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presents

American Select HealthNext® Major Medical Plan

\$2,000,000 Lifetime Maximum

Individual Major Medical Insurance
Plans - Colorado and Georgia

**Insurance Plans for Individuals
and Their Families**

Choice of
Multiple PPO Networks

Family Premium and Preferred
Health Discount

American Select HealthNext® Major Medical

Design The Plan That's Right For You

The Policy Will Pay 100% of Covered Expenses up to the \$2,000,000 Lifetime Maximum After You Have Met Your Out-Of-Pocket Expenses¹

American Select HealthNext® Major Medical Plan																									
Choose Your Calendar Year Deductible (maximum 3 individual calendar year deductibles per family per calendar year)	<i>Deductible</i> <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000																								
	Then Choose Your Coinsurance. Coinsurance Maximum(s) does not include calendar year deductibles, copays, service deductibles or non-covered expenses. The PPO and NonPPO out of pocket maximum(s) accumulate separately.	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th colspan="2" style="text-align: center;">PPO</th> <th colspan="2" style="text-align: center;">NonPPO</th> </tr> <tr> <th style="text-align: left;"><i>Coinsurance</i></th> <th style="text-align: left;"><i>Coinsurance Maximum</i></th> <th style="text-align: left;"><i>Coinsurance</i></th> <th style="text-align: left;"><i>Coinsurance Maximum</i></th> </tr> </thead> <tbody> <tr> <td><input type="checkbox"/> 80/20%-\$5,000</td> <td>\$1,000</td> <td>60/40%-\$10,000</td> <td>\$4,000</td> </tr> <tr> <td><input type="checkbox"/> 80/20%-\$20,000</td> <td>\$4,000</td> <td>60/40%-\$40,000</td> <td>\$16,000</td> </tr> <tr> <td><input type="checkbox"/> 50/50%-\$5,000</td> <td>\$2,500</td> <td>50/50%-\$10,000</td> <td>\$5,000 (CO only)</td> </tr> <tr> <td><input type="checkbox"/> 50/50%-\$20,000</td> <td>\$10,000</td> <td>50/50%-\$40,000</td> <td>\$20,000 (CO only)</td> </tr> </tbody> </table>	PPO		NonPPO		<i>Coinsurance</i>	<i>Coinsurance Maximum</i>	<i>Coinsurance</i>	<i>Coinsurance Maximum</i>	<input type="checkbox"/> 80/20%-\$5,000	\$1,000	60/40%-\$10,000	\$4,000	<input type="checkbox"/> 80/20%-\$20,000	\$4,000	60/40%-\$40,000	\$16,000	<input type="checkbox"/> 50/50%-\$5,000	\$2,500	50/50%-\$10,000	\$5,000 (CO only)	<input type="checkbox"/> 50/50%-\$20,000	\$10,000	50/50%-\$40,000
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Physicians Office Visits. ⁽²⁾ After your copay, the balance of the PPO office visit charge is paid at 100%. All other covered services performed during the office visit are subject to the calendar year deductible and coinsurance.	\$50 PPO \$75 NonPPO plus selected deductible & NonPPO coinsurance																								
Inpatient Hospital Service Deductible ⁽³⁾ (per admission)	\$200																								
Outpatient Ambulatory Surgical Facility Service Deductible ⁽³⁾ (per visit)	\$200																								
Outpatient Testing Service Deductible ⁽³⁾⁽⁴⁾ (per visit)	\$200																								
Hospital Emergency Room Service Deductible ⁽³⁾ (per occurrence)	\$200 (waived if admitted as an inpatient immediately following emergency room visit)																								
Outpatient MRI, Cat Scan and Nuclear Imaging Test Service Deductible ⁽³⁾ (per test)	\$200																								

- (1) Out of pocket expenses include any applicable deductibles, copays, coinsurance, amounts in excess of usual, reasonable and customary charges and non-covered expenses.
 (2) Physician Office Visit Copay does not apply to the calendar year deductible and coinsurance.
 (3) Service deductible is in addition to the chosen calendar year deductible/coinsurance and does not apply to the calendar year deductible and out of pocket coinsurance maximum.
 (4) Applies to outpatient x-rays, laboratory and diagnostic testing **not performed in a physician's office**. Additionally, this Service Deductible does not apply to charges subject to the Outpatient MRI, CAT Scan, Nuclear Imaging Tests Service Deductible.

Plan Benefits and Features

Plan Benefits are subject to applicable calendar year deductible, coinsurance, copay and/or service deductible(s) unless noted or mandated otherwise.

- Ambulance Service (\$1000 for ground or water, \$5000 for air maximum per occurrence)
- Ambulatory Surgical Centers
- Anesthetics and their Administration
- Chemotherapy and Radiation Therapy
- Child Health Supervision Services—For children through age 6. Includes physical exams, developmental assessment, immunizations and lab exams at defined age intervals. Not subject to calendar year deductible. (In CO, covered at defined age intervals for children through age 12.)
- Common Accident Deductible
- Dental Treatment as a result of a covered injury to sound natural teeth
- Dressings, Sutures, Casts, Splints, Trusses, Crutches
- Emergency Treatment received outside the U.S.
- Home Health Care up to \$2,500 maximum per year (In CO, up to 60 visits per calendar year; \$2,500 maximum does not apply.)
- Hospice Care up to \$2,000 lifetime maximum benefit (In CO, up to \$100 per day per six-month benefit period; \$2,000 maximum does not apply.)
- Hospital Daily Room and Board (semi-private room rate)
- Hospital Inpatient Miscellaneous Medical Services and Supplies
- Hospital Outpatient Services
- Intensive Care (up to 3x semi-private room rate)
- Major Medical Calendar Year Deductible Carryover
- Mammograms—Females: One baseline ages 35-39 and one every year for ages 40 and older. (In CO, one base line ages 35-39; one every two years for ages 40-49 and one every year for ages 50 and older. In CO, routine mammogram is not subject to any copays, calendar year deductibles, coinsurance or service deductibles.)
- Medically necessary services not available from a PPO provider and referred to a NonPPO provider considered for payment at PPO level
- Medical Benefits for Emergency Services, as defined in the policy, considered for payment at PPO level
- Organ Transplants or Replacements
- Oxygen and other Gases
- Pap Smear—One screening per calendar year including the physician's office visit
- Physical, Respiratory and Speech Therapy for Rehabilitative Treatment
- Physician Charges
- Private Duty Nursing (\$1000 max. benefit per calendar year)
- Prostate Exams—Males: Age 40 and over. One per calendar year, including the office visit and PSA test (In CO, males age 50 and over [40 if high risk]; and not subject to any copays, calendar year deductibles, coinsurance or service deductibles.)
- Psychiatric Care (per calendar year) - Inpatient up to 55 days of active treatment or \$2,000, whichever occurs first. Outpatient payable at 50% up to \$20 per visit, 55 visits
- Rental of durable medical equipment
- Skilled Nursing Facility for convalescent care
- Spinal Manipulation and Other Manipulative Therapy \$500 maximum per calendar year
- X-rays, Laboratory Tests, and Other Diagnostic Tests

Plan benefits may be subject to exclusions, limitations and maximum benefits and may vary by state. Complete description of benefits is contained in the Policy.

Plan For Individuals And Their Families

Optional Rx Copay Drug Card

Outpatient covered prescription drugs subject to the following copays plus an Rx deductible of \$500 or \$1000 per person per calendar year:

\$15 generic, \$25 formulary, \$40 brand name. After copay, the balance of the cost of the drug paid at 100% at participating pharmacies. Mail order (most states) included with 2x applicable copay for 90-day supply.

A reduced benefit may be offered or the benefit eliminated if any proposed insured is on maintenance medications.

To determine an affiliated participating network pharmacy, call Express Scripts at 800-234-7345. Express Scripts has over 50,000 affiliated pharmacies nationwide. Simply present your Rx card and pay the applicable copay and deductible. Charges for covered Rx drugs purchased from non-affiliated pharmacies will be paid to the insured up to the amount that would be paid if purchased through an affiliated participating pharmacy, less the covered person's drug copayment and Rx deductible.

Prescription Drug Card benefits are not payable for drugs purchased without a prescription; contraceptive drugs, devices or supplies; immunization agents or therapeutic devices. A complete listing of the Rx exclusions is listed in the Prescription Drug Card Benefit Rider.

An Express Scripts discount card is provided if you don't select the Optional Rx Copay Drug Card. The discount card is not an insurance benefit.

Additional Optional Benefits

24 Hour Occupational Coverage—To be eligible for this optional Rider, the applicant and/or spouse must be: (1) a sole proprietor, partner, owner or other individual gainfully employed in an occupation eligible for the Rider; and (2) eligible to opt out of Workers' Compensation by their state law and have done so. This optional Rider provides benefits for injuries or sicknesses, that arise out of or in the course of employment, on the same basis as any other covered illness. Benefits are payable provided the covered person is not insured or required to be covered under any Workers' Compensation or similar law, and the expenses are incurred while the Rider is in force. The Rider will terminate on the date the covered person changes occupation, or on the date the covered person becomes covered or is required to be covered by Workers' Compensation. If the covered person's occupation changes, the covered person is required to provide notification within 30 days of the date of the change in occupa-

tion. If the Rider terminates because the covered person's occupation changes, the individual can request to the plan administrator to add this Rider to their policy under their new occupation if gainfully employed in an eligible occupation and is eligible to opt out of Workers' Compensation and has done so. If this Rider is not elected, there is no on the job coverage.

Supplemental Accident Benefit—Paid at 100% up to \$500 maximum per occurrence with NO calendar year deductible. Charges for the covered injury must be incurred within 90 days of the date of the injury, provided initial treatment was received within 72 hours of the injury. Covered expenses in excess of \$500 will be payable as any other covered expense.

Initial Premium Rate Guarantee—Initial premium rates, excluding fees, will be guaranteed for either 6 or 12 months. Initial premium rates may change if you move, change your plan or add/delete covered dependents.

General Information

- * Family premium discount applies when a policy is issued with two or more family members applying together.
- * Available Effective Dates are the 1st or 15th of any month, subject to underwriting approval.
- * Due to the level of service deductibles and/or copays existing within these plans, the insured may be responsible for most of the costs associated with routine health care.
- * 10 Day Free Look Provision.

Eligibility:

- * Individuals can apply for coverage if they are between the ages of 18 through 64.
- * Individual's dependents can apply for coverage if they are a legally married spouse through age 64, and unmarried dependent children under age 19 (20 in GA) (under age 25 if enrolled full time in an accredited two-year or four-year college or university).
- * Children only coverage available for infant through age 18 (19 in GA) (24 if full-time student). Parent/guardian must be applicant.

Termination of Insurance:

Insurance will remain in force until the earliest of:

- * The date there is fraud or material misrepresentation with regard to the policy or its benefits.
- * The date the insured's premium is due if not received by the end of the grace period.
- * The premium due date following the date the policy terminates.
- * The date of death of the covered insured.
- * The premium due date following the date the insurer terminates all policies in the insured's state of residence.
- * Dependent child's coverage terminates on the premium due date following: the date of the covered dependent's marriage; the date the covered dependent reaches age 19 (20 in GA) (or 25 if a full-time student). (Termination of insured's insurance will also result in dependent termination.)

In the absence of fraud or misrepresentation, insureds cannot be singled out for a rate increase nor can their policy be cancelled due to claims on an individual basis.

American Select HealthNext® Plan Illustrative Claim Examples

Benefit Plan Selected: \$2,500 Calendar Year Deductible (per person); Coinsurance: 80/20 in network to \$5,000 or 60/40 out-of-network to \$10,000

Hospital Admission - First Claim

	In Network	Out of Network
If you choose a hospital:	Network	Network
Covered Expenses*	\$100,000	\$100,000
Less Inpatient Hospital Service Ded. Amount**	- 200	- 200
	\$ 99,800	\$ 99,800
Less Cal. Yr. Ded. Amount**	- 2,500	- 2,500
	\$ 97,300	\$ 97,300
Less Coins. at 80% In-Network, 60% Out-of-Network, up to the Out-of-Pocket Max., You pay	- 1,000	- 4,000
TOTAL The Plan pays	\$ 96,300	\$ 93,300
TOTAL You pay	\$ 3,700	\$ 6,700

Physician Office Visit (POV)

	In Network	Out of Network
If you choose a physician:	Network	Network
Office Visit Charge	\$ 150	\$ 150
Less POV Copayment Amount**	- 50	- 75
	\$ 100	\$ 75
POV Exam/Lab Charges	\$ 100	\$ 100
Less Amount Applied Toward Cal. Yr. Ded. Amount**	\$ 100	\$ 175
TOTAL The Plan pays	\$ 100	\$ 0
TOTAL You pay	\$ 150	\$ 250

Outpatient Ambulatory Surgery (OAS)

	In Network	Out of Network
Total OAS Exp.* (Facility & Surgeon's Fees)	\$4,000	\$4,000
OAS Facility Exp.	\$2,000	\$2,000
Less OAS Facility Svc. Ded.**	-200	-200
Less Cal. Yr. Ded. Amount** (assumes previously satisfied)	Satisfied	Satisfied
Less Coins. at 80% In-Network; 60% Out-of-Network	-1,440	-1,080
Subtotal (You Pay)	\$ 360	\$ 720
Professional Fees for Surgery	\$2,000	\$2,000
Less Amt. Applied to Cal. Yr. Ded. Amt.** (assumes previously satisfied)	Satisfied	Satisfied
Less Coins. at 80% In-Network; 60% Out-of-Network	-1,600	-1,200
Subtotal (You Pay)	\$400	\$800
TOTAL The Plan pays	\$3,040	\$2,280
TOTAL You pay	\$ 960	\$1,720

* Covered Expenses assume that any Preferred Provider Discount has been taken. If the service is provided by an out of network provider, it assumes that the charges are usual, reasonable and customary.

** The insured is responsible for these amounts plus the balance of coinsurance up to the out-of-pocket coinsurance maximum and any expenses incurred not covered under the Policy. The balance of co-insurance, 20% in-network or 40% out-of-network, is included in the amount shown above that you pay.

The above example is for illustrative purposes only and assumes that submitted charges are covered expenses under the Policy provisions. All expenses that a covered person may incur may not be covered under Policy provisions. The amounts shown above that the plan pays, the amounts that you pay and the amounts applied to the deductible, coinsurance and out-of-pocket maximum will vary based on an actual claim submitted and the plan of benefits you selected.

Insureds are encouraged to utilize in-network providers whenever possible. By using an in-network provider and the plan of benefits you selected, your out of pocket expenses may be reduced, as shown in the examples above.

Exclusions and Limitations

Exclusions and Limitations (may vary by state)

Except as specifically provided for in the policy, the policy does not cover:

- preexisting conditions; • **GA only: charges incurred prior to the date the covered person has been covered under the policy for six consecutive calendar months for the care or treatment of: hernia; tonsils; adenoiditis; any disease or disorder of the reproductive system; any rectal disease or disorder; gall bladder; varicose veins; or laminectomy, discectomy or spinal fusion. Any such condition may also be excluded as a preexisting condition. This limitation shall not apply to services provided for an emergency where such condition is not excluded as a preexisting condition.** This exclusion will not apply to a covered person receiving treatment due to a malignancy, provided such treatment is not being rendered to a preexisting condition; • expenses incurred before the effective date; • expenses incurred after coverage under the policy terminates, regardless of when the condition originated; • any conditions specifically excluded by riders or exclusions attached to the policy; • expenses incurred to treat complications resulting from treatment, drugs, supplies, devices, procedures or conditions which are not covered under the policy; • experimental, investigational, or unproven services; • expenses determined to be educational; • amounts in excess of the usual, reasonable and customary charges; • expenses the covered person is not required to pay, or which would not have been billed if no insurance existed; • care in government institutions unless the covered person is obligated to pay for such care; • charges incurred for illness or injury that arises out of, as a result of, or in the course of employment; • non-emergency treatment received outside of the United States; • charges incurred by a covered person while on active duty in the Armed Services; • expenses resulting from a declared or undeclared war, or from voluntary participation in a riot or insurrection; • expenses incurred or expense related thereto, while engaging in an illegal act or occupation or during the commission, or the attempted commission, of a felony; • pregnancy or childbirth, except for complications of pregnancy; • charges incurred for voluntary termination of pregnancy; • any drug (including birth control pills), implants or injections, supply, treatment, device or procedure that prevents or terminates conception and/or childbirth; • treatment of infertility, including but not limited to any attempt to induce fertilization by any method other than by natural means; in vitro fertilization, artificial insemination or similar procedures whether the covered person is the donor, recipient or surrogate (in CO, diagnosis of infertility also not covered); • any drugs, supplies, treatments, devices or procedures related to sex transformation or reversal thereof, sexual dysfunctions, penile implants or sexual inadequacies; • sterilization or reversal of sterilization; • physical exams or other services or supplies not needed for medical treatment; • prophylactic treatment, including surgery or diagnostic testing; • outpatient treatment of alcoholism; • outpatient treatment of

chemical dependency, substance abuse and/or drug addiction; • programs, treatment, supplies, or procedures for tobacco use cessation; • expenses resulting from intentional self-inflicted injury, suicide or attempted suicide, whether sane or insane; • charges incurred which result from: (a) the voluntary taking of drugs, except those taken as prescribed by a physician, (b) the voluntary taking of poison, (c) the voluntary inhaling of gas, or (d) in GA, being intoxicated or under the influence of any narcotic unless administered on the advice of a physician, (d) in CO, being under the influence of alcohol; • dental treatment or care; • orthodontia or other treatment involving the teeth and supporting structures; • in CO: treatment by any method for jaw joint problems, including temporomandibular joint dysfunction (TMJ) • surgical or non-surgical correction of refractive error; vision therapy; routine vision exams to assess the initial need for or changes to prescription eyeglasses or contact lenses; the purchase, fitting or adjustment of eyeglasses or contact lenses; eyeglasses or contact lenses for the treatment of aphakia; • routine hearing exams to assess the need for or change to hearing aids; the purchase, fittings or adjustments of hearing aids; • cosmetic or reconstructive procedures, services or supplies; • charges for breast reduction unless medically necessary; • charges for breast augmentation; • removal of breast implants; • **outpatient prescription medications** (unless covered under the optional Rx drug card, if elected); • medications and drugs, including vitamins and vitamin-mineral supplements, available over-the-counter (OTC) whether or not by a physician's prescription order; • any expense related to the treatment of hair loss; • treatment of weak, strained, flat, unstable, or unbalanced feet, metatarsalgia, bunions or the removal of one or more corns, calluses or toenails; • charges for blood or blood plasma that has been replaced; • treatment of autism (CO only), developmental delays and learning disabilities, testing and training for education or vocation; • treatment of acne; • weight loss programs, diets, or treatment of obesity, extreme obesity or morbid obesity, including surgery for reconstruction, repair or reversal of a gastric bypass; • transportation charges; • rest and/or recuperation cures or care in a skilled nursing facility, convalescent nursing home or facility, extended care facility, or home for the aged, whether or not part of a hospital; • services or supplies for personal comfort or convenience, including custodial care or homemaker services; • services and/or supplies furnished and/or provided by an immediate family member or a person who ordinarily resides in the home of the covered person or by the employer of an immediate family member, except for covered expenses rendered while hospital confined; • any charges incurred in connection with a hospital admission on Friday or Saturday unless the attending physician states in writing that the admission was an emergency; • immunizations not necessary for the treatment of an illness or injury; • expenses incurred for occupational therapy; • acupuncture unless the charges incurred are in lieu of anesthesia; • marriage or family counseling; • sex therapy.

Pre-Existing Conditions-Definition and Limitation - Colorado

An illness, injury or pregnancy of a covered person for which the covered person has incurred charges, received medical advice, treatment, services, diagnostic tests, consultation from a physician or taken prescription medication during the 12 months prior to the covered person's effective date of coverage under the policy. Benefits will be payable for a pre-existing condition, unless the condition is specifically excluded under the policy or excluded by endorsement or rider attached to the policy, if at the end of a continuous period of 12 months commencing on or after the effective date of the covered person's coverage, the person has been covered under prior creditable coverage where there is not a break in coverage greater than 90 days immediately prior to the covered person's effective date.

Pre-Existing Conditions-Definition and Limitation - Georgia

An illness or injury of a covered person for which the covered person has received medical advice, treatment, services, diagnostic tests, consultation or medication during the twelve (12) months prior to the covered person's effective date of coverage under the policy. Benefits will be payable for a pre-existing condition, unless the condition is specifically excluded under the policy or excluded by endorsement or rider attached to the policy, if at the end of a continuous 12-month period commencing on or after the effective date of the covered person's coverage, the person has not received medical advice, treatment, services, diagnostic tests, consultation or medication in connection with such illness or injury; or, at the end of the two (2) year period commencing on the effective date of the covered person's coverage, the person has been covered under the policy.

Health conditions duly disclosed in the application for coverage of the covered person and otherwise covered by this policy, unless the condition is specifically excluded by endorsement or rider attached to the policy, are covered from the effective date of coverage under the policy.

Failure to fully disclose information can result in rescission (voiding) or reformation of coverage and the denial of a claim. Please refer to the Application and the Policy for further details.

Coverage under the plan may be uniformly modified prospectively subject to HIPAA and state law.

This brochure is a brief description of the important features of the Policy. It is not a contract.

Applicants should not cancel any existing medical insurance plan until they have been notified in writing by the insurance company or its designated plan administrator that their new insurance is in effect.

Notice to Colorado Residents

Colorado law requires carriers to make available a Colorado Health Plan Description Form, which is intended to facilitate comparison of health plans. The form must be provided automatically within three (3) business days to a potential policyholder who has expressed interest in a particular plan or who has selected the plan as a finalist from which the ultimate selection will be made. The carrier also must provide the form, upon oral or written request, within three (3) business days, to any person who is interested in coverage under or who is covered by a health benefit plan of the carrier.

If a covered person obtains services from a non-PPO provider, the covered person may be billed by the non-PPO provider for any calendar year deductibles, coinsurance, co-payments or service deductibles and any amount that exceeds the usual, reasonable and customary charge. Reimbursement rates to non-PPO providers for specific health care services and the access plan may be obtained by sending a written request to the plan administrator. Depending upon the PPO network you choose, there may not be providers in the following counties: Dolores, Hinsdale, Jackson, San Juan, and San Miguel.

Underwritten By



Premiums may also vary based on PPO network and occupation. The plans described in this brochure are intended for distribution to Colorado and Georgia residents only.

In CO: Policy Form #EM 28 18 (04-01)-P-CO Plan #HL2 02/03-001-CO
In GA: Policy Form #EM 28 18 (04-01)-P-GA Plan #HL2 02/03-001-GA

Insurance premiums vary by effective date, age, sex, state, zip code, plan, deductibles and coinsurance selected and underwriting decision.

National Program Manager



Marketed By