

FOCUS

One Choice

A Simple Plan
Providing
Major
Medical
Coverage

UPDATED



Focus One Choice is designed for healthy and wellness-conscious individuals and families



AmeriBenefit Plan
Group Insurance for Members of
AmeriBenefit Plan (a nonprofit association)

Underwritten by:



Focus One Choice is distributed by:



America's Health Care/Rx Plan Agency, Inc. (AHCP)

FOCUS

One Choice

Select Your Coverage

The deductible and benefit options you select will determine the premium cost for your insurance plan.

The higher the deductible, the lower your premium.

This is because with a higher deductible, you are agreeing to pay more of the routine medical expenses yourself. By using insurance only for higher-cost expenses, you:

- Lower your insurance costs, and
- Are able to budget your medical/insurance expenses

With the Focus One Choice Plan, you'll also receive the benefit of preferred provider discounts on the covered out-of-pocket hospital and physician expenses you pay. This can save you money on routine medical care when using a preferred provider.



Focus One Choice is designed to be an in-network PPO product. Utilizing out-of-network medical providers will generally result in higher out-of-pocket costs to you. Out-of-network provider services include a larger, separate calendar year deductible and lower benefit payment thereafter, subject to a higher out-of-pocket maximum.

ABP Association Benefits Make Your Coverage Complete

Focus One Choice is sold in connection with the national AmeriBenefit Plan (ABP) (a nonprofit association).

ABP provides you with volume-driven discounts on many health-related purchases

AND

valuable health care benefits that complement your Focus One Choice and lower your total medical expenses.

ABP offers a variety of member benefit packages. Details on each of these plans can be found on the AmeriBenefit Plan website at: www.ameribenefitplan.com.

CGI and the Association are unaffiliated entities.

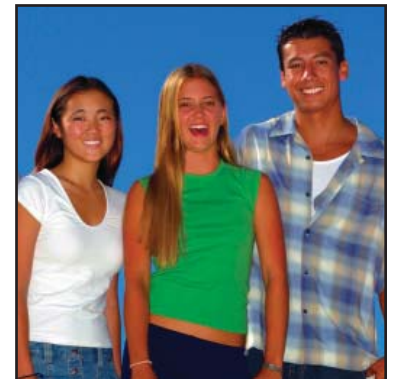
A portion of your Association dues is paid to the insurance company for certain administrative and other services it provides to the Association. CGI does not receive any other compensation from the Association.

America's Health Care/Rx Plan Agency, Inc. (AHCP) and its sales agents receive compensation from ABP for promoting the Association.

Do you qualify?

You need to discuss your health and the health of any family members to be covered with your AHCP agent. In most cases, your AHCP agent will ask you a number of select preliminary medical questions that indicate whether you qualify* to complete an application for a Focus One Choice medical plan. Focus One Choice is designed for healthy and wellness-conscious individuals and their families.

If you qualify, your AHCP agent will then ask you to complete an application for coverage. You will be asked a number of health questions about yourself and each family member who is to be covered by Focus One Choice, and this information will be verified directly with you by the underwriting insurance company, Continental General Insurance Company.



AmeriBenefit Plan

* Refer to HIPAA Eligible Individual section of this brochure and on state insert for exceptions.

FOCUS One Choice—Choose Your Benefit Needs

Deductibles—In-Network

The **Deductible** is the amount you pay for covered expenses during a calendar year.

For Family coverage, choose either Single Deductible or Traditional Deductible. For a Single Deductible plan, charges for all family members accumulate toward a common deductible. For a Traditional Deductible plan, each family member satisfies his or her own per person deductible until the Family Maximum is met.

In-Network deductibles are shown (out-of-network deductibles are double these amounts).

