

IAC Health Insurance Plans

Group Advantage Series



Traditional & Consumer
Driven Health Insurance Plans
*Fully Insured Medical insurance
for 2-50 employees*



MEMBER OF THE IHC GROUP

NYSE:IHC

Medical, Life, AD&D, and Dental Insurance
underwritten by Standard Security Life
Insurance Company of New York

Vision Insurance underwritten by
Fidelity Security Life Insurance Company



MEMBER OF THE IHC GROUP

NYSE:IHC



Insurers Administrative Corporation

MEMBER OF THE IHC GROUP

NYSE: IHC

Why IAC?

Founded in 1978, Insurers Administrative Corporation (IAC) is one of the country's largest specialists in the administration of fully insured individual, small and large group health insurance, and self-insured health and welfare plans.

Uncommon — We offer employers more intelligent, cost saving alternatives to financing their health care benefits.

Forward-Thinking — New and unique plan designs offer significant premium savings and sensible alternatives to traditional copay plans.

Excellent Track Record — Consistent, results-oriented performance for 28 years with unwavering support for the small group employer community. We are a leader in timely and professional claims payment and customer service.

IAC is a member of the Independence Holding Company (IHC) group. IHC is a publicly-traded health and life insurance holding company with more than \$1 billion in assets (NYSE: IHC). Over the past 26 years, IHC has built a solid reputation for financial stability and has grown to become a respected industry leader.



Life Insurance Company of New York

MEMBER OF THE IHC GROUP

NYSE: IHC

Why Standard Security Life Insurance Company of New York?

Standard Security Life Insurance Company of New York is rated A (Excellent) by A.M. Best Company. A.M. Best Company rates an insurer on its relative financial strength and ability to meet its obligations to insureds.

IAC Health Insurance Plans

Group Advantage Series

Employees can choose innovative benefit plans featuring consumer driven products or more traditional health plans

Our health insurance plans are designed with today's small employer in mind, allowing you to create flexible and affordable health plan choices for your employees.

IAC Health Insurance Plans provide a continuum of benefits, from the traditional to some of the most innovative consumer driven health plans being marketed today. We are confident you'll find several plan selections to fit your current health plan strategy.

IAC Health Insurance Plans encourage employee choice in several ways! For groups enrolling 10 or more employee lives, an employer can offer up to three separate and distinct health plans.

For groups under 10 employee lives, an employer can offer up to three different deductible, coinsurance, and out-of-pocket maximum amounts under the same plan.

Regardless of the final plan design selected, employees and family members have the opportunity to access self-help and value-added benefits.



IAC Health Plans

IAC Health Plans allow you to develop a long-term strategy to control premium costs, now and into the future.

\$1,000,000 benefit per calendar year, \$5,000,000 maximum while insured

New healthcare financing vehicles — Including Health Reimbursement Arrangements (HRAs) and Health Savings Accounts (HSAs).

Employee Choice Coverage — Help meet your employees' needs and control costs by offering up to three plan designs available in the portfolio.

Employer Choices in Coverage — Offer wellness benefits, 100% accident coverage, life and dental options to customize your plan to fit your needs.

Optional prescription drug benefits — An array of choices which **automatically include oral contraceptives**.

Preferred Providers Organizations (PPOs) — Over 60 regional PPO networks to choose from. Select multiple networks for multi-site locations.

Employee Self-Help Tools

MyHealthCompass™ — Provides comparison hospital information using pricing, quality of care, and treatment outcome data and serves as an excellent resource to research physicians. MyHealthCompass also provides a wealth of information on self-help and wellness strategies.

Optum® Health Forums — An online resource for researching health issues and how to live a healthier, more productive life.

Optum® 24-hour NurseLine — Provides 24-hour telephone access to registered nurses for guidance with treating various health related conditions.



MEDEX Plus Traveler's Emergency Program — Provides for emergency air transport and healthcare coordination when your covered employee is traveling 100 miles or more away from home. MEDEX assists with prescription refills, lost or stolen travel documents, legal problems, finding a doctor or dentist, medical evacuation, repatriation services and more.

Centers of Excellence and high-risk premature birth expert programs — We provide access to top experts for patient care during critical, life threatening illnesses and conditions.

Optional: Optum Care 24 EAP — This optional, full benefit Employee Assistance Program (EAP) provides your employees with professional guidance in handling serious life situations which often affect work performance and absenteeism. Employee Assistance Programs are one of the best ways to alleviate “presenteeism”.

Presenteeism occurs when employee productivity is hindered by serious unresolved personal problems. Presenteeism has the potential to cost employers as much as health benefits cost in lost productivity!

Key Advantages to the IAC Health Plans

Each Group Advantage Series plan includes benefits to enable your employees to take a more active role in leading healthier lifestyles.

Mammography and routine cervical cytologic screening (pap smear) examinations — Covered at 100% for all plans.

LabOne LabCard® — Covers lab tests at 100% coverage with no copay, deductible, or coinsurance! Available as a discount program only on Single Deductible, HRA Advantage and HSA Advantage plans.

Emergency coverage — In real emergencies, coverage is provided at PPO level benefits regardless of where hospital care is received for the first 48 hours following the emergency or until a patient can be safely moved to a PPO network hospital.

Inpatient confinement — If confined as an inpatient at their selected PPO network facility, charges incurred by pathologists, radiologists, and anesthesiologists are covered at PPO level benefits regardless of whether they are part of the PPO network.

8 Plans to choose from

Deluxe Plan

Our traditional coverage featuring 100% payment of covered charges after separate copays for office visits, laboratory tests, and diagnostic imaging (up to \$150 per visit). Services must be received on the same day and billed on the same provider bill.

Value Plan

Slightly more cost sharing on the part of the insured allows this plan to cost less than the Deluxe Plan. An ideal blend of traditional benefits with 100% payment of covered charges for physician office visits after a copay.

Copay Advantage Plan

One of our most popular plans!

Lower premium expenses without sacrificing important health benefits. This plan uses two separate out-of-pocket maximum amounts to achieve reduced premiums: one for medical services & supplies and a second for surgery and hospitalization.

For most insureds, the plan works the same as our Value plan when an insured does not require hospitalization or surgery. The plan provides an intelligent way to reduce premiums without the need for a higher deductible.

Copay Saver Plan

Features no in-network deductible for in-network physician visits and medical services & supplies (copays and coinsurance apply). In-network calendar year deductible applies only to less frequently used services, such as surgery or hospitalization, so premium costs are reduced to the levels of high deductible plans, **without** requiring employees to pick up all the up-front costs of their health care.

Single Deductible Plan

Ask your IAC agent how you can save when you purchase this plan to use with an HSA or HRA!

Affordable high-deductible coverage that works well with a Health Reimbursement Arrangement (HRA) and qualifies for a Health Savings Account (HSA). Employees enjoy the convenience of one deductible for all covered expenses, whether services received are from in- or out-of-network providers. An optional \$20 copay for physician office visits allows you to ease the transition to these cost saving health coverage plan strategies.

Note: Electing the Office Visit Copay makes the plan ineligible for an HSA under current federal guidelines.



HSA Advantage

Includes the Health Savings Account (HSA) set-up!

Experience lower premiums and tax advantages by offering employees a qualified high deductible health plan (HDHP) and a Health Savings Account (HSA). Our streamlined enrollment process takes the hassle out of the HSA set-up process.

Minimum deductibles are \$1,100 for individuals and \$2,500 for family plans. You and/or your employees can make contributions to the HSA. Funds can be withdrawn tax-free by employees to pay for qualified medical expenses. A wide range of investment options are also available. HSA Advantage requires a \$2.50 monthly bank fee paid from the employee's HSA for account balances under \$2,500.

Dual Choice Advantage

Two health plan choices - and each choice has the same price! This benefit program empowers employers to offer each employee two plans for the same competitive premium. Our exclusive plan offering encourages employees to choose the health plan with best benefits for them.

Plan 1

Plan 1 introduces a *daily deductible*, a consumer driven concept that lowers premium without having employees switch to a high deductible plan. Employees have a daily deductible of \$250 (individuals) or \$500 (families). Covered charges incurred on any given day that exceed the daily deductible amount are covered by the plan at 100%. Employees pay daily deductibles (or a portion of a daily deductible) until the \$4,000 out-of-pocket maximum is met. The plan then covers additional covered charges at 100% for the remainder of the calendar year.

Example: A 4 day hospital stay for an employee would result in only \$1,000 (\$250 per day) out-of-pocket to that employee. The plan would cover all the remaining eligible expenses on each day.

Plan 2

Plan 2 is a Single Deductible Plan (see left).

HRA Advantage

Includes the Health Reimbursement Arrangement (HRA) set-up!

This is a Single Deductible Plan paired with a Health Reimbursement Arrangement (HRA). With an HRA, you, as the employer, own the funds in the account and decide the amount to contribute to your employees health care costs. HRA Advantage makes the administration and set-up of this tax advantaged program easy. You receive monthly, quarterly, and annual statements of HRA activity and are notified when to deposit funds to cover eligible reimbursements. Most importantly, claims are automatically submitted to the HRA administrator, avoiding the typical paper chase hassles.

In-Network	Deluxe	Value	Copay Advantage
Outpatient Physician Office Visit or Physician Visit at a Free-standing Urgent Care Facility	100% of covered charges after \$30 copay	Choice of: 100% of covered charges after \$35 copay (or) deductible and coinsurance	100% of covered charges after \$35 copay
Mammography, Routine Pap Smears	100% of covered charges with no deductible, copay or coinsurance ⁵	100% of covered charges with no deductible, copay or coinsurance ⁵	100% of covered charges with no deductible, copay or coinsurance ⁵
Outpatient Diagnostic Lab, X-ray, MRI, CT, Nuclear Imaging and other tests	100% of covered charges after \$30 copay up to \$150 per visit, then deductible and coinsurance apply <i>Lab tests performed by LabOne: 100% of covered charges with no deductible, copay or coinsurance</i>	Deductible and coinsurance apply <i>Lab tests performed by LabOne: 100% of covered charges with no deductible, copay or coinsurance</i>	Deductible and coinsurance apply <i>Lab tests performed by LabOne: 100% of covered charges with no deductible, copay or coinsurance</i>
Individual Calendar Year Deductible Options ¹ <i>Family max is three except Single Deductible plan</i>	\$250 (MI, PA, WI only) \$500 • \$750 • \$1,000 \$1,500 • \$2,000 • \$5,000	\$250 (MI, PA, WI only) \$500 • \$750 • \$1,000 \$1,500 • \$2,000 • \$5,000	\$1,000 • \$1,500 \$2,000 • \$5,000
Coinsurance Options	90% or 80%	80%	80% or 70%
Individual Out-of-pocket Maximum ¹ <i>Family max is two</i>	\$1,500 • \$3,000	\$2,000 • \$3,000 • \$4,000	Medical Services and Supplies: \$2,000 ³ Inpatient Facility Confinement and Surgical Services: \$4,000 ³
Inpatient Confinement Copay	No Copay	\$500, then deductible and coinsurance apply	\$250, then deductible and coinsurance apply
Outpatient Surgery Copay	No Copay	\$250, then deductible and coinsurance apply	No Copay
Ambulance (All Providers)	\$100 copay, then deductible and coinsurance apply ⁵	\$100 copay, then deductible and coinsurance apply ⁵	\$100 copay, then deductible and coinsurance apply ⁵
Emergency Room <i>Copay waived if admitted as inpatient</i>	\$100 copay, then deductible and coinsurance apply	\$100 copay, then deductible and coinsurance apply	\$100 copay, then deductible and coinsurance apply
General Outpatient Medical Services and Supplies, Non-Surgical Back Treatment ²	Deductible and coinsurance apply	Deductible and coinsurance apply	Deductible and coinsurance apply
Outpatient Mental, Nervous, and Chemical Dependency Care	Deductible and 50% coinsurance applies ⁶	Deductible and 50% coinsurance applies ⁶	Deductible and 50% coinsurance applies ⁶
Out-of-Network			
Individual Calendar Year Deductible ¹ <i>Family max is three unless otherwise specified</i>	Deductible is 3x the in-network deductible, up to \$10,000	Deductible is 4x the in-network deductible, except on the \$2,000 & \$5,000 options, which are 3x the in-network deductible	Deductible is 2x the in-network deductible
Individual Out-of-pocket Maximum ¹ <i>Family max is two</i>	3x the in-network out-of-pocket maximum	3x the in-network out-of-pocket maximum	Medical Services & Supplies: \$5,000 Inpatient Facility Confinement & Surgical Services: \$10,000
Coinsurance	70% or 50%	60%	50%
Copays	Office visit & lab copays do not apply, all other copays apply	Office visit copay (if elected) does not apply, all other copays apply	Office visit copay does not apply, all other copays apply

HSA-qualified high deductible options available with the Single Deductible Plan.

Copay Saver

Single Deductible

100% of covered charges after \$30 copay	Choice of: 100% of covered charges after \$20 copay (or) 100% coverage after deductible																																				
100% of covered charges with no deductible, copay or coinsurance ⁵	100% of covered charges with no deductible, copay or coinsurance ⁵																																				
Lab, x-ray, and other tests: \$30 copay, then coinsurance applies MRI, CT and nuclear imaging: \$150 copay, then coinsurance applies Lab tests performed by LabOne: 100% of covered charges with no deductible, copay or coinsurance	Lab: 100% of covered charges after \$20 copay (if selected) or 100% of covered charges after deductible X-ray, MRI, CT, nuclear imaging, and other tests: 100% of covered charges after deductible Lab tests performed by LabOne: LabOne Select Discount																																				
\$1,000 Applies only to Inpatient Confinement & Outpatient Surgical Services	In- and out-of-network expenses all accumulate to a common individual or family deductible																																				
	<table border="1"> <thead> <tr> <th></th> <th>Individual</th> <th>Family</th> </tr> </thead> <tbody> <tr> <td>\$1,000</td> <td>\$1,000</td> <td>\$2,500</td> </tr> <tr> <td>\$1,100</td> <td>\$1,100</td> <td>\$2,500</td> </tr> <tr> <td>\$1,700</td> <td>\$1,700</td> <td>\$3,350</td> </tr> <tr> <td>\$2,600</td> <td>\$2,600</td> <td>\$5,150</td> </tr> <tr> <td>\$3,500</td> <td>\$3,500</td> <td>\$7,500</td> </tr> <tr> <td>\$5,000</td> <td>\$5,000</td> <td>\$10,000</td> </tr> <tr> <td>\$10,000</td> <td>\$10,000</td> <td>\$10,000</td> </tr> </tbody> </table>		Individual	Family	\$1,000	\$1,000	\$2,500	\$1,100	\$1,100	\$2,500	\$1,700	\$1,700	\$3,350	\$2,600	\$2,600	\$5,150	\$3,500	\$3,500	\$7,500	\$5,000	\$5,000	\$10,000	\$10,000	\$10,000	\$10,000												
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Surgery performed in a physician's office: \$150 copay, Other services: \$30 copay, then coinsurance applies	100% coverage after deductible																																				
\$30 copay, then 80% coinsurance applies	Deductible and 50% coinsurance applies ⁶																																				
\$2,000	Out-of-network maximum out-of-pocket table																																				
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60%	70%																																				
All copays are 2x in-network copay	Office visit & lab copay (if elected) do not apply																																				

Employee Choice Options

The extent of Employee Choice allowed is based on your group's size:

Groups enrolling 2 - 9 employees

Offer up to three plan choices **within one** of the plan selections to the left. You can also offer an **HSA Advantage** in addition to one other additional plan.

Examples:

Create 3 offerings of the Value Plan by selecting various copay, deductible, and out-of-pocket options *or* Offer 2 variations of the Value Plan with an HSA Advantage Plan

Groups enrolling 10 or more employees

Offer up to any three of the plan designs to the left. You can also offer the **HSA Advantage** as one of your plan designs!

Example:

Offer a Deluxe, Value, and Copay Advantage Plan. Select which copay, deductible and out-of-pocket options to offer with each plan.

¹Amount excludes any provider copays and/or Rx deductibles/copays. Out-of-pocket maximum also excludes calendar year deductible. Once the out-of-network deductible has been satisfied, the in-network deductible is deemed satisfied. Once the out-of-network maximum out-of-pocket has been satisfied, the in-network deductible and maximum out-of-pocket are deemed satisfied.

²Non-surgical back treatment subject to \$1,000 maximum benefit per calendar year. Not applicable in TN or WI.

³In- and out-of-network maximums for **each type of service accumulate separately**; however, once the out-of-network maximum out-of-pocket for a category of services has been satisfied, the in-network maximum out-of-pocket for that category of services is deemed satisfied.

⁴Maximum out-of-pocket corresponds to the selected deductible.

⁵In- or out-of-network.

⁶In- and out-of-network coinsurance is 50%.

Note: Benefit limits may apply - see Certificate of Coverage for details.

HSA Advantage

In-Network

Outpatient Physician Office Visit or Physician Visit at a Free-standing Urgent Care Facilities	Deductible and coinsurance apply in- or out-of-network		
Mammography, Routine Pap Smears	100% of covered charges		
Outpatient Diagnostic Lab, X-ray, MRI, CT, Nuclear Imaging and other tests Copay Options	Deductible and coinsurance apply <i>Lab tests performed by LabOne: LabOne Select Discount</i>		
Individual Calendar Year Deductible	In- and out-of-network expenses all accumulate to either an individual or family deductible	Individual \$1,100 \$1,700 \$2,600 \$3,500 \$5,000	Family \$2,500 \$3,350 \$5,150 \$7,500 \$10,000
Coinsurance	100%		
Additional Out-of-pocket Maximum	\$0		
General Outpatient Medical Services and Supplies, Non Surgical Back Care ² , Ambulance, Emergency Room	Deductible and coinsurance apply		
Outpatient Mental, Nervous, and Chemical Dependency Care	Deductible and 50% coinsurance applies ³		

Take Advantage of competitively priced, high-quality coverage.

Offer up to three deductible amounts for employees to choose from.

The HSA Advantage plan includes a tax-favored Health Savings Account (HSA)* for your employees, with no extra paperwork or hassle for you!

