Defined Solutions Limited Benefit Medical Insurance

These Guidelines provide information to help you manage the Defined Solutions Limited Benefit Medical Insurance Plan Underwritten by Companion Life Insurance Company.

The Third-Party Administrator for your medical insurance is Insurers Administrative Corporation (IAC). Please direct all communications regarding your medical insurance to:

INSURERS ADMINISTRATIVE CORPORATION
P.O. Box 15250
Loves Park, IL 61132-5250

Customer Service: (800) 397-5800 -Billing Inquiries (800) 964-4948-Claim Inquiries
Fax: (815)-633-0277
Email: hpaadmin@iacusa.com

Please include your case number on all communications about your insurance.

Billed Information

Applicable effective dates are the 1st, 8th, 15th and 22nd. Premiums for your coverage are due on the same date as your effective date. If the premium due is not received on or before the expiration date of the 31-day Grace Period, coverage will cease automatically as of the due date for non-payment of premium. Only Visa , Mastercard and Automatic Bank Withdrawal is accepted for the initial payment.

Adding Dependents

1. When a dependent is to be added, an enrollment form must accompany the request. The coverage for the added dependent will be effective the following premium due date after the request is received or a future premium due date if requested.
2. Send the enrollment form to Insurers Administrative Corporation at the address above. Do ***not*** send any premium. After the addition of the dependent is processed, you will be billed for the additional premium on the next billing.
3. You will receive written confirmation of the addition of your request for dependent coverage.

Defined Solutions

THE IHC GROUP
Independence Holding Company

Changes in Existing Coverage

1. The effective date is the day after IAC's administrative office receives your completed enrollment form or a future date if requested.

2. Refund of the Plan cost including fees will be considered if IAC is notified of cancellation in writing within 30 days of the receipt of the policy. Otherwise the policy is cancelled as of the current paid through date.

3. Plan upgrades are not allowed after issue.

Address Changes

Please submit any address changes in writing to IAC.

Reinstatements

Reinstatements are not applicable.

DS 03/09

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Independence Holding Company

Welcome! Your Defined Solutions limited benefit medical insurance is underwritten by Companion Life Insurance of Columbia, SC.

Your Identification Cards (ID Cards) are provided at the bottom of this letter. You should cut out these ID Cards and keep one in your wallet for information when visiting a medical provider.

As a reminder, print your Policy/Certificate including:

- Certificate of Insurance/Schedule of Benefits
- Completed Application

If you have problems when printing these documents, please send an email to PolicyService@hpainsurance.com.

Please review your Policy/Certificate and other materials carefully. If you want to retrieve these documents at a later date, go to Policyholder information at www.hpainsurance.com.

Should you have a claim or billing question, please contact the appropriate department by using this quick reference:

Claims Customer Service	Premium Billing Customer Service
1-800-964-4948	1-800-397-5800

This information is also provided on the ID Cards below:

Defined Solutions

MultiPlan
Limited Benefit Plan

To locate a provider:
www.multiplan.com

Plan: **DS500 - Individual**
Case ID: **DL01040546**
Member ID: **b01117888**
McCarty
01 Sheena **02**
03 **04**

RxBin: 003858
RxPCN: A4
RxGrp: INAV

EXPRESS SCRIPTS
Charting the Future of Pharmacy

www.express-scripts.com
Pharmacist Questions: (800) 234-7345

Claims Customer Service
800-964-4948

SEND MEDICAL CLAIMS TO:
IAC, PO Box 21456, Eagan, MN 55121
ELECTRONIC CLAIM INFORMATION: http://edihelp.iacusa.com

Defined Solutions Health Plan is Administered by:
Insurers Administrative Corporation
PO Box 15250, Loves Park, IL 61132-5250
For billing please call 800-397-5800

This card is not a guarantee of coverage.

DEFINED SOLUTIONS ENROLLMENT FORM FOR INSURANCE

Underwritten by: **Companion Life Insurance Company**, Columbia, South Carolina

DO NOT LEAVE ANY BLANKS

New Enrollment **Change of Family Status**

APPLICANT INFORMATION

Applicant's Name McCarty (Last) Sheena (First) M (MI)

Home Address 12907 S Blackfoot Dr (Street) Olathe (City) KS (State) 66062 (Zip)

Home Telephone (913) 839-2678 Work Telephone (913) 538-8403

Email Address classy18k@comcast.net (Required for this program)

Sex: ☐ Male ☒ Female Date of Birth 10/22/1960 Social Security Number xxx-xx-6721

Marital Status: ☐ Single ☒ Married

Coverage Type: ☒ Applicant Only ☐ Applicant + Spouse ☐ Applicant + Children
☐ Applicant + 1 Child ☐ Family (Applicant, Spouse and Child(ren))

DEPENDENT INFORMATION

Dependent Name	Date of Birth Mo/Day/Yr	Relationship	Social Security No.

PLAN INFORMATION

Plan Selected:

☒ DS 500 ☐ DS 750 ☐ DS 1000

Monthly Premium: $99.70

Requested Effective Date: Month 2/15/2010

Choose one day of month: ☐ 1st ☐ 8th ☒ 15th ☐ 22nd

Method of Payment: ☐ Bank Draft ☒ Credit Card

APPLICANT AUTHORIZATION

DO NOT CANCEL OTHER COVERAGE UNTIL NOTIFIED IN WRITING BY THE INSURANCE COMPANY OF ACCEPTANCE OF THIS APPLICATION

I certify that all answers contained herein are true and complete. I understand and agree that the falsity of any answer or statement in this application which materially affects the risk or hazard assumed by the Insurance Company may bar the right to any recovery under any Certificate issued. I understand that no coverage will become effective under the Certificate until written approval is received from the Insurance Company. I understand that no benefits will be payable for expenses incurred as a result of a Pre-Existing Condition (as defined in the policy) until coverage has been in effect under this plan for 12 consecutive months. I have read any Fraud notice applicable to my state of residence on the reverse side of this application.

Sheena M McCarty (Electronic Signature) — Applicant Signature

2/4/2010 — Date

PRODUCER'S STATEMENT

I, the undersigned, certify that I am currently licensed as an accident & health agent in the resident state of the applicant. I certify that the information contained herein is correct to the best of my knowledge. I have advised the applicant that this coverage is not intended to replace major medical coverage and not to terminate any existing coverage until receiving notice that the certificate being applied for by this application is approved in writing. I understand that I have no right to bind this coverage, to alter the terms of the policy or certificate in any manner, or to adjust any claim for benefits under the policy or certificate.

Signature of Producer _____ Date _____

PRODUCER'S INFORMATION

Name:	**HPA Sales**	Producer/Agent #:	**DS000000000**
Company Name:		Business Phone:	**800-277-3323**
Street Address:		Business Fax:	
City/State/Zip:		Email Address:	**newsales@hpainsurance.com**

GENERAL AGENT INFORMATION (to be filled out by the GA Only, if applicable)

Name:		General Agent #:	
Name of Agency:		GA's Phone #:	
		GA's Fax #:	

FRAUD WARNING NOTICES: (If the Applicant lives in a state where one of the fraud warning notices apply, please review the notice that applies to your state.)

Arkansas / Louisiana	Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
DC	It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.
Florida	Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.
Kentucky / Ohio	I understand that any person who, with intent to defraud, or knowing that he or she is facilitating a fraud against an insurer, submits an application containing a false or deceptive statement is guilty of insurance fraud.
New Mexico/ Pennsylvania	Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.
Tennessee	It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

MONTHLY AUTOMATIC PAYMENT PLAN for DEFINED SOLUTIONS PLAN

Complete All Applicable Areas

To initiate the Automatic Payment Plan, the following must accompany your application:

- This fully completed and signed form.
- Credit Card information;
  - **OR** -
- Bank Account information

Coverage purchased by check is subject to clearance of the check, and coverage purchased by credit card is subject to acceptance of the credit card issuer.

Companion Life Insurance Company, Columbia, S.C. (CLI) or its designated administrators, is hereby authorized to debit my bank account or credit card for the CLI insurance premiums and any applicable Communicating for America, Inc., association membership dues for the initial amount, if applicable, and for each month thereafter until this Authorization is terminated. I understand that the applicable initial premiums collected will be refunded to me if my health insurance certificate is not issued. I agree that the named institution shall be fully protected in honoring any such payments. The institution's rights and treatment of each payment shall be the same as if it were signed by me. If any such payment is dishonored, whether with or without cause, I understand that the institution shall not be liable whatsoever, even though such dishonor results in a forfeiture of insurance. This Authorization will remain in effect until the bank is notified of termination by me in writing. To terminate insurance coverage, I will also notify CLI or its administrators in writing.

☒ Credit Card Payment Choose one: ☐ MasterCard ☒ Visa

Initial Amount collected upon receipt of application **$99.70**

Name (as it appears on card) **Sheena M McCarty**

Card# **xxxxxxxxxxxx8914** Exp. Date **2/2013**

Signature of Cardholder **Sheena M McCarty** Date **2/4/2010**
(Electronic Signature)

☐ Monthly Bank Account Bank Draft

Initial Amount collected upon receipt of application _____

Name of Bank _____

Address _____

Routing No. _____ Account No. _____

Signature of Cardholder or Depositor _____
(Electronic Signature)

Date _____

Name (please print) _____

Payment Confirmation # **VRFE4E8D4864**

ADDITIONAL DEPENDENT INFORMATION

Dependent Name	Date of Birth Mo/Day/Yr	Relationship	Social Security No.

PLAN INFORMATION

Companion Life Insurance Company
PO Box 37457
Phoenix, AZ. 85069

Companion Life Insurance Company, herein called the Company, hereby certifies that it has issued and delivered to the Policyholder a group Policy, described on the Schedule of Benefits page. The group Policy covers certain Covered Persons as described in the Policy.

This Certificate describes the benefits and provisions of the Policy. This Certificate becomes effective only if: (1) the Insured is eligible for insurance; (2) We have received the Insured's application/enrollment form; (3) the required premium has been paid; and (4) the Insured becomes insured in accordance with all of the provisions of the Policy.

No agent may change the Policy or waive its provisions.

This Certificate takes the place of any other certificate previously issued to the Insured under the Policy. It should be kept in a safe place.

30 Day Right To Return

Carefully read this Certificate including all provisions, benefits and limitations as soon as you receive it. It is important that you understand and are satisfied with the coverage provided under this Certificate. If you are not satisfied with this Certificate, return it to the Company at its home office within 30 days after you receive it. All premiums will be refunded and coverage will be considered to be void from its beginning.

IN WITNESS WHEREOF Companion Life Insurance Company caused this Certificate to be executed on the Date of Issue to take effect on the Certificate Effective Date.

Donald H. Dunkley

_____

President

For service or complaints about the Policy, please address
any inquiries to the address shown above or call 1-800-518-4510.

TABLE OF CONTENTS

Schedule of Benefits

Name of Insured (Certificateholder): **Sheena M McCarty**

Member/Insured Identification Number: **b01117888**

Certificate Number: **DL01040546**

Policyholder: **Communicating for America, Inc.**

Policy Number: **CA0101001**

Certificate Effective Date: **2/15/2010**

Plan Chosen: **DS500 - Individual**

PLAN	DS 500	DS 750	DS 1000
Physician Office Visit Benefit	$50 per visit	$60 per visit	$75 per visit
Maximum visits per calendar year per Covered Person.	2	4	5
Maximum benefit per calendar year per Covered Person:	$100	$240	$375
Wellness Benefit Covers routine physical examinations and related lab and x-ray tests.	$50 per visit	$100 per visit	$150 per visit
Maximum visits per calendar year per Covered Person.	1	1	1
Outpatient Diagnostic X-ray, Lab & Advanced Studies Benefit	$50 per visit	$75 per visit	$100 per visit
Maximum benefit per calendar year per Covered Person.	2	3	3
Emergency Room Benefit *Benefit is payable in addition to other benefits which may apply as the result of an injury due to illness. Treatment must be performed within 72 hours of the accident.*	$0	$75	$100
Maximum visits per calendar year per Covered Person	0	2	2
Inpatient Confinement Benefits *The maximum benefit payable per calendar year per Covered Person is 30 days, in the aggregate for the following:*			
Hospital Confinement *Maximum benefit of 30 days confinement per calendar year per insured person.*	$500 per day	$750 per day	$1,000 per day
Confinement for Mental, and Nervous Disorders *Benefit is payable in lieu of Hospital Confinement Benefit.*	$250 per day	$375 per day	$500 per day
Skilled Nursing Benefit *Maximum benefit of 10 days per calendar year per Covered Person. Skilled nursing stay must follow hospital confinement of at least 3 days.*	$250 per day	$375 per day	$500 per day

PLAN	DS 500	DS 750	DS 1000
Inpatient Surgical Facility Benefit			
Maximum Benefit Per Calendar Year: **Surgical Procedure Units:** *Benefit is based on the Payment Factor shown in Section 3 Schedule of Surgical Indemnity Benefits times the Surgical Procedure Units, as indicated.*	$500 1	$1,000 1	$1,500 1
Outpatient Surgical Facility Benefit Per Surgery			
Maximum Benefit Per Calendar Year: **Surgical Procedure Units:** *Surgeries performed at an Outpatient Surgical Facility Center or a Hospital outpatient surgical facility.* *Benefit is based on the Payment Factor shown in Section 3 Schedule of Surgical Indemnity Benefits times the Surgical Procedure Units, as indicated.* *Venipuncture procedures are not considered surgical procedures, but are considered under the Outpatient Lab Benefit*	$250 1	$500 1	$750 1
Anesthesiology Benefit *A maximum of 2 anesthesia benefit per covered surgical procedures per calendar year per Covered Person, one for Inpatient Surgery and one for Outpatient surgery.*	25% of Surgical Benefit	25% of Surgical Benefit	25% of Surgical Benefit
Outpatient Prescription Drug Card Benefit *Covers Generic prescriptions only* *Maximum Benefit per person per month:* *Maximum Benefit per person per calendar year:* *Discount only on Brand & Formulary*	N/A Rx Discount only	$15 Copay $100 $1,200	$10 Copay $200 $2,400

Pre-Existing Conditions: No benefits will be payable for expenses incurred as a result of a Pre-Existing Condition until coverage has been in effect under this Policy for 12 consecutive months.

SECTION 1
DEFINITIONS

1.01 "Accident" means sudden, unexpected and unintended injury which is independent of any Sickness and which takes place while the Covered Person's coverage is in force.

1.02 **"**Calendar Year" means the period from January 1 through December 31 of the same year.

1.03 "Certificate" means the individual Certificate issued to the Insured. It describes the coverage under the Policy.

1.04 "Company" means Companion Life Insurance Company, located in Columbia, South Carolina.

1.05 "Complication of Pregnancy" means:

(a) conditions requiring Hospital Confinement whose diagnoses are distinct from pregnancy, but are adversely affected by pregnancy when the pregnancy is not terminated, including

but not limited to: acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity; and

(b) non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy occurring during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy do not include false labor, occasional spotting, Physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, pre-eclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication. Deliver by cesarean section is considered a Complication of Pregnancy if the cesarean section is involuntary.

1.06 "Confinement (or Confined)" means that period of time during any Hospital stay that the Covered Person is actually admitted on an inpatient basis. Two or more Confinements for the same or related causes that are separated by less than 90 days will be considered the same Confinement. "Confinement" does not include that period of time during which a Covered Person is in a Hospital emergency room, an observation room, a free-standing surgical facility, or outpatient facility.

1.07 "Covered Benefits" means those services or supplies that:

(a) are for necessary treatment and recommended by a Physician;

(b) are received while the Covered Person is insured under the Policy, subject to any Extension of Benefits; and

(c) are not excluded under Section 4.

1.08 "Covered Person(s)" means the Insured and his or her Dependents insured under the Policy.

1.09 "Dependent" means an Insured's:

(a) married spouse who lives with the Insured and is under age 70; or

(b) unmarried child (natural, step or adopted) who is not eligible for medical coverage as an Insured under the Policy or any other group policy and who:

(1) is less than 21 years old and is dependent on the Insured; or

(2) is less than 23 years old and going to an accredited school full-time. Such child must be dependent on the Insured for principal support and maintenance; or

(3) becomes incapable of self-support because of mental retardation or physical handicap while insured under the Policy and prior to reaching the limiting age for Dependent children. The child must be dependent on the Insured for support and maintenance.

The Company must receive proof of incapacity within 31 days after coverage would otherwise terminate. Then, coverage will continue for as long as the Insured's insurance stays in force and the child remains incapacitated.
Additional proof may be required from time to time but not more often than once a year after the child attains age 23; or

(4) is not living with the Insured, but the Insured is legally required to support such child, and the child would otherwise qualify under (1), (2) or (3) above.

The term Dependent does not include:

(a) a grandchild of the Insured (except where required by law); or

(b) a child who engages for compensation, profit or gain in any employment or business for 30 or more hours per week, unless such child is a full-time student a described in (b)(2) above.

1.10 "Effective Date" means the date, starting at 12:01 A.M. at the Insured's residence, that coverage for a Covered Person takes effect under this Certificate. The "Certificate Effective Date" means the date, starting at 12:01 A.M., that coverage under this Certificate takes effect.

1.11 "Hospital" means a licensed institution that has on its premises:

(a) permanent and full-time facilities for the care of overnight resident bed patients under the supervision of a licensed Physician;
(b) 24-hour-a-day nursing service by graduate registered nurses; and
(c) the patient's written history and medical records.

It shall also have (or have available on a pre-arranged basis) laboratory, x-ray equipment and operating rooms where major surgical operations may be performed by licensed Physicians, or be accredited by the Joint Commission on Accreditation of Hospitals.

"Hospital" shall not include any institution or portion thereof used as a place for rehabilitation, rest, the aged, education or training; or a nursing or convalescent home or an extended care facility for the care of convalescent patients.

1.12 "Immediate Family" means the parents, spouse, children, or siblings of a Covered Person, or any person residing with a Covered Person.

1.13 "Insured" means the person shown on the Schedule of Benefits as the Certificateholder of this Certificate.

1.14 "Physician" means a practitioner of the healing arts who:
(a) is practicing within the scope of his or her license in the state where so licensed; and
(b) is not a member of the Covered Person's Immediate Family.

1.15 "Policy" means the group Policy issued to the Policyholder.

1.16 "Policyholder" means the Communicating for America, Inc. that holds the Master Policy.

1.17 "Pre-Existing Condition" means a disease, Accident, Sickness or physical condition for which a Covered Person:
(a) had treatment;
(b) incurred expense;
(c) took medication; or
(d) received a diagnosis or advice from a Physician;

during the 12-month period immediately before the Effective Date of his or her coverage. The term Pre-Existing Condition will also include conditions which are related to such disease, Accident, Sickness or physical condition.

1.18 "Schedule of Benefits (or Schedule)" means the benefit schedule set forth in the Policy or Certificate.

1.19 "Sickness" means illness or disease which begins while the Covered Person's coverage is in force and is the direct cause of the loss.

1.20 "Total Disability or (Totally Disabled)" means the Insured is disabled and prevented from performing the material and substantial duties of his or her occupation. For Dependents, "Totally Disabled" means the inability to perform a majority of the normal activities of a person of like age in good health.

SECTION 2
ELIGIBILITY AND EFFECTIVE DATES

2.01 All persons who:
(a) are members in good standing of the Association to which the Policy is issued; and
(b) are under age 70;

are eligible to be insured under the Policy. Evidence of insurability acceptable to the Company may be required.

2.02 The insurance on eligible persons will take effect at 12:01 A.M., local time at the Insured's address on the Certificate Effective Date shown in the Schedule if:

(a) an application/enrollment form is completed and received by the Company on or before said Certificate Effective Date;
(b) the underwriting rules of the Company are met; and
(c) the first premium is received by the Company on or before said Certificate Effective Date.

2.03 If and where Dependent coverage is available under the Policy, each Insured will be eligible for such coverage on the latest of the following dates:

(a) the day the Insured becomes eligible for insurance; or
(b) the day the Insured acquires his or her first Dependent.

2.04 Dependent coverage may be elected by:

(a) completing and signing an application/enrollment form within 31 days of the date the Dependent becomes eligible; and
(b) paying any required premium for such Dependents.

2.05 The Effective Date of coverage for each eligible Dependent will be the first of the month following the date of:

(a) the Company's acceptance of the application/enrollment form; and
(b) receipt of the first premium by the Company.

However, if on such date the coverage for the eligible Insured has not yet taken effect, the Effective Date for Dependent coverage will be the same as the Certificate Effective Date for such Insured.

A newborn child will become insured for Accident or Sickness automatically on the day he or she is born as long as the Insured's coverage was in force on that date. Accident or Sickness includes prematurity, congenital defects and birth abnormalities. The newborn child's coverage will not continue past the 31-day period following birth unless:

(a) the Company is notified by the end of that 31-day period of the addition of such newborn child; and
(b) any applicable additional premium is paid.

An adopted child who has not attained 18 years of age, will become insured for Accident and Sickness automatically as of the date of adoption or placement for adoption. Placement for adoption means the assumption and retention by a person of legal obligation for total or partial support of a child in anticipation of the child's adoption. Coverage for an adopted child will not continue past the 31-day period following birth unless:

(a) the Company is notified by the end of the 31-day period of the addition of such adopted child; and
(b) any applicable additional premium is paid.

In all other instances if a Dependent is Totally Disabled or otherwise does not meet the Company's underwriting requirements on the date coverage (with respect to that particular Dependent) would otherwise take effect, the coverage of the Dependent will be deferred until the date the Company approves coverage under the Policy for such Dependent.

2.06 If a Covered Person is Totally Disabled on the date the Policy replaces another group policy or plan in its entirety, when his or her coverage would otherwise take effect, coverage will take effect on the earlier of the following dates:

(a) with respect to coverage for the disabling condition:
   (i) the day following the expiration of any extension of benefits or continuation of coverage provided under the group policy or plan the Policy replaces; or
   (ii) the day coverage would otherwise take effect if the group policy or plan the Policy replaces does not provide an extension of benefits or continuation of coverage; and

(b) with respect to coverage for conditions other than the disabling condition:
   (i) the day following the expiration of any continuation of coverage provided under the group policy or plan the Policy replaces; or
   (ii) the day coverage would otherwise take effect if the group policy or plan the Policy replaces does not provide for continuation of coverage.

SECTION 3
BENEFIT PROVISIONS

HEALTH INDEMNITY BENEFITS. Subject to the provisions of the Policy, the Company will pay Covered Benefits for one or more of the following:

Daily In-Hospital Indemnity Benefit
If a Covered Person, while insured, is Confined in a Hospital as a result of Accident or Sickness, the Company will pay the Daily In-Hospital Indemnity Benefit amount, as shown in the Schedule, for each day of Confinement, for up to the Maximum Number of Days of Confinement, as shown in the Schedule. No benefit will be paid during any period the Covered Person is not under the regular care and attendance of a Physician.

Surgical Indemnity Benefit
If a Covered Person has a covered surgery performed, the Company will pay the Surgical Indemnity Benefit amount. This amount is based on the Payment Factor amount, as shown in the Schedule of Surgical Indemnity Benefits, times the number of Surgical Procedure Units, as shown in the Schedule.

If two or more procedures are performed through the same incision or operative field, payment will be made only for the procedure of the larger benefit. If more than one procedure is performed but each through separate incisions or in a separate operative field, the amount payable shall be the specified amount for the primary procedure plus 50% of the amount payable for all other surgical procedures performed.

Unlisted Procedures: In addition to the procedures listed in the Schedule of Surgical Indemnity Benefits, amounts shall be payable for any other covered operations. The amounts for such procedures shall be determined by the Company in amounts consistent with those listed in the Schedule of Surgical Indemnity Benefits.

Anesthesia Indemnity Benefit
If the Surgical Indemnity Benefit is payable, the Company will pay the Anesthesia Indemnity Benefit amount, as shown in the Schedule, for the administration of anesthesia.

Outpatient Physician Office Visit Indemnity Benefit
The Company will pay the Outpatient Physician Office Visit Indemnity Benefit, as shown in the Schedule, for a Physician office visit as a result of Sickness or Accident, not to exceed the Maximum Number of Office Visits per Calendar Year, as shown in the Schedule.

Outpatient Diagnostic X-Ray and Laboratory Indemnity Benefit
(Applicable only if this benefit is not excluded on the Schedule.)
The Company will pay the Outpatient Diagnostic X-Ray and Laboratory Indemnity Benefit, as shown in the Schedule, when a Covered Person has diagnostic x-ray and laboratory tests performed. This benefit is limited to once per day of testing, not to exceed the Maximum Number of Testing Days per Calendar Year, as shown in the Schedule. These include tests that show a need for treatment or that are made because of definite symptoms of Accident or Sickness.

Outpatient Prescription Drug Indemnity Benefit Option
(Applicable only if this benefit is not excluded on the Schedule.)
The Company will pay the Outpatient Prescription Drug Indemnity Benefit, as shown in the Schedule, for each prescription filled for a Covered Person. This benefit is subject to the Outpatient Prescription Drug Indemnity Benefit Maximums, as shown in the Schedule.

SCHEDULE OF SURGICAL INDEMNITY BENEFITS

Surgical Procedure	**Payment Factor** See Schedule of Benefits for "Plan Chosen"		
	DS 500	**DS 750**	**DS 1000**
All Outpatient Procedures	**$250**	**$500**	**$750**
All Inpatient Procedures	**$500**	**$1,000**	**$1,500**

3.04 If a Covered Person is Totally Disabled on the date a change in benefits takes effect, such change, with respect to that Covered Person, will be deferred until the date of cessation of such disability.

3.05 A charge is incurred on the date that treatment is given, service is rendered or a supply is furnished.

SECTION 4
EXCLUSIONS AND LIMITATIONS

4.01 With respect to all of the benefits provided under the Policy, no benefits will be payable as the result of:

(a) suicide or any attempt thereat, while sane;
(b) any intentionally self-inflicted injury or Sickness;
(c) rest care or rehabilitative care and treatment;
(d) cosmetic surgery or care or treatment solely for cosmetic purposes, or complications therefrom. This exclusion does not apply to cosmetic surgery resulting from a covered Accident if initial treatment of the Covered Person is begun within 12 months of the date of the Accident;
(e) immunization shots and routine examinations such as: health exams; periodic check-ups; pre-marital exams; and routine physicals;
(f) routine newborn care, including routine nursery charges;
(g) voluntary abortion, except with respect to the Insured or covered Dependent spouse:
    (1) where such person's life would be endangered if the fetus were carried to term; or
    (2) where medical complications have arisen from an abortion;
(h) normal pregnancy, except for Complications of Pregnancy;
(i) the treatment of:
    (1) mental illness;
    (2) functional or organic nervous disorder, regardless of cause;
    (3) alcohol abuse;
    (4) drug use, unless such drugs were taken on the advice of a Physician and taken as prescribed for more than 10 days in any Calendar Year, with respect to payment of the Daily In-Hospital Indemnity Benefit;
(j) participation in a riot, civil commotion, civil disobedience, or unlawful assembly. This does not include a loss which occurs while acting in a lawful manner within the scope of authority;
(k) committing, attempting to commit, or taking part in a felony or assault, or engaging in an illegal occupation;
(l) participation in a contest of speed in power driven vehicles, parachuting, parasailing, bungee-jumping, or hang gliding;

(m) air travel, except:
  (1) as a fare-paying passenger on a commercial airline on a regularly scheduled route; or
  (2) as a passenger for transportation only and not as a pilot or crew member;
(n) any Accident occurring as a result of the Covered Person being intoxicated (where the blood alcohol content meets the legal presumption of intoxication under the law of the state where the Accident took place);
(o) sex changes;
(p) experimental treatments or surgery;
(q) the reversal of tubal ligation and vasectomies;
(r) artificial insemination, in vitro fertilization, and test tube fertilization, including any related testing, medications, or Physician's services, unless required by law;
(s) treatment of exogenous obesity or weight control;
(t) an act of war, whether declared or undeclared, or while performing police duty as a member of any military or naval organization. This exclusion includes Accident sustained or Sickness contracted while in the service of any military, naval or air force of any country engaged in war. The Company will refund the pro rata unearned premium for any such period the Covered Person is not covered;
(u) accident or sickness arising out of and in the course of any occupation for compensation, wage or profit. Expenses which are payable under Occupational Disease Law or similar law, whether or not application for such benefits have been made;
(v) Pre-Existing Conditions, except as described in the Schedule.

4.02 In addition to the Exclusions and Limitations for all coverages, the following are not covered under the Out-Patient Physician Office Visit Indemnity Benefit and the Outpatient Diagnostic X-Ray and Laboratory Indemnity Benefit:
(a) visits made, examinations given, or x-rays or laboratory tests performed as an in-patient while Confined to a Hospital;
(b) routine eye examinations or fitting of glasses;
(c) fitting of hearing aids;
(d) dental examinations or dental care other than expenses resulting from accidental injury; and
(e) benefits which are provided under any other part of the Policy.

4.03 In addition to the Exclusions and Limitations for all coverages, the following are not covered under the Outpatient Prescription Drug Indemnity Benefit, if applicable:
(a) drugs and medicines which may be lawfully obtained without a Physician's prescription; except insulin;
(b) therapeutic devices or appliances. This includes hypodermic needles, syringes, support garments and other non-medical items;
(c) drugs labeled "Caution – limited by federal law to investigational use" or experimental drugs;
(d) drugs, medicines or insulin, in whole or in part, used by or administered to a Covered Person while Confined in a Hospital, rest home, sanatorium, extended care facility, convalescent hospital, nursing home or similar institution;
(e) immunization agents, biological sera, blood or blood plasma; or
(f) contraceptive materials, devices or medications or infertility medication, except where required by law.

SECTION 5
TERMINATION OF INSURANCE

5.01 The insurance on an Insured will cease at 12:01 A.M., local time at the Insured's address on the earliest of:
(a) the date the Insured ceases to be a member in good standing of the Association;
(b) the date the Insured notifies the Company, in writing, of cancellation;
(c) the end of the last period for which premium payment has been made to the Company, subject to the grace period;

(d) the date the Policy terminates; or
(e) the last day of the premium payment period during which the Insured attains age 70.

5.02 The insurance on a Dependent will cease at 12:01 A.M., local time at the Insured's address on the earliest of:
(a) the date the Insured's coverage terminates;
(b) the end of the last period for which premium payment has been made to the Company, subject to the grace period; or
(c) the date the Dependent no longer meets the definition of Dependent, as defined in the Policy.

5.03 The Company shall have the right to terminate the coverage of any Covered Person who submits a fraudulent claim under the Policy.

5.04 EXTENSION OF BENEFITS: Whenever termination of coverage under this section occurs because of termination of the Policy in it's entirety, such termination shall be without prejudice to:
(a) any Hospital Confinement which commenced while the Policy was in force, with respect to In-Hospital Indemnity Benefits; or
(b) any covered treatment or service for which benefits would be provided under the Policy and which commenced while the Policy was in force; provided; however, that the Covered Person is and continues to be Hospital Confined or Totally Disabled. Such Extension of Benefits shall continue for up to 90 days.

SECTION 6
PREMIUMS

6.01 All premiums are payable on or before the date they are due. Premiums are payable by a mode of payment that has been selected by the Insured.

6.02 The premium rates may be changed by the Company. If the rates are changed, the Company will give at least 31 days advance written notice. If an increase takes place on other than a premium due date, they will be due on the date of the increase to the next premium due date. If such premium is not paid when due, the coverage will automatically be discontinued as of the date the pro rata premium was due. Any partial payment of premium will be refunded.

6.03 If a change in benefits increases the Company's liability, premium rates may be changed on the date that the liability is increased.

6.04 The Company will promptly refund any unearned premium upon notification of the death of any Covered Person under the Policy. The refund of premiums will be made directly to:
(a) the decedent's spouse at the time of the decedent's death;
(b) the Insured, if the decedent was a covered Dependent child; or
(c) the decedent's estate, if neither (a) or (b) applies.

SECTION 7
GENERAL PROVISIONS

7.01 ENTIRE CONTRACT-CHANGES: The entire contract shall include:
(a) the Policy;
(b) the application of the Policyholder;
(c) the Insured's application/enrollment form, if any, attached to this Certificate; and

(d) all endorsements and amendments.

Statements made by the Policyholder or the Insured are representations and not warranties, if fraud was not intended. (The words "if fraud was not intended" do not apply in Georgia or North Carolina.) No such statements will be used to avoid the insurance, reduce benefits, or defend a claim under the Policy unless:

(a) the statement is in writing; and
(b) a copy of that statement is given to the Insured or his or her beneficiary.

The terms of the Policy can be changed only by endorsement or amendment signed by the President or Secretary of the Company. No agent may change the Policy or waive its provisions.

7.02 TIME LIMIT ON CERTAIN DEFENSES: The validity of the Policy cannot be contested after two years from its date of issue, except for nonpayment of premiums. After coverage for a Covered Person has been in force for two years, the Company cannot:

(a) void the coverage; or
(b) deny a claim for loss that starts after the two-year period, because of statements in the application/enrollment form unless they were fraudulent misstatements.

7.03 GRACE PERIOD: A grace period of 31 days will be allowed for each premium payment after the first premium. Coverage will stay in force during this time. The coverage under the Policy will terminate at the end of the grace period if the premium has not been paid. The Insured must still pay all unpaid premium due for the grace period.

7.04 NOTICE OF CLAIM: Written notice of claim must be given to the Company at our home office, or to any third party administrator authorized by the Company. Such notice should be made within 30 days after any loss covered by the Policy (60 days in Kentucky, six months in Montana). If it is not reasonably possible to give notice within that time, the claim may not be denied or reduced due to the delay.

7.05 CLAIM FORMS: Claim forms should be used for filing proof of loss. They will be sent to the claimant within 15 days of receipt of notice of claim. If claim forms are not supplied within 15 days, a claimant can give proof as follows:

(a) in writing;
(b) setting forth the nature and extent of the loss; and
(c) within the time stated in the Proof of Loss provision.

(If the Insured resides in Georgia, the reference to 15 days is changed to 10 working days.)

7.06 PROOF OF LOSS: Proof of loss for which the Policy provides any periodic payment contingent upon continuing loss must be given to the Company within 90 days after termination of the period for which the Company is liable. For any other loss, proof of loss must be given to the Company within 90 days after such loss. Late proof may be accepted if:

(a) it was not reasonably possible to give proof in that time; and
(b) the proof is given within one year from the date proof of loss was otherwise required. This one year limit will not apply in the absence of legal capacity.

7.07 TIME OF PAYMENT OF CLAIMS: All accrued benefits for loss for which the Policy provides periodic payment will be paid each month, subject to written proof of loss. Any balance not paid when liability ends will be paid immediately upon receipt of written proof. Benefits for any other covered loss will be paid as soon as the Company receives written proof of such loss.

7.08 PAYMENT OF BENEFITS: Benefits payable may be assigned to the provider(s) of covered benefits. Otherwise, all benefits payable under the Policy will be paid to the Insured. Accrued benefits that are not paid at the Insured's death will be paid to his or her beneficiary or estate. If a benefit is to be paid to the Insured's estate, or to an Insured or beneficiary who is not competent to give a valid release, the Company may pay up to $1,000.00 of such benefit to one of the Insured's relatives who is deemed by the Company to be justly entitled to it. Such payment, made in good faith, fully discharges the Company to the extent of the payment.

7.09 PHYSICAL EXAMINATION: The Company has the right to have a Covered Person examined by a Physician of its choice as often as reasonably necessary while a claim is pending. The Company will pay for such examination. In case of death, the Company may request an autopsy where it is not forbidden by law.

7.10 LEGAL ACTIONS: No legal action may be brought to recover under the Policy:
(a) within 60 days after written proof of loss has been furnished as required; or
(b) more than three years (five years in Kansas, six years in South Carolina and the applicable statute of limitations in Florida) from the time written proof of loss is required to be furnished.

7.11 CONFORMITY WITH STATE LAWS: A provision of the Policy that, on the Certificate Effective Date, conflicts with a law of the state of issue is hereby changed to meet the minimum standards of that law as of the Certificate Effective Date.

7.12 MISSTATEMENT OF AGE: If the age of any Covered Person is incorrectly stated, the amount of benefits payable will be the amount shown on the Schedule. The premium will be adjusted so that the Company will be paid any amount due based on such Covered Person's true age.

7.13 CERTIFICATES: The Company will supply individual Certificates for each Insured. This Certificate will describe:
(a) the insurance benefits;
(b) to whom benefits will be paid;
(c) any limitations of the Policy; and
(d) all other essential features of the Policy.

If more than one Certificate is issued under the Policy to an Insured, only the last one issued will be in effect.

COMPANION LIFE INSURANCE COMPANY

Columbia, South Carolina 29223

Effective Date: _____
(if different from Certificate)

EMERGENCY ROOM VISIT INDEMNITY BENEFIT

The Policy/Certificate to which this Rider is attached is hereby amended as follows:

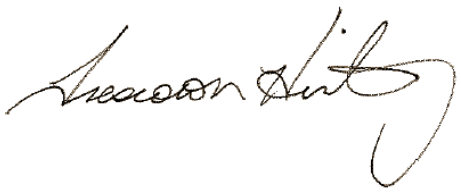
Subject to the terms and conditions of the Policy/Certificate, the Company will pay an Emergency Room Visit Indemnity Benefit for services that result from a Sickness that are Medically Necessary and are provided on an Emergency basis that do not result in Hospital Confinement. Emergency Room Visit Indemnity Benefits will be paid for an Insured or a Dependent. The Emergency Room Visit Indemnity Benefit amount is shown on the Schedule of Benefits. Benefits payable under this Rider will not exceed the [Policy/Calendar] Year maximum benefit amount shown on the Schedule of Benefits.

Emergency is defined as the sudden onset of a medical condition manifested by symptoms of such severity that the failure to immediately provide Medically Necessary care could reasonably be expected to result in:

A. Placing the patient's health in serious jeopardy; or
B. Serious impairment to bodily functions; or
C. Serious dysfunction of any bodily organ or part.

A Covered Person shall have free choice of any Physician and the Physician-patient relationship shall be maintained.

This Rider only applies if it is elected and the required premiums are paid. This Rider is subject to all of the provisions of the Policy/Certificate as long as this Rider does not amend them. This Rider will terminate on the same date as the Policy/Certificate to which it is attached.



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President

COMPANION LIFE INSURANCE COMPANY

Columbia, South Carolina 29223

Effective Date: _____
(if different from Certificate)

DAILY IN-HOSPITAL INDEMNITY BENEFIT FOR MENTAL ILLNESS

The Policy/Certificate to which this Rider is attached is hereby amended to include a new benefit as follows:

Daily In-Hospital Indemnity Benefit for Mental Illness
If a Covered Person, while insured, is Confined in a Hospital as a result of Mental Illness, the Company will pay the Daily In-Hospital Indemnity Benefit amount, as shown in the Schedule for Mental Illness, for each day of Confinement, for up to the Maximum Number of Days of Confinement, as shown in the Schedule. No benefit will be paid during any period the Covered Person is not under the regular care and attendance of a Physician.

Any exclusion or limitation in the policy/certificate relating to mental illness will be disregarded to the extent that it is inconsistent with this benefit.

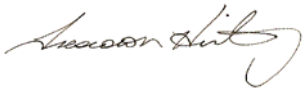
"Mental Illness" shall be defined as any Sickness which is:

(a) listed in the current edition of the Diagnostic and Statistical Manual of Mental Health Disorders (or any successor diagnostic manual) published by the American Psychiatric Association; and

(b) usually treated by a mental health provider or other qualified provider, using psychotherapy, psychotropic drugs or other similar methods of Treatment.

Mental Illness includes any such conditions whether or not related to an underlying physical, genetic, chemical, organic or biological cause, although it may be associated with physical symptoms, manifestations or expressions. Specific conditions include but are not limited to: bipolar disorder; depression and depressive disorders; psychoses; mood disorders; manic-depressive illness; anxiety disorders; stress disorders including post-traumatic stress disorders; somatoform disorders; factitious disorders; eating disorders; adjustment disorders; and personality disorders. However, for purposes of the Policy, Mental Illness does not include mental retardation or Alzheimer's disease and other forms of dementia with an objectifiable organic basis.

This Rider only applies if it is elected and the required premiums are paid. This Rider is subject to all of the provisions of the Policy/Certificate as long as this Rider does not amend them. This Rider will terminate on the same date as the Policy/Certificate to which it is attached.



