

Major medical insurance

Personal Health Plans

Simple solutions for individuals and families



Personal Health Plans are underwritten by Standard Security Life Insurance Company of New York, a member of The IHC Group. The IHC Group is an insurance organization composed of Independence Holding Company (NYSE: IHC) and its operating subsidiaries. The IHC Group has been providing life, health and stop-loss insurance for nearly 30 years. For information on Independence Holding Company and The IHC Group, visit www.ihcgroup.com.

Personal Health Plans are available to members of Communicating for America, Inc. (CA). Membership in CA is not required for residents of Georgia, Kansas, Montana and South Dakota.



IHC PHP 0211



Simple solutions to take control of your medical costs.

Most families have to budget for every aspect of their financial life; from their housing costs to the type of vehicle they drive to their grocery spending. Budgeting for health care, however, has been difficult due to the lack of available options and tools. Many consumers have chosen to budget based on the premium cost, with little thought to the out-of-pocket costs associated with health care. The Personal Health Plans portfolio has numerous options to meet your budget and your situation.

Our Personal Health Plans are built on provider choice:

Network options

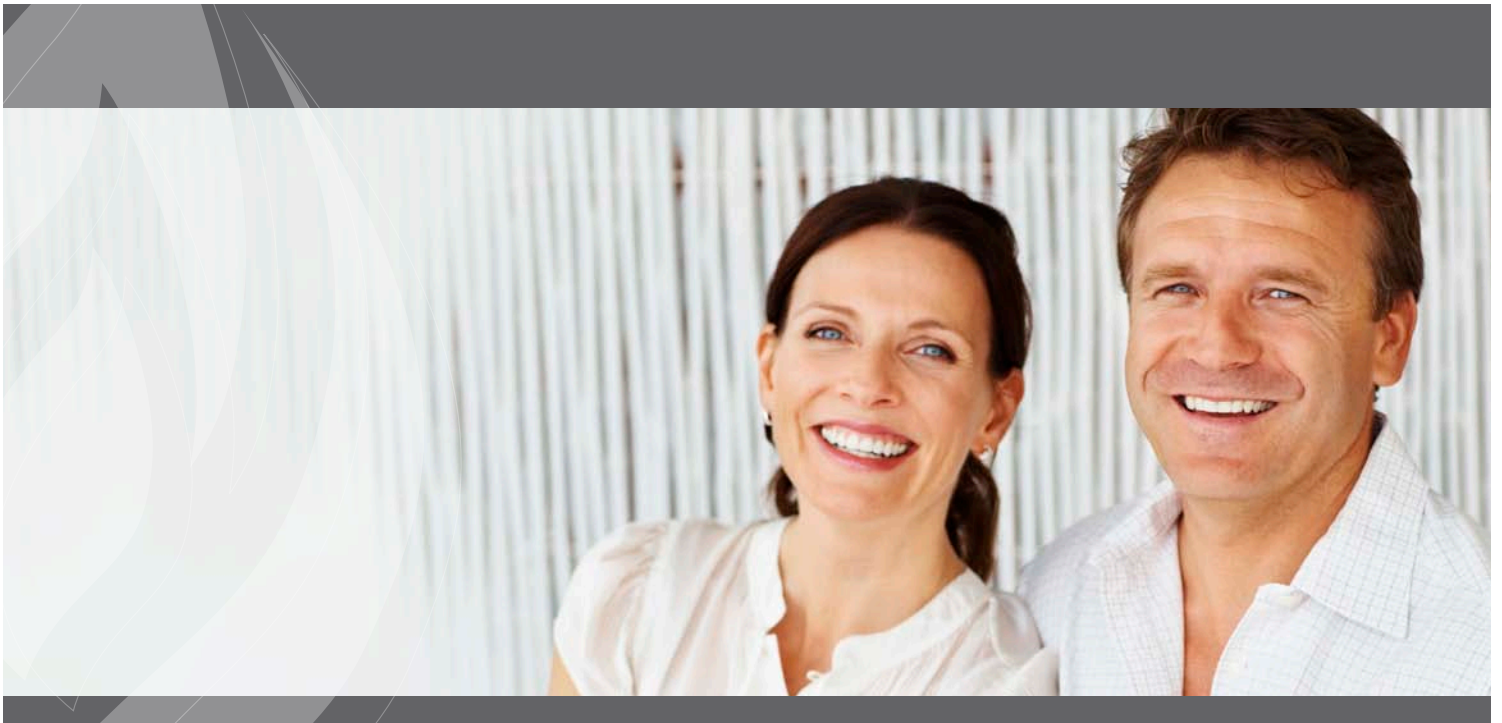
With Personal Health Plans you can choose among the preferred provider networks that we have available in your area. You will receive the highest level of coverage when your health care services are performed by providers within your selected network.

Emergency care

When emergency medical attention is needed, you can receive care without worrying about finding an in-network provider. Covered charges resulting from emergency services received from an out-of-network provider will be considered in-network, subject to the Usual and Reasonable Charge. Transfer to an in-network facility or provider must be arranged within 48 hours or as soon as the transfer can take place without detriment to your health.

