

Imerica makes it easy for you
to get insured, pay for health
insurance and make smart
decisions about your healthcare.



LIFE & HEALTH INSURANCE

Imerica Life and Health Insurance Company
304 Inverness Way South, Suite 405
Englewood, CO 80112

www.imerica.com

Your health. Your money. Your way.™



**Health Insurance
Plans for Individuals
and Families**

HSA-Qualified Plans
Health Savings Accounts

PPO Co-pay Plans



Choose Imerica.



There's a growing movement in America called consumer-driven healthcare. The idea is that affordable, quality healthcare is achievable if you, the consumer, have the ability to control your money and make informed decisions. We are part of that movement. And we're here to place the power back in your hands.

Imerica makes it easy for you to get insured, pay for health insurance and make smart decisions about your healthcare.

With affordable health insurance and health savings accounts (HSAs), we offer simple solutions that let you control your healthcare dollars today and save for tomorrow.

Simple and easy.

Imerica has consolidated the fragmented process of purchasing a health plan from an insurer and securing an HSA account separately through a bank. Partnering with FirstBank, one of the nation's largest privately-held banks, we've streamlined the process.

One application

There's just one application form to complete to apply for Imerica health insurance and to open an HSA.

One card

You'll be issued an ImeriCard Visa debit card for convenient access to your HSA funds.





Choices.

Imerica offers you a choice of health plans to meet your individual needs. Individuals and families can choose from one of our HSA-qualified plans and combine it with a health savings account from FirstBank, or choose from one of our more traditional preferred provider organization (PPO) co-pay plans.

Quality benefits

All of our insurance plans include coverage for the following*:

- Doctor office visits
- Emergency room care
- Ambulance service
- Inpatient hospital visits
- Intensive care
- 24-hour occupational coverage
- Diagnostic testing
- Therapy services
- Allergy treatments
- Mammograms
- PAP test screening
- Prostate cancer screening
- Colorectal cancer screening
- Skilled nursing care
- Hospice care
- Organ transplants
- Homeopathic treatment

*Some benefits have specific limits in addition to the deductible and co-insurance described in this brochure. Refer to the policy/certificate for complete details.





HSAs have Tax Benefits*

- Contributions are tax deductible – no need to itemize.
- Withdrawals for qualified expenses are tax-free.
- Unspent money rolls over year-to-year, earning interest that's tax-free.

*The Internal Revenue Service allows you to put a specified amount into your HSA each year. For 2009, the maximum contribution is \$3,000 for individuals and \$5,950 for families. The amount is indexed each year for inflation. (See IRS Publication 969 for details.)

Imerica HSA-Qualified Plans

Imerica's flagship products are our HSA-qualified plans. These plans provide health insurance with lower monthly premiums than traditional insurance and help protect you from large, unexpected medical expenses. Combine them with an HSA for savings and tax advantages. Individuals and families can each choose from four plans: Platinum, Gold, Silver and Bronze.

Tax Savings for Self-Employed



If you are self-employed, you may be able to deduct your health plan premiums from your federal income tax return.

Imerica HSA-Qualified Plan 100% plan

Annual deductible	\$5,650.00
Monthly health plan premium.	\$469.97
Annual health plan premium	\$5,639.64

Tax Deductions

HSA contribution	\$5,650.00
Annual health plan premium	\$5,639.64

Total Deductions \$11,289.64

Tax Savings \$3,161.10
x 28% tax bracket

Premium based on an Imerica HSA-qualified plan with 100% co-insurance for a 40-year-old male and female with two children, in a preferred risk category, living in Columbia, SC, 29201, with a 1/1/09 effective date.

Flexible, affordable coverage

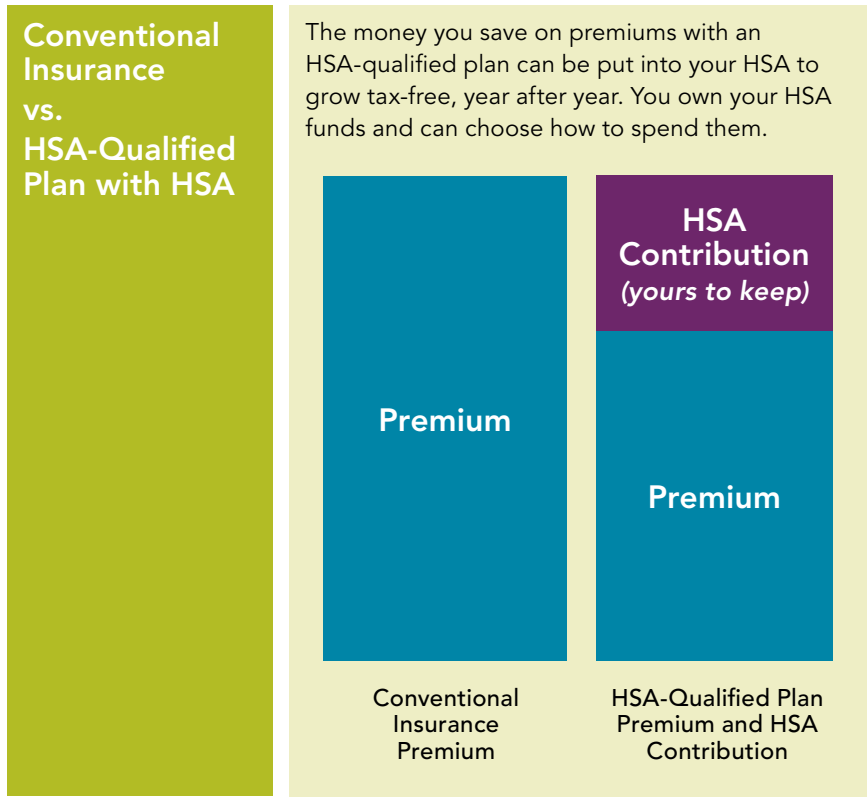
Our HSA-qualified plans offer a wide range of options to fit the needs of you and your family:

- Choice of \$2 million, \$5 million or \$8 million in lifetime coverage.
- Deductibles ranging from \$2,000 to \$5,500 for individuals and \$4,000 to \$11,000 for families.
- Co-insurance levels ranging from 100 percent (Imerica pays all your in-network covered charges beyond the deductible) to 50 percent** (Imerica pays half of your in-network covered charges beyond your deductible).
- Twelve- or 24-month premium rate guarantee, depending on plan. (See General Information for details.)
- HSA Platinum, Gold and Silver series allow your entire family's covered medical expenses to count toward one deductible.

** Not available in Georgia.

Health Savings Accounts

Get the most value from your HSA-qualified plan by putting money saved on premiums into a tax-advantaged HSA account that you control. Your HSA funds can be used to pay your qualified out-of-pocket healthcare expenses, or saved to pay for future healthcare or retirement expenses.



America Life and Health Insurance Company is not licensed or authorized to provide tax, legal or investment advice. Establishing an HSA involves tax and legal considerations. The HSA-qualified plans described herein are HSA eligible under current federal law. The deductibility of HSA contributions for purposes of state taxes may vary from state to state. Contributions are subject to certain limitations, and customers are encouraged to consult with a tax or legal advisor with questions regarding HSAs and for the applicability of any tax deductions or tax benefits.



HSA-Qualified Expenses

Your HSA can be used to pay for many different kinds of medical expenses.* They include:

- Acupuncture
- Ambulance
- Alcoholism treatment
- Birth control pills
- Chiropractor fees
- Contact lenses/eyeglasses/vision correction surgery
- Dental treatment/orthodontics
- Diagnostic devices
- Fertility enhancement
- Hearing aids
- Hospital charges
- Medicines and drugs prescribed by your doctor
- Psychologist, psychoanalyst fees
- Smoking-cessation programs
- Vasectomy
- X-rays

See IRS Publication 502 for a complete list of expenses that can be reimbursed from an HSA.

*HSA reimbursement of medical expenses does not mean that those expenses will be considered covered charges under the insurance coverage.



Preferred Provider Organizations (PPOs) may help you reduce your out-of-pocket expenses. PPOs negotiate discounted rates with providers who agree to be part of their network. While you have the option of using an out-of-network provider, staying within the network could save you money.



Imerica PPO Plans

If you are looking for more traditional coverage, consider one of our PPO co-pay plans. We offer competitively-priced medical insurance along with traditional office visit and prescription co-pays.

Flexible, affordable coverage:

- Choice of \$2 million, \$5 million or \$8 million in lifetime coverage.
- Deductibles ranging from \$1,500 to \$10,000.
- Co-insurance choices of 80 percent (Imerica pays the majority of your in-network covered charges beyond the deductible) or 50 percent* (Imerica pays half of your in-network covered charges beyond the deductible).
- Families have a maximum of three individual deductibles and three co-insurance limits to fulfill.
- Twelve-month premium rate guarantee. (See General Information for details.)
- PPO Platinum and Gold series include:
 - Four annual doctor visit co-pays – \$15 for primary care physicians; \$60 for specialists.
 - Prescription co-pays for brand and generic drugs.

* Not available in Georgia.

All Imerica Plans Offer Optional Benefits

(Additional premium required)

Primary insured and dependent life insurance

- The spouse/child(ren) life insurance benefit is only available if the primary insured elects the primary life benefit.
- Primary insured: \$10,000 benefit
- Spouse: \$10,000 benefit; Child(ren): \$5,000 benefit

Supplemental accident insurance

- Paid at 100%, up to a \$500 or \$1,000 maximum benefit per occurrence with no calendar-year deductible. Charges for the covered injury must be incurred within 3 months of the date of the accident. After the supplemental accident benefit maximum has been reached, remaining covered charges apply to the policy/certificate deductible and co-insurance.

Maternity (Available with PPO plans only)

- The maximum benefit is \$4,000. It is paid after the calendar-year deductible and co-insurance have been met, and when the insured person's delivery occurs after 18 months of continuous coverage under the rider. Varies by state.



PPO Series – Not HSA Qualified

Benefits	PPO Platinum Series	PPO Gold Series (not available in GA)	PPO Silver Series (not available in GA)
Lifetime Maximum Options	\$2 million \$5 million \$8 million	\$2 million \$5 million \$8 million	\$2 million \$5 million \$8 million
In-Network Deductible Choices per Member (Maximum 3 Per Family)	\$ 1,500 \$ 2,500 \$ 5,000 \$10,000	\$ 1,500 \$ 2,500 \$ 5,000 \$10,000	\$ 2,500 \$ 5,000 \$10,000
Out-of-Network Deductible	\$2,000 per person in addition to in-network deductible		
Co-insurance (Plan Pays/You Pay After You Meet Deductible)	In-Network: 80% / 20% Out-of-Network: 60% / 40%	In-Network: 50% / 50% Out-of-Network: 30% / 70%	In-Network: 50% / 50% Out-of-Network: 30% / 70%
Out-of-Pocket Maximum In-Network / Out-of-Network (Not Including Deductible)	\$2,000 / \$8,000	\$5,000 / \$14,000	\$5,000 / \$14,000
Family Maximum Combined Out-of-Pocket	3 times deductible plus 3 times co-insurance		
Physician Office Visit	Office co-pay rider included: 4 visit maximum; \$15 primary care physician / \$60 specialist After 4 visits deductible and co-insurance apply		Subject to deductible and co-insurance
Emergency Room Care	Subject to deductible and co-insurance		
Hospitalization Inpatient and Outpatient	Subject to deductible and co-insurance		
Pharmacy	Generic: \$0 deductible w/ \$15 co-pay Brand: \$500 deductible w/ \$40 co-pay	Generic: \$0 deductible w/ \$15 co-pay Brand: \$500 deductible w/ \$40 co-pay and 50% co-insurance	Discount drug card only
Wellness Benefits	Subject to co-insurance only. Routine Physical Exams: Up to \$500, no waiting period Preventive: no maximum, no waiting period Mammograms, PAP test screening, childhood immunizations, prostate cancer screening, colorectal cancer screening		



HSA Single Series

Benefits	HSA Platinum Series	HSA Gold Series	HSA Silver Series (not available in GA)	HSA Bronze Series (not available in CO)
Lifetime Maximum Options	\$2 million \$5 million \$8 million	\$2 million \$5 million \$8 million	\$2 million \$5 million \$8 million	\$2 million \$5 million \$8 million
Deductible Choices (In-Network/ Out-of-Network)	\$2,000 / \$ 4,000 \$2,850 / \$ 5,700 \$5,500*/ \$11,000* *24-month rate guarantee	\$2,000 / \$4,000 \$2,850 / \$5,700	\$2,000 / \$4,000 \$2,850 / \$5,700	\$5,000
Co-insurance (Plan Pays/You Pay After You Meet Deductible)	In-Network: 100% / 0% Out-of-Network: 80% / 20%	In-Network: 80% / 20% Out-of-Network: 60% / 40%	In-Network: 50% / 50% Out-of-Network: 30% / 70%	In-Network: 100% / 0% Out-of-Network: 80% / 20%
In-Network Co-insurance (Out-of-Pocket Maximum not including Deductible)	In-Network: \$0	In-Network: w/ \$2,000 Deductible: \$3,500 w/ \$2,850 Deductible: \$2,650	In-Network: w/ \$2,000 Deductible: \$3,500 w/ \$2,850 Deductible: \$2,650	In-Network: \$0 Subject to plan benefit limitation of \$20,000 maximum per insured per calendar year on outpatient expenses.
Out-of-Network Co-insurance (Out-of-Pocket Maximum Not Including Deductible)	Out-of-Network: w/ \$ 4,000 Deductible: \$4,000 w/ \$ 5,700 Deductible: \$4,000 w/ \$11,000 Deductible: \$4,000	Out-of-Network: w/ \$4,000 Deductible: \$7,000 w/ \$5,700 Deductible: \$5,300	Out-of-Network: w/ \$4,000 Deductible: \$7,000 w/ \$5,700 Deductible: \$5,300	Out-of-Network: Plan pays 80% / You pay 20% Subject to plan benefit limitation of \$20,000 maximum per insured per calendar year on outpatient expenses.
Maximum HSA Contribution	\$3,000 2009 IRS Maximum	\$3,000 2009 IRS Maximum	\$3,000 2009 IRS Maximum	\$3,000 2009 IRS Maximum
Physician Office Visit	Subject to deductible and co-insurance			
Emergency Room Care	Subject to deductible and co-insurance			
Hospitalization Inpatient and Outpatient	Subject to deductible and co-insurance HSA Bronze: \$20,000 maximum per insured per calendar year on outpatient expenses			
Pharmacy	Subject to deductible & co-insurance			Discount drug card only
Human Organ, Tissue and Bone Marrow Transplant	The lifetime maximum benefit is \$500,000 per individual for in-network transplant and \$200,000 for out-of-network transplant.			
Wellness Benefits	Subject to co-insurance only. Routine Physical Exams: Up to \$500, no waiting period Preventive: no maximum, no waiting period Mammograms, PAP test screening, childhood immunizations, prostate cancer screening, colorectal cancer screening			

Twelve-month premium rate guarantee unless otherwise noted under Deductible Choices.

HSA Family Series

Benefits	HSA Platinum Series	HSA Gold Series	HSA Silver Series (not available in GA)	HSA Bronze Series (not available in CO)
Lifetime Maximum Options	\$2 million \$5 million \$8 million	\$2 million \$5 million \$8 million	\$2 million \$5 million \$8 million	\$2 million \$5 million \$8 million
Deductible Choices (In-Network/ Out-of-Network)	\$ 4,000 / \$ 8,000 \$ 5,650* / \$11,300* \$11,000* / \$22,000* *24-month rate guarantee	\$4,000 / \$ 8,000 \$5,650* / \$11,300* \$7,500* / \$15,000* *24-month rate guarantee	\$4,000 / \$ 8,000 \$5,650* / \$11,300* \$7,500* / \$15,000* *24-month rate guarantee	\$5,000 per insured (\$10,000 combined family) The maximum family deductible must be met by two or more insured persons in a family. One insured person cannot satisfy the family deductible.
Co-insurance (Plan Pays/You Pay After You Meet Deductible)	In-Network: 100% / 0% Out-of-Network: 80% / 20%	In-Network: 80% / 20% Out-of-Network: 60% / 40%	In-Network: 50% / 50% Out-of-Network: 30% / 70%	In-Network: 100% / 0% Out-of-Network: 80% / 20%
In-Network Co-insurance (Out-of-Pocket Maximum not including Deductible)	In-Network: \$0	In-Network: w/ \$4,000 Deductible: \$7,000 w/ \$5,650 Deductible: \$5,350 w/ \$7,500 Deductible: \$3,500	In-Network: w/ \$4,000 Deductible: \$7,000 w/ \$5,650 Deductible: \$5,350 w/ \$7,500 Deductible: \$3,500	In-Network: \$0 Subject to plan benefit limitation of \$20,000 maximum per insured per calendar year on outpatient expenses.
Out-of-Network Co-insurance (Out-of-Pocket Maximum Not Including Deductible)	Out-of-Network: w/ \$ 4,000 Deductible: \$8,000 w/ \$ 5,650 Deductible: \$8,000 w/ \$11,000 Deductible: \$8,000	Out-of-Network: w/ \$4,000 Deductible: \$14,000 w/ \$5,650 Deductible: \$10,700 w/ \$7,500 Deductible: \$ 7,000	Out-of-Network: w/ \$4,000 Deductible: \$14,000 w/ \$5,650 Deductible: \$10,700 w/ \$7,500 Deductible: \$ 7,000	Out-of-Network: Plan pays 80% / You pay 20% Subject to plan benefit limitation of \$20,000 maximum per insured per calendar year on outpatient expenses.
Maximum HSA Contribution	\$5,950 2009 IRS Maximum	\$5,950 2009 IRS Maximum	\$5,950 2009 IRS Maximum	\$3,000 2009 IRS Maximum Per insured person, up to two people. If over two people are insured, consult your tax advisor.
Physician Office Visit	Subject to deductible and co-insurance			
Emergency Room Care	Subject to deductible and co-insurance			
Hospitalization Inpatient and Outpatient	Subject to deductible and co-insurance HSA Bronze: \$20,000 maximum per insured per calendar year on outpatient expenses			
Pharmacy	Subject to deductible & co-insurance			Discount drug card only
Human Organ, Tissue and Bone Marrow Transplant	The lifetime maximum benefit is \$500,000 per individual for in-network transplant and \$200,000 for out-of-network transplant.			
Wellness Benefits	Subject to co-insurance only. Routine Physical Exams: Up to \$500, no waiting period Preventive: no maximum, no waiting period Mammograms, PAP test screening, childhood immunizations, prostate cancer screening, colorectal cancer screening			

Twelve-month premium rate guarantee unless otherwise noted under Deductible Choices.



General Information

Applications subject to underwriting approval – A telephone interview may be conducted with each applicant age 18 and over. A trained professional will call at the applicant's requested contact time to conduct the interview. After the interview, the application will be reviewed by an Imerica underwriter, who will determine eligibility for the plan and its benefits. Agents will have access to underwriting requirements and declinable conditions, medications and occupations lists. Each applicant should review the underwriting guidelines with their agent before an application is completed.

10-day free look – An insured person has the right to return the policy/certificate within 10 calendar days of its initial delivery. If the insured person chooses to return the policy/certificate within the 10-day period, we will refund any premium that has been paid. If the policy/certificate is returned within the 10-day period, it will be void as of the effective date and we will have no liability under any of the terms or provisions of the policy/certificate.

Effective dates – Policy/certificate effective dates are the first or fifteenth day of any month.

Eligibility –

- Adults (primary insured and legally married spouse): ages 18 through 63.
- Unmarried dependent children (parent must be enrolled as the primary member): ages 1 through 18 years (varies by state).
- Full-time student dependents: ages 19 to 22 years or more (varies by state).

Rate guarantee – Premium rates for all initial coverage shall be guaranteed for 12 or 24 months, depending on the plan, and then are subject to rate adjustments as determined by Imerica. Initial premium rates may change if the insured person moves, changes their plan, or changes the number of dependents covered.

Exclusions and Limitations

No insurance benefits are provided for services, procedures, supplies, drugs, devices or treatments that are not covered charges or specifically provided in the benefits section of the policy/certificate. In addition, no insurance benefits are provided for, or relating to, the following services, procedures, supplies, drugs, devices or treatments, regardless of medical necessity:

Absence of insurance for a loss for which no charge would be made in the absence of healthcare coverage or for a service which your physician advertises as a free service.

Addiction expenses related to nicotine addiction, caffeine addiction and non-chemical addictions including, but not limited to gambling, sex, spending, shopping, working and religion.

Alcoholism disorder expenses related to the treatment of alcoholism disorders, except for in-patient hospital confinements.

Blood storage expenses except for autologous collection in preparation for a pre-certified surgery. (Pre-certification not applicable in CO or MO.)

Commission of a felony expenses related to treatment of an injury or sickness of an insured person that occurs during or results from the commission of a felony by the insured person.

Cosmetic expenses related to cosmetic surgery or treatment to improve your appearance or correct a deformity without restoring a physical bodily function, and complications resulting from cosmetic surgery or procedures. This exclusion does not apply to treatment of congenital anomalies of eligible dependants covered from birth. This also does not apply to treatment to correct conditions resulting from a covered injury or sickness occurring while your certificate of insurance was in-force.

Cryopreservation of bodily fluids.

Custodial care expenses related to care provided in rest homes, health resorts, homes for the aged, halfway houses, or places mainly for domiciliary or custodial care.

Dental care expenses for services and supplies related to dental care, including those services and supplies related to temporomandibular (jaw or craniomandibular) joint disorders (not applicable in GA for TMJ.) This exclusion does not apply to expenses resulting from a covered injury to natural teeth rendered within one year of the injury.

Eating disorder expenses related to treatment of eating disorders including, but not limited to, anorexia nervosa or bulimia. Charges for medical stabilization necessitated by life-threatening sickness resulting from such disorders will be covered.

Employment for wage or profit or workers' compensation expenses for treatment of an injury or sickness arising out of, or in the course of, employment for wage or profit unless the insured person is eligible for and has selected the 24-Hour Occupational Coverage Rider; and expenses for treatment of injury or sickness for which the insured person has or had a right to recovery under any workers' compensation or similar law.

Excess charges are amounts deemed above reasonable and customary charges for the services rendered.

Family member expenses related to treatment or services performed by a member of your family or any person who regularly lives in your home. Family members include you, your spouse, you and your spouse's parents, children, sisters, and brothers.

Federal facility expenses related to treatment, diagnosis, or care provided while confined in a federal facility, unless you are legally obligated to pay for charges for such confinement.

Foreign travel and residency expenses related to treatment, drugs or medical care received outside the United States or its possessions, unless expenses are incurred to treat an emergency medical condition while on a trip of not more than 60 days.

Growth hormone expenses for treatment, medication or hormones intended to stimulate growth, unless medically necessary.

Hearing expenses related to (1) hearing aids; or (2) routine hearing tests and audiograms that are not performed in connection with an injury or sickness.

Human organ, tissue and bone marrow transplant expenses relating to, or arising from, human organ, tissue and bone marrow transplants beyond those already provided in the policy/certificate.

Hypnosis expenses related to hypnosis, including its use in place of anesthesia.

Infertility expenses related to the diagnosis and/or treatment of infertility, reversal of voluntary sterilization or fertilization procedures. Examples of fertilization procedures include, but are not limited to: ovulation induction procedures, in vitro fertilization, embryo transfer or similar procedures that augment or enhance your reproductive capability.

Internet expenses related to telemedicine or treatment, diagnosis, or care provided over the Internet or electronic mail.

Investigational and/or experimental expenses related to services that are investigational or experimental in nature.

Liposuction expenses related to suction-assisted lipectomy or diastasis recti repair, including instances when diastasis recti repair is associated with an umbilical or ventral hernia.

Manipulative service expenses beyond the benefit limits stated in covered charges/schedule of benefits.

Mental or nervous disorder expenses except as otherwise provided in covered charges/schedule of benefits.

Non-covered charges expenses related to any benefit not specifically provided within the policy/certificate.

Non-medical expenses even if recommended by a physician. This includes, but is not limited to: work hardening or strengthening programs; travel expenses; self-help training; services or supplies at a health spa or similar facility; a personal trainer; massage therapy; elastic bandages; support hose; shoes; shoe inserts and pressure garments; personal hygiene and convenience items; water aerobics and cybex machines; television, telephone, cots and visitors' meals; charges for telephone consultations, failure to keep a scheduled visit, completion of a claim form and information required to process your claims and similar expenses.

Outpatient prescription drug expenses are covered by discount drug card only for Bronze Series.

Pregnancy expenses related to pregnancy or childbirth, unless provided by a supplemental rider. Complications of pregnancy are covered to the extent provided for other sickness if the insured person's coverage is in-force at the time of loss.

Private-duty nursing services except when such services are required for home healthcare.

Research expenses related to research studies, or any treatment for which the patient or the patient's representative must sign an informed consent document identifying the treatment in which the patient is to participate as a research or clinical research study.

Routine expenses for newborn infants, expenses for routine and well-baby care, including any nursery or related charges.

Routine physical excludes immunizations, use of prophylactic injections including gammaglobulins and flu shots, and well-child care including immunizations.

Self-harm expenses related to treatment of self-inflicted injuries or sickness or attempted suicide, whether sane or (except in CO or MO) insane.

Sexual dysfunction expenses related to gender identity disorders, gender reassignment or sex transformation, sexual dysfunctions or inadequacies. This exclusion includes sex therapy and counseling, penile prosthesis and all other procedures, equipment and drugs developed for male impotence.

Substance abuse expenses related to the treatment of substance abuse, which includes drugs, controlled substances, or any other type of substance.

Take-home prescription drug expenses relating to non-prescription drugs or any take-home prescriptions, except for a prescription of anti-rejection drugs as provided in the human organ transplant benefit.

Travel expense except as provided for in the ambulance benefit and transplant network transport benefit.

Vision expenses related to: a) eye refractions or eye examinations, eyeglasses or contact lenses. This exclusion does not apply for initial prosthetic lenses or sclera shells following intraocular surgery; and b) radial keratotomy, keratomileusis or excimer laser photo refractive keratectomy, which are not performed in connection with an injury or sickness.

War expenses related to injuries, sickness, diseases or disorders as a result of war or act of war, declared or undeclared.

Weight expenses related to weight reduction programs, weight management programs, related nutritional supplies, treatment for obesity, or surgery for removal of excess skin or fat.

Waiting period on certain conditions We will not pay benefits for charges incurred prior to the date the insured person has been covered under the policy/certificate for 6 consecutive calendar months for the care and treatment of a hernia (unless strangulated), varicose veins, adenoids, appendix, and tonsils. This limitation does not apply to services provided due to an emergency medical condition where such condition is not excluded as a pre-existing condition. (Not applicable in all states.)

Additional Information

Premium – Rates used to determine the initial premium due under the policy/certificate will be the company's published rates. Premiums are payable to the company or its authorized administrator. Premiums will be determined by, but not limited to, such factors as the table of premiums and applicable fees then in effect and by the current attained age, place of residence, and experience class of the covered persons. In some states Imerica plans are based on durational rating, in addition to attained age, trend, and experience increases, that may be applied at the renewal. After the 12- or 24-month premium rate guarantee expires, the company reserves the right to change premiums, on a class basis, under the coverage on any premium due date by giving the insured person at least 31 days prior written notice. (GA and TX allow 60 days.)

Pre-existing conditions – We will not pay benefits for charges that are incurred within the first 12 months after the person became an insured person for a pre-existing condition, unless those conditions were fully disclosed on the enrollment application and benefits relating to those conditions are not specifically excluded in any amendatory endorsement attached to the policy/certificate of insurance. No claim for covered charges incurred more than 12 months after a person became an insured person will be reduced or denied solely on the grounds that the charge is due to a pre-existing condition, unless the condition is excluded or limited by name or specific description in an amendatory endorsement that is attached to the policy/certificate of insurance.

Covered charges – Reasonable and customary charges, fees or expenses incurred for services and supplies which are medically necessary. A covered charge is "incurred" on the date the service or treatment is provided or the supply is obtained. Covered charges must be incurred while your coverage is in force.

Renewability – Coverage is guaranteed renewable except when:

- Premium was due and not paid.
- We determine the insured person has committed an act of fraud or made a material misrepresentation of material fact under the terms of the coverage.
- We do not renew all plans with the same type and level of benefits in the state your coverage was issued.
- We no longer sell major medical health coverage in the state in which your coverage was issued.
- You reach the maximum benefit while covered under the policy/certificate.
- Your plan is determined to be a small employer health plan pursuant to governing laws.

Arbitration – The policy/certificate contains an arbitration provision to resolve claim disputes without litigation. The decision of the arbitrators will be final and binding unless prohibited by state. There is also a provision that provides for resolution of disputes over medical necessity. (Not applicable in all states.)

Coordination of benefits (COB) – Applies when an insured person or the eligible dependant has healthcare coverage under more than one plan. If the COB provision applies, the order of benefit of determination rules state that when the plan is a primary plan, its benefits are determined before those of the other plan and without considering the other plan's benefits. When the plan is a secondary plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefit. (Not applicable in all states.)

Medicare coordination of benefits – If a covered person is eligible for Medicare coverage, a benefit otherwise payable under the policy/certificate shall be reduced by the amount of any similar Medicare benefit so that the total reimbursements shall not exceed 100% of such person's actual expense otherwise reimbursable under the policy.

Pre-certification – Certain benefits must be pre-certified. The physician recommending such benefits must call our utilization review organization to obtain certification at least 72 hours before service is rendered. The utilization review organization will confirm or deny certification based upon the medical necessity of the proposed service. If the certified review process is not complied with, there will be a \$500 penalty per certifiable service. (See the policy/certificate of insurance for details. Pre-certification requirements not applicable in all states.)

Extension of benefits – If an insured person is totally disabled on the date the coverage is terminated for a reason other than fraud or non-payment of premium, coverage will be extended for the disabling condition only, until the earliest of: 1) the end of 12 months; 2) the date the insured person is no longer disabled; or 3) payment of the maximum benefit.

State Variations

Colorado

Mandatory benefits – Biologically-based mental illness, child health supervision services, diabetes self-management training and education, general anesthesia for dental care for eligible dependents, prosthetic devices and orthopedic appliances, treatment of cleft lip and palate, treatment of inherited enzymatic disorders, treatment of congenital defects and birth abnormalities, and telemedicine.

Internet – Expenses related to telemedicine or treatment, diagnosis or care provided over the Internet, or via electronic mail, will not be excluded solely because such services are provided through telemedicine and not through face-to-face consultation. Telemedicine treatment, diagnosis, and care will be considered payable in rural communities of 150,000 or fewer residents, if coverage would have otherwise been covered under the policy.

Pre-existing conditions – You will receive credit if you were previously covered by credible coverage that was continuous to a date not more than 90 days prior to the effectiveness of this insurance.

Expense-incurred benefits – If there is other valid coverage, not with the company providing benefits for the same loss on a provision of service basis or an expense-incurred basis and we have not been given written notice prior to the occurrence or commencement of loss, the only liability under this policy is for the portion of the loss that would have been provided had we been notified of the other coverage. The total amount covered

between the insurance, other valid insurance that we were informed of, and other valid insurance that we were not informed of will not exceed the amount which the services rendered would have cost in the absence of such coverage. Other valid coverage includes: group insurance, individual insurance, automobile medical payment insurance, coverage provided by hospital or medical service organizations, union welfare plans or employer or employee benefit organizations. If we refuse to renew your coverage because we learn of other coverage which duplicates the benefits of the policy, we will refuse to renew your policy on the first premium due date occurring after the 31-day period following our decision to refuse renewal, or any anniversary date. We will return the pro-rata portion of any unused premium.

Georgia

Mandatory benefits – bone mass measurement testing, chlamydia screening tests, colorectal cancer screening, diabetes self-management training and education, child wellness services, clinical trial program for treatment of children's cancer, coverage for surveillance tests for women, general anesthesia for dental care, mastectomy and lymph node dissection care, and temporomandibular joint disorder (TMJ).

Additions to optional benefits

(Subject to the policy deductible and co-insurance) –

Human heart transplant – After your coverage has been in-force for 12 months, covered charges are payable for human heart transplants, including any charge for acquisition, transportation or donation of a human heart when a human heart transplant is performed. Such coverage is provided the same as any other physical illness. Human heart transplants and related services must be pre-certified by the company prior to the time the initial pre-transplant work-up is undertaken. During the pre-certification process, we may direct you to a center of excellence.

Morbid obesity – Coverage is provided for the diagnosis of morbid obesity by a physician based on guidelines set by appropriate health and medical associations and organizations. The treatment for morbid obesity shall be a clinical decision made by the physician based on set guidelines.

Bone marrow transplant – Benefits are payable for bone marrow transplants for the treatment of breast cancer and Hodgkin's disease. Such coverage is provided the same as any other physical illness.

Mental disorders – Benefits are payable for the treatment of mental disorders, when performed by someone other than a physician, with the exception of a board certified psychiatrist or duly licensed psychologist. Such benefits are provided the same as any other physical illness up to the following maximum benefits: inpatient care for up to 30 days per calendar year; outpatient care for up to 48 visits per calendar year.

Other Georgia-specific requirements

Charges – related to any benefit not specifically provided within the policy/certificate.

(Georgia Continued)

Carry-over deductible – (For PPO Series only.) Covered charges incurred after September 30 which have not been paid by Imerica because the deductible has not been met, may be applied toward satisfaction of an insured person's deductible for the next calendar year. This carryover feature does not apply to any deductibles provided in additional benefit riders attached to the policy.

Substance abuse – Benefits exclude expenses related to the treatment of substance abuse, which includes drugs, controlled substances or any other type of substance.

Renewability – Coverage is guaranteed renewable except when:

- Premium was due and not paid.
- We do not renew all plans with the same type and level of benefits in the state your coverage was issued.
- We no longer sell major medical health coverage in your state.
- The insured person is deceased.

Expense-incurred benefits – If there is other valid coverage, not with the company providing benefits for the same loss on a provision of service basis or an expense-incurred basis and we have not been given written notice prior to the occurrence or commencement of loss, the only liability under this policy is for the portion of the loss that would have been had we been notified of the other coverage. The total amount covered between the insurance, other valid insurance that we were informed of, and other valid insurance that we were not informed of will not exceed the amount which the services rendered would have cost in the absence of such coverage. Other valid coverage includes group or blanket insurance.

Administrative remedies – Appeal of decision a) if we make a decision which the insured person wishes to appeal, a written request must be sent within 60 days of the date of our written notice of our decision. The appeal shall be addressed to the attention of Vice President, Claims Department. b) The insured person's request must provide: i) The policy number, name of insured person, and a written statement of the reasons for the appeal and the facts of the matter; and ii) copies of any evidence or supporting documentation. c) Within 45 days after the date of receipt of a timely-filed request for reconsideration, we must provide written notice to the insured person that: i) the decision has been reversed or modified; ii) the decision has been reaffirmed; or iii) additional information is requested regarding the insured person (which shall include any information from third parties, such as healthcare providers). d) Within 30 days after the requested information is received, we must notify the insured person as provided in (c) (i) or (ii) herein. e) If the insured person does not provide the information requested within 60 days of the requesting date, we will reconsider the decision based on the information in the file.

Texas

Mandatory benefits – childhood immunizations, colorectal cancer screening, phenylketonuria, newborn hearing screening and craniofacial abnormalities.

Mammography – annual screening by low-dose mammography for females age 35 and older.

Maternity – The maximum benefit is \$4,000. When the birth occurs, if an insured person has been covered under the benefit for:

- less than 12 months: benefit is \$500;
- at least 12 months but less than 36 month: benefit is \$1,000;
- 36 months and beyond: benefit is \$4,000.

Absence of insurance – No benefits provided for a loss for which no charge would be made in absence of healthcare coverage, other than for support, maintenance and treatment of serious mental illness provided by a tax-supported institution of the State of Texas.

Cosmetic – No benefits are provided for expenses related to cosmetic surgery or treatment to improve your appearance or correct a deformity with restoring a physical bodily function, and complications resulting from cosmetic surgery or procedures. This exclusion does not apply to treatment of congenital anomalies, treatment to correct conditions resulting from a covered injury or sickness occurring while your contract was in-force; or to breast reconstruction incidental to mastectomy.

Pre-authorization – When an authorized service (other than non-emergency air ambulance service) is recommended by a physician for the care and treatment of an insured person, your provider will be required to call our utilization review organization to obtain authorization at least 72 hours before the use of such authorized service. The utilization review organization will confirm or deny authorization based upon the medical necessity of the proposed authorized service, including the appropriateness of the treatment location and/or the length of stay. When a service is either authorized or denied, the utilization review organization will inform you, your provider and Imerica. Pre-authorization does not alter or extend any provision, exclusion, or limitation of the contract. Confinement, care, services, or supplies that are excluded from coverage under any provision, exclusion, or limitation of the contract are not covered whether pre-authorization has been received or not. If the authorized service is denied, the service will not be covered. There is a \$500 penalty per service for not complying with pre-authorization.

