

Care Access Plan

A fixed-benefit indemnity plan with hospital, surgical and critical illness insurance benefits for you and your family.



Optional benefits include preventive wellness, diagnostic testing and physician office visits.

Underwritten by Madison National Life Insurance Company, Inc. (MNL), a member of the IHC Group. For more information about MNL and the IHC Group, visit www.ihcgroup.com. This product is not considered to be Minimum Essential Coverage as defined by the Patient Protection and Affordable Care Act (ACA). Plans are administered by Ebix Health Administration Exchange, Inc. (EHAЕ).



Care Access Plan pays fixed-benefit amounts to protect against covered medical expenses resulting from hospitalization, surgery, chemotherapy and radiation services.

- › No plan calendar year or lifetime dollar amount maximums. Daily benefits are paid for each covered illness or injury. Optional coverage may include benefit-specific maximums.
- › Every Care Access Plan automatically includes a lump sum \$10,000 critical illness benefit for the primary insured and covered spouse, along with a \$2,500 for each covered dependent child. As an option, the critical illness benefit may be increased to meet your family's specific needs.

Affordability

- › Choose a plan that's right for you to help protect against financial loss associated with unexpected hospital stays or surgical procedures.
- › From day one, receive daily in-hospital and/or outpatient surgical benefits immediately when you select a \$0 deductible plan. Or, choose from several per injury or illness deductible options to lower your monthly premium.
- › Care Access Plan are guaranteed renewable; you and your family cannot be singled out for a rate increase for a rate increase or cancellation based solely on changes to your health.

Enroll at any time

- › Care Access Plan does not have open enrollment periods; you and your family can secure coverage immediately at any time of the year.

A fixed-benefit hospital and surgical plan may not be right for everyone. Care Access Plan is not major medical insurance; it provides fixed-indemnity after the deductible, if any, for medical expenses, covered outpatient surgery, chemotherapy and radiation services, and critical illness. Carefully designed plan benefits keep plan premiums affordable. It is very important you review the plan information closely. You may still be responsible for the Affordable Care Act (ACA) shared responsibility payment (tax).

Critical illness insurance provides a lump-sum cash benefit payment, directly to you, when a covered medical condition is diagnosed after the effective date. Benefits can be used any way you choose – medical treatment, replace lost income while you are recovering, daily household expenses, childcare, or maintain a business.

Critical illness benefits include a fixed benefit amount for the following:

- › Cancer
- › Major organ transplant
- › Severe burn
- › Heart attack
- › Coma
- › Kidney failure
- › Stroke

A plan that's right for you

Choose from three Care Access Plans, numerous critical illness benefits, as well as several optional outpatient benefits that allow individuals and families to select coverage that blends protection with affordability. Plan highlights include:

- › Coverage from an insurance company rated A- (Excellent) by A.M. Best Company, a widely recognized rating agency that rates the financial strength of insurance companies and their ability to meet policyholder obligations
- › Benefits for inpatient hospitalization, surgery, diagnosis of critical illness and ambulance as well as covered outpatient chemotherapy and radiation therapy services
- › Plan pays the fixed-benefits you select, regardless of the amount your providers charge for services
- › Flexibility to choose any doctor or hospital in America, plus additional cost savings available when you choose a provider that is part of the MultiPlan national network

