

AMERICAN MEDICAL ACCESS ASSOCIATION HOSPITAL/MEDICAL INDEMNITY PLAN

OVERVIEW OF THE PLANS

BENEFITS	<i>PLAN PAYS:</i>	<i>PLAN PAYS:</i>	<i>PLAN PAYS:</i>
	Option 1	Option 2	Option 3
Doctor Visits	\$50 per visit Limit 5 visits per year	\$50 per visit Limit 5 visits per year	\$75 per visit Limit 7 visits per year
Lab & X-Ray Benefit	Not included	\$100 per day Limit 3 days per year	\$100 per day Limit 5 days per year
Accident Benefit	100% Limit \$500 per accident	100% Limit \$1,000 per accident	100% Limit \$1,000 per accident
Daily In-Hospital Benefit	\$250 per day 30 day maximum	\$500 per day 30 day maximum	\$1,000 per day 30 day maximum
Deductible	No deductible	No deductible	No deductible
Surgical Benefit	Per Schedule of Surgical Indemnity Benefits \$1,200 maximum	Per Schedule of Surgical Indemnity Benefits \$1,800 maximum	Per Schedule of Surgical Indemnity Benefits \$2,400 maximum
Anesthesia Benefit	20% of Surgical Benefit Amount	20% of Surgical Benefit Amount	20% of Surgical Benefit Amount
Prescription Drugs Benefit	Not included	\$20 per prescription Limit 10 prescriptions per year	\$20 per prescription Limit 15 prescriptions per year

This summary is intended to highlight the main features of the proposed group insurance plan. By the very nature of a summary, it does not include all of the specific benefits or limitations in the contract. The Master Group Policy and your specific state laws will govern in all cases.

Association group health insurance plan available to members of National Association of Consumers Direct where approved and through licensed insurance agents only. Available through age 69 to members, their spouses and children to age 24; except disabled children as defined herein. Plans, benefits, rates and availability vary by state. See certificate for details on benefits, exclusions and limitations.

MONTHLY PREMIUMS	Option 1	Option 2	Option 3
Member	\$ 86.20	\$ 136.10	\$ 182.80
Member + 1	\$ 136.78	\$ 229.97	\$ 316.93
Member + 2 or more	\$ 185.66	\$ 320.79	\$ 446.95

Premiums effective as of October 1, 2004

NOTE: The NACD association access / membership benefit fee of \$28 is included in the above premiums.

All billing for this program is handled on a direct debit or credit card basis
For Direct Debit Payment: A \$2 monthly fee will be added to the above premiums
For Credit Card Payment: A 2.5% monthly processing fee will be added to the above premiums

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COMMONLY ASKED QUESTIONS

WHO IS ELIGIBLE FOR COVERAGE?

Any eligible individual and their dependents who become members of National Association of Consumers Direct. However, any dependents who are totally disabled on the proposed effective date will not be insured until the dependent ceases to be disabled. A dependent is totally disabled if they are unable to perform the majority of the normal activities of a person of like age who is in good health.

WHO ARE ELIGIBLE DEPENDENTS?

- ◆ Member's spouse (under age 70)
- ◆ Member's unmarried children—natural, adopted or stepchildren up to age 21 (or up to age 23 if a full-time student)
- ◆ Children who are over the age of 21 who become physically or mental incapable of self-support prior to reaching age 21 and while covered under these plans

WHEN SHOULD I ENROLL MY DEPENDENTS?

Eligible dependents must be enrolled within 31 days of the date the dependent becomes eligible (enrollment date of Member, birth or adoption).

WHAT ARE THE MEDICAL UNDERWRITING REQUIREMENTS?

All individual and family members of National Association of Consumers Direct are automatically accepted unless any individual in the family is pregnant or in the process of adopting a child.

WHERE IS THE PLAN AVAILABLE?

Please contact your representative for plans that are available in your area. Or, you can contact American Benefit Administrative Services, Inc. at (800) 736-7872 for a listing of approved states and/or a representative in your area.

HOW DO I PAY FOR MY COVERAGE?

All premiums for this program are collected on either a direct debit basis (*an additional \$2 monthly fee will apply*) or via credit card debit (*an additional 2.5% monthly processing fee will apply*).

