AICPA
Group Catastrophic
Major Medical Plan

Gives you a $1 million financial safety net that picks up where your basic health care plan leaves off

THIS $1 MILLION GROUP CATASTROPHIC MAJOR MEDICAL PLAN HELPS KEEP YOUR ASSETS INTACT

A basic plan may not be enough

If you have a traditional fee-for-service plan, an individual or managed care plan, or even Medicare, that plan may well have caps or limits on its benefits. One catastrophic non-job related injury or sickness can all too quickly use up those basic health care coverage benefits, leaving you with tens or even hundreds of thousands of dollars of medical costs to pay — costs that likely can only be met by using your existing savings and assets.

Sponsored by the American Institute of Certified Public Accountants (AICPA), this plan is designed as supplemental coverage when your basic coverage (including Medicare) falls short or reached its limit.

Pays expenses that exceed the limit of your basic health care coverage

The AICPA catastrophic major medical plan picks up where your basic health care plan leaves off. After your deductible is met, it will pay up to $1 million of eligible reasonable and customary expenses for medical treatment over a three-year benefit period after your basic health insurance limits have been reached.

The plan will also pay for medical expenses should you choose to consult a non-network provider for care. This can be a valuable benefit should you want to receive highly specialized care, such as cancer treatment, at a particular institution. All AICPA members in good standing who have a basic health care plan individually or through work or Medicare Parts A and B are eligible to enroll. You can also enroll your lawful spouse and unmarried, children under age 30, as long as they are also covered under a basic healthcare Plan or Medicare Parts A and B.

AICPA®

For New York residents who are members of the American Institute of Certified Public Accountants and their families

How the plan works

You become eligible for benefits when your medical costs within a 24 month period exceed the deductible you have chosen — the greater of the benefits paid by your basic plan or $25,000 or $50,000. (To help determine which deductible amount is right for you, check your current health care plan to find out its caps and limits.) In most cases, the benefits that have been paid by your basic plan can satisfy your deductible for this additional coverage.

Your acceptance is guaranteed (No health or medical questions)

Once enrolled, your coverage cannot be cancelled by the underwriter for health reasons. Regardless of your age or health condition, your coverage can remain in force as long as your premium payments are current, you remain an AICPA member and the group policy remains in force. Coverage for your dependent spouse and children, if enrolling will end when your insurance ends, if dependents' insurance ends under the group policy, when the person ceases to be a dependent or if the premium is not paid for the dependent when due.

A PRUDENT, ECONOMICAL CHOICE

The group rates offered through the AICPA catastrophic major medical plan provide you with an economical way to make sure you'll get the quality of care you require — without jeopardizing your personal assets.

The semi-annual cost with a $50,000 deductible for a member is only $116.16 — the equivalent of only $19.36 per month.

Or, you can provide this coverage for yourself, your spouse and your dependent children for just $269.81 semi-annually, or $44.97 per month.

OPEN NOW to see how economical this plan can be...

DECIDE TODAY to put this important insurance protection in place.

Provides benefits for a hospital stay

If you are not a Medicare beneficiary, you will receive a $2,000 credit toward your plan deductible for each day you are confined in a hospital, regardless of the actual charge but not in excess of the elected cash deductible amount. After your deductible is met, your hospital benefits for inpatient or intensive care charges per benefit period are:

- $75 per day for the first 30 days
- $100 per day for the next 100 days
- $150 per day thereafter

If you are a Medicare beneficiary, your benefits will equal the reasonable and customary inpatient or intensive care charges up to $400 per day for hospital room and board charges, and up to $800 per day for confinement in an intensive care unit after your deductible is satisfied.

Pays for convalescent care

Anyone at any age may require convalescent care or custodial care in a convalescent home due to a non-job related injury or sickness. That's why this is an important benefit for you — a benefit that is either not included or is limited in most basic health insurance plans. This plan pays up to $300 per week for convalescent care, to a lifetime maximum of $46,800, while insured.

The confinement must begin within 14 days after hospitalization ends and must be due to the injury or sickness which required the hospitalization.

NOTE: Convalescent Home means a licensed institution that has on its premises: organized facilities to care for and treat its patients, a staff of physicians to supervise such care and treatment, and a registered nurse on duty at all times.

Convalescent home does not mean a place, or part of one, which is used mainly for: the aged, alcoholics, drug addicts, persons with mental, nervous or emotional disorders.

Includes home health care benefits

The plan pays for up to 100 home health care visits per benefit period for occupational, speech or respiratory therapy, medical social work, special meals and nutritional services. Each visit by a member of a home health care team will be considered one home health care visit. Four hours of home health aide services will be considered one home health care visit. The plan of care must be in lieu of confinement in a hospital or skilled nursing facility, and set up and approved by a physician and a certified home health care agency. And should the insured require medically necessary private duty nursing care by a registered or licensed practical nurse, the plan pays up to $300 per day, to a maximum of $30,000 per benefit period.

AICPA
Group Rates

Semi-Annual Premiums

$25,000 DEDUCTIBLE PLAN

MEMBER	MEMBER & SPOUSE	MEMBER & CHILDREN	MEMBER, SPOUSE & CHILDREN
$211.20	$422.40	$279.36	$490.56

$50,000 DEDUCTIBLE PLAN

MEMBER	MEMBER & SPOUSE	MEMBER & CHILDREN	MEMBER, SPOUSE & CHILDREN
$116.16	$232.32	$153.65	$269.81

Special provisions

If 2 or more insured family members are injured in the same accident, the covered charges incurred by each such person due to the accident will be combined. If the total exceeds one deductible amount, no further deductible will be required for such persons for any injury caused by the accident.

In the event of a recurring illness or injury, all eligible expenses up to the lifetime maximum are covered once the benefit period begins. If the benefit period for the illness or injury ends, and you have no eligible expenses for that illness or injury in the next 12-consecutive month period, any recurrence will be treated as a new illness or injury with a new deductible and benefit period.

30-day Free Look

If you are not completely satisfied for any reason after you review the benefits in your certificate of insurance, simply return the certificate within 30 days after receiving it. We'll send you a full refund of any premium paid and your certificate will be considered never issued. You will be under no further obligation.

THIS PLAN COVERS A WIDE RANGE OF MEDICAL EXPENSES

Once the deductible for this insurance plan is satisfied, it pays up to 100% of eligible reasonable and customary expenses that may be limited or not paid by your basic health plan, including:

- *Doctor's fees for diagnosis, treatment or surgery*
- *Physical therapy and anesthesiologist services*
- *X-rays, lab tests, radiation treatment, blood and plasma, artificial limbs, crutches*
- *Prescribed medications*
- *Hospice care*
- *Ambulance services up to $2,000 per benefit period*
- *Charges for diagnosis and treatment for psychiatric, mental, nervous or emotional disorders, ailments or illness up to 30 days per calendar year while hospitalized and up to 30 visits per calendar year for outpatient visits if you are a Medicare beneficiary*

SPONSORED BY: AICPA®

BROUGHT TO YOU BY: AON

ADMINISTERED BY: NEBCO Group Benefits. Individual Attention.

Underwritten by:

The United States Life Insurance Company in the City of New York*

www.agac.com

The most prominent independent ratings agencies continue to recognize The United States Life Insurance Company in the City of New York in terms of insurer financial strength. For current insurer financial strength ratings, please consult the Web site at www.americangeneral.com/ratings.

The underwriting risks, financial and contractual obligations and support functions associated with products issued by The United States Life Insurance Company in the City of New York (United States Life) are its responsibility.

IT TAKES JUST MINUTES TO ENROLL.

1) Determine which family members you want to insure.
2) Select the deductible right for you.
   (Choose the deductible that fits best with your basic plan benefit limits.)
3) Complete the enrollment form.
4) Mail your enrollment form *along with a check for your first semi-annual premium made payable to The United States Life Insurance Company to:*

AICPA Insurance Programs
c/o NEBCO
PO Box 152501
Irving, TX 75015-9955

Coverage becomes effective on the first day of the month following receipt of your enrollment form and receipt of your first premium payment.

A TYPICAL HEALTH INSURANCE PLAN MAY NOT BE ENOUGH to cover the expenses associated with a catastrophic illness or injury. That's why you'll want to carefully consider enrolling for this coverage today, while this is on your mind.

IF YOU HAVE ANY QUESTIONS,
please call toll-free 1-888-294-0028
or visit www.cpai.com.

ELIGIBILITY: All AICPA members in good standing who are residents of New York and who have a basic health insurance plan including Medicare Parts A and B are eligible to enroll. You can also enroll your lawful spouse and unmarried, dependent children under age 19 (age 25 if a full-time student). You must be able to perform the normal activities of a person of like age, sex or retired status on the date insurance is to take effect. If you are not, insurance will take effect on the day your resume such activities.

PRE-EXISTING CONDITION MEANS: An injury or sickness which manifested itself within six months before a person became insured in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment; an injury or sickness for which a person was recommended or received medical advice, diagnosis, care or treatment within six months before a person became insured; or a pregnancy that exists on the date a person became insured. No charges incurred for a pre-existing condition will be considered covered charges until a person stays insured for 12 continuous months. Credit will be given for the above waiting periods if a person has been insured under a previous plan and the coverage under the previous plan ended no more than 63 days prior to the effective date of the group policy, as required by law.

