TO: BROTHER PRESIDENTS – RETIRED FIREFIGHTERS ASSOCIATIONS

FROM: BOB CHECCO – PRESIDENT
RETIRED NYC FIREFIGHTERS
MARTIN/ST.LUCIE DIV. FL.
WWW.FDNYFLORIDARETIREES.COM

DATE: JANUARY 14, 2008

SUBJECT: CATASTROPHE INSURANCE

I WOULD LIKE TO TELL MY STORY CONCERNING THE CATASTROPHE INSURANCE I HAVE BEEN CARRYING FOR MANY, MANY YEARS. (UFOA MARSH INSURANCE) (UFA SEABURY & SMITH CATASTROPHE INS. FORMERLY ALBERT H. WOHLERS & CO.)

AT OUR MARCH 2007 MEETING I MENTIONED THAT MY WIFE SPENT FOUR DAYS IN THE HOSPITAL IN DECEMBER 2006. COST $21,478.77. THEN SHE SPENT THREE DAYS IN THE HOSPITAL IN MARCH 2007. COST $68,691.57. OUT OF POCKET I PAID $300.00 FOR EACH HOSPITAL STAY. MY COVERAGE IS MEDI-CARE PRIMARY AND SECONDARY GHI.

I DID NOT FILE ANY CLAIM FOR THE ABOVE HOSPITAL STAYS. BECAUSE I WAS UNDER THE IMPRESSION I HAD TO LAY OUT OF POCKET $10,000.00 BEFORE THE CATASTROPHE INSURANCE KICKED IN. ONE OF THE BROTHERS AT THE MEETING SAID TO ME, "FILE A CLAIM, YOU ARE ENTITLED TO BE REIMBURSED FOR THE $600.00

I FILED A CLAIM AND I RECEIVED TWO $300.00 CHECKS.

I WAS THEN TOLD BY ONE OF THE BROTHERS THAT I SHOULD FILE FOR ANY MONEY I PAID OUT OF POCKET FOR ANY PRESCRIPTIONS MY WIFE ORDERED SINCE DECEMBER 2006. ONCE YOU FILE A CLAIM AND IT IS ACCEPTED, THE BENEFIT PERIOD IS THREE YEARS.

I FILED ALL THE EXPRESS SCRIPT AND WALGREEN PRESCRIPTIONS RECEIPTS SHE USED FROM DECEMBER 2006 TO NOVEMBER 2007. TOTAL $2,000.00. I FILED THIS CLAIM OCTOBER 23, 2007 AND RECEIVED FOUR CHECKS IN NOVEMBER 2007 TOTALING $2,000.00

AFTER THE ABOVE I CALLED APPROXIMATELY 15 ACTIVE AND RETIRED BROTHERS, AND THEY ALL FELT AS I, THAT $10,000.00 HAD TO COME OUT OF YOUR POCKET BEFORE YOU FILE A CLAIM. NOT SO.

THIS IS THE STORY FROM A GUY WHO SPENT A WEEK IN THE HOSPITAL JULY 2004 AND NEVER FILED A CLAIM - BECAUSE I NEVER LAID OUT $10,000.00.

I HOPE THE ABOVE HELPS SOMEONE. THE ABOVE SHOWS THE IMPORTANCE OF BELONGING TO A RETIREE ASSOCIATION.

MARSH
Affinity Group Services
a service of Seabury & Smith

Are you thinking about filing a Catastrophe Major Medical claim?

If you are, please take a few moments to review this letter and the enclosed material.

Filing a claim under your UFOA Catastrophe Major Medical plan:

Step 1

Ask your health care provider for a fully itemized bill. An itemized bill contains:

- The patient's name;
- The date(s) of service;
- A description of the services, prescriptions or supplies
- Appropriate medical or drug coding (CPT/HCPCS/Revenue codes or NDC #)
- The fee for each service, prescription or supply;
- The diagnosis or ICD-9 code; and
- The name, address, telephone number, professional status and Federal Tax Identification number of the health care provider.

Step 2

Submit your itemized bills directly to all of your basic medical insurance carriers. Your health care provider may file your claim for you. Please check with them.

Be sure to keep copies of all the itemized bills for your records.

Step 3

Once you have received the corresponding EOB's from all your other insurance carriers along with any appeal determinations, fully complete the front and back of the enclosed UFOA Catastrophe Major Medical claim form.

Attach copies of the itemized bills you wish to submit for consideration under the UFOA Catastrophe Major Medical plan and copies of all corresponding EOB's from your basic medical insurance plans.

Keep copies of all information submitted to this plan for your records.

Mail to: United States Life Ins. Co.
PO Box 1581, MSN 2E
Neptune, NJ 07754-1581

All charges submitted will be considered in accordance with the provisions of the plan. Submitted charges cannot be withdrawn.

If additional information is needed to make a determination regarding your claim, every effort will be made to obtain that information directly from your health care providers, while keeping you informed.

If you have any questions, please feel free to call our Customer Service Department toll-free at 1-888-895-1095 option # 1.

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The United States Life Insurance Company
in the City of New York

A member company of American International Group, Inc.