Forced providers

Certain providers, such as radiologists, pathologists, anesthesiologists and assistant surgeons may have relationships with network facilities but have chosen not to be included in your selected PPO network. Knowing that you are not always able to select these providers when admitted to an in-network hospital, Personal Health Plans considers charges for these 'forced providers' at the in-network benefit level. The benefit for covered charges will be based on the Usual and Reasonable Charge if both the hospital and admitting physician participate in your selected PPO network.



Personal Health Plans portfolio

Deluxe

The Deluxe plan offers the most comprehensive benefits of all plans in the PHP portfolio. With 13 deductible, three coinsurance and four out-of-pocket selections, the plan design combinations are virtually limitless. Those looking for an office visit copay and low out-of-pocket options should look to the Deluxe plan.

Advantage

Designed to offer lower premiums without sacrificing benefits, the Advantage plan employs a two-bucket approach to the out-of-pocket maximum. One amount applies to medical services and supplies and a second to surgical services and inpatient confinement.

Premier

This smart health plan utilizes a unique daily deductible that can reduce out-of-pocket exposure when compared with a calendar-year deductible. Covered charges that exceed the daily deductible amount on any given day are paid at 100 percent when visiting in-network providers.

High-Deductible Health Plan (HDHP)

HDHP is a consumer-directed high-deductible health plan and is the only plan qualified for use with a health savings account (HSA) within the PHP portfolio. Enjoy the tax savings available through an HSA and the simplicity of a common, family deductible.

All plans in the Personal Health Plans portfolio are underwritten by Standard Security Life Insurance Company of New York. Standard Security Life is a member of The IHC Group and is rated A- (Excellent) by A.M. Best Company, a widely recognized rating agency that rates insurance companies on their relative financial strength and ability to meet their obligations to their insured.

Deluxe plan

All benefits listed are per covered person and apply to in-network charges unless otherwise noted.

Calendar-year maximum	\$1 million
Calendar-year deductible In-network and out-of-network deductibles accumulate separately. When the out-of-network deductible is satisfied, the in-network deductible will be considered satisfied for the remainder of the calendar year.	▶ \$1,000 ▶ \$4,500 ▶ \$15,000 ▶ \$1,500 ▶ \$5,000 ▶ \$20,000 ▶ \$2,000 ▶ \$5,500 ▶ \$25,000 ▶ \$2,500 ▶ \$7,500 ▶ \$3,500 ▶ \$10,000 Family deductible: Three times the individual deductible amount Out-of-network deductible: Three times the in-network deductible
Coinsurance	▶ 80% ▶ 70% ▶ 50% Out-of-network coinsurance ¹ : 50%
Coinsurance out-of-pocket maximum² In-network and out-of-network out-of-pocket amounts accumulate separately. When the out-of-network out-of-pocket is satisfied, the in-network out-of-pocket will be considered satisfied for the remainder of the calendar year.	▶ \$2,000 ▶ \$6,000 ▶ \$4,000 ▶ \$10,000 Family out-of-pocket: Three times the individual out-of-pocket maximum Out-of-network out-of-pocket: Three times the in-network out-of-pocket maximum
Physician office visit Other covered services performed during an office visit are subject to deductible and coinsurance. Out-of-network physician office visits are subject to the out-of-network deductible and coinsurance.	▶ \$40 copay per in-network physician office visit; after copay, plan pays 100% of balance of the office visit consultation charge OR ▶ No copay; covered charges are subject to the plan deductible and coinsurance
Routine mammography and Pap test	100% (copay, deductible and coinsurance waived) Out-of-network ¹ : 100% (copay, deductible and coinsurance waived)
Preventive services Covered preventive services are those rated with an “A” or “B” by the United States Preventive Services Task Force (USPSTF). For an updated list of covered services visit: www.uspreventiveservicestaskforce.org .	100% (copay, deductible and coinsurance waived) Out-of-network: No coverage
Emergency room Copay is waived if admitted inpatient immediately following emergency room visit.	\$100 copay, then deductible and coinsurance
Ambulance	Deductible, then 80% coinsurance
Outpatient surgical services copay	▶ No copay; covered charges are subject to the plan deductible and coinsurance OR ▶ \$250 copay per outpatient surgery; then subject to deductible and coinsurance
Inpatient confinement copay	▶ No copay; covered charges are subject to the plan deductible and coinsurance OR ▶ \$500 copay per inpatient confinement; then subject to deductible and coinsurance

1 Out-of-network covered charges are subject to the Usual and Reasonable Charge.

2 The out-of-pocket amount does not include the plan deductible, prescription drug deductible, copays, or pre-certification penalty amounts.

Advantage plan

All benefits listed are per covered person and apply to in-network charges unless otherwise noted.

Calendar-year maximum	\$1 million
Calendar-year deductible In-network and out-of-network deductibles accumulate separately. When the out-of-network deductible is satisfied, the in-network deductible will be considered satisfied for the remainder of the calendar year.	<ul style="list-style-type: none"> ▶ \$1,000 ▶ \$2,000 ▶ \$3,000 ▶ \$4,000 <ul style="list-style-type: none"> ▶ \$5,000 ▶ \$10,000 ▶ \$20,000 ▶ \$25,000 Family deductible: Three times the individual deductible amount Out-of-network deductible: Three times the in-network deductible
Coinsurance	80% Out-of-network coinsurance ¹ : 50%
Coinsurance out-of-pocket maximum² In-network and out-of-network out-of-pocket amounts accumulate separately. When the out-of-network out-of-pocket is satisfied, the in-network out-of-pocket will be considered satisfied for the remainder of the calendar year.	Medical services and supplies: \$3,000 Inpatient confinement and surgery: \$6,000 Family out-of-pocket: Three times the individual out-of-pocket maximums Out-of-network out-of-pocket: Three times the in-network out-of-pocket maximums
Physician office visit Other covered services performed during an office visit are subject to deductible and coinsurance. Out-of-network physician office visits are subject to the out-of-network deductible and coinsurance.	<ul style="list-style-type: none"> ▶ \$40 copay per in-network physician office visit; after copay, plan pays 100% of balance of the office visit consultation charge OR <ul style="list-style-type: none"> ▶ No copay; covered charges are subject to the plan deductible and coinsurance
Routine mammography and Pap test	100% (copay, deductible and coinsurance waived) Out-of-network ¹ : 100% (copay, deductible and coinsurance waived)
Preventive services Covered preventive services are those rated with an "A" or "B" by the United States Preventive Services Task Force (USPSTF). For an updated list of covered services visit: www.uspreventiveservicestaskforce.org .	100% (copay, deductible and coinsurance waived) Out-of-network: No coverage
Emergency room Copay is waived if admitted inpatient immediately following emergency room visit.	\$100 copay, then deductible and coinsurance
Ambulance	Deductible and coinsurance
Outpatient surgical services copay	▶ No copay; covered charges are subject to the plan deductible and coinsurance
Inpatient confinement copay	▶ No copay; covered charges are subject to the plan deductible and coinsurance

¹ Out-of-network covered charges are subject to the Usual and Reasonable Charge.

² The out-of-pocket amount does not include the plan deductible, prescription drug deductible, copays, or pre-certification penalty amounts.

Premier plan

All benefits listed are per covered person and apply to in-network charges unless otherwise noted.

Calendar-year maximum	\$1 million
Daily deductible In-network and out-of-network deductibles accumulate separately. When the out-of-network deductible is satisfied, the in-network deductible will be considered satisfied for the remainder of the calendar year.	<ul style="list-style-type: none"> ▶ \$500 ▶ \$1,000 Family deductible: Two times the individual deductible amount Out-of-network deductible: Two times the in-network deductible
Coinsurance	100% Out-of-network coinsurance ¹ : 100%
Coinsurance out-of-pocket maximum² In-network and out-of-network out-of-pocket amounts accumulate separately. When the out-of-network out-of-pocket is satisfied, the in-network out-of-pocket will be considered satisfied for the remainder of the calendar year.	<ul style="list-style-type: none"> ▶ \$4,000 ▶ \$8,000 Family out-of-pocket: Two times the individual out-of-pocket maximum Out-of-network out-of-pocket: Two times the in-network out-of-pocket maximum
Physician office visit Other covered services performed during an office visit are subject to deductible and coinsurance. Out-of-network physician office visits are subject to the out-of-network deductible and coinsurance.	<ul style="list-style-type: none"> ▶ \$40 copay per in-network physician office visit; after copay, plan pays 100% of balance of the office visit consultation charge OR <ul style="list-style-type: none"> ▶ No copay; covered charges are subject to the plan deductible and coinsurance
Routine mammography and Pap test	100% (copay, deductible and coinsurance waived) Out-of-network ¹ : 100% (copay, deductible and coinsurance waived)
Preventive services Covered preventive services are those rated with an "A" or "B" by the United States Preventive Services Task Force (USPSTF). For an updated list of covered services visit: www.uspreventiveservicestaskforce.org .	100% (copay, deductible and coinsurance waived) Out-of-network: No coverage
Emergency room	Deductible, then 100%
Ambulance	Deductible, then 100%
Outpatient surgical services copay	▶ No copay; covered charges are subject to the plan deductible and coinsurance
Inpatient confinement copay	▶ No copay; covered charges are subject to the plan deductible and coinsurance

¹ Out-of-network covered charges are subject to the Usual and Reasonable Charge.

² The out-of-pocket maximum includes daily deductible amounts and excludes copays, pre-certification penalty amounts and prescription drug deductibles.

HDHP plan

All benefits listed are per covered person and apply to in-network charges unless otherwise noted.

Calendar-year maximum	\$1 million																								
<p>Calendar-year deductible On a family plan, you and all covered dependents share one common calendar year deductible amount for covered charges.</p> <p>In-network and out-of-network deductibles accumulate separately. When the out-of-network deductible is satisfied, the in-network deductible will be considered satisfied for the remainder of the calendar year.</p>	<table> <tr> <td>Individual</td> <td>Family</td> </tr> <tr> <td>▶ \$1,800</td> <td>▶ \$3,600</td> </tr> <tr> <td>▶ \$2,700</td> <td>▶ \$5,450</td> </tr> <tr> <td>▶ \$3,500</td> <td>▶ \$7,000</td> </tr> <tr> <td>▶ \$5,250</td> <td>▶ \$10,500</td> </tr> </table> <p>Out-of-network deductible: Three times the in-network deductible</p>	Individual	Family	▶ \$1,800	▶ \$3,600	▶ \$2,700	▶ \$5,450	▶ \$3,500	▶ \$7,000	▶ \$5,250	▶ \$10,500														
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<p>Coinsurance out-of-pocket maximum On a family plan, you and all covered dependents share one common calendar year out-of-pocket amount for covered charges.</p> <p>The calendar-year out-of-network out-of-pocket amount includes the deductible and in- and out-of-network amounts.¹</p>	<p>▶ 100% coinsurance The in-network out-of-pocket amount is the selected deductible for an individual or family</p> <p>Out-of-network: 70% coinsurance The out-of-network out-of-pocket is based on the selected deductible</p> <table> <thead> <tr> <th>Individual</th> <th><i>Out-of-network</i></th> <th>Family</th> <th><i>Out-of-network</i></th> </tr> <tr> <th><i>Selected deductible</i></th> <th><i>out-of-pocket</i></th> <th><i>Selected deductible</i></th> <th><i>out-of-pocket</i></th> </tr> </thead> <tbody> <tr> <td>\$1,800</td> <td>\$12,000</td> <td>\$3,600</td> <td>\$22,000</td> </tr> <tr> <td>\$2,700</td> <td>\$14,700</td> <td>\$5,450</td> <td>\$25,000</td> </tr> <tr> <td>\$3,500</td> <td>\$15,500</td> <td>\$7,000</td> <td>\$28,000</td> </tr> <tr> <td>\$5,250</td> <td>\$16,500</td> <td>\$10,500</td> <td>\$32,000</td> </tr> </tbody> </table> <p>▶ 80% coinsurance² The in-network out-of-pocket amount is \$5,250 for an individual and \$10,500 for a family</p> <p>Out-of-network: 50% coinsurance The out-of-network out-of-pocket is \$15,750 for an individual and \$31,500 for a family</p>	Individual	<i>Out-of-network</i>	Family	<i>Out-of-network</i>	<i>Selected deductible</i>	<i>out-of-pocket</i>	<i>Selected deductible</i>	<i>out-of-pocket</i>	\$1,800	\$12,000	\$3,600	\$22,000	\$2,700	\$14,700	\$5,450	\$25,000	\$3,500	\$15,500	\$7,000	\$28,000	\$5,250	\$16,500	\$10,500	\$32,000
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Preventive services Covered preventive services are those rated with an "A" or "B" by the United States Preventive Services Task Force (USPSTF). For an updated list of covered services visit: www.uspreventiveservicestaskforce.org .	<p>100% (deductible and coinsurance waived)</p> <p>Out-of-network: No coverage</p>																								

¹ The out-of-pocket amount does not include the pre-certification penalties and any other expenses not covered.

² The 80 percent coinsurance is not available with the individual deductibles of \$3,500 and \$5,250 and the family deductibles of \$7,000 and \$10,500.

³ Out-of-network covered charges are subject to the Usual and Reasonable Charge.

Outpatient prescription drug benefit options

Deluxe, Advantage and Premier plans

- ▶ **Discount only***; a discount is available at participating pharmacies.
- ▶ **Generic:** \$30 copay
Brand name and specialty: Discount only*; a discount is available at participating pharmacies.
- ▶ **Generic:** \$30 copay
Brand name and specialty: Subject to the calendar year medical deductible and coinsurance. (This option is not available with the Premier plan.)
- ▶ **Generic:** \$30 copay
Brand name deductible: \$500, then —
Formulary: \$50 copay
Non-formulary: \$75 copay
Specialty medications: \$100 copay
((\$500 deductible applies per calendar year; maximum of three per family)
- ▶ **Generic:** \$30 copay
Brand name deductible: \$1,000, then —
Formulary: \$50 copay
Non-formulary: \$75 copay
Specialty medications: \$100 copay
((\$1,000 deductible applies per calendar year; maximum of three per family)

HDHP plan

- ▶ **Discount only***; a discount is available at participating pharmacies.
- ▶ **Deductible and coinsurance;** all covered outpatient prescription drugs are subject to the calendar-year medical deductible and coinsurance.

* The discount only option is not an insurance benefit and Standard Security does not make payments directly to the providers. The prescription drugs will not be covered expenses under your policy and they will not apply to your deductible and coinsurance. You are obligated to pay the provider directly, but will receive a discount from participating pharmacies based on a pre-negotiated discount fee schedule.

Optional benefits

Supplemental accident coverage

Your family's active lifestyle can lead to bumps and bruises along the way. The supplemental accident benefit pays 100 percent of each accident's covered charges up to the selected maximum of \$500 or \$1,000 per covered injury. This benefit applies to both in- and out-of-network charges and is available for an unlimited number of accidental injuries while coverage is in force under the rider. The \$500 or \$1,000 benefit includes subsequent follow-up care received within three months of the date of the injury. Covered charges incurred after the maximum benefit is paid, or three months after the accident, are subject to the plan deductible and coinsurance.

24-hour occupational coverage

Available to qualified sole proprietors, partners or business owners who are eligible under state law to legally opt out of and are not covered by workers' compensation. Benefits may be payable for covered charges for work-related injuries or sicknesses.

Vision

Receive savings through EyeMed Vision Care on eye care needs including exams, frames, bifocals, non-disposable contact lenses and more. Choose from two options:

Plan 1 – \$10 exam copay/\$25 lenses copay/\$100 frame allowance

Plan 2 – \$20 exam copay/\$20 lenses copay/\$100 frame allowance

Refer to the EyeMed Vision Plan overview for additional details and state availability.

Life*

Life insurance is available in increments of \$10,000 up to a total of \$100,000 for the primary insured. This benefit is not available to residents of Florida, Georgia, Kansas and Texas.

* Term life insurance benefits are subject to a reduction schedule based on age. This life benefit amount will be reduced to a percentage of that amount as follows: age 65-69: 65 percent, age 70-74: 40 percent, age 75-79: 25 percent, age 85+: 10 percent. Death by suicide, while sane or insane, is not covered if the death occurs within 12 months of the effective date of coverage under this optional rider.



Health Savings Account (HSA)

A health savings account (HSA) is a special tax-advantaged savings account that is available for use in conjunction with a qualified high-deductible health plan. Funds in your HSA can be withdrawn tax-free for qualified out-of-pocket medical expenses and other expenses not covered by your health insurance, such as: deductibles, eye exams, glasses, over-the-counter medications, long-term care premiums and more!

Since HSAs were authorized by the federal government in 2004, millions of Americans have enrolled in a high-deductible health plan that makes them eligible for an HSA. With PHP, it is easy to open a qualified HSA at the same time you apply for your health plan.

While you are free to open your HSA with any authorized vendor, PHP has teamed with Freedom HSA to create a convenient solution to your HSA banking needs.

Freedom HSA offers:

- ▶ No initial deposit
- ▶ No minimum balance
- ▶ Competitive interest rates
- ▶ FDIC insurance

It is easy to make deposits into your Freedom HSA by transferring funds online from your checking or savings account, or by sending a check or money order. You can access your funds with a debit card that can be used at any provider that accepts Visa® cards.

By selecting a high-deductible plan that does not have office visit and prescription copays, you may see your insurance premium decrease. You can use your premium savings to help fund your HSA, which in turn can be used to pay eligible out-of-pocket charges with tax-advantaged funds.

This brochure is not intended to render tax, investment or legal advice. For tax-related questions and/or advice, consult your accountant or attorney.



Teladoc* – Quality health care when and where you need it.

Teladoc is a national network of board-certified physicians providing efficient, cost-effective cross-coverage consultations by telephone or video conference. Your access to Teladoc allows you to resolve your routine medical issues on demand 24/7 from wherever you happen to be. Teladoc is just a click or call away!

Teladoc physicians can diagnose, recommend treatment and prescribe medication for conditions like:

- ▶ Sinus infection
- ▶ Sore throat and stuffy nose
- ▶ Bronchitis
- ▶ Urinary tract infections
- ▶ Allergies
- ▶ Respiratory infections
- ▶ Pink eye
- ▶ Pediatric care

Teladoc is health care made simple and on your terms.

- ▶ Request a consultation anytime online or by phone.
- ▶ Teladoc physicians respond within 23 minutes on average but guaranteed within three hours or it's free.
- ▶ Access Teladoc from home, work or while traveling. Compare that to the time spent sitting in a waiting room.
- ▶ Save money by avoiding expensive trips to the emergency room or urgent care facility.

*Teladoc is automatically included in states where Personal Health Plans are filed as group association which requires membership in Communicating for America, Inc. Membership is optional in the states of Georgia, Kansas, Montana and South Dakota where the plans are available on an individual basis only. If membership is not selected, Teladoc benefits are not available. Teladoc is not available in Oklahoma.

Teladoc does not replace the primary care physician or guarantee that a prescription will be written. Teladoc operates subject to state regulation and may not be available in certain states. Teladoc does not prescribe DEA controlled substances, non-therapeutic drugs and certain other drugs which may be harmful because of their potential for abuse. Teladoc physicians reserve the right to deny care for potential misuse of services.

Teladoc, Inc., 2002-2010

More than the basics

Take charge of your health by maximizing the services available on every Personal Health Plan.

MyHealthCompass

A provider evaluation tool that provides access to powerful hospital and physician information that includes:

- ▶ Quality ratings – Rankings according to complication and mortality rates, case volume and length of stay
- ▶ Pricing reports – Price comparisons by hospital, medical procedure, payor and location – local, state and national
- ▶ Profiles – Detailed information on hospitals and physicians, such as specialties, credentials, hospital affiliations and sanctions
- ▶ Health care secrets – Easy-to-understand information on medical conditions and insurance issues

Personal wellness profile

This online tool takes lifestyle and health factors into consideration, and provides recommendations for risk reduction and health enhancement.

Access to chiropractors and alternative medicine[†]

Members receive a 25 percent discount on provider services through the American Specialty Health alternative health care network of more than 20,000 credentialed providers.

Optum 24 Hour NurseLine

Health questions can come up at any time. When you call the Nurse Access Line, a registered nurse will listen to your concerns and help you choose the right care for your situation.

[†]Disclosures

THIS PLAN IS NOT INSURANCE. THIS IS NOT A MEDICARE PRESCRIPTION DRUG PLAN*
This plan does not meet the minimum creditable coverage requirements under M.G.L.c. 111M and 956 CMR 5.00. The plan provides discounts at certain health care providers for medical services. The range of discounts will vary depending on the type of provider and service. The plan does not make payments directly to the providers of medical services. Plan members are obligated to pay for all health care services but will receive a discount from those health care providers who have contracted with the discount medical plan organization. You may access a list of participating health care providers at choosehealthy.com/careington. Upon request the plan will make available a written list of participating health care providers. You have the right to cancel within the first 30 days after receipt of membership materials and receive a full refund, less a nominal process fee (nominal fee for MD residents is \$5). Discount Medical Plan Organization and administrator: **Careington International Corporation**, 7400 Gaylord Parkway, Frisco, TX 75034; phone 800-441-0380.

The program and its administrators have no liability for providing or guaranteeing services by providers or the quality of service rendered by providers. This program is not available in Montana and Vermont.
*Medicare statement applies to MD residents when pharmacy discounts are part of the program.

Limited benefits

Non-surgical back treatment

Covered expenses for outpatient non-surgical back treatment are payable up to the maximum benefit of 10 visits per calendar year, per covered person. Benefits are subject to applicable copays, deductible and coinsurance.

Home health care

After the applicable deductible has been satisfied, covered medical expenses will be paid at the coinsurance level selected, up to 21 visits per calendar year, per insured.

Mental or nervous and chemical dependency disorders

Outpatient mental or nervous disorders and outpatient chemical dependency disorders

Covered charges are subject to applicable copays, deductible and coinsurance up to the maximum benefit of \$25 per visit. For all plans except the HDHP plan, charges incurred for outpatient treatment do not accumulate toward the plan's maximum out-of-pocket amounts.

Inpatient mental or nervous disorders

Covered charges are subject to applicable copays, deductible and coinsurance, up to a maximum benefit of \$250 per day.

Inpatient chemical dependency disorders

Benefits are not provided for inpatient treatment of chemical dependency disorders.

Skilled nursing facility center

After the applicable copays and deductible have been satisfied, covered medical expenses are payable at the selected coinsurance level up to the maximum benefit of \$100 per day, per insured person.

Hospice care

Covered expenses are not subject to any copays, deductible or coinsurance and are payable up to a maximum benefit of six months per calendar year. Bereavement support services for the insured's family are covered during the three-month period after the insured's death, up to \$250.

Organ transplant

Center of Excellence providers

Covered expenses are paid up to the plan's \$1 million calendar-year maximum benefit. When the insured uses a Center of Excellence provider, a lodging allowance of up to \$5,000 is available for one companion or two if the insured recipient is a minor.

Non-Center of Excellence providers

Covered expenses are paid up to \$250,000 per transplant.

Occupational, physical and speech therapies

After the applicable deductible has been satisfied, covered medical expenses will be paid at the coinsurance level selected up to a maximum of 30 treatments per calendar year for any one type of therapy, and up to 60 treatments per calendar year for any combination of these therapies.

Hospital room and board

Your Personal Health Plan covers hospital room-and-board charges according to the plan you selected, on the basis of the average semi-private room rate. If the hospital does not have semi-private rooms, the plan will pay the Usual and Reasonable Charge limited to 90 percent of that hospital's lowest-priced private room.

Intensive care

Intensive care room-and-board provided through in-network hospitals will be paid at the most common rate for intensive care units. If provided through out-of-network facilities, covered charges will be paid at up to three times the most common semi-private room rate. Observation room and intermediate care unit services will be paid at a rate of up to two times the most common semi-private room rate.

Complications of pregnancy

Complications of pregnancy are covered the same as any other illness. Normal pregnancy is not a covered benefit.

Additional plan provisions

Initial rate guarantee

Premiums are based on several factors including, but not limited to: age, gender, spouse age, the number of children covered on the plan, home address, benefits selected, effective date and underwriting decisions. Rates will not change for the initial 12 months of coverage from the effective date unless one or more of the following events occur during that time: 1) A change of residence; 2) Administrative or PPO fees change; 3) The number of dependents covered under the plan changes; or 4) A change in benefit options or PPO network.

Eligibility

If you are a dues-paying member of Communicating for America, Inc.,* aged 18 to 64, and a permanent resident of the United States, you and your eligible dependents may apply to purchase a Personal Health Plan. You can apply by completing an application for insurance and qualifying for coverage based on the plan's underwriting guidelines. Eligible dependents include: your lawful spouse under age 65 and dependent children under age 26.

*Membership in Communicating for America is not required for residents of Georgia, Kansas, Montana and South Dakota.

Effective date

You may request that your coverage become effective on either the 1st or 15th of the month. We must receive your application before the requested effective date. If your application is approved, your coverage will become effective on the requested effective date following approval. Your applicable premium must be paid before your coverage under the policy goes into effect. If the company is unable to approve your application within 60 days of the application date, the requested effective date will not be honored and a new, currently dated application may be required. If you or any dependent is confined as an inpatient or totally disabled, as defined by the policy, on the effective date, the approval of coverage is void and coverage will not take effect. A new application will be required to consider coverage in the future.

Covered charges

Covered charges are the charges for services or supplies that are eligible for reimbursement under the policy. In order for a charge to be a covered charge, it must be: listed as a covered expense under the certificate; medically necessary; usual and reasonable; authorized or ordered by a physician; incurred while coverage under the policy is in force and not excluded by the policy. Covered charges are subject to applicable copays, deductibles, coinsurance amounts, limitation and maximums, unless otherwise noted in the schedule of benefits section of the certificate of coverage.

Usual and Reasonable Charge

The Usual and Reasonable Charge is the lesser of the actual charge made by the provider, the negotiated rate, and the reasonable charge (as determined by us) made for the same service or supply in the same geographic area.

Pre-certification and pre-determination of benefits requirement

Pre-certification and pre-determination are screening processes used to determine if the proposed hospital confinement, services, drugs or supplies are medically necessary. Failure to obtain the required pre-certification for inpatient confinement or specific medical treatment and services will result in a \$500 penalty. This pre-certification penalty is in addition to deductibles, copays and coinsurance. Pre-determination is required in order to receive benefits for certain charges including non-emergency care ambulance, durable medical equipment that exceeds \$1,000 and certain prescription medications. Failure to comply with the pre-determination requirement will result in no benefits being paid and no coverage for such charges. Pre-certification and pre-determination are not pre-authorization or pre-approval of coverage and do not guarantee payment of benefits.

Pre-existing conditions

A pre-existing condition is defined as a condition, whether physical or mental and regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was received within the 12 months immediately preceding the effective date of coverage. A pre-existing condition will be considered a covered charge at the end of a continuous 12-month period following the covered person's effective date of coverage if no medical advice, diagnosis, care or treatment in connection with the injury or sickness has been received. Otherwise, pre-existing conditions will be considered covered charges after two years of continuous coverage unless specifically excluded by the policy or by an endorsement or rider attached to the certificate.

The pre-existing condition limitation does not apply to any covered person who is under the age of 19.

Pre-existing conditions and disclosed health history

Health conditions that are fully disclosed in writing on the application for insurance are not subject to the pre-existing limitation and are covered from the effective date of coverage under the certificate unless the condition is specifically excluded under the policy or by an endorsement or health condition rider attached to the certificate of coverage.

Important disclosure on insurance application

Standard Security Life may rescind or void the insurance coverage of a covered person only if the individual, or the application on behalf of that individual, performs an act, practice or omission that constitutes fraud; or makes an intentional misrepresentation of material fact.

Termination of insurance

A covered person's insurance under the policy will remain in force until: written request to terminate coverage is received, premium due is not paid by the end of the grace period; fraud or intentional misrepresentation of material fact is determined to have been committed under the terms of the policy; the insurer lawfully discontinues offering all health insurance in the state where the certificate was issued (subject to advance notice); death or termination of the policy. A dependent child's coverage will terminate on the premium due date following the date the child ceases to meet the definition of an eligible dependent. Coverage terminates for dependents on the date your coverage terminates.

EXCLUSIONS

Consult the certificate of coverage for a complete description of the charges, services and supplies excluded from coverage.

Except as specifically provided for in the policy, the expenses for any of the following are excluded from coverage:

- Any service or supply in connection with the implant of an artificial organ
- Any treatment, service, supply or prescription medication that: a) is not due to a sickness or injury; b) is not recommended by a physician or c) is not medically necessary
- Outpatient prescription medications, including but not limited to specialty medications unless covered by the Prescription Medication Benefit Rider
- Hospital or physician charges for weekend hospital admissions for non-emergency procedures, unless medically necessary or unless surgery is scheduled for the next day
- Any injury or sickness which arises out of or in the course of any employment for wage or profit
- An injury or sickness incurred while on active duty with the military of any country or international organization; or resulting from war or any act of war or the participation in a riot or insurrection
- Treatment, services or supplies for any loss sustained, incurred due to or contracted as a consequence of a covered person: a) being intoxicated; b) being under the influence of any narcotic, barbituate, hallucinatory or other drug, unless administered by a physician and taken in accordance with the prescribed dosage or c) being under the influence of any illegal drug as defined by state or federal law
- Treatment, services or supplies related to the teeth, gums and any other associated structures
- Treatment, services or supplies as the result of prognathism, retrognathism, micrognathism or any treatment, services or supplies to reposition the maxilla (upper jaw), mandible (lower jaw) or provided for temporomandibular joint (TMJ) dysfunction
- Treatment, services or supplies for: a) breast augmentation; b) the removal of breast implants and c) breast reduction surgery unless medically necessary due to a sickness
- Surgery to correct refractive errors, routine eye exams, glasses, visual therapy or contact lenses
- Contraceptive drugs and devices; pregnancy; voluntary sterilization or reversal; fertility treatments including any impregnation techniques and voluntary abortion
- A newborn's well-baby charges including hospital expenses and nursery charges

- Attempted suicide or intentionally self-inflicted injury or sickness while sane or insane
- Treatment, services or supplies for inpatient chemical dependency disorders
- Treatment, services or supplies to eliminate or reduce a dependency on or an addiction to tobacco
- Treatment, services or supplies related to paring or removal of corns, calluses, bunions or toenails
- Orthotics or any treatment, services or supplies related to the feet by means of posting or strapping, or range-of-motion studies
- Treatment, services or supplies for obesity, extreme obesity, morbid obesity or weight reduction, including all forms of surgery
- Treatment, services or supplies received from a provider if such provider is a close relative of or lives in the same household as the covered person, or is an owner, partner, officer, director or employee of the same employer as the covered person
- Private-duty nursing or custodial care
- Inpatient personal-convenience items
- Telephone and e-mail consultations or missed-appointment fees
- Treatment, services or supplies received or purchased outside the United States, unless the charges are incurred while traveling on business or for pleasure for a period not to exceed 90 days, and the charges are incurred for urgent care, provided the treatment, services and supplies used in connection with the urgent care are approved for use in the United States
- Treatment, services or supplies for complications of conditions that are not covered under the policy
- Non-emergency care ambulance services, durable medical equipment that exceeds \$1,000 and certain prescription medications, unless pre-determined
- Any conditions specifically excluded by riders, endorsements or exclusions attached to the policy
- Charges incurred after coverage under the policy terminates, regardless of when the condition originated
- Charges in excess of the Usual and Reasonable Charges

Satisfaction guaranteed

If you are not completely satisfied with the health insurance coverage and you have not filed a claim; you may return the certificate of coverage within 10 days of your receipt and receive a premium refund.

Important information

The information included in this brochure is an outline of features, plan provisions, benefits and other information about the Personal Health Plans. Plans offered may be subject to change and are not available in all states. This brochure is not a contract and is not intended to serve as legal interpretation of the benefits, which are provided under the Master Policy (Policy #SSL 2008-CA) issued to Communicating for America, Inc. in the District of Columbia. The exact provisions governing the insurance contract are contained in the Master Policy (form #SSL GP 607-A) underwritten by Standard Security Life Insurance Company of New York. As previously described, plans are available in certain states on an individual basis and will be issued separate policy forms. Some provisions, benefits, exclusions or limitations may vary depending on your state of residence. Certain terms and conditions apply. Any provision of this policy that is in conflict with any applicable federal or state law is hereby amended to meet the minimum requirements of such law. For complete details about the Personal Health Plans, please refer to the health insurance Certificate of Coverage (SSL GC 607-A).

Applicants should not cancel any existing insurance until they have been notified in writing that their new insurance is in effect.

Vision benefits described in this brochure are underwritten by Fidelity Security Life Insurance Company, Kansas City, MO; Policy form M-9004 issued to the Multiple Unit Security Trust II.

Standard Security Life Insurance Company of New York

Standard Security Life Insurance Company of New York is the insurer for health and life insurance benefits described in this brochure. Standard Security Life Insurance Company of New York, a member of The IHC Group, is rated A- (Excellent) by A.M. Best Company, a widely recognized rating agency that rates the relative financial strength of insurance companies and their ability to meet policyholder obligations.

The IHC Group

The IHC Group is an insurance organization composed of Independence Holding Company (NYSE: IHC), its operating subsidiaries and affiliates. The IHC Group has been providing life, health and stop-loss insurance solutions for nearly 30 years. With more than \$1.3 billion in assets as of June 2010, The IHC Group serves more than one million customers through its operating companies, which include three A- (Excellent) A.M. Best-rated insurance carriers, third-party administrators, managing general underwriters and marketing organizations.

Communicating for America, Inc.

Communicating for America, Inc. endorses the Personal Health Plans and is a national nonprofit association founded in 1972. Originally founded as an advocate for the self-employed and rural members, CA has evolved into one of the largest and most respected associations in the country with members in communities of all sizes. Along with a legislative voice on important issue in Washington, D.C., CA provides high-quality, valuable member benefits. CA, Inc. is not compensated by Standard Security Life Insurance Company of New York for its endorsement. Association membership is optional in Georgia, Kansas, Montana and South Dakota.

Personal
Health Plans