WHEN DOES COVERAGE BEGIN?

Eligible Members will be effective on the first day of the month following approval of the application and receipt of the first premium. Coverage is not effective on the date of the application. The effective date for the dependent of an enrolled Member will be the same as the Member's (unless the Member adds additional dependent coverage at a later time).

WHEN DOES COVERAGE END?

An insured Member's coverage ends when the Member is no longer eligible, premiums are discontinued (subject to the grace period), when the policy terminates, or when the Member is no longer in good standing with National Association of Consumers Direct, whichever occurs first. Coverage on a dependent ends on the earliest date they no longer meet the definition of an eligible dependent or on the date the Member's coverage terminates, whichever occurs first.

WHO FILES THE CLAIMS UNDER MY COVERAGE?

Either the Member or provider can file the claim with American Benefit Administrative Services, Inc. in Naperville, Illinois, as shown on the reverse side of the Member's I.D. card.

CAN MEMBERS USE ANY HOSPITAL, DOCTOR OR PHARMACY?

Yes. Covered Members and dependents can use any hospital, doctor or pharmacy.

ARE PRE-EXISTING CONDITIONS COVERED?

No benefits will be payable for expenses incurred as a result of a Pre-Existing Condition until the earlier of:

- a. the end of a continuous period of 12 months commencing on or after the covered person's effective date of coverage under these plans during all of which the covered person has received no medical advice or treatment in connection with such Pre-Existing Condition; or
- b. the end of a two-year period commencing on the covered person's effective date of coverage under this plan.

WHAT IS A PRE-EXISTING CONDITION?

A Pre-Existing Condition is a disease, accident, sickness or physical condition for which a covered person: (a) had treatment; (b) incurred expense; (c) took medication; or (d) received a diagnosis or advice from a physician during the 12-month period immediately preceding the date coverage begins, including conditions which are related to such disease, accident, sickness or physical condition.

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PLAN LIMITATIONS AND EXCLUSIONS

With respect to all of the insured health indemnity benefits provided under this plan, no benefit will be payable as the result of:

1. Suicide or any attempt thereat, while sane or insane (in Missouri, the words "or insane" do not apply);
2. Any intentionally self-inflicted injury or sickness;
3. Rest care or rehabilitative care and treatment;
4. Cosmetic surgery or care or treatment solely for cosmetic purposes, or complications therefrom. This exclusion does not apply to cosmetic surgery resulting from a covered accident if initial treatment of the covered person is begun within 12 months of the date of the covered accident;
5. Immunization shots (except where required by law) and routine examinations such as: health exams, periodic check-ups, pre-marital exams, and routine physicals;
6. Routine newborn care, including routine nursery charges;
7. Voluntary abortion, except with respect to the insured or covered spouse: a) where such person's life would be endangered if the fetus were carried to term, or b) where medical complications have arisen from an abortion;
8. Pregnancy of a dependent child, unless required by law;
9. The treatment of: a) mental illness; b) functional or organic nervous disorder, regardless of cause; c) alcohol abuse; d) drug use, unless such drugs were taken on the advice of a physician and taken as prescribed, for more than 10 days in any calendar year, with respect to payment of the Daily In-Hospital Benefit;
10. Participation in a riot, civil commotion, civil disobedience, or unlawful assembly. This does not include a loss which occurs while acting in a lawful manner within the scope of authority;
11. Committing, attempting to commit, or taking part in a felony or assault, or engaging in an illegal occupation;
12. Participation in a contest of speed in power driven vehicles, parachuting, parasailing, bungee jumping or hang gliding;
13. Air travel, except; a) as a fare-paying passenger on a commercial airline on a regularly scheduled route; or b) as a passenger for transportation only and not as a pilot or crew member;
14. Any accident occurring as a result of the covered person being intoxicated (where the blood alcohol content meets the legal presumption of intoxication under the law of the state where the accident took place);
15. Sex changes;
16. Experimental treatments or surgery;
17. The reversal of tubal ligation and vasectomies;
18. Artificial insemination, in vitro fertilization, and test tube fertilization, including any related testing, medications, or physician's services, unless required by law;
19. Treatment of exogenous obesity or weight control;
20. An act of war, whether declared or undeclared, or while performing police duty as a member of any military or naval organization. This exclusion includes accident sustained or sickness contracted while in the service of any military, naval or air force of any country engaged in war. The company will refund the pro rata unearned premium for any such period the covered person is not covered;
21. Accident or sickness arising out of and in the course of any occupation for compensation, wage or profit, or expenses which are payable under Occupational Disease Law or similar law, whether or not application for such benefits has been made;
22. Pre-existing conditions, except as previously described; or
23. Air or ground ambulance service (except where required by law).