Out-of-Network

	Out-of-network maximum out-of-pocket table			
	Individual		Family	
	Ded. ¹	OOP ¹	Ded. ¹	OOP ¹
Individual Calendar Year Deductible/ Additional Out-of-pocket Maximum	\$1,100.....\$1,400	\$1,700.....\$1,650	\$2,500.....\$2,500	\$3,350.....\$2,800
	\$2,600.....\$750	\$3,500.....\$1,500	\$5,150.....\$1,000	\$7,500.....\$2,500
	\$5,000.....\$2,500		\$10,000.....\$5,000	
Coinsurance	70%			
Copays	N/A			

¹Maximum out-of-pocket corresponds to the selected deductible.

²Non-surgical back treatment subject to \$1,000 maximum benefit per calendar year. Not applicable in TN or WI.

³Out-of-network coinsurance is 50%.

Note: Benefit limits may apply - see Certificate of Coverage for details.

*The HSA is not an insurance product and is not provided, administered or guaranteed by Standard Security Life Insurance Company of New York.

Why offer the HSA Advantage?

Reduced insurance premiums — Insurance premiums are generally 20 to 40% lower when as compared to IAC's traditional low deductible plan offerings

One-stop shopping — A qualified HSA account is automatically set up for each participating employee with Bancorp Bank after the employee insurance certificates are sent. Our one-stop HSA frees you from shopping around for an HSA bank and filling out volumes of additional paperwork. Choose the **HSA Advantage** plan to establish a high deductible health plan and Health Savings Account in one easy, streamlined process

HSA with The Bancorp Bank

- FDIC insured account
- Debit Visa Card
- Online checking account access that includes viewing account balances, transactions, cleared checks and printing account history
- Unlimited check writing — first 50 personalized checks provided free of charge
- 24 hour toll-free customer service, 365 days-a-year
- Preparation of IRS forms for yearly contributions and distributions
- No monthly bank fees for accounts with a \$2,500 balance; \$2.50 monthly maintenance charge deducted directly from the employee's HSA for accounts under \$2,500

Flexible contributions — Elect to contribute **any** amount to your employees' HSAs, up to the federally mandated maximum

Satisfied employees

Tax Savings — Contributions are made on a tax-deferred basis

Earned Interest — Funds grow with tax-deferred interest earning

Employee Funds — Accumulated savings belong to the employee through their working years and retirement. Funds may be withdrawn penalty free at any time by the employee for any eligible medical expense under the health plan or Section 213d of the Internal Revenue Code (IRC). After retirement, funds may be withdrawn for any expenses and are treated as ordinary income for tax purposes.

Long-term Savings — Account balance rolls over year to year allowing funds to accumulate on a long-term basis

Investing HSA funds — Employees can also invest funds directly from their HSA account to over 6,000 stocks, bonds and mutual funds, including over 600 popular no-load non transaction fee funds. Account holders should keep a minimum balance of funds in the HSA account of \$2,500 for fees and eligible health care expenditures. Investment brokerage fees apply.

Neither IAC, Standard Security Life Insurance Company of New York, The Bancorp Bank nor its subsidiaries (collectively "Bancorp") nor American Health Value (AHV) are registered investment advisers nor is IAC, Standard Security Life Insurance Company of New York, Bancorp, or AHV acting in the capacity of a registered investment advisor with respect to the offering by PFIC, Securities Corporation Investment Services of Health Savings Account ("HSA") investment options. Participation in the investment options is voluntary. Under no circumstances is Bancorp or AHV offering any of the HSA investment options and makes no representations with respect to the investment options offered by PFIC, Securities Corporation. The Bancorp Bank and AHV disclaim any and all liability, contingent or otherwise, for the performance of the investment options. Please see a financial adviser for personal investment advice.

Dual Choice Advantage

In-Network	Plan 1	Plan 2	
Outpatient Physician Office Visit or Physician Visit at a Free-standing Urgent Care Facility	Daily Deductible and coinsurance apply	Deductible and coinsurance apply	Two plan designs, same rate
Mammography	100% of covered charges ⁴	100% of covered charges	
Outpatient Diagnostic Lab, X-ray, MRI, CT, Nuclear Imaging and other tests Copay Options	Daily Deductible and coinsurance apply <i>Lab tests performed by LabOne: LabOne Select Discount</i>	Deductible and coinsurance apply <i>Lab tests performed by LabOne: LabOne Select Discount</i>	Let your employees select the plan best for them
Individual Deductible ¹	Daily: \$250 individual \$500 family	Calendar year: \$2,000 individual \$4,000 family	
Coinsurance	100%	100%	Plan 2 is an HSA-qualified plan if the Rx Discount Only outpatient prescription drug option is selected!
Out-of-pocket Maximum ²	\$4,000 individual or family	\$2,000 individual \$4,000 family	
General Medical Services and Supplies, Non Surgical Back Treatment ³ , Ambulance, Emergency Room	Daily Deductible and coinsurance apply	Deductible and coinsurance apply	
Outpatient Mental, Nervous, and Chemical Dependency Care	Daily Deductible and coinsurance apply	Deductible and 50% coinsurance apply ⁵	¹ Amount excludes any Rx deductibles/copays.
Out-of-Network			² Includes calendar year or daily deductible(s).
Individual Deductible ¹	Daily: \$500 individual \$1,000 family	Calendar year: In- and out-of-network expenses accumulate towards the network deductible	³ Non-surgical back treatment subject to \$1,000 maximum benefit per calendar year. Not applicable in TN or WI.
Out-of-pocket Maximum ²	Individual or family: \$8,000	Individual: \$3,350 Family: \$6,150	⁴ In- or out-of-network.
Coinsurance	100%	70%	⁵ Out-of-network coinsurance is 50%.
Copays	N/A	N/A	Note: Benefit limits may apply - see Certificate of Coverage for details.

In Plan 1, outpatient drug prescription charges do not apply towards the "daily" deductible amount. Payment of outpatient prescription drugs are determined by the Rx prescription drug option purchased.

HRA Advantage

In-Network

Outpatient Physician Office Visit or Physician Visit at a Free-standing Urgent Care Facility	100% of covered charges after \$20 copay (or) 100% of covered charges after deductible																					
Mammography, Routine Pap Smears	100% of covered charges																					
Outpatient Diagnostic Lab, X-ray, MRI, CT, Nuclear Imaging and other tests Copay Options	<p>Lab: 100% of covered charges after \$20 copay (if selected) or 100% coverage after deductible</p> <p>X-ray, MRI, CT, nuclear imaging, and other tests: 100% of covered charges after deductible</p> <p>Lab tests performed by LabOne: LabOne Select Discount</p>																					
Individual Calendar Year Deductible ¹	<table border="1"> <thead> <tr> <th>In- and out-of-network expenses all accumulate to either an individual or family deductible</th> <th>Individual</th> <th>Family</th> </tr> </thead> <tbody> <tr> <td></td> <td>\$1,000</td> <td>\$2,500</td> </tr> <tr> <td></td> <td>\$1,700</td> <td>\$3,350</td> </tr> <tr> <td></td> <td>\$2,600</td> <td>\$5,150</td> </tr> <tr> <td></td> <td>\$3,500</td> <td>\$7,500</td> </tr> <tr> <td></td> <td>\$5,000</td> <td>\$10,000</td> </tr> <tr> <td></td> <td>\$10,000</td> <td>\$10,000</td> </tr> </tbody> </table>	In- and out-of-network expenses all accumulate to either an individual or family deductible	Individual	Family		\$1,000	\$2,500		\$1,700	\$3,350		\$2,600	\$5,150		\$3,500	\$7,500		\$5,000	\$10,000		\$10,000	\$10,000
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Coinsurance	100%																					
Additional Individual Out-of-pocket Maximum ¹	\$0																					
General Outpatient Medical Services and Supplies, Non Surgical Back Care ² Ambulance, Emergency Room	Deductible and coinsurance apply																					
Outpatient Mental, Nervous, and Chemical Dependency Care	Deductible and 50% coinsurance apply ³																					

Our HRA takes you out of the paperwork loop.

Out-of-Network

Individual Calendar Year Deductible / Out-of-pocket Maximum ¹	<p>Out-of-network maximum out-of-pocket table</p> <table border="1"> <thead> <tr> <th>Individual Ded.¹</th> <th>Individual OOP¹</th> <th>Family Ded.¹</th> <th>Family OOP¹</th> </tr> </thead> <tbody> <tr> <td>\$1,000.....</td> <td>\$1,500</td> <td>\$2,500.....</td> <td>\$2,500</td> </tr> <tr> <td>\$1,700.....</td> <td>\$1,650</td> <td>\$3,350.....</td> <td>\$2,800</td> </tr> <tr> <td>\$2,600.....</td> <td>\$750</td> <td>\$5,150.....</td> <td>\$1,000</td> </tr> <tr> <td>\$3,500.....</td> <td>\$1,500</td> <td>\$7,500.....</td> <td>\$2,500</td> </tr> <tr> <td>\$5,000.....</td> <td>\$2,500</td> <td>\$10,000.....</td> <td>\$5,000</td> </tr> <tr> <td>\$10,000.....</td> <td>\$5,000</td> <td>\$10,000.....</td> <td>\$5,000</td> </tr> </tbody> </table>	Individual Ded. ¹	Individual OOP ¹	Family Ded. ¹	Family OOP ¹	\$1,000.....	\$1,500	\$2,500.....	\$2,500	\$1,700.....	\$1,650	\$3,350.....	\$2,800	\$2,600.....	\$750	\$5,150.....	\$1,000	\$3,500.....	\$1,500	\$7,500.....	\$2,500	\$5,000.....	\$2,500	\$10,000.....	\$5,000	\$10,000.....	\$5,000	\$10,000.....	\$5,000
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\$10,000.....	\$5,000	\$10,000.....	\$5,000																										
Coinsurance	70%																												
Copays	Office visit & lab copay (if elected) do not apply																												

¹Amount excludes any provider copays and/or Rx deductibles/copays. Maximum out-of-pocket corresponds to the selected deductible.

