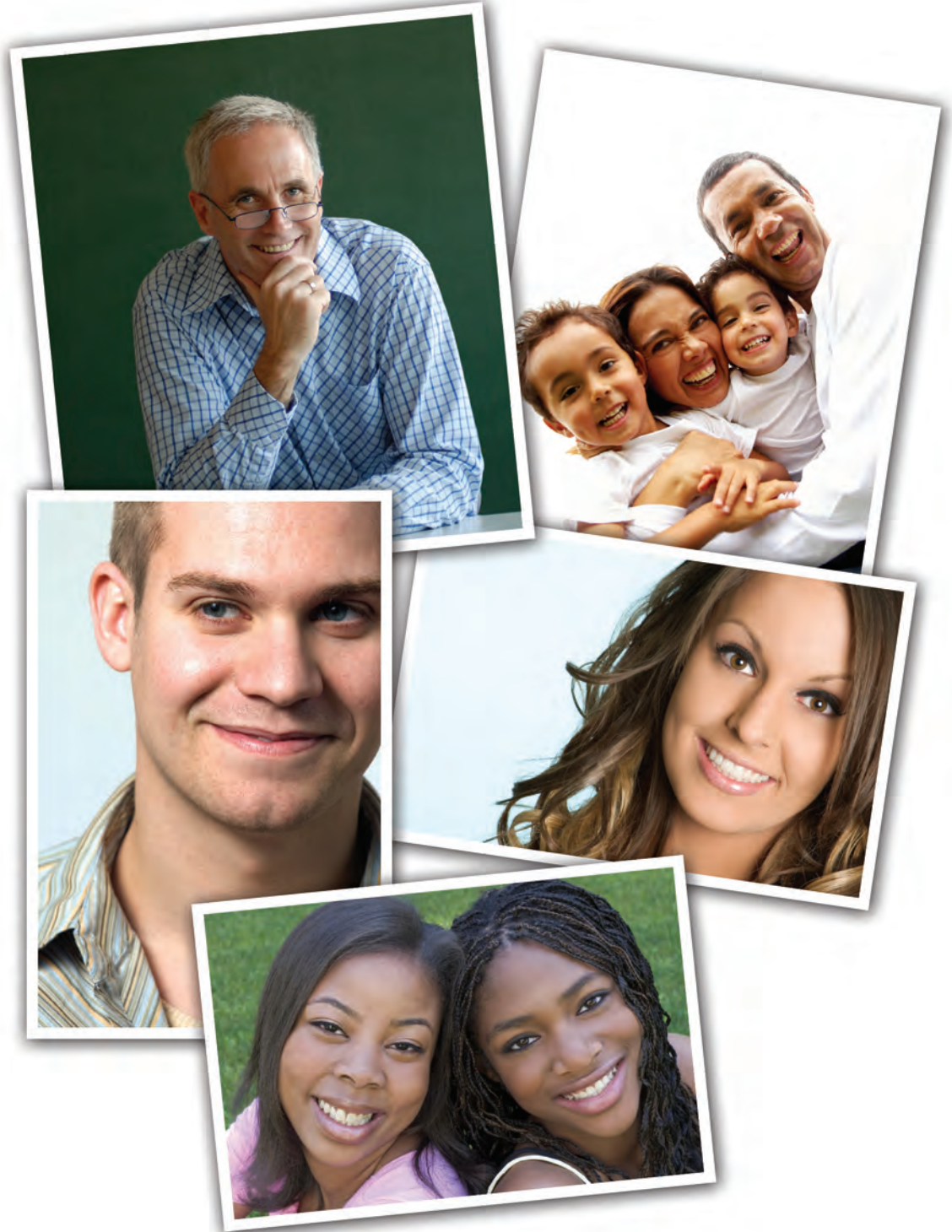


Personal Health Plans

Simple Solutions for Individuals and Families

Fully insured medical insurance



Personal Health Plans are underwritten by Standard Security Life Insurance Company of New York, a member of The IHC Group, and available to members of Communicating for America, Inc. Membership is optional for residents of Colorado, Georgia, Kansas, Montana and South Dakota.

 **THE IHC GROUP**
Independence Holding Company

Simple Solutions for Individuals and Families

Before you purchase health insurance, research your options to ensure you choose a company you can count on—one that cares about helping you select the best plan for your situation.

Health plans built on choice.

- Multiple options for copays and deductibles
- More than 50 PPO networks
- Choice of prescription drug benefits
- Value-added benefits included with every plan—use one or use them all, depending on your changing health needs
- Personalized customer support by telephone during normal business hours—or 24/7 online access at a time that's convenient for you

Forced Providers Covered In-Network

Certain providers, such as radiologists, pathologists, anesthesiologists and assistant surgeons may, have relationships with network facilities but are not included in your PPO network. Understanding 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 covered charges will be based on usual and reasonable charges if both the hospital and admitting physician participate in your selected PPO network.



Choose From Six Plan Designs

Deluxe Plan

- Most comprehensive plan
- Offers the lowest out-of-pocket options

Advantage Plan

- Provides lower premiums without sacrificing benefits
- Employs two separate out-of-pocket maximums to achieve reduced premiums: one for medical services and supplies, and a second for outpatient surgical services and inpatient confinement

Value Plan

- When affordability is your top priority
- Offers comprehensive coverage for hospitalization and surgery, and limited coverage for typical services like office visits and diagnostic exams

Copay Plan

- Creative use of copays, coinsurance and deductible help make benefits economical
- An affordable option when you prefer the predictability of copays

Premier Plan

- A smart health plan designed to keep premiums low without exposing you to high deductibles
- Covered charges that exceed the daily deductible amount on any given day are covered at 100 percent

High-Deductible Health Plan

- A consumer-directed health plan that offers lower premiums and is qualified for use with a health savings account (HSA)
- Achieve premium savings through in-network 100 percent coinsurance with a single deductible, or choose the in-network 80 percent coinsurance option for even greater premium savings

See separate plan overviews for details and outpatient prescription drug options.

Consumer-Directed Options

Premier Plan

The Premier Plan protects you and your pocketbook. Instead of a higher calendar-year deductible, this plan offers a choice of two daily deductibles. For example, select the in-network \$500 daily deductible and an individual's out-of-pocket amount for in-network covered charges will not exceed \$500 each day, whether receiving an X-ray, surgery or other covered services.

Example (In-Network)	Cost of Service	What You Pay* (Premier Plan)	What You Pay** (Traditional PPO Plan)
Day one Physician office visit	\$72	\$40 copay	\$40 copay
Day two X-ray taken	\$68	\$68 applied to out-of-pocket	\$68 applied to deductible
Two weeks later: Blood work, ultrasound and CT scan all on the same day	\$2,047	\$500 applied to out-of-pocket	\$2,047 applied to deductible
One month later: Outpatient gallbladder removal	\$4,000	\$500 applied to out-of-pocket	\$385 applied to deductible \$723 out-of-pocket
Later that year: Accident resulting in a four-day hospital stay	\$28,000	\$500 each day, for a total of \$2,000 applied to out-of-pocket	\$3,277 out-of-pocket
TOTAL COST	\$34,187	\$3,108	\$6,540

*Based on \$500 daily in-network deductible, \$4,000 calendar-year out-of-pocket and \$40 physician office visit charge copay. Cost of services is after PPO network discount.

**Based on \$2,500 calendar-year deductible, 80 percent coinsurance, \$4,000 calendar-year out-of-pocket maximum. Cost of services is after PPO network discount.

High-Deductible Health Plan

This insurance plan can be used in conjunction with a tax-favored health savings account (HSA).* An HSA allows you to set aside tax-free money that can accrue interest and may be used toward qualified medical expenses. Because your balance is carried over each year, you can use your HSA to save for future medical expenses, such as the following year's out-of-pocket expenses, or retirement.

The example below shows potential tax savings and a 50 percent savings on premium. Plus, any unused HSA funds roll over and can be used for next year's deductible!

	HDHP 80% \$5,450 deductible	Deluxe Plan \$1,500 deductible
Annual premium	\$2,397	\$4,777
Annual HSA deposit	\$2,000	\$0
Tax savings (28% tax bracket)	\$560	\$0
Total cost of annual health premiums after tax savings	\$1,837	\$4,777

* Always consult with your personal tax adviser regarding the tax implications of an HSA.

Covering More Than the Basics

Take charge of your health by taking advantage of all we have to offer. Personal Health Plans include these benefits and services:

Optum® 24-Hour NurseLine

Provides 24/7 telephone access to registered nurses for guidance with treating various health-related conditions.

Personal Wellness Profile

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

MyHealthCompass™

A health care tool that provides pricing and quality-of-care comparisons for medical services performed in various cities, states or regions.

Lab Card Select®

Receive outpatient laboratory testing at a significant savings over other labs when your covered lab services are performed by Quest Diagnostics, a fully accredited and certified laboratory.

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 nearly 20,000 credentialed providers.

*DISCLOSURE:

1. THIS PLAN IS NOT INSURANCE.
2. The plan provides discounts at certain health care providers for medical services.
3. The plan does not make payments directly to the providers of medical services.
4. 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.
5. Discount Medical Plan Organization and administrator: Careington International Corporation, 7400 Gaylord Parkway, Frisco, TX 75034; phone 800-441-0380.

^ Note to Texas Consumers: Regulated by the Texas Department of Licensing and Regulation, P.O. Box 12157, Austin, Texas 78711; telephone 800-803-9202 or 512-463-6599; Web site: www.license.state.tx.us/complaints. This program is not available in Vermont and Montana.

TelaDoc™ – Medical Care by Telephone

TelaDoc is a national network of board-certified physicians providing cross-coverage consultations 24 hours a day, 365 days a year. TelaDoc physicians use electronic health records (EHRs) and telephone consultations to diagnose, recommend treatment and write short-term non-DEA- controlled prescriptions, when appropriate. TelaDoc does not replace the existing primary care physician relationship, but instead enhances it with an efficient, cost-effective alternative for minor medical problems. Members simply make a phone call and, in most cases, speak to a physician in about 30 minutes (three hours guaranteed).

TelaDoc treats non-emergency conditions like:

- Allergies
- Bronchitis
- Cold or Flu
- Pink Eye
- Poison Ivy
- Respiratory Conditions
- Sinus Infections
- Urinary Tract Infections

TelaDoc services are available for all ages at a low cost to you – only \$10 per consultation!

* TelaDoc™ is not an insurance benefit

Disclaimers:

TelaDoc does not replace the primary care physician. TelaDoc is not available in Oklahoma. TelaDoc does not guarantee that a prescription will be written, and operates subject to state regulations. TelaDoc does not prescribe DEA controlled substances. TelaDoc physicians reserve the right to deny care for potential misuse of services. TelaDoc, Inc. © 2002–2010.

Optional Enhancements

In addition to the many benefits and services included, these optional benefits are also available:

Wellness/Preventive Care

Includes routine physicals, colorectal screening, well-child care, prostate cancer screening and flu shots. Covers 100 percent up to \$250 or \$500 per insured per calendar year at in-network providers.

Outpatient Prescription Drug Coverage

Choose an optional drug benefit to meet your needs.

Vision Insurance Benefit

Receive savings through EyeMed Vision Care® on eye care needs including 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.

Supplemental Accident Coverage

Choose either \$500 or \$1,000 maximum benefit. Plan pays 100 percent of each accident's covered charges up to the selected benefit per insured. Charges for the covered injury must be incurred within three months after the date of the injury and while coverage under the optional rider is in force. Covered charges incurred after the maximum benefit is paid, or three months after the accident, are subject to the plan's applicable copay, deductible and coinsurance. Benefit applies to both in- and out-of-network providers.

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 sickness.

18-Month Initial Rate Guarantee

Extend your plan's initial 12-month rate guarantee period for an additional six months.

Additional Life Insurance*

Up to \$100,000 of life insurance is available for the primary insured. Not available in Florida, Georgia, Kansas or Texas.

*Term life insurance benefits are subject to a reduction schedule based on age. The life benefit amount will be reduced to a percentage of that amount as follows: Age 65-69: 65%, Age 70-74: 40%, Age 75-79: 25%, Age 80-84: 15%, Age 85+: 10%. 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.

Health Empowerment Package

Enhance your Personal Health Plan by adding our Health Empowerment Package.* These optional low-cost, high-value services will help you take control of your physical and financial well-being.

Optum Care24SM

This resource offers access to master's-level counselors, attorneys, financial advisers and dependent-care resources. Using Care24, you can address parenting challenges, relationship and marriage problems, work-related stress, addictions, dependent-care concerns, and more. You also have access to legal consultations and financial advisers.

TravelGuard

Travel worry-free with TravelGuard! When traveling more than 100 miles away from home and faced with a serious injury, illness or travel-related emergency, TravelGuard assists you with emergency services such as medical transportation, emergency message relay, travel document replacement, legal referrals, security and evacuation assistance.

You also have access to concierge services like flight re-booking, pre-trip travel advice, ground transportation and translation services.

Weight Watchers[®]

Weight Watchers offers a multidimensional, comprehensive way to learn how to achieve and maintain a healthy body weight for life by incorporating healthful eating, physical activity, behavior modification, a weight-maintenance phase, and group support. You can choose from Local Meeting vouchers, an online subscription or the Deluxe Edition At-Home kit at a savings of more than 20 percent!

AskAFS Financial Counseling

AskAFS provides you with personal, private and actionable solutions to your financial concerns through a confidential counseling helpline, online assistance and on-site seminars. AskAFS services include assistance with budgeting, taxes, savings and retirement planning, eldercare, home ownership, mortgages and bankruptcy debtor education.

*These services are not insurance. Services are not available in Nevada; other restrictions may apply.

Outpatient Prescription Drugs

Options for any Budget

Personal Health Plans automatically include a discount drug program. If you prefer insurance coverage for prescriptions, a variety of optional upgrades are available.

Mail Order, Telephonic and Internet Prescription Drug Purchases

If you select an optional prescription drug benefit, you can purchase up to a 90-day prescription supply for the cost of a 60-day supply using our convenient mail order, telephone and Internet service.

Online Convenience

We make it easy for you to access your health plan benefits anytime using our convenient Web tool.

- View claim payment status including an explanation of benefits (EOB)
- Request a new health plan identification card or certificate of creditable coverage
- Submit name and address changes

PPO Networks

Choice. Personal Health Plans lead the way.

Personal Health Plans provide access to more than 50 regional and national PPO networks. You can benefit from lower out-of-pocket costs when you receive services from an in-network provider.

Additionally, discounted services are available through the MultiPlan network for those times when you are traveling outside your regional network's coverage area.



Additional Provisions

Emergency Care at Out-of-Network Hospitals

If you are taken to an out-of-network hospital for emergency care, we will pay for covered services at in-network benefit levels subject to usual and reasonable charges. However, you must arrange for transfer to an in-network hospital within 48 hours or as soon as this transfer can take place without detriment to your health. Otherwise, covered services will be paid at out-of-network benefit levels.

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, they 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.

Non-Surgical Back Treatment

Covered expenses for outpatient non-surgical back treatment are payable up to the maximum benefit of \$250 per calendar year under the Copay and Value Plans; up to \$500 per calendar year under all other plans. Applicable copay, deductible and coinsurance apply.

Home Health Care

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

Routine Mammography, Breast Screening and Pap Smear

Covered at 100 percent in- and out-of-network.

Mental or Nervous and Chemical Dependency Disorders

The combined maximum lifetime benefit for mental and nervous and chemical dependency treatment is \$10,000 per insured. Covered outpatient charges do not accumulate towards the plan's maximum out-of-pocket amounts except on the High-Deductible Health Plan.

Outpatient Mental or Nervous and Chemical Dependency Disorders

Applicable copay, deductible and coinsurance apply. Up to \$25 per visit, maximum of 50 visits or \$1,250 per insured, per calendar year, on all plans except Premier, Value and Copay Plans. Premier plan is limited to \$1,250 per calendar year. Up to \$50 per visit, maximum 10 visits or \$500 calendar year for Value and Copay Plans.

Inpatient Mental or Nervous Disorders

Applicable copay, deductible and coinsurance apply. Limited to 10 inpatient days and up to \$2,500 per insured per calendar year on all plans except Value and Copay. Limited to five inpatient days and up to \$1,000 per insured per calendar year for Value and Copay Plans.

Inpatient Chemical Dependency Disorders

Benefits are not provided for inpatient chemical dependency treatment.

Complications of Pregnancy

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

Skilled Nursing Facility Care

After your applicable deductible and copays have been satisfied, covered medical expenses will be paid at the coinsurance level you have selected, up to a \$100 daily benefit, limited to 50 days per calendar year, per insured.

Hospice Care

The plan will pay covered medical expenses for hospice care for up to six months. The plan also covers bereavement support services for the insured person's family during the three-month period after death, up to \$250.

Organ Transplant Benefit

Center of Excellence Providers:

Covered transplant services are paid up to \$1 million lifetime maximum. If the \$100,000 calendar-year maximum is elected for the Deluxe Plan, covered transplant services are paid up to \$100,000 lifetime maximum. When the insured person uses a Center of Excellence, a lodging and transportation allowance of up to \$5,000 is available for one companion, or two companions if the insured recipient is a minor.

In-Network Providers:

Covered transplant services are paid subject to a lifetime maximum benefit of \$250,000. If the \$100,000 calendar-year maximum is elected for the Deluxe Plan, covered transplant services are paid up to \$100,000.

Out-of-Network Providers:

Covered transplant services are paid subject to a lifetime maximum benefit of \$175,000. If the \$100,000 calendar-year maximum is elected for the Deluxe Plan, covered transplant services are paid up to \$100,000.

Occupational, Physical and Speech Therapies

Applicable copay, deductible, and coinsurance apply. 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.

Additional 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, or 18 months if elected, 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., under age 65 and a permanent resident of the United States, you and your eligible dependents may apply to purchase the Personal Health Plans. 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 unmarried child(ren) primarily dependent upon you for support and maintenance under age 19 or under 25 only if enrolled as a full-time student actively attending an accredited college, vocational school or high school. Full-time status is defined as actively attending at least 12 hours of classes per week or, if less, attending the minimum hours of class the school considers full-time status.

Child(ren) Only Coverage

Child(ren) only coverage is available for child(ren) 2 months through 17 years of age. When covered children attain age 18, they can be issued coverage under their own individual plan and charged an appropriate adult rate if they reside in a state where the coverage is available. Premium is based on the rates applicable to the state in which the child resides. Children of foreign nationals with legal residency in the United States are not eligible for coverage.

Applications for child(ren) only coverage will be declined if either parent or legal guardian of the child(ren) to be included under the coverage is currently an expectant parent or has undergone infertility treatment within one (1) year of the date of application for the child(ren) only coverage.

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. The Usual and Reasonable Charge 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 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.

Additional Provisions

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.

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: Failure to fully disclose health information on the application for insurance can result in rescission or reformation of coverage.

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 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 marries or ceases to meet the definition of an eligible dependent. Coverage terminates for dependents on the date your coverage terminates.

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. 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.

Personal Health Plans

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 is an insurance organization composed of Independence Holding Company (NYSE: IHC), its operating subsidiaries and affiliates. With more than \$1.3 billion in assets, 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.* The IHC Group has been providing life, health and stop-loss insurance solutions for more than 25 years.

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 issues 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 not required in Colorado, Georgia, Kansas, Montana and South Dakota.

Services provided by TravelGuard, Optum, Weight Watchers®, AskAFS, personal wellness, LabOne, MyHealthCompass™ or TelaDoc® are not insurance benefits and are not underwritten by Standard Security Life Insurance Company of New York. Information contained herein regarding the advantages of an HSA should in no way be construed as providing legal or tax advice. Always consult your tax or legal advisers with any questions about tax or legal matters. Please consult your financial adviser when selecting an HSA custodian. Refer to Internal Revenue Code (IRC) Section 213(d) for a complete list of eligible expenses and maximum contributions. In addition, the HSA is not an insurance product and is not provided, administered or guaranteed by Standard Security Life Insurance Company of New York.

*IHC assets and number of customers as of 12-31-08.

Personal Health Plans - Deluxe Plan

Simple Solutions for Individuals and Families

Plan Benefits	In-Network	Out-of-Network
Lifetime Maximum Per Insured	\$5 million	
Calendar-Year Maximum Per Insured	\$1 million	
Individual Calendar-Year Deductible	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$3,500 <input type="checkbox"/> \$4,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$5,500 <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$25,000 Family: 3x Individual	Individual: 3x In-network Family: 3x Individual
Coinsurance	<input type="checkbox"/> 80% <input type="checkbox"/> 70% <input type="checkbox"/> 50%	50%
Individual Calendar-Year Out-of-Pocket Maximum ¹	<input type="checkbox"/> \$2,000 <input type="checkbox"/> \$4,000 <input type="checkbox"/> \$6,000 <input type="checkbox"/> \$10,000 Family: 3x Individual	Individual: 3x In-network Family: 3x Individual
Physician Charge at Office Visit <i>Other covered services performed are subject to deductible and coinsurance.</i>	\$40 Copay or Deductible and Coinsurance	Deductible and Coinsurance
Routine Mammography ²	100% of Covered Charges	100% of Covered Charges
Emergency Room (ER copay waived if immediately admitted)	\$100 Copay, then Deductible and Coinsurance	\$100 Copay, then Deductible and 50% Coinsurance
Ambulance	Deductible and 80% Coinsurance	
OUTPATIENT		
Diagnostic Lab, X-ray and Tests	Deductible and Coinsurance	Deductible and 50% Coinsurance
Diagnostic Imaging including MRI, CT, and Nuclear Imaging	Deductible and Coinsurance	Deductible and 50% Coinsurance
Surgery	Deductible and Coinsurance	Deductible and 50% Coinsurance
General Outpatient Medical Services and Supplies; Non-Surgical Back Treatment ³	Deductible and Coinsurance	Deductible and 50% Coinsurance
Mental, Nervous and Chemical Dependency Care ³	Deductible and 50% Coinsurance	Deductible and 50% Coinsurance
INPATIENT		
Surgical Services and Confinement	Deductible and Coinsurance	Deductible and 50% Coinsurance
Mental and Nervous Care ³	Deductible and Coinsurance	Deductible and 50% Coinsurance

Additional Premium-Saving Options—Save Up to 10%

Outpatient Services ³	\$20,000 per insured calendar-year maximum
Calendar-Year Maximum ³	\$100,000 per insured In- and Out-of-Network
Outpatient Surgery ³	\$250 Copay per occurrence then Deductible and Coinsurance
Inpatient Confinement ³	\$500 Copay per occurrence then Deductible and Coinsurance

¹ Does not include medical and Rx deductibles, copays, pre-certification penalty amounts, expenses for outpatient mental, nervous and/or chemical dependency disorders and any other expenses not covered. In- and out-of-network out-of-pocket maximums accumulate separately. Once the out-of-network deductible has been satisfied, the in-network deductible is deemed satisfied. Once the out-of-network out-of-pocket maximum has been satisfied, the in-network deductible and out-of-pocket maximum are deemed satisfied.

² Deductible, coinsurance and copay waived.

³ See back for additional details and benefit limitations.

Note: Plan overview complements the Personal Health Plans brochure. See certificate of coverage for details.

Outpatient Prescription Drug Options

Option 1

Provides a discount on prescription drug purchases at participating pharmacies.

This is not an insurance benefit.

Option 2

Not applicable

Option 3

Generic Copay \$30

Formulary, non-formulary and specialty drugs available with discount card.

Discount card is not an insurance benefit.

Option 4

Generic Copay \$30

Formulary, non-formulary and specialty drugs subject to calendar-year medical deductible and coinsurance.

Option 5

Generic Copay \$30
Formulary \$50*
Non-Formulary \$75*
Specialty Drugs \$100*

*\$500 separate Rx calendar-year deductible per insured for all non-generic drugs (maximum of three per family)

Option 6

Generic Copay \$30
Formulary \$50**
Non-Formulary \$75**
Specialty Drugs \$100**

**\$1,000 separate Rx calendar-year deductible per insured for all non-generic drugs (maximum of three per family)



THE IHC GROUP
Independence Holding Company

Medical insurance underwritten by Standard Security Life Insurance Company of New York, a member of The IHC Group

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, microtrognathism 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

Non-Surgical Back Treatment

\$500 maximum benefit per calendar year in- or out-of-network.

Outpatient Mental, Nervous and Chemical Dependency Care

Up to \$25 per visit, combined maximum 50 visits up to \$1,250 per calendar year in- or out-of-network.

Inpatient Mental and Nervous Care

Maximum of 10 inpatient days, up to \$2,500 per calendar year in- or out-of-network.

Additional Premium-Saving Options

If you want to save on your monthly premiums, consider selecting all or any combination of the following options:

- \$20,000 Outpatient Services Calendar-Year Maximum: Outpatient treatment will be limited to a \$20,000 calendar year maximum per covered person.
- \$250 Outpatient Surgical Services Copay: All covered charges incurred for surgical services, including surgery, assistant surgery and anesthesiology services received in an outpatient hospital or ambulatory surgical center will be subject to the \$250 copay per occurrence. Covered charges in excess of the copay are paid at your selected calendar-year deductible and coinsurance.
- \$500 Inpatient Confinement Copay: All covered charges incurred for each inpatient confinement will be subject to a \$500 copay per occurrence. Covered charges in excess of the copay are paid at your selected calendar-year deductible and coinsurance.
- \$100,000 Calendar-Year Maximum: All covered charges will be limited to a \$100,000 calendar-year maximum benefit per covered person. The \$1 million calendar-year maximum benefit will not be applicable.

Personal Health Plans - Advantage Plan

Simple Solutions for Individuals and Families

Plan Benefits	In-Network	Out-of-Network
Lifetime Maximum Per Insured	\$5 million	
Calendar-Year Maximum Per Insured	\$1 million	
Individual Calendar-Year Deductible	<input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,000 <input type="checkbox"/> \$3,000 <input type="checkbox"/> \$4,000 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$25,000 Family: 3x Individual	Individual: 3x In-network Family: 3x Individual
Coinsurance	80%	50%
Individual Calendar-Year Out-of-Pocket Maximum ¹	Medical Services & Supplies: \$3,000 Inpatient Confinement & Surgery: \$6,000 Family: 3x Individual	Individual: 3x In-network Family: 3x Individual
Physician Charge at Office Visit <i>Other covered services performed are subject to deductible and coinsurance.</i>	\$40 Copay or Deductible and 80% Coinsurance	Deductible and 50% Coinsurance
Routine Mammography ²	100% of Covered Charges	100% of Covered Charges
Emergency Room (ER copay waived if immediately admitted)	\$100 Copay, then Deductible and 80% Coinsurance	\$100 Copay, then Deductible and 50% Coinsurance
Ambulance	Deductible and 80% Coinsurance	
OUTPATIENT		
Diagnostic Lab, X-ray and Tests	Deductible and 80% Coinsurance	Deductible and 50% Coinsurance
Diagnostic Imaging including MRI, CT, and Nuclear Imaging	Deductible and 80% Coinsurance	Deductible and 50% Coinsurance
Surgery	Deductible and 80% Coinsurance	Deductible and 50% Coinsurance
General Outpatient Medical Services and Supplies; Non-Surgical Back Treatment ³	Deductible and 80% Coinsurance	Deductible and 50% Coinsurance
Mental, Nervous and Chemical Dependency Care ³	Deductible and 50% Coinsurance	Deductible and 50% Coinsurance
INPATIENT		
Surgical Services and Confinement	Deductible and 80% Coinsurance	Deductible and 50% Coinsurance
Mental and Nervous Care ³	Deductible and 80% Coinsurance	Deductible and 50% Coinsurance

¹ Does not include medical and Rx deductibles, copays, pre-certification penalty amounts, expenses for outpatient mental, nervous and/or chemical dependency disorders and any other expenses not covered. In- and out-of-network out-of-pocket maximums accumulate separately. Once the out-of-network deductible has been satisfied, the in-network deductible is deemed satisfied. Once the out-of-network out-of-pocket maximum has been satisfied, the in-network deductible and out-of-pocket maximum are deemed satisfied.

² Deductible, coinsurance and copay waived.

³ See back for additional details and benefit limitations.

Note: Plan overview complements the Personal Health Plans brochure. See certificate of coverage for details.

Outpatient Prescription Drug Options

Option 1

Provides a discount on prescription drug purchases at participating pharmacies.

This is not an insurance benefit.

Option 2

Not applicable

Option 3

Generic

Copay

\$30

Formulary, non-formulary and specialty drugs available with discount card.

Discount card is not an insurance benefit.

Option 4

Generic

Copay

\$30

Formulary, non-formulary and specialty drugs subject to calendar-year medical deductible and coinsurance.

Option 5

Generic

Formulary

Non-Formulary

Specialty Drugs

*\$500 separate Rx calendar-year deductible per insured for all non-generic drugs (maximum of three per family)

Copay

\$30

\$50*

\$75*

\$100*

Option 6

Generic

Formulary

Non-Formulary

Specialty Drugs

**\$1,000 separate Rx calendar-year deductible per insured for all non-generic drugs (maximum of three per family)

Copay

\$30

\$50**

\$75**

\$100**



THE IHC GROUP
Independence Holding Company

Medical insurance underwritten by Standard Security Life Insurance Company of New York, a member of The IHC Group

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

Non-Surgical Back Treatment

\$500 maximum benefit per calendar year in- or out-of-network.

Outpatient Mental, Nervous and

Chemical Dependency Care

Up to \$25 per visit, combined maximum 50 visits up to \$1,250 per calendar year in- or out-of-network.

Inpatient Mental and Nervous Care

Maximum of 10 inpatient days, up to \$2,500 per calendar year in- or out-of-network.

Personal Health Plans - Copay Plan

Simple Solutions for Individuals and Families

Plan Benefits	In-Network	Out-of-Network
Lifetime Maximum Per Insured	\$5 million	
Calendar-Year Maximum Per Insured	\$1 million	
Individual Calendar-Year Deductible Must be satisfied before any copays apply	<input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 Family: 3x Individual	Individual: 3x In-network Family: 3x Individual
Coinsurance	100%	70%
Individual Calendar-Year Out-of-Pocket Maximum ¹	Individual: Medical Services and Outpatient Surgical Services & Supplies: \$0 Individual: Inpatient Confinement & Surgical Services: <input type="checkbox"/> \$4,000 <input type="checkbox"/> \$8,000 ³ Family: 3x individual	Individual: Medical Services and Outpatient Surgical Services & Supplies: \$10,000 ² Individual: Inpatient Confinement & Surgical Services: 3x In-network ³ Family: 3x individual
Physician Office Visit	Deductible, then \$40 Copay	Deductible, then \$70 Copay, then 70% Coinsurance
Routine Mammography ⁴	100% of Covered Charges	100% of Covered Charges
Emergency Room (ER copay waived if immediately admitted)	Deductible, then \$200 Copay per occurrence	Deductible, then \$400 Copay per occurrence, then 70% Coinsurance
Ambulance	Deductible, then \$200 Copay per occurrence	
OUTPATIENT Diagnostic Lab, X-ray and Tests including MRI, CT, and Nuclear Imaging	Deductible, then \$40 Copay	Deductible, then \$70 Copay, then 70% Coinsurance
General Outpatient Medical Services and Supplies; Non-Surgical Back Treatment ⁵	Deductible, then \$40 Copay	Deductible, then \$70 Copay, then 70% Coinsurance
Mental, Nervous and Chemical Dependency Care ⁵	Deductible, then \$40 Copay, then 50% Coinsurance	Deductible, then \$70 Copay, then 50% Coinsurance
Surgical Services: Hospital or Ambulatory Facility	Deductible, then \$200 Copay per visit	Deductible, then \$400 Copay per visit, then 70% Coinsurance
Surgery and Anesthesiology	Deductible, then \$500 Copay per visit	Deductible, then \$750 Copay per visit, then 70% Coinsurance
INPATIENT Surgical Services and Confinement	Deductible, then \$500 Copay per day	Deductible, then \$750 Copay per day, then 70% Coinsurance
Skilled Nursing	Deductible, then \$500 Copay per day	Deductible, then \$750 Copay per day, then 70% Coinsurance
Mental and Nervous Care ⁵	Deductible, then \$500 Copay per day	Deductible, then \$750 Copay per day, then 70% Coinsurance

¹ Does not include medical and Rx deductibles, outpatient copays, pre-certification penalty amounts, expenses for outpatient mental, nervous and/or chemical dependency disorders, inpatient coinsurance and any other expenses not covered. Once the out-of-network deductible has been satisfied, the in-network deductible is deemed satisfied. Once the out-of-network out-of-pocket maximum has been satisfied, the in-network deductible and out-of-pocket maximum are deemed satisfied.

² Only outpatient coinsurance applies to out-of-network out-of-pocket.

³ Only inpatient confinement and surgical services copays apply to out-of-pocket maximum.

⁴ Deductible, coinsurance and copay waived.

⁵ See back for additional details and benefit limitations.

Note: Plan overview complements the Personal Health Plans brochure. See certificate of coverage for details.

Outpatient Prescription Drug Options

Option 1

Provides a discount on prescription drug purchases at participating pharmacies.

This is not an insurance benefit.

Option 2

Not applicable

Option 3

Generic Copay \$30

Formulary, non-formulary and specialty drugs available with discount card.

Discount card is not an insurance benefit.

Option 4

Generic Copay \$30

Formulary, non-formulary and specialty drugs subject to calendar-year medical deductible and coinsurance.

Option 5

Generic Copay \$30
 Formulary \$50*
 Non-Formulary \$75*
 Specialty Drugs \$100*

*\$500 separate Rx calendar-year deductible per insured for all non-generic drugs (maximum of three per family)

Option 6

Generic Copay \$30
 Formulary \$50**
 Non-Formulary \$75**
 Specialty Drugs \$100**

**\$1,000 separate Rx calendar-year deductible per insured for all non-generic drugs (maximum of three per family)



THE IHC GROUP
 Independence Holding Company

Medical insurance underwritten by Standard Security Life Insurance Company of New York, a member of The IHC Group

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

Non-Surgical Back Treatment

\$250 maximum benefit per calendar year in- or out-of-network.

Outpatient Mental, Nervous and

Chemical Dependency Care

Up to \$50 per visit, combined maximum 10 visits up to \$500 per calendar year in- or out-of-network.

Inpatient Mental and Nervous Care

Maximum of five inpatient days, up to \$1,000 per calendar year in- or out-of-network.

Personal Health Plans - Premier Plan

Simple Solutions for Individuals and Families

Plan Benefits	In-Network	Out-of-Network
Lifetime Maximum Per Insured	\$5 million	
Calendar-Year Maximum Per Insured	\$1 million	
Individual Daily Deductibles ¹ <i>Maximum of 2 per family</i>	<input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000	3x In-network
Coinsurance	Deductible then 100%	Deductible then 100%
Individual Calendar-Year Out-of-Pocket Maximum ² <i>Maximum of 2 per family</i>	<input type="checkbox"/> \$4,000 <input type="checkbox"/> \$8,000	2x In-network
Physician Charge at Office Visit <i>Other covered services performed are subject to daily deductible and coinsurance.</i>	\$40 copay then 100% or Deductible then 100%	Deductible then 100%
Routine Mammography ³	100% of Covered Charges	100% of Covered Charges
Emergency Room	Deductible then 100%	Deductible then 100%
Ambulance	Deductible then 100%	
OUTPATIENT		
Diagnostic Lab, X-ray and Tests	Deductible then 100%	Deductible then 100%
MRI, CT, and Nuclear Imaging	Deductible then 100%	Deductible then 100%
Surgery	Deductible then 100%	Deductible then 100%
General Outpatient Medical Services and Supplies; Non-Surgical Back Treatment ⁴	Deductible then 100%	Deductible then 100%
Mental, Nervous and Chemical Dependency Care ⁴	Deductible then 100%	Deductible then 100%
INPATIENT		
Surgical Services and Confinement	Deductible then 100%	Deductible then 100%
Mental and Nervous Care ⁴	Deductible then 100%	Deductible then 100%

¹ Does not include Rx deductibles, copays, pre-certification penalty amounts and any other expenses not covered. Once the out-of-network deductible has been satisfied, the in-network deductible is deemed satisfied.

² Out-of-pocket maximum includes daily deductible amounts; and excludes Rx deductibles, copays, pre-certification penalty amounts and any other expenses not covered. In-network and out-of-network out-of-pocket maximums accumulate separately. Once the out-of-network out-of-pocket maximum has been satisfied, the in-network deductible and out-of-pocket maximum are deemed satisfied.

³ Daily deductible and copay waived.

⁴ See back for additional details and benefit limitations.

Note: Plan overview complements the Personal Health Plans brochure. See certificate of coverage for details.

Outpatient Prescription Drug Options

Option 1

Provides a discount on prescription drug purchases at participating pharmacies.

This is not an insurance benefit.

Option 2

Not applicable

Option 3

Generic

Copay

\$30

Formulary, non-formulary and specialty drugs available with discount card.

Discount card is not an insurance benefit.

Option 4

Not applicable

Copay

Option 5

Generic

Formulary

Non-Formulary

Specialty Drugs

Copay

\$30

\$50*

\$75*

\$100*

*\$500 separate Rx calendar-year deductible per insured for all non-generic drugs (maximum of three per family)

Option 6

Generic

Formulary

Non-Formulary

Specialty Drugs

Copay

\$30

\$50**

\$75**

\$100**

**\$1,000 separate Rx calendar-year deductible per insured for all non-generic drugs (maximum of three per family)



THE IHC GROUP
Independence Holding Company

Medical insurance underwritten by
Standard Security Life Insurance
Company of New York, a member
of The IHC Group

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

Non-Surgical Back Treatment

\$500 maximum benefit per calendar year in-or out-of-network.

Outpatient Mental, Nervous and Chemical Dependency Care

Up to \$1,250 per calendar year in- or out-of-network.

Inpatient Mental and Nervous Care

Maximum of 10 inpatient days, up to \$2,500 per calendar year in- or out-of-network.

Personal Health Plans - HDHP

Simple Solutions for Individuals and Families

Plan Benefits	In-Network	Out-of-Network
Lifetime Maximum Per Insured	\$5 million	
Calendar-Year Maximum Per Insured	\$1 million	
Calendar-Year Deductible	Individual: <input type="checkbox"/> \$1,800 <input type="checkbox"/> \$2,700 <input type="checkbox"/> \$3,500 ¹ <input type="checkbox"/> \$5,250 ¹ Family: <input type="checkbox"/> \$3,600 <input type="checkbox"/> \$5,450 <input type="checkbox"/> \$7,000 ¹ <input type="checkbox"/> \$10,500 ¹	Individual: 3x In-network Family: 3x In-network
Coinsurance	<input type="checkbox"/> 100% <input type="checkbox"/> 80%	70% 50%
Individual Calendar-Year Out-of-Pocket Maximum ²	100% Plans Selected Deductible	100% Plans Individual If In-Network Deductible is: Out-of-Pocket is: \$1,800 \$12,000 \$2,700 \$14,700 \$3,500 \$15,500 \$5,250 \$16,500 Family If In-Network Deductible is: Out-of-Pocket is: \$3,600 \$22,000 \$5,450 \$25,000 \$7,000 \$28,000 \$10,500 \$32,000 80% Plans Individual: \$5,250 Family: \$10,500
Physician Charge at Office Visit	Deductible and Coinsurance	Deductible and Coinsurance
Routine Mammography ³	100% of Covered Charges	100% of Covered Charges
Emergency Room	Deductible and Coinsurance	Deductible and Coinsurance
Ambulance	Deductible and Coinsurance	
OUTPATIENT		
Diagnostic Lab, X-ray and Tests	Deductible and Coinsurance	Deductible and Coinsurance
MRI, CT, and Nuclear Imaging	Deductible and Coinsurance	Deductible and Coinsurance
Surgery	Deductible and Coinsurance	Deductible and Coinsurance
General Outpatient Medical Services and Supplies; Non-Surgical Back Treatment ⁴	Deductible and Coinsurance	Deductible and Coinsurance
Mental, Nervous and Chemical Dependency Care ⁴	Deductible and Coinsurance	Deductible and Coinsurance
INPATIENT		
Surgical Services and Confinement	Deductible and Coinsurance	Deductible and Coinsurance
Mental and Nervous Care ⁴	Deductible and Coinsurance	Deductible and Coinsurance

Outpatient Prescription Drug Options

Option 1

Provides a discount on prescription drug purchases at participating pharmacies.

This is not an insurance benefit.

Option 2

All covered drugs are subject to calendar-year medical deductible, coinsurance and out-of-pocket.

- These deductibles not available on the 80 percent plans.
- Calendar-year deductible amounts and in- and out-of-network coinsurance amounts combine toward calendar-year out-of-pocket maximum. Does not include pre-certification penalties and any other expenses not covered.
- Deductible and coinsurance waived.
- See back for additional details and benefit limitations.



Medical insurance underwritten by Standard Security Life Insurance Company of New York, a member of The IHC Group

Note: Plan overview complements the Personal Health Plans brochure. See certificate of coverage for details.

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

Non-Surgical Back Treatment

\$500 maximum benefit per calendar year in- or out-of-network.

Outpatient Mental, Nervous and Chemical Dependency Care

Up to \$25 per visit, combined maximum 50 visits up to \$1,250 per calendar year in- or out-of-network.

Inpatient Mental and Nervous Care

Maximum of 10 inpatient days, up to \$2,500 per calendar year in- or out-of-network.