In addition to the Plan Limitations and Exclusions outlined above, the following are not covered under the Outpatient Physician Office Visit Benefit and the Outpatient Diagnostic X-Ray and Laboratory Benefit:

1. Visits made, examinations given, or x-rays or laboratory tests performed as an in-patient while confined to a Hospital;
2. Routine eye examinations or fitting of glasses;
3. Fitting of hearing aids;
4. Dental examinations or dental care other than expenses resulting from accidental injury; and
5. Benefits which are provided under any other part of this Plan.

In addition to the Plan Limitations and Exclusions for all coverages, the following are not covered under the Outpatient Prescription Drug Indemnity Benefit:

1. Drugs and medicines which may be lawfully obtained without a Physician's prescription, except insulin;
2. Therapeutic devices or appliances. This includes hypodermic needles, syringes, support garments and other non-medical items;
3. Drugs labeled "Caution – limited by Federal Law to investigational use" or experimental drugs;
4. Drugs, medicines or insulin, in whole or in part, used by or administered to a covered person while confined in a Hospital, rest home, sanatorium, extended care facility, convalescent hospital, nursing home or similar institution;
5. Immunization agents, biological sera, blood or blood plasma; or
6. Contraceptive materials, devices or medications or infertility medication, except where required by law.

Pre-Existing Condition Limitation

No benefits will be payable for expenses incurred as a result of a Pre-Existing Condition until the earlier of:

- a. the end of a continuous period of 12 months commencing on or after the covered person's effective date of coverage under these plans during all of which the covered person has received no medical advice or treatment in connection with such Pre-Existing Condition; or
- b. the end of a two-year period commencing on the covered person's effective date of coverage under this plan.

A Pre-Existing Condition is a disease, accident, sickness or physical condition for which a covered person: (a) had treatment; (b) incurred expense; (c) took medication; or (d) received a diagnosis or advice from a physician during the 12-month period immediately preceding the date coverage begins, including conditions which are related to such disease, accident, sickness or physical condition.



MEMBERSHIP BENEFITS

INTERACTIVE HEALTH AND WELLNESS PROGRAM

Participate online with a private and personal health and wellness program created with Duke University Medical Center. You can also access thousands of health related topics in the information library.

RETAIL PHARMACY DISCOUNTS

A network of hundreds of retail pharmacies offer **savings of up to 30%** on brand medications and savings of up to 50% on generics. Convenient and valuable savings available at your local pharmacies.

MAIL ORDER MEDICATIONS AND DIABETIC SUPPLIES

Ninety-day mail order medication orders (**savings up to 70%**) and discount diabetic supplies are a toll free call away. Excellent customer service and easy ordering options.

DISCOUNT VISION BENEFITS

Receive discounts of 50% on frames and 25% on lenses at national vision retail outlets. You can also save on contact lenses and Ophthalmology services.

HEARING AID SERVICES

Discounts of 15% can be received through BelTone Retail outlets nationally on a variety of hearing enhancement technologies.

DENTAL PPO NETWORK

Receive savings of up to 25% when you obtain dentals services through one of over 42,000 dentists nationwide that are part of the preferred provider network.

24 HR NURSE HOTLINE

Advice from a nurse can be received through this 24 hour service. A toll free number will connect you with a trained medical professional to offer medical advice

NATIONAL DOCTOR/HOSPITAL PPO NETWORK

Services provided through a national Preferred Provider Network can offer savings of up to 30% at over 380,000 providers.

NEWSLETTERS

Periodic newsletters for members only with consumer and health related articles.

Member benefits provided by:

