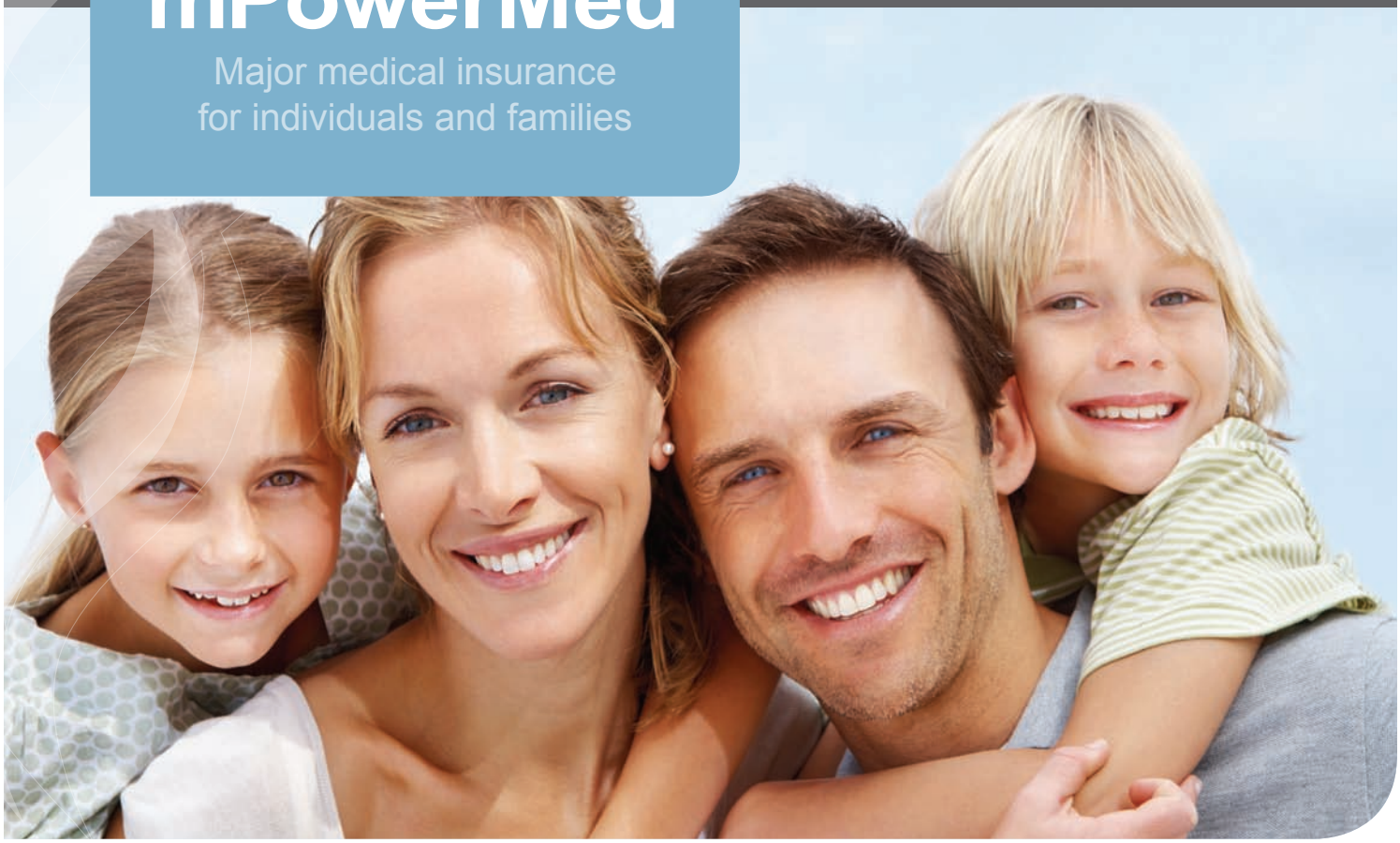
mPowerMed

Major medical insurance
for individuals and families



Underwritten by Madison National Life Insurance Company, Inc., a Wisconsin insurance company. Madison National Life is 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 solutions for nearly 30 years. For information on The IHC Group, see www.ihcgroup.com.

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

THE IHC GROUP
Independence Holding Company

mPowerMed allows you 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. mPowerMed plans and benefit choices provide the opportunity for you to design coverage that balances premium cost with potential out-of-pocket expenses.

mPowerMed advantages

Options that fit your needs.
mPowerMed provides numerous plan options that offer first-dollar benefits—benefits applied before the deductible—for office visit charges and prescription drugs. You control your costs by choosing how extensive those first-dollar benefits are, as well as your out-of-pocket in the event of a catastrophic claim.

Nationwide coverage with a local focus.
Our mPowerMed PPO plans allow you to choose among several preferred provider networks. If you obtain services from a network hospital, mPowerMed plans provide additional out-of-pocket protection through our unique “forced provider” benefit. This pays in-network benefits, subject to the Usual and Reasonable Charge, for covered services provided by anesthesiologists, pathologists and assistant surgeons at an in-network hospital, even if they have chosen not to join the PPO network.

Peace of mind.
mPowerMed plans empower you to make decisions about your health care. All plans include a critical illness benefit that pays a designated lump sum upon the diagnosis of a covered critical illness on the primary insured. You can use the critical illness benefit to pay for out-of-pocket expenses, experimental treatment, or your day-to-day expenses while you recuperate.

mPowerMed partners offer experience and strength

Madison National Life Insurance Company
Independence Holding Group

Madison National Life Insurance Company, Inc., headquartered in Madison, Wis., is the underwriting carrier for mPowerMed. Madison National Life is rated A- (Excellent) by A.M. Best Company, Inc., a widely-recognized rating agency that rates insurance companies on their relative financial strength and ability to meet their obligations to their insured. Madison National Life is a member of The IHC Group.

THE IHC GROUP
Independence Holding Company

For almost three decades member companies of The IHC Group have built a reputation of commitment to the markets they serve. With over one million customers nationwide, The IHC Group's focus is to be an innovative partner to small businesses, individuals and families.

mPowerMed portfolio

There is not one simple solution that fits everyone's needs when it comes to medical insurance. With mPowerMed plans from Madison National Life you have options. Three coverage levels provide you with the flexibility to create a plan that best meets your needs and budget.

M5 is the most comprehensive plan series offered in the mPowerMed portfolio. This set of health plans may be appealing to consumers looking to limit their out-of-pocket expenses. The unlimited number of office visit copays, highest critical illness benefit and lowest out-of-pocket options make M5 the most popular mPowerMed series.

N2 is a smart set of plans that provide options for first-dollar coverage while maintaining affordability through carefully selected limits and out-of-pocket amounts. Designed for those concerned more about financial protection against large claims than routine medical charges, the mPowerMed N2 plans can provide additional savings by eliminating the office visit copay.

HSA5 is a comprehensive high-deductible health plan with qualified options that promote tax-savings when paired with a health savings account (HSA). An HSA allows you to set aside money in a special tax-advantaged account to fund your out-of-pocket medical costs. You may elect to open a Freedom HSA along with your mPowerMed plan for easy enrollment and administration.

Maximize mPowerMed benefits while reducing monthly premium by selecting a preferred provider organization (PPO) network that includes the physicians, clinics and hospitals in your area. By using a participating provider, you will have access to negotiated discounts for covered medical care.

mPowerMed features

Forced providers in-network

Certain providers such as radiologists, pathologists, anesthesiologists and assistant surgeons may have relationships with network facilities but are not included in the PPO network. Understanding that you are not always able to select these providers when admitted to an in-network hospital, your mPowerMed plan will consider charges for these “forced providers” at the in-network benefit level if both the hospital and admitting physician participate in your selected PPO network. Covered charges will be based on the Usual and Reasonable Charge.

National network

You can travel with peace of mind knowing that if you selected a regional PPO network and are outside of that network’s service area, you and your family have access to in-network benefits through a national network. Simply call the number on the back of your mPowerMed identification card to locate the closest network provider.

Air, land and water ambulance

While many competing plans may exclude air ambulance services or limit the benefit paid for an ambulance trip, mPowerMed is different. Covered charges apply to deductible and coinsurance, without a limitation or maximum specific to ambulance services.

First-dollar generic drug coverage

If you select an mPowerMed plan with a prescription drug copay option, you will have first-dollar coverage for all covered generic drugs. Benefits vary by the plan chosen. Please refer to pages six through 11 for full coverage details.

Waiver of pre-existing condition limitation

With all mPowerMed plans, if you fully disclose an existing condition that is not specifically excluded from coverage, Madison National Life will review the claim without applying the pre-existing condition limitation.

Critical illness coverage

Even with the best major medical benefits, you and your family could be left to cover out-of-pocket costs associated with a critical illness, such as:

- Health plan deductible and coinsurance
- Lost pay due to time off work for the employee and the caregiver
- Travel expenses to and from treatment
- Child care or elder care

Critical illness coverage provides financial protection through a designated lump-sum benefit paid upon diagnosis of a covered critical illness. Available to the primary insured, critical illness coverage is automatically included with all plans at no additional charge.

The M5 and HSA5 plans include a $5,000 benefit and the N2 plan includes a $2,500 benefit.

Covered critical illness	Percentage of plan benefit paid
Life-threatening cancer, more than 90 days after the effective date	100%
Life-threatening cancer, within the first 90 days after the effective date	10%
Cancer in situ, more than 90 days after the effective date	25%
Kidney (renal) failure	100%
Heart attack	100%
Stroke	100%
Coma	100%
Major organ transplant	100%
Severe burn	100%

Benefits are available upon diagnosis of the first occurrence of each covered critical illness. If the primary insured experiences more than one occurrence of the same critical illness, the benefit will not be paid a second time. However, if a benefit has been paid for cancer in situ, the benefit available for a subsequent life-threatening cancer will be reduced by that benefit amount. Please see page 14 for a full description of each covered critical illness. **Critical illness coverage is not available to residents of Colorado, Georgia or South Dakota.**

PPO plans

Plan specifics	M5 PPO
Critical illness (Primary insured only)	$5,000
Calendar-year maximum	$2,000,000
Physician office visit copay Out-of-network physician office visits are subject to the out-of-network deductible and coinsurance.	◗ $35 copay per in-network physician office visit; after copay, plan pays 100% of the balance of the office visit charge; other covered services performed during the office visit are subject to deductible and coinsurance OR ◗ No copay; covered charges are subject to deductible and coinsurance
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 ◗ $5,000 ◗ $1,500 ◗ $10,000 ◗ $2,500 ◗ $20,000 ◗ $3,500 Family deductible: 2 times the individual deductible amount Out-of-network deductible: 2 times the in-network deductible
Coinsurance and out-of-pocket maximum Out-of-pocket limits shown are in excess of the deductible. 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.	In-network: ◗ 100% Coinsurance, $0 Out-of-pocket; ◗ 80% Coinsurance, $4,000 Out-of-pocket; ◗ 50% Coinsurance, $6,000 Out-of-pocket Out-of-network: 70% Coinsurance, $3,000 Out-of-pocket; 60% Coinsurance, $8,000 Out-of-pocket; 50% Coinsurance, $12,000 Out-of-pocket Family out-of-pocket: 2 times the individual out-of-pocket amount
Outpatient prescription drugs *If you find a drug for less than the copay amount, you pay that cost, not the full copay!*	◗ Generic: No copay Brand name/formulary: $250 deductible[1], then $50 copay Brand name/non-formulary: $500 deductible[1], then $75 copay Specialty medication: 50% coinsurance OR ◗ Generic: $15 copay Brand name/formulary: $50 copay Brand name/non-formulary: $75 copay Specialty medication: 50% coinsurance OR ◗ Generic: $20 copay All other covered outpatient prescription drugs: same as any other illness; subject to deductible and coinsurance OR ◗ Discount only; prescription drugs will not be covered expenses and will not apply toward deductible or coinsurance. (The discount is available at participating pharmacies and is not an insurance benefit.)
Routine mammography and Pap smear	100%—in- and out-of-network covered charges are not subject to copay, deductible or coinsurance
Wellness benefits Covered services include a routine physical exam, well-child exams, PSA test, digital screening and colorectal cancer examination.	In-network: 100%—covered charges are not subject to copay, deductible or coinsurance Out-of-network: Subject to the out-of-network deductible and coinsurance
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.	In-network: 100%—covered charges are not subject to copay, deductible or coinsurance Out-of-network: No coverage
ER copay	$100; then subject to in-network deductible and coinsurance (Waived if admitted inpatient immediately following emergency room visit.)
Outpatient surgical services copay	No copay; subject to deductible and coinsurance
Inpatient hospital confinement copay	No copay; subject to deductible and coinsurance

[1] Deductibles are per covered person per calendar year up to a maximum of three per family.

Plan specifics	N2 PPO
Critical illness (Primary insured only)	$2,500
Calendar-year maximum	$1,250,000[1]
Physician office visit copay Out-of-network physician office visits are subject to the out-of-network deductible and coinsurance.	• $35 copay per in-network physician office visit; after copay, plan pays 100% of the balance of the office visit charge; other covered services performed during the office visit are subject to deductible and coinsurance. Limit of 3 covered office visits per covered person per calendar year; additional visits are subject to deductible and coinsurance OR • No copay; covered charges are subject to deductible and coinsurance
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 • $5,000 • $1,500 • $10,000 • $2,500 • $20,000 • $3,500 Family deductible: 2 times the individual deductible amount Out-of-network deductible: 2 times the in-network deductible
Coinsurance and out-of-pocket maximum Out-of-pocket limits shown are in excess of the deductible. 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.	In-network: Coinsurance / Out-of-pocket • 100% / $0 • 80% / $6,000 • 50% / $6,000 Out-of-network: Coinsurance / Out-of-pocket 70% / $3,000 60% / $12,000 50% / $12,000 Family out-of-pocket: 2 times the individual out-of-pocket amount
Outpatient prescription drugs *If you find a drug for less than the copay amount, you pay that cost, not the full copay!*	• Generic: $15 copay Brand name deductible: $500[2] per covered person per calendar year, then: Formulary: $50 copay Non-formulary: $75 copay Specialty medication: 50% coinsurance OR • Generic: $20 copay All other covered outpatient prescription drugs: same as any other illness; subject to deductible and coinsurance OR • Discount only; prescription drugs will not be covered expenses and will not apply toward deductible or coinsurance. (The discount is available at participating pharmacies and is not an insurance benefit.)
Routine mammography and Pap smear	100%—in- and out-of-network covered charges are not subject to copay, deductible or coinsurance
Wellness benefits Covered services include a routine physical exam, well-child exams, PSA test, digital screening and colorectal cancer examination.	In-network: 100%—covered charges are not subject to copay, deductible or coinsurance Out-of-network: Subject to the out-of-network deductible and coinsurance
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.	In-network: 100%—covered charges are not subject to copay, deductible or coinsurance Out-of-network: No coverage
ER copay	$100; then subject to in-network deductible and coinsurance (Waived if admitted inpatient immediately following emergency room visit.)
Outpatient surgical services copay	$250; then subject to deductible and coinsurance
Inpatient hospital confinement copay	$500; then subject to deductible and coinsurance

[1] The calendar-year maximum amount is $1 million through December 31, 2011.

[2] Maximum of three brand name deductibles per family, per calendar year.

HSA-qualified plans

Plan specifics	HSA5 PPO
Critical illness (Primary insured only)	$5,000
Calendar-year maximum	$2,000,000
Physician office visit	Covered charges are subject to deductible and coinsurance
Calendar-year deductible[1]	In-network Individual / Family • $1,500 / $3,000 • $2,500 / $5,000 • $3,500 / $7,000 • $5,000 / $10,000 • $5,650 / $11,300 Out-of-network deductible: 2 times the in-network deductible
Coinsurance and out-of-pocket maximum[1] Out-of-pocket limits shown are in excess of the deductible.	In-network Coinsurance / Individual Out-of-pocket / Family Out-of-pocket / Out-of-network Coinsurance* • 100% / $0 / $0 / 70% • 80%[2] / $2,000 / $4,000 / 60% • 80%[3] / $3,000 / $6,000 / 60% • 50%[3] / $3,000 / $6,000 / 50% * Individual and family out-of-network out-of-pocket: 2 times the in-network out-of-pocket for the 60% and 50% out-of-network coinsurance; $3,000 individual/$6,000 family on the 70% out-of-network coinsurance
Outpatient prescription drugs	• Same as any other illness; covered prescription drugs are subject to deductible and coinsurance OR • Discount only; prescription drugs will not be covered expenses and will not apply toward deductible or coinsurance. (The discount is available at participating pharmacies and is not an insurance benefit.)
Routine mammography and Pap smear	100%—in- and out-of-network covered charges are not subject to deductible or coinsurance
Wellness benefits Covered services include a routine physical exam, well-child exams, PSA test, digital screening and colorectal cancer examination.	In-network: 100%—covered charges are not subject to deductible or coinsurance Out-of-network: Subject to the out-of-network deductible and coinsurance
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.	In-network: 100%—covered charges are not subject to deductible or coinsurance Out-of-network: No coverage
ER copay	No copay; subject to in-network deductible and coinsurance

The calendar-year deductible and out-of-pocket maximum amounts are subject to annual cost of living adjustments as may be required by federal guidelines to maintain the plan's eligibility as an HSA-qualified plan.

[1] For PPO plans, in-network and out-of-network deductibles and out-of-pocket amounts accumulate separately. When the out-of-network amount is satisfied, the in-network amount will be considered satisfied for the remainder of the calendar year.

[2] Option not available with individual deductibles of $5,000 and $5,650 or family deductibles of $10,000 and $11,300.

[3] Options are not available with individual deductibles of $3,500, $5,000 and $5,650 or family deductibles of $7,000, $10,000 and $11,300.

HSA-qualified plans

Plan specifics	HSA5 Traditional
Critical illness (Primary insured only)	$5,000
Calendar-year maximum	$2,000,000
Physician office visit	Covered charges are subject to deductible and coinsurance
Calendar-year deductible	Individual: $1,500; $2,500; $3,500; $5,000; $5,650 Family: $3,000; $5,000; $7,000; $10,000; $11,300
Coinsurance and out-of-pocket maximum Out-of-pocket limits shown are in excess of the deductible.	Coinsurance: 100%; 80%[1]; 80%[2]; 50%[2] Individual Out-of-pocket: $0; $2,000; $3,000; $3,000 Family Out-of-pocket: $0; $4,000; $6,000; $6,000
Outpatient prescription drugs	• Same as any other illness; covered prescription drugs are subject to deductible and coinsurance OR • Discount only; prescription drugs will not be covered expenses and will not apply toward deductible or coinsurance. (The discount is available at participating pharmacies and is not an insurance benefit.)
Routine mammography and Pap smear	100%—covered charges are not subject to deductible or coinsurance
Wellness benefits Covered services include a routine physical exam, well-child exams, PSA test, digital screening and colorectal cancer examination.	100%—covered charges are not subject to deductible or coinsurance
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%—covered charges are not subject to deductible or coinsurance
ER copay	No copay; subject to deductible and coinsurance

The calendar-year deductible and out-of-pocket maximum amounts are subject to annual cost of living adjustments as may be required by federal guidelines to maintain the plan's eligibility as an HSA-qualified plan.

[1] Option not available with individual deductibles of $5,000 and $5,650 or family deductibles of $10,000 and $11,300.

[2] Options are not available with individual deductibles of $3,500, $5,000 and $5,650 or family deductibles of $7,000, $10,000 and $11,300.

Traditional plans

Plan specifics	M5 Traditional
Critical illness (Primary insured only)	$5,000
Calendar-year maximum	$2,000,000
Physician office visit copay	• $35 copay per physician office visit; after copay, plan pays 100% of the balance of the office visit charge; other covered services performed during the office visit are subject to deductible and coinsurance OR • No copay; covered charges are subject to deductible and coinsurance
Calendar-year deductible	• $1,000 • $5,000 • $1,500 • $10,000 • $2,500 • $20,000 • $3,500 Family deductible: 2 times the individual deductible amount
Coinsurance and out-of-pocket maximum Out-of-pocket limits shown are in excess of the deductible.	In-network Coinsurance / Out-of-pocket • 100% $0 • 80% $4,000 • 50% $6,000 Family out-of-pocket: 2 times the individual out-of-pocket amount
Outpatient prescription drugs *If you find a drug for less than the copay amount, you pay that cost, not the full copay!*	• Generic: No copay Brand name/formulary: $250 deductible[1], then $50 copay Brand name/non-formulary: $500 deductible[1], then $75 copay Specialty medication: 50% coinsurance OR • Generic: $15 copay Brand name/formulary: $50 copay Brand name/non-formulary: $75 copay Specialty medication: 50% coinsurance OR • Generic: $20 copay All other covered outpatient prescription drugs: same as any other illness; subject to deductible and coinsurance OR • Discount only; prescription drugs will not be covered expenses and will not apply toward deductible or coinsurance. (The discount is available at participating pharmacies and is not an insurance benefit.)
Routine mammography and Pap smear	100%—covered charges are not subject to copay, deductible or coinsurance
Wellness benefits Covered services include a routine physical exam, well-child exams, PSA test, digital screening and colorectal cancer examination.	100%—covered charges are not subject to copay, deductible or coinsurance
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%—covered charges are not subject to copay, deductible or coinsurance
ER copay	$100; then subject to deductible and coinsurance (Waived if admitted inpatient immediately following emergency room visit.)
Outpatient surgical services copay	No copay; subject to deductible and coinsurance
Inpatient hospital confinement copay	No copay; subject to deductible and coinsurance

[1] Deductibles are per covered person per calendar year up to a maximum of three per family.

Plan specifics	N2 Traditional
Critical illness (Primary insured only)	$2,500
Calendar-year maximum	$1,250,000[1]
Physician office visit copay	• $35 copay per physician office visit; after copay, plan pays 100% of the balance of the office visit charge; other covered services performed during the office visit are subject to deductible and coinsurance. Limit of 3 covered office visits per covered person per calendar year; additional visits are subject to deductible and coinsurance OR • No copay; covered charges are subject to deductible and coinsurance
Calendar-year deductible	• $1,000 • $5,000 • $1,500 • $10,000 • $2,500 • $20,000 • $3,500 Family deductible: 2 times the individual deductible amount
Coinsurance and out-of-pocket maximum Out-of-pocket limits shown are in excess of the deductible.	In-network Coinsurance / Out-of-pocket • 100% $0 • 80% $6,000 • 50% $6,000 Family out-of-pocket: 2 times the individual out-of-pocket amount
Outpatient prescription drugs *If you find a drug for less than the copay amount, you pay that cost, not the full copay!*	• Generic: $15 copay Brand name deductible: $500[2] per covered person per calendar year, then: Formulary: $50 copay Non-formulary: $75 copay Specialty medication: 50% coinsurance OR • Generic: $20 copay All other covered outpatient prescription drugs: same as any other illness; subject to deductible and coinsurance OR • Discount only; prescription drugs will not be covered expenses and will not apply toward deductible or coinsurance. (The discount is available at participating pharmacies and is not an insurance benefit.)
Routine mammography and Pap smear	100%—covered charges are not subject to copay, deductible or coinsurance
Wellness benefits Covered services include a routine physical exam, well-child exams, PSA test, digital screening and colorectal cancer examination.	100%—covered charges are not subject to copay, deductible or coinsurance
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%—covered charges are not subject to copay, deductible or coinsurance
ER copay	$100; then subject to deductible and coinsurance (Waived if admitted inpatient immediately following emergency room visit.)
Outpatient surgical services copay	$250; then subject to deductible and coinsurance
Inpatient hospital confinement copay	$500; then subject to deductible and coinsurance

[1] The calendar-year maximum amount is $1 million through December 31, 2011.
[2] Maximum of three brand name deductibles per family, per calendar year.

Maximize your health care dollars with an HSA

A health savings account (HSA) is a special tax-advantaged 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, long-term care premiums and much more!

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

While you are free to open an HSA with any authorized vendor, mPowerMed 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 funds with a debit card that can be used at any provider that accepts Visa®.

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

Benefit limitations (Limitations apply to PPO and Traditional plans)	M5 and HSA5	N2
Physical, speech and occupational therapies After the deductible has been satisfied, covered charges will be paid at the selected coinsurance level.	Maximum of 30 treatments for one type of therapy and up to 60 treatments for any combination of therapies per calendar year per covered person	Maximum of 20 treatments for one type of therapy and up to 40 treatments for any combination of therapies per calendar year per covered person
Home health care After the deductible has been satisfied, covered charges will be paid at the selected coinsurance level.	Maximum of 35 visits per calendar year per covered person	Maximum of 21 visits per calendar year per covered person
Organ transplant: Center of Excellence provider If a Center of Excellence is utilized, a travel expense allowance is included for up to $5,000 for one companion, or two companions if the insured is a minor.	Subject to the policy's calendar-year maximum of $2,000,000	Subject to the policy's calendar-year maximum of $1,250,000[1]
Organ transplant: provider not listed as a Center of Excellence	Maximum benefit of $250,000 per transplant	
Skilled nursing facility care After the deductible has been satisfied, covered charges will be paid at the selected coinsurance level.	Maximum of $100 per day, per covered person	
Outpatient mental or nervous disorders and chemical dependency disorders	Maximum of $25 per visit, subject to deductible and coinsurance (Benefits are not provided for inpatient chemical dependency treatment.)	
Inpatient mental or nervous disorders	Maximum of $250 per day, subject to deductible and coinsurance	
Non-surgical back treatment (Including but not limited to chiropractic care)	Maximum of 10 visits per calendar year per covered person, subject to deductible and coinsurance	
Hospice care	The plan will pay covered expenses for hospice care for up to six months, not subject to any copays, deductible or coinsurance[2]	

[1] The calendar-year maximum amount is $1 million through December 31, 2011.
[2] Hospice charges on the HSA5 plans are subject to deductible and coinsurance

Optional benefits

Supplemental accident

Your family's active lifestyle can lead to bumps and bruises along the way. Our supplemental accident benefit pays 100 percent up to the selected per-accident maximum of $500, $1,000 or $2,500 and applies for covered charges incurred for treatment of an accidental bodily injury. This benefit also covers follow-up care received within three months from the date of the accident and is available for an unlimited number of accidents while coverage under the rider is inforce. Covered charges incurred after the maximum benefit is paid, or more than three months after the accident, are subject to deductible and coinsurance.

Life insurance

mPowerMed offers a term life insurance benefit for you as the primary insured. If you elect life insurance coverage, you may select a benefit from $10,000 to $100,000, in increments of $10,000. The life insurance benefit is payable as long as the mPowerMed health plan is inforce on the date of the primary insured's death.*

* Term life insurance benefits are subject to a reduction schedule based on age. The selected 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 80-84: 15 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 rider.

Important information

Covered critical illness descriptions

Benefits payable are subject to the following definition of each covered critical illness. Diagnosis must be made by a legally qualified physician through the use of clinical or laboratory findings.

Life-threatening cancer: For a cancer to be considered life-threatening and a covered critical illness it must be characterized by an uncontrolled growth and spread of malignant cells and the invasion of tissue such as leukemia or lymphoma. Diagnosis must be made by a physician pursuant to a pathological or clinical diagnosis. Life-threatening cancer does not include pre-malignant lesions, benign tumors or polyps, skin cancer (other than invasive metastatic malignant melanoma in the dermis or deeper or skin malignancies that have become metastatic) or early prostate cancer diagnosed as T1NOMO or equivalent staging.

Cancer in situ: A diagnosis of cancer by a physician in which the tumor cells have not invaded neighboring tissue is considered cancer in situ. Included in this covered critical illness is early prostate cancer diagnosis (stage one) and melanoma not invading the dermis of the skin. Benign tumors or polyps, pre-malignant lesions or other skin malignancies are not considered a cancer in situ covered critical illness.

Kidney (renal) failure: End-stage renal failure is considered a covered critical illness when characterized by chronic and irreversible failure of both kidneys that requires periodic and ongoing dialysis.

Heart attack: A heart attack is considered a covered critical illness when it is an acute myocardial infarction resulting in the death of a portion of the heart muscle due to a blockage of one or more coronary arteries and resulting in the loss of normal heart function. The diagnosis must be based on new electrocardiographic changes consistent with an evolving heart attack and serial measurement of cardiac biomarkers showing a pattern to a level consistent with a diagnosis of heart attack.

Stroke: Stroke includes any acute cerebrovascular accident producing neurological impairment and resulting in paralysis or a neurological deficit, persisting for at least 96 hours and expected to be permanent. Transient ischemic attack (mini-stroke), head injury, chronic cerebrovascular insufficiency and reversible ischemic neurological deficits are not considered covered critical illnesses.

Coma: For a coma to be considered a covered critical illness the insured person must be in a state of unconsciousness from which she or he cannot be aroused and external stimulation produces no more than primitive avoidance reflexes for a period of at least 96 hours.

Major organ transplant: An organ transplant is considered a covered critical illness when an organ or tissue fails and must be replaced by one from a suitable human donor. Covered transplant organs and tissues are limited to liver, kidney, lung, entire heart, small intestine, pancreas, pancreas-kidney or bone marrow. The organ recipient must be registered by the United Network for Organ Sharing or the National Marrow Donor Program.

Severe burn: A severe third-degree burn covering at least 20 percent of the body is considered a covered critical illness.

Out-of-pocket maximums

The out-of-pocket maximum amount does not include the deductible, copays, plan penalties, outpatient mental, nervous or chemical dependency disorders or expenses not covered by the plan. However, for HSA5 plans, outpatient mental, nervous or chemical dependency disorders **do** apply to the out-of-pocket maximum.

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) The number of dependents covered under the plan changes; or 3) A change in benefit options or PPO network.

Eligibility

If you are a dues paying member of Communicating for America, Inc., under age 65 and a permanent resident of the United States, you and your eligible dependents may apply to purchase the mPowerMed plan. You can apply by completing an application for insurance and by qualifying for coverage based on the plan's underwriting guidelines. Eligible dependents include: your lawful spouse under age 65 and your child(ren) up to age 26.

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 inforce and not excluded by the policy. Covered charges are subject to applicable copays, deductibles, coinsurance amounts, limitations and maximums, unless otherwise noted in the schedule of benefits section of the Certificate of Coverage.

The Usual and Reasonable Charge, as determined by us, is the reasonable charge made by most providers or other suppliers of medical services and supplies within a specific geographic area significant enough to establish a representative base of charges for treatment.

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 nonemergency 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 mPowerMed plan application 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: Failure to fully disclose health information on the mPowerMed application for coverage can result in recission or reformation of coverage.

Termination of insurance

A covered person's insurance under the policy will remain inforce 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 date the insured person reaches the maximum benefit, the insurer lawfully discontinues offering coverage under the policy or 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 spouse's coverage terminates on the premium due date following a divorce, legal separation or annulment of such marriage. 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 LIST AND 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:

- A pre-existing condition
- Any service or supply in connection with the implant of an artificial organ
- Any treatment, service, supply or prescription medication which: 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 nonemergency 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
- Email 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
- Nonemergency care ambulance services, durable medical equipment that exceeds $1,000 and certain prescription medications, unless predetermined
- 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 Charge

Madison National Life Insurance Company, Inc.

Madison National Life Insurance Company, Inc., is a member of The IHC Group. Founded in 1961 and domiciled in Madison, Wisc., Madison National Life is licensed in 49 states and the District of Columbia. Madison National Life is rated A- (Excellent) for financial strength by A.M. Best Company, Inc., a widely recognized rating agency of insurance companies that rates insurers on their relative financial strength and ability to meet their obligations to their insured. (An A++ rating from A.M. Best is its highest rating.)

Group Association Major Medical Insurance

In most states, insurance coverage is available to members of Communicating for America, Inc. (CA), the Group Policyholder. Coverage is available to members under a Group Certificate of Coverage, Form No. MNL GC 107. CA is not compensated by Madison National Life for its endorsement.

Communicating for America, Inc.

Communicating for America, Inc. (CA) 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 issues in Washington, D.C., CA provides high-quality, valuable member benefits.

Individual Major Medical Insurance

In the states of Colorado, Georgia, Kansas, Montana and South Dakota, health insurance coverage is offered under an Individual Health Insurance Policy, Form No. MNL IP 107.

mPowerMed health insurance - 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/Policy within 10 days of your receipt and receive a premium refund.

Health insurance coverage under the mPowerMed plans is not available in all states.

The information included in this brochure is an outline of features, plan provisions, benefits and other information about mPowerMed. Plans offered may be subject to change. This brochure is not intended to serve as legal interpretation of the benefits, exclusions or limitations which are provided under the Certificate/Policy. 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.

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

THE IHC GROUP
Independence Holding Company