



Health Plan Administrators  
Independence Holding Group

## Secure STM

- **Perfect solution for**
  - *Those between jobs*
  - *New hires and exiting employees*
  - *College graduates*
  - *Part-time workers*
- **Convenient features**
  - *Coverage from 30 days to 12 months*
  - *Single, monthly and daily rates*
  - *Unlimited re-applies in most states*
  - *\$2,000,000 lifetime maximum per covered person*



Insured by: Standard Security Life Insurance Company of New York Rated A- (Excellent) by A.M. Best Company  
Administered by: Health Plan Administrators, Inc. (HPA)

# Secure Short-term Medical (STM)

## Why the Secure STM?

Accidents and medical troubles are impartial to your insurance status. They can happen at any time; and if you are without coverage, they can cause serious financial hardship. The Secure short-term medical (STM) insurance plan allows you to purchase quality, affordable major medical coverage on a temporary need basis. Coverage is provided for physician services, surgery, outpatient and inpatient care.

## Who qualifies for Secure STM?

The Secure STM is available to individuals age 18 to 64, their spouses and dependent children under age 19 (or under age 25 if a full-time student). All applying for coverage must have a social security number and answer "no" to all health qualification questions on the application. Child-only coverage is available for ages 2 through 18.

## How are benefits covered?

### First, you meet the deductible you

**selected.** Choose from five options: \$250, \$500, \$1,000, \$2,500 or \$5,000

**Next, the Secure STM plan pays at the coinsurance level you selected, 80% or 50% of the next \$5,000 of covered expenses**

**After this, Secure STM pays 100% of covered expenses up to your coverage period maximum of \$2 million**

## Do I need to visit a network provider?

No. With the Secure STM you can visit any provider without restrictions or benefit reductions. However, if you visit a Private Health Care System (PHCS) network provider, you may be able to take advantage of discounts for covered services.

## What is a Family Deductible?

With the family deductible, your insured family is only required to satisfy a maximum of three deductibles during the coverage period.

## What medical expenses are covered?\*

All of the following benefits are subject to the plan deductible and coinsurance. Benefits are limited to the Usual, Customary and Reasonable charge for each covered expense, in addition to any specific limits stated in your policy.

- Hospital charges paid at the average semi-private room rate, medical care and treatment
- Outpatient hospital or ambulatory surgical center charges
- Physician services for treatment and diagnosis
- Surgeon services in the hospital or ambulatory surgical center
- Assistant surgeon services up to 20% of the primary surgeons benefit
- Anesthesia services up to 20% of the primary surgeons benefit
- Intensive care up to three times the average semi-private room rate
- X-Ray exams, laboratory tests and analysis

- X-Ray and radioactive isotope therapy, anesthesia, oxygen, casts, splints, crutches, braces, surgical dressings, artificial limbs or eyes, rental of medical supplies
- Blood or blood derivatives and their administration
- Ambulance services up to \$250 per trip
- Gallbladder surgery up to a \$2,500 coverage period maximum
- Injury or disorders of the knees up to a \$2,500 coverage period maximum
- Organ, tissue or bone marrow transplants up to \$150,000 coverage period maximum
- Acquired Immune Deficiency Syndrome (AIDS) up to \$10,000 coverage period maximum\*\*
- Mammography, pap smear and screens

*\*Benefits may vary by state.*

*\*\*The AIDS maximum of \$10,000 per coverage period does not apply to policies/certificates issued to residents of AZ, CA, DC, ID, IN, ME, MO, NH, NC or ND. The maximum benefit in KS is \$75,000 per coverage period.*

## What is the Usual, Customary and Reasonable Charge?

A Usual, Customary and Reasonable charge is the charge typically made by physicians or suppliers of medical services, medicines and supplies within a specific geographic area.

## Is there a pre-existing condition limitation?

Secure STM will not provide benefits for any loss caused by or resulting from a pre-existing condition. A pre-existing condition is any medical condition or sickness for which medical advice, a diagnosis, treatment, consultation or medication was recommended or received from a doctor within five years immediately preceding your Secure STM coverage effective date. It also includes symptoms which would have caused a reasonable person to seek diagnosis, care or treatment within five years immediately prior to the coverage effective date. The pre-existing condition limitation may vary by state.

## Do I need to pre-certify any treatment?

You must notify the pre-certification service 10 days prior to a non-emergency hospital admission or surgery and 48 hours (or as soon as reasonably possible) following an emergency admission to the hospital for pre-certification of admission. Failure to pre-certify will result in a benefit reduction of 50%. Pre-certification is not a guarantee of benefits.

## Is there a free look period?

If you are not completely satisfied with the Secure STM coverage, and you have not filed a claim, you may return the policy/certificate of insurance within 10 days and receive a premium refund.

## What are my payment options?

Choose from two convenient payment options.

- You can pay for coverage in **monthly** payments for up to **6 or 12 months at a time**. We accept monthly payments by check, money order, credit card or automatic bank withdrawal. If you select this option, and your need for insurance ends before your coverage period ends, you can cancel at any time through written notification to our Policy Service Department. (The 12 month coverage option is not available in all states.)
- The **single** payment option is ideal if you know the exact number of days coverage is needed. This option has a **special reduced rate** and you only pay for the coverage you need through one, single payment. You can pay in full for any number of days, from a minimum of 30 days to a maximum of 180 days of coverage by check, money order or credit card.

## When does my coverage start?

Your coverage can begin as early as the day following the U.S. postmark stamp on your envelope. If you apply online, coverage can begin the day following your online application submission. You can request a later effective date, but no more than 60 days after the application date. All coverage is subject to approval and payment of the first premium.

## How long will Secure STM coverage last?

Secure STM is specifically designed to fill a temporary insurance need. Coverage stops at the end of the period for which you apply. Depending on the payment option you select, coverage can continue for one to six or up to 12 months. *The 12-month coverage option is not available in all states.*

## Can I continue coverage?

If your need for temporary health insurance continues, you may apply for another Secure STM plan. Your application is subject to eligibility, underwriting requirements and state availability of the coverage. The next coverage period is not a continuation of the previous period meaning, amongst other things, a new pre-existing condition limitation will apply.

## When does coverage terminate?

Coverage ends when: the premium is not paid when due; you enter full-time active duty in the Armed Forces; you become eligible for Medicare; the elected coverage period expires; Standard Security Life Insurance Company of New York determines fraud or misrepresentation has been made in filing a claim for benefits; a dependent ceases to be eligible for coverage as defined in the policy; you cease to be a member of the association; or the group master policy terminates.\*

*\*Applies only to states where association membership is required.*

## What services are not covered?

Following is a partial list of services or charges not covered by Secure STM:\*\*

- Any services that are not medically necessary, as defined in the policy
- Eye exams, eyeglasses, hearing aids
- Dental or orthodontic services
- Over-the-counter medications and prescription drugs
- Treatment of foot conditions
- Conditions resulting from an act of war
- Maternity and newborn treatment prior to discharge, any infertility treatments or sterilization treatments
- Spinal manipulation or adjustment
- Services performed by family members or for which a charge would otherwise not be incurred
- Medical care received outside of the United States, Canada or their possessions
- Services payable by Medicare or Worker's Compensation coverage
- Cosmetic surgery, treatment for acne, hair loss or varicose veins
- Transplant services to the transplant donor
- Routine physical exams and tests, preventive care and immunizations
- Experimental or investigational services
- Learning disorders, attention deficit disorder, hyperactivity or autism
- Mental or nervous disorders, depression or suicide attempt
- Alcohol or drug dependency and disorders
- Obesity treatments
- Sleep disorders
- Participation in school or organized competitive sports or any high risk sport
- Certain surgeries during the first six months

\*\*The limitations and exclusions may vary by state. Please see the Policy/Certificate of Insurance for detailed information about these and other plan limitations and exclusions.

## What is the STM enhancement series discount program?

Included with your coverage is Communicating for America (CA) Healthy Lifestyle Enhancement Series, which provides members with discounts for the following services and or purchases.\*

- Vitamins, herbs and nutritional supplements—25% off already low prices
- Nurse-on-call access to a registered nurse 24 hours a day, seven days a week
- Chiropractic services—10%-30% off at more than 30,000 private chiropractors and alternative health services
- Prescription drugs—15%-60% off on generic drugs and 15%-25% off on brand-name prescriptions at more than 45,000 pharmacies nationwide
- Vision care—20%-60% off exams, eyeglasses and contact lenses through a network of more than 40,000 providers nationwide, including optical retailers such as Pearle Vision®, Target Optical®, Sears Optical® and LensCrafters®
- Dental services—Save 20%-50% on dental expenses from over 62,000 providers nationwide in the **CAREINGTON International** dental network.\*\*

\*\*Discount dental program not available in MT or VT.

*\*The Healthy Lifestyle Enhancement Series is not insurance, nor is it affiliated with Standard Security Life Insurance Company of New York or a part of the STM insurance plan. Access to discount services is administered by CAREINGTON International. Enhancement series benefits may vary by state.*

## About Communicating for America

Communicating for America, Inc.\*\*\* (CA) provides many discounts to its members. Your enrollment as a member of CA is completed upon receipt of the association annual dues. Your membership information will be mailed shortly thereafter.

