Simple HSA Plan

Single deductible health insurance plan that qualifies for use with a Health Savings Account

Underwritten and Administered by:

How it Works

Simple HSA offers affordable coverage AND savings through an optional tax-favored Health Savings Account (HSA).

This high deductible, broad coverage health plan is ideal for people who want premium savings combined with greater control over how their healthcare dollars are spent.

What is an HSA?

Health Savings Accounts (HSAs) combine a tax favored account with high-deductible health insurance. HSAs offer the following tax advantages:

- Tax-deductible: Contributions to the HSA are tax-deductible, just like an IRA.
- Tax-deferred: Interest earnings accumulate tax-deferred.
- Tax-favored: Distributions from an HSA for qualified medical expenses are tax-free.

What are qualified medical expenses that allow for tax-free distributions from an HSA?

Qualified medical expenses include:

- Out-of-pocket medical expenses such as amounts applied to your deductible and coinsurance amounts.
- Certain expenses such as:
  - COBRA coverage
  - Qualified long term care insurance
  - When individuals reach age 65 and over:
    - Any health insurance (such as Medicare) premium, other than Medicare supplement insurance
    - Premiums for individual health insurance other than a Medicare Supplement
    - Retiree medical premiums under an employer plan

The maximum annual HSA contribution is the lesser of 100% of the annual deductible under the high deductible health plan or an indexed amount which varies by year. See separate HSA brochure for current indexed amount.

HSA's offer:

- **Financial Savings** – high deductible plans are typically less expensive and deductibles can be paid with tax-free dollars.
- **Financial Growth** – you keep what you don't spend and there are many investment options for HSA funds.
- **Choice** – funds remain under your complete control and what is not spent, accumulates. Fund balances follow you if you change employment.

Who is eligible to have an HSA?

Eligible individuals must be covered under a high deductible health insurance plan.

You can not set up an HSA if:

- You do not have a high deductible health plan
- You can be claimed as a dependent on another person's tax return
- You are entitled to Medicare benefits
- You have other insurance that does not qualify as a high deductible health plan [exceptions include: coverage for accidents, disability, dental care, vision care, long term care, specified disease or illness and insurance paying a fixed amount per day (or other period) of hospitalization].

CGI Administers the Health Insurance

Continental General Insurance Company (CGI) 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 and maintain that account with a financial institution or financial advisor as the HSA administrator. Questions or inquiries regarding HSA funding need to be directed to the HSA administrator, not the insurance company.

Simple HSA Benefits

Select the Deductible and Out-of-Pocket Maximum that fits your budget.

Calendar Year Deductible (In-Network)

Individual Options:	**$1,000**	**$1,700**	**$2,000**	**$2,500**	**$5,000**
Family Options:	**$2,000**	**$3,400**	**$4,000**	**$5,000**	**$10,000**

When more than one person is covered, entire Family Deductible must be satisfied before benefits are payable.

Out-of-Network Deductible is equal to the In-Network amount and is satisfied separately.

Benefits and Coinsurance

In-Network benefits are paid at **100%**, after deductible is reached. There is no additional coinsurance for you to pay.

Out-of-Network benefits are paid at **80%** after deductible is reached. You pay 20% of remaining expenses up to the out-of-pocket maximum.

Maximum Out-of-Pocket (In-Network)

Same as your selected deductible. No additional expense once your deductible is satisfied.

Individual Options:	**$1,000**	**$1,700**	**$2,000**	**$2,500**	**$5,000**
Family Options:	**$2,000**	**$3,400**	**$4,000**	**$5,000**	**$10,000**

Out-of-Network amounts will be double the In-Network amount selected.

Included Benefits

Doctor Office Visits

Subject to Deductible and Coinsurance.

Prescriptions

Subject to Deductible and Coinsurance. Preferred pricing drug card included to lower your costs at retail network pharmacies and mail orders (up to a 90-day supply). Prescriptions will be filled with generic equivalent when available and doctor has allowed generic medication. If doctor specifies brand-name only, then cost of brand-name drug is covered and charged against deductible. If insured chooses brand name when generic is available and generic is allowed by doctor, only cost of generic is covered.

Wellness Benefit

Subject to Deductible and Coinsurance, up to $500 maximum benefit per calendar year. Pap smears, mammograms and prostate exams are covered but are not subject to the $500 calendar year maximum.

Centers of Excellence Transplants Lifetime Maximum

$1,000,000 per person

Lifetime Maximum

$5,000,000 per person

Optional Benefits

Supplemental Accident Expense

First-dollar coverage of $500 or $1,000 per person per accident. (Must choose same amount for all covered family members)

Critical Payment Rider

Benefits for Primary Insured Only—Benefit amount varies with age:

0-40: $25,000	41-50: $20,000
51-60: $15,000	61-64:$10,000

The following conditions have 100% maximum benefit payable: Life-Threatening Cancer, Heart Attack (Survived 30 days or longer), Stroke (Survived 30 days or longer), End Stage Renal Failure, Major Organ Transplant (Heart, lung, liver or pancreas), Multiple Sclerosis (After 180 days), Permanent Paralysis of Two Limbs (of 180 days or longer), Loss of Two or More Limbs.

