

# Imprint *One*

A premier PPO health insurance plan  
with flexibility and options for small  
businesses with two to 50 employees



**Underwritten by Madison National Life Insurance Company, Inc., a Wisconsin insurance company, and Standard Security Life Insurance Company of New York.** Madison National and Standard Security Life are members of The IHC Group, an insurance organization composed of Independence Holding Company (NYSE:IHC) and its operating subsidiaries. The IHC Group has been providing life, health and stop-loss insurance solutions for nearly 30 years. For information on Independence Holding Company and The IHC Group, visit [www.ihcgroup.com](http://www.ihcgroup.com).

Note: This plan overview must be presented with the Imprint group health insurance brochure.



IHC ImpOne 0511

# Why Imprint One?

No two small businesses are alike, and neither are their employees. Imprint One provides flexibility and options, allowing small business owners to provide the right benefits — and at the right price.



Leave a lasting impression

## Benefits

### Physician visit copay

If selected, the copay applies to the in-network physician's consultation charge at an urgent care center or physician's office.

- D \$30
  - D \$40
  - D No copay – covered charges apply to deductible and coinsurance
- If a copay is selected, it applies per in-network visit. After the copay, the plan pays 100% of the balance of the physician office or urgent care center visit charge. Other covered services performed during the visit are subject to deductible and coinsurance.
- Out-of-network visit: deductible and coinsurance

### Deductible<sup>1</sup>

The deductible options listed apply per calendar year to in-network covered charges. A covered family has a maximum of two individual deductible amounts.

In-network and out-of-network deductibles accumulate separately. However, when the out-of-network deductible is satisfied, the in-network deductible will be considered satisfied for the remainder of the calendar year.

- D \$0
  - D \$250
  - D \$500
  - D \$1,000
  - D \$1,500
  - D \$2,000
  - D \$4,000
  - D \$6,000
  - D \$8,000
- Out-of-network deductible: two times the in-network deductible on deductibles of \$500 or greater; \$1,000 on the \$0 and \$250 deductibles

### Coinsurance<sup>1</sup>

After the deductible has been satisfied, the plan will pay the selected percentage of covered in-network charges.

- D 100%
  - D 90%
  - D 80%
  - D 50%
- Out-of-network coinsurance: For the 100% and 90% in-network options, the out-of-network coinsurance is 70%; for the 80% or 50% in-network options, the out-of-network coinsurance is 50%.

### Out-of-pocket maximum<sup>2</sup>

In addition to the deductible, the insured person is responsible for the selected out-of-pocket amount per calendar year for in-network covered charges. A covered family has a maximum of two individual out-of-pocket amounts.

In-network and out-of-network out-of-pocket amounts accumulate separately. However, when the out-of-network out-of-pocket is satisfied, the in-network out-of-pocket will be considered satisfied for the remainder of the calendar year.

- D \$1,500
  - D \$2,000
  - D \$3,000
  - D \$4,000
  - D \$5,000
  - D \$10,000
- Out-of-network out-of-pocket: two times the in-network out-of-pocket amount

### Calendar-year maximum benefit

\$5 million

<sup>1</sup> Not all benefit selection combinations are available in all markets.

<sup>2</sup> Expenses incurred for the following charges do not accumulate toward the out-of-pocket maximum: outpatient treatment of mental, nervous or chemical dependency disorders; pre-certification deductibles; copays; deductible amounts; and charges excluded under the policy.

## Prescription drug coverage

<b>Option 1</b> <i>Included in plan unless an option below is selected</i>	Generic: \$10 copay Brand name prescription deductible: \$5,000 then, Formulary: \$50 copay; Non-formulary: \$100 copay; Specialty drugs: \$150 copay Maximum three prescription deductibles per calendar year, per family
<b>Option 2</b>	Generic: \$10 copay Brand name: subject to the major medical plan deductible and coinsurance
<b>Option 3</b>	All covered prescription drugs apply to the major medical plan deductible and coinsurance
<b>Option 4</b>	Generic: \$10 copay Brand name formulary: \$50 copay Brand name non-formulary: \$100 copay Specialty drugs: \$150 copay
<b>Option 5</b>	Generic: \$10 copay Brand name formulary: \$50 copay and 30% coinsurance of the remaining charge Brand name non-formulary: \$100 copay and 50% coinsurance of the remaining charge Specialty drugs: \$150 copay
<b>Option 6 and 7</b>	Available only with the Imprint <i>HD</i> plan
<b>Option 8</b>	Generic: \$10 copay Brand name formulary: \$25 copay Brand name non-formulary: \$40 copay Specialty drugs: \$50 copay

## Optional benefits

### Maternity coverage

Coverage is available for routine pregnancy and delivery subject to the plan deductible and coinsurance. Maternity coverage is optional for groups of two to 14 employees and required for groups of 15 or more employees, unless otherwise specified by state law. If purchased, maternity services are covered subject to deductible and coinsurance for the insured employee and dependents.

### Supplemental accident coverage

In-network and out-of-network covered charges incurred as the direct result of an accident are paid at 100 percent up to the selected maximum of \$500, \$1,000 or \$2,000. Covered services must be received within three months after the date of the accident. After the per accident benefit maximum has been reached, additional covered charges are subject to copays, deductible and coinsurance.

### 24-hour occupational coverage

Available to eligible business owners, partners, sole proprietors or corporate officers not covered by workers' compensation or similar legislation. This option provides coverage for work-related injuries and sickness; it is not intended to replace workers' compensation coverage.

### Term life insurance and AD&D insurance coverage

The minimum amount of term life insurance is \$10,000 and the maximum is \$100,000. Benefits reduce beginning at age 65.\*

### Dependent life insurance

Optional for a covered spouse and children, dependent life insurance is available in the following amounts:

Spouse: \$2,000

Children 14 days to six months: \$100

Children six months to 19 years (up to age 25 for a full-time college student): \$1,000

### Dental coverage

Dental insurance coverage is available with numerous plan options, including many without waiting periods. See separate dental plan overview for information.

\* The selected life insurance benefit amount is reduced as follows: age 65–69: 65%; age 70–74: 40%; age 75–79: 25%; age 80–84: 15%; age 85+: 10%.

## Features

All benefits listed apply per insured individual

<b>Routine mammography, prostate cancer screening and cytological screening</b>	100% - in- and out-of-network covered charges are not subject to the plan copay, deductible or coinsurance
<b>Wellness benefits</b> Covered services includes well-child care, routine adult physicals, colorectal cancer screening services and annual flu shots	In-network: 100% - covered charges are not subject to the plan copay, deductible or coinsurance  Out-of-network: 100% after the selected physician visit copay, if no copay is selected, a \$40 copay will apply to covered wellness charges
<b>Preventive services</b> Covered preventive services are those rated with an "A" or "B" by the United States Preventive Services Task Force (USPSTF). For an updated list of covered services visit: <a href="http://www.uspreventiveservicestaskforce.org">www.uspreventiveservicestaskforce.org</a>	In-network: 100% - covered charges are not subject to the plan copay, deductible or coinsurance  Out-of-network: no coverage
<b>Outpatient diagnostic tests, lab and X-ray</b>	In-network charges are paid at 100% up to \$150 per visit, then deductible and coinsurance. Out-of-network charges are subject to deductible and coinsurance.
<b>Air, ground and water ambulance</b>	After \$100 copay, subject to deductible and coinsurance
<b>Emergency room</b>	After \$100 copay, subject to deductible and coinsurance (copay is waived if admitted)  In an emergency, as defined by the certificate, out-of-network covered charges will be paid at the in-network deductible and coinsurance benefit level.
<b>Inpatient facilities and surgical services</b>	Subject to deductible and coinsurance
<b>Outpatient physical, occupational or speech therapy</b>	Subject to deductible and coinsurance up to a maximum benefit of 30 treatments per calendar year for any one type of therapy and 60 treatments per calendar year for any combination of therapies
<b>Mental, nervous and chemical dependency disorders</b>	Covered charges for all mental, nervous and chemical dependency disorders are subject to deductible and coinsurance.  Inpatient mental and nervous care: maximum benefit of \$250 per day  Outpatient mental, nervous or chemical dependency care: 50% coinsurance after deductible, maximum benefit of \$25 per visit.  Inpatient chemical dependency care: not a covered benefit
<b>Organ transplant</b> Covered human organ and tissue transplants include those for bone marrow, cornea, heart, heart-lung, lung, pancreas, pancreas-kidney, kidney, liver and small bowel.	Center of Excellence provider: subject to deductible and coinsurance up to the plan's \$5 million calendar-year maximum benefit  Non-Center of Excellence provider: subject to deductible and coinsurance up to a maximum benefit of \$400,000 per transplant
<b>Non-surgical back treatment</b>	Subject to deductible and coinsurance up to a maximum benefit of 20 visits per calendar year
<b>Oral surgery</b>	Subject to deductible and coinsurance up to a maximum benefit of \$5,000 per surgery
<b>Skilled nursing care</b>	Subject to deductible and coinsurance up to a maximum benefit of \$100 per day
<b>Home health care</b>	Subject to deductible and coinsurance up to a calendar-year maximum benefit of 60 visits
<b>Hospice care</b>	100% after deductible – up to a calendar year maximum benefit of six months; covered charges are not subject to coinsurance

This plan overview is intended as a summary only. Provisions and availability may vary by state. For complete details, refer to the group policy (MNL MMP 0205 or SSL MMP 0205). Imprint is underwritten by Madison National Life Insurance Company, Inc. and Standard Security Life Insurance Company of New York.



# Imprint *Two*

An affordable PPO health insurance  
plan for small businesses with  
two to 50 employees



**Underwritten by Madison National Life Insurance Company, Inc., a Wisconsin insurance company, and Standard Security Life Insurance Company of New York.** Madison National and Standard Security Life are members of The IHC Group, an insurance organization composed of Independence Holding Company (NYSE:IHC) and its operating subsidiaries. The IHC Group has been providing life, health and stop-loss insurance solutions for nearly 30 years. For information on Independence Holding Company and The IHC Group, visit [www.ihcgroup.com](http://www.ihcgroup.com).

Note: This plan overview must be presented with the Imprint group health insurance brochure.



IHC ImpTwo 0511

# Why Imprint Two?

Small business owners want to take care of their employees, but staying on budget is often a concern. Imprint Two strikes a balance between quality and affordability, providing cost-friendly benefits with plan options employees desire.



Leave a lasting impression

## Benefits

### Physician visit copay

If selected, the copay applies to the in-network physician's consultation charge at an urgent care center or physician's office.

- \$30
- \$40
- No copay – covered charges apply to deductible and coinsurance

If a copay is selected, it applies per in-network visit. After the copay, the plan pays 100% of the balance of the physician office or urgent care center visit charge. Other covered services performed during the visit are subject to deductible and coinsurance.

Out-of-network visit: deductible and coinsurance

### Deductible

The deductible options listed apply per calendar year to in-network covered charges. A covered family has a maximum of two individual deductible amounts.

In-network and out-of-network deductibles accumulate separately. However, when the out-of-network deductible is satisfied, the in-network deductible will be considered satisfied for the remainder of the calendar year.

- \$1,000
- \$1,500
- \$2,500
- \$5,000

Out-of-network deductible: two times the in-network deductible

### Coinsurance

After the deductible has been satisfied, the plan will pay the selected percentage of covered in-network charges.

- 80%
- 50%

Out-of-network coinsurance: 50%

### Out-of-pocket maximum<sup>1</sup>

In addition to the deductible, the insured person is responsible for the selected out-of-pocket amount per calendar year for in-network covered charges. A covered family has a maximum of two individual out-of-pocket amounts.

In-network and out-of-network out-of-pocket amounts accumulate separately. However, when the out-of-network out-of-pocket is satisfied, the in-network out-of-pocket will be considered satisfied for the remainder of the calendar year.

Outpatient Services and Supplies	Inpatient Confinement and Surgical Services
<input type="checkbox"/> \$2,000.....	\$4,000
<input type="checkbox"/> \$3,000.....	\$5,000
<input type="checkbox"/> \$4,000.....	\$6,000
<input type="checkbox"/> \$10,000.....	\$10,000

Charges applied to the selected coinsurance fall into two separate and distinct out-of-pocket amounts.

Out-of-network out-of-pocket: two times the in-network out-of-pocket amount

### Calendar-year maximum benefit

\$5 million

<sup>1</sup> Expenses incurred for the following charges do not accumulate toward the out-of-pocket maximum: outpatient treatment of mental, nervous or chemical dependency disorders; precertification deductibles; copays; deductible amounts; and charges excluded under the policy.

## Prescription drug coverage

<b>Option 1</b> <i>Included in plan unless an option below is selected</i>	Generic: \$10 copay Brand name prescription deductible: \$5,000 then, Formulary: \$50 copay; Non-formulary: \$100 copay; Specialty drugs: \$150 copay Maximum three prescription deductibles per calendar year, per family
<b>Option 2</b>	Generic: \$10 copay Brand name: subject to the major medical plan deductible and coinsurance
<b>Option 3</b>	All covered prescription drugs apply to the major medical plan deductible and coinsurance
<b>Option 4</b>	Generic: \$10 copay Brand name formulary: \$50 copay Brand name non-formulary: \$100 copay Specialty drugs: \$150 copay
<b>Option 5</b>	Generic: \$10 copay Brand name formulary: \$50 copay and 30% coinsurance of the remaining charge Brand name non-formulary: \$100 copay and 50% coinsurance of the remaining charge Specialty drugs: \$150 copay
<b>Option 6 and 7</b>	Available only with the Imprint <i>HD</i> plan
<b>Option 8</b>	Generic: \$10 copay Brand name formulary: \$25 copay Brand name non-formulary: \$40 copay Specialty drugs: \$50 copay

## Optional benefits

### Maternity coverage

Coverage is available for routine pregnancy and delivery subject to the plan deductible and coinsurance. Maternity coverage is optional for groups of two to 14 employees and required for groups of 15 or more employees, unless otherwise specified by state law. If purchased, maternity services are covered subject to deductible and coinsurance for the insured employee and dependents.

### Supplemental accident coverage

In-network and out-of-network covered charges incurred as the direct result of an accident are paid at 100 percent up to the selected maximum of \$500, \$1,000 or \$2,000. Covered services must be received within three months after the date of the accident. After the per accident benefit maximum has been reached, additional covered charges are subject to copays, deductible and coinsurance.

### 24-hour occupational coverage

Available to eligible business owners, partners, sole proprietors or corporate officers not covered by workers' compensation or similar legislation. This option provides coverage for work-related injuries and sickness; it is not intended to replace workers' compensation coverage.

### Term life insurance and AD&D insurance coverage

The minimum amount of term life insurance is \$10,000 and the maximum is \$100,000. Benefits reduce beginning at age 65.\*

### Dependent life insurance

Optional for a covered spouse and children, dependent life insurance is available in the following amounts:

Spouse: \$2,000

Children 14 days to six months: \$100

Children six months to 19 years (up to age 25 for a full-time college student): \$1,000

### Dental coverage

Dental insurance coverage is available with numerous plan options, including many without waiting periods. See separate dental plan overview for information.

\* The selected life insurance benefit amount is reduced as follows: age 65–69: 65%; age 70–74: 40%; age 75–79: 25%; age 80–84: 15%; age 85+: 10%.

## Features

All benefits listed apply per insured individual

<b>Routine mammography, prostate cancer screening and cytological screening</b>	100% - in- and out-of-network covered charges are not subject to the plan copay, deductible or coinsurance
<b>Wellness benefits</b> Covered services includes well-child care, routine adult physicals, colorectal cancer screening services and annual flu shots	In-network: 100% - covered charges are not subject to the plan copay, deductible or coinsurance Out-of-network: 100% after the selected physician visit copay, if no copay is selected, a \$40 copay will apply to covered wellness charges
<b>Preventive services</b> Covered preventive services are those rated with an "A" or "B" by the United States Preventive Services Task Force (USPSTF). For an updated list of covered services visit: <a href="http://www.uspreventiveservicestaskforce.org">www.uspreventiveservicestaskforce.org</a>	In-network: 100% - covered charges are not subject to the plan copay, deductible or coinsurance Out-of-network: no coverage
<b>Outpatient diagnostic tests, lab and X-ray</b>	Subject to deductible and coinsurance
<b>Air, ground and water ambulance</b>	After \$100 copay, subject to deductible and coinsurance
<b>Emergency room</b>	After \$100 copay, subject to deductible and coinsurance (copay is waived if admitted) In an emergency, as defined by the certificate, out-of-network covered charges will be paid at the in-network deductible and coinsurance benefit level.
<b>Inpatient facilities and surgical services</b>	After \$250 copay, subject to deductible and coinsurance (out-of-network copay is \$500)
<b>Outpatient physical, occupational or speech therapy</b>	Subject to deductible and coinsurance up to a maximum benefit of 30 treatments per calendar year for any one type of therapy and 60 treatments per calendar year for any combination of therapies
<b>Mental, nervous and chemical dependency disorders</b>	Covered charges for all mental, nervous and chemical dependency disorders are subject to deductible and coinsurance. Inpatient mental and nervous care: maximum benefit of \$250 per day Outpatient mental, nervous or chemical dependency care: 50% coinsurance after deductible, maximum benefit of \$25 per visit. Inpatient chemical dependency care: not a covered benefit
<b>Organ transplant</b> Covered human organ and tissue transplants include those for bone marrow, cornea, heart, heart-lung, lung, pancreas, pancreas-kidney, kidney, liver and small bowel.	Center of Excellence provider: subject to deductible and coinsurance up to the plan's \$5 million calendar-year maximum benefit Non-Center of Excellence provider: subject to deductible and coinsurance up to a maximum benefit of \$400,000 per transplant
<b>Non-surgical back treatment</b>	Subject to deductible and coinsurance up to a maximum benefit of 20 visits per calendar year
<b>Oral surgery</b>	Subject to deductible and coinsurance up to a maximum benefit of \$5,000 per surgery
<b>Skilled nursing care</b>	Subject to deductible and coinsurance up to a maximum benefit of \$100 per day
<b>Home health care</b>	Subject to deductible and coinsurance up to a calendar-year maximum benefit of 60 visits
<b>Hospice care</b>	100% after deductible – up to a calendar year maximum benefit of six months; covered charges are not subject to coinsurance

This plan overview is intended as a summary only. Provisions and availability may vary by state. For complete details, refer to the group policy (MNL MMP 0205 or SSL MMP 0205). Imprint is underwritten by Madison National Life Insurance Company, Inc. and Standard Security Life Insurance Company of New York.



# Imprint *HD*

An affordable PPO health insurance plan with HSA-qualified options for small businesses with two to 50 employees



Underwritten by Madison National Life Insurance Company, Inc., a Wisconsin insurance company, and Standard Security Life Insurance Company of New York. Madison National Life and Standard Security Life are members of The IHC Group, an insurance organization composed of Independence Holding Company (NYSE:IHC) and its operating subsidiaries. The IHC Group has been providing life, health and stop-loss insurance solutions for nearly 30 years. For information on Independence Holding Company and The IHC Group, visit [www.ihcgroup.com](http://www.ihcgroup.com).

Note: This plan overview must be presented with the Imprint group health insurance brochure.



# Why Imprint HD?

When simplicity and cost are key concerns, Imprint *HD* offers an affordable, high-deductible solution with clearly defined benefits. Tax savings may be achieved when an HSA-qualified Imprint *HD* plan is chosen and paired with a health savings account.



## Benefits

### Physician visit copay

If selected, the copay applies to the in-network physician's consultation charge at an urgent care center or physician's office.

- \$30<sup>NQ</sup>
  - \$40<sup>NQ</sup>
  - No copay—covered charges apply to deductible and coinsurance
- If a copay is selected, it applies per in-network visit. After the copay, the plan pays 100% of the balance of the physician office or urgent care center visit charge. Other covered services performed during the visit are subject to deductible and coinsurance.
- Out-of-network visit: deductible and coinsurance

### Deductible<sup>1</sup>

The deductible options listed apply per calendar year to in-network covered charges. Covered charges of all insured family members accumulate to satisfy the calendar-year family deductible.

In-network and out-of-network deductibles accumulate separately. However, when the out-of-network deductible is satisfied, the in-network deductible will be considered satisfied for the remainder of the calendar year.

	Individual	Family
<input type="checkbox"/> \$1,500	\$1,500	\$3,000
<input type="checkbox"/> \$2,500	\$2,500	\$5,000
<input type="checkbox"/> \$3,500	\$3,500	\$7,000
<input type="checkbox"/> \$5,000	\$5,000	\$10,000
<input type="checkbox"/> \$10,000 <sup>NQ</sup>	\$10,000 <sup>NQ</sup>	\$10,000
<input type="checkbox"/> \$15,000 <sup>NQ</sup>	\$15,000 <sup>NQ</sup>	\$15,000
<input type="checkbox"/> \$20,000 <sup>NQ</sup>	\$20,000 <sup>NQ</sup>	\$20,000
<input type="checkbox"/> \$25,000 <sup>NQ</sup>	\$25,000 <sup>NQ</sup>	\$25,000

Out-of-network deductible: two times the in-network deductible

### Coinsurance

After the deductible has been satisfied, the plan will pay the selected percentage of covered in-network charges.

- 100%
- 80%
- 70%
- 50%

Out-of-network coinsurance: for the 100% in-network option, the out-of-network coinsurance is 70%; for the 80%, 70% or 50% in-network options, the out-of-network coinsurance is 50%.

### Out-of-pocket maximum<sup>1,2</sup>

In addition to the deductible, the insured person is responsible for the selected out-of-pocket amount per calendar year for in-network covered charges. Covered charges applied to the selected coinsurance percentage for all insured family members accumulate to satisfy the calendar-year family out-of-pocket maximum.

In-network and out-of-network out-of-pocket amounts accumulate separately. However, when the out-of-network out-of-pocket is satisfied, the in-network out-of-pocket will be considered satisfied for the remainder of the calendar year.

Coinsurance	Individual out-of-pocket	Family out-of-pocket
100%	\$0	\$0
80%, 70% and 50%	\$1,500	\$3,000

Out-of-network out-of-pocket: two times the in-network out-of-pocket. For 100% plans, the individual out-of-network out-of-pocket is \$1,500 and the family out-of-network out-of-pocket is \$3,000.

### Calendar-year maximum benefit

\$5 million

<sup>NQ</sup> Benefit selections do not meet federal guidelines for use with a health savings account. Based on the total calendar-year out-of-pocket amount (deductible plus coinsurance) certain benefit combinations will not qualify for use with a health savings account.

<sup>1</sup> The calendar-year deductible and out-of-pocket amounts on HSA-qualified plans are subject to annual cost-of-living adjustments as may be required by federal guidelines to maintain the plan's eligibility.

<sup>2</sup> Expenses incurred for the following charges do not accumulate toward the out-of-pocket maximum: outpatient treatment of mental, nervous or chemical dependency disorders; precertification deductibles; copays; deductible amounts; and charges excluded under the policy.

## Prescription drug coverage

<b>Option 1</b>	Available only with the Imprint <i>One</i> and Imprint <i>Two</i> plans
<b>Option 2<sup>NQ</sup></b>	Generic: \$10 copay Brand name: subject to the major medical plan deductible and coinsurance
<b>Option 3</b>	All covered prescription drugs apply to the major medical plan deductible and coinsurance
<b>Option 4<sup>NQ</sup></b>	Generic: \$10 copay Brand name formulary: \$50 copay Brand name non-formulary: \$100 copay Specialty drugs: \$150 copay
<b>Option 5<sup>NQ</sup></b>	Generic: \$10 copay Brand name formulary: \$50 copay and 30% coinsurance of the remaining charge Brand name non-formulary: \$100 copay and 50% coinsurance of the remaining charge Specialty drugs: \$150 copay
<b>Option 6</b> <i>Included in plan unless an option above is selected</i>	Discount only; outpatient prescription drugs are excluded from the insurance coverage and expenses are not applied to deductible or coinsurance The discount-only option is not an insurance benefit.
<b>Option 7</b>	<i>Coming soon...</i>
<b>Option 8<sup>NQ</sup></b>	Generic: \$10 copay Brand name formulary: \$25 copay Brand name non-formulary: \$40 copay Specialty drugs: \$50 copay

<sup>NQ</sup> Benefit selections do not meet federal guidelines for use with a health savings account.

## Optional benefits

### Maternity coverage

Coverage is available for routine pregnancy and delivery subject to the plan deductible and coinsurance. Maternity coverage is optional for groups of two to 14 employees and required for groups of 15 or more employees, unless otherwise specified by state law. If purchased, maternity services are covered subject to deductible and coinsurance for the insured employee and dependents.

### Supplemental accident coverage

In-network and out-of-network covered charges incurred as the direct result of an accident are paid at 100 percent up to the selected maximum benefit of \$500, \$1,000 or \$2,000. Covered services must be received within three months after the date of the accident. After the per accident benefit maximum has been reached, additional covered charges are subject to copays, deductible and coinsurance.

### 24-hour occupational coverage

Available to eligible business owners, partners, sole proprietors or corporate officers not covered by workers' compensation or similar legislation. This option provides coverage for work-related injuries and sickness; it is not intended to replace workers' compensation coverage.

### Term life insurance and AD&D insurance coverage

The minimum amount of term life insurance is \$10,000 and the maximum is \$100,000. Benefits reduce beginning at age 65.\*

### Dependent life insurance

Optional for a covered spouse and children, dependent life insurance is available in the following amounts:

Spouse: \$2,000

Children 14 days to six months: \$100

Children six months to 19 years (up to age 25 for a full-time college student): \$1,000

### Dental coverage

Dental insurance coverage is available with numerous plan options, including many without waiting periods. See separate dental plan overview for information.

## Services

### Health savings account (HSA)

A tax-advantaged savings account can be used in conjunction with Imprint *HD*, when HSA-qualified benefits are selected, to maximize total health care dollars. Employers and employees can make HSA contributions on a tax-deferred or tax-deductible basis. HSA funds remain with the employee regardless of their employment and accumulate year after year to pay for qualified health care expenses.

Freedom HSA offers competitive interest rates, online banking, a convenient debit card and investment options. Consult your tax adviser regarding the tax implications of an HSA. Visit [www.freedomhsa.org](http://www.freedomhsa.org) for more information.

### Health reimbursement arrangement (HRA)

Any plan in the Imprint portfolio can be coupled with an HRA, which allows employers to set aside a specific amount of pre-tax dollars to reimburse employees for predetermined medical expenses. These flexible arrangements allow employers to control their health care dollars while providing a valuable employee benefit. Employers establish which expenses HRA funds may be used for (e.g., deductibles, copays, coinsurance, specific medical expenses), and unused funds remain with the employer at the end of the year. Consult your tax adviser for more information about HRAs.

\* The selected life insurance benefit amount is reduced as follows: age 65–69: 65 percent; age 70–74: 40 percent; age 75–79: 25 percent; age 80–84: 15 percent; age 85+: 10 percent.

## Features

All benefits listed apply per insured individual

<b>Routine mammography, prostate cancer screening and cytological screening</b>	100%—in- and out-of-network covered charges are not subject to the plan copay, deductible or coinsurance
<b>Wellness benefits</b> Covered services include well-child care, routine adult physicals, colorectal cancer screening services and annual flu shots.	In-network: 100%—covered charges are not subject to the plan copay, deductible or coinsurance  Out-of-network: 100% after the selected physician visit copay, if no copay is selected, a \$40 copay will apply to covered wellness charges
<b>Preventive services</b> Covered preventive services are those rated with an “A” or “B” by the United States Preventive Services Task Force (USPSTF). For an updated list of covered services visit <a href="http://www.uspreventiveservicestaskforce.org">www.uspreventiveservicestaskforce.org</a>	In-network: 100%—covered charges are not subject to the plan copay, deductible or coinsurance  Out-of-network: no coverage
<b>Outpatient diagnostic tests, lab and X-ray</b>	Subject to deductible and coinsurance  If a physician visit copay is selected, in-network charges are paid at 100% up to \$150 per visit, then deductible and coinsurance. Out-of-network charges are subject to deductible and coinsurance.
<b>Air, ground and water ambulance</b>	Subject to deductible and coinsurance
<b>Emergency room</b>	Subject to deductible and coinsurance  In an emergency, as defined by the certificate, out-of-network covered charges will be paid at the in-network deductible and coinsurance benefit level.
<b>Inpatient facilities and surgical services</b>	Subject to deductible and coinsurance
<b>Outpatient physical, occupational or speech therapy</b>	Subject to deductible and coinsurance up to a maximum benefit of 30 treatments per calendar year for any one type of therapy and 60 treatments per calendar year for any combination of therapies
<b>Mental, nervous and chemical dependency disorders</b>	Covered charges for all mental, nervous and chemical dependency disorders are subject to deductible and coinsurance  Inpatient mental and nervous care: maximum benefit of \$250 per day  Outpatient mental, nervous or chemical dependency care: 50% coinsurance after deductible, maximum benefit of \$25 per visit  Inpatient chemical dependency care: not a covered benefit
<b>Organ transplant</b> Covered human organ and tissue transplants include those for bone marrow, cornea, heart, heart-lung, lung, pancreas, pancreas-kidney, kidney, liver and small bowel.	Center of Excellence provider: subject to deductible and coinsurance up to the plan’s \$5 million calendar-year maximum benefit  Non-Center of Excellence provider: subject to deductible and coinsurance up to a maximum benefit of \$400,000 per transplant
<b>Non-surgical back treatment</b>	Subject to deductible and coinsurance up to a maximum benefit of 20 visits per calendar year
<b>Oral surgery</b>	Subject to deductible and coinsurance up to a maximum benefit of \$5,000 per surgery
<b>Skilled nursing care</b>	Subject to deductible and coinsurance up to a maximum benefit of \$100 per day
<b>Home health care</b>	Subject to deductible and coinsurance up to a calendar-year maximum benefit of 60 visits
<b>Hospice care</b>	100% after deductible—up to a calendar year maximum benefit of six months; covered charges are not subject to coinsurance

This plan overview is intended as a summary only. Provisions and availability may vary by state. For complete details, refer to the group policy (MNL MMP 0205 or SSL MMP 0205). Imprint is underwritten by Madison National Life Insurance Company, Inc. and Standard Security Life Insurance Company of New York.

