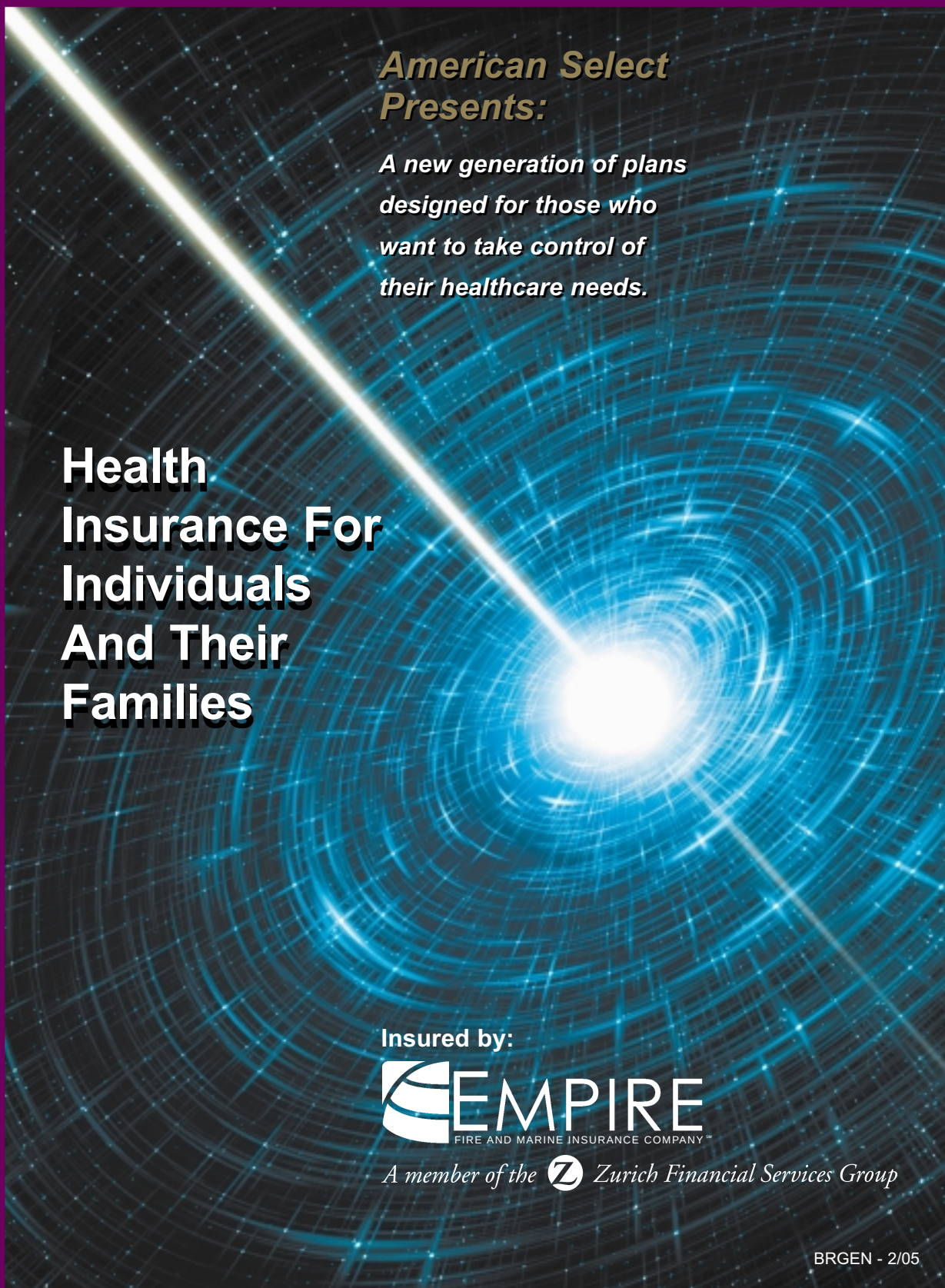
StarCare

Association Group Major Medical Plans

- Up To $5,000,000 Lifetime Maximum Benefit
- Physician Office Visit Copay And Rx Copay Drug Card Included
- Family Premium Discount
- Preferred Health Discount
- Plan Flexibility Via Deductible, Coinsurance And Optional Rider Choices
- Simplicity - Two Plans To Choose From
- Choice Of Multiple PPO Networks
- Initial 12 Month Rate Guarantee



American Select Presents:

A new generation of plans designed for those who want to take control of their healthcare needs.

Health Insurance For Individuals And Their Families

Insured by:

EMPIRE
FIRE AND MARINE INSURANCE COMPANY℠

A member of the Zurich Financial Services Group

BRGEN - 2/05

A Choice of 2 Major Medical Benefit Plans

The policy will pay 100% of covered expenses up to the Lifetime Maximum after you have met your Out-Of-Pocket Expenses(1)

Benefit	OPTIMUM PPO	COST SAVER PPO
Lifetime Maximum Benefit	$5,000,000	
Calendar Year Deductibles	$1,500, $2,500 Maximum two individual calendar year deductibles per family	$1,500, $2,500 Maximum three individual calendar year deductibles per family
Coinsurance/Stop Loss - PPO and NonPPO stop loss accumulate separately	*PPO* 80/20%-$5,000 80/20%-$10,000 50/50%-$10,000	*NonPPO* 60/40%-$10,000 60/40%-$20,000 50/50%-$20,000
Physician Office Visits - Copay(2) applies to physician office visit charge	$35 PPO(3) Includes covered lab exams, x-rays and diagnostic tests up to $100 NonPPO - Subject to copay plus deductible and NonPPO coinsurance and covers office visit charge only	$50 PPO Covers office visit charge only NonPPO subject to copay plus selected deductible and NonPPO coinsurance
Service Deductibles(2) Inpatient Hospital Admission (per admission) Outpatient Ambulatory Surgical Facility (per visit) Outpatient Testing(4) (per visit) Hospital Emergency Room(5) (per occurrence) Outpatient MRI, Cat Scan and Nuclear Imaging Test (per test)	$100 per admission, per visit, per test or per occurrence	$200 per admission, per visit, per test or per occurrence
Outpatient Prescription Drugs Rx Copay Drug Card	Rx Drug Copays: $15 Generic, $25 Formulary, $40 Brand Name Copay applies after a $500 separate Rx calendar year deductible per insured	
Optional Benefits	Supplemental Accident 24 Hour Occupational Coverage	

(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) Copay and service deductible, if applicable, are in addition to the chosen calendar year deductible/coinsurance and do not apply to the calendar year deductible.

(3) After your chosen PPO copay, balance of PPO office visit charge paid at 100%. Additionally, after your chosen copay, x-rays, lab exams and diagnostic tests up to $100 performed by and billed from a PPO physician paid at 100%. Covered expenses in excess of $100, expenses billed by an outside lab, and all other covered services performed during the office visit are subject to calendar year deductible and coinsurance.

(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 and Nuclear Imaging Test Service Deductible.

(5) Waived if admitted as an inpatient immediately following emergency room occurrence.

American Select StarCare Series Plan Benefits and Features*

What's Covered or Included in These Plans?

All benefits subject to applicable copay, deductibles and coinsurance unless otherwise stated or mandated.

OPTIMUM PPO	COST SAVER PPO
Ambulance Service (maximum benefit per occurrence) - $1,000 for ground or water, $5,000 for air	
Anesthetics and their Administration	
Chemotherapy and Radiation Therapy	
Dental Treatment to Sound Natural Teeth resulting from a covered injury	
Dressings, Sutures, Casts, Splints, Trusses, Crutches, Rental of Durable Medical Equipment	
Emergency Treatment Received Outside the U.S.	
Hospital Daily Room and Board (semi-private rate), Hospital Inpatient Miscellaneous Medical Services and Supplies, Hospital Outpatient Services	
Inpatient Psychiatric Care, Chemical Dependency, Substance Abuse, Alcohol and Drug Rehabilitation - Up to 55 days or $2,000 per calendar year, whichever occurs first	
Outpatient Psychiatric Care - 50% coinsurance up to $20 per visit with a maximum of 55 visits per calendar year	
Organ Transplants or Replacements - For specific transplants or replacements	
Oxygen and Rental of Equipment for the Administration of Oxygen	
Physical, Respiratory and Speech Therapy for Rehabilitative Treatment	
Physician Charges - Inpatient and outpatient	
Preexisting Conditions - Covered if disclosed on the application and not otherwise excluded under the policy or by rider or endorsement	
Skilled Nursing Facility for Convalescent Care	
Confinement in an Intensive, Intermediate, Observation or Specialized Care Unit - No limits	**Confinement in an Intensive, Intermediate, Observation or Specialized Care Unit** - Not to exceed 3 times the hospital's semi-private room rate
Home Health Care (in lieu of a covered hospital confinement) - Up to 40 visits per calendar year	**Home Health Care** (in lieu of a covered hospital confinement) - Limited to a $2,500 maximum benefit per calendar year
Homeopathic Treatment - When provided by a licensed homeopathist up to $50 per visit to a maximum of $500 per calendar year	**Homeopathic Treatment** - Not covered
Hospice Care - Up to a $5,000 lifetime maximum	**Hospice Care** - Up to a $2,000 lifetime maximum
Hospice Care Bereavement Counseling (not subject to calendar year deductible, service deductible, copayments or coinsurance) - Covered up to 3 months after insured's death up to maximum of $500	**Hospice Care Bereavement Counseling** - Not covered
Private Duty Nursing - Up to $2,000 per insured per calendar year	**Private Duty Nursing** - Up to $1,000 per insured per calendar year
Spinal Manipulation and other Manipulative Therapy - Up to 15 visits per insured per calendar year	**Spinal Manipulation and other Manipulative Therapy** - Up to $500 per insured per calendar year
Preventive Care Benefits* (subject to applicable copay, deductibles and coinsurance unless otherwise stated or mandated)	
Child Health Supervision (includes immunization) - Specific age intervals from birth to 6 years	
Pap Smear - One screening per calendar year	
Mammograms - One baseline 35-39. Age 40 and over covered yearly	
Prostate Cancer Screening (PSA) Tests - One per calendar year for males age 40 and over	
Routine Physical Exams - Covered after insured 12 months; up to $150 maximum per examination per covered member/spouse per benefit period (every two years), including lab tests (blood/urine) associated with the same routine physical exam. Subject to coinsurance only.	**Routine Physical Exams** - Not covered