The following conditions have a lower maximum benefit payable: Alzheimer's Disease: 50%

Coronary Artery Bypass Surgery: 25%

Angioplasty: 10%

Benefits for Specialized Situations*

Mental & Nervous Disorders
(inpatient and outpatient)

If hospitalized, covered charges are paid at 50% up to a maximum benefit of $2,000 per calendar year for inpatient expenses. Doctor visits are paid at 50% up to $10 a visit, to a maximum of $550 for a calendar year. Treatment for drug abuse is not covered. Prescription drugs are covered at 50%, up to a calendar year maximum of $550.

Treatment for Spinal Manipulation

Plans pay up to $15 a day for manipulation of spinal subluxation and associated treatment or services, with a $300 individual or a $600 family maximum benefit per calendar year. In addition, x-ray charges are payable up to a $75 individual or a $150 family maximum benefit per calendar year.

Sterilization

Benefits are provided up to a lifetime maximum benefit of $350 for sterilization.

Allergy Testing

Benefits are provided up to a maximum benefit of $500 per calendar year for the member and $1,000 for the member and dependents combined, for allergy testing and allergy injections, including, but not limited to, injectable antigens and extracts.

Growth Disorder

Benefits are provided up to a lifetime maximum benefit of $25,000 for the treatment of growth disorder or abnormally short stature, including, but not limited to, growth hormone deficiency therapy (GHDT).

Occupational, Speech and Physical Therapy

Plan pays up to $50 of allowable expenses per visit, with a maximum of $1,250 each calendar year for each of the following: occupational; speech; and physical therapy; and for related diagnostic testing. These services must be performed by licensed occupational, speech and physical therapists under the supervision of a doctor.

Hospice Benefit
(inpatient and outpatient)

We help pay for hospice care and services that are provided by a hospice care program or other hospice care provider approved by us. If inpatient hospice care is received, we pay up to $200 a day for room and board up to a lifetime maximum of $10,000. A $100 a day benefit for outpatient hospice care is allowed up to a lifetime maximum of $3,500.

Cosmetic Surgery/Treatment

Expenses for cosmetic surgery/treatment are payable if required to restore a part of the body which has been altered as a result of accidental bodily injury, surgery or disease that occurred or was first diagnosed while insured with us and for which benefits are payable.

Repair of Injury to Teeth

We will pay for repair of injury to sound natural teeth (including their replacement), as a result of an accidental bodily injury that occurs while the member is insured. Treatment must be given within ninety (90) days of the date of the accident.

Home Health Care

Benefits are limited to 40 visits per calendar year. Such care must be a part of a written home health care plan of care and prescribed by a physician in place of hospital confinement.

Treatment of TMJ & CMD

Benefits will be paid for surgery of the jaw or any treatment of temporomandibular joint (TMJ) disorder and craniomandibular disorder (CMD) up to a lifetime maximum benefit of $2,500 per insured person. This limitation does not apply to treatment of jaw fractures or removal of tumors of the jaw.

Important Features to Help Control Your Healthcare Costs

Deductible

Your deductible is the amount you pay for covered expenses during a Calendar Year before your health insurance begins paying benefits. The higher your deductible, the lower your premium. For family coverage, there is a common deductible. Covered medical expenses for all covered family members apply toward the same deductible. In order to be in compliance with the federal HSA laws, the deductible is subject to increase from year to year in compliance with the cost of living adjustment.

Out-of-Pocket Limit

Your maximum out-of-pocket limit is equal to your in-network deductible or two times the deductible for out-of-network. Once you meet your deductible, CGI pays 100% of all covered charges for the balance of the year. In order to be in compliance with the federal HSA laws, the out-of-pocket limit is subject to increase from year to year in compliance with the cost of living adjustment.

PPO Network

A Preferred Provider Organization (PPO) network is comprised of physicians, hospitals and other health care providers who have agreed to work with CGI to provide healthcare services at pre-negotiated rates. Using PPO providers is one of the most effective ways to minimize your out-of-pocket costs, receive appropriate medical care and eliminate any balance billings.

LabOne **

LabOne is another cost containment program. It does not replace existing lab benefits. LabOne is a fully accredited and certified laboratory which offers significant savings over other labs.

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

You will receive LabOne discounts for your lab testing and specimens for covered services. Claims are subject to deductible and coinsurance.

Preferred Pricing Prescription Card

Preferred pricing available through network retail pharmacies and mail orders. When you use your prescription card, claims are electronically processed with CGI. No need to send in paper receipts.

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 PPO network.

* Benefits vary by state. All benefits are subject to deductible and/or coinsurance.
** Not available in all states.

24-Hour Care Coordination

Continental General Provides These Valuable Services to Make Your Plan Even Better!

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
- Receive advice on maximizing your benefits
- Initiate inpatient precertification
- Receive general medical information. Should you need information for a specific medical condition, a medical professional will provide useful information.

Case Management – Special Care for Special Cases:
A Registered Nurse Case Manager is available to work with you and your doctor to facilitate 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:
Our Registered Nurse Case Managers help 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.

Enhanced PPO Referral Service:
Whether you are home or travelling, 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:

- 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 your CGI PPO plan

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!

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.

Disease Management Early Identification Program:
Our Health Support program allows us to help our insureds by identifying those at risk for, or who have already had diseases such as cardiac disease, diabetes and asthma. 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.

Important Information

(May vary by state)

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 CGI for certain administrative and other services it provides to the Association. CGI does not receive any other compensation from the Association.

Hospital Preadmission Certification*

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 Precertification will result in a precertification penalty of $500 or 20% of covered charges, up to $1,000 maximum, whichever is greater, for each treatment 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; (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.

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

Applications Are Subject to Underwriting and CGI Approval

Upon receipt of the application at CGI, the Member will receive a verification telephone call to confirm that the application is completed correctly. The application will then be reviewed by CGI underwriters. 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 CGI's Home Office. Should CGI reject the application, its only obligation will be the return of premium money.

Health Insurance Portability and Accountability Act

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, CGI will offer coverage to Eligible Individuals. Refer to the state-specific page(s) that follow the Exclusions and Limitations 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.

* Obtaining precertification does not assure that benefits will be paid for the hospitalization. CGI will make the final determination whether benefits are payable based on the terms of the Policy, following submission of the claim.

Exclusions and Limitations

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 storage of 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 Injury or Sickness 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 may be 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.
- 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, except for strabismus and amblyopia.
- For Treatment, services or supplies furnished by a department or agency of the United States Government.
- For services and supplies eligible for payment by a governmental or charitable program, except as required by law.
- For hearing aids, including fittings and examinations.
- Which are not Necessary to the care or Treatment of an Injury or Sickness.
- Which would not have been made if no insurance existed.
- For recreational or educational therapy or vocational rehabilitation.
- Except as allowed under Covered Expenses Subject To Limitations, for speech or occupational therapy and related diagnostic testing.
- For which the Insured Person is not legally obligated to pay.
- For Treatment or services which are not generally accepted medical practices in the United States for a given Injury or Sickness.
- 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.
- For Preexisting conditions (refer to page 6).
- For a private room in excess of the average semiprivate Room and Board rate.
- In excess of 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 an Injury or Sickness caused by any act of war, whether or not declared.
- For surrogate pregnancy.
- For breast reconstruction, unless due to a Medically Necessary mastectomy or to produce a symmetrical appearance of the other breast related to a mastectomy.
- For the Treatment of complications with a surgical or medical Treatment that is not a covered surgical or medical Treatment.
- For Services and supplies that are covered under an extension of group health benefits provision by a previous employer-related health plan, health insurance plan or other coverage arrangement.
- For Injury that results either directly or indirectly from the Insured Person's participation in a hazardous activity, including, but not limited to: aviation; bungee jumping; hand gliding; piloting or riding in a hot air balloon; mountain/rock climbing; participating in rodeo events; scuba diving below 75 feet; skydiving/parachuting; piloting experimental or ultra-light aircraft; vehicle racing, competing, qualifying and/or testing (auto, motorcycle, powerboat, snowmobile and other types of vehicles); and driving or riding in all-terrain and off-road vehicles (3 and 4 wheelers).
- For Injury or Sickness, or complications thereof, 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, or as the result of continued use of these substances, unless it has been administered or prescribed on the advice of a Doctor/Physician and taken as recommended.
- For Injury or Sickness that results either directly or indirectly from the Insured Person's committing or attempting to commit or participation in a felony.
- 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 this 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.
- For elective abortion.
- For genetic testing.
- For alcoholism, drug Treatment or chemical dependency.

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 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.

Please Note

- This 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.
- State laws may require that the coverage described in this brochure or on the website may be changed. Please refer to your State Specific Benefits for a description of these changes, if applicable.
- This plan is not being sold as an employment benefit plan, and the employer is not responsible, either directly or indirectly, for paying the premium or benefits; therefore, 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.
- If a Preferred Provider Organization (PPO) is used in conjunction with this certificate, the PPO list is subject to change (modifications, deletions or additions) without advance notice to the insured person.

For more information on this plan, contact your local QQLink agent.

At Continental General Insurance Company (CGI), we believe our success is measured by the well-being of our insureds. For more than 40 years, we have offered health insurance products at affordable prices. Our mission is to fully serve the needs of all those associated with our company.

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