hours in the case of caesarean section), and will be delivered within 24 hours after discharge, or of the time of the mother's request, whichever is later. Such home care coverage is not subject to deductibles, coinsurance or copayments.

Coverage provided under this benefit for care and treatment during pregnancy will include not less than two payments, at reasonable intervals and for services rendered, for prenatal care and a separate payment for the delivery and postnatal care provided.

**POST MASTECTOMY RECONSTRUCTION.** Charges for all stages of reconstructive breast surgery after a mastectomy for the breast on which the mastectomy has been performed in a manner determined by the attending physician and the patient to be appropriate..

Coverage is also provided for all stages of reconstructive breast surgery performed on a non-diseased breast to establish symmetry with the diseased breast in a manner determined by the attending physician and the patient to be appropriate.

**HOME CARE.** Charges incurred for up to 40 home care visits in any continuous 12 month period. Each visit by a member of a home care team will be considered as one home care visit. Four hours of home health aide service shall be considered as one home care visit.

"Home care" means the care and treatment of a covered person who is under the care of a physician but only if hospitalization or confinement in a skilled nursing facility as defined in subchapter XVIII of the federal Social Security Act, would otherwise have been required if home care was not provided, and the plan covering the home health service is established and approved in writing by such physician.

Home care shall be provided by an agency possessing a valid certificate of approval or license issued pursuant to the public health law and shall consist of one or more of the following:

- a. Part-time or intermittent home nursing care by or under the supervision of a registered professional nurse.
- b. Part-time or intermittent home health aide services which consist primarily of caring for the patient.
- c. Physical, occupational or speech therapy if provided by the home health service or agency.
- d. Medical supplies, drugs and medications prescribed by a physician and laboratory services by or on behalf of a certified home health agency to the extent such items would have been covered under the contract if the covered person had been hospitalized or confined in a skilled nursing facility as defined in subchapter XVIII of the federal Social Security Act.

Each visit by a member of a home care team will be considered as one home care visit. Four hours of home health aide service will be considered as one home care visit.

**PREADMISSION TESTING.** Charges incurred for preadmission tests performed in hospital facilities prior to scheduled surgery. Benefits will be provided for tests ordered by a physician which are performed in the out-patient facilities of a hospital as a planned preliminary to admission of the patient as an in-patient for surgery in the same hospital provided that:

- a. tests are necessary for and consistent with the diagnosis and treatment of the condition for which surgery is to be performed;
- b. reservations for a hospital bed and for an operating room were made prior to the performance of these tests;
- c. the surgery actually takes place within seven days of such presurgical tests; and
- d. the patient is physically present at the hospital for the tests

**Second Surgical Opinion.** Charges for a second surgical opinion by a qualified physician on the need for surgery.

**MASTECTOMY CARE.** Charges incurred for a period of time determined to be medically appropriate by the attending physician in consultation with the covered person for inpatient care for the covered person under a lymph node dissection or a lumpectomy for the treatment of breast cancer or a mastectomy covered by the policy. Coverage of prosthesis and physical complications for all stages of mastectomy, including lymphedmas are covered by the policy.

**MEDICAL CONDITIONS LEADING TO INFERTILITY** Charges incurred for hospital, surgical and medical care for diagnosis and treatment of correctable medical conditions otherwise covered by the policy solely because the medical condition results in infertility.

Charges incurred for hospital, surgical and medical care which would correct malformation, disease or dysfunction resulting in infertility.

Charges incurred for diagnostic tests and procedures provided as part of hospital, surgical and medical care that are necessary to determine infertility or that are necessary in connection with any surgical or medical treatments or prescription drug coverage if provided, including, but not limited to, such diagnostic tests and procedures as hysterosalpingogram, hysteroscopy, endometrial biopsy, laparoscopy, sono-hysterogram, post coital tests, testis biopsy, semen analysis, blood tests and ultrasound; and if such policy provides coverage for prescription drugs, such coverage shall include prescription drugs approved by the federal Food and Drug Administration.

Charges incurred for hospital, surgical and medical care of artificial insemination are covered by this policy.

**SECOND MEDICAL OPINION FOR CANCER DIAGNOSIS.** Charges incurred for a second medical opinion by an appropriate specialist, including but not limited to a specialist affiliated with a specialty care center for the treatment of cancer, in the event of a positive or negative diagnosis of cancer or a recurrence of cancer or a recommendation of a course of treatment for cancer.

**MAMMOGRAPHY SCREENING.** Charges incurred hospital, surgical and medical care for mammography screening for occult breast cancer. The coverage will be as follows:

- a. upon recommendation of a physician, a mammogram at any age for covered persons having a prior history of breast cancer or who have a first degree relative with a prior history of breast cancer;
- b. a single baseline mammogram for covered persons aged 35 through 39 inclusive;
- c. an annual mammogram for covered persons aged forty and older.

Mammography screening means an X-ray examination of the breast using dedicated equipment, including X-ray tube, filter, compression device, screens, films and cassettes, with an average glandular radiation dose less than 0.5 rem per view per breast.

**DIABETES SUPPLIES, EQUIPMENT AND SELF-MANAGEMENT EDUCATION.** Charges incurred for the following necessary treatment equipment and supplies for the treatment of diabetes, if recommended or prescribed by a physician or other licensed health care provider legally authorized to prescribe:

- a. blood glucose monitors;
- b. blood glucose monitors for the visually impaired;
- c. data management systems;
- d. test strips for glucose monitors and visual reading and test strips;
- e. insulin;
- f. injection aids;
- g. cartridges for the visually impaired;
- h. syringes;
- i. insulin pumps and appurtenances thereto;
- j. insulin infusion devices; and
- k. oral agents for controlling blood sugar.

Benefits will be provided for diabetes self-management education to ensure that persons with diabetes are educated as to the proper self-management and treatment of their diabetic condition including information on proper diets. Such coverage for self-management education and education relating to diet will be: a) limited to visits medically necessary upon the diagnosis of diabetes; b) where a physician diagnoses a significant change in the patient's symptoms or conditions which necessitate changes in a patient's self-management; or c) where reeducation or refresher education is necessary. Such education may be provided by a physician or other licensed health care provider, or their staff, as part of an office visit for diabetes diagnosis or treatment. It may also be provided by a certified diabetes nurse educator, certified nutritionist, certified dietician or registered dietician upon the referral of a physician or other licensed health care provider. Education provided by the certified diabetes nurse education, certified nutritionist, certified dietician or registered dietician will be limited to group settings wherever practicable. Coverage for self-management education and education relating to diet will also include home visits when deemed medically necessary.

**PROSTATE CANCER SCREENING.** Charges incurred for diagnostic screening for prostate cancer. Benefits will be payable for:

- a. standard diagnostic testing including, but not limited to a digital rectal examination and a prostate specific antigen test at any age for men having a prior history of prostate cancer; and
- b. an annual standard diagnostic examination including, but not limited to, a digital rectal examination and a prostate specific antigen test for men age 50 and over

who are asymptomatic and for men age 40 and over with a family history of prostate cancer or other prostate cancer risk factors.

**CERVICAL CYTOLOGY SCREENING.** Charges incurred for annual cervical cancer for women 18 years of age and older. This coverage shall include: a) an annual pelvic examination; b) collection and preparation of a Pap smear; and c) laboratory and diagnostic services provided in connection with examining and evaluating the Pap smear.

**CHIROPRACTIC CARE.** Charges incurred for chiropractic care provided by a chiropractor licensed pursuant to New York law in connection with the detection or correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for the purpose of removing nerve interference, and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation of or in the vertebral column.

**EXPERIMENTAL OR INVESTIGATIONAL TREATMENT.** Charges for experimental or investigational treatment as required by law.

#### **LIMITATIONS AND EXCLUSIONS**

We will not pay benefits for:

Treatment, services or supplies which:

- Are not Medically Necessary;
- Are not prescribed by a Doctor as necessary to treat Sickness or injury;
- Are experimental/investigational in nature, except as required by law;
- Are received without charge or legal obligation to pay; or
- Is provided by an immediate family member.

#### **Additional Limitations and Exclusions**

Except as specifically provided for in this Policy or any attached Riders, We will not pay benefits for Sickness or injuries that are caused by:

#### **Alcoholism or Drug Addiction**

**Dental Procedures** –Dental care or treatment except for such care or treatment due to accidental injury to sound natural teeth within 12 months of the accident and except for dental care or treatment necessary due to congenital disease or anomaly.

**Elective Procedures and Cosmetic Surgery** – Cosmetic surgery, except that cosmetic surgery shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other disease of the involved part and reconstructive surgery because of congenital disease or anomaly of a covered dependent child which has resulted in a functional defect.

**Felony or Illegal Occupation** Commission of or attempt to commit a felony or to which a contributing cause was the insured's being engaged in an illegal occupation.

**Suicide or Injuries Which Any Covered Person Intentionally Does to Himself-** suicide, attempted suicide or intentionally self-inflicted injury.

**War or Act of War.** War or act of war (whether declared or undeclared; participation in a felony, riot or insurrection; service in the Armed Forces or units auxiliary thereto. Losses as a result of acts of terrorism committed by individuals or groups will not be excluded from coverage unless the Covered Person who suffered the loss committed the act of terrorism.

**Worker's Compensation** –benefits provide under any State or Federal workers' compensation, employers' liability or occupational disease law.

#### **Pre-existing Condition Limitation**

There is no coverage for a pre-existing condition for a continuous period of [6] [12] months following the effective date of coverage under this Policy.

This limitation does not apply to:

- genetic information in the absence of a diagnosis of the condition related to such information;
- a newborn child who is enrolled in the plan within 30 days after birth; nor to a child who is adopted or placed for adoption before attaining 18 years of age; and as of the last day of the 30-day period beginning on the date of birth, adoption or placement for adoption, is covered under creditable coverage;
- pregnancy; and
- an individual, and any dependent of such individual, who is eligible for a federal tax credit under the federal Trade Adjustment Assistance Reform Act of 2002 and who has three months or more of creditable coverage.

In determining whether a pre-existing condition limitation applies, we will credit the time the covered person was previously covered under creditable coverage, if the previous creditable coverage terminated less than 63 days prior to the effective date of the Covered Person's coverage under the policy.

Creditable coverage includes (a) a group health plan; (b) health coverage; (c) Part A or Part B of title XVIII of the Social Security Act; (d) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928; (e) Chapter 55 of title 10, United States Code; (f) a medical care program of the Indian Health Service or of a tribal organization; (g) a state health benefits risk pool; (h) a health plan offered under chapter 89 of title 5, United States Code; (i) a public health plan, including health coverage provided under a

plan established or maintained by a foreign country or political subdivision (as defined in regulations); (j) a health plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)) and coverage under S-CHIP.

## **TERMINATION OF INSURANCE**

### **Termination of a Named Insured's Coverage**

The coverage on a Named Insured will terminate on the earliest of the following dates:

- the date the Policy terminates; or
- midnight on the last day, for which premium was paid, if premium is not paid by the end of the grace period, or
- 90 days after the date written notice was provided that the Named Insured is no longer in an eligible class; or
- the date the Named Insured's class is no longer included for insurance; or
- on the date the Named Insured asks Us to end their coverage.

If we discontinue to offer this coverage to a particular class we will provide the class the option to purchase other coverage currently offered in such market without regard to the claims experience of the class or any health related status to any insureds covered or new insureds who may become eligible for such coverage.

### **Extension of Benefits**

Termination of coverage will not affect any claim that began while the coverage was in force.

If a Covered Person is Confined in a Hospital on the date coverage terminates We will continue to pay any applicable benefits until the earlier of

- the date the Covered Person is discharged from the Hospital; or
- 90 days after the date the coverage terminates.

### **When Coverage Ends on the Named Insured's Spouse and/or Dependents**

If this is Named Insured and Spouse coverage or two-parent family coverage, coverage on the Named Insured's Spouse will end:

- if the Policy terminates;
- if the premiums are not paid for the Named Insured's Spouse when they are due;
- on the date the Named Insured asks Us to end their Spouse's coverage;
- on the date the Named Insured dies; or
- on the date the next premium is due after the Named Insured divorces their Spouse.

If this is family coverage, coverage on the Named Insured's dependents will end:

- if this Policy terminates;
- if the premium is not paid for the Named Insured's dependents when it is due;

- on the date the Named Insured asks Us to end their Dependent coverage; or
- on the date the Named Insured dies.

Coverage will end on each Dependent child when they no longer qualifies as a Dependent as defined in the Certificate. It is the Named Insured's responsibility to notify Us if any Dependent no longer qualifies as an eligible Dependent. If this is family coverage and all of the dependents no longer qualify as eligible dependents and We are not notified, the extent of Our liability will be to refund premium for the time period for which they did not qualify. Coverage will not end on a Dependent child who reaches the limiting age if that child is incapable of self-sustaining employment by reason of mental illness, developmental disability, mental retardation as defined in the mental hygiene law or physical handicap and who became so incapable prior to the attainment of the age at which dependent coverage would otherwise terminate and who is dependent upon such employee or member for support and maintenance.

### **Conversion Options**

If the Named Insured chooses not to enroll in Cobra and coverage under this policy ceases because of termination of employment for any reason whatsoever, the Named insured who has been under the policy for at least three months shall be entitled to have coverage issued without evidence of insurability upon application made to us within forty-five days after such termination, and payment of premium applicable to the class of risk, age and form and amount of insurance. At our option an individual or group policy may be offered. We will issue a policy then available which is most comparable to this policy.

Any pre-existing condition limitation under any converted policy issued will be reduced by the time coverage began under this Policy.

If a Named Insured's spouse or dependent's eligibility ends, including death of the Named Insured, that spouse or dependent may convert his or her coverage to a new individual policy by applying for the converted policy and paying the required premium. The converted policy will be on a form having benefits similar to this policy. Premium will be based on Our table of rates then in effect for the class and age of the dependent or spouse on the effective date of coverage. Any pre-existing condition limitation under any new policy issued under this conversion option will be reduced by the time coverage began under this Policy.

If covered on the date the marriage terminates because of divorce or annulment, the Named Insured your ex-spouse can also be issued his or her own replacement policy without evidence of insurability. In the event this policy form is no longer offered, we will issue a policy then available which is most comparable to this policy.

We will provide written notice of the conversion privilege and its duration within fifteen days before or after the date of termination of group coverage, provided that if such notice be given more than fifteen days but less than ninety days after the date of termination of group coverage, the time allowed for the exercise of such privilege of conversion shall be extended for forty-five days after the giving of such notice. If notice is not given within ninety days after the date of termination of group coverage, the time allowed for exercise of this conversion privilege shall expire at the end of such ninety days.

## **GENERAL PROVISIONS**

### **Coverage Provided by the Policy**

We insure a Covered Person for loss according to the provisions of the Policy.

When making a benefit determination under the Policy, We have discretionary authority to determine the Covered Person's eligibility for the benefits and interpret the terms and provisions of the Policy.

### **State Laws**

Any provision of the Policy that, on the effective date, does not agree with state laws where the Named Insured lives will be amended to conform to the minimum requirements of those laws.

## **HOW TO FILE A CLAIM/CLAIM PROVISIONS**

### **How to File a Claim**

A claim form must be completed within 90 days after the covered loss begins or as soon as it is reasonably possible. The claim form, along with proof of loss, should be sent to Us at Our home office.

If the Named Insured does not have a claim form, he must give Us a written statement describing the loss within 90 days after the covered loss begins or as soon as it is reasonably possible. The statement should include his name and Certificate Schedule Number as shown in the Certificate Schedule. It must also include proof of loss and how the loss occurred. The Named Insured should send the statement to Us at Our home office. When We receive the statement describing the loss, We will send him claim forms within 15 days. If he does not receive claim forms, his written statement along with the proof of loss will be used to process his claim.

### **Proof of Loss**

The Named Insured must give Us a written proof of loss within 90 days after the covered loss begins. If he is not able to give Us written proof of loss within 90 days, it will not have a bearing on this claim if proof is given to Us as soon as it is reasonably possible, except in the absence of legal capacity.

Refer to the applicable benefit section(s) for written proof of loss requirement.

## **Payment of Claim**

Benefits will be paid to the Named Insured or to the designated beneficiary on record. If no named beneficiary is on record with us all or any part of the benefits owed will be paid to the estate. In lieu of paying benefits to the estate we may at our option pay benefits to any one or more of the following surviving relatives:

- spouse;
- mother;
- father
- child or children; and
- brothers or sisters.

If there are no survivors in any of these classes, we may pay benefits for expenses on account to a Hospital or Doctor's office or other person actually supporting him or her and who is deemed by us to be entitled to payment. Any payments made in good faith will end our liability to the extent of the payment.

## **Time of Payment of Claim**

We will pay any benefits due not more than 60 days after We receive written proof of loss.

## **Questions Concerning the Named Insured's Claim**

If the Named Insured has questions concerning his claim, he can call Us at Our home office.

## **Physical Examinations**

We can require that any Covered Person be examined by a Physician of Our choice at Our expense as often as it is reasonably necessary while his claim is pending.

## **Legal Action**

We cannot be sued for benefits under the Policy until 60 days after written proof of loss has been given as required by the Policy or the expiration of 3 years from the time We receive written proof of loss.

## **UTILIZATION REVIEW**

We review proposed and rendered health services to determine whether the services are or were medically necessary or experimental or investigational ("medically necessary"). This process is called Utilization Review (UR). Utilization Review includes all review activities, whether they take place prior to the service being rendered (prospective); when the service is being rendered (concurrent); or after the service is rendered (retrospective).

We have developed Utilization Review policies to assist Us in administering the Utilization Review program. These policies describe the process and procedures of Utilization Review activities. Reviews are conducted by registered nurses and our Medical Directors. All determinations that services are not medically necessary will be made by licensed physicians. Our failure to make a utilization review determination within the applicable time frames set forth below shall be deemed an adverse determination subject to an internal appeal.

### Prospective Reviews

All requests for prior authorization of care are reviewed for medical necessity (including the appropriateness for the proposed level of care and/or provider). The initial review is performed by a nurse. If a nurse determines that the proposed care is medically necessary, the nurse will authorize the care. If the nurse determines that the proposed care is not medically necessary or that further evaluation is needed, the nurse will refer the case to a licensed physician.

If we have all the information necessary to make a determination regarding a prospective review, we will make a determination and provide notice to the Covered Person (or their designee) and the Covered Person's provider, by telephone and in writing, within three business days of receipt of the request. If we need additional information, we will request it within three business days. The covered person or their provider will then have 45 calendar days to submit the information. We will make a determination and provide notice to the Covered Person (or their designee) and the Covered Person's provider, by telephone and in writing, within three business days of the earlier of our receipt of the information or the end of the 45-day time period.

With respect to urgent prospective claims, if we have all the information necessary to make a determination, we will make a determination and provide notice to the Covered Person (or their designee) and the Covered Person's provider, by telephone and in writing, within 72 hours of receipt of the request. If we need additional information, we will request it within 24 hours. The Covered Person or their provider will then have 48 hours to submit the information. We will make a determination and provide notice to the Covered Person and their provider by telephone and in writing within 48 hours of the earlier of our receipt of the information or the end of the 48-hour time period.

### Concurrent Reviews

When the Covered Person is receiving services that are subject to concurrent review, a nurse will periodically assess the medical necessity and appropriateness of care received throughout the course of treatment. Once a case is assigned for concurrent review, a nurse will determine whether the services are medically necessary. If so, the nurse will authorize the care. If the nurse determines that medical necessity is lacking or that further evaluation is needed, the nurse will refer the case to a licensed physician.

Utilization review decisions for services during the course of care (concurrent reviews) will be made and notice provided to the Covered Person's provider, by telephone and in writing, within one business day of receipt of all information necessary to make a decision but no later than 15 calendar days of receipt of the request.

For concurrent reviews that invoke urgent matters, we will make a determination and provide notice to the Covered Person and their provider within 24 hours of receipt of the request.

If care is authorized, the notice will identify the number of approved services, the new total of approved services, the date of onset of services and the date of the next scheduled concurrent review of the case.

### Retrospective Reviews

At our option, a nurse will review retrospectively the medical necessity of claims that are subject to utilization review. If the nurse determines that care received was medically necessary, the nurse will authorize the benefits. If the nurse determines that medical necessity was lacking, the nurse will refer the case to a licensed physician.

If we have all information necessary to make a determination regarding a retrospective claim, we will make a determination and provide notice to the Covered Person and their provider within 30 calendar days of receipt of the claim. If we need additional information, we will request it within 30 calendar days. The Covered Person or their provider will then have 45 calendar days to provide the information. We will make a determination and provide notice to the Covered Person and their provider within 15 calendar days of the earlier of our receipt of the information or the end of the 45-day time period.

### Notice of Adverse Determination

A notice of adverse determination (notice that a service is not medically necessary) will include the reasons, including clinical rationale, for our determination. The notice will also advise the Covered Person of their right to appeal our determination, give instructions for requesting an external appeal and for initiating an external appeal and specify that the Covered Person may request a copy of the clinical review criteria used to make the determination. The notice will specify additional information, if any, needed for use to review an appeal. We will send notices of determination to the Covered Person or their designee and the Covered Person's health care provider.

If, prior to making an adverse determination, no attempt was made to consult with the provider who recommended the service at issue, the provider may request reconsideration by the same clinical peer reviewer who made the adverse determination. For prospective and concurrent reviews, the reconsideration will take place within one business day of the request for reconsideration. If the adverse determination is upheld, a notice of adverse determination will be given to the provider, by telephone and in writing.

### Internal Appeals of Adverse Determinations

The Covered Person, their designee and, in retrospective review cases, the Covered Person's health

care provider, may request an internal appeal of an adverse determination, either by phone, in person or in writing. The Covered Person has up to 180 calendar days after he or she receives notice of the adverse determination to file an appeal. We will acknowledge the Covered Person's request for an internal appeal within fifteen calendar days of receipt. This acknowledgment will include the name, address and telephone number of the person handling the Covered Person's appeal and, if necessary, inform the Covered Person of any additional information needed before a decision can be made. A clinical peer reviewer who is in the same or similar specialty as the provider who typically manages the disease or condition at issue and who is not subordinate to the clinical peer reviewer who made the initial adverse determination will perform the appeal.

We will decide internal appeals related to prospective reviews within 30 calendar days of receipt of the appeal request. Written notice of determination will be provided to the Covered Person or their designee (and the Covered Person's health care provider if he or she requested the review) within two business days after the determination is made, but no later than 30 calendar days after receipt of the appeal request.

We will decide internal appeals related to retrospective reviews within 60 calendar days of the receipt of the appeal request. Written notice of the determination will be provided to the Covered Person or their designee (and the Covered Person's health care provider if he or she requested the review) within two business days after the determination is made, but no later than 60 calendar days after receipt of the appeal request.

Reviews of continued or extended health care services, additional services rendered in the course of continued treatment, services in which a provider requests an immediate review or any other urgent matter will be handled on an expedited basis. Expedited appeals are not available for retrospective reviews.

For expedited appeals, the Covered Person's provider will have reasonable access to the clinical peer reviewer assigned to the appeal within one business day of receipt of the request for an appeal. The Covered Person's provider and clinical peer reviewer may exchange information by telephone or fax. Expedited appeals will be determined within the lesser of 72 hours or two business days of receipt of the appeal request. Written notice will follow within 24 hours of the determination but no later than 72 hours of the appeal request.

If the Covered Person is not satisfied with resolution of his or her expedited appeal, he or she may file a standard internal appeal or an external appeal. Our failure to render a determination of the Covered Person's appeal within 60 calendar days shall be deemed a reversal of the initial adverse determination.

#### Notice of Determination of Internal Appeal

The notice of determination of the Covered Person's internal appeal will indicate that it is a "final adverse determination" and will include the clinical rationale for our decision. It will also explain the Covered Person's rights to an external appeal, together with a description of the external appeal process and the time frames for initiating an external appeal. We will send notices of determination to the Covered Person or their designee and to the Covered Person's health care provider.

### **EXTERNAL APPEAL**

#### **Covered Person's Right To An External Appeal**

Under certain circumstances, a Covered Person has a right to an external appeal of a denial of coverage. Specifically, if coverage is denied under the policy on the basis that the service is not Necessary Treatment or is Experimental/Investigational Treatment, a Covered Person or his representative may appeal the decision to an External Appeal Agent, an independent entity certified by New York State to conduct such appeals.

#### **Covered Person's Right To Appeal A Determination That A Service Is Not Necessary Treatment**

If coverage is denied under the policy on the basis that the service is not Necessary Treatment, a Covered Person may appeal to an External Appeal Agent if the Covered Person satisfies the following two(2) criteria:

- (a) The service, procedure or treatment must otherwise be a covered expense under the policy; and
- (b) The Covered Person must have received a final adverse determination through Our internal appeal process and We must have upheld the denial or the Covered Person and We must agree in writing to waive any internal appeal.

#### **Covered Person's Rights To Appeal A Determination That A Service Is Experimental/Investigational Treatment**

If coverage is denied under the Policy on the basis that the service is Experimental/Investigational Treatment, a Covered Person may appeal to an External Appeal Agent if the Covered Person satisfies the following two criteria:

- (a) The service must otherwise be a covered expense under the policy; and
- (b) The Covered Person must have received a final adverse determination through Our internal appeal process and We must have upheld the denial or the Covered Person and We must agree in writing to waive any internal appeal.

In addition, the Covered Person's attending Physician must certify that the Covered Person has a life-threatening or disabling condition or disease. A "life-threatening condition or disease" is one which, according

to the current diagnosis of the Covered Person's attending Physician has a high probability of death. A "disabling condition or disease" is any medically determinable physical or mental impairment that can be expected to result in death, or that has lasted or can be expected to last for a continuous period of not less than twelve (12) months, which renders the Covered Person unable to engage in any substantial gainful activities. In the case of a child under the age of eighteen, a "disabling condition or disease" is any medically determinable physical or mental impairment of comparable severity.

The Covered Person's attending Physician must also certify that the Covered Person's life-threatening or disabling condition or disease is one for which standard health services are ineffective or medically inappropriate or one for which there does not exist a more beneficial standard service or procedure -covered by the policy or one for which there exists a clinical trial (as defined by law).

In addition, the Covered Person's attending physician must have recommended one of the following:

- (a) A service, procedure or treatment that two (2) documents from available medical and scientific evidence indicate is likely to be more beneficial to the Covered Person than any standard covered service. "Medical and scientific evidence" is defined as (1) peer-reviewed scientific studies published in, or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff; (2) peer-reviewed medical literature, including literature related to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus, Medline and MEDLARS database Health Services Technology Assessment Research; (3) peer-reviewed abstracts accepted for presentation at major medical association meetings; (4) peer-reviewed literature shall not include publications or supplements to publications sponsored to a significant extent by a pharmaceutical manufacturing company or medical device manufacturer; (5) medical journals recognized by the secretary of Health and Human Services under section 1861(t)(2) of the federal Social Security Act; (6) the following standard reference compendia (A) the American Hospital Formulary Service-Drug Information; (B) the American Medical Association Drug Evaluation; (C) the American Dental Association Accepted Dental Therapeutics; and (D) the United States Pharmacopeia – Drug Information; and (7) findings studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes

including the federal Agency for Health Care Policy and Research, National Institute of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, Congressional Office of Technology Assessment and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services; or

- (b) A clinical trial for which the Covered Person is eligible. "Clinical trial" is defined as a peer-reviewed study plan which has been (1) reviewed and approved by a qualified institutional review board, and (2) approved by one of the National Institutes of Health (NIH), or an NIH cooperative group or an NIH center or the Food and Drug Administration in the form of an investigational new drug exemption, or the Federal Department of Veteran Affairs, or a qualified nongovernmental research entity as identified in guidelines issued by individual NIH institutes for center support grants, or an institutional review board of a facility which has a multiple project assurance approved by the Office of Protection from Research Risks of the National Institutes of Health.

For purposes of this section, the Covered Person's attending physician must be a licensed, board-certified or board eligible physician qualified to practice in the area appropriate to treat the Covered Person's life threatening or disabling condition or disease.

### **The External Appeal Process**

If, through Our internal appeal process, the Covered Person has received a final adverse determination upholding a denial of coverage on the basis that the service is not necessary treatment or is experimental/investigational treatment, the Covered Person has 45 days from receipt of such notice to file a written request for an external appeal. If the Covered Person and Us have agreed in writing to waive any internal appeal, the Covered Person has 45 days from receipt of such waiver to file a written request for an external appeal. We will provide an external appeal application with the final adverse determination issued through Our internal appeal process or our written waiver of an internal appeal.

The Covered Person may also request an external appeal application from the New York State Department of Insurance at 800-400-8882. The completed application should be submitted to the New York State Department of Insurance at the address indicated on the application. If the Covered Person satisfies the criteria for an external appeal, the New York State Department of Insurance will forward the request to a certified External Appeal Agent.

The Covered Person will have an opportunity to submit additional documentation with their request. If the External Appeal Agent determines the information the

Covered Person submits represents a material change from the information on which We based our denial, the External Appeal Agent will share this information with Us in order for Us to exercise Our right to reconsider Our decision. If We choose to exercise this right, We will have three business days to amend or confirm Our decision. Please note that in the case of an expedited appeal (described below), We do not have a right to reconsider our decision.

In general, the External Appeal Agent must make a decision within 30 days of receipt of the Covered Person's completed application. The External Appeal Agent may request additional information from the Covered Person, his physician or Us. If the External Appeal Agent requests additional information, it will have five (5) additional business days to make its decision. The External Appeal Agent must notify the Covered Person in writing of its decision within two (2) business days.

If the Covered Person's attending Physician certifies that a delay in providing the service that has been denied poses an imminent or serious threat to the Covered Person's health, the Covered Person may request an expedited external appeal. In that case, the External Appeal Agent must make a decision with three days of receipt of the completed application. Immediately after reaching a decision, the External Appeal Agent must try to notify the Covered Person and Us by telephone or facsimile of that decision. The External Appeal Agent must also notify the Covered Person in writing of its decision.

If the External Appeal Agent overturns Our decision that a service is not Necessary Treatment or approves coverage of Experimental/Investigational Treatment, We will provide coverage subject to the other terms and conditions of the policy. Please note that if the External Appeal Agent approves coverage of Experimental/Investigational Treatment that is part of a clinical trial, the policy will only cover the costs of services required to provide treatment to the Covered Person according to the design of the trial. We shall not be responsible for the costs of investigational drugs or devices, the costs of non-health care services, the costs of managing research, or costs which would not be covered under the policy for non-experimental or non-investigational treatments provided in such clinical trial.

The External Appeal Agent's decision is binding on both the Covered Person and Us. The External Appeal Agent's decision is admissible in any court proceeding.

We will charge the Covered Person a fee of \$50 for an external appeal. The external appeal application will instruct the Covered Person on the manner in which he must submit the fee. We will also waive the fee if we determine that paying the fee would pose a hardship to the Covered Person. If the External Appeal Agent overturns the denial of coverage, the fee shall be refunded to the Covered Person.

## **Covered Person's Responsibilities**

### **It is the Covered Person's Responsibility to initiate an external appeal process.**

The Covered Person may initiate the external appeal process by filing a completed application with the New York State Department of Insurance. A designee, including a health care provider, may be appointed at any time in order to pursue an external appeal, however, the Department may request written confirmation of the appointment as designee from the patient.

**Under New York State law, the Covered Person's completed request for appeal must be filed within 45 days of either the date upon which he receives written notification from Us that it has upheld a denial of coverage or the date upon which he receives a written waiver of any internal appeal. We have no authority to grant an extension of this deadline.**

Additionally, a health care provider has the right, pursuant to Section 4910(b) of the Insurance Law to pursue an external appeal of a retrospective adverse determination in his own right. Retrospective adverse determination means a determination for which utilization review was initiated after health care services have been provided. To request an appeal of a retrospective adverse determination, a provider must complete a "New York State External Appeal Application for Health Care Providers to Request An External Appeal of A Retrospective Final Adverse Determination". This is a separate document from the Consumer External Appeal application and must be made available upon request by the health plan. For provider appeals, the Member must sign and acknowledge the request and consent to the release of medical records.

**American Medical and Life Insurance Company  
New York, New York**

**GROUP LIMITED BENEFITS HEALTH INSURANCE CERTIFICATE SCHEDULE**

Named Insured: [John Member]  
 Certificate Schedule Number: [12345]  
 Group Policy Number: 50001  
 Policy Holder: National Congress of Employers  
 Certificate Effective Date: [January 1, 2009]  
 Certificate Anniversary Date: January 1, of each year  
 Open Enrollment Period: January 1 through December 31 during each Policy Year

1. Description of Eligible Classes

- I. - All active members of National Congress of Employers as determined by bylaws or charter of the Association
- II. - Dependents of Named Insured as defined in the Policy.

2. Eligibility Period: 365 days  
 3. Waiting Period: 0 days  
 4. Plan Type: Association  
 Member Contribution 100%  
 Voluntary  
 5. Coverage: [Named Insured] [Named Insured and Spouse] [Family]  
 6. Benefits:

<b>Accident Medical Benefit</b>	
Accident Medical Benefit Deductible	\$100 per Policy Year per Covered Person
Accident Medical Benefit	[80%] [100%]
Accident Medical Maximum Benefit	[\$1,000][\$2,500][\$5,000] per Policy Year per Covered Person
<b>Hospital Confinement Benefits</b>	
Hospital Confinement Benefit	[\$100] [\$250] [\$500] [\$750] [\$1,000] per day of confinement
Maximum Benefit	[15] [30] [100] days per Policy Year per Covered Person
[Hospital Intensive Care Unit Confinement Benefit	[\$100] [\$250] [\$500] [\$1,000] per day of confinement]
Maximum Benefit Period	Up to [15] [30] [100] days per Policy Year per Covered Person
Surgery Benefit	
Option 2 Maximum Benefit per Surgery	[50%] [80%] [100%] RBRVS

Maximum Benefit	[\$2,000] [Unlimited]
Anesthesia Benefit	[10%] [20%] [25 %] of surgical benefit.
<b>[Hospital Admission Benefit]</b>	
Hospital Admission Benefit	[\$500] [\$750] [\$1,000] per admission
Maximum Benefit	Unlimited]
<b>[Doctor's Office Visit Benefits]</b>	
Doctor's Office Benefit	[\$40] [\$50] [\$75] [\$100] per visit
Maximum Benefit	5 visits per Policy Year per Covered Person
<b>[Preventive Care Test Benefit]</b>	
Preventive Care Test Benefit	[\$50] [\$75] [\$100] per Test
Maximum Benefit	1 Tests per Policy Year per Covered Person]
<b>[Urgent Care/Emergency Room Benefit]</b>	
Urgent Care/Emergency Room Benefit	[\$50] [\$75] [\$100] [\$150] per Visit
Maximum Benefit	[1] [2] Visits per Policy Year per Covered Person
<b>[Diagnostic Tests, X-ray and Laboratory Benefit]</b>	
Diagnostic Test Benefit	[\$40] [\$50] [\$75] [\$100] [\$250] per day
Maximum Benefit	[2] [3] Tests per Policy Year per Covered Person
<b>[Mental Health Benefit]</b>	
Mental Health Inpatient Benefit	[\$40] [\$50] [\$75] [\$100]per day
Mental Health Inpatient Maximum Benefit	30 days per Policy Year per Covered Person
Mental Health Outpatient Benefit	[\$40] [\$50] [\$75] [\$100] per treatment
Mental Health Outpatient Maximum Benefit	[\$800] [\$1,000] [\$1,500] [\$2,000] per Policy Year per Covered Person
<b>[Accidental Death and Dismemberment Benefit]</b>	
Accidental Death Benefit	[\$2,000] [\$5,000] [\$10,000] [\$15,000] Primary Insured; 50% Spouse; 25% Dependent
Dismemberment Benefit	[\$2,000] [\$5,000] [\$10,000] [\$15,000] Primary Insured; 50% Spouse; 25% Dependent Loss of both hands or both feet - 100% Loss of sight of both eyes - 100% Loss of one hand and one foot - 75% Loss of one hand and sight of one eye - 50% Loss of one foot and sight of one eye - 50% Loss of one hand - 25% Loss of sight of one eye - 25%

- 7 Pre-existing Condition Limitation Period [6] [12] months following the effective date of coverage under this Policy
8. Rates: [See Attached Rate Sheet] [(See page 1 of your Cinergy Health Preferred Member Handbook)]
9. Rate Guarantee Period A change in premium rate will not take effect before 12 months after the policy effective date



## ARKANSAS AMENDATORY ENDORSEMENT

This amendatory endorsement is made a part of the Policy or Certificate to which it is attached and is subject to all terms and provisions of such Policy or Certificate not inconsistent herewith. This amendatory endorsement is applicable only to Insured Persons who are **residents** of the State of Arkansas on the Certificate Date and on the date the claim is incurred.

1. The "Coverage for the Named Insured's adopted child(ren)" provision in the "Eligibility and Effective Date" section is deleted in its entirety. The following shall be substituted in its place:

We will cover the Named Insured's adopted child(ren) from the moment of birth if You take physical custody of the infant upon the infant's release from the hospital and file a petition pursuant to Section 115-c of the Domestic Relations Law within sixty days of birth provided that no notice of revocation to the adoption has been filed pursuant to Section 115-b of the Domestic Relations Law and consent to the adoption has not been revoked. However, coverage of the initial hospital stay shall not be required where a natural parent has insurance coverage available for the infant's care.

A child adopted by You or Your insured Spouse will automatically become insured as a dependent. The effective date of the coverage will be the earlier of:

- the date of placement for the purpose of adoption; or
- the date on which You assume a legal obligation for total or partial support of the child.

Coverage for adopted children will be to the same extent as is provided for other covered dependent children and will include the necessary care and treatment of pre-existing medical conditions.

Coverage will continue for the adopted child unless the placement is disrupted prior to the final adoption; and

- the child is permanently removed from placement;
- the legal obligation terminates; or
- You rescind, in writing, the agreement of adoption or agreement assuming financial responsibility.

For each newborn, step child and/or adopted child, You must:

- notify Us of his birth or placement in Your residence;
- complete the required application for him; and
- pay the required premium for him, if any.

If a newborn is not enrolled within 90 days of birth coverage will be provided from the date that notice is given. Any Additional premium required should be made to the Holder within 90 days of notification of birth.

If an adopted child is not enrolled within 90 days of adoption coverage will be provided from the date that notice is given. Any Additional premium required should be made to the Holder within 90 days of notification of placement for the purposes of adoption.

2. The "Time of Payment of Claim" provision in the "How to File a Claim/Claim Provisions" section is deleted in its entirety. The following shall be substituted in its place:

We will pay any benefits due not more than 30 days after We receive written proof of loss electronically or 45 days if the claim is submitted by other means.

There are no other changes to the certificate.

This endorsement takes effect and expires concurrently with the policy or certificate to which it is attached, and is subject to all of the terms and conditions of the policy not inconsistent therewith.

In Witness Whereof, We have caused this Endorsement to be signed by

Chairman, President and CEO

Executive Vice President & Chief Compliance Officer

*SERFF Tracking Number:* CMPL-125943982                      *State:* Arkansas  
*Filing Company:* American Medical and Life Insurance Company   *State Tracking Number:* 41079  
*Company Tracking Number:* AMI NCE 11-08  
*TOI:* H14G Group Health - Hospital Indemnity              *Sub-TOI:* H14G.000 Health - Hospital Indemnity  
*Product Name:* AMI NCE 11-08  
*Project Name/Number:* AMI NCE 11-08/AMI NCE 11-08

## **Rate Information**

Rate data does NOT apply to filing.

SERFF Tracking Number: CMPL-125943982 State: Arkansas  
Filing Company: American Medical and Life Insurance Company State Tracking Number: 41079  
Company Tracking Number: AMI NCE 11-08  
TOI: H14G Group Health - Hospital Indemnity Sub-TOI: H14G.000 Health - Hospital Indemnity  
Product Name: AMI NCE 11-08  
Project Name/Number: AMI NCE 11-08/AMI NCE 11-08

## Supporting Document Schedules

**Satisfied -Name:** Certification/Notice **Review Status:** Disapproved 04/15/2009  
**Comments:**  
**Attachment:**  
AR\_AR Certif of Compliance with Rule 19.pdf

**Satisfied -Name:** Application **Review Status:** Disapproved 04/15/2009  
**Comments:**  
Please see cover letter for complete details.

**Satisfied -Name:** Filing Authorization **Review Status:** Disapproved 04/15/2009  
**Comments:**  
**Attachment:**  
AML authorization letter - 01-31-2008.pdf

**Satisfied -Name:** Readability **Review Status:** Disapproved 04/15/2009  
**Comments:**  
**Attachment:**  
READABILITY CERTIFICATION.pdf

**Satisfied -Name:** By Laws **Review Status:** Disapproved 04/15/2009  
**Comments:**  
**Attachment:**  
NCE-AMENDED CONSTITUTION AND BYLAWSNCERS5 07.pdf

**Satisfied -Name:** Handbook **Review Status:** Disapproved 04/15/2009  
**Comments:**

*SERFF Tracking Number:* CMPL-125943982                      *State:* Arkansas  
*Filing Company:* American Medical and Life Insurance Company   *State Tracking Number:* 41079  
*Company Tracking Number:* AMI NCE 11-08  
*TOI:* H14G Group Health - Hospital Indemnity              *Sub-TOI:* H14G.000 Health - Hospital Indemnity  
*Product Name:* AMI NCE 11-08  
*Project Name/Number:* AMI NCE 11-08/AMI NCE 11-08

**Attachment:**

Cinergy\_Preferred\_1000\_Handbook\_Dec08.pdf

SERFF Tracking Number: CMPL-125943982 State: Arkansas  
Filing Company: American Medical and Life Insurance Company State Tracking Number: 41079  
Company Tracking Number: AMI NCE 11-08  
TOI: H14G Group Health - Hospital Indemnity Sub-TOI: H14G.000 Health - Hospital Indemnity  
Product Name: AMI NCE 11-08  
Project Name/Number: AMI NCE 11-08/AMI NCE 11-08

**Review Status:**

**Satisfied -Name:** 3-26-2009 Our Response Disapproved 04/15/2009

**Comments:**

Dear Ms. Minor:

Thank you for your note of March 19 concerning this submission.

You asked about proper identification of American Medical as the insurer of the plan that is marketed by Cinergy Health. The association does not have a separate marketing brochure. However, we note that the Cinergy brochure at the bottom of page 3 does identify American Medical as the underwriter. On page 6, the question "Is Cinergy Health an Insurance Carrier?" explains that Cinergy is not an insurer but that it is an agency that works with insurers to develop and implement insurance plans. The Liability provision on page 11 of the brochure also explains that Cinergy is not an insurer, HMO or underwriter.

Considering the above, we believe the language in the brochure takes care to avoid the impression that Cinergy is the insurer of the plan. If you have questions or would like to discuss, please call me at 513-984-6050 and I will be happy to discuss.

Thank you for your consideration.

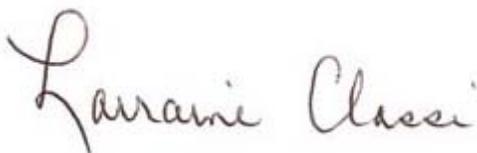
## Certificate of Compliance with Arkansas Rule and Regulation 19

Insurer: American Medical and Life Insurance Company

Form Number(s):

- AMLI GRP LM 2007 CERT NY, Certificate of Coverage
- AMLI GRP LM 2007 SCHED, Group Limited Benefits Health Insurance Certificate Schedule
- GRP LM 2007-AE-AR-(11/08), Arkansas Amendatory Endorsement

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.



---

Signature of Company Officer

Lorraine Classi

---

Name

---

Executive VP

Title

---

12-12-2008

Date



8 West 38th Street · Suite 1002  
New York, NY 10018

Lorraine Classi

EXECUTIVE VICE PRESIDENT OF OPERATIONS

646.223.9300 ext. 801

TOLL FREE 800.822.0004

FAX 212.354.9089

[lclassi@usamli.com](mailto:lclassi@usamli.com)

[www.usamli.com](http://www.usamli.com)

January 31, 2008

NAIC Company Code: 81418

Re: Policies and Related Forms

To: All Departments of Insurance

American Medical and Life Insurance Company hereby authorizes Compliance Research Services, LLC to represent us in the submission of the above-referenced forms and to negotiate with insurance departments for their approval.

Sincerely,

Lorraine Classi  
Executive Vice President & Chief Compliance Officer



## READABILITY CERTIFICATION

**RE:** American Medical and Life Insurance Company

**NAIC #** 81418

**FEIN #** 13-2562243

This is to certify that form(s) listed below have achieved at least the minimum required score on the Flesch Reading Ease Test.

<u>Forms</u>	<u>Score</u>
AMLI GRP LM 2007 CERT NY, Certificate of Coverage	41
AMLI GRP LM 2007 SCHED, Group Limited Benefits Health Schedule	53
GRP LM 2007-AE-AR-(11/08), Arkansas Amendatory Endorsement	47



J. David Simon, CLU

President

513-984-6050

[dsimon@crssolutionsgroup.com](mailto:dsimon@crssolutionsgroup.com)

December 11, 2008

**AMENDED CONSTITUTION AND BY-LAWS**  
**OF**  
**THE N.C.E**

ARTICLE I  
NAME & OFFICE

**Section 1 – Name**

The name of the Association shall be **The N.C.E. also known as The NATIONAL CONGRESS OF EMPLOYERS.**

**Section 2 – Office**

The principal offices of the association shall be located at 1001, Pennsylvania Avenue, Washington D.C. and additional Chapter offices in New York and any other location the Board deems appropriate.

ARTICLE II  
SEAL

**Section 1 – Seal**

The association shall have a common seal consisting of a design to be determined by vote of the Board of Directors. The Seal shall contain the name of the Organization in a semi-circular fashion and the year of formal organization, 1996 surrounding or overwritten on an acceptable symbol embodying the purpose of the Organization.

## ARTICLE III

### PURPOSE

#### **Section 1 – Mission:**

The mission of the Association is to impact public policy at the state and federal level and be a key business resource for small, independent business in America. To render public services as non-partisan, non-profit, and non-stock organization. To develop acquaintance and fellowship, undertake projects, and act upon matters of common interest and welfare to the members of the association; To instill, foster, encourage, and promote among members of the association the importance of adhering to the highest ethical standards of their respective professions; To establish facilities and provide forum for the interchange of ideas, opinions, technical know-how, and experiences among members of the association and other national and international organizations.

#### **Section 2 - Core Values**

We Believe Deeply That:

- Small, independent business is essential to America.
- Free enterprise is essential to the start-up and expansion of small business.
- Small business is threatened by government intervention.
- An informed, educated, concerned and involved public is the ultimate safeguard for small independent business.
- Members determine the public policy positions of the organization.
- Our Members, collectively and individually, determine the success of N.C.E's endeavors, and each person has a valued contribution to make.
- Honesty, integrity and respect for human and spiritual values are important in all aspects of life, and are essential to a sustaining a successful work environment.

ARTICLE IV  
MEMBERSHIP

**Section 1 – Qualifications**

The N.C.E. is a private, not for profit, fraternal organization which neither seeks nor accepts public or corporate funding in any form. Membership is reserved for those individuals that embody the purposes and ideals of the N.C.E. as defined by the Board of Directors. The Board and its Membership Committee reserves the right to deny membership to any applicant for any reason. Notwithstanding the foregoing, the Board shall not deny membership on the basis of race, religion or gender.

**Section 2 - Classification of Members**

Membership into this organization shall be classified as follows:

1. CHARTER MEMBERS – These shall include the names of founding members; Hon. George F. Sabatella, Hon. Robert DiCarlo, Christopher G. Sabatella, Mathew D. Saronson and Andrea Ceretti, Michael DiFilippo
2. ACTIVE MEMBERS – These shall include individuals operating sole proprietorships “Freelancers” and other like situated individuals duly enrolled and in good standing, having been approved for full membership by the Board of Directors or their duly authorized delegated Membership Committee.
2. AFFILIATE MEMBERS – These shall include individuals are members of another like intended Association which has entered into a reciprocity agreement with the NCE.
4. HONORARY MEMBERS – These shall include individuals who are conferred membership as such by the Board of Directors.

## **Section 2 – Rights and Privileges**

1. CHARTER MEMBER – They shall be entitled to all the privileges and services offered by the association, and shall serve as permanent members of the Board of Directors.
2. ACTIVE MEMBER – They shall be entitled to all the privileges and services offered by the association. Each member may vote and be voted upon, for office in the Organization
3. AFFILIATE MEMBER – This Affiliate Members shall enjoy the same rights as Active Members. They shall be free to participate in the political, educational and charitable activities of the Organization. However, Association members are not entitled to hold office nor vote nor be voted upon.
4. HONORARY MEMBER – They shall be entitled to all privileges and services offered by the Association. However, they may neither vote nor be voted upon.
5. OTHER PRIVILEGES - Other membership privileges include participation in various activities, programs and publications of the Association as may be designated from time to time by the Board of Directors.

### **Section 3 – Fees and Dues**

1. The Board of Directors may at any meeting of the Board adjust the membership dues applicable to the classes of members enumerated in these Bylaws, without amending the Bylaws. Provided, however, that any dues increase which exceeds the cumulative increase of the Composite Consumer Price Index since the last dues increase must be confirmed by a majority of the Board of Directors. Dues shall be payable in advance of the month due.
2. The Board of Directors shall determine the charges for all other fees Associated with meetings or any other products provided by the Association.
3. Monthly membership dues will include fees for general membership meetings and publications.

### **Section 4 – Admission and Effectiveness of Membership**

1. Applications for membership shall be made in writing. Applications shall be processed by the membership committee. The applicant will be advised of action taken in their application.
3. Effectiveness of membership shall start from the payment of entrance fees and membership dues of the applicant and after submission of other requirements that may be imposed by the membership committee and/or Board of Directors.
3. Fees shall be paid within thirty (30) days after official approval of application for membership.

### **Section 6 – Members in Good Standing**

In order to be a member in good standing, a member shall have paid all dues and assessments within (30) days after the same shall have become due and payable.

### **Section 7 – Liability of Members**

Members who have not fully paid their annual dues and other obligations to the association shall be liable for any indebtedness of the association to the extent of their unpaid accounts.

### **Section 8 – Termination of Membership**

Any member may be separated from membership for any of the following causes:

1. Any member who shall have defaulted in the payment of dues and assessments for two (2) successive month shall be automatically suspended after due notices had been given and will forfeit all rights and privileges in the association; provided, however, that any member so suspended may be reinstated to full standing upon payment of all dues in arrears and upon the approval of the majority of the Board of Directors;
2. Any other cause or causes detrimental to the association upon which, after due notice, investigation and hearing, the Board of Directors vote in favor of termination.

## **ARTICLE V**

### **MEETINGS**

#### **Section 1 – Annual Meetings**

The annual general membership meeting, for the purpose of election of the Board of Directors, shall be held on the third Friday of December of each year at the principal office of the association or at any place in State of New York or Discript of Columbia to be decided on by the Board of Directors.

The order of business shall be as follows:

- Reading of the Minutes of the last Annual General Membership Meeting and approval thereof;
- Report of the Treasurer;
- Report of the President;
- General Annual Elections of the Board of Directors;
- Unfinished business;
- New and other business;
- Report of the election committee and announcement of the results of the election.

### **Section 2 – Special Meetings**

Special meetings of the association may be called anytime by the Executive Director or by a majority of the Board of Directors whenever either shall deem it necessary.

### **Section 3 – Notice of Meetings**

The notice of the annual meetings or special meetings must be advised to all members in writing at least one week before the meeting.

### **Section 4 – Quorum**

A simple majority (50% + 1) of the Active members in good standing, including proxies, shall constitute a quorum for the election of the Directors or for the transaction of any other business except in those cases where the By-Laws require the affirmative vote of a greater proportion.

## **ARTICLE VI**

### **VOTING RULES AND REGULATIONS**

## **Section 1 – Election Committee**

An election committee shall be appointed by the Board of Directors to conduct elections. It shall be formed not later than ninety (90) days before the election from among members who do not intend to run for office. No member of the election committee can be voted upon. The members of the committee shall select their chairperson. The administrative officer shall be an ex-officio member. The committees empowered to formulate rules and regulations concerning the manner of elections and questions of eligibility, breaking of all ties, and such other matters relative to the elections. The committee shall automatically be dissolved after it has canvassed the election returns and proclaimed the winning candidates. The rules to be set by the committee on elections shall be disseminated to the membership at least three (3) days prior to the election.

## **Section 2– Manner of Nomination**

A certified list of official representatives of members in good standing shall be sent out together with nomination forms to all members in good standing of the association not later than sixty (60) days prior to the election.

Any voting member may nominate a maximum of nine (9) names from those enumerated in the certified list. Nominations shall be received by the Election Committee not later than thirty (30) days prior to the election after which date the nominations shall be deemed closed.

The Election Committee will inform all nominees of their nomination and acceptance therefore shall be received from them in writing.

The final list of candidates, arranged alphabetically, will be circulated to all voting members not later than 15 days before the election. The list shall not indicate the number of nominations received by each candidate.

In the event that the number of candidates equal or would be less than the number of elective positions, the nomination shall be declared re-opened by the Election Committee on the floor during election day.

#### **Section 4 – Voting of Members**

Founding and Active members of good standing (Voting Members) may vote at all meetings. Each Voting Member is entitled to one vote that may be cast in person either in person or with approval of the Board of Directors via telephonic participation. In voting for members of the Board of Directors, each Voting Member shall vote a maximum of nine (9) different candidates. If any voting member cannot attend the election, he may submit a written proxy to the committee on election before the election, which shall be used for quorum purposes only.

#### **Section 5 – Certification**

Prior to the elections, the Committee on Elections shall certify that all the candidates are qualified and have been nominated in accordance with the Constitution and By-Laws of The N.C.E..

#### **Section 6 – Election of Directors**

The election of Directors shall be by secret ballot. Action on all other matters shall be by ‘aye’ or ‘nay’ vote or by other means as the majority present may decide.

#### **Section 7 – Manner in Deciding a Tie**

Should there be a tie in the election for Director, the same shall be decided by drawing lots.

#### **Section 8 – Campaign**

Any candidate for election may campaign for his candidacy by sending personalized letters only to members of the association. Any other form of

campaigning is disallowed and considered a violation of election rules. However, on the election floor, candidates may distribute personal business cards.

### **Section 9 – Violation of Rules**

Any willful violation of election rules by any member of the association shall disqualify them from running for office and/or voting during the election and will subject them to disciplinary action.

## ARTICLE VII BOARD OF DIRECTORS

### **Section 1 – Number and Term of Office**

The management of the affairs of the association shall be vested in the Board of Directors consisting of no fewer than four (4) and no greater than nine (9) members who shall be elected bi-annually by the voting members of the association.

### **Section 2 – Quorum**

The Directors shall act only as a Board. No individual Director shall have the power to act in behalf of the Board. An attendance of a quorum of Directors is necessary at all meetings for the transaction of any business and every decision of majority of those present shall be valid as an Association act. A Quorum shall consist of a simple majority of Directors (50% +1)

### **Section 3 – Regular Meetings**

The Board of Directors shall hold regular meetings every second Wednesday of the month at the office of the association or at any date and place to be designated by the Board.

### **Section 4 – Special Meetings**

Special meetings of the Board of Directors may be called by the Executive Director or at the written request of the majority of the directors. Notice of

special meeting shall be given at least twenty-four (24) hours before the date of the meeting. Notice of such meeting shall be deemed waived if all members of the Board are present.

### **Section 5 – Powers**

The Board of Directors shall exercise the following powers and such other powers as may be provided for by the laws of the State of New York:

1. To promulgate such rules and regulations not inconsistent with these By-Laws;
2. To manage the affairs of the association within the context of the By-Laws and Articles of Incorporation;
3. To purchase or acquire or sell or dispose of assets for the association on such terms and conditions as it shall be deemed proper;
4. To employ and fix the compensation of the administrative officer, employees, and other officers of the association;
5. To act on all matters as may be designated by the association as a whole.
6. To alter, merge or subdivide the association as the Board sees fit and to best serve the interests of the membership.
7. To perform any and all tasks necessary to further the interests of the Association, limited only by these by-laws and the laws of the State of New York.
7. To enter into contracts, form or execute trusts, subsidiary organizations,
8. to enter into partnership agreements or strategic alliances with like intended associations or groups.
9. Approves an annual budget and financial audit
10. Approves the time and place for the annual meetings of the members and the Board of Directors and all business meetings of the Board.
11. Hire staff as it deems necessary
12. Approves all committees and organizational appointments

13. Fills vacancies on the Board of Directors
14. Serves as the primary strategic planning unit for the corporation.
15. Establishes organizational policies and develops strategies and allocates resources to implement same.

### **Section 6 – Resignation**

Any Director or officer may resign his office in writing. Such resignation should take effect upon approval and clearance by the Board.

### **Section 7 – Vacancy**

In the event of any vacancy in the Board of Directors by reason of resignation, termination, death, inability to discharge responsibilities, or for any other reason acceptable to the Board, said vacancy shall, with the approval of the remaining Board of Directors be filled by the surviving spouse of the Director, for the remainder of that Director's Term of Office. Subsequent vacancies shall likewise be filled in the same manner from candidates ranked in the descending order of number of votes received.

If the vacancy is in the ranks of principal officers of the Board, it shall be filled by election from among the members of the Board during the next regular or special meeting held for the purpose.

## **ARTICLE VIII**

### **OFFICERS**

#### **Section 1 – Principal Officers**

Within the next fifteen (15) days after the election, as provided for in Article V, Section 1, the members of the Board of the Directors shall elect from among themselves the Executive Director, President, Secretary and Treasurer.

#### **Section 2 - Subordinate Officers**

The Boards, in its discretion, may create those new, subordinate offices they deem necessary. The subordinate officers shall be members of the association, shall be appointed by the Board of Directors. The subordinate officers may be employed by the Board of Directors who shall determine the compensation of all subordinate officers.

### **Section 3 – Compensation of Officers**

The President, Executive Director, Secretary, Treasurer, and members of the Board of Directors shall receive no compensation. Salaries and compensation of other officers shall be fixed by the Board of Directors, provided that no member of the association shall be appointed or elected to any position carrying with it compensation.

## ARTICLE IX

### DUTIES OF OFFICERS

#### **Section 1 – Powers and Duties of the Executive Director**

The Executive Director shall be the Chief Executive Officer of the association and, as such, shall exercise all the powers and discharge all such duties regularly or continually inherent in his office under the law, and such others as may be required by resolutions of the Board of Directors and of the association.

#### **Section 2 – Powers and Duties of the President**

The President shall act as Deputy Executive Officer and shall exercise and discharge all the powers and the duties of the President in case of the disability or absence of the latter. The President shall have direction of the following standing committees:

1. Membership Committee
2. Political Action Committee
3. Member Benefit Committee
4. Education Committee

5. Legal Committee
6. Charitable Works Committee
7. Other committees and functions as may be assigned to him.

Each committee shall be headed by a Chairperson.

#### **Section 5 – Powers and Duties of the Secretary**

The Secretary, who must be a member of the N.C.E., shall be the custodian of all corporate records and other minutes of all meetings of the association and of the Board of Directors. He shall issue notices of meetings and prepare the Order of Business thereof. He shall keep in safe custody the seal of the association and when authorized by the Board of Directors shall affix such seal to any instrument requiring the same. The seal so affixed shall be attested by him. He shall perform such other duties as may be delegated to him by the Executive Director or the Board of Directors or as may be required of him.

#### **Section 6 – Powers and Duties of the Treasurer**

The Treasurer shall be the finance officer of the association and as such shall be the custodian of all funds and properties of the association. He shall have charge of all the books of accounts of the association. He shall be responsible for all the collection of all the fees and dues from members. He shall make such disbursements as may be authorized by the Board. He shall make an annual financial report to the association and such other reports as the Board of Directors may require.

### ARTICLE X COMMITTEES

#### **Section 1 – Standing Committees**

There shall be three major standing committees governed by a fourth, governed by the Executive Committee, namely:

1. Membership Committee

2. Political Action Committee
3. Member Benefit Committee

All standing committees shall submit their master programs for the fiscal year to the Board not later than the second regular Board meeting.

### **Section 2 – Executive Committee**

It shall be composed of the Executive Director, the President, the Secretary, the Treasurer, and the Chairman of each of the three Standing Committees.

The committee shall be responsible for the preparation of the annual budget for submission to the Board of Directors not later than the second regular meeting of the Board. It shall also formulate policies and procedures in furtherance of the objectives of the association for submission to the Board, and direct the governance and running of the standing committees. It shall also perform such other duties as may be delegated by the Board of Directors.

## ARTICLE XI GENERAL PROVISIONS

### **Section 1 – Fiscal Year**

The fiscal year shall begin on January 1 and end on December 31 of the same year.

### **Section 2 – Budget**

The Board of Directors shall approve the annual budget of the association within fifteen (15) days after receipt of the recommended budget from the Executive Committee. The approved budget shall be the appropriated measure of the association. No expenditures in excess of the budget shall be authorized without the prior approval of the Board of Directors.

### **Section 3 – Signatories**

All disbursements of funds of the association shall be made by checks. Checks shall be signed by the Executive Director and countersigned by the President. The Board of Directors may authorized any officer or officers to sign in place of the duly authorized signatories.

## ARTICLE XII AMENDMENTS

### **Section 1 – Amendments**

A two-third majority of the members of the Board of Directors may amend or repeal these By-Laws or adopt new By-Laws.

## ARTICLE XIII TRANSITORY PROVISIONS

### **Section 1 – Regular Members**

All Charter, Active and Honorary members of the association in good standing as of the approval of these amended By-Laws are ipso facto members of the association.

## ARTICLE XIV ASSOCIATION RELATIONSHIPS

### **Section 1- Affiliation With Other Professional Organizations**

All members shall be encouraged to maintain active membership in local, national, and international organizations. The Association shall maintain an affiliation with its sister Associations the National Congress of Employees. The Association may seek affiliation with like intended organizations as determined by the Board of Directors.

## ARTICLE XV

## LIQUIDATION

### **Section 1 – Disolution**

In the event of the liquidation and dissolution of the N.C.E., any properties, funds or monies, securities or other assets remaining in the treasury of, or to the account of, or otherwise belonging to, the N.C.E. shall be disposed of as follows:

- (a) All liabilities and obligations of the N.C.E. shall be paid and discharged, or adequate provision shall be made therefore:
  
- (b) Assets held by the N.C.E. subject to legally valid requirements for their return, transfer, or conveyance, upon dissolution and liquidation, shall be returned, transferred, or conveyed in accordance with such requirements: and
  
- (c) All remaining assets held by the N.C.E. shall be transferred or conveyed, without obligation, to another not for profit organization or foundation selected by the Board of Directors in office at the point dissolution is decided upon.



# cinergy™

## HEALTH

Your Life. Your Health. Your Plan.



# Cinergy Health Preferred • Member Handbook

# CINERGY HEALTH PREFERRED

## Your Affordable Health Insurance Solution

**Welcome and thank you for choosing Cinergy Health!** We understand how important it is for you to sensibly manage the healthcare for yourself and your family. Choosing the right partner is critical and Cinergy Health will continually strive to provide you with the best programs, services and value available in a health plan. **Cinergy Health** offers healthcare coverage that is affordable, easy to use and understand, and covers many different types of medical expenses.

Your **Cinergy Health Preferred** Insurance Plan is a Limited Medical Benefit Plan designed as an affordable alternative to higher-priced major medical plans. Your **Cinergy Health Preferred** plan provides first-dollar coverage for the essential healthcare you need without the burden of big deductibles. The **Cinergy Health Preferred** plans are not major medical insurance. The intent is to provide specific health coverage that is limited to the Schedule of Benefits included in this Member Handbook.

This booklet contains general information that will help you understand the details of your **Cinergy Health Preferred Plan**, how to utilize your membership ID cards and how to maximize your benefits. We encourage you to review the enclosed Certificate of Insurance and familiarize yourself with your benefits. You should also refer to the Member Terms and Conditions, which further explain the details of your plan.

This plan is available to all members of the National Congress of Employers (NCE), of which you are a member. NCE is a non-profit advocacy group working on behalf of America's growing small businesses and self-employed, toward legislative reform affecting Health Insurance, Taxation and Regulations. As a member you are adding your voice to thousands of other members for these causes, as well as being entitled to all of the association's many benefits.

### Member ID Cards: Front



  
**cinergy**  
 HEALTH  
 Your Life. Your Health. Your Plan.

**Name: HORTENSIA MORALES and Family**  
**Member #: 44**  
**Limited Medical Insurance Plan**  
 Effective Date: 12/15/07    Group Name: CH / NCE Assoc.    Group #: NCE11  
 Plan Name: Cinergy Health Preferred Family 1000

**Member Services: 1-800-847-1148**

### Back



**Cinergy Health Preferred Plan**

Underwritten by an AM Best Rated Carrier

Plan benefits are assignable to any qualified healthcare provider. For maximum savings and assistance with locating preferred providers in your area, or for any other questions call Member Services toll free at **1-800-847-1148**. For additional information or to search our preferred providers go to **www.CinergyHealth.com**.

 **MultiPlan**

**Providers:** This card does not guarantee eligibility. To verify coverage, submit a claim or check the status of a claim please call **1-800-364-4137**. For electronic claims submission please use Payor ID # 23212

Send claims to: **Cinergy Health, Inc.**  
1844 N Nob Hill Rd. #623  
Plantation, FL 33322

<b>Plan Name:</b>	<b>Cinergy Health Preferred Family 1000</b>
<b>Membership Effective date:</b>	<b>12/15/07</b>
<b>One-time Registration Fee:</b>	<b>\$50</b>
<b>Monthly Fee:</b>	<b>\$279.31</b>

### Disclosure

This plan is offered through a membership and at the sole discretion of the National Congress of Employers and may vary by availability, vendor or member's state of residence. This is **NOT Major Medical Insurance** and is not meant to replace catastrophic health insurance or major medical coverage.

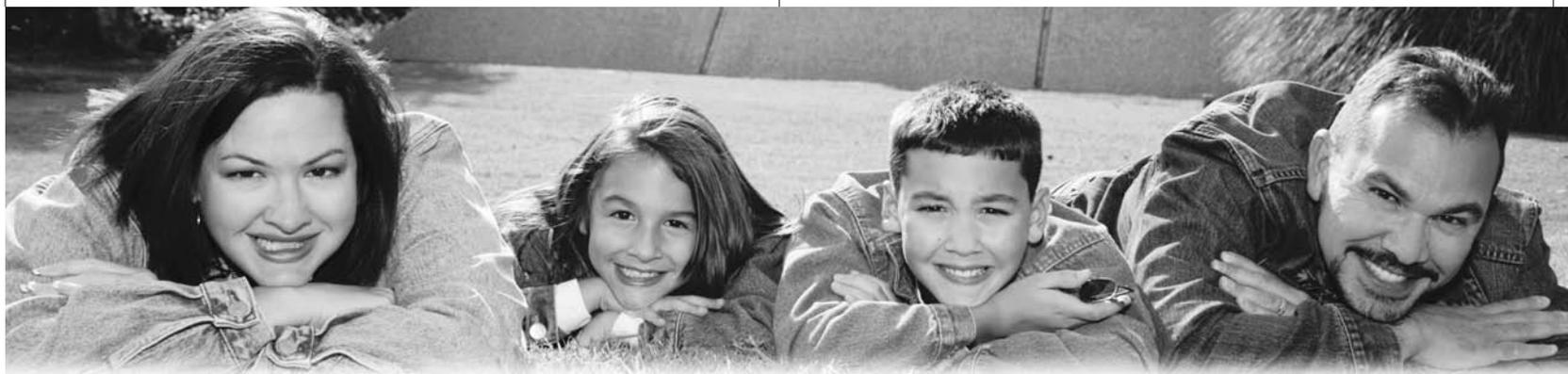
### Refund Policy

Please take the time to fully review your Certificate of Coverage. You may cancel the Plan before your effective date or within 10 calendar days of receipt of your Certificate of Coverage and receive a full refund minus the application fee. To request cancellation and a refund you must submit your request in writing and it must be postmarked before your effective date or within 10 days of receipt of your Certificate of Coverage. If you have any questions please call Customer Service at **800-847-1148**.

### Cinergy Health, Inc.

(also doing business as "Cinergy Plans, Inc." (AL, TX, ND & NH),  
"Cinergy Health Insurance Agency, Inc." (CA) and "Cinergy Health and Life, Inc." (KY & ME)).

**19495 Biscayne Blvd. • Suite 604 • Aventura, Florida 33180 • 1-800-847-1148 • www.cinergyhealth.com**



## THE PREFERRED DIFFERENCE

There has been a dramatic increase across the country of consumers choosing limited medical benefit plans like **Cinergy Health Preferred** over the alternatives: remaining uninsured or paying for costlier major medical insurance.

The reasons for this shift are clear. Think of limited medical plans as the flip-side of catastrophic coverage: instead of paying out-of-pocket for big deductibles and your everyday medical expenses while guarding against the infrequent, but much larger medical expenses associated with a serious illness or accident, limited medical plans pick up the tab for most of your common health care services such as doctors' visits, lab tests, X-rays, short-term hospital stays, minor

surgeries and maternity care. However, there are annual caps on most benefits. The lack of health insurance forces people to delay medical care until symptoms become more severe. Having good medical coverage promotes timely intervention with appropriate medical attention. As a result adults and children alike shorten recovery time and achieve better health outcomes.

**Cinergy Health Preferred** is intended to be used for your day-to-day health insurance needs. This plan provides the opportunity to off-set most of your medical expenses for regular healthcare services so you can avoid waiting in the "no insurance" line at an emergency room. Since **Cinergy Health Preferred** provides coverage starting on your

first medical visit without the hurdle of big deductibles, people tend to seek care more regularly in order to maintain better health.

The growing popularity of limited medical plans is driven by both practicality and price. Consumer healthcare data shows that less than 20% of the population uses more than \$2,000 annually in health-care services. It is difficult to pay major medical insurance premiums of \$12,000 annually when one's health care needs are minimal. Limited medical plans can cover most of the common medical costs in exchange for a premium that is generally half the cost of a major medical plan.

### Examples of Major Medical Insurance Quotes\*

SAMPLE PLANS	New York City Insurance Plan	Los Angeles Insurance Plan	Miami Insurance Plan
Monthly Cost	\$1,112	\$1,110	\$673
Family Deductible	\$4,000	\$7,500	\$20,000
Doctor Visits	\$30 for primary care \$50 for specialist	\$35	\$15 for primary care \$30 for specialists
Hospitals	20% co-insurance after deductible	No charge	20% co-insurance after deductible
Maternity	20% co-insurance after deductible	Not Covered	Not Covered

\*Based on quotes provided for a family of four with two adults age 40 and two children ages 7 and 10 on 3/10/08 (eHealthInsurance).

It is important to note that not all limited medical plans are the same. Some plans have very low annual caps and do not include coverage for surgeries or maternity. **Cinergy Health Preferred** is a leader in the industry by including unlimited surgical benefits to ensure greater coverage.

Another unique and critical feature is that the **Cinergy Health Preferred** plan, underwritten by the American Medical and Life Insurance Company, is creditable coverage. Having creditable coverage protects you if or when you ever replace your **Cinergy Health Preferred** plan with a major

medical plan. The absence of creditable coverage permits other insurance companies to impose lengthy waiting periods on your pre-existing medical conditions or worse, decline coverage altogether.

## How to Use this Plan

Please review the Summary of Benefits on the following page as well as your Certificate of Coverage. To receive care you may go to any doctor, urgent care center, hospital, lab or diagnostic facility of your choice and qualify for coverage. **You are not required to visit network providers in order to receive coverage.** However, to minimize your share of the costs we are here to help guide you in selecting convenient and cost-effective participating healthcare providers in your area.

We have partnered with **MultiPlan**, a national medical Preferred Provider Organization (PPO), which includes nearly 700,000 participating providers that offer reduced fees to **Cinergy Health** members. To locate participating providers in your area, check the sample directory enclosed in this Member Handbook. If you have Internet access you may simply search the network on our website at **www.cinergyhealth.com** or call our Member Care Center at **800-847-1148** for personal assistance. When you visit the healthcare provider, remember to present your **Cinergy Health** card with the MultiPlan logo. Your healthcare provider may file claims on your behalf so that you do not need to wait for reimbursement.

**If you have any questions about your plan coverage, membership status, how to access care or if you need to file a claim for covered services, please call Member Care Services toll-free at 1-800-847-1148 for prompt friendly assistance. Our offices are open Monday through Friday from 9:00 am to 8:00 pm Eastern.**

We are always pleased to hear from you. We welcome your written testimonials on how our program has truly made a difference for you and your family. And if you encounter any challenges please allow us the opportunity to satisfy your needs.

## How to File a Claim

Please keep your membership cards with you at all times so they will be easily accessible. Remember to present your membership card to your healthcare provider at the time of service. Ordinarily your healthcare provider will file claims directly with the insurance carrier as indicated on the back of your membership ID card. Payment of claims will be made to your healthcare provider. This way you do not have to wait for reimbursement. If you prefer, you may file the claim yourself for reimbursement for payments you have made to your healthcare provider. However, if you file the claim

yourself the fee charged by your provider may be slightly higher since we do not re-price non-assigned claims. One claim form is included with this Membership Handbook. Additional claim forms are available for easy download from our website at **www.CinergyHealth.com**. You can also download other important documents from our website including Beneficiary Designation Forms and your Certificate of Coverage. For assistance with claims please call Member Care Services at **800-847-1148**.



## Cinergy Health Preferred 1000 Plan

# SUMMARY OF MEDICAL BENEFITS

**FOR A COMPLETE EXPLANATION OF BENEFITS REFER TO THE CERTIFICATE OF INSURANCE**

Healthcare Services	Benefit Description
<b>Doctor Office Visits</b>	The plan will pay 100% up to \$100 per physician office visit, per covered person if you seek preventive care or treatment for a covered sickness or accident. This benefit covers up to five visits per person, per year including two visits for prevention or wellness check-ups such as physical exams and cancer screenings.
<b>Preventative Test Benefit</b>	The plan will pay 100% up to \$100 per covered preventative test. This benefit covers one test per person, per year.
<b>Emergency Room and Urgent Care Visits</b>	The plan will pay 100% up to \$100 per visit, per person for emergency care of a covered sickness or accident. This benefit covers one visit per person, per year.
<b>Diagnostic Testing, X-Rays and Laboratory</b>	The plan will pay 100% up to \$100 per service date for up to three (3) tests per person per year for diagnostic testing, x-rays and laboratory fees.
<b>Hospital Admissions</b>	The plan will pay a benefit of \$1000 per covered person, per admission to the hospital for an unlimited number of admissions per year.
<b>Daily Hospital Confinement</b>	The plan will pay 100% up to \$1000 per day if you are admitted to a hospital as a patient because of a covered sickness or accident. Coverage is limited to 30 days per year including first day hospital stays. This benefit pays in addition to the hospital admission benefit.
<b>Hospital Intensive Care Unit Confinement</b>	The plan will pay 100% up to \$1000 per day if you are admitted to a hospital ICU as a patient because of a covered sickness or accident; covers a maximum of 15 days including first day hospital stays.
<b>Surgeries</b>	The plan will pay 80% of covered surgery to an unlimited annual maximum if any covered Person undergoes a surgical procedure with anesthesia due to a covered accident or sickness. Reimbursements are based on RBRVS, which is the methodology used by the federal government to determine benefits payable under Medicare.
<b>Anesthesia</b>	The plan will pay 100% of the cost for Anesthesia not to exceed 25% of the surgical benefit.
<b>Inpatient Mental Healthcare</b>	The plan will pay 100% up to \$100 per day for up to 30 days of inpatient mental health care per person per year.
<b>Outpatient Mental Healthcare</b>	The plan will pay 100% up to \$100 per office visit for outpatient mental healthcare for up to 20 visits per year.
<b>Accident Medical Expenses</b>	The plan will pay 100% up to \$5,000 per Covered Person per year for charges incurred due to injuries received in a Covered Accident. Covered charges are subject to a \$100 Policy Year deductible.
<b>Accidental Death &amp; Dismemberment</b>	The plan will pay up to \$15,000 per Covered Person if the loss occurs as the result of an injury.

This medical benefit plan has some limitations with which you should be familiar. Please read your Certificate of Insurance. In most cases, the benefits per family member each year will be more than most people will need especially when paired with our national PPO Network of 700,000 providers. If you exceed your benefit level you will be responsible for any charges beyond those limits although discounts will still be available through the participating network physicians. Insurance benefits are provided under a group insurance policy and are subject to the carrier's underwriting guidelines, exclusions, limitations, terms and conditions of coverage as set forth in the insurance policy and certificate, which includes a pre-existing limitation and other restrictions.

### Help Stop Healthcare Fraud

If you suspect healthcare fraud please visit [www.usamli.com](http://www.usamli.com) and click on the "Fraud" link. American Medical and Life Insurance Company's Special Investigation Unit will aggressively investigate all suspected Fraud claims reported. Each year hundreds of millions of dollars are lost to fraud. We all ultimately pay for fraud whether through higher premiums or higher cost of goods and services. In effect, our pockets are being picked whenever a fraud is committed. Together we can make a difference. Help us send a message that fraud will not be tolerated. Call the AMLI hotline 24 hours a day or submit a report in writing to American Medical and Life Insurance Company, 8 West 38th Street, Suite 1001, New York, N.Y. 10018, Attention: SIU Director ALL COMPLAINTS ARE KEPT STRICTLY CONFIDENTIAL



## FREQUENTLY ASKED QUESTIONS



### What is a Limited Medical Benefit Plan?

A Limited Medical Benefit Plan is designed to pay the smaller, more common claims that the majority of people incur such as, physician office visits, labs and x-rays, minor accidents and short hospital admissions. These plans do not have co-pays or require the member to choose a physician network. Members can choose to see any healthcare provider of their choice. **These plans are not designed to cover catastrophic claims and are not intended to be an equal replacement for Major Medical Insurance.**

### Is this Major Medical Insurance?

No. Limited Medical Benefit Plans offer "limited" benefit medical cash reimbursement coverage for basic medical expenses for an affordable cost. Unlike major medical, these plans do not coordinate benefits, so it pays regardless of any other non-mandatory coverage the covered person may have.

### Who is Eligible for Coverage?

The **Cinergy Health Preferred** Limited Medical Benefit Plans are guaranteed issue to all eligible NCE members and their dependents, and most medical conditions are accepted. Enrollees are issued individual policies and/or certificates of insurance.

### Who are Eligible Dependents?

- A. Covered Person's Spouse
- B. Covered Person's unmarried children-natural, adopted or stepchildren up to age 19 (or age 26 if a full-time student.)
- C. Children who are over the age of 19 who become physically, or mentally incapable of self-support.

### Is Cinergy Health an Insurance Carrier?

No. **Cinergy Health** is not an insurance carrier, however, we work with insurance carriers to develop and implement innovative health programs for clients across the United States. Our mission is to develop the next generation of medical plans that are affordable, easy to use and enable broader access to affordable healthcare. **Cinergy Health** is a licensed insurance agency.

### If my doctor is not listed as a PPO provider, will that change the benefit I will receive?

No. The plan will pay the same benefits in your schedule of benefits whether you go to a PPO provider or a Non-PPO provider. You are free to use any licensed provider or hospital of your choice. If you go to a participating PPO provider, chances are your benefits will go further and cover more of the bill.

### If I have other coverage, will these plans still pay benefits?

Yes. **Cinergy Health Preferred** pays in addition to any other non-mandatory coverage you may have.

### Do these plans cover Maternity?

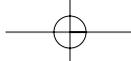
Yes. Maternity is covered the same as any other "sickness" benefit and will pay subject to the limits of the plan chosen. There are no pre-existing exclusions for pregnancy.

### Why should I use a PPO Provider?

By utilizing an in-network provider, you may reduce your out-of-pocket expense because the PPO provider will charge a negotiated reduced fee for his / her service. To search for preferred providers visit **[www.cinergyhealth.com](http://www.cinergyhealth.com)** and click on Provider Search.

### What if I have a pre-existing medical condition?

The **Cinergy Health Preferred** plans are made available on a guaranteed issue basis. Upon initial enrollment into the plan, there is a 6 month waiting period for pre-existing conditions for which the member was seen, treated or diagnosed within the 6 month period prior to enrollment. The Pre-existing condition clause may be waived if prior creditable coverage has been in force.



# LOCAL PARTICIPATING PROVIDERS

**Below is a partial list of the primary care physicians closest to your zip code. For additional participating providers, please call Member Care Services at the 1-800-847-1148 or visit [www.cinergyhealth.com](http://www.cinergyhealth.com) to search for participating providers. *This local directory is for reference only. While every effort is made to ensure current, accurate data, changes occur daily and may not be reflected here.***

## Primary Care Physicians

Practice or Doctor Name  
Street Address  
City, State Zip

Practice or Doctor Name  
Street Address  
City, State Zip

Practice or Doctor Name  
Street Address  
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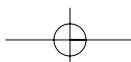
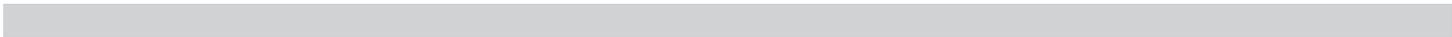
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Practice or Doctor Name  
Street Address  
City, State Zip

Practice or Doctor Name  
Street Address  
City, State Zip





## NCE BENEFITS

As a member of NCE you are entitled to terrific savings and valuable benefits including:

### Medical Records Software:

The program is a life saver when accurate health records are needed in a hurry. Save time when changing doctors by printing medical history with a mouse click. From children's immunization records to the family's genealogy all at the user's fingertips. The Record Keeping Software is available for you to download. This software organizes your family's Financial, Health, and Personal possessions records in a straightforward way. Go to [www.mymemberinfo.com/mrpsd/familykeys.htm](http://www.mymemberinfo.com/mrpsd/familykeys.htm) and click on Download Software, or call **800-292-3797** for assistance.

### Financial Counseling Services:

Financial planning helps you meet life's goals through the proper management of your finances. These goals may include buying a home, saving for your children's education or planning for retirement. Getting there requires planning and often times professional guidance. The intent of the financial planning service is to provide access to professional planners who can focus on the individual needs of each member. Each member is entitled to an initial consultation with a financial planner at no charge along with a custom financial plan, discounted rates for the services and no charge access to a special Financial Planning web site.

Our Financial Planning and Counseling Services are designed to provide skilled financial guidance and assistance that helps Members:

- Re-Organize Debt Structure
- Repair Credit
- Consolidate Debt and Relieve Debt Pressures
- Organize Assets to Enhance

Performance

- Assess Financial Objectives and Develop a Plan
  - Diversify Your Portfolio for Protection
  - Identify Special Funds to meet financial objectives
1. Simply call **1-800-562-2929** (extension # 4) Monday - Friday: 8:00 AM - 8:30 PM EST.
  2. Identify yourself with your membership ID number.
  3. The representative will evaluate your needs and refer you to the appropriate professional most convenient to you and your location. You pay the discounted fees directly to the professional.

### Tax Advice Hotline:

Unlimited Tax Advice is right at your fingertips! Tax laws are getting more and more complicated all the time. You have important questions about changes in government regulations, capital gains, deductions and credits. To avoid making costly errors, you need answers you can trust and second opinions on matters that are particularly complex.

This valuable service gives you unlimited phone calls and prompt, qualified advice on your tax issues - all year long. Our toll-free number directly connects you to *tax experts*, professionals who are knowledgeable in requirements and consequences. There's never a charge for phone calls to our experienced staff of tax specialists. Plus all your financial dealings are kept *strictly confidential*.

1. Simply call **1-800-924-3091** 10:00 AM – 6:00 PM EST.
2. Identify yourself as a **Cinergy Health** member and mention code 101.
3. You will be connected to a tax

professional to assist you with your individual needs.

### ID Theft Guardian:

Membership includes a comprehensive plan to assist members in the event of ID Theft and help protect you from becoming a victim of Identity Theft in the future. **Your 3-Point Protection Plan Includes:**

#### 1. IDENTITY THEFT RESOLUTION

**SERVICE** - A toll free service that connects you with trained and experienced customer service representatives in the event of an identity theft occurrence.

#### 2. FAMILY RECORDS SOFTWARE

- Personal data organizer software to allow you an easy, convenient and secure way to organize and record your financial, health and personal possession information all in one location. Please call for instructions on how to download this software.

#### 3. ID THEFT PREVENTION

- Helpful hints to deter identity theft.

Your Fraud Resolution Program is a confidential and easily accessible service that provides an administrative structure for dealing with Identity Theft. For assistance please call customer service toll-free at **866-212-4432**.

### Auto Maintenance:

Call the toll free number **800-292-3797** and a Customer Service representative will help you locate a nearby auto center. As a member, you receive up to 10% off auto maintenance service items such as; brake service, tire and battery services and various other general auto maintenance. Select your center of choice and use the following codes to access your savings!

**Aamco:** DJ0603  
**Jiffy Lube:** DVD10  
**Meineke:** 01-2003  
**Pep Boys:** 80218678  
**Maaco:** DJ0103  
**Pro-Care:** PC0805  
**Mr. Transmission:** MT-2003  
**MultiState Transmissions:** MS-2003  
**Dr. Nicks:** DN-2003  
**Milex Centers:** MX-2003  
**Alta Mere Window Tinting & Alarm Centers:** AM-2003  
**Tire Kingdom, Merchant's Auto, Tire Centers and National Tire and Battery:** 03-2004

### Car Rental Savings:

Whether you are traveling or just in need of temporary transportation, call any of the car rental companies (listed below) and mention the special member code to receive 10% - 25% discounts off rack rates!

**Avis:** Call 1-800-331-1212 and mention your Avis Worldwide Discount #T001800

**National:** Call 1-800-CAR-RENT and use the ID# 5002210

**Budget:** Call 1-800-527-0700 and use BCD# 866200

**Alamo:** Call 1-800-GOALAMO and use the ID# 7011274

**Hertz:** Call 1-800-654-3131 and use the CDP# 1609824

**Free Hertz Gold membership:** To apply on-line go to <http://bapmember.hertz.com> and click on enrolled accounts (U.S.) and click on fee-waived Hertz #1 Club Gold Application, enter the CDP# of 1609824 and Pin-Code is bapgold.

### 24 Hour Roadside Emergency Dispatch Assistance:

Call **1-800-325-9028** and provide your Membership number. Customer Service will contact the best priced Service Provider and dispatch that provider to the member's location. The customer must pay the Service Provider directly for all expenses incurred at the time of the disablement.

### Floral Savings:

Special occasions warrant beautiful floral arrangements! Before ordering flowers, be sure to compare costs using your member code at FTD and American Blooms.

- 15% off all orders at FTD.com. - [www.ftd.com/membersonly](http://www.ftd.com/membersonly) using code 10835
- 15% off all orders at **1-800-SEND-FTD** using member code 10835
- Call **1-888-399-1700** using member code "dividend" or visit [www.bloomstoday.com](http://www.bloomstoday.com) to save at Blooms Today

### Moving and Storage Savings:

To compare prices for your moving and storage needs call Suddath Moving & Storage at **1-888-614-7271** and mention code 102655 to receive 60% savings off retail prices depending on the region of the country and service available at the time of need.

### Magazines Subscription Savings:

Enjoy the convenience and savings of a magazine delivered to your home! Call or visit one of the following

- 30% off any purchase [www.magazinepromotion.com/index.php?affid=uhp0a](http://www.magazinepromotion.com/index.php?affid=uhp0a) using code uhp0a30
- 30% off any purchase by calling **1-888-ALL-MAGS** using code uhp0a30

### Hotel Savings:

When traveling for business or pleasure, be sure to call and compare the room costs offered through this service using code 64713. Members receive 15% - 30% off room rates at:

**Ramada Inn 800-462-8035**  
**AmeriHost Inn 800-996-2087**  
**Days Inn 800-268-2195**  
**Howard Johnson 800-769-0939**  
**Travelodge 800-545-5545**  
**Wingate 877-202-8814**  
**Knights Inn 800-682-1071**

### Amusement Park Savings:

Do you plan to visit an amusement park on your next vacation? Simply visit [www.adventureclubonline.com](http://www.adventureclubonline.com) and enroll with code 69801 for member benefits at: Sea World (Orlando, FL, San Diego, CA & San Antonio, TX), Busch Gardens (Tampa Bay, FL and Williamsburg, VA), Adventure Island (FL), Water Country (VA) and Sesame Place (PA).

### Movie Ticket Savings:

Call **800-292-3797** to order tickets (minimum 6 per order) at 20% to 35% savings and tickets will be mailed to you. Tickets are good for use at the following theaters: AMC, Loews, & Regal/Edwards.

### Tradesman Referral:

Available 24 hours a day, 7 days a week, this service matches members to pre-screened and customer rated pros for home improvement, maintenance and repair needs. Call **1-866-849-1118** to locate repair professionals. \$750 service guarantee! Receive monthly tips and Advice!

***Savings are not guaranteed when special rates are offered at participating locations on the above programs. Member pricing is subject to change without notice.***



## TERMS AND CONDITIONS

These are the terms and conditions of your **Cinergy Health Preferred** membership. Your **Preferred Plan** (Program) includes insured benefits made available through the National Congress of Employers and discount services made available through contracted Network Sponsors (discount services not available in all states). These terms and conditions take effect on the date of your plan's activation.

### MEMBERSHIP AGREEMENT AND QUALIFIED

**USERS:** You, the Member, must be actively registered and current on your Membership fees for the Program to receive the available services. You may use your membership only for your personal benefit and, if you have a Family plan, for the benefit of your eligible Family Members. To add a dependent to your Family plan or to change your plan election, please call Member Care Services at **800-847-1148**. Primary member must be at least 18 years of age and reside in the United States. Membership Information as defined in these terms and conditions may include information that is mailed to you, information that is available on our public Internet site at **www.cinergyhealth.com**, and information available by calling Member Care Services at **800-847-1148**.

**FREE LOOK PROVISION:** You have the right to cancel the Plan before your effective date or within 10 calendar days of receipt of your Certificate of Coverage and receive a full refund minus the application fee. To request cancellation and a refund you must submit your request in writing and it must be postmarked before your effective date or within 10 days of receipt of your Certificate of Coverage.

### REQUEST FOR PLAN CHANGES OR

**CANCELLATION:** All membership plan changes and cancellations must be completed in writing and mailed to: **Cinergy Health**, 19495 Biscayne Blvd., Suite 604, Aventura, FL 33180, or faxed to (305)792-9669. E-mail requests are not accepted. **PLAN CHANGES:** Plan Changes may only be processed for accounts that are in good standing and will become effective with your next monthly billing. Members may change their plan one time per twelve-month period if it is not due

to a life-changing event such as marriage, birth of a child, etc. For Plan Change Eligibility Requirements please refer to your Certificate of Coverage. **CANCELLATIONS:** Your request to cancel must be postmarked (if sent by mail) or received (if sent by fax) before the effective date of the month for which you wish to cancel. If your cancellation is postmarked or received after your free-look period, you will remain active through the end of the current effective month and any billings for future months will be stopped or refunded. All refunds, if due, will be processed within ten (10) business days from when your cancellation is received. Your Effective month begins and ends on the 1st or the 15th of each month depending on your first effective date. A member who cancels their plan can register again only one time per twelve-month period.

**GRACE PERIOD:** After your first payment and unless you have sent a prior written request for cancellation, if your payment is not paid (honored) on your payment due date, you are eligible for a grace period. This grace period begins on your unpaid billing date and ends twenty days after your unpaid effective date. If the payment is not paid before the grace period ends, the membership and associated insurance coverage will terminate at midnight on the last day of the effective month your last payment was paid (honored). At the time of payment you will be required to bring your account current on all past-due fees.

**MONTHLY PAYMENTS:** At the time of registration, our members authorize monthly billing to be either automatically drafted from a checking or savings account, or automatically debited from a credit card, on a specified billing date. As a member, you agree that your inquiries or challenges to checking account, savings account and credit card charges shall be limited to the most recent two (2) monthly charges.

**DISCLAIMER OF WARRANTIES:** We and all Network Sponsors are not merchants, manufacturers, or direct providers of the services available to the Member. Accordingly, We do not give any warranties, expressed or implied, as to description, quality, merchantability, fitness for any particular purposes, productiveness, or any other matter, for any services or merchandise

purchase received by the Member or provided through membership in the Program. You are not relying on **Cinergy Health's** skill or judgment in selecting a Service Provider for the services available to you.

**GENERAL RELEASE:** You and your Family Members hereby forever release, acquit and discharge Cinergy Health and all Network Sponsors and their respective officers, directors, employees and agents from any and all liabilities, claims, demands, actions and causes of action that you, or your Family Members, may have by reason of any monetary damage or personal injury sustained as a result of or during the providing of any and all services under the Program. The sole recourse available to you or your Family Members shall be cancellation of the Program membership. **Cinergy Health** provides savings through third-party Network Sponsors and this program is **NOT MAJOR MEDICAL INSURANCE**.

**ARBITRATION:** This Agreement may only be amended, changed, or modified in writing. The laws of the State of Florida shall govern the interpretation, construction, and enforcement of this Agreement. Any dispute arising from, out of, or relating to this Agreement may be resolved by voluntary binding, non-appealable, private arbitration, conducted in accordance with the Florida Arbitration Code. These provisions shall survive termination of this Agreement and the Member's activation or Membership in the Program.

**GRIEVANCE PROCEDURE:** If you have any complaints, please call the toll-free Member Service number listed on the back of your membership card. If you feel that your complaint was not handled to your satisfaction you may submit a written grievance to: **Cinergy Health, Inc.** Attention: Resolution Dept., 19495 Biscayne Blvd., Suite 604, Aventura, Florida 33180.

**THIS MEMBER AGREEMENT CONSTITUTES THE ENTIRE AGREEMENT BETWEEN THE MEMBER AND CINERGY HEALTH, INC. THERE ARE NO WARRANTIES EXPRESS OR IMPLIED OTHER THAN EXPRESSLY STATED HEREIN. PLEASE CONSULT YOUR MEMBER HANDBOOK AND CERTIFICATE OF**

## **INSURANCE FOR LIMITATIONS, EXCLUSIONS AND EXCEPTIONS APPLICABLE TO INDIVIDUAL BENEFITS.**

**CHANGE IN MEMBERSHIP TERMS:** Subject to applicable law, we reserve the right to change or terminate any term, provision, or condition of the membership without limitation. Prior notice will be provided to you when required by applicable law.

**TERMINATION:** We reserve the right to terminate any membership of any Member or Household Member or deny activation to any person for any reason, including for a Member's failure or refusal to pay a participating Service Provider for services.

**DISCLAIMER:** Neither We nor any third-party Provider (Network Sponsors) shall be liable or responsible to make any payment to a Service Provider used by a Member of the Program. We and Network Sponsors are **NOT** insurers, guarantors, or underwriters and are **NOT** responsible or liable for a Member's or Household Member's type, quality or cost of medical care or any other goods or services provided to a Member or Household Members under the Program. Participating Service Providers are independent contractors. We and Network Sponsors are **NOT** liable for or responsible for the provision or omission of any medical services, treatments, consultations, diagnoses, or advice that may be given or not given to a Member or a Household Member by a medical or health service or product provider. We and Network Sponsors do **NOT** practice medicine or interfere with, participate in, nor are a part of the medical provider-patient/member relationship. The selection of a Service Provider is the obligation of and the sole decision of the Member, and such decision shall not be based upon the advice, credentialing, or recommendation of **Cinergy Health** and/or any Network Sponsors.

**LIABILITY:** We and all Network Sponsors assume no liability with regard to any medical services provided, or to be provided, by any participating Service Provider. Claims with regard to medical services shall be made against the Service Providers of such services and not **Cinergy Health** or any Network Sponsors. **Cinergy Health's** sole obligation hereunder shall be to provide you access to Service Provider's services at preferred rates. **Cinergy Health** is not a licensed insurer, health maintenance organization, or underwriter of health care services. We are not licensed to provide and do not provide medical or health services or advice to individuals. Service Providers are solely responsible for the professional advice and treatment rendered to Members and we disclaim any liability with respect to such matters. In the event any product or service purchased or received by the Member

is cancelled, modified, defective, or otherwise unsatisfactory to the Member, the Member will look solely to the Service Providers, Seller, Merchant, or Manufacturer of the product or service for any repair, exchange, refund, or satisfaction for the claim. All medical services requested are subject to the availability of such services, and any information provided to the Member is subject to change without notice.

**PRIVACY:** We understand that most of our Service Providers are "Covered Entities" under the Health Information Portability and Accountability Act ("HIPAA") privacy regulations. As a HIPAA Covered Entity, our Service Providers are legally obligated to maintain the privacy of all patient information that they create or receive. Although **Cinergy Health** is not a HIPAA Covered Entity, we recognize the impact that the HIPAA privacy regulations have on our members. **Cinergy Health** remains committed to interacting with you and your Service Providers as responsible professionals who are dedicated to maintaining the privacy of information that we receive on-the-job, consistent with applicable law and regulations.

### **Insured Benefits**

The **Cinergy Health Preferred Plan** that you purchased includes insured benefits made available to **Cinergy Health** Preferred members through their automatic membership in the National Congress of Employers (NCE). The insured benefits are contained in a group Limited Benefit Medical Plan. NCE is the policyholder of that plan and makes the benefits available to its members. As a **Cinergy Health Preferred** member you have automatic membership in NCE, therefore the insured benefits within that group Limited Benefit Medical plan are available to you while you are a **Cinergy Health Preferred** member. This program is **NOT MAJOR MEDICAL INSURANCE** and is not intended to cover all medical expenses. For a complete listing of benefits, limitations and exclusions please see the Certificate of Insurance.

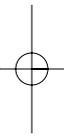
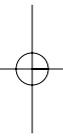
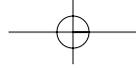
You will receive a Certificate of Insurance for the insured benefits in the Preferred Plan. The Group Policy controls in all circumstances. Any differences between the Certificate of Insurance and the Group Policy will be settled according to the specific terms, provisions, limitations, and exclusions contained in the Group Policy. This insured coverage is not available in all states and the limitations and exclusions may vary by state. In order to make a claim for an insurance benefit, complete and submit the standard claim form which will be forwarded to the insurance company or its designated third party administrator (TPA). Claim forms may be obtained by contacting Member Services at **800-847-1148** or via download from our Internet site, **www.cinergyhealth.com**. The claim form will set forth where it is to be sent when completed,

or you can contact Member Services for such information.

Any person who knowingly, and with intent to defraud any insurance company or other person, files an application for insurance or a claim containing any materially false information, or attempts to mislead by concealing information material to an application or claim, commits a criminal fraudulent act and shall be subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each violation.

### **NATIONAL CONGRESS OF EMPLOYERS TERMS AND CONDITIONS:**

1. The **Cinergy Preferred Plan** provides access to membership in the National Congress of Employers (hereafter "NCE"). NCE membership is a program designed to provide valuable information and access to products and services for the benefit of members.
2. All insurance matters are handled directly with licensed entities. NCE assumes no liability or risk with regard to insurance services and neither receives nor processes premiums or claims and receives no commission with regard to insurance processed. NCE is not an insurance company and does not sell insurance.
3. Membership is effective in conjunction with paid membership in the **Cinergy Preferred Plan**. NCE Membership is automatically cancelled upon cancellation of the plan per the **Cinergy Health** terms and conditions of membership.
4. Your participation in the **Cinergy Health Preferred Plan** automatically enrolls you as a member of the National Congress of Employers (Association). In this regard, you appoint the Secretary of the Association at any particular time as your proxy to receive notice of and attend all meetings of the members and vote on your behalf and to otherwise act for you in the same manner and with the same effect as if you were personally present. This proxy shall be valid until revoked by you at any time prior to voting at any meeting, by executing and delivering a subsequently dated proxy to the Secretary of the Association, or by voting in person.



**Cinergy Health, Inc.**

19495 Biscayne Blvd. • Suite 604 • Aventura, Florida 33180

**1-800-847-1148 • [www.cinergyhealth.com](http://www.cinergyhealth.com)**



SERFF Tracking Number: CMPL-125943982 State: Arkansas  
 Filing Company: American Medical and Life Insurance Company State Tracking Number: 41079  
 Company Tracking Number: AMI NCE 11-08  
 TOI: H14G Group Health - Hospital Indemnity Sub-TOI: H14G.000 Health - Hospital Indemnity  
 Product Name: AMI NCE 11-08  
 Project Name/Number: AMI NCE 11-08/AMI NCE 11-08

## Superseded Attachments

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Original Date:	Schedule	Document Name	Replaced Date	Attach Document
No original date	Form	Group Limited Benefits Health Insurance Certificate Schedule	12/12/2008	AMLI GRP LM 2007 SCHED NCE-NY Cert Schedule.pdf

**American Medical and Life Insurance Company  
New York, New York**

**GROUP LIMITED BENEFITS HEALTH INSURANCE CERTIFICATE SCHEDULE**

Named Insured: [John Member]  
 Certificate Schedule Number: [12345]  
 Group Policy Number: 50001  
 Policy Holder: National Congress of Employers  
 Certificate Effective Date: [January 1, 2009]  
 Certificate Anniversary Date: January 1, of each year  
 Open Enrollment Period: January 1 through December 31 during each Policy Year

1. Description of Eligible Classes

- I. - All active members of National Congress of Employers as determined by bylaws or charter of the Association
- II. - Dependents of Named Insured as defined in the Policy.

2. Eligibility Period: 365 days  
 3. Waiting Period: 0 days  
 4. Plan Type: Association  
 Member Contribution 100%  
 Voluntary  
 5. Coverage: [Named Insured] [Named Insured and Spouse] [Family]  
 6. Benefits:

<b>Accident Medical Benefit</b>	
Accident Medical Benefit Deductible	\$100 per Policy Year per Covered Person
Accident Medical Benefit	[80%] [100%]
Accident Medical Maximum Benefit	[\$1,000][\$2,500][\$5,000] per Policy Year per Covered Person
<b>Hospital Confinement Benefits</b>	
Hospital Confinement Benefit	[\$100] [\$250] [\$500] [\$750] [\$1,000] per day of confinement
Maximum Benefit	[15] [30] [100] days per Policy Year per Covered Person
[Hospital Intensive Care Unit Confinement Benefit	[\$100] [\$250] [\$500] [\$1,000] per day of confinement]
Maximum Benefit Period	Up to [15] [30] [100] days per Policy Year per Covered Person
Surgery Benefit	
Option 2 Maximum Benefit per Surgery	[50%] [80%] [100%] RBRVS

Maximum Benefit	[\$2,000] [Unlimited]
Anesthesia Benefit	[10%] [20%] [25 %] of surgical benefit.
<b>[Hospital Admission Benefit]</b>	
Hospital Admission Benefit	[\$500] [\$750] [\$1,000] per admission
Maximum Benefit	Unlimited]
<b>[Doctor's Office Visit Benefits]</b>	
Doctor's Office Benefit	[\$40] [\$50] [\$75] [\$100] per visit
Maximum Benefit	5 visits per Policy Year per Covered Person
<b>[Preventive Care Test Benefit]</b>	
Preventive Care Test Benefit	[\$50] [\$75] [\$100] per Test
Maximum Benefit	1 Tests per Policy Year per Covered Person]
<b>[Urgent Care/Emergency Room Benefit]</b>	
Urgent Care/Emergency Room Benefit	[\$50] [\$75] [\$100] [\$150] per Visit
Maximum Benefit	[1] [2] Visits per Policy Year per Covered Person
<b>[Diagnostic Tests, X-ray and Laboratory Benefit]</b>	
Diagnostic Test Benefit	[\$40] [\$50] [\$75] [\$100] [\$250] per day
Maximum Benefit	[2] [3] Tests per Policy Year per Covered Person
<b>[Mental Health Benefit]</b>	
Mental Health Inpatient Benefit	[\$40] [\$50] [\$75] [\$100]per day
Mental Health Inpatient Maximum Benefit	30 days per Policy Year per Covered Person
Mental Health Outpatient Benefit	[\$40] [\$50] [\$75] [\$100] per treatment
Mental Health Outpatient Maximum Benefit	[\$800] [\$1,000] [\$1,500] [\$2,000] per Policy Year per Covered Person
<b>[Accidental Death and Dismemberment Benefit]</b>	
Accidental Death Benefit	[\$5,000] [\$10,000] [\$15,000] Primary Insured; 50% Spouse; 25% Dependent
Dismemberment Benefit	[\$5,000] [\$10,000] [\$15,000] Primary Insured; 50% Spouse; 25% Dependent Loss of both hands or both feet - 100% Loss of sight of both eyes - 100% Loss of one hand and one foot - 75% Loss of one hand and sight of one eye - 50% Loss of one foot and sight of one eye - 50% Loss of one hand - 25% Loss of sight of one eye - 25%

- 7 Pre-existing Condition Limitation Period [6] [12] months following the effective date of coverage under this Policy
8. Rates: [See Attached Rate Sheet] [(See page 1 of your Cinergy Health Preferred Member Handbook)]
9. Rate Guarantee Period A change in premium rate will not take effect before 12 months after the policy effective date