LIMITATIONS: Benefits will be paid for covered charges incurred for the following medical services only to the extent described: Charges for dental care, treatment or surgery services will be covered only if such charges result from a non-job related injury to natural teeth, the injury is caused by an accident which occurs while insured, and such services are rendered within 12 months of the accident or they are made by a hospital while hospitalized. Charges for treatment for temporomandibular joint dysfunction (TMJ) services will be covered, except for those charges for crowns or bridgework. Charges for eye exams to prescribe or fit corrective lenses for eye glasses will be covered only if such charges result from a non-job related injury and the injury is caused by an accident which occurs while insured. Charges for cosmetic treatment or surgery services will be covered only if such charges result from a non-job related injury or sickness or a congenital disease or anomaly of a dependent child resulting in a functional defect. Charges incurred for diagnosis and treatment of alcoholism, alcohol abuse, substance abuse or substance dependency will be covered. Non Medicare Beneficiaries receive coverage for charges incurred for outpatient diagnosis and treatment in a certified or accredited alcoholic or substance abuse treatment center, up to 60 visits per calendar year. Up to 20 of such visits may be for family members of the alcoholic or substance abuser. Medicare Beneficiaries receive the aforementioned coverage plus that for charges incurred while the person is hospitalized; and for charges incurred for inpatient rehabilitation in a certified or accredited alcoholic or substance abuse treatment center, up to 30 days per calendar year. Charges incurred for diagnosis and treatment of psychiatric, mental, nervous or emotional disorders, ailments or illness will be covered. Non Medicare Beneficiaries receive coverage for charges incurred for outpatient visits, up to 30 visits per calendar year, subject to a maximum benefit of $50 per visit (the facility for such visits must have been issued an operating certificate by the commissioner of mental health pursuant to the mental hygiene law; or be operated by the office of mental health, a psychiatrist or psychologist licensed to practice in New York or a professional corporation of such psychiatrists or psychologists); and charges incurred for up to three psychiatric emergency visits per calendar year, subject to a benefit of $60 per visit. Benefits provided for emergency visits will reduce benefits otherwise payable for outpatient care as described. Medicare Beneficiaries receive the aforementioned coverage plus coverage for charges incurred while hospitalized, up to 30 days per calendar year. Benefits provided for emergency visits will reduce benefits otherwise payable for inpatient or outpatient care as described.

CHARGES NOT COVERED: Charges to buy or rent air conditioners, air purifiers, motorized transportation equipment, escalators or elevators in private homes, eye glass frames or lenses, hearing aids, swimming pools or supplies for them or general exercise equipment will not be covered. Charges for a routine physical exam, except charges for preventive mammography and cytologic screening will not be covered.

EXCLUSIONS: No medical care benefits will be paid by the group policy for charges incurred for treatment which is given after a person's insurance ends, regardless of when the injury or sickness occurred; is not essential for the necessary care or treatment of the injury or sickness involved; would be given free of charge if the person was not insured; results from a war or an act of war; results from intentionally self-inflicted injury; is given by a person's spouse or his or his spouse's father, mother, son, daughter, brother or sister; or is given by a person's employer or an employee of such employer.

The insurance described in this brochure meets the minimum standards for limited benefit health insurance as defined by the New York State Insurance Department. It does NOT provide basic hospital, basic medical, major medical, nursing home and/or home care, or long term care insurance as defined by the New York State Insurance Department.

This plan is underwritten by The United States Life Insurance Company in the City of New York. This brochure is a brief summary of benefits only and is subject to the terms, conditions, exclusions and limitations of Group Policy No. E-199,144, Form No. G-19000. Coverage may vary or may not be available in all states.

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IMPORTANT NOTICE

To Persons On Medicare

This Insurance Duplicates Some Medicare Benefits
This is not Medicare Supplement Insurance

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductible or coinsurance and is not a substitute for Medicare Supplement Insurance.

This insurance duplicates Medicare Benefits when:

- any expenses or services covered by the policy are also covered by Medicare; or
- it pays the fixed dollar amount stated in the policy and Medicare covers the same event.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice care
- other approved items and services

Before You Buy This Insurance

Check the coverage in all health insurance policies you already have.

For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare,* available from the insurance company.

For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

Notice Regarding High Deductible Health Plans (HDHP) and Health Savings Accounts (HSA)

Based on current Internal Revenue Code related to Health Savings Account (HSA) eligibility, Catastrophic Major Medical Insurance would disqualify an individual from HSA eligibility. To be eligible to contribute to an HSA account, an individual must be covered by a High Deductible Health Plan (HDHP) but cannot be covered by any other health insurance that is not an HDHP. HSA eligibility criteria can be traced to Section 223 of the IRC, specifically 223(c)(1)(B) where it itemizes coverage that can be disregarded for purposes of the deductible.

For More Information on the Internal Revenue Code and Health Savings Account eligibility visit: www.irs.gov

Before You Buy This Insurance

If you currently have a Catastrophic Major Medical Insurance Plan, you should consider the information above if you are considering, now or in the future, enrollment in an HDHP with an HSA.If you currently have an HDHP with an HSA, you would no longer be eligible for the HSA if you purchase a Catastrophic Major Medical Insurance Plan. This information is being provided to assist in the explanation of coverage implications to members based on the AICPA Insurance Program providers understanding and interpretation of the regulations as of August 1, 2008. Any person who is considering an HSA should consult their personal tax advisor.

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