

HOW DOES THE PLAN WORK AND WHY WOULD I NEED IT?

Getting the very best care for a life threatening non-job related injury or sickness is important. With catastrophic major medical insurance coverage, you may receive up to \$1,000,000 of insurance protection above and beyond your basic health insurance coverage.

ELIGIBILITY

All active members in good standing and lawful spouses who are residents of New York and are insured under a basic plan are eligible for coverage. Unmarried, dependent children under 19 years of age (25 if full-time student) are eligible to enroll for coverage under this plan. Your insurance will take effect upon the insurance company's receipt of your enrollment form and initial premium. The effective date will be shown on your Certificate Schedule. Once insured, your coverage can continue as long as your premium payments are current, and the group policy remains in force.

HOSPITAL AND INTENSIVE CARE BENEFITS

If you are not a Medicare beneficiary, you will receive a \$2,000 credit toward your plan deductible for each day of confinement in a hospital, regardless of the actual charge. After your deductible is met, your hospital benefits for inpatient care per benefit period are:

- First 30 days \$75 per day
- Next 100 days \$100 per day
- Thereafter \$150 per day

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

OTHER COVERED CHARGES

Up to 100% of the following reasonable and customary expenses after your deductible has been met:

- Private Duty Nursing (\$30,000 per benefit period) \$300 per day.
- Ambulance Service (\$2,000 per benefit period)
- Convalescent Care (\$46,800 lifetime maximum) \$300/wk.
- Home Health Care 100 visits per benefit period.
- Diagnosis and Treatment of psychiatric, mental, nervous or emotional disorders, ailments or illness, alcoholism or alcohol abuse and substance abuse or substance dependence (as described below).
- Charges by your doctor for diagnosis, treatment, and surgery.

CHARGES NOT COVERED

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

WHEN ARE BENEFITS PAID?

Benefits are payable starting on the date you incur charges for an injury or sickness in excess of the cash deductible. The benefit period will begin on the date on which the first covered charge is incurred that is used to satisfy the deductible for such injury or sickness. Benefits for any injury or sickness will end the earlier of:

1. the date the applicable maximum benefit has been paid.
2. the end of the benefit period (three years), or
3. the end of a period of 12 consecutive months during which no charge is incurred for the injury or sickness.

A new deductible will be required for an injury or sickness when the benefit period expires. If two or more insured family members are injured in the same accident, the covered charges incurred by each individual due to the accident will be combined. If the total exceeds one cash deductible amount, no further cash deductible will be required for the individuals for any injury caused by the accident.

LIMITATIONS

This Plan does not cover loss caused by or resulting from: eye examinations to prescribe or fit corrective lenses or eyeglass frames, hearing aids, dental care, treatment or surgery except to the extent that it is necessary to treat a non-job related injury caused by an accident which occurs while the person is insured; or cosmetic treatment or surgery unless such charges are the result of a non-job related injury or sickness or are necessitated by congenital defects in a dependent child which have resulted in a functional defect. Also, this plan does not cover charges to buy or rent air conditioners, air purifiers, motorized transportation equipment, escalators or elevators in private homes, swimming pools or supplies for them and general exercise equipment.

Charges incurred for diagnosis and treatment of alcoholism, alcohol abuse, substance abuse or substance dependency will be covered.

Non Medicare Beneficiaries receive coverage for outpatient diagnosis and treatment in a certified or accredited alcoholic or substance abuse treatment center, up to 60 visits per calendar year. Up to 20 of such visits may be for family members of the alcoholic or substance abuser. Medicare Beneficiaries receive the aforementioned coverage plus that for charges incurred while the person is hospitalized; and for inpatient rehabilitation in a certified or accredited alcoholic or substance abuse treatment center, up to 30 days per calendar year.

Charges incurred for diagnosis and treatment of psychiatric, mental, nervous or emotional disorders, ailments or illness will be covered.

Non Medicare Beneficiaries receive coverage for outpatient visits, up to 30 visits per calendar year, subject to a maximum benefit of \$50 per visit (the facility for such visits must have been issued an operating certificate by the commissioner of mental health pursuant to the mental hygiene law; or be operated by the office of mental health, a psychiatrist or psychologist licensed to practice in New York or a professional corporation of such psychiatrists or psychologists); for up to three psychiatric emergency visits per calendar year, subject to a benefit of \$60 per visit. Benefits provided for emergency visits will reduce benefits otherwise payable for outpatient care as described. Medicare

Beneficiaries receive the aforementioned coverage plus coverage while hospitalized, up to 30 days per calendar year. Benefits provided for emergency visits will reduce benefits otherwise payable for inpatient or outpatient care as described.