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President

COMPANION LIFE INSURANCE COMPANY
Columbia, South Carolina 29223

Effective Date: _____
(if different from Certificate)

Preventive Care Indemnity Benefit

The Policy/Certificate to which this Rider is attached is hereby amended as follows:

Subject to the terms of the Policy/Certificate, a Preventive Care Indemnity Benefit will be paid for a Covered Person as described below:

A. The Company will pay the indemnity benefit shown in the Schedule of Benefits for an annual physical examination for the Insured and his covered Dependents up to the [Policy/Calendar] Year maximum shown on the Schedule of Benefits. These services will only be covered to the extent that the services are provided by, or under the supervision of, a single Physician during the course of one (1) visit. Services include:
    1. A history;
    2. Physical Examination;
    3. X-rays;
    4. Laboratory services including, but not limited to, a Pap test, colorectal screening and prostate cancer screening.

B. The Company will pay the indemnity benefit shown in the Schedule of Benefits for a low-dose screening mammogram for any nonsymptomatic woman covered under the Policy/Certificate with the following frequency.
    1. One (1) baseline mammogram for women aged thirty-five (35) through thirty-nine (39);
    2. One (1) every two (2) years for women aged forty (40) through forty-nine (49); and
    3. One (1) annually for women age fifty (50) AND OVER.

C. The Company will pay the indemnity benefit shown in the Schedule of Benefits for well child care from the moment of birth to Age six (6) years. [Benefits will be limited to one (1) Physician's visit at the following specified age intervals: 1 visit at age 30 days to 1 year, and annually thereafter, up to Age 6.]
    Covered well child care is the periodic review of a child's physical and emotional status. This periodic review will only be covered to the extent that the services are provided by, or under the supervision of, a single Physician during the course of one (1) visit. A review shall include:
    1. A history;
    2. Complete physical examination;
    3. Developmental assessment;
    4. Anticipatory guidance;
    5. Appropriate immunizations;
    6. Laboratory tests; and
    7. Hearing and vision screening;

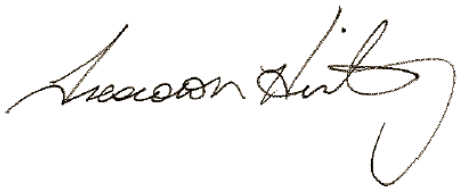
    In keeping with prevailing medical standards.

Such services must be provided within one (1) month prior to or after reaching each Age without benefit or carrying over any visitations. In the event an appropriate immunization, lab test or portion of an examination cannot be performed at a particular Age, such service shall be deemed to be covered upon the next scheduled visit.

If a benefit is already shown for one of the above-described benefits, the benefit terms of the Policy/Certificate will control to the extent the terms are not consistent with the above described benefit.

The benefits described above will be paid directly to the provider of services. To authorize the benefit payment to the Covered Person, the Insured must make the proper authorization on the medical claim form.

This Rider only applies if it is elected and the required premiums are paid. This Rider is subject to all of the provisions of the Policy/Certificate as long as this Rider does not amend them. This Rider will terminate on the same date as the Policy/Certificate to which it is attached.



President

COMPANION LIFE INSURANCE COMPANY

Columbia, South Carolina 29223

Effective Date: _____
(if different from Certificate)

DAILY INDEMNITY BENEFIT FOR CONFINEMENT IN A SKILLED NURSING FACILITY

The Policy/Certificate to which this Rider is attached is hereby amended to include a new benefit as follows:

Daily Skilled Nursing Facility Indemnity Benefit
If a Covered Person, while insured, is Confined in a Skilled Nursing Facility as a result of Accident or Sickness except for Mental Illness, the Company will pay the Daily Indemnity Benefit amount, as shown in the Schedule for Skilled Nursing Facility, for each day of Confinement, for up to the Maximum Number of Days of Confinement, as shown in the Schedule. No benefit will be paid during any period the Covered Person is not under the regular care and attendance of a Physician.

Any exclusion or limitation in the policy/certificate relating to confinement in a skilled nursing facility will be disregarded to the extent that it is inconsistent with this benefit.

"Skilled Nursing Facility" shall be defined as:

(a) a special unit or ward of a Hospital used primarily as a nursing or convalescent home; or

(b) an institution that has a transfer agreement with one or more Hospitals and meets fully all of the requirements of Title XVIII of the Social Security Act of 1965, as now or hereafter amended, commonly known as "Medicare".

This Rider only applies if it is elected and the required premiums are paid. This Rider is subject to all of the provisions of the Policy/Certificate as long as this Rider does not amend them. This Rider will terminate on the same date as the Policy/Certificate to which it is attached.

_____
President

Communicating for America
Membership Application

Yes, I want CA working for me!

I understand benefits are offered at the sole discretion of CA and may vary by availability, vendor or state of residence of the member.

I elect the Standard membership level at $8.00 per month.

Name: **Sheena M McCarty**

Address: **12907 S Blackfoot Dr**

City: **Olathe** State: **KS** Zip: **66062**

Home Phone: **(913) 839-2678** Business Phone: **(913) 538-8403**

Date of Birth: **10/22/1960** Fax: _____

Email Address: **classy18k@comcast.net**

Social Security: **xxx-xx-6721**

I hereby apply for membership. I understand that my membership will remain in effect as long as I qualify under membership guidelines and pay my membership dues. I understand that benefits are offered at the sole discretion of CA and may vary by availability, vendor or state of residence. Should I elect at any time not to participate in one or more of CA's sponsored benefit programs, I authorize CA to continue my membership dues and other association benefit fees at the payment mode selected by me at the time of application.

I wish to be a member of CA and I agree to the terms and conditions listed above.

Member Signature: **Sheena M McCarty (Electronic Signature)**

Enroller Name: **HPA Sales**

Enroller Number: **DS000000000**

For additional information about the benefits and programs offered through Communicating for America, Inc., call 1.800.432.3276 or visit www.CAbenefits.org.

For use with Defined Solutions.