	Economy	Value	Superior
Inpatient services (per day)			
Inpatient hospital confinement Covers room and board, miscellaneous hospital expenses and general nursing while hospital confined. This benefit is not paid for any day of ICU confinement.	\$1,000	\$2,000	\$3,000
Inpatient ICU/CCU confinement Covers room and board, miscellaneous hospital expenses, and general nursing while confined in the intensive care unit or critical care unit of a hospital. This benefit is paid in lieu of inpatient hospital confinement.	\$1,500	\$3,000	\$4,500
Accident (maximum of 10 days per covered injury) Provides an additional benefit per day of inpatient confinement when confinement is the direct result of a covered injury.	\$1,000	\$1,000	\$1,000
Inpatient physician visits Covers one physician visit per day during inpatient confinement.	\$40	\$50	\$60
Inpatient surgical services (per surgery)			
Total benefit for inpatient surgical service Covers surgery performed while inpatient confinement. If two or more surgical procedures are performed through the same incision, the amount shown applies to the first surgery and 50 percent of the benefit shown applies to the second surgery. If two or more surgeries are performed through different incisions, the benefit shown applies to each surgery.	\$3,000 Total payable as follows	\$6,000 Total payable as follows	\$9,000 Total payable as follows
Surgeon	\$2,000	\$4,000	\$6,000
Assistant surgeon	\$400	\$800	\$1,200
Anesthesiologist	\$600	\$1,200	\$1,800
Outpatient surgical services (per surgery)			
Total benefit for outpatient surgical service	\$1,300 Total payable as follows	\$2,600 Total payable as follows	\$3,900 Total payable as follows
Facility Covers services and supplies provided by the outpatient surgical facility such as use of the operating room, general nursing, casts, splints and diagnostics such as radiology and pathology. (benefit is not payable if surgery is performed in a doctor's office).	\$400	\$800	\$1,200
Surgeon Covers surgeon's services when performed at an outpatient surgical facility. If two or more surgical procedures are performed through the same incision, the amount shown applies to the first surgery and 50 percent of the benefit shown applies to the second surgery. If two or more surgeries are performed through different incisions, the benefit shown applies to each surgery.	\$600	\$1,200	\$1,800
Assistant surgeon	\$120	\$240	\$360
Anesthesiologist	\$180	\$360	\$540

Benefits listed are subject to the per injury or illness deductible, if applicable.

	Economy	Value	Superior																					
Other covered services (per event)																								
Ambulance (per trip) Ground or water Air	\$100 \$500	\$250 \$1,000	\$500 \$2,000																					
Second surgical opinion Benefit payable for a second opinion prior to a surgery; not subject to the per illness or injury deductible.	\$100	\$100	\$100																					
Chemotherapy and radiation (per treatment up to lifetime maximum of 100 treatments) Covers outpatient chemotherapy treatment including chemotherapy medication and radiation therapy, for the treatment of cancer.	\$300	\$600	\$900																					
Customize your plan options																								
Per injury or illness deductible	\$0 > \$1,000 > \$2,500	\$0 > \$1,000 > \$2,500 > \$5,000 > \$7,500	\$0 > \$1,000 > \$2,500 > \$5,000 > \$7,500																					
Critical illness benefit* Benefit payable for one of the following conditions: cancer-in-situ, major organ transplant, severe burns, life threatening cancer, heart attack, stroke, kidney (renal) failure, and coma. The covered person must be positively diagnosed by a legally qualified physician as having a critical illness for the first time following the coverage effective date.		Benefit includes: Applicant: \$10,000 Spouse: \$10,000 Child(ren) \$2,500 Buy-up options: <table> <tr> <td>Applicant:</td> <td>Spouse:</td> <td>Child(ren):</td> </tr> <tr> <td>\$15,000</td> <td>\$15,000</td> <td>\$5,000</td> </tr> <tr> <td>\$20,000</td> <td>\$20,000</td> <td>\$7,500</td> </tr> <tr> <td>\$25,000</td> <td>\$25,000</td> <td>\$10,000</td> </tr> <tr> <td>\$30,000</td> <td>\$30,000</td> <td></td> </tr> <tr> <td>\$35,000</td> <td>\$35,000</td> <td></td> </tr> <tr> <td>\$40,000</td> <td>\$40,000</td> <td></td> </tr> </table>		Applicant:	Spouse:	Child(ren):	\$15,000	\$15,000	\$5,000	\$20,000	\$20,000	\$7,500	\$25,000	\$25,000	\$10,000	\$30,000	\$30,000		\$35,000	\$35,000		\$40,000	\$40,000	
Applicant:	Spouse:	Child(ren):																						
\$15,000	\$15,000	\$5,000																						
\$20,000	\$20,000	\$7,500																						
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\$30,000	\$30,000																							
\$35,000	\$35,000																							
\$40,000	\$40,000																							
Optional health maintenance benefit[†]																								
Wellness and preventive care (maximum one visit per person, per year) Covered services include routine physical examination including diagnostic tests that are performed during the exam, routine Pap smear, screening mammography, immunizations and prostate and colorectal cancer screening; not subject to per injury or illness deductible.	\$200	\$200	\$200																					
Outpatient physician office visit or retail health clinic (per person) Not subject to per injury or illness deductible.	\$50 (maximum 2 visits per year)	\$60 (maximum 4 visits per year)	\$60 (maximum 4 visits per year)																					
Outpatient urgent care or emergency room visit (maximum one visit per person, per year) Not subject to per injury or illness deductible.	\$75	\$150	\$300																					
Optional post-procedure diagnostic testing (each test covered once per person, per year)																								
Outpatient diagnostic X-ray and lab Covers X-rays and lab tests performed in an outpatient setting and not done in conjunction with a wellness or preventive care examination; not subject to per injury or illness deductible.	\$100	\$100	\$100																					
Outpatient advanced studies Covers Angiogram, Arteriogram, Computed Tomography Scan (CT); Electroencephalogram (EEG), Magnetic Resonance Imaging (MRI), Myelogram, Positron Emission Tomography Scan (PET), Thallium Stress Test; not subject to per injury or illness deductible.	\$250	\$500	\$1,000																					

[†]Benefit is only payable within 30 days following an inpatient confinement or outpatient surgery for a covered illness or injury.

Benefits listed are subject to the per injury or illness deductible, if applicable.

Refer to page 7 for more information regarding the per injury or illness deductible.

*Not available in all states

Benefit examples*

Indemnity benefit example for inpatient confinement

Plan selected: Value

Medical situation: A covered person is admitted to the hospital with pneumonia and acute respiratory failure. Inpatient confinement is five days, two of which are in the intensive care unit. The condition was not pre-existing.

Claims benefits example (based on covered benefits):

Daily intensive care benefit	\$6,000 (\$3,000 per day x 2 days)
Daily inpatient hospital confinement benefit	\$6,000 (\$2,000 per day x 3 days)
Doctor visits while hospital confined benefit	\$250 (\$50 per day x 5 days)
Benefits payable before per injury or illness deductible	\$12,250
Less per injury or illness deductible	\$0
Total benefits paid	\$12,250

Indemnity benefit example for outpatient benefits

Plan selected: Superior

Per injury or illness deductible selected: \$1,000

Medical situation: A covered person undergoes laparoscopic gall bladder surgery. Same-day surgery is performed at an outpatient hospital surgical facility. The condition was not pre-existing.

Claims benefits example (based on covered benefits):

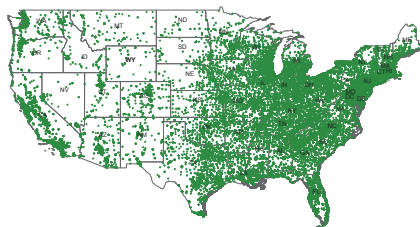
Outpatient surgery facility benefit	\$1,200
Outpatient surgeon benefit	\$1,800
Outpatient assistant surgeon benefit	\$360
Anesthesiologist benefit	\$540
Benefits payable before per injury or illness deductible	\$3,900
Less per injury or illness deductible	(\$1,000)
Total benefits paid	\$2,900

*The benefit examples shown above are intended for illustrative purposes only. These examples do not contemplate the provider's actual charges for services rendered nor the full extent of the covered person's out-of-pocket costs.

Using the nationwide MultiPlan network is simple!

Care Access Plan fixed-indemnity benefits are paid the same, regardless of which providers you use. That means you have the flexibility to use any doctor or hospital in the United States.

If you wish to save even more on out-of-pocket costs, discounts are available through the MultiPlan discount network. 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 on your final bill for both covered and non-covered expenses.



Covered critical illness descriptions

Benefits payable are subject to the following diagnosis of each covered critical illness. Diagnosis must be made by a legally qualified physician through the use of clinical and/or laboratory findings. The critical illness benefit is not available in CO, GA and SD. Additional states may follow.