²Non-surgical back treatment subject to \$1,000 maximum benefit per calendar year. Not applicable in TN or WI.

³Out-of-network coinsurance is 50%.

Note: Benefit limits may apply - see Certificate of Coverage for details.

*The HRA is not an insurance product and is not provided, administered or guaranteed by Standard Security Life Insurance Company of New York.

Optional Benefits

Preventative Care Coverage¹ (Wellness Benefit Coverage)

After \$35 copay, the health plan pays 100% of covered wellness charges first, up to \$250, \$350 or \$500 per insured, per calendar year with **no waiting period!** Applies to both in- and out-of-network providers. **Includes:** Routine physical exams & related lab charges, well-child care including immunizations, prostate cancer screening services and flu shots.

Supplemental Accident Coverage¹

Choose a \$500, \$1,000 or \$2,000 per accident benefit amount for your employees. The health plan pays 100% of each accident's covered charges up to the selected benefit amount per person; then the plan's deductible and coinsurance apply. Benefit applies to both in- and out-of-network providers.

Maternity Coverage¹

Maternity services are covered the same as any other illness with this benefit. Covers the insured employee, dependent spouse, and dependent children. Available to groups insuring five or more employees (unless otherwise specified by state law). Mandatory for groups insuring 15 or more employees (by federal regulation).

Life Insurance and Accidental Death & Dismemberment¹

A minimum of \$10,000 and a maximum of \$100,000 in life and accidental death and dismemberment (AD&D) insurance is available. Benefits are available as a flat amount per covered employee or by employee classification. There is a maximum of three different classes, and the face amount of coverage per class cannot exceed two times the face amount of the previous class. The payable life insurance benefit is reduced according to the following age reduction schedule:

- Ages 65-69:** 65% of selected amount
- Ages 70-74:** 40% of selected amount
- Ages 75-79:** 25% of selected amount
- Ages 80-84:** 15% of selected amount
- Ages 85+:** 10% of selected amount

24-hour Occupational Coverage¹

On the job coverage for work-related injuries and sickness according to the selected health plan's provisions. **Available only to eligible business owners, partners, sole proprietors or corporate officers who are not eligible for Worker's Compensation coverage.**

Employee Assistance Program Care24 (EAP)

Employer benefits include human resources support, smoking cessation programs, legal and crisis counselors and critical incident stress management. Employee benefits include phone and in-office counseling, service referrals, audio health information library and more!

¹ See Certificate of Coverage and Schedule of Benefits for additional details.



Prescription Drug Options¹

Options	Generic	Brand Deductible	Preferred Brand	Non-Preferred Brand	Specialty Drugs
Option 5: Rx Copay ²	\$10	None	\$25	\$40	\$50
Option 4: Rx Coinsurance ²	\$10	None	\$30 + 20%	\$50 + 20%	\$60 + 20%
Option 3: Rx Deductible ²	\$20	\$250 Calendar Year	\$30 + 20%	\$50 + 20%	\$60 + 20%
Option 2: Rx Insurance ²	\$15	None	\$100	\$150	\$200
Option 1: Rx Discount Only	If no other Rx option is selected, the plan automatically includes the Rx Discount Only drug feature, providing discounts of up to 25% at Express Scripts pharmacies. This option is a discount program only and is not an insurance benefit.				
Option 6: Rx SAAOI Plan ³	Covered prescription drugs are paid the Same As Any Other Illness (SAAOI) under the health plan; subject to any applicable plan deductible or coinsurance.				

Mail Order and Internet Prescription Drug Purchases

When using an optional prescription drug benefit to purchase through Express Scripts' mail order or Internet services, your employees can purchase up to a 90-day supply for the cost of just two months' prescriptions.

Prescription Drug Formulary

The Prescription Drug Formulary is a list of quality generic and brand name medications offering the potential for cost savings. There are often two or more medications used to accomplish the same therapeutic effect. When a physician prescribes one of the listed medications, if medically appropriate, insureds will have a lower out-of-pocket cost for that prescription.

If the insured or their physician is reluctant to choose a particular medication from the formulary list, they are not required to do so. However, when non-formulary brand name prescription drugs are used, a higher copay applies.

Specialty Drugs

Specialty drugs are prescription medications that may be administered by a Physician as an outpatient or self-administered in a home setting and are listed on the Specialty Drug List. Specialty Medications must be obtained from CuraScript in order for the Specialty Medication to be covered at the In Network benefit level, even if the Specialty Medication is to be administered by a Physician or at a Physician's office. The CuraScript telephone number will be listed on the insured's identification card. The insured should call CuraScript to arrange for delivery of any prescribed Specialty Medication.

Specialty Medications are subject to the Pre-Certification Program requirements. Pre-Certification is a screening process using established medical criteria to determine whether any proposed Specialty Medication is Medically Necessary. It may also include proposing alternative treatment plans. **NO BENEFITS WILL BE PAID FOR SPECIALTY MEDICATION IN THE ABSENCE OF PRE-CERTIFICATION.** As an industry leader of Specialty Pharmacy Services, CuraScript provides specialty medications to individuals with chronic illnesses requiring complex, high-cost treatment.

¹ -See Express Scripts Formulary for current list of preferred prescription drugs. When a brand name medication is dispensed because of an insured person's preference and a less expensive FDA-approved generic medication could have been dispensed, the insured person's out-of-pocket costs may be increased by the difference in the price of the insured's preferred brand medication and the established Maximum Allowable Cost (MAC) price for the generic equivalent. MAC pricing is a statistically derived maximum allowable base price that will be paid for prescription drugs for which a less expensive, FDA-approved generic equivalent is available. This method assures that the cost to the plan does not increase when an insured person makes a decision to use a more expensive product. MAC pricing increases generic utilization and helps to equitably control the cost of outpatient prescription drugs dispensed.

² -Not available on the HSA Advantage plan.

³ - Available on the HSA Advantage, Single Deductible or HRA plans only.

Advantage Dental

Two great plans to choose from —
one with orthodontia!

Dental Plan I	<u>Plan covers</u>
Preventive Services (Type I)	100%
Exam	X-rays
Sealants	Cleaning
Fluoride Treatment	
Basic Services (Type II)	80%
Fillings	
Simple Extractions	
Oral Surgery	
Recementing and Repair to Full and Partial Dentures	
Major Services (Type III)	50%
Root Canal	
Endodontics, Periodontics	
Restorative Services	
Prosthetic Services	
Orthodontia (Type IV)	50%

Dental Plan II	<u>Plan covers</u>
Preventive Services (Type I)	90%
Exam	X-rays
Sealants	Cleaning
Fluoride Treatment	
Basic Services (Type II)	60%
Fillings	
Simple Extractions	
Oral Surgery	
Recementing and Repair to Full and Partial Dentures	
Major Services (Type III)	50%
Root Canal	
Endodontics, Periodontics	
Restorative Services	
Prosthetic Services	
Orthodontia (Type IV)	Not covered

- No network constraints - **choose any dentist**
- No waiting period for preventive or basic services
- \$1,000 orthodontia lifetime benefit available on Plan I
- Lifetime deductible for Preventative Care (while insured):
Plan I: \$25 Plan II: \$50
- Calendar year deductibles:
Basic & Major services: \$50 (Plan I and Plan II)
Orthodontia: \$50 (Plan I *only*)
- Calendar year maximum for preventive, basic and major services: Plan I \$1,500 or Plan II \$1,000

See the dental plan overviews for complete details.



Advantage Vision

Two plan designs to choose from!