* Plan benefits, including Preventive Care Benefits, may be subject to exclusions, limitations and maximum benefits and may vary by state. Complete description of benefits is contained in the Master Policy and outlined in the Certificate. All covered expenses are subject to any applicable calendar year deductible, service deductibles, copayments, coinsurance and policy maximums, unless otherwise specified.

Rx Copay Drug Card

Outpatient covered prescription drugs are subject to a separate $500 Rx calendar year deductible per person and then subject to the following copays:

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

Rx Copay Card

$15 generic
$25 formulary
$40 brand name

For all plans, a reduced benefit may be offered 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 Copay Drug Card and pay the deductible and applicable copay. 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 Copay 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 certificate.

While you are meeting your Rx Copay Drug Card deductible, and for drugs not covered under the Rx benefit, simply present your Rx Card at an affiliated network pharmacy to receive a discount on drug purchases. While the cost of the drug is your responsibility until your deductible is met and the plan benefits are payable, you can enjoy the valuable discount when you utilize the affiliated pharmacy(ies). The Rx discount is not an insurance benefit. The Rx discount is not available for drugs purchased at pharmacies not affiliated with Express Scripts.

Additional Plan Features

Calendar Year Deductible Carryover - Covered expenses incurred during the last three months of a calendar year that are applied to the medical plan's calendar year deductible will also apply toward the following year's calendar year deductible. This does not apply to the separate Rx Drug Card deductible.

Common Accident Deductible - If two or more covered persons sustain an injury in the same accident, only one calendar year deductible will be applied to all covered medical expenses arising out of that accident..

Initial 12 Month Rate Guarantee - Initial premium rates, excluding fees, guaranteed for 12 months. Initial premium rates may change if you move, change your plan or add/delete covered dependents.

Medical Emergencies - Medical benefits for emergency (as defined in the policy) services will be considered for payment at participating provider benefit level. Emergency services must be provided within 72 hours following the onset of the injury or illness.

Medically Necessary Covered Services Not Available From A PPO Provider - and referred to a NonPPO provider will be considered for payment at PPO level.

Discounts

* Family premium discount of 5% applies when a certificate is issued with two or more family members applying together.

* Preferred Health discount of 20% applies to qualified individuals ages 18-39.

Optional Benefits

Supplemental Accident - 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.

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 inforce. 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 occupation. 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 certificate 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.

General Information

*** Effective dates are the 1st or 15th of a month contingent on underwriting approval.**

*** 10 Day Free Look Provision.**

Eligibility:

* Members can apply for coverage if they are a dues paying member of Consumer Benefits of America between the ages of 18 through 64.
* Member's dependents can apply for coverage if they are a legally married spouse through age 64, and unmarried dependent children under age 19 (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 18 (24 if full-time student). Parent must be enrolled as a member of CBA.

Termination of Insurance:

Insurance will remain in force until:

* The date there is fraud or material misrepresentation with regard to the policy or its benefits.
* The date the member'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 member.
* The premium due date following the date the insurer terminates all certificates in a specific state.
* 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 (or 25 if a full-time student). (Termination of covered member'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 certificate be cancelled due to claims on an individual basis.

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

Precertification of Care

Hospital admissions and certain procedures, services or supplies, as outlined in the Policy, require precertification before a covered person receives them. PRECERTIFICATION IS NOT PREAUTHORIZATION AND DOES NOT GUARANTEE THAT AN ADMISSION, SERVICE OR PROCEDURE IS COVERED UNDER THE POLICY.

Non-Precertification Penalty

Failure to precertify when required will result in a $500 non-precertification penalty.

Claim Examples

Optimum PPO 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

If you choose a hospital:	In Network	Out of Network
Covered Expenses*	$100,000	$100,000
Less Inpatient Hospital Service Ded. Amount**	- 100	- 100
	$ 99,900	$ 99,900
Less Cal. Yr. Ded. Amount**	- 2,500	- 2,500
	$ 97,400	$ 97,400
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	**$ 96,400**	**$ 93,400**
TOTAL You pay	**$ 3,600**	**$ 6,600**

Physician Office Visit (POV)

If you choose a physician:	In Network	Out of Network
Office Visit Charge	$ 150	$ 150
Less POV Copayment Amount**	- 35	- 35
	$ 115	$ 115
POV Exam/Lab Charges	$ 100	$ 100
Less Amount Applied Toward Cal. Yr. Ded. Amount**	$ 0	$ 215
TOTAL The Plan pays	**$ 215**	**$ 0**
TOTAL You pay	**$ 35**	**$ 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	$2,000
OAS Facility Svc. Ded. (You Pay)**	**-100**	**-100**
Less Cal. Yr. Ded. Amount** (assumes previously satisfied)	Satisfied	Satisfied
Less Coins. at 80% In-Network; 60% Out-of-Network	-1,520	-1,140
Subtotal (You Pay)	**$ 380**	**$ 760**
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	**$3,120**	**$2,340**
TOTAL You pay	**$ 880**	**$1,660**

* 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.

Cost Saver PPO 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

If you choose a hospital:	In Network	Out of 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)

If you choose a physician:	In Network	Out of Network
Office Visit Charge	$ 150	$ 150
Less POV Copayment Amount**	- 50	- 50
	$ 100	$ 100
POV Exam/Lab Charges	$ 100	$ 100
Less Amount Applied Toward Cal. Yr. Ded. Amount**	$ 100	$ 200
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	$2,000
OAS Facility Svc. Ded. (You Pay)**	**-200**	**-200**
Less Cal. Yr. Ded. Amount** (assumes previously satisfied)	Satisfied	Satisfied
Less Coins. at 80% In-Network; 60% Out-of-Network	-1,440	-1,080
Subtotal (You Pay)	**$ 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 & Limitations

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

• preexisting conditions; • **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; • expenses covered by any optional rider attached to the policy providing additional benefits; • 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, which are covered by other insurance, except Medicaid, 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; • diagnosis and 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; • 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) being under the influence of alcohol; • dental treatment or care; • orthodontia or other treatment involving the teeth and supporting structures; • treatment by any method for jaw joint problems including temporomandibular joint dysfunction (TMJ), TMJ pain syndromes, craniomandibular disorders, myofascial pain dysfunction or other conditions of the joint linking the jaw bone (mandible) and skull and the complex of muscles, nerves and other tissues related to the joint; • 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; • 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, 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

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 or certificate, 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 or certificate, are covered from the effective date of coverage under the policy.

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 Master Group Policy. It is not a contract. The Policy provisions will govern in all circumstances.

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.

Consumer Benefits of America

Money Saving Programs

for
Self-Employed Persons,
Family Groups
and
Individuals

Membership benefits include:

- Accidental Death and Dismemberment Coverage
- Car Rental Discounts
- Discount Vision Program
- Discount Flowers and Gifts
- Hotel Discounts
- Integrative Medicine Library Website
- LegalCare - Free Unlimited Telephone Consultations
- Merchandise Discounts
- Moving Discounts
- Worldwide Assistance Service
- Vacation and Cruise Discounts
- 24-Hour Nurse Network - Unlimited Telephone Calls
- And more!!

Consumer Benefits of America's mission is to promote consumer awareness in the marketplace. The association membership includes benefits which are designed to enhance the mission and provides members with the advantage of "group buying".

Underwritten By

EMPIRE FIRE AND MARINE INSURANCE COMPANY
Omaha, NE

Empire is rated A (Excellent) by A.M. Best Company (A.M. Best is an independent analyst of the insurance industry; rating based on financial and operating performance)

A member of the Zurich Financial Services Group

Check for state availability.
Policy Form #EM 28 01 (02-01)-P
Master Group Policy: StarCare Optimum PPO: Policy #SC 05/04-001
StarCare CostSaver PPO: Policy #SC 05/04-002

The Master Group Policy is issued to Consumer Benefits of America in the state of Illinois. Benefits, exclusions, limitations and availability may vary by state. Insurance premiums vary by age, sex, state, zip code, plan deductibles and coinsurance selected, effective date and underwriting decision. Premiums may also vary based on PPO network and occupation.

National Program Manager

American Select
INSURANCE MANAGEMENT CORPORATION

Marketed By

US Select Marketing division