- › **Cancer in situ:** A diagnosis of cancer wherein the tumor cells still lie within the tissue of origin without having invaded neighboring tissue. Cancer in situ must be diagnosed pursuant to a pathological or clinical diagnosis. Cancer in situ includes early prostate cancer diagnosed as T1N0M0 or equivalent staging and melanoma not invading the dermis. Cancer in situ does NOT include: other skin malignancies, pre-malignant lesions (such as intraepithelial neoplasia), or benign tumors or polyps.
- › **Major organ transplant:** The clinical evidence of major organ(s) failure which requires the malfunctioning organ(s) or tissue of the covered person to be replaced with an organ(s) or tissue from a suitable human donor (excluding the covered person) under generally accepted medical procedures. The organs and tissues covered by this definition are limited to: liver, kidney, lung, entire heart, small intestine, pancreas, pancreas-kidney or bone marrow. In order for the major organ transplant to be covered under this rider, the covered person must be registered by the United Network of Organ Sharing or the National Marrow Donor Program.
- › **Severe burn:** The diagnosis, by a legally qualified physician board-certified as a plastic surgeon, that the body has sustained third degree burns covering at least 20 percent of the surface area of the covered person's body.
- › **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.

The schedule of benefits outlines the critical illness benefit amounts.

Eligibility

If you are a dues-paying member of America's Business Benefit Association (ABBA) or Communicating for America, Inc. (CA), 19 to 64.5 years of age and a permanent resident of the United States, you and your eligible dependents may apply to purchase the Care Access 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/domestic partner 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 non-emergency 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 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 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.

Intentional misrepresentation or fraud in the application for coverage may result in rescission or reformation of coverage.

Coordination of benefits

The Care Access Plan does not coordinate benefits with other health insurance plans.

Plan and benefit details

Per injury or illness deductible

If you selected a per injury or illness deductible, the 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.

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.

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

Daily hospital room and board and miscellaneous hospital services inpatient indemnity benefit

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

Daily hospital intensive care and miscellaneous hospital services inpatient indemnity 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. Benefit 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. This benefit is paid in lieu of the daily hospital room and board benefit.

Surgeon benefit

The 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 benefit is paid for services rendered by an assistant surgeon or by a licensed surgical assistant who is performing duties within the scope of his or her 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.

Outpatient chemotherapy and radiation therapy for cancer treatment benefit

The outpatient chemotherapy and radiation therapy for cancer treatment benefit is paid 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.

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 each other or the original physician who will perform the surgery, or financially associated with the original physician, and do not assist in the surgery. This benefit is not subject to the per injury or per illness deductible, if applicable.

Hospital definition

A hospital is an institution that: operates pursuant to law; has 24-hour nursing services by registered nurses; has a staff of one or more doctors; provides inpatient therapeutic and diagnostic services for illness or injury; provides facilities for major surgery or has a formal arrangement with another institution for surgical facilities; and is approved by the Joint Commission on the Accreditation of Health Care Facilities as a Hospital (JCAHO); the American Hospital Association (AHA); the American Osteopathic Healthcare Association (AOHA); the American Osteopathic Association accreditation (AOA); or the Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation.

The definition of a hospital does not include: A rest or nursing home, home for the aged or convalescent home; a skilled nursing facility; an extended care facility; hospice; a place for custodial care; or a birthing center.

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

Consult the certificate of insurance for a complete list of exclusions and description of the benefits not covered.

Except as specifically provided for in the policy, the plan does not provide any benefits when a covered person receives 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 shown as included on the schedule of benefits)
- › 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 non-emergency 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 Law 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
- › 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 material
- › Treatment for which the covered person is not required to pay; or treatment rendered by a person who ordinarily resides in your household or 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
- › 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
- › Physical, speech or occupational therapy
- › Hospice or home health care
- › Treatment, services or supplies to improve the appearance or self-perception of a covered person, which does not restore a bodily function including, without limitation, cosmetic or plastic surgery, hair loss or skin wrinkling, or the complications of any such treatment
- › Pregnancy except complications of pregnancy

About Independence American Insurance Company

Independence American Insurance Company is domiciled in Delaware and licensed to write property and casualty insurance in all 50 states and the District of Columbia. Its products include short-term medical, employer medical stop-loss, hospital indemnity, fixed-indemnity limited benefit, group and individual dental, pet insurance, and non-subscriber occupational accident insurance in Texas. Independence American is rated A- (Excellent) for financial strength by A.M. Best Company, a widely recognized rating agency that rates insurance companies on their relative financial strength and ability to meet policyholder obligations (an A++ rating from A.M. Best is its highest rating).