- Thousands of participating providers at more than 800 stores nationwide
- Vision exams by fully credentialed optometrists and ophthalmologists
- Benefits for exams and lenses once every 12 months, with discounts for secondary purchases
- Benefits for frames once every 24 months, with discounts for secondary purchases
- Benefits and discounts available for non-member providers

Featuring the nation's #1 Optical Source:



offered through
EyeMed 
 The Eye Care Plan of America™

Exam with Dilation as Necessary:

Standard Plastic Lenses:

- Single Vision
- Bifocal
- Trifocal
- Lenticular

Frames:

Any frame available at provider location

Lens Options:

- UV Coating
- Tint (*Solid or Gradient*)
- Standard Scratch-resistance
- Standard Polycarbonate
- Standard Progressive (*add-on to bifocal*)
- Standard Anti-reflective Coating
- Other Add-ons and Services

Contact Lenses: (In Lieu of Lenses)

Includes fit, follow-up and materials

Conventional

- Disposables
- Medically Necessary

Laser Vision Correction:

- Lasik or PRK
- From U.S. Laser Network

	Option 1	Option 2
	<u>Cost at member providers</u>	<u>Cost at member providers</u>
	\$10 Copay	\$20 Copay
	\$25 Copay	\$20 Copay
	\$25 Copay	\$20 Copay
	\$25 Copay	\$20 Copay
	\$25 Copay	\$20 Copay
	\$0 Copay, \$100 allowance toward any frame plus 20% off balance over \$100	\$0 Copay, \$100 allowance toward any frame plus 20% off balance over \$100
	\$12 Copay	\$12 Copay
	\$12 Copay	\$12 Copay
	\$15 Copay	\$15 Copay
	\$35 Copay	\$35 Copay
	\$45 Copay	\$45 Copay
	\$45 Copay	\$45 Copay
	20% Discount	20% Discount
	\$0 Copay, plus 15% discount off balance over \$115	\$0 Copay, plus 15% discount off balance over \$115
	\$0 Copay, plus balance over \$115	\$0 Copay, plus balance over \$115
	\$0 Copay, plus balance over \$250	\$0 Copay, plus balance over \$250
	15% off retail price - or - 5% off promotional price	15% off retail price - or - 5% off promotional price

Vision benefits are underwritten by Fidelity Security Life Insurance Company.
 See the vision plan overviews for complete details.

Preferred provider organizations

(PPO Networks)

The IAC Health Plans are PPO network plans. Employees covered under the health plan can expect to incur lower out-of-pocket costs when they receive services from an in-network provider. Benefits provided for services received from providers for facilities who are not members of the employer selected network are reduced.

Coverage outside the primary PPO network service area

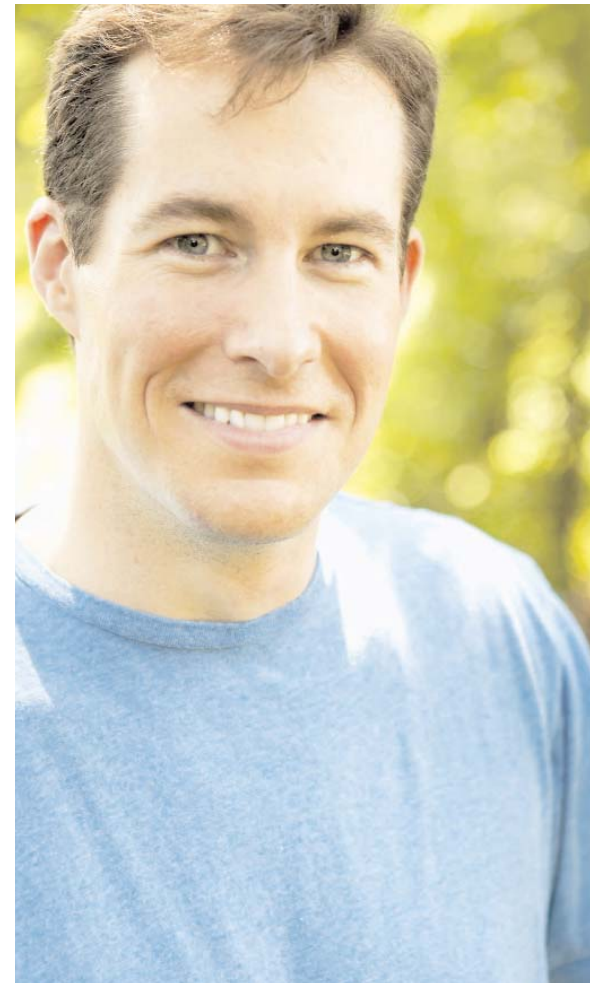
Coverage is available when traveling outside the primary PPO network service area. Private Health Care Systems (PHCS) and First Health® Network are national networks that may be used to access discounted healthcare services when employees travel outside of their primary regional network's service area. Although out-of-network benefits apply when employees access providers outside of their regional network's service area, medical fees charged at member facilities may be up to 20 percent less, due to our discounting arrangement with the PPO network.

PHCS and First Health® Network are also available as a primary provider network. Each gives your employees and their families the security of having in-network benefits available when participating physicians and facilities are used for their healthcare anywhere in the country.

Services received from out-of-network providers at in-network facilities

Certain providers such as radiologists, pathologists, anesthesiologists, and emergency room personnel may have relationships with network facilities but are not included in the network.

If care is received from such providers, covered charges are considered at the in-network coinsurance percentage rate. The resulting benefits are based on usual, customary and reasonable charges.



Emergency inpatient treatment at out-of-network hospitals

Your employees shouldn't have to worry about which hospital to select when they find themselves in a medical emergency.

Insured employees and dependents who are admitted to an out-of-network hospital for a medical emergency will have covered services paid by their plan at in-network benefit levels. However, they must arrange for transfer to an in-network hospital within 48 hours or as soon as this transfer can take place without detriment to their health. Otherwise, covered services will be paid at out-of-network benefit levels.

Refer to the Schedule of Benefits for any state-specific variations.

Outpatient laboratory testing

LabOne LabCard

Charges for outpatient laboratory tests are covered at 100% when testing is performed at a LabOne facility and are not subject to copays, deductibles or coinsurance.

Doctors who customarily collect specimens in the office simply send those specimens to LabOne. LabOne sends a courier to pick up the specimen, completes the testing and sends the results to the physician.

Charges for laboratory testing performed by other providers are subject to the applicable plan deductibles and coinsurance depending on the in-/out-of-network benefit selected. See the schedule of benefits for further details. The LabOne Labcard is not available on the Single Deductible, HSA Advantage or HRA Advantage plans.

LabOne Select

LabOne Select is included on the Single Deductible, HSA Advantage and HRA Advantage plans and offers discounted laboratory testing when an insured uses LabOne for testing, then the applicable health insurance plan deductibles and coinsurance apply depending on the in/out-of-network benefit selected. Specimens are collected and sent to LabOne as described above.

Major medical benefits

The plan covers these, and other medical expenses:

- Hospital room and board
- Medical services and supplies/hospital services
- Physician services
- Licensed emergency ambulance
- Imaging, laboratory and diagnostic tests
- Radiation therapy
- Ambulatory surgical center services
- Anesthetics, oxygen and their administration
- Chemotherapy, antibiotic therapy and infusion therapy
- Blood and its administration, but not the cost of blood or blood components if replaced by donation
- Initial supply but not replacement of casts, splints, trusses, crutches and braces (excluding dental braces and orthodontics)
- Rental (or at our option, lease or purchase) of a wheelchair, hospital bed, crutches, canes and other durable medical equipment

Expenses must be medically necessary in order to be covered under the plan and are subject to applicable copayments, deductibles and coinsurance.

Many other covered services and benefits are outlined in this brochure. For complete details, please refer to the Certificate of Insurance.



Limited major medical benefits

Non-surgical back treatment

Includes benefits for non-surgical back treatment, including treatment by a chiropractor, covered same as any other illness up to \$1,000 per person per calendar year. \$1,000 benefit limitation does not apply in TN or WI.

Covered services include:

- Initial exam
- Spinal adjustment and manipulation
- Diagnostic x-rays

Covered services must be:

- Medically necessary
- Delivered by a qualified physician
- Designed to accomplish a specific diagnosis related goal within a reasonable length of time

Non-covered services:

- Thermography
- Orthomolecular therapy
- Iridology
- Preventative care
- Lifestyle education
- Palliative care
- Long-term chronic care
- Contact reflex analysis
- Maintenance
- Stress management
- Dietary supplements
- Three dimensional contour studies
- Nutritional counseling
- Experimental or investigational procedures

Home healthcare

After the deductible has been met, the plan will pay covered charges at the selected coinsurance level up to 60 days per calendar year.

Occupational, physical and speech therapies

A combined total of 60 treatments are covered per calendar year for occupational therapy, physical therapy and speech therapy, with a maximum of 30 treatments per calendar year for any single therapy.

Hospice care

When a physician certifies a patient's life expectancy is less than six-months and hospice care is medically necessary, the plan will pay 100% of covered hospice care services for up to six months.

Covered charges are subject to applicable deductible and coinsurance. Refer to the Certificate of Coverage for details.

Limited major medical benefits (continued)

Specific organ transplants

The plan provides access to the **United Resource Network (URN)** for organ transplants. In addition to contracting with providers and Centers of Excellence, this specialized network offers expertise, patient advocacy and case management services. URN helps ensure that your employees who need these complex services receive the highest level of care.

Benefit levels for organ transplants vary depending on the providers selected by the insured, as follows:

United Resource Network providers

- Up to \$1 million while insured
- Allowance of up to \$5,000 is available for necessary travel and room and board expenses for a companion, or two companions, if the insured is a minor

PPO network providers

- Paid up to \$400,000 while insured

Out-of-network providers

- Paid up to \$200,000 while insured

Complications of pregnancy

Complications of pregnancy are covered the same as any other illness. However, normal pregnancy is not covered unless the optional maternity benefit is selected.

Extended care and skilled nursing facility care

After the applicable copay and/or deductible has been met, the plan will reimburse eligible covered medical expenses at the selected coinsurance level as follows:

- Up to \$100 per day
- Up to 60 days per calendar year



Mammography and breast screening

The plan will cover physician required periodic breast and mammogram screening services for insured women, as follows:

- **Benefit level** — Paid 100% in- or out-of-network
- **Frequency** — A baseline mammogram and annual mammograms thereafter
These services may be provided more frequently when recommended by a physician or as required by state law.

Mental and nervous conditions, substance abuse and chemical dependency treatment

The maximum benefit for mental and nervous and chemical dependency is \$10,000 combined while insured.

Outpatient mental and nervous or chemical dependency

- Covers physician services, medical services and supplies
- Paid at 50% coinsurance after deductible (all plans except Copay Saver)
- Limited to \$50 daily plan maximum benefit, up to 25 visits per calendar year up to \$1,250 per calendar year
- For all plans except the Single Deductible, HSA Advantage, and HRA Advantage plans, charges do not accumulate towards the plan's maximum out-of-pocket amount

Inpatient mental and nervous

- Covers room and board and medical services and supplies
- Applicable copays, deductible and coinsurance apply
- Maximum of 10 inpatient days, up to \$2,500 per calendar year

Inpatient chemical dependency

Benefits are not provided for inpatient chemical dependency treatment, unless otherwise mandated by law.

Refer to Certificate of Coverage for additional information.

Applying for coverage

Effective date of coverage

Employer groups may request that coverage under **Group Advantage Series** to become effective on **either the 1st or the 15th** of the month. The application and supporting material must be submitted to IAC prior to the requested effective date.

Coverage effective date and premium due date

When coverage is made effective on the 15th day of a month, the premium due date for the next and subsequent months will be the **1st of the month**.

Employers should never cancel existing coverage until they receive written notice that coverage under the Group Advantage Series has been approved.

Minimum Employer Contribution

As a participating employer, you are required to contribute a portion of the premiums under your group's plan. The minimum contribution is 50% of the employee cost or 25% of the employee and dependent cost.



Premium rates and rating practices

Employer class

This group medical insurance plan marketed and administered by Insurers Administrative Corporation is available only to a distinct class comprised of eligible employers which elect to participate and adopt the Multiple Unit Security Trust (the Trust) for the purpose of establishing a group insurance plan for their eligible employees and their eligible dependents. Employers are considered to be plan administrators, as defined by ERISA, for the insurance plan selected by them for their employees. The Trust is the policyholder of this plan of insurance.

Premium rates and rate guarantee

The insurance company has the right to determine the premium rates available to new participating employers applying for the policy each month.

Rate guarantees

Each employer who joins the Trust and is accepted for insurance under the group policy has an initial 6-month rate table guarantee or an initial 12-month rate table guarantee.

When premiums are due and grace period

Premium due date

The first premium payment is due with the submission of the application for insurance and must be a business check from the employer. Subsequent premiums are due on the first of each succeeding month.

Grace period

A grace period of 31 days will be allowed for the payment of any premium due after the initial premium. If not paid within that period, coverage will terminate automatically as of the due date of the unpaid premium.

Premium changes

Premiums may change during a rate table guarantee period if:

- The employer adds or deletes employees
- The business moves to another geographic area
- The employer modifies the plan of benefits
- The provider access or other administrative fees change

The manual rate table developed during each rating period which is used to calculate premiums is predicated upon the then current combined claims experience of all employers participating in the plan, adjusted for future utilization and medical inflation. Additional premium may be required due to industry or health status of an employer group within the rating practice of the state of issue.

Renewal premiums

Renewal premiums that are developed from the manual rate table will vary from employer to employer due to case characteristics including benefit options selected, age, gender, geographic location, or change in census.

An employer's renewal premiums may also increase up to an additional 15% or more per year as permitted by state law, based on the following factors:

- Employer's claims experience
- Changing health status of employees or their dependents
- Employer's length of participation in the plan



Renewability of coverage

The plan will renew on a monthly basis at the employer's option, except for the following reasons:

- Non-payment of premiums
- Fraud or misrepresentation of or by the employer, or with respect to coverage of an insured, fraud or misrepresentation by the insured or such person's representative
- For failure to comply with policy provisions, including failure to provide proof, whenever requested by us, that the employer is complying with the contribution and participation requirements
- For not maintaining employee or dependent participation or contribution requirements
- Relocation of the Employer to a place outside the geographic service area of the Policy
- The Insurance Commissioner of the state in which the employer originally obtained coverage finds that the continuation of coverage would not be in the best interests of the policyholder or certificateholders or finds that the continuation of coverage would impair our ability to meet our obligations
- The type of coverage under the policy is no longer offered by us in the state in which the employer originally obtained coverage in which event We will provide ninety (90) days prior written notice of the discontinuance and we will offer the employer the option to purchase any other health insurance coverage currently being offered by Us to employers in the small group market in that state
- We decide to discontinue offering all health insurance in the small group market in the state where the employer originally obtained coverage under the policy for his or her employees in which event we will provide the applicable state authorities and the employer written notice 180 days prior to the discontinuation and we will discontinue all health insurance issued or issued for delivery in the small group market in that state and will not renew coverage

Termination of benefits

Insurance automatically terminates on the earliest of the following dates:

- The date of termination of the policy
- The date of termination of any section or part of the policy with respect to insurance under such section or part
- The date the insured employee or employer fails to make the required premium contribution
- The date the insured employee enters the armed forces of any country, state or international organization
- The last day of the month in which You no longer meet the eligibility criteria established in the Policy
- The date the insured employee's employer ceases to be an insured employer under the policy

Late applicants

A person who waives coverage during an initial enrollment period or who requests coverage outside of an initial enrollment period is a Late Applicant. However, applicants who are eligible under HIPAA and who qualify for a special enrollment period as a result of a “qualifying event” will not be considered late enrollees, unless coverage is not selected during the special enrollee enrollment period.

Qualifying events include loss of coverage due to:

Legal separation, divorce, death, termination of employment, a reduction in the number of hours of employment.

Qualifying events for eligibility of new dependents:

Marriage, birth, adoption, placement for adoption.

Employees and their new dependents may be added following one of these qualifying events if coverage is applied for within 30 days of the event.

Events that do not qualify:

Loss of coverage due to any of the following occurrences does not constitute a qualifying event under HIPAA:

Failure to pay premiums on a timely basis, termination of coverage for cause.

Examples of a loss of coverage for cause include the making of a fraudulent claim or an initial misrepresentation of fact in connection with a group health plan.



A late applicant's coverage...

Approval date — Will be the first of the month following the date we receive and approve the application for coverage.

Deferral period — Will be the first nine (9) months following the applicant's "approval date". During this period, no benefits are payable.

Effective date — Will be the first of the month following the completion of the deferral period. However, covered charges will be subject to the pre-existing limitation period described below.

Pre-existing limitation period — Will be the nine (9) consecutive months following the deferral period. During the pre-existing limitation period, any eligible charges incurred in connection with a condition that was pre-existing within the 6-month period preceding the applicant's "approval date" will not be covered.

The pre-existing condition limitation credit as explained under the additional provisions section of this brochure may reduce this nine (9) month pre-existing condition limitation period.

Refer to the Certificate of Coverage for details.

Definition of Employer

An employer is a sole proprietorship, partnership, or corporation that is actively pursuing business interests and is applying for coverage in connection with its own employee welfare benefit plan. The employer will be deemed the health plan administrator for the purposes of compliance with and duties arising under the Employee Retirement Income Security Act (ERISA) and Consolidated Omnibus Budget Reconciliation Act (COBRA).

Ineligible Employer Groups

- Employee leasing companies
- Seasonal, part-time, or temporary employment situations

Definition of Employee

No director of a corporation shall be deemed an employee solely because of such a directorship.

An employee of the employer who is:

1. Working at least thirty (30) hours per week in the service of the Employer at its usual place of business. In AZ, the number of hours are as agreed to upon the hiring of the employee.
 - Compensated for such service by a regular periodic wage or salary that is subject to FICA and federal income tax withholding by the employer
 - Not a seasonal or temporary employee and is scheduled to work at least 9 months per year
2. A partner or proprietor actively engaged in the business of the Employer on a full-time basis
3. those new employees who are added from time to time as they become eligible.

If both husband and wife are Employees of the Employer, each person must apply as an Employee. If both husband and wife are covered as Employees, a Child may be covered as the dependent of either Employee, but not both.

Definition of dependent

Eligible dependents are an insured employee's:

- Lawful spouse
- Unmarried children dependent upon the insured employee for support and maintenance and are:
 - less than nineteen (19) years of age or
 - between nineteen (19) and twenty-five (25) years of age and a full-time student

Refer to the Certificate of Coverage for additional definitions of eligible dependents.

Pre-certification requirements

Except in Georgia and Missouri where precertification is not required

Pre-certification

is a screening process that uses established medical criteria to determine whether a proposed length of an inpatient hospital confinement, a proposed treatment plan, or proposed services and supplies are medically necessary and appropriate. It may also include proposing alternative treatment plans, concurrent length of stay reviews and discharge planning.

Services requiring pre-certification

- Proposed inpatient confinements in a hospital of more than 23 hours
- Prescription drug orders for growth hormones, immunosuppressants, AZT or HIV anti-retroviral medication, "off-label" use, orphan drugs, investigative new drugs (IND) and Group C cancer drugs

Pre-certification of non-emergency services

In non-emergency situations the pre-certification service must be contacted

by the insured person at least seven days prior to incurring charges on account of any of the above occurrences by calling the pre-certification service indicated on the health plan identification card. The pre-certification service will contact the insured person's doctor to obtain any information necessary.

Pre-certification of emergency services

In emergency situations, an insured person should go directly to the hospital for immediate care. In the event of an emergency condition resulting in hospitalization, the pre-certification service must be contacted within 48 hours of admission to the hospital (or as soon as reasonably possible). The insured person's doctor must verify that an emergency situation existed.

IMPORTANT: Additional deductible for failure to pre-certify

Failure to pre-certify an inpatient confinement will result in an additional deductible amount of \$500 per occurrence, and, if the specified prescription drugs are not pre-certified, no benefits will be payable toward their cost.

Pre-certification is not a guarantee of payment. Determination of eligibility, covered charges and benefits to be paid is made by Insurers Administrative Corporation in accordance with the terms of the Master Policy. If the insured person complies with pre-certification requirements, the additional \$500 precertification deductible amount(s) will be waived.

Additional Provisions

Usual, reasonable and customary

Definition

This is the usual charge we determine to be within the range of fees charged for treatment, services and supplies generally furnished for sickness or injuries of comparable severity and nature in the geographical area in which the treatment, services or supplies are furnished. In reaching a determination as to what amount should be considered as usual, reasonable and customary for treatment, services and supplies, we use and subscribe to a standard industry reference source that collects data and makes it available to its member companies. The data base used reflects the amounts charged by providers for health care services based on the smallest geographic zip code areas generating a statistically credible charge distribution. This data is updated and published twice annually. The data is reflective of reported provider charges from the lowest to the highest for each service or supply. The data is also adjusted periodically to reflect negotiated fee schedules with providers not included in the data base. We then use a specific representative percentile of that range of charges to determine the usual, reasonable and customary charge for all insureds under this policy.

When it is determined by this specific payment methodology that a charge by a provider is above the usual, reasonable and Customary amount, the charge is not a covered charge.

Covered charges

Covered charges are charges incurred as a result of an Injury or Sickness by or on behalf of an insured while the policy is in force with respect to such insured and which:

- Are medically necessary for the treatment of an injury or sickness and which have been recommended and prescribed by a physician
- Are not in excess of the usual, reasonable and customary charges made for the services performed or supplies furnished, or are not in excess of such Charges as would have been made in the absence of this insurance
- Are not excluded from coverage by the terms of the policy
- Do not exceed any amounts payable under the terms of the policy

Pre-existing conditions

A pre-existing condition is a condition, whether physical or mental and regardless of cause, for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period ending on the enrollment date of the insured person. A pre-existing condition will not be covered for a period of 12 months after the enrollment date.

Pre-existing condition limitation credit

An insured person who has creditable coverage as defined in the Health Insurance Portability and Accountability Act (HIPAA) to a date no more than 63 days (or more, if required by state law) prior to the enrollment date under this plan will be given credit for the full or partial satisfaction of a pre-existing condition limitation waiting period by such creditable coverage. The pre-existing condition limitation waiting period will be reduced to the extent of the insured person's prior creditable coverage.

Major Medical Exclusions

Expenses for any of the following are excluded from coverage:

1. A Pre-Existing Condition, until a continuous period of (a) twelve (12) months has elapsed from the Enrollment Date for other than Late Enrollees and (b) nine (9) months has elapsed from the Effective Date with respect to Late Enrollees. This paragraph does not apply to a newborn or newly adopted child or child placed for adoption under the age of 18 if such child is enrolled for coverage within 31 days from the date of birth or the date of adoption or placement for adoption. We will credit the time the Insured Person was covered by a plan of Creditable Coverage against this Pre-existing Condition exclusion period if no more than 63 days elapsed between the termination of the Insured's prior Creditable Coverage and the Insured Person's Enrollment Date or, the Late Enrollee's Effective Date; or
2. Equipment, other than Durable Medical Equipment, including, but not limited to, modifications to motor vehicles or motor homes such, as wheelchair lifts or ramps; water therapy devices, such as Jacuzzi's or hot tubs; and exercise equipment; or
3. Physical examinations, immunizations and check-ups which are not Medically Necessary for the treatment of Injury or Sickness, except as specified in the certificate of coverage or unless the Optional Wellness Benefit Rider is specified as applicable on the Schedule of Benefits; or
4. Prophylactic Treatment, surgery or diagnostic testing, except as specified in the certificate of coverage; or
5. Human organ or tissue transplant expenses except as specified in the certificate of coverage; or
6. Outpatient prescription drugs, including Specialty Medications, except as specified in the certificate of coverage or unless the Optional Prescription Medication Benefit Rider is specified as applicable on the Schedule of Benefits; or
7. Any service or supply in connection with the implant of an artificial organ, except as specified in the certificate of coverage or
8. Any treatment, service or supply which is not due to a Sickness or Injury, unless specifically indicated in the certificate of coverage as covered; or
9. Any treatment, service or supply which is not recommended by a Physician; or
10. Any treatment, service or supply or prescription which is not Medically Necessary; or
11. Treatment, services or supplies for which no Charge is made or for

which the Insured Person is not required to pay; or

12. Any treatment, service or supply provided by a government owned or operated facility or by government employed health care providers, unless the Insured Person is legally required to pay the Charges incurred or We are required to provide reimbursement by local, state or federal law; or

13. Hospital and Physician Charges for weekend Hospital admissions 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; or

14. An Injury or Sickness which arises out of or in the course of any employment for wage or profit or Dependent unless the optional hour 24-hour Occupational Rider is specified as applicable in the Schedule of Benefits and an Injury or Sickness for which the Employee or Dependent has or had a right to recovery under any Workers' Compensation or Occupational Disease Law; or

15. Physical or psychological examinations required by any third party, such as by a court or for employment, licensing, insurance, school, sports or recreational purposes; or

16. An Injury or Sickness incurred while on active duty with the military of any country or international organization; or

17. An Injury or Sickness resulting from war or any act of war (declared or undeclared) or the participation in a riot or insurrection; or

18. An Injury or Sickness incurred (a) during the commission or attempted commission of a crime or felony or while engaged in an illegal act; or (b) while imprisoned; or

19. Treatment, services or supplies for any loss sustained, incurred due to, or contracted as a consequence of an Insured Person (a) being intoxicated or (b) being under the influence of any illegal narcotic, barbiturate, hallucinatory or other drug, unless administered by a Physician and taken in accordance with the prescribed dosage. An Insured Person is conclusively determined to be intoxicated by drug or alcohol if a chemical test administered in the jurisdiction where the loss or cause of loss occurred is at or above the legal limit set by that jurisdiction; or

20. Treatment, services or supplies related to: (a) the teeth; and (b) the gums other than tumors; and (c) any other associated structures; (d) the prevention or correction of teeth irregularities and malocclusion of jaws by wire appliances, braces or other mechanical aids; and (e) dental implants, regardless of the cause; or

21. 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 both maxilla and mandible, unless due to an Injury, which occurs while covered under the Policy, to Sound Natural Teeth, provided that such treatment is received within 12 months following the date of Injury; or

22. Treatment, services or supplies provided for temporomandibular joint (TMJ) dysfunction; or

23. Treatment, services or supplies to improve the appearance or self-perception of an Insured 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; provided however, this Section does not apply to Charges for or related to the correction of a congenital anomaly; or

24. 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 a Sickness; and (c) breast reduction surgery unless Medically Necessary due to a Sickness;

Major Medical Exclusions (continued)

25. Surgery to correct refractive errors, such as radial keratotomy or radial keratectomy; or
26. Routine eye exams, glasses, visual therapy, or contact lenses, except for the first pair of glasses or lenses for use after cataract surgery; or
27. Routine hearing exams to assess the need for, or change to, hearing aids; and the purchase, fittings or adjustments of hearing aids; or
28. Contraceptive devices, including injectible, implantable or intradermal patch contraceptives, and any professional service fees related to the insertion or removal of such contraceptives, unless prescribed by a Physician as Medically Necessary treatment of a Sickness; or
29. Pregnancy of an Employee or Dependent unless the Optional Pregnancy Benefit Rider is specified as applicable on the Schedule of Benefits; or
30. Penile implants and fertility and sterility studies; or
31. Treatment, services or supplies: (a) to restore or enhance fertility; or (b) to reverse sterilization; or
32. Impregnation techniques such as: (a) artificial insemination; or (b) in vitro fertilization; including but not limited to: artificial insemination, in vitro zygote and intra-fallopian transfers, gamete intra-fallopian transfer, genetic counseling, and all Charges related to such in vitro fertilization; or
33. Voluntary abortion; except if the life of the mother would be in danger if the fetus were carried to term, or except for complications of a voluntary abortion; or
34. The non-therapeutic release of nuclear energy; or
35. Hypnosis; or
36. Attempted suicide or intentionally self-inflicted Injury or Sickness, while sane or insane; or
37. Treatment, services or supplies for Mental, Nervous or Chemical Dependency Disorders except as specified in the certificate of coverage; or
38. The voluntary taking of poison; or the voluntary inhaling of gas; or
39. Treatment, services or supplies to eliminate or reduce a dependency on or an addiction to tobacco, including but not limited to: nicotine withdrawal programs; nicotine products, such as transdermal patches and gums; hypnotism; and goal oriented behavioral modification; or
40. Marriage or family counseling, recreational therapy, equine therapy, educational therapy, social therapy, or sex therapy; or
41. Sexual reassignments or sexual dysfunctions or inadequacies; or
42. Meridian therapy (acupuncture), except when used in lieu of an anesthetic; or
43. Treatment, services or supplies related to paring or removal of corns, calluses, bunions or toenails (other than partial or complete removal of nail roots), except when prescribed by an attending Physician who is treating the Insured Person for a metabolic disease, such as diabetes mellitus or a peripheral-vascular disease such as arteriosclerosis; or
44. Treatment, services or supplies related to the feet by means of posting or strapping, or range of motion studies; or
45. Orthotics; or
46. Treatment, services or supplies for obesity or weight reduction, including wiring of the teeth and all forms of intestinal bypass surgery and complications resulting from such surgery; or
47. Treatment, services or supplies received from a Physician, Nurse or other provider if such person: (a) is a Close Relative of the Insured Person, or (b) lives in the same household as the Insured Person, except for Charges rendered while a Hospital Inpatient; or
48. Treatment, services or supplies received from a Physician, Nurse or other provider if such person is an employee of the same Employer as the Insured Person; or
49. Treatment, services or supplies that are Experimental or Investigational; or
50. Any surgical removal of an organ or tissue unless Medically Necessary; or
51. Private duty nursing; or
52. Any over-the-counter medication or medication that may be obtained without a prescription; or
53. Custodial Care, regardless of who prescribes or renders such Care; or
54. 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 Emergency Care, provided the treatment, services or supplies used in connection with the Emergency Care are approved for use in the United States; or
55. Any education or training materials including, but not limited to, programs or materials for pre-natal education and management of pain, asthma and heart disorders; or
56. Inpatient personal convenience items including, but not limited to, beauty or barber services, radio and television, massages, telephone charges, take home supplies, guest meals, and motel accommodations; or
57. Telephone consultations, missed appointment fees, fees for completing claim forms, fees related to obtaining hospital pre-certification, and fees related to the provision of medical records; or
58. Treatment, services or supplies for complications of conditions that are not covered under the Policy except for complications of a voluntary abortion; or
59. Physical, speech and occupational therapy except as specified in the certificate of coverage; or
60. Hospice care services except as specified in Section - Benefits; or
61. Home Health Care services except as specified in the certificate of coverage; or
62. Non Surgical Back Treatment except as specified in the certificate of coverage.

See schedule of benefits and Certificate of Coverage for additional details.

Accidental death and dismemberment exclusions

Accidental Death and Dismemberment Benefits are not payable for any loss caused directly by:

1. Intentionally self-inflicted Injury or suicide while sane or insane;
2. Sickness including any medical or surgical treatment of Sickness;
3. Infections, except pyogenic infection resulting from an accidental bodily Injury or resulting from accidental ingestion of a contaminated substance;
4. The Insured Person's participation in a riot or insurrection. "Participation" means taking an active part in common with others. "Riot" means any use or threat to use force or violence by three or more persons without authority of law;
5. Active duty as a member of any military, naval or air force;
6. War or any act of war, declared or not;
7. The Insured Person's commission or attempted commission of a felony, assault or illegal action;
8. Voluntary use of any alcohol, drug or narcotic unless prescribed by a Physician and taken as prescribed;
9. Voluntary inhalation of any kind of gas including carbon monoxide;
10. Travel or flight in, or descent from, any aircraft except as a fare paying passenger of a commercial airline flying on regularly scheduled routes between definitely established airports;
11. The Insured Person's driving a vehicle while legally intoxicated according to the laws of the area where the accident occurred. An Insured Person is conclusively determined to be intoxicated by drug or alcohol if a chemical test administered in the jurisdiction where the loss or cause of loss occurred is at or above the legal limit set by that jurisdiction.

Refer to the Certificate of Coverage for additional details.

Outpatient prescription medication benefit exclusions

Charges for the following Outpatient Prescription Medication and supplies will not be considered as Covered Charges under this Outpatient Prescription Medication Rider and no payments will be payable for such Charges:

1. Contraceptive devices; or
2. Over-the-Counter medications, supplies or products; or
3. Medications or other agents to increase or enhance fertility or the likelihood of conception; or
4. Medications for the treatment of erectile dysfunction or to assist in or enhance sexual performance; or
5. Vitamins; provided however, pre-natal vitamins will be considered Covered Charges;
6. Medications to eliminate or reduce a dependency or an addiction to tobacco including, but not limited to, the cessation or termination of cigarette, cigar, or tobacco smoking or the use of smokeless tobacco, including nicotine products, gums and transdermal patches;
7. Medications for the treatment of hair loss or for the purpose of regrowing lost hair, such as Rogaine, Minoxidil;
8. Immunization agents, biological sera, blood or blood plasma;
9. Experimental or Investigational Medication;
10. Medications covered under Workers' Compensation;
11. Medications for the treatment of obesity or diet control;
12. Medications taken, prescribed or administered while an Inpatient at a Hospital, Rest Home, Sanitarium, Skilled Nursing Facility, Convalescent Hospital, Nursing Home or similar institution which operates a facility for dispensing Drugs;
13. Therapeutic devices or appliances, support garments and other non-medicinal substances regardless of intended use;
14. Homeopathic medications;
15. Any medication purchased outside the United States of America;
16. Any medication which requires Pre-Certification and which is not pre-certified as defined in Section - Accessing and Administering Your Benefits;
17. Specialty drugs unless pre-certified through IAC and obtained through Express Scripts mail order service

Refer to the Certificate of Coverage for additional details.

IMPORTANT INFORMATION

Information included in this brochure is an outline of features, plan provisions, benefits and other information about the Group Advantage Health Plans. It is not intended to serve as legal interpretation of benefits, which are provided under the Master Policies issued to the Multiple Unit Security Trust I. The exact provisions governing the Health Insurance contract are contained in the Master Policy underwritten by Standard Security Life Insurance Company of New York. Some of the provisions, benefits, exclusions or limitations may vary depending upon the insured person's state of residence. These health plans may not be available in every state. Check with your agent for availability. Certain terms and restrictions apply. Any provision of this plan that is in conflict with applicable state law is hereby amended to meet the minimum requirements of such law.

For complete details about the Group Advantage Health plans, please refer to the Certificate of Coverage SSLMMC0205, Policy number SSLMMP0205, underwritten by Standard Security Life Insurance Company of New York.

Health benefits described in this brochure are underwritten by Standard Security Life Insurance Company of New York in AL, AR, AZ, GA, IA, IL, IN, KS, MI, MO, MS, NC, NE, NM, NV, OH, OK, PA, SC, TN, TX, UT, WI, and WV.

Vision coverage is underwritten by Fidelity Security Life Insurance Company, Kansas City, Missouri. For details on vision benefits, refer to Certificate of Coverage C-9004 and Policy numbers VC-37, VC-38 and VC-20.

Provisions, benefits, and limitations described herein may vary according to the insured's state of residence at time of issue. For additional details, see the Certificate of Coverage.

IAC Health Plans

Group Advantage Series



Standard Security Life Insurance Company of New York, is the insurer for health, dental, life, and accidental death & dismemberment benefits described in this brochure.*

Standard Security Life Insurance Company of New York has been **rated A (Excellent)** by A.M. Best Company, which rates an insurer on its relative financial strength and ability to meet its obligations to insureds.

While the Excellent rating reflects the company's outstanding financial performance and capitalization, it is not a warranty of the company's present or future financial position. A.M. Best reports that companies rated A (Excellent) "*have an excellent ability to meet their ongoing obligations to policyholders*".



Insurers Administrative Corporation (IAC), Phoenix, AZ, is a licensed and bonded third-party administrator established in 1978.

IAC offers total services of underwriting, billing and claims administration for the Group Advantage Series. IAC is one of the largest third-party administrators in the nation with more than 300 employees serving the insurance needs of individuals and employers in the areas of medical, dental, vision, life and AD&D, critical care coverage, self-funding, 401K and Section 125 plans.

*Vision benefits described in this brochure are underwritten by Fidelity Security Life Insurance Company, Kansas City, MO.

Services provided by BanCorp Bank, MEDEX, Optum®, Express Scripts, LabOne, or MyHealthCompass™ are not insurance benefits and are not underwritten by Standard Security Life Insurance Company of New York or Fidelity Security Life Insurance Company. Information contained herein regarding the advantages of an HSA or HRA should in no way be construed as providing legal or tax advice. Always consult your tax or legal advisors with any questions about tax or legal matters. Consult your agent when selecting an HSA bank. Refer to Internal Revenue Code (IRC) Section 213(d) for a complete list of covered services and maximum contributions. In addition, the HSA or HRA is not an insurance product and is not provided, administered or guaranteed by Standard Security Life Insurance Company of New York or Fidelity Security Life Insurance Company.