Individual Coverage

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

Family Coverage

Single Deductible

- \$1,000 per Family
 \$2,000 per Family
 \$3,000 per Family
 \$5,000 per Family
 \$10,000 per Family

Traditional Deductible

- \$500 per person (Family Maximum \$1,000)
 \$1,000 per person (Family Maximum \$2,000)
 \$1,500 per person (Family Maximum \$3,000)
 \$2,500 per person (Family Maximum \$5,000)
 \$5,000 per person (Family Maximum \$10,000)

Benefit Percentages and Out-of-Pocket Maximum*

*Out-of-Pocket Maximums are per person and are in addition to the deductible. The Family Maximum for the Single Deductible plans is the same as the per person amount and for the Traditional Deductible plan it is double the per person amount.

In-Network Benefits		Out-of-Network Benefits	
Benefit Percentage	Out-of-Pocket Maximum*	Benefit Percentage	Out-of-Pocket Maximum*
<input type="checkbox"/> 100%	\$0	80%	\$2,000
<input type="checkbox"/> 90%	\$1,000	70%	\$3,000
<input type="checkbox"/> 80%	\$1,000	60%	\$4,000
<input type="checkbox"/> 80%	\$2,000	60%	\$8,000
<input type="checkbox"/> 60%	\$2,000	50%	\$7,500
<input type="checkbox"/> 60%	\$4,000	50%	\$7,500

Physician Office Visits

Copays apply to In-Network only. Out-of-Network services subject to Deductible and Coinsurance.

*All other covered services (such as lab tests, injections, x-rays) payable subject to Deductible and Coinsurance.

- Covered Subject to Deductible and Coinsurance
 \$25 Copay for doctor visits only*
 \$50 Copay for doctor visits only*
 \$25 Dr. Visit Copay/\$25 Lab Tests, Injections Copay/\$50 X-rays Copay
 \$50 Dr. Visit Copay/\$25 Lab Tests, Injections Copay/\$50 X-rays Copay

\$500 Wellness Benefit

Expenses above \$500 per person per year and out-of-network expenses are not covered. Covered charges include routine physicals, immunizations, pediatric exams and preventive screenings. Pap smears, mammograms and prostate exams (including PSA tests) accumulate toward but are not subject to the benefit maximum.

- \$500 per person, per year—Subject to Deductible and Coinsurance
 Covered expenses are credited toward your deductible and are payable once deductible and coinsurance are met.
 \$500 per person, per year—First Dollar Benefit
 Pays 100% of covered expenses up to \$500 per person per calendar year without any need to meet your deductible.

Prescription Drug Coverage

See additional details of Rx Drug Coverage on Page 5.

- Pharmacy Advantage
 Generic Only—\$0 Deductible with \$12 Retail Copay (30 day supply) and \$24 Mail Order Copay (90 day supply)
 Three Tier—\$250 Deductible per person for Brand Name Only. Maximum Family Deductible of 3x per person amount. Generic \$15 Copay; Brand Formulary \$25 Copay/20% Coinsurance; Non-Formulary \$35 Copay/30% Coinsurance

Additional Deductibles for Treatment Facilities

In-Network Amounts shown (Out-of-Network Amounts are Double).

- No Additional Deductible
 \$500 Outpatient Surgical Facility/\$1,000 Inpatient Hospitalizations

Lifetime Maximum

\$5,000,000 Per Person (\$1,000,000 per person maximum on covered Centers of Excellence Organ Transplants)

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.

- Accident Expense**
 \$1,000 \$2,500 \$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.

- Critical Payment** Available for Primary Insured only. Benefit varies by age at issue.
 Age 0-40: \$25,000 Age 41-50: \$20,000
 Age 51-60: \$15,000 Age 61-64: \$10,000

- Family Protection** Additional Term Life; Available for Primary Insured only. Benefit varies by age at issue.
 Ages 49 & Under: \$35,000 Age 50-59: \$25,000 Age 60-64: \$15,000

Benefits for Specialized Situations*

Mental and Nervous Disorders

Allows 50% of covered expenses not to exceed benefits of \$2,000 per person per Calendar Year for inpatient expenses and \$550 per person per Calendar Year for outpatient expenses. Doctor visits subject to a maximum benefit of \$10 per visit. Treatment for alcoholism and substance abuse is not covered.

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 \$1,250 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 Sound Natural Teeth

Resulting from an accidental injury occurring while insured with us. Treatment must be received within 90 days of the date of injury.

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.

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

Initial 12-month Rate

To help control your costs, we will maintain your initial premium 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.

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 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 the bottom of page 6 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.

More Information About Prescription Drug Benefits

Pharmacy Advantage

The Pharmacy Advantage prescription drug program offers discounts on preferred generic and brand name drugs at more than 56,000 participating pharmacies. (Not an insurance benefit.)

When you present your prescription drug card to a participating pharmacy, you can receive overall savings when paying for your prescriptions. While savings vary by the drug and where it was purchased, those using the card can average nearly a 15% savings off standard retail prices throughout the year. You can save even more by taking advantage of the mail-order program that is available with your Pharmacy Advantage card that provides additional discounts on popular drugs.

Generic-Only*

Our Generic-only Prescription Program will save you out-of-pocket costs when you select a generic drug. You pay no more than your \$12 copay when you purchase up to a 30-day supply of a generic drug at a retail pharmacy. You can reduce the cost of your drugs by choosing generic drugs.

Take advantage of our mail-order program for generic drugs you take on a regular basis for additional savings. You pay a \$24 copay for a 90-day supply. Our mail-order program provides free shipping and easy reordering.

You can purchase brand name drugs at a discount when using your Generic-only drug program.

Three Tier*

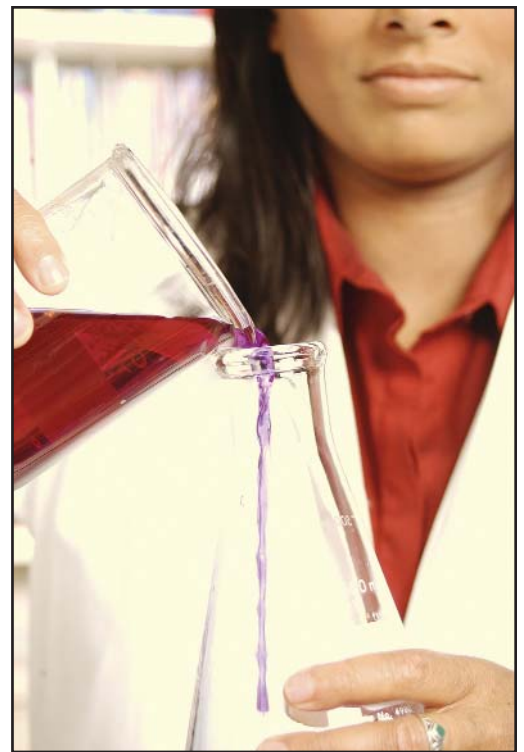
Our Three Tier Drug Program is for Generic, Formulary and Non-Formulary brand name drugs and reduces your overall cost of prescription drugs. Greatest savings are realized when you and your doctor choose formulary or generic drugs. If you choose a brand name when a generic is available and allowed by your doctor, additional out-of-pocket charges will be incurred.

The formulary is an expansive list of prescription medications that have met strict clinical criteria for safety and quality. This list is updated periodically based on a drug's safety and efficacy, therapeutic advantages, impact on patient outcomes and cost effectiveness. Our pharmacy benefit manager works with medical directors, physician providers and pharmacists to update the list.

You pay no more than your \$15 copay when you purchase up to a 30-day supply of a generic drug at a retail pharmacy. If you purchase a brand name drug, you will be subject to a \$250 prescription drug deductible. This deductible is per person per calendar year with a 3 times family maximum. If the brand name drug is on the formulary list you will then pay 20% of the drug cost after a \$25 copay. If the brand name drug is not on the formulary list, you will then pay 30% of the drug cost after a \$35 copay.

Take advantage of the mail-order program for drugs you take on a regular basis for additional savings. You pay a \$30 copay for a 90-day supply of generic drugs. Brand name drugs will be subject to the \$250 prescription drug deductible shown above. Then you will pay 20% of the drug cost after a \$50 copay if the brand name drug is on the formulary list. If the brand name drug is not on the formulary list, you will pay 30% of the drug cost after a \$70 copay. Our mail-order program provides free shipping and easy reordering.

*Outpatient drugs for Mental and Nervous Disorders are payable at 50% of covered expenses up to a \$550 per person per Calendar Year maximum benefit.



LabOne

LabOne is offered as an additional cost containment program designed to compliment your healthcare plan. LabOne does not replace existing lab benefits. LabOne is a fully accredited and certified laboratory which performs most lab tests. They offer quality laboratory testing at significant savings over other labs. LabOne is a member-driven program that provides outpatient laboratory testing for covered services when specimens are sent to LabOne.

At the time of service, simply request that lab work be sent to LabOne for processing. LabOne will submit claims for services directly to the insurance company. If a provider is unable to collect the specimen, LabOne has contracted draw sites available.

If you have a deductible of \$500 or \$1,000 you will be in the LabOne Program and the insurance company is able to cover the full cost of lab testing for covered services. Therefore, LabOne provides outpatient lab services and specimens at no charge. You pay no deductible, no copayment and no coinsurance for these lab services.

If you have a deductible of \$1,500 or greater you will be in the LabOne Select Program and will receive discounts for your lab testing and specimens for covered services. 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!

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.

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

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 Pregnancy Support Program

We want you to have a healthy baby! That's why we have developed Building Blocks, a pregnancy support program. During an initial confidential interview with an RN Case Manager, you will receive valuable educational materials and information.

The nurse can discuss any special concerns you may have and answer your questions.

After your baby is born, your nurse will continue to stay in touch with you to provide ongoing support. If you have a high-risk pregnancy, your nurse will coordinate with your physician to provide specialized case management. This service is available to you even if you do not have maternity coverage!

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.



Other Important Facts

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

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.

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.

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 self-inflicted 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 Outpatient prescription drugs under the medical plan.
- 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.

In addition, the Outpatient Prescription Drug Benefit does not cover:

- Contraceptives;
- Expenses for administration or injection of any drug;
- Non-legend drugs, except those shown as covered in the certificate booklet;
- Immunization agents, biological sera, blood or blood plasma;
- Refills in excess of the number prescribed by the physician or after one year from the original order;
- Any portion of a prescription or refill that exceeds a 30-day supply (90-day supply for mail);
- Nicorette, nicotine patches, or any other device designed to enable the person to quit smoking;
- Any type of equipment or device used to render drugs effective;
- TPN (Total Parenteral Nutrition);
- Retin-A or its therapeutic equivalent for a person over age 25;
- Minoxidil or its therapeutic equivalent or any other drug developed to treat alopecia;
- Yohimbine, progesterone, growth hormones, vitamins, fluoride supplements or minerals;
- Injectable drugs, other than those shown as covered in the certificate booklet;
- Any costs related to the mailing, sending or delivery of prescription drugs;
- Prescription or refill for drugs that are lost, stolen, spilled, spoiled or damaged.

Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act (HIPAA) and related state laws require insurance companies 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 company 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 all the following requirements:

1. Have been insured under Creditable Coverage (meaning: employer-sponsored coverage; health insurance coverage; Medicare; Medicaid; TRICARE; tribal organization programs; public health plans and Peace Corp plans) for at least 18 months with no more than a 63-day gap in coverage. **The most recent coverage must have been under an employer-sponsored, governmental or church plan.**
2. Are not eligible for coverage under an employer-sponsored plan, Medicare or Medicaid.
3. Do not have other health insurance coverage.
4. Whose most recent coverage was not terminated for nonpayment or fraud.
5. Who are not eligible for COBRA or state continuation.

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 company 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: M1AGH, M1AGL)



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