Mail to:

United States Life Ins Co
P O Box 1581, MSN 2E
Neptune, NJ 07754-1581

1-888-895-1095

Name of Insured (first, middle initial, last) (Please Print)			Social Security Number	Policy Number E-199,141	
Insured's Address, Street & No.			City	State	Zip
Phone No.	Date of Birth	Male ☐ Female ☐	Employed At	Occupation	
Single ☐ Divorced ☐ Other ☐ Married ☐ Widowed ☐	If Married, Spouse's Name			Spouse's Date of Birth	
Patient's Name for whom claim is being made (first, middle initial, last)			Patient's Relationship to Insured	Single ☐ Married ☐	
Patient's Address, Street & No.			City	State	Zip
Patient's Sex Male ☐ Female ☐	Patient's Date of Birth	If over age 19 and attending school or college, give name and address of school			
Nature of Sickness or Injury	Date first treated for this condition	If related to an injury, how, when and where did the injury occur?			
If hospitalized, give name and address of hospital			Dates of confinement		
Treating Physician's Name					
Treating Physician's Address, Street & No.		City	State	Zip	
Treating Physician's Telephone Number					

Please indicate by checking yes or no and providing the policy number if you and/or the patient have coverage under any of the following plans.

Medicare - Yes ☐ No ☐ Policy # _____ GHI - Yes ☐ No ☐ Policy # _____

United - Yes ☐ No ☐ Policy # _____ H.I.P. - Yes ☐ No ☐ Policy # _____

BlueCross - Yes ☐ No ☐ Policy # _____ AARP - Yes ☐ No ☐ Policy # _____

Other - Yes ☐ No ☐ Policy # _____

Please list all other coverages you and/or the patient may have.

Policy # _____ Insurance Co. Name & Address _____

Policy # _____ Insurance Co. Name & Address _____

_____ _____

Signature of Insured Date

AIG AMERICAN GENERAL

Health Insurance Portability and Accountability Act ("HIPAA")
Authorization to Obtain and Disclose Information

Patient's Name	Date of Birth	Social Security Number

I hereby authorize all of the people and organizations listed below to give The United States Life Insurance Company in the City of New York and the American General Life Companies LLC, (an affiliated service company), collectively the "Companies", and their authorized representatives, as well as other agents and insurance support organizations, (collectively, the "Recipient"), the following information:

- any and all information relating to my health (except psychotherapy notes) and my insurance policies and claims, including, but not limited to, information relating to any medical consultations, treatments, or surgeries; hospital confinements for physical and mental conditions; use of drugs or alcohol; and communicable diseases including HIV or AIDS.

I hereby authorize each of the following entities to provide the information outlined above:

- any physician or medical practitioner;
- any hospital, clinic or other health care facility;
- any insurance or reinsurance company (including, but not limited to, the Recipient or any other AIG American General company which may have provided me with life, accident, health, and/or disability insurance coverage, or to which I may have applied for insurance coverage, but coverage was not issued);
- any consumer reporting agency or insurance support organization;
- my employer, group policy holder, or benefit plan administrator; and
- the Medical Information Bureau (MIB).

I understand that the information obtained will be used by the Recipient to:

- determine my eligibility for benefits under and/or the contestability of an insurance policy; and
- detect health care fraud or abuse or for compliance activities, which may include disclosure to MIB and participation in MIB's fraud prevention or fraud detection programs.

I hereby acknowledge that the insurance companies listed above are subject to federal privacy regulations. I understand that information released to the Recipient will be used and disclosed as described in the AIG American General Notice of Health Information Privacy Practices, but that upon disclosure to any person or organization that is not a health plan or health care provider, the information may no longer be protected by federal privacy regulations.

I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization or other law allows the Recipient to contest a claim under the policy or to contest the policy itself, by sending a written request to: United States Life Ins. Co., PO Box 1581, MSN 2E, Neptune, NJ 07754-1581. I understand that my revocation of this authorization will not affect uses and disclosure of my health information by the Recipient for purposes of claims administration and other matters associated with my claim for benefits under insurance coverage and the administration of any such policy.

I understand that the signing of this authorization is voluntary; however, if I do not sign the authorization, the Companies may not be able to obtain the medical information necessary to consider my claim for benefits.

This authorization will be valid for 24 months or the duration of any claim for benefits under my insurance coverage, whichever is later. A copy of this authorization will be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

_____ _____

Name Date

_____

Signature of Patient/Guardian/Representative

AIG AMERICAN GENERAL

Fraud Statement

FOR RESIDENTS OF:

ALASKA: A person who knowingly and with intent to injure, defraud, or deceive an insurance company files a claim containing false, incomplete, or misleading information may be prosecuted under state law.

ARIZONA: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

ARKANSAS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

CALIFORNIA: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

COLORADO: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

DELAWARE: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

FLORIDA: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

HAWAII: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

IDAHO: Any person who knowingly, and with intent to defraud or deceive any insurance company, files a statement containing any false, incomplete or misleading information is guilty of a felony.

INDIANA: A person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete or misleading information commits a felony.

KENTUCKY: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

LOUISIANA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

MAINE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

MINNESOTA: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

NEVADA: Any person who misrepresents or falsifies essential information requested on this form may, upon conviction, be subject to a fine and imprisonment under state or federal law, or both.

NEW HAMPSHIRE: Any person who, with a purpose to injure, defraud or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

NEW JERSEY: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

NEW MEXICO: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

OHIO: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

OKLAHOMA: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

OREGON: Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application, or (2) by filing a claim containing a false statement as to any material fact, may be violating state law.

PENNSYLVANIA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

TENNESSEE: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

TEXAS: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

VIRGINIA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

WASHINGTON: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

WEST VIRGINIA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

FOR RESIDENTS OF ALL OTHER STATES NOT LISTED ABOVE:
Warning: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim, containing any materially false information, or conceals for the purpose of misleading, information concerning any facts materially thereto, commits a fraudulent insurance act, which may be a crime and subject such person to criminal and civil penalties.

GLOSSARY

These are some key terms you may hear or see during the processing of your claim. Please keep this list handy in case you need to refer to it. Please note, however, it is not a legal document. Your UFOA Catastrophe Major Medical provisions are found in your certificate.

ALLOWABLE CHARGE/APPROVED AMOUNT
Medical expenses listed as eligible in the certificate, which the patient actually incurred and is legally obligated to pay.

When a medical provider gives a discount or agrees to accept the base plan allowance as payment in full, the provider is agreeing to reduce their charges, and the balance of their original charge is written off. Since you are not legally obligated to pay the amount written off by the provider, that amount cannot be applied toward your deductible. Claims involving Medicare, HMO's, PPO's, pharmacy discounts, and prompt payment discounts are examples of such situations.

BENEFIT PERIOD
Your benefit period begins on the date your first eligible expense is incurred toward the deductible, and will end upon whichever comes sooner: the completion of three years from the day the first eligible expense toward the deductible was incurred; or when $2,000,000 has been paid; or the end of twelve consecutive months during which no charge was incurred for injury or sickness; or if after 24 consecutive months from the date your first eligible expense was incurred, 90 consecutive days pass without at least $150 of eligible expenses being incurred.

CONVALESCENT/CUSTODIAL CARE
Convalescent Home is a licensed institution that maintains a daily record on the condition of and the services rendered to each patient, and has on its premises: organized facilities to care for and treat its patients, a staff of physicians to supervise such care and treatment, and a registered nurse on duty at all times.

Custodial Care Facility means a licensed facility that provides care made up of services and supplies needed by an insured person to assist him or her in the activities of daily living. Such facility must maintain a daily record on the condition of and services to each patient.

A copy of the facility license will be required to determine if the facility qualifies under the policy.

EXPLANATION OF BENEFITS
An explanation of benefits, also known as an EOB, is a statement of payment or denial from your health insurer, providing a detailed description of how benefits were provided under their plan for a claim filed with them. This explanation usually includes the amount paid, the benefits available, reasons for denying payment, and any applicable appeal process.

ITEMIZED BILL
An itemized bill provides a breakdown of the health care provider's fee and contains:

- The patient's name;
- The date(s) services were rendered;
- A description of the services rendered, the CPT/Revenue code(s) for each service, and the fee for each service;
- The diagnosis or ICD-9 code; and
- The name, address, telephone number, professional status, and Federal Tax Identification number of the health care provider.

HOME HEALTH CARE
If you need care at home while you are recovering, your UFOA Catastrophe Plan will cover up to 100 visits per calendar year (maximum 4 hours per visit) in any one benefit period. Coverage is provided for part-time or intermittent home health care aide services, physical therapy, occupational therapy, and speech therapy.

The visits must be under a program of care prescribed by your physician and provided by a certified health care agency. Treatment/services must be in lieu of a confinement in a hospital or skilled nursing facility.

Daily records of treatment will be required, as well as itemized bills from the agency.

LICENSED
This means a health care provider has met certain standards set by a state or local government agency.

MEDICALLY NECESSARY
Service or supplies that:

- Are proper and needed for the diagnosis or treatment of your medical condition;
- Are provided for the diagnosis, direct care, and treatment of your medical condition;
- Meet the standards of good medical practice in the local area, and
- Are not mainly for the convenience of you or your doctor.

PLAN OF CARE
A written plan for your care set up and approved by your physician. It tells what services you will get in order to reach and help you keep your best physical, mental, and social well being.

PROPER PROOF OF LOSS
Examples of proper proofs of loss are itemized bills from your medical providers and explanations of benefits from your base plan insurance carrier. Proper proof of loss does not include cancelled checks, balance due statements, or cash register receipts.

REASONABLE AND CUSTOMARY
"Reasonable and Customary" means the charge is the normal charge for a certain procedure or service performed by individual medical providers in your area. When applying expenses toward the deductible, the eligible expenses will be the reasonable and customary allowance, which may be less than the medical provider charged.

TREATMENT PLAN
All services and supplies ordered by a doctor and furnished/coordinated by home health care providers.