*\*\*\*CA is not affiliated with Standard Security Life Insurance Company of New York, nor is it a part of the insurance coverage. CA is a 501c5 non-profit association headquartered in Fergus Falls, Minn., providing members valued benefits and savings since 1972. CA membership does not apply to residents of the following states: ID, KS, LA, ME, MD, MN, MT, ND, NH, NV or SD.*

The Secure STM is insured by Standard Security Life Insurance Company of New York (Standard Security), a member of the IHC Group. Standard Security is rated A- (Excellent) by A.M. Best Company, a widely recognized rating agency that rates insurance companies on their relative financial strength and ability to meet their obligations to their insureds. Standard Security has chosen Health Plan Administrators, Inc. (HPA), also a member of the IHC Group, to provide service for your Secure STM plan.

The IHC Group is an insurance organization comprised of Independence Holding Company (NYSE: IHC) and its operating subsidiaries. The IHC Group has been providing life, health and stop-loss insurance solutions for over 25 years. For more information on Independence Holding Company and the IHC Group, visit [www.ihcgroup.com](http://www.ihcgroup.com).

This brochure provides a brief description of the benefits, exclusions and other provisions of the group policy Form SSL-STMP-1104 and individual policy SSL-ISTM-1104. For complete listing, see the Policy/Certificate of Insurance. Benefits may vary by state. Secure STM is not available in all states. Association membership may be required in some jurisdictions.

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**COMPLETE THE FOLLOWING INFORMATION ABOUT YOURSELF:**

Applicant: Name \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_  
 Social Security Number (SSN #) \_\_\_\_\_  
 Occupation \_\_\_\_\_ Telephone \_\_\_\_\_  
 Street Address \_\_\_\_\_  
 \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Billing Address (if different) \_\_\_\_\_  
 \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 E-mail address \_\_\_\_\_

**COMPLETE THE FOLLOWING TO INSURE YOUR SPOUSE AND/OR CHILDREN:**

Spouse: Name \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_  
 SSN # \_\_\_\_\_ Occupation \_\_\_\_\_  
 Child's Name \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ SSN # \_\_\_\_\_  
 Child's Name \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ SSN # \_\_\_\_\_  
 Child's Name \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ SSN # \_\_\_\_\_

**COMPLETE THE FOLLOWING PLAN CHOICES:**

**A. Coverage Effective Date:**  
 Day after US Post Office Date Stamp  
 Later Effective Date: \_\_\_\_\_

**B. Coverage Length:**  
 **Single Payment:** Specify number of days of coverage \_\_\_\_\_ days (minimum 30 days, maximum 180 days) or  
 **Monthly Payment:** Up to 6 Months  
 **Monthly Payment:** Up to 12 Months

**C. Coinsurance:**  80/20 of \$5,000  50/50 of \$5,000

**D. Deductible:**  \$250  \$500  \$1,000  \$2,500

**E. Payment Method:**  Check or Money Order  
 Credit Card  Monthly Automatic Bank Withdrawal

SSL-STM-0506-APP

**ANSWER THE FOLLOWING MEDICAL HISTORY QUESTIONS:**

I understand that any material misstatement or omission of information made on this form will be considered a misrepresentation and may be the basis for later rescission of my coverage and that of my dependents. In the event of rescission or termination for any reason, the Insurer shall have the right to deduct any premium due and unpaid from any claims payable to me or my dependents.

- Will there be any other health insurance in force on the policy date?..... Yes  No
- Is the proposed insured, spouse, or any dependent child now pregnant?..... Yes  No
- Has any person applying for coverage been declined for health insurance for a condition that is still present?..... Yes  No
- Is any proposed insured currently eligible for Medicaid?..... Yes  No
- Are you or any person proposed for coverage over 300 pounds if male or over 250 pounds if female?..... Yes  No
- Within the past 5 years have you or any person proposed for coverage been aware of, received an abnormal test report, been diagnosed with, treated by or received follow-up care with a member of the medical profession or taken medication for:

<input type="checkbox"/> heart disorder including but not limited to heart attack	<input type="checkbox"/> emphysema or COPD (chronic obstructive pulmonary disease)	<input type="checkbox"/> degenerative disc disease or herniated disc
<input type="checkbox"/> stroke	<input type="checkbox"/> diabetes	<input type="checkbox"/> rheumatoid or psoriatic arthritis
<input type="checkbox"/> cancer	<input type="checkbox"/> liver disorder	<input type="checkbox"/> degenerative joint disease of the knees or hips
<input type="checkbox"/> tumor	<input type="checkbox"/> kidney disorder other than stones	<input type="checkