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Fully Insured Limited Benefit Health Insurance For Individuals

Designed Especially [REDACTED]
Presented By: David W Ranck
Date Prepared: 9/29/2008

This proposal expires in 60 days and is not valid for an initial effective date of more than 60 days from the date shown. The member must be eligible for the premiums and benefits proposed.

- ✓ You control the cost... Choose the plan you need
- ✓ Guaranteed issue for all eligible association members*
- ✓ Pre-existing conditions are covered after 6 months
- ✓ No medical questions (except pregnancy) no physical examinations
- ✓ Freedom to use any licensed doctor or hospital, or use the PPO network
- ✓ No claim forms needed when the network is used
- ✓ First dollar coverage... Pays in addition to other private insurance
- ✓ No deductibles, no coinsurance, no copays for BasicPlus' fixed indemnity medical benefits (Rx Card has copays)
- ✓ Benefits may be assigned or paid directly to the member
- ✓ List billing available to all entities with 10 or more enrollees
- ✓ Employment not required
- ✓ 12-Month rate guarantee on medical benefits

*See Page 2, Frequently Asked Questions—Am I eligible for coverage?





UNIQUE

BasicPlus allows you, the member, to purchase the plan that is right for you. You pay for only the benefit plan you want.

AFFORDABLE

BasicPlus offers a variety of affordable monthly premiums. The cost is determined by the benefit plan you select.

INNOVATIVE

BasicPlus is a valuable, lower-cost alternative for those members that do not want to participate in the expensive one-size-fits-all approach to health insurance plans.

AVAILABLE

BasicPlus is available to all eligible members, including unemployed, part-time, seasonal and contract workers. You, the member, decide which benefit plan you want.

SIMPLE

BasicPlus is easy to enroll in and simple to use.

Frequently Asked Questions:

Am I eligible for coverage? Yes, all members of an approved association who are under age 70 are eligible provided they are not disabled*, or pregnant, or have not been confined in a hospital more than once in the 12 months preceding enrollment and are not scheduled for surgery or a hospital confinement at the time of enrollment; reside in the U.S., and are not in full-time military service. *Disabled means: confined to a hospital, convalescent facility, other residential treatment facility, or at home under a doctor's order; or unable because of injury or sickness to engage in the usual activities of a person who is the same age and gender.

Are my dependents eligible? Yes, if you are insured under the plan. Spouses (not legally separated or divorced) who are under age 70 and children, including stepchildren and adopted children, who are unmarried, dependent on you for support and under age 19 (23 if a full-time student) are eligible provided they meet the same requirements listed above.

How do I enroll? Once you have met the eligibility requirements above, complete an enrollment form.

Are there any medical questions or physical examinations required? We ask if the applicant or any of their dependants are pregnant. If that question should be answered "yes", you are not eligible. Physical exams are not required.

When is coverage effective? If you are eligible, coverage will be effective on the 1st of the month following our receipt of all your enrollment forms with full premium by the 20th of the month prior to the requested effective month

When does coverage terminate? Coverage will remain in effect until the first of the following occurs: you request cancellation; the end of the last period for which all required premium has been paid; the date membership ends; the date you reach age 70; the date the group policy terminates. Spouse and children's coverage terminates concurrently with yours, or earlier if they no longer qualify as a dependant, or you request termination of coverage.

How are premiums billed? Monthly premiums can be charged to a MasterCard or Visa credit or debit card or paid by automatic funds transfer. Monthly list billing is available to entities with 10 or more Member enrollees. All billings will include an administrative fee.

How are claims paid? All claims for all insured benefits are paid directly to the insured unless assigned. Claim forms are available from the Plan Administrator. Services and discounts for the Value-Added program are handled directly with the participating provider. There are no claim forms to file.

Are there any limitations on pre-existing conditions? A "pre-existing condition" is defined as any injury or sickness for which diagnosis has been made, treatment has been recommended, or has been rendered, or expenses have been incurred within 6 months prior to becoming covered under the plan. It includes any condition manifesting itself in symptoms, which would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment. Plan benefits are not payable for a "pre-existing condition" for the first 6 months following an insured's effective date.



Choose From Six Plans

Choose >>>>>>	Plan 1A	Plan 1B	Plan 2A	Plan 2B	Plan 3A	Plan 3B
Inpatient Benefits						
Hospitalization - per day	\$500	\$500	\$700	\$700	\$1,000	\$1,000
Intensive Care - per day	\$1,000	\$1,000	\$1,400	\$1,400	\$2,000	\$2,000
Nursing Facility - per day	\$250	\$250	\$350	\$350	\$500	\$500
Alcohol / Drug Abuse - per day	\$250	\$250	\$350	\$350	\$500	\$500
Mental Illness - per day	\$250	\$250	\$350	\$350	\$500	\$500
Heart Attack / Stroke / Cancer - per day	\$1,000	\$1,000	\$1,400	\$1,400	\$2,000	\$2,000
Surgical Benefits - In / outpatient						
Surgery Schedule - per procedure	\$500	\$500	\$1,000	\$1,000	\$1,500	\$1,500
Anesthesia Schedule - per procedure	\$125	\$125	\$250	\$250	\$375	\$375
Outpatient Benefits						
Doctor's Office Visits - per visit	6 at \$40	6 at \$40	6 at \$50	6 at \$50	6 at \$60	6 at \$60
Neighborhood Clinic counts as doctor visit	\$20	\$20	\$25	\$25	\$30	\$30
Diagnostic Tests - per visit	3 at \$40	3 at \$40	3 at \$50	3 at \$50	3 at \$60	3 at \$60
Wellness Visits - per visit	N/A	N/A	1 at \$100	1 at \$100	1 at \$150	1 at \$150
Emergency Room - (sickness) per visit	N/A	N/A	2 at \$100	2 at \$100	2 at \$150	2 at \$150
Accident Benefit - up to per accident	\$500	\$500	\$500	\$500	\$1,000	\$1,000
Rx Outpatient Drug Card*	N/A	Included	N/A	Included	N/A	Included
Value-Added Benefits Program	Included	Included	Included	Included	Included	Included

* insured Rx card is not available in all states.

The Value-Added Benefits:

Beech Street Physician and Hospital Referral Plan —provides access to thousands of medical facilities and physicians nationwide at substantial discounts.

Companion Global Healthcare Network — provides high-quality medical care overseas at a fraction of the U.S. cost.

Discount Rx Card — access to quality Rx vendors nationwide at substantial savings compared to retail drug store prices. This plan is not provided if the insured outpatient Rx is elected.

The Value-Added Benefits are not insurance. Members will receive discounts on medical services when they go to certain providers who are contracted with the plan. Members are solely responsible for payment for all healthcare services provided under the Value-Added Benefits. No portion of any provider's fee will be reimbursed or otherwise paid by the plan.

All benefits, except the value added benefit program, are fully insured per covered person per calendar year. The administrative fee is not included in the premiums. The administrative fee must be added to each billing. See the benefit description on page 4.

Refer to the certificate for coverage limitations and exclusions. Association dues and fees are not included in the premiums. The association dues and fees must be added to each billing.



Benefits:

Hospitalization — *BasicPlus* pays the amount selected per day for up to 150 days per calendar year with a lifetime maximum of 500 days for all inpatient confinements.

Intensive Care — if included in the elected plan, *BasicPlus* pays double the daily hospital benefit for intensive care confinement while in the hospital, up to 30 days per calendar year, subject to the lifetime confinement maximum.

Nursing Facility — if included in the elected plan, *BasicPlus* pays 50% of the daily hospital benefit for care while confined in a convalescent facility, up to 60 days per calendar year following within 3 days of a hospitalization of at least 3 days, subject to the lifetime confinement maximum.

Alcohol / Drug Abuse — if included in the elected plan, *BasicPlus* pays 50% of the daily hospital benefit for treatment of alcohol or drug abuse while hospital confined, up to 30 days per calendar year, subject to the lifetime confinement maximum.

Mental Illness — if included in the elected plan, *BasicPlus* pays 50% of the daily hospital benefit for treatment of mental illness while hospital confined, up to 30 days per calendar year, subject to the lifetime confinement maximum.

Heart Attack / Stroke / Cancer — if included in the elected plan, *BasicPlus* pays double the daily hospital benefit for heart attack, stroke or cancer, up to 30 days per calendar year, subject to the lifetime confinement maximum.

Surgery — if included in the elected plan, *BasicPlus* pays a fixed amount per procedure in accordance with the selected schedule for surgery performed in a hospital or outpatient surgery facility, even if the billed amount is lower.

Anesthesia — if included in the elected plan, *BasicPlus* pays an amount equal to 25% of the surgery benefit paid.

Doctor's Office Visits — *BasicPlus* pays the amount selected per doctor's office visit for treatment of an injury or sickness, up to the number of visits selected per covered person per calendar year.

Neighborhood Clinic Visits — *BasicPlus* pays 50% of the amount selected for a doctor's office visit for treatment of an injury or sickness performed at a facility other than a doctor's office, staffed by a physician as defined by the policy other than a MD. Counts as a doctor's office visit.

Diagnostic Testing or X-ray — if included in the elected plan, *BasicPlus* pays the amount selected per visit for medically necessary diagnostic testing and x-rays of injury or sickness performed in a doctor's office or outpatient facility, up to the number of visits selected per covered person per calendar year.

Wellness Visits (Preventive Care) for Adults and Children — if included in the elected plan, *BasicPlus* pays the amount selected per doctor's office visit for well care, up to the number of visits selected, per covered person, per calendar year. Well care includes physical examinations, assessments, and screenings.

Emergency Room — if included in the elected plan, *BasicPlus* pays the amount selected for an emergency room visit due to sickness only when not confined to a hospital, up to the number of visits selected per covered person per calendar year.

Accident Benefit — if included in the elected plan, *BasicPlus* pays benefits for an accident claim, up to the amount selected, after all other benefits have been paid.

Optional Rx Drug Card — if included in the elected plan, *BasicPlus* pays benefits for outpatient Rx drugs as follows:

\$50 calendar year deductible per person plus \$15 max retail generic copay; greater of \$50 or 50% retail copay on brand name Rx

Maximum Rx benefit: retail 30 days supply / \$250 per covered person per month. Discount is available if benefits are exhausted. This benefit is not available in all states. There are limitations and exclusions refer to the Certificate for detailed information. The Rx benefit does not have a 12-month rate guarantee.



Search for providers at www.flexmedinsurance.com

Administration:

Eligibility - All members are eligible provided they:

- are a member and remain a member in good standing in an association that has been approved in writing by the Company;
- are under age 70;
- are not disabled* or pregnant;
- have not been confined in a hospital more than once in the past 12 months preceding enrollment and are not scheduled for surgery or a hospital confinement at the time of enrollment;
- reside in the United States;
- are not in full-time military service.

*Disabled means: confined to a hospital, convalescent facility, other residential treatment facility, or at home under a doctor's order; or unable because of injury or sickness to engage in the usual activities of a person who is the same age and gender.

Members' dependents are also eligible. Dependents include spouses (if not legally separated or divorced) and children, including adopted and stepchildren up to age 21 (23 if a full-time student), who are unmarried and dependent on the member for support. To be eligible, dependents must meet the same requirements as the member.

Newborns are covered from birth provided we are notified of the birth and the appropriate premium is paid within 31 days of birth. Otherwise, the newborn is considered a late enrollee and may not be enrolled.

Enrollment Process - Members are given information about the plan design and rates by the association or when applicable their employer or their agent. During the initial enrollment period (or any subsequent enrollment period), eligible members may complete an enrollment form to participate in the plan.

Rate Increases / Policy Cancellation - No individuals can be singled out for cancellation or rate increase under the policy. The association has the right to cancel the policy by providing written notice to the Company. Termination will be effective on the latter of: (a) the date we receive the notice; or (b) the requested termination date. After the first anniversary date of the policy, the Company has the right to terminate any or all of the insurance under the Policy as of any premium due date by giving notice to the Policyholder, or each Member, at least 60 days prior to the termination.

Effective Date of Coverage - Coverage becomes effective

on the first day of the month coinciding with or immediately following the date a completed enrollment form is received, provided that full premium for the coverage has been received and the applicant is eligible for the coverage.

Termination for Employees / Dependents - A covered member automatically ceases to be insured on the occurrence of any of the following events:

- the date he or she requests cancellation;
- the end of the last period for which all required premium has been paid;
- the date membership in the approved association ends;
- the date the member reaches age 70;
- the date the association ceases to offer the plan; or
- the date the policy terminates.

Spouse's and children's coverage terminates concurrently with that of the member or earlier, if they no longer qualify as a dependent or if the member requests termination of coverage.

Premium Payments - Monthly premiums can be charged to a MasterCard or Visa credit or debit card or paid by automatic funds transfer. Monthly list billing is available to entities with 10 or more Member enrollees. All billings will include an administrative fee.

Pre-Existing Conditions Limitation - A "pre-existing condition" is defined as any injury or sickness for which diagnosis has been made, treatment has been recommended, or has been rendered, or expenses have been incurred within 6 months prior to becoming covered under the plan. It includes any condition manifesting itself in symptoms, which would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment. Plan benefits are not payable for a "pre-existing condition" for the first 6 months following an insured's effective date.

Payment of Claims - All claims are paid directly to the insured member unless assigned to a provider. Claims are paid to a specific provider if a valid assignment is made and accepted. The member will receive an administration kit which includes claim forms and instructions for filing claims.

Services and discounts under the discount drug program and value-added discount benefits program are handled directly with the participating provider. There are no claims to file.

Evidence Of Coverage- All insured employees will receive a certificate of insurance and an identification card.



Summary of Exclusions and Limitations Applicable To All Benefits (See the Certificate of Insurance for the exact listing)

Benefits are not provided for injury or sickness of a covered person which results directly or indirectly, wholly or partly, from:

- Suicide or attempted suicide, while sane or insane.
- Intentionally self-inflicted injury or sickness.
- Rest care or rehabilitative care and treatment, unless otherwise provided.
- 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.
- Immunization shots and routine examinations and physicals, unless otherwise provided.
- Routine newborn care, including routine nursery charges.
- Voluntary abortion, except with respect to the insured or covered dependent spouse when such person's life would be endangered if the fetus were carried to term or where medical complications have arisen from an abortion.
- Pregnancy of the member, spouse or a dependent child, unless required by law.
- Mental illness, functional or organic nervous disorder, alcohol abuse, drug use unless such drugs were taken on the advice of a Physician for more than 10 days in any Calendar Year, with respect to payment of the Daily In-Hospital Indemnity Benefit, unless otherwise provided.
- Participation in a riot, civil commotion, civil disobedience, or unlawful assembly.
- Attempting to commit, or taking part in a felony or assault, or engaging in an illegal occupation.
- Participation in a contest of speed in power-driven vehicles, parachuting, parasailing, bungee jumping, or hang gliding.
- Air travel except as a fare paying passenger on a regularly scheduled air carrier.
- Any accident occurring because the insured person was intoxicated.
- Sex changes.
- Experimental or investigational treatment.
- The reversal of tubal ligation or vasectomies.
- Artificial insemination, in vitro fertilization, and test tube fertilization.
- Exogenous obesity or weight control.
- An act of war, whether declared or undeclared or while performing police duty as a member of any military or naval organization.
- Sickness or injury arising out of and in the course of any occupation for compensation, wage or profit.
- Air or ground ambulance service, unless otherwise provided.
- Unless specifically provided in the Plan, dental care or oral surgery.
- Unless specifically provided in the Plan, refractions, eyeglasses or their fitting, or hearing aides.
- Services related to educational or vocational testing or training.
- Outpatient food, food supplements, or vitamins.
- Surgery to correct vision problems which are not caused by a sickness or injury.
- Treatment by a surgeon, nurse, dentist or doctor who normally lives with the covered person; is a member of the covered person's family; is the covered person's employer or is contracted for or by a union, employee benefit association, trustee, or similar organization.
- Smoking cessation
- The following are not covered under the Out-Patient Physician Office Visit Indemnity Benefit and the Outpatient Diagnostic X-Ray and Laboratory Indemnity Benefit: visits made, examinations given, or x-rays or laboratory tests performed as an in-patient while Confined to a Hospital; routine eye examinations or fitting of glasses; fitting of hearing aids; dental examinations or dental care other than expenses resulting from accidental injury; and benefits which are provided under any other part of this Policy.
- The following are not covered under the Outpatient Prescription Drug Indemnity Benefit, if applicable: drugs and medicines which may be lawfully obtained without a Physician's prescription; except insulin; therapeutic devices or appliances. This includes hypodermic needles, syringes, support garments and other non-medical items; drugs labeled "Caution – limited by federal law to investigational use" or experimental drugs; 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; immunization agents, biological sera, blood or blood plasma; or contraceptive materials, devices or medications or infertility medication, except where required by law.



Exclusions, Limitations and Provisions Specific to the Outpatient Prescription Drug Plans

Prescription Drug means all outpatient Medically Necessary Legend non-injectable medications shown on the Formulary, unless otherwise specifically excluded and any of the following. Outpatient means a Prescription Drug is not taken in or administered by a hospital or any other health care facility or office. *Diabetic Products* - Over-the-counter/Diabetic supplies -alcohol swabs, lancets, lancets devices, test strips and tablets (urine, blood glucose, ketone). Insulin and insulin syringes. *Family Planning* -Oral contraceptives. *Nutritional Products* -Prenatal Legend Vitamins. *Other Legend Drugs* -Acne products (Retin-A only up to 24th birthday). Compounds -one ingredient must be Legend. *Cough and Cold*. Immunosuppressants. All over-the-counter and injectable medications are excluded unless shown above. If classifications contain both prescribed and over-the-counter or both injectable and non-injectable products, only the non-injectable, prescribed products will be covered unless shown above.

PRESCRIPTION DRUG BENEFIT PROVISION- The benefit amounts are payable for Medically Necessary Covered Charges incurred for the purchase of outpatient Prescription Drugs from a Participating or Non-Participating Pharmacy. Any Deductible must be satisfied before benefits will be paid and the Copayment must be incurred for each Prescription Drug or authorized refill. All benefit amounts are subject to the maximum benefits payable.

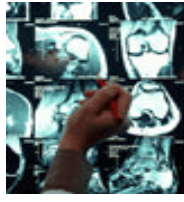
Prescription Drugs Purchased With Drug Card- The insured person will be given a prescription drug card, and is required to present the prescription drug card to the Participating Pharmacy and must pay any appropriate Deductible and/or Copayment amount at the time each Prescription Drug is filled or refilled. When a Prescription Drug card is used at a Participating Pharmacy, benefits are assigned to the Participating Pharmacy.

Prescription Drugs Purchased Without Drug Card- If a Prescription Drug is purchased at a Non-Participating Pharmacy, or purchased at a Participating Pharmacy without the prescription drug card, the insured person must pay the full cost for the Prescription Drug at the time of purchase and complete a claim form. Reimbursement subject to any Deductible and/or Copayment will be made directly to the insured person when a Non-Participating Pharmacy is used, or where purchase is made without the Prescription Drug card at a Participating Pharmacy.

EXCLUSIONS/LIMITATIONS- Prescription Drug benefits are not payable for the following items except as set forth above: All over-the-counter products and medications unless shown under the definition of Prescription Drug. This includes, but is not limited to, electrolyte replacement, infant formulas, miscellaneous nutritional supplements and all other over-the-counter products and medications. Blood glucose meters; insulin-injecting devices. Depo-Provera; condoms, contraceptive sponges, and spermicides; sexual dysfunction drugs. Biologicals (including allergy tests); blood products; growth hormones; hemophilic factors; MS injectables; immunizations; all other injectables unless shown under the definition of Prescription Drug. All other medical supplies and durable medical equipment unless shown under the definition of Prescription Drug. Liquid nutritional supplements; pediatric Legend Drug vitamins; prescribed versions of Vitamins A, D, K, B12, Folic Acid and Niacin - used in treatment versus as a dietary supplement; all other Legend Drug vitamins and nutritional supplements. Anorexiant; Any cosmetic drugs including,

but not limited to, Renova, skin pigmentation preps; Any drugs or products used for the treatment of baldness; Topical dental fluorides. Refills in excess of that specified by the prescribing Physician; or refills dispensed after one year from the original date of the prescription. Any drug labeled "Caution - limited by Federal Law for Investigational Use" or experimental drugs. Any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment. Drugs needed due to conditions caused, directly or indirectly, by an Insured Person taking part in a riot or other civil disorder; or the Insured Person taking part in the commission of a felony. Drugs needed due to conditions caused, directly or indirectly, by declared or undeclared war or an act of war; or drugs dispensed to an Insured Person while on active duty in any armed force. Any expenses related to the administration of any drug. Drugs or medicines taken while in or administered by a hospital or any other health care facility or office. Drugs covered under Worker's Compensation, Medicare, Medicaid or other Governmental programs. Drugs, medicines or products, which are not Medically Necessary. Diaphragms; Erectile dysfunction Legend drugs, unless specifically listed in the definition of Prescription Drug; Infertility Legend drugs. Epi-Pen, Epi-Pen Jr., Ana-Kit, Ana-Guard; Glucagon-auto injection; Imitrex-auto injection. Smoking deterrents, Legend or over-the-counter. Vacation supplies and replacement of lost, stolen, spilled, broken or dropped Prescription Drugs. All newly marketed pharmaceuticals or currently marketed pharmaceuticals with a new FDA approved Indication for a period of one year from such FDA approval for its intended indication. Brand Name Prescription Drugs if the benefit purchased covers only Generic Equivalent Drugs.

Limitations If the benefit purchased covers both Brand and Generic Drugs, and if a Brand Name Prescription Drug is dispensed in lieu of an available Generic Prescription Drug, then in addition to any Deductible and/or Copayment amount, the Insured Person will be responsible for the cost of such Prescription Drug which exceeds the cost of its Generic alternative. The Days Supply is limited to up to a maximum of 30 days at Participating and Non-Participating Pharmacies.



BasicPlus is available to eligible association members in the states of: Alabama, Alaska, Arizona*, Arkansas*, Colorado, Delaware, District of Columbia, Florida*, Georgia*, Illinois, Iowa*, Kansas, Kentucky, Louisiana*, Maine*, Massachusetts*, Michigan*, Mississippi, Missouri, Nebraska, Nevada*, New Hampshire*, New Mexico*, North Carolina*, North Dakota*, Ohio, Oklahoma*, Pennsylvania*, Rhode Island*, South Carolina, Tennessee*, Texas, Utah, Vermont*, Virginia, West Virginia, Wisconsin, and Wyoming.

*Insured Rx card is not available (Discount Card is issued)

BasicPlus is available to approved associations with members residing in multiple states provided the member's address is in a state where the program is available.

IMPORTANT— **BasicPlus** is not comprehensive major medical insurance. Policy forms are intended to comply fully with all applicable state insurance statutes and regulations. Because of differing state requirements, benefits, terms and conditions may vary by state from the description according to the approved association's location and/or the member's state of residence.

This information is a brief description of the important features of the plan. It is not a contract. Terms and conditions of coverage will be set forth in the group policy and adopted by each participating employer group. The group policy is subject to the laws of the jurisdiction in which it is issued. The availability of this offer may change. Please keep this material as a reference and refer to the Certificate of Insurance for additional specific details. Some provisions, benefits, exclusions or limitations listed herein may vary, depending on the approved association's location or a member's state of residence.

BasicPlus Insurance Services, LLC / P.O. Box 767850 / Roswell, GA 30076

Toll Free Fax 1-877-226-2987 / email: info@flexmedinsurance.com

Agents must contact BasicPlus prior to marketing this plan.

Insurance benefits provided by: Companion Life Insurance Company

Companion Life Insurance Co. (www.CompanionLife.com) has specialized in employee benefits for more than 35 years. The company markets life, dental, disability, specialty accident and health insurance products in 45 states and the District of Columbia and holds an

A.M. Best rating of A+ (Superior)

Administered by: TCC, Inc. / P.O. Box 22557 / Charleston, SC 29413 / 1-800-851-6268.

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