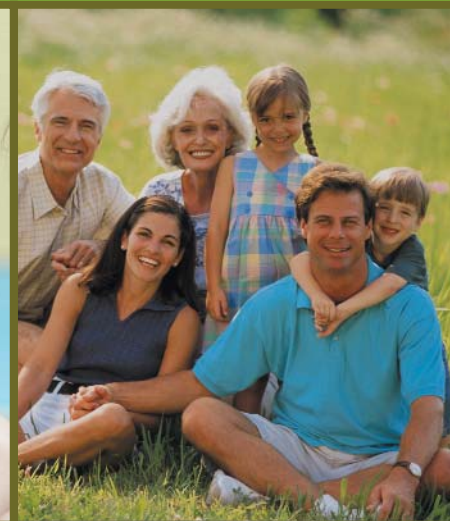


CGI

HS Advantage Plus

Valuable Insurance for
Association Members &
Their Families



✓ **High Deductible
Health Insurance**
Qualifies for use with a
Health Savings Account

✓ **Protection** For You
and Your Family

✓ **24 Hour Coverage**
For The Self-employed



Part of the *advantage* Series

What is an HSA?

Health Savings Accounts, commonly referred to as HSAs, were first allowed in 2004. An HSA is a special savings account used to pay for qualified medical expenses for people with a special type of major medical insurance called a high deductible health plan (HDHP). CGI's HSAdvantage Plus qualifies as an HDHP.

An HSA allows you the opportunity to save, tax free, for routine healthcare and other qualified expenses while your HDHP insurance gives you financial security from the large expenses of a major illness.

An HSA provides triple tax savings:

- **Tax-deductible**—contributions are tax-deductible
- **Tax-deferred**—interest earnings accumulate tax-deferred
- **Tax-favored**—withdrawals for qualified medical expenses are tax-free



What Can an HSA Pay For?

You can use your account to pay for any "qualified medical expense" permitted under federal tax law. This includes most medical care and services applied to your deductible and coinsurance, dental and vision care, and even over-the-counter drugs such as aspirin.

Examples of Some Qualified Medical Expenses

- Ambulance
- Braces
- Home modifications for handicapped
- Contact Lenses
- Crutches
- Hearing aid and batteries
- Dental Fees
- Dentures
- Eyeglasses and examination fees
- Artificial Limbs
- Nursing Homes
- Non-prescription Medicines (antacids, allergy medicines, pain relievers, cold medicines)
- Orthopedic shoes
- Oxygen/oxygen equipment
- Transportation (essentially and primarily for medical care)
- Vision correction surgery (LASIK, etc.)
- Wheelchairs

Any withdrawals not used for qualified medical expenses are taxable as income and subject to an additional 10% tax penalty.

More information about HSAs can be found at the U.S. Department of Treasury's HSA website: www.Treas.Gov/Offices/Public-Affairs/HSA.

Let's See How an HSA Works:



How a Health Savings Account (HSA) Works

HSA Health Savings Account

Purchase an HSA-qualified High Deductible Health Plan (HDHP)

Tax-deductible funds deposited into account by consumer

Funds withdrawn tax-free by consumer to pay for qualified expenses, such as:

- braces
- contact lenses and eyeglasses
- hearing aids
- dental fees
- doctor's fees
- lab fees
- vitamins
- x-rays and more!

OR

Funds accumulate, tax deferred, for future use

You control how the funds are used.



How Much Can I Contribute?

The annual maximum contribution is the annual deductible of your High Deductible Health Plan up to \$2,650 for single and \$5,250 for family coverage (for 2005). However, this maximum is based on the full months you qualify. If you do not qualify for the entire year (for example, if you were not covered by a HDHP the entire year) your maximum contribution will be a pro-rated amount. If you or your spouse are between the ages of 55 and 65, there is an additional "catch-up" contribution available. In 2005 it is \$600 and it increases by \$100 a year until it reaches \$1,000. The chart below shows the maximum deposits for each of the CGI HSAdvantage Plus deductible choices.

PLAN DEDUCTIBLE

MAXIMUM 2005 DEPOSIT*

INDIVIDUAL COVERAGE

\$1,000	\$1,000
\$1,500	\$1,500
\$2,650	\$2,650
\$5,000	\$2,650

FAMILY COVERAGE

\$2,000	\$2,000
\$3,000	\$3,000
\$5,250	\$5,250
\$10,000	\$5,250

TRADITIONAL DEDUCTIBLE

\$2,000 with a \$4,000 Family Maximum	\$4,000
\$2,625 with a \$5,250 Family Maximum	\$5,250

* Does not include "catch-up" contribution, if applicable.

Open Your HSA at My Health Savings Bank

My Health Savings Bank provides convenient and affordable Health Savings Accounts. There are no application or account set-up fees to open an HSA with My Health Savings Bank. Visit www.MyHealthSavingsBank.com for details. Banking Services Provided by The Bancorp Bank. Member FDIC. Equal Housing Lender.

Convenient

- Apply online, by mail or by phone
- 24/7 Customer Service
- Full online account access to monitor deposits and withdrawals
- Options for contributions include direct deposit, E-Transfers and credit card
- Over 20,000 deposit locations nationwide
- Interest paid on account balances over \$1.00

Affordable

- No fees to open an HSA
- No fees for the first 90 days
- No fees for HSAs when automatic monthly deposits selected
- No fees for HSAs when balance is over \$2,500
- Free first order of checks
- Free HSA Debit VISA®

Continental General Insurance Company is not engaged in rendering tax, investment or legal advice. Federal and state tax regulations are subject to change. If tax, investment or legal advice is required, seek the services of a licensed professional. Insureds need to establish their own HSA. Questions or inquiries regarding HSA funding need to be directed to the HSA administrator, not the insurance company.



CGI HSAdvantage Plus

BENEFIT

CHOICES

IN-NETWORK DEDUCTIBLES

- Out-of-Network amounts are 2 times the In-Network amount

Single Deductibles

All claims are credited to a single deductible regardless of which family member has the expense. No one in the family has claims paid until the deductible is met, but once it's met, claims are payable for any family member.

Traditional Deductibles

Each family member has his or her own individual deductible, but there is a maximum cumulative family deductible for all members of 2 times the per-person amount. Claims are paid once an individual family member has met his or her own deductible or once the maximum cumulative family deductible is met.

Individual Coverage

- \$1,000
- \$1,500
- \$2,650
- \$5,000*

Family Coverage

- \$2,000
- \$3,000
- \$5,250
- \$10,000*

Family Coverage

- \$2,000 (\$4,000 Family Maximum)
- \$2,625 (\$5,250 Family Maximum)

*Not available with 80/60 plan

BENEFIT PERCENTAGE

Benefit Percentage

In-Network Out-of-Network

- 100% 80%
- 80% 60%
- 80% 60%

Out-of-Pocket Maximum (excluding deductible)

In-Network Out-of-Network

- \$0 \$1,000
- \$1,000 \$2,000
- \$2,000 \$4,000

WELLNESS BENEFITS

- In-Network Only (Out-of-Network not covered)

- Subject to Deductible & Coinsurance up to \$500 maximum per person per year**
- First-dollar benefit to Maximum of \$500**

OPTIONAL BENEFITS

Accident Expense

Pays first-dollar doctor, hospital, x-ray, lab test and related charges up to the selected maximum per person per calendar year.

- \$1,000 \$2,500
- \$1,500 \$5,000

Critical Payment

Provides the Primary Insured a lump-sum benefit payment when surviving a covered critical illness or surgery, such as life-threatening cancer, stroke, angioplasty or Alzheimer's.

- Age 16-40: \$25,000 Age 51-60: \$15,000
- Age 41-50: \$20,000 Age 61-64: \$10,000

Family Protection

Term life for the Primary Insured only.

- Age 16-49: \$35,000
- Age 50-59: \$25,000
- Age 60-64: \$15,000

Included in Your Plan:

Lifetime Maximum Per Person

\$5,000,000

\$1,000,000 Centers of Excellence
Organ Transplant

Prescription Drugs

Discounts at participating pharmacies when you use your prescription drug card. Brand drugs will be applied toward the deductible and coinsurance when specified brand-name only by your doctor. If you choose a brand-name when generic is available and allowed by your doctor, the generic cost will be applied toward the deductible and coinsurance. Outpatient mental nervous drugs are paid at 50% of cost up to \$550 a calendar year.

LabOne Select

Discounts for lab testing and specimens for covered services when you use a LabOne outpatient laboratory. Claims are subject to deductible and coinsurance.

Care Coordination Programs

For 24-7 Medical and Benefit Support
Call **1-877-575-4207 ANY TIME, ANY DAY** to:

- Gain assistance in finding the physician, specialty or medical provider you need
- Locate preferred providers near you
- Initiate inpatient precertification
- Receive general medical information. Should you need information for a specific medical condition, a medical professional will provide helpful information.

Non-Network Negotiation Service

If there is no provider within our network who performs the service you require, we will help locate a non-network provider and attempt to negotiate the cost with this provider to help save you money. Our purpose is to eliminate or reduce any balance billing you will receive from these providers. We will be your advocate with these medical providers!

Enhanced PPO Referral Service

Whether you are home or traveling, one convenient number (**1-877-575-4207**) connects you with customer service representatives who work closely with you to locate and direct you to a PPO provider. Using a PPO provider is your best way to keep more money in your pocket:

- Lower copayment for you
- Protection from charges above reasonable and customary amounts
- Gives you the comfort of knowing that your PPO benefits travel with you while you are vacationing or away from home
- When you obtain medical services from a Travel PPO provider outside your state of residence, covered charges will be paid in accordance with in-network benefits as outlined in the insurance company's PPO plan

Disease Management Early Identification Program

We know that if you manage certain conditions when they are first identified, you can lead a more productive life. Our Registered Nurse Case Managers provide education and support to you and your doctor to help manage these conditions.

Case Management— Special Care for Special Cases

A Registered Nurse Case Manager is available to work with you and your doctor to facilitate quality cost-effective care. This service applies to catastrophic illnesses and injuries as well as other medical conditions to monitor and coordinate care, from hospitalization through rehabilitation.

"Building Blocks" High Risk Pregnancy Program

Our Registered Nurse Maternity Case Manager helps identify pregnancy risks, answer questions and provide valuable information and support. If you are a high risk mother, we offer a personal case manager to work with you and your doctor. This service is available, even if you do not have maternity coverage with us.

Cancer Case Management Program

Our Registered Nurse Oncology Case Manager answers questions, provides educational information and discusses treatment options with you. In addition, the Case Manager maintains contact with you and your physicians to assist in coordinating your care and maximizing your medical benefits.

Additional Information

Health insurance plans offered through the Association are not available in all states. Submission materials may vary by state.

Initial 12-month Rate

To help control your costs, we will maintain your initial rate for medical benefits during the first 12 months of coverage. Exceptions that may affect your rate during the first 12 months are: 1) moving to a different location; 2) changing your benefit levels; 3) changing your optional coverage; 4) administrative charge adjustments; and 5) changing your network.

Applications are Subject to Underwriting and Home Office Approval

Upon receipt of the enrollment materials at the Home Office, the Member will receive a verification telephone call to make sure the application is completed correctly. The enrollment materials will then be reviewed by the Home Office's underwriters. The underwriter will determine eligibility for the plan and its benefits. No insurance for the Member or dependents will become effective unless and until written notice of approval specifying the effective date of coverage is received from the Home Office. Should the Home Office reject the application, its only obligation will be the return of your initial payment.

The insurance company reserves the right to rescind, cancel or terminate coverage for any individual who is found to have not fully disclosed any material answer or information during verification or on an insurance application.

Please Note:

- This brochure is not an insurance certificate booklet. Not all policy provisions, exclusions and limitations are listed. The certificate booklet, which is issued upon approval of coverage, will contain a summary of the coverage with a complete list of covered charges, exclusions and limitations. To review a sample copy of the certificate booklet, just ask your agent.
- Your state laws may mandate that the coverage described in this brochure be changed. Please refer to the insert accompanying this brochure for a description of these changes, if applicable.
- This plan is not being sold as an employment benefit plan, and the Member's employer is not responsible, either directly or indirectly, for paying the premium or benefits; therefore, any state small employer laws do not apply.
- No agent has the authority to change any benefits, to bind coverage with the insurance company, or to promise a specific effective date.

More About Your Valuable Health Coverage

Benefits for Specialized Situations*

Mental Illness

Inpatient and outpatient payable at 50%, with a \$2,000 calendar year maximum for inpatient confinement and a \$550 calendar year maximum for outpatient expenses. Doctor visits paid at \$10 per visit included in the \$550 outpatient calendar year maximum.

Treatment for Spinal Subluxation

\$15 per day up to a calendar year maximum of \$300 per individual or \$600 per family. X-rays payable up to a calendar year maximum of \$75 per individual or \$150 per family.

Sterilization

\$350 lifetime maximum.

Allergy Testing

Payable up to a calendar year maximum of \$500 per individual or \$1,000 per family.

Growth Disorder

Payable up to \$25,000 lifetime maximum.

Occupational, Speech and Physical Therapy

Payable up to \$50 per visit with a maximum of 25 visits per calendar year.

Hospice Benefit

\$200 per day up to a \$10,000 inpatient lifetime maximum. \$100 per day up to a \$3,500 outpatient lifetime maximum.

Cosmetic Surgery/Treatment

Payable if required to restore a part of the body altered as a result of accidental bodily injury, surgery or disease that occurred while insured with us and for which benefits are payable.

Repair of Injury to Teeth

Resulting from an accidental injury occurring while insured with us.

Emergency Room Additional Deductible

An additional deductible of \$75 applies for emergency room visits due to sickness. It is waived if admitted to hospital within 24 hours.

Extended Care Facility

60-day maximum benefit following a hospital confinement when a person is totally disabled.

Treatment of TMJ & Craniomandibular Disorder (CMD)

\$2,500 lifetime maximum.

Home Health Care

40 visits per calendar year.

Hospital Preadmission Certification

Unless varied by state law, your doctor or hospital must contact us, at the phone number on your insurance card, at least 72 hours before a scheduled admission to the hospital or within 48 hours following an emergency admission. There is no need to precertify outpatient services.

Precertification will assure that you maximize your medical benefits and have the opportunity to take advantage of our Case Management services, where appropriate.

Failure to Obtain Certification:

A precertification penalty of \$500 or 20% of covered charges, up to \$1,000 maximum, whichever is greater, for each treatment will apply where precertification is required but not obtained. The penalty will apply before the deductible and coinsurance and will not be applied to the out-of-pocket maximum.

Preexisting Conditions

Unless varied by state law, a preexisting condition is, within a two (2) year period immediately prior to the effective date of insurance, any condition that: (a) produced signs or symptoms; or (b) would cause an ordinarily prudent person to seek medical advice, consultation, diagnosis, care or treatment, or (c) resulted in medical advice or consultation given or treatment recommended (or rendered) in any manner by a medical care provider; or (d) caused medication to be taken for treatment of a condition, sign or symptom.

Preexisting condition also includes any related or resultant complication of a preexisting condition.

After two (2) consecutive years of coverage under the plan, benefits are payable for preexisting conditions unless specifically excluded from coverage by either plan provisions or an exclusion rider. Conditions fully disclosed on the initial application for insurance, during the telephone verification process or when evidence of insurability is required will be covered unless otherwise excluded from coverage by name or specific description. Any covered preexisting condition is subject to all other terms of this plan.

* Benefits vary by state. All benefits are subject to deductible and/or coinsurance.

Limitations, Exceptions and Reductions on Optional Benefit for Critical Payment

- 90-day waiting period—No benefits will be paid during this time.
- When an Insured Person attains age 70, the applicable Maximum Benefit shown in the Schedule of Benefits is reduced to 50% of the amount which would otherwise be payable. Benefits are paid based on the Maximum Benefit in effect on the Date of Diagnosis.
- Only Specified Critical Illnesses and Specified Surgeries as defined in the certificate or policy are covered.
- No benefits are payable for a Preexisting Condition which occurs during the first 24 consecutive months of insurance. See above for a definition of Preexisting Conditions.
- Benefits for one Insured Person cannot exceed the applicable Maximum Benefit.
- No benefits are payable if a claim results from any of the following: suicide or attempted suicide, while sane or insane; war or act of war, whether declared or not; participating in or contracting with the armed forces; misuse of alcohol or the use of or taking of any narcotic, barbiturate or any other drug unless taken or used as prescribed by a Doctor; an Insured Person intentionally causing a self-inflicted injury or participating in or attempting to participate in an illegal activity.

Additional Information

Exclusions

No benefits will be paid for charges:

- For transportation, except local transportation to or from a hospital by ambulance.
- For fertility or infertility treatment.
- For replacement of artificial limbs and eyes.
- For blood or blood plasma which has been replaced.
- For donation of any body organ by an Insured Person.
- For services performed by a person who ordinarily resides in the Insured Person's home or is a Close Relative of the Insured Person or by the Insured Person's Employer or partner.
- For any Cosmetic Surgery/Treatment, unless required to restore a part of the body which has been altered as a result of certain conditions that occurred while the Insured Person was insured by the Policy.
- For Custodial Care.
- Applied to a Deductible or Coinsurance amount.
- For services or Treatment not prescribed by a Doctor or for services or Treatment not shown as covered.
- For any Sickness or Injury that is subject to and paid or payable under any state or federal workers' compensation law or other similar statute or occupational disease law.
- For expenses incurred prior to the effective date of insurance or after the insurance terminates, except as maybe provided under an Extended Benefits provision.
- For Treatment or services Experimental or Investigational in nature.
- For services in a nursing or convalescent home or Extended Care Facility.
- Which are not Necessary to the care or Treatment of a Sickness or Injury.
- For eye refractions, eye glasses, or contact lens, including fittings and examinations, or eye surgery, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring), including, but not limited to radial keratotomy and vision therapy.
- For Treatment, services or supplies furnished by a department or agency of the United States Government.
- For hearing aids, including fittings and examinations.
- For services and supplies eligible for payment by a governmental or charitable program, except as required by law.
- Which would not have been made if no insurance existed.
- For recreational or educational therapy or vocational rehabilitation.
- Except as allowed under Covered Charges Subject To Limitations, for speech or occupational therapy and related diagnostic testing.
- For which the Insured Person is not legally obliged to pay.
- For Treatment or services which are not generally accepted medical practices in the United States for a given Sickness or Injury.
- For Treatment of obesity, morbid obesity or for weight reduction purposes.
- For Injury that results from participation in any assault, strike, civil disorder or riot.
- For the Treatment of sexual dysfunction or inadequacies.
- For routine physical or premarital examination except as covered under any preventive medical benefit.
- For preexisting conditions.
- For a private room in excess of the average semiprivate Room and Board rate.
- In excess of Reasonable/Usual and Customary charges.
- For services or supplies prohibited by law.
- For sex changes.
- For reversal of sterilization.
- For Treatment of controlled or prohibited substance abuse, including any conditions caused by, or related in any manner to, such abuse.
- Resulting from any suicide, attempted suicide or intentionally selfinflicted Injury or Sickness while sane or insane.
- For examination, Treatment or surgery of the teeth, gums or direct supporting structure except for repair of Injury to sound natural teeth within ninety (90) days of the date of the accident.
- For a Sickness or Injury caused by any act of war, whether or not declared.
- For surrogate pregnancy.
- For the Treatment of complications with a surgical or medical Treatment that is not a covered surgical or medical Treatment.
- Services and supplies that are covered under an extension of group health benefits provision by a previous employer-related health plan.
- For Injury that results either directly or indirectly from the Insured Person's participation in a hazardous activity.
- For Injury that results either directly or indirectly from the Insured Person's committing or attempting to commit or participation in a felony.
- For Sickness or Injury resulting either directly or indirectly from the Insured Person's Intoxication or being under the influence of alcohol, drugs, controlled substances, or any other substance capable of mental or physical impairment, unless prescribed on the advice of a Doctor.
- For pregnancy, except Covered Complications of Pregnancy.
- For benefits if they are provided by Medicare or any government program (except Medicaid).
- For the following conditions during the first six months coverage is in force unless such conditions are treated on an emergency basis: hernia, removal of adenoids and/or tonsils, varicose veins, hemorrhoids, middle ear disorders or disorders of the reproductive organs.
- For routine newborn or well child care except as covered under any preventive medical benefit.
- For elective abortion.
- For genetic testing.
- For alcoholism, drug Treatment or chemical dependency.

Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act (HIPAA) and related state laws require insurance carriers to offer coverage to Eligible Individuals on a guaranteed-issue basis and without a preexisting condition exclusion. Such coverage is not required in states that have enacted alternative mechanisms. Where required by state law, the insurance carrier will offer coverage to Eligible Individuals. Refer to your brochure insert for the type of coverage available to Eligible Individuals in your area.

In general, Eligible Individuals are individuals who satisfy the following requirements:

- Have been insured under Creditable Coverage for at least 18 months (with no more than a 63-day gap in coverage), the most recent being under an employer-sponsored, governmental or church plan;
- Are not eligible for coverage under an employer-sponsored plan, Medicare or Medicaid;

- Do not have other health insurance coverage;
- Whose most recent coverage was not terminated for nonpayment or fraud;
- Who are not eligible for COBRA or state continuation.

Creditable Coverage means: employer-sponsored coverage; health insurance coverage; Medicare; Medicaid; CHAMPUS; tribal organization programs; public health plans; Peace Corp plans.

Our Plans are Sold in Connection with a National Association

By joining the Association, you'll have access to savings on a broad range of healthcare and life-style products and services—many of which you'll use every day. This health insurance is sold in connection with Association membership. The health insurance plans are described in this brochure.

CGI and the Association are unaffiliated entities. A portion of your Association dues is paid to the insurance carrier for certain administrative and other services it provides to the Association. CGI does not receive any other compensation from the Association.

Our Commitment

At Continental General Insurance Company, we are committed to providing valuable service and health insurance products at affordable prices. Our mission is to fully serve the needs of all those associated with our company.

To apply for a health insurance plan or to receive your free quote, contact your agent.



Your representative is:

PLANS UNDERWRITTEN BY:
Continental General Insurance Company
(Policy form: MIAGH, MIAGL)



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