AMERICA™
PROTECT

The N.C.E.

Defined Benefit Medical Plan

Policy Specimen

SAMPLE

American Medical Life Insurance Company
Hicksville, 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: 10892

National Congress of Employers (NCE)-

AMERICA PROTECT

Issued to:
(herein called the Holder)

Policy Date: December 1, 2006

American Medical 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 an employee who is 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 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: 1-800-822-0004

For American Medical Life Insurance Company:

President Secretary

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.

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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-200-SCHED NY 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 of specific description in this Certificate.

Covered Person

A *Covered Person* is any person covered under the 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 of 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.

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 rehabilitory care.

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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 until;
- 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 special 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;
- 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 30 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 policyholder 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 he is not a member of an eligible class on the effective date shown on the Certificate Schedule. The coverage will be effective in 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 21 years of age or under 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 who is licensed to practice in the State of New York. 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 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.
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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 this benefit if any Covered Person incurs charges due to injuries received in a Covered Accident. Covered charges are subject to:
- Policy Year deductible;
- insured percent;
- Policy Year maximum amount; and
- the provisions of this Certificate.

The Policy Year deductible, insured percent and Policy Year maximum amount 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 his license. **]**

Hospital Confinement Benefit
We will pay this benefit 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 maximum benefit period shown on the Certificate Schedule.

If a Covered Person is confined in a Hospital and is discharged and Confined again for the same or related condition within 90 days, we will treat this later Hospital Confinement 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 Confinement as a new and separate Confinement.

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 following his birth unless he 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 this benefit 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 amount shown on the Certificate Schedule for each day the Covered Person is confined, up to the maximum benefit period shown on the Certificate Schedule. If a Covered Person is confined in a Hospital Intensive Care Unit and is discharged and Confined again for the same or related condition within 90 days, we will treat the later Confinement as a continuation of the previous Confinement. If more than 90 days have passed between the periods of Hospital Intensive Care Unit Confinement, We will treat this later Confinement as a new and separate Confinement.

If any Covered Person is confined to a Hospital care unit that does not meet the definition in this Certificate 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 following his birth unless he is injured or sick.

If the Hospital Confinement Intensive Care Unit maximum benefit period has been paid in full, any additional dates of Hospital Intensive Care Unit Confinement will be paid under the Hospital Confinement benefit, provided that in no event will We pay more than the maximum benefit period for the Hospital Confinement shown on the Certificate Schedule.

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 this benefit 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

had 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 amount for the same Covered Accident or Covered Sickness, and 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.

HOSPITAL ADMISSION BENEFIT
We will pay this benefit 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.

We will pay the amount shown on the Rider Schedule.

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.

Doctor's Office Visit Benefit
We will pay this benefit if any Covered Person incurs charges for and requires a Doctor's office visit due to injuries sustained 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 acting within the scope of his license.

We will pay the amount shown on the Certificate Schedule.

We will pay up to the maximum number of visits 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 this benefit 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 amount shown on the Certificate Schedule for one of the following preventive care tests:
- 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
- Hemoccult 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

We will pay one benefit per Policy Year for Named Insured coverage or two benefits per Policy Year for Named Insured and Spouse coverage or family coverage.

There is no limit to the number of years a Covered Person can receive benefits for preventive care tests, as long as the coverage is in force.

Benefits for preventive care tests will be paid under the Diagnostic Tests Benefit

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

Urgent Care/Emergency Room Visit Benefit
We will pay this benefit if any Covered Person incurs charges for and requires an urgent care facility or emergency room visit due to injuries sustained 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, but not limited to chiropractors, osteopaths, and podiatrists.

We will pay the amount shown on the Certificate Schedule.

We will pay up to the maximum number of visits 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 amount shown on the Certificate Schedule when any Covered Person incurs charges for diagnostic, x-ray and/or laboratory testing.

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

- the maximum amount per day;
- the maximum number of testing days per Policy Year; and
- the definitions, limitations, exclusions and other provisions of this Certificate.

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

Benefits are payable for the number of testing days per Policy Year per Covered Person shown in the Certificate Schedule.

A benefit for a colonoscopy test will be paid under either the Preventive Care Test benefit or under the Diagnostic Tests benefit, not both. If the test is ordered by a Physician for a Covered Accident or Covered Sickness, only the Diagnostic Tests benefit will be paid.

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 test, verifying the patient's name, the type of test performed and the date of treatment. For Diagnostic Tests, also include the diagnosis and the charges incurred**.**

MANDATORY BENEFITS UNDER NEW YORK STATE INSURANCE LAW. The following benefits are mandatory under NYS Law in some circumstances and will be provided as benefits in Your Policy if required by law.

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.

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.

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.

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.

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.

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**.**

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;
- Are received without charge or legal obligation to pay; or
- Is provided by an immediate family member.

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 – Treatment for the Alcoholism or Drug Addition, whether provided by a Physician, social worker, therapist or other health care professional.

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.

Manipulations of the Musculoskeletal System –care in connection with the detection and correction by manual or mechanical means of structural imbalance, distortion or subluxation in the human body for purposes of removing nerve interference and the effects thereof, where such interference is the result of or related to distortion, misalignment or subluxation or of or in the vertebral column.

Mental Illness – is a psychiatric or psychological condition including but not limited to affective disorders, neuroses, anxiety, stress and adjustment reactions. However, Alzheimer's disease and other organic senile dementias are covered under this Policy.

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 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 was

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 under the Policy will terminate on the earliest of the following dates:

- the date the Policy terminates; or
- the end of the grace period following the premium due date We fail to receive the required premium for the Named Insured; or
- 90 days after the date written notice was provided that You are no longer in an eligible class; or
- the date Your class is no longer included for insurance; or

- on the date the Named Insured asks Us to end his 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 Your Spouse and/or Dependents
If this Named Insured and Spouse coverage or two-parent family coverage, coverage on Your Spouse will end:
- if the Policy terminates;
- if the premiums are not paid for Your Spouse when they are due or within the grace period;
- on the date You ask Us to end Your Spouse's coverage;
- on the date You die; or
- on the date the next premium is due after You divorce Your Spouse.

If this is family coverage, coverage on Your Dependent children will end:
- if the Policy terminates;
- if the premium is not paid for Your Dependent children when it is due or within the grace period;
- on the date You ask Us to end Your Dependent children's coverage; or
- on the date You die.

Coverage will end on each child when he no longer qualifies as a Dependent child as defined in this Certificate. It is Your responsibility to notify Us if any Dependent child no longer qualifies as an eligible Dependent. If this is family coverage and all of Your Dependent children no longer qualify as eligible dependents and You do not notify Us, the extent to 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 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..

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. Send the claim form along with proof of loss 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 we 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.

SAMPLE

American Medical and Life Insurance Company
Hicksville, New York

GROUP LIMITED BENEFITS HEALTH INSURANCE

CERTIFICATE SCHEDULE

Named Insured:

Certificate Schedule Number: **SELECT 500**

Group Policy Number: 10892

Policy Holder: National Congress of Employers (NCE) -
AMERICA PROTECT

Certificate Effective Date: December 1, 2006

Certificate Anniversary Date: December 1, 2007

Open Enrollment Period: November 1 thru January 31st during each Policy Year

1. Description of Eligible Classes

All members of the National Congress of Employers Association (NCE) –America Protect Group who are gainfully employed a minimum of 15 – 20 hours per week.

Active Employment means the named insured is working at the worksite for earnings that are paid regularly, and he is performing the material and substantial duties of his regular occupation. Normal vacation is considered active employment. The worksite must be:

- At the usual place of business;
- An alternative worksite; or
- A location to which the named insured's job requires him to travel.]

Dependents of Named Insured as defined in the Policy.

2. Eligibility Period: 1st of covered month

3. Waiting Period 0 days

4. Plan Type: Member Contributions -100 %- Voluntary

5. Coverage: [Named Insured] [Named Insured and Spouse] [Family]

6. Benefits:

Accident Medical Benefit	
Deductible	$100 Annual Deductible
Co Insurance	Not Applicable
Maximum Amount	$1000 per Policy Year per covered person
Hospital Confinement Benefits	
Hospital Confinement Benefit	$500 per day of continuous confinement
Maximum Benefit Period	up to 30 days per continuous confinement
Hospital Intensive Care Unit Confinement Benefit	$500 per day of continuous confinement
Maximum Benefit Period	up to 15 days per continuous confinement
Surgery With Anesthesia Benefit	
Maximum Amount per Surgery	80% 2006 RBRVS up to an unlimited Maximum.
Anesthesia Benefit	25% of surgical benefit.
Hospital Admission Benefit	
Hospital Admission Benefit	$500 per admission
Doctor's Office Visit Benefits	
Doctor's Office Benefit	$50 per visit
Maximum Benefit Period	Up to 5 visits per Policy Year per covered person
Preventive Care Benefit	$50 per visit
Maximum Benefit Period	Up to 1 visit per policy Year per covered person
Urgent Care/Emergency Room Benefit	$50 per visit
Maximum Benefit Period	up to 1 visits per Policy Year per covered person
Diagnostic Tests, X-ray and Laboratory Benefit- (includes preventative testing benefits)	$50 per service Up to 3 per Policy Year per covered person

Riders:	
Accidental Death [and Dismemberment Rider	$5,000
Rider Effective Date:	12/01/2006
7. Pre-existing Condition Limitation Period	12 months following the effective date of coverage under this Policy

SAMPLE

American Medical and Life Insurance Company
Hicksville, New York

GROUP LIMITED BENEFITS HEALTH INSURANCE

CERTIFICATE SCHEDULE

Named Insured:

Certificate Schedule Number: **SELECT 750**

Group Policy Number: 10892

Policy Holder: National Congress of Employers (NCE) -
AMERICA PROTECT

Certificate Effective Date: December 1, 2006

Certificate Anniversary Date: December 1, 2007

Open Enrollment Period: November 1 thru January 31st during each Policy Year

1. Description of Eligible Classes

All members of the National Congress of Employers Association (NCE) –America Protect Group who are gainfully employed a minimum of 15 – 20 hours per week.

Active Employment means the named insured is working at the worksite for earnings that are paid regularly, and he is performing the material and substantial duties of his regular occupation. Normal vacation is considered active employment. The worksite must be:

- At the usual place of business;
- An alternative worksite; or
- A location to which the named insured's job requires him to travel.]

Dependents of Named Insured as defined in the Policy.

2. Eligibility Period: 1st of covered month

3. Waiting Period 0 days

4. Plan Type: Member Contributions -100 %- Voluntary

5. Coverage: [Named Insured] [Named Insured and Spouse] [Family]

6. Benefits:

Accident Medical Benefit	
Deductible	$100 Annual Deductible
Co Insurance	Not Applicable
Maximum Amount	$2500 per Policy Year per covered person
Hospital Confinement Benefits	
Hospital Confinement Benefit	$750 per day of continuous confinement
Maximum Benefit Period	up to 30 days per continuous confinement
Hospital Intensive Care Unit Confinement Benefit	$750 per day of continuous confinement
Maximum Benefit Period	up to 15 days per continuous confinement
Surgery With Anesthesia Benefit	
Maximum Amount per Surgery	80% 2006 RBRVS up to an unlimited Maximum.
Anesthesia Benefit	25% of surgical benefit.
Hospital Admission Benefit	
Hospital Admission Benefit	$750 per admission
Doctor's Office Visit Benefits	
Doctor's Office Benefit	$75 per visit
Maximum Benefit Period	Up to 5 visits per Policy Year per covered person
Preventive Care Benefit	$75 per visit
Maximum Benefit Period	Up to 1 visit per policy Year per covered person
Urgent Care/Emergency Room Benefit	$75 per visit
Maximum Benefit Period	up to 1 visits per Policy Year per covered person
Diagnostic Tests, X-ray and Laboratory Benefit- (includes preventative testing benefits)	$75 per service Up to 3 per Policy Year per covered person

Riders:	
Accidental Death [and Dismemberment Rider	$10,000
Rider Effective Date:	12/01/2006
7. Pre-existing Condition Limitation Period	12 months following the effective date of coverage under this Policy

SAMPLE

American Medical and Life Insurance Company

Hicksville, New York

GROUP LIMITED BENEFITS HEALTH INSURANCE

CERTIFICATE SCHEDULE

Named Insured:

Certificate Schedule Number: **SELECT 1000**

Group Policy Number: 10892

Policy Holder: National Congress of Employers (NCE) -
AMERICA PROTECT

Certificate Effective Date: December 1, 2006

Certificate Anniversary Date: December 1, 2007

Open Enrollment Period: November 1 thru January 31st during each Policy Year

1. Description of Eligible Classes

All members of the National Congress of Employers Association (NCE) –America Protect Group who are gainfully employed a minimum of 15 – 20 hours per week.

Active Employment means the named insured is working at the worksite for earnings that are paid regularly, and he is performing the material and substantial duties of his regular occupation. Normal vacation is considered active employment. The worksite must be:

- At the usual place of business;
- An alternative worksite; or
- A location to which the named insured's job requires him to travel.]

Dependents of Named Insured as defined in the Policy.

2. Eligibility Period: 1st of covered month

3. Waiting Period 0 days

4. Plan Type: Member Contributions -100 %- Voluntary

5. Coverage: [Named Insured] [Named Insured and Spouse] [Family]

6. Benefits:

Accident Medical Benefit	
Deductible	$100 Annual Deductible
Co Insurance	Not Applicable
Maximum Amount	$5000 per Policy Year per covered person
Hospital Confinement Benefits	
Hospital Confinement Benefit	$1000 per day of continuous confinement
Maximum Benefit Period	up to 30 days per continuous confinement
Hospital Intensive Care Unit Confinement Benefit	$1000 per day of continuous confinement
Maximum Benefit Period	up to 15 days per continuous confinement
Surgery With Anesthesia Benefit	
Maximum Amount per Surgery	80% 2006 RBRVS up to an unlimited Maximum.
Anesthesia Benefit	25% of surgical benefit.
Hospital Admission Benefit	
Hospital Admission Benefit	$1000 per admission
Doctor's Office Visit Benefits	
Doctor's Office Benefit	$100 per visit
Maximum Benefit Period	Up to 5 visits per Policy Year per covered person
Preventive Care Benefit	$100 per visit
Maximum Benefit Period	Up to 1 visit per policy Year per covered person
Urgent Care/Emergency Room Benefit	$100 per visit
Maximum Benefit Period	up to 1 visits per Policy Year per covered person
Diagnostic Tests, X-ray and Laboratory Benefit- (includes preventative testing benefits)	$100 per service Up to 3 per Policy Year per covered person

Riders:	
Accidental Death [and Dismemberment Rider	$15,000
Rider Effective Date:	12/01/2006
7. Pre-existing Condition Limitation Period	12 months following the effective date of coverage under this Policy

AMERICA™
PROTECT

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