PRE-EXISTING CONDITIONS

Pre-existing condition means:

- an injury or sickness which manifested itself within 6 months before a person became insured under a given benefit section of the group policy in such a manner as would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment;
- an injury or sickness for which a person was recommended or received medical advice, diagnosis, care or treatment within 6 months before a person became insured under a given benefit section of the group policy; or
- a pregnancy that exists on the date a person became insured under a given benefit section of the group policy.

No charges incurred for a pre-existing condition will be considered covered charges under a benefit section until the person stays insured under such benefit section for 12 continuous months.

IS IT EXPENSIVE?

You have a choice of \$35,000 or \$50,000 deductible amounts. The deductible for each insured person per injury or sickness will be the greater of the cash deductible chosen, or the eligible benefits payable under your basic health insurance plan. Reasonable and customary eligible expenses count toward satisfaction of your deductible. Eligible expenses paid for by your basic health insurance policy (except inpatient hospital charges for non Medicare beneficiaries) as well as those paid out of your pocket apply toward meeting your deductible. These expenses must be for covered charges incurred within a 24-month period. Additionally, the deductible is reduced by \$2,000 each day of inpatient hospital confinement if you are not a Medicare beneficiary.

MONTHLY PREMIUM RATES

DEDUCTIBLE	MEMBER ONLY	MEMBER & SPOUSE	MEMBER & CHILD	FAMILY
\$35,000	\$25.70	\$51.39	\$33.99	\$59.68
\$50,000	\$19.36	\$38.72	\$25.61	\$44.97

To calculate annual, semiannual, or quarterly rates, multiply rates shown by 12, 6 or 3, respectively.

EXCLUSIONS AND LIMITATIONS

No medical care benefits will be paid by the group policy for charges incurred for treatment which:

1. Is given after a person's insurance ends, regardless of when the injury or sickness occurred. However, medical care benefits may be provided in the Benefits After Insurance Ends provision of a given benefit section.
2. Is not essential for the necessary care or treatment of the injury or sickness involved.
3. Would be given free of charge if the person was not insured. However, medical care benefits will be paid for covered charges incurred by a state for medical assistance to an insured person under Title XIX of the Social Security Act of 1965.
4. Results from a war or an act of war.
5. Results from intentionally self-inflicted injury.
6. Is given by a person's spouse or his or her spouse's father, mother, son, daughter, brother or sister.
7. Is given by a person's employer or an employee of such employer.

HELP SECURE YOUR FUTURE

To apply for this coverage, complete the enclosed application form, sign, date and return it with your first modal premium check made payable to Selman & Company:

ACerS Members' Insurance Program
6110 Parkland Boulevard
Cleveland, Ohio 44124

Questions? Call us toll-free at: 1-800-556-7614
Or e-mail us at enrollment@selmaninsurance.com

30-DAY FREE LOOK

Once you receive your certificate of insurance, if you're not 100% satisfied within the first 30 days, we'll send you a full refund of any premiums paid during that period and your certificate will be considered never issued. You will be under no further obligation.

This plan is underwritten by The United States Life Insurance Company in the City of New York, a member company of American International Group, Inc.

THE ADMINISTRATOR



For more than 30 years, associations across the country have looked to Selman & Company for specialized

insurance protection. As the administrator for your endorsed insurance plan, our responsibilities are to provide you with a strong valuable plan of benefits, competitive rates and the personal service you require.

The underwriting risks, financial obligations and support functions associated with the products issued by The United States Life Insurance Company in the City of New York are solely its responsibility. The United States Life Insurance Company in the City of New York is responsible for its own financial condition and contractual obligations.

THE UNDERWRITER



The most prominent independent ratings agencies continue to recognize The United State Life

Insurance Company in the City of New York, a member company of American International Group, Inc., in terms of insurer financial strength. For current insurer financial strength ratings, please consult the Web site at www.aigag.com/ratings.

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

This brochure is a summary of benefits only and is subject to the terms, conditions, limitations and exclusions of Group Policy Number E-233,619, Form Number G-19000.