About The IHC Group

Independence Holding Company (NYSE: IHC) is a holding company that is principally engaged in underwriting, administering and/or distributing group and individual disability, specialty and supplemental health, pet, and life insurance through its subsidiaries since 1980. The IHC Group (including through its 92% ownership of American Independence Corp. (NASDAQ: AMIC)) owns three insurance companies (Standard Security Life Insurance Company of New York, Madison National Life Insurance Company, Inc. and Independence American Insurance Company), a majority of Ebix Health Administration Exchange, Inc., a fully insured third party administrator, and IHC Specialty Benefits, Inc., which is a technology-driven insurance sales and marketing company that creates value for insurance producers, carriers and consumers (both individuals and small businesses) through a suite of proprietary tools and products (including ACA plans and small group medical stop-loss). All products are placed with highly rated carriers.

“IHC” and “The IHC Group” are the brand names for plans, products and services provided by one or more of the subsidiaries and affiliate member companies of The IHC Group (“IHC Entities”). Plans, products and services are solely and only provided by one or more IHC Entities specified on the plan, product or service contract, not The IHC Group. Not all plans, products and services are available in each state.

Communicating for America, Inc.

Communicating for America, Inc., (CA) is a national non-profit advocacy organization that supports affordable healthcare for all Americans. Since 1972, more than 100,000 consumers have trusted CA to help them find affordable health insurance and Gap plans to stretch their healthcare dollar while advocating on their behalf with insurance companies, regulators and lawmakers.

America’s Business Benefit Association

America’s Business Benefit Association (ABBA) is a national, not-for-profit association that provides individuals, small businesses and self-employed consumers with business benefits, services and health-related options, including access to valuable association-endorsed health insurance benefits.

About Ebix Health Administration Exchange, Inc.

Ebix Health Administration Exchange, Inc. doing business as Ebix Health Administration (“Ebix HAE”) is an administrative services company that operates in 50 jurisdictions in both the individual and employer markets. Through certain administrative agreements with insurance carriers and its affiliation with Ebix Incorporated, Ebix HAE offers state-of-the-art and highly efficient open health insurance exchanges. Ebix HAE also provides pet insurance solutions that furnish pet owners, specialty pet hospitals, universities and general veterinary practices with the only open exchange in the country.

Important Information

This brochure provides a very brief description of the important features of Fixed-Benefit Indemnity Insurance . This brochure is not a certificate of coverage and only the actual certificate provisions will control. The certificate itself sets forth in detail the rights and obligations of both the certificate holder and the insurance company. It is, therefore, important that you READ THE CERTIFICATE CAREFULLY. For complete details, refer to the Certificate Form #IAIC HICERT D610 (may vary by state).

The association insurance products included in ABBA and CA memberships are underwritten by Madison National Life Insurance Company, Inc. (MNL), a Wisconsin insurance company. Madison National Life Insurance Company, Inc. is a member of The IHC Group. Not available in all states. Exclusions and limitations apply. Benefits terminate on the date the covered person attains age 70. Benefits are offered at the sole discretion of ABBA or CA and may vary by vendor or state. There is no ownership affiliation between ABBA, CA and MNL.

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR THE MINIMUM ESSENTIAL COVERAGE REQUIRED BY THE AFFORDABLE CARE ACT (ACA) LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

A CRITICAL ILLNESS INSURANCE PLAN PAYS OUT LUMP-SUM CASH BENEFITS UPON DIAGNOSIS OF CERTAIN COVERED ILLNESSES AS SHOWN IN THE CERTIFICATE. THIS PRODUCT IS NOT INTENDED TO QUALIFY AS THE MINIMUM ESSENTIAL COVERAGE REQUIRED BY THE AFFORDABLE CARE ACT (ACA).

