Select

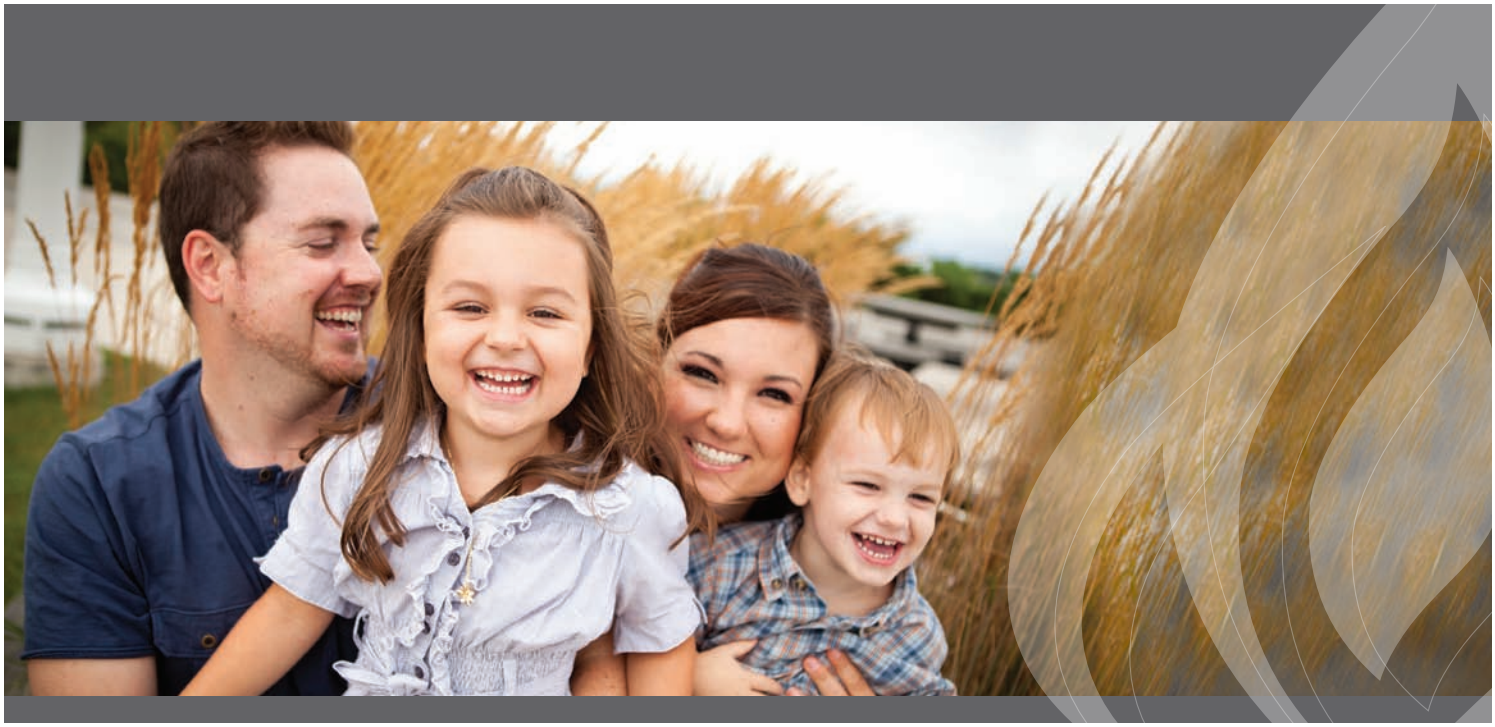
Specified hospital and surgical indemnity benefits for you and your family

Select is a group association fixed indemnity insurance plan 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 Independence Holding Company and The IHC Group, see www.ihcgroup.com.

Select plans are available to members of Communicating for America, Inc. (CA) the Policyholder of the "Group Fixed Indemnity Health Insurance Policy." Individual policies are issued in the states of Colorado, Maine and South Dakota so membership in CA is not required for these residents. Additional states are expected to follow. Please ask your broker or agent for details.

THE IHC GROUP
Independence Holding Company

MNL HIP 0311



Select health insurance plans pay fixed benefit amounts to protect against covered medical expenses resulting from hospitalization, surgery and certain outpatient therapy services.

Select may be the right fit if you are looking for:

Financial protection

Every Select plan provides coverage for hospitalization and surgery charges. You can choose from six plans with varying levels of benefits for inpatient and outpatient surgeries, hospital confinement, chemotherapy and more.

Extra coverage

Choose from our available optional indemnity benefits and add coverage that is important to you, including benefits for physician office visits, prescription drugs and preventive care.

Millions of Americans find that traditional major medical plans do not meet their needs because of cost or because they cannot meet the underwriting requirements. Select allows applicants to choose from the available options to build a plan that fits their budget.

A fixed indemnity hospital and surgical plan may not be right for everyone. Select is not major medical insurance, but can be used to complement your insurance plan. Plan premiums are affordable because of the limited nature of each benefit. It is very important that you review the plan information closely.

Providing numerous possibilities

- Coverage from an insurance company rated A- (Excellent), for financial strength, by A.M. Best Company, Inc., a widely recognized rating agency that rates the financial strength of insurance companies on their ability to meet policyholder obligations;
- Many plan options with a range of premium levels to choose from;
- Flexibility to choose any doctor or hospital; however, additional cost savings are available when choosing a MultiPlan network provider;
- Benefits for inpatient hospitalization, surgery and certain outpatient services;
- Plan pays the benefits you select, regardless of amount charged for services; and
- Protection so you cannot be singled out for rate increases or cancellation based on your claims.

MultiPlan – Your discount provider network

The Select plans give you access to provider discounts through the MultiPlan PPO network. While you have the flexibility to choose any provider, the discounts available through MultiPlan providers help to lower your out-of-pocket costs. MultiPlan is one of the country's largest independent PPO networks with more than 500,000 providers in 50 states. These providers have agreed to negotiated discounts, which are reflected in your final bill.

If your plan benefits are higher than provider charges after any available MultiPlan discounts, the balance will be paid directly to you if benefits were assigned to the health care provider.

Using the MultiPlan network is simple

- Visit www.multiplan.com or call 800-672-2140 to determine which providers in your area are part of the MultiPlan network.
- Present your Select ID card at the time of your service.
- The provider will electronically send the billing information to MultiPlan.
- You will receive an explanation of benefits (EOB) that will show you:
  - The amount charged by the provider
  - The MultiPlan network discount if you visited a network provider
  - The amount paid by your Select series plan
  - The amount you owe the provider

Select your benefits

Per injury or illness deductible

❑ $250 ❑ $500 ❑ $1,000 ❑ $1,500 ❑ $2,000 ❑ $2,500 ❑ $3,000 ❑ $5,000 ❑ $7,500 ❑ $10,000

The selected deductible applies per covered person for each period of treatment and must be satisfied for each separate injury or illness before plan benefits begin. If multiple covered persons in a family are injured in the same accident, only one deductible must be satisfied for each period of treatment.

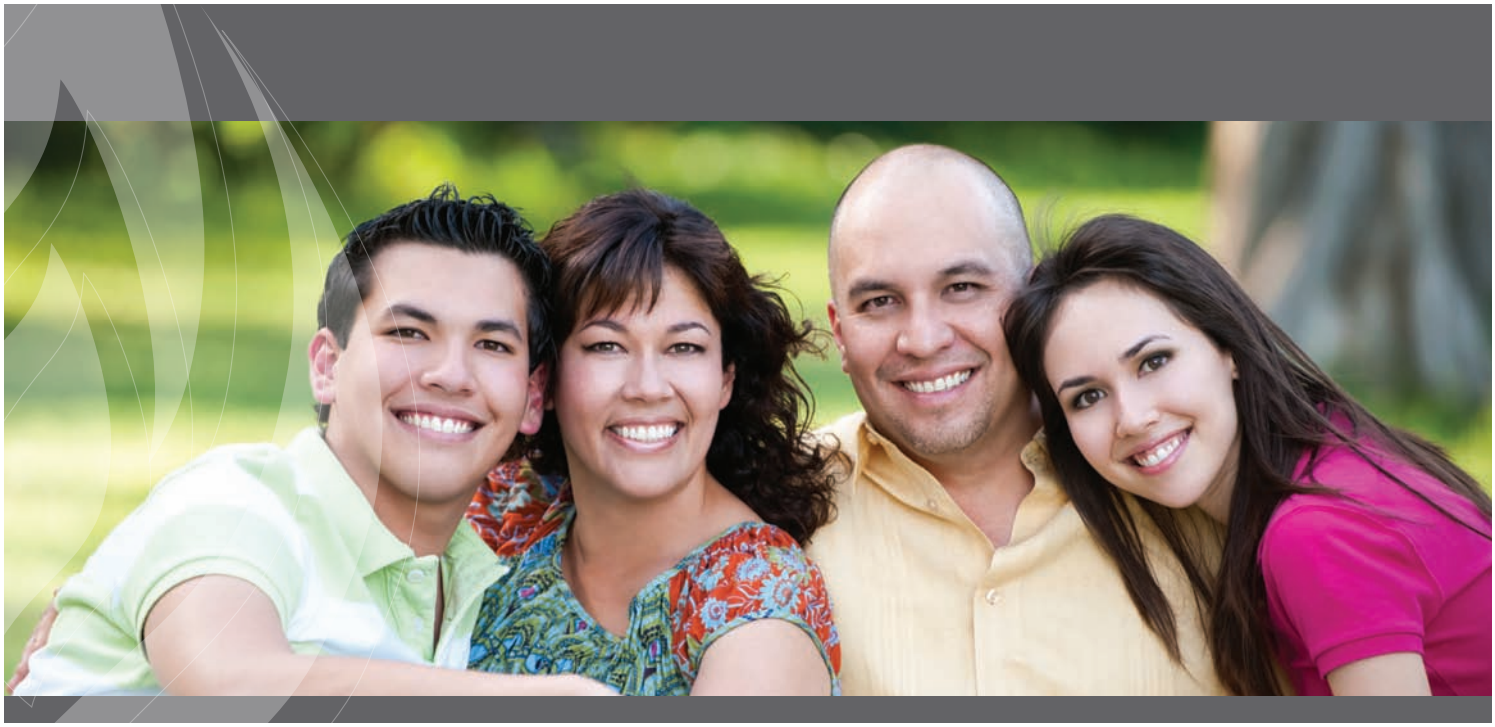
Per injury or illness lifetime maximum benefit $500,000

Inpatient fixed indemnity benefits *Subject to the per injury or illness deductible*

	Select 200	Select 300	Select 400	Select 500	Select 600
Daily hospital room and board	$200	$300	$400	$500	$600
Daily hospital intensive care	$600	$900	$1,200	$1,500	$1,800
Physician visits while hospital confined (limited to one inpatient doctor visit per day)	$20	$30	$40	$50	$60
Miscellaneous hospital services (per day)	❑ $200 ❑ $400 ❑ $600	❑ $300 ❑ $600 ❑ $900	❑ $400 ❑ $800 ❑ $1,200	❑ $500 ❑ $1,000 ❑ $1,500	❑ $600 ❑ $1,200 ❑ $1,800
Surgeon (per surgery)	❑ $600 ❑ $1,000 ❑ $2,000	❑ $900 ❑ $1,500 ❑ $3,000	❑ $1,200 ❑ $2,000 ❑ $4,000	❑ $1,500 ❑ $2,500 ❑ $5,000	❑ $1,800 ❑ $3,000 ❑ $6,000
Assistant surgeon (per surgery)	20% of the selected inpatient surgeon benefit				
Anesthesiologist (per surgery)	30% of the selected inpatient surgeon benefit				

Outpatient fixed indemnity benefits *Subject to the per injury or illness deductible*

Surgery facility (per surgery)	❑ $200 ❑ $400 ❑ $600	❑ $300 ❑ $600 ❑ $900	❑ $400 ❑ $800 ❑ $1,200	❑ $500 ❑ $1,000 ❑ $1,500	❑ $600 ❑ $1,200 ❑ $1,800
Surgeon (per surgery)	❑ $400 ❑ $600 ❑ $800	❑ $600 ❑ $900 ❑ $1,200	❑ $800 ❑ $1,200 ❑ $1,600	❑ $1,000 ❑ $1,500 ❑ $2,000	❑ $1,200 ❑ $1,800 ❑ $2,400
Assistant surgeon (per surgery)	20% of the selected outpatient surgeon benefit				
Anesthesiologist (per surgery)	30% of the selected outpatient surgeon benefit				
Second surgical opinion office visit	$100	$100	$100	$100	$100
Chemotherapy and radiation therapy (limited to a lifetime maximum benefit of 100 treatments)	$300	$450	$600	$750	$900
Physical, speech and occupational therapy	$50 per therapy, limited to 30 treatments for any one type of therapy and limited to 60 treatments for any combination of therapies.				



Additional indemnity benefits

Ambulance	The plan pays $500 per trip for ground ambulance to and from a hospital or other qualified facility, subject to the per injury or illness deductible.
Continued care	• Skilled nursing: $100 per day, limit 60 days per injury or illness • Private-duty nursing: $50 per shift, limit 40 eight-hour shifts per injury or illness • Home health care: $100 per visit, limit 80 visits per injury or illness • Hospice care: $2,000, paid once while covered under the policy The plan pays the stated continued care benefit when continued care services begin within 15 days following a hospital confinement, subject to the per injury or illness deductible

Optional indemnity benefits

Outpatient physician office visit	❑ $25 per visit, limit one visit per covered adult and two visits per covered child per calendar year ❑ $50 per visits, limit two visits per covered adult and four visits per covered child per calendar year The selected physician office visit benefit is not subject to the per injury or illness deductible.
Outpatient prescription medication	❑ No prescription deductible ❑ $100 brand name—prescription deductible per calendar year ❑ $200 brand name—prescription deductible per calendar year The outpatient prescription medication calendar year deductible family maximum is satisfied when three covered persons have each satisfied their prescription medication calendar-year deductible. If this optional benefit is selected, the prescription medication indemnity benefit is limited to the following: • Generic: $4 benefit per prescription, limit of six per calendar year, not subject to the prescription medication deductible • Brand name: after the prescription medication deductible, if selected, has been met, the following benefits apply: - Formulary: $20 benefit per prescription* - Non-formulary: $20 benefit per prescription* - Specialty: $50 benefit per prescription, limit of six per calendar year

* The outpatient formulary and non-formulary prescription medication benefit is limited to a combined calendar-year maximum benefit of six per covered person per calendar year. The benefit is not subject to the per injury or illness deductible.

More optional indemnity benefits

Preventive care

❑ $100 per visit ❑ $200 per visit

Benefit is payable after the covered person has been covered under this optional benefit for six consecutive months. This optional benefit pays the selected benefit amount per visit, limited to two visits per calendar year. Covered services include: one routine physical examination including diagnostic tests that are performed during or in conjunction with the routine examination, routine Pap smear, annual screening mammogram, immunizations and prostate and colorectal cancer screenings. The benefit is not subject to the per injury or illness deductible.

Critical illness deductible waiver

❑ 50% ❑ 100%

After a six-month waiting period, the per injury or illness deductible will be waived by the percentage amount selected when the covered person is diagnosed for the first time following the covered person's coverage effective date under the policy with one of the following critical illnesses, as defined in the policy:

- Heart attack
- Stroke
- Life-threatening cancer
- Coma
- Kidney (renal) failure

The deductible is waived for the initial period of treatment and is limited to one deductible waiver during the covered person's lifetime.

Outpatient diagnostic testing

Diagnostic X-ray and lab tests	Advanced study tests
❑ $50	$250
❑ $75	$500
❑ $100	$1,000

This optional benefit pays the selected amount, subject to the per injury or illness deductible. The diagnostic X-ray and lab tests benefit is limited to two tests per calendar year. The advanced study tests benefit is limited to one test per calendar year. *The diagnostic testing benefit is payable only when the covered person receives outpatient testing within 30 days following an inpatient confinement or outpatient surgery for a covered injury or illness.*

Emergency room

If selected, this option pays a benefit amount equal to 25 percent of the selected plan's daily hospital room and board benefit for an emergency treatment in an emergency room. The benefit is limited to two emergency room visits per calendar year and is not subject to the per injury or illness deductible.

Inpatient confinement enhancement

Increase the benefits paid under the plan when the total number of inpatient confinement days exceeds one of the following during the same period of treatment:

❑ 30 days ❑ 60 days ❑ 90 days

When the total number of inpatient confinement days exceeds the number of days selected, during the period of treatment, this optional benefit increases plan benefits based on the multiples below:

- Daily hospital room and board: two times the selected plan's benefit amount
- Daily hospital intensive care: 1.5 times the selected plan's benefit amount
- Miscellaneous hospital services: 1.5 times the selected miscellaneous services benefit

These enhanced benefits are paid retroactively beginning with the first day of inpatient care and are applicable for every inpatient day related to that period of treatment for the same covered injury or illness. Benefits are subject to the per injury or illness deductible.

Plan and benefit details

Per injury or illness deductible

The selected per injury or illness deductible must be satisfied for each separate covered injury or illness before plan benefits begin. The deductible applies per covered person for each period of treatment. However, if multiple covered persons in a family are injured in the same accident, only one deductible must be satisfied for each period of treatment. A period of treatment begins: 1) when a covered person is initially admitted to the hospital, 2) when services are provided in an outpatient surgical facility or 3) when chemotherapy or radiation therapy is received on an outpatient basis. The period of treatment ends 180 consecutive days later for the same or related injury or illness. If treatment extends past 180 days for the same injury or illness, a new period of treatment will begin and a new per injury or illness deductible will be required. A separate period of treatment will apply to each covered injury or illness.

Per injury or illness lifetime maximum benefit

The selected maximum benefit applies per covered person for each covered injury or illness. When a covered person reaches the per injury or illness lifetime maximum benefit, no further benefits are payable for that injury or illness.

The following benefits are subject to the per injury or illness deductible:

Daily hospital room and board benefit

The daily hospital room and board benefit is paid for each day of inpatient confinement and general nursing furnished by the hospital. This benefit is not paid if benefits are paid under the daily hospital intensive care benefit.

Daily hospital intensive care benefit

The daily hospital intensive care benefit is paid for each day of inpatient confinement in the hospital's intensive care or cardiac care unit, burn unit or other specialized care unit of a hospital. This benefit is paid in lieu of the daily hospital room and board benefit.

Miscellaneous hospital services benefit

The selected miscellaneous hospital inpatient services benefit is paid for each day of inpatient confinement and includes hospital miscellaneous medical services and supplies, X-rays, laboratory tests and other diagnostic tests, chemotherapy or radiation services for the treatment of cancer, services of a radiologist or radiology group and for services of a pathologist or pathology group for interpretation of diagnostic tests or studies necessary for the treatment of the covered person while confined inpatient. This benefit does not include fees charged for take-home drugs, personal convenience items or items not intended primarily for the use of the covered person while confined inpatient.

Surgeon benefit

The inpatient surgeon benefit or outpatient surgeon benefit is paid per surgery and is based on whether it was performed while admitted as an inpatient or performed at an outpatient surgical facility. If two surgeries are performed through the same incision, then 100 percent of the surgeon benefit is paid for the first surgery and 50 percent of the surgeon benefit is paid for the second and subsequent surgeries. If two surgeries are performed through different incisions, then 100 percent of the surgeon benefit is paid for each surgery.

Assistant surgeon benefit

The assistant surgeon inpatient benefit or the assistant surgeon outpatient benefit is paid for services rendered by an assistant surgeon or by a licensed surgical assistant who is performing duties within the scope of her or his license. The benefit is paid per surgery and is based on whether the surgery was performed while admitted as an inpatient or performed at an outpatient surgical facility.

Anesthesiologist benefit

The anesthesiologist inpatient benefit or the anesthesiologist outpatient benefit is paid per surgery when a covered person receives anesthesia. The benefit paid is based on whether the related surgery was performed while admitted as an inpatient or performed at an outpatient surgical facility.

Outpatient surgical facility benefit

The outpatient surgical facility benefit is paid per outpatient surgery in an outpatient surgical facility and includes services and supplies furnished by the facility, such as use of the operating and recovery rooms, administration of drugs and medicines during surgery; dressings, casts, splints and diagnostic services including radiology, laboratory or pathology performed at the time of surgery. Benefits are not payable when surgery is performed in a physician's office.

Second surgical opinion office visit benefit

This benefit pays $100 for a second surgical opinion prior to the surgery. If the second surgical opinion disagrees with the first opinion, a $100 second surgical opinion benefit will be paid for a third opinion. The benefit is only payable if the physicians providing the second and third opinions are not affiliated with or financially associated with the original physician and do not assist in the surgery.

Outpatient chemotherapy and radiation therapy for cancer treatment benefit

The outpatient chemotherapy and radiation therapy for cancer treatment benefit is 1.5 times the daily room and board benefit based on the plan selected. The benefit is per outpatient treatment for chemotherapy, including chemotherapy medication and radiation therapy for the treatment of cancer, limited to a lifetime maximum benefit of 100 treatments.

Outpatient physical, speech and occupational therapy benefit

This benefit pays $50 per therapy when a covered person receives outpatient therapy within 30 days following an inpatient confinement or outpatient surgery. Benefits are limited to 30 treatments for one type of therapy and 60 treatments for all therapies combined.

Optional critical illness deductible waiver benefit: covered conditions

If selected, the benefit will be payable subject to the following definition of each covered critical illness:

- **Heart attack**: 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 function of the heart. The diagnosis must be made by a legally qualified physician board-certified as a cardiologist and based on both new clinical presentation and electrocardiographic changes consistent with an evolving heart attack, and serial measurement of cardiac biomarkers showing a pattern and to a level consistent with the diagnosis of a heart attack. A heart attack does NOT include an established (old) myocardial infarction.

- **Life-threatening cancer**: A malignant neoplasm is characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue and which is not specifically excluded. Leukemias or lymphomas are included. Cancer must be diagnosed pursuant to a pathological or clinical diagnosis. **Life-threatening cancer does not include**: pre-malignant lesions (such as intraepithelial neoplasia), benign tumors or polyps, any skin cancer (other than invasive malignant melanoma in the dermis or deeper or skin malignancies that have become metastatic), or early prostate cancer diagnosed as T1N0M0 or equivalent staging.

- **Kidney (renal) failure**: End-stage renal failure is a chronic and irreversible failure of both kidneys, which requires the covered person to undergo periodic and ongoing dialysis. The diagnosis must be made by a legally qualified physician board-certified in nephrology.

- **Stroke**: Any acute cerebrovascular accident producing neurological impairment and resulting in paralysis or other measurable objective neurological deficit persisting for at least 96 hours and expected to be permanent. The diagnosis must be made by a legally qualified physician board-certified as a neurologist. A stroke does NOT include transient ischemic attack (mini-stroke), head injury, chronic cerebrovascular insufficiency and reversible ischemic neurological deficits.

- **Coma**: The diagnosis, by a legally qualified physician board-certified as a neurologist, that a covered person is in a state of unconsciousness from which the person cannot be aroused, in which external stimulation will produce no more than primitive avoidance reflexes, and that this state has persisted continuously for at least 96 hours.

Coordination of benefits

The Select series does not coordinate benefits with other inforce health insurance plans.

Eligibility

If you are a dues-paying member of Communicating for America, Inc., between 19 and under 64.5 years of age and a permanent resident of the United States, you and your eligible dependents may apply to purchase a Select series plan. You can apply by completing an application for insurance, and you and your eligible dependents, if applying, must qualify for coverage based on the plan's underwriting guidelines. Eligible dependents include: your lawful spouse between 19 and under 64.5 years of age, and your child(ren) under age 26.

Effective date

You may request that your coverage become effective on either the 1st, 8th 15th or 22nd 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.

Precertification

Precertification is a screening process used to determine if the proposed inpatient confinement or outpatient chemotherapy or radiation treatment is medically necessary and appropriate. Failure to obtain the required precertification will result in no benefits being paid. Precertification is required at least seven days prior to each nonemergency inpatient confinement and within 48 hours of inpatient admission or as soon as reasonably possible for emergency inpatient confinement. Precertification is also required seven days prior to receiving outpatient chemotherapy and radiation therapy. Precertification is not pre-authorization or pre-approval of coverage and it does not guarantee payment of benefits. Payment of benefits will be determined in accordance with and subject to all the terms, conditions, limitations and exclusions of the policy.

Termination of insurance

A covered person's insurance under the policy will terminate on the earliest of the following: the date of termination of the group policy; the premium due date following the date a written request to terminate coverage is received; the date the premium is not paid; the date of death; the last day of the month following the date of attainment of age 65; the last day of the month following the date of Medicare eligibility; the last day of the month following termination of membership with the group policyholder; or the date the person enters the armed forces. A dependent spouse's coverage also terminates on the premium due date following a divorce or legal separation. 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. **Failure to fully disclose health information in the application for insurance can result in recission or reformation of coverage.**

Pre-existing condition definition and limitation

A pre-existing condition is a disease, accidental bodily injury, illness or physical condition for which a covered person: had treatment; incurred charge; took medication; or received a diagnosis or advice from a doctor; during the 12-month period immediately preceding the insured person's coverage effective date.

Covered benefits are payable for a pre-existing condition after the insured person has been continuously covered under the policy for 12 consecutive months. This does not apply to a newborn or newly adopted child placed for adoption under age 18 if such child is enrolled for coverage within 31 days from the date of birth or date of adoption or placement for adoption.

Exclusions

This is not a complete list of the policy's exclusions. Consult the Certificate of Insurance for a complete list and description of the benefits not covered.

Except as specifically provided for in the policy, the plan does not provide any of the following treatments, services or supplies:

- A pre-existing condition, as defined
- Preventive care, including routine physical examinations and immunizations (unless the optional preventive care benefit rider is selected)
- Treatment that is not medically necessary or not recommended by a doctor, or is not due to an injury or illness
- Any treatment provided by a government-owned or government-operated facility or by government-employed health care providers
- A weekend hospital confinement occurring between noon on any Friday and noon the following Sunday for nonemergency procedures, unless medically necessary or unless surgery is scheduled for the next day
- An illness or injury which arises out of or in the course of any employment for wage or profit or an illness or injury for which you or your covered dependent spouse has or had a right to recovery under any workers' compensation or Occupational Disease Law. This exclusion does not apply to an employment related injury or illness if you or your covered dependent spouse is a sole proprietor, partner or owner eligible under state law to legally elect to not be covered under workers' compensation and who is not insured under, and who does not have or had a right to recovery for such employment related injury or illness under any Workers' Compensation Law or Occupational Disease Law
- Physical or psychological examinations required by any third party, such as by a court or for employment, licensing, insurance, school, sports or recreational purposes
- An injury or illness incurred while on active duty with the military of any country or international organization, or resulting from war, act of war or participation in a riot or insurrection
- An injury or illness incurred during the commission or attempted commission of a crime or felony or while engaged in an illegal act or while imprisoned
- An injury or illness, incurred due to, or contracted as a consequence of a covered person being intoxicated or under the influence of illegal narcotics or other drugs, unless the drug is administered by a doctor and taken in accordance with the prescribed dosage
- An injury or illness for which treatment, services or supplies were 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 an emergency, provided the treatment, services or supplies used in connection with the emergency are approved for use in the United States
- Treatment, services or supplies for: a) breast augmentation; b) the removal of breast implants unless medically necessary and related to surgery performed as reconstructive surgery due to an illness; and c) breast reduction surgery unless medically necessary due to an illness
- Surgery to correct refractive errors
- Routine eye exams, glasses or contact lenses, or visual therapy
- Routine hearing exams or hearing aids
- Penile implants and fertility and sterility studies
- Pregnancy; routine newborn care; voluntary abortion; infertility including impregnation techniques; or reversal of sterilization
- Mental illness disorders; substance abuse; tobacco cessation programs and products
- Marriage or family counseling, recreational therapy, equine therapy, educational therapy, social therapy, sex therapy; or sexual reassignments, dysfunctions or inadequacies
- Meridian therapy (acupuncture), or spinal manipulation

- Orthotics; treatment, services or supplies related to the feet by means of posting, strapping or range-of-motion studies; or related to paring or removal corns, calluses, bunions or toenails

- Obesity or weight reduction including all forms of surgery and complications resulting from such surgery; education or training materials

- Treatment for which the covered person is not required to pay; or treatment rendered by a person who ordinarily resides in your household or is a member of your immediate family

- Custodial care, domiciliary care or rest cures regardless of who prescribes or renders such care; inpatient personal convenience items

- An injury or illness resulting from participation in hazardous avocations including: mountain or rock climbing, skydiving, hang gliding, motor vehicle racing, scuba diving, rodeo or private aviation

- Telephone consultations, missed appointment fees and fees for completing claim forms

- Treatment, services or supplies for complications of conditions that are not covered under the policy

- Outpatient prescription medications (unless the optional outpatient prescription medication benefit rider is selected)

- Treatment, services or supplies related to the teeth, gums, or any other associated structures

- Treatment for temporomandibular joint (TMJ) dysfunction

- Experimental or investigational procedures, drugs or treatment methods

- Intentionally self-inflicted injury or illness while sane; except a self-inflicted injury or illness that is the result of a medical condition

- Outpatient treatment, services and supplies except as specifically provided for in the policy

Partners

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

The IHC Group

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.

Communicating for America, Inc. (CA) was established more than 35 years ago to provide benefits and services to individuals, families and small businesses. CA's mission is to promote health, well-being and the advancement of all self-employed Americans and small business owners; give members the right and opportunity to set policies and goals; and deliver valued member benefits at the best price and of the highest quality.

Communicating for America, Inc. is the Policyholder for the "Group Fixed Indemnity Health Insurance Policy." Therefore, Select plans are available to members of CA. In Colorado, Maine and South Dakota individual policies are issued and residents are not required to be a member of CA. Additional individual states are expected to follow. Please contact your broker or agent for details.

Satisfaction guaranteed

If you are not completely satisfied with the insurance coverage you have purchased 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 Select series fixed indemnity hospital and surgical insurance plan. Plans offered may be subject to change. This brochure is not intended to serve as legal interpretation of the benefits which are provided under the master policy form number MNL MMHI POL D610 issued to Communicating for America, Inc. in the District of Columbia. The exact provisions governing the insurance contract are contained in the master policy underwritten by Madison National Life Insurance Company, Inc. 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 Select series' plans, please refer to the health insurance Certificate of Insurance form number MNL HICERT D610. If there is a discrepancy between the master policy and this brochure, the master policy prevails.

Select

Specified hospital and surgical indemnity benefits for you and your family

THE IHC GROUP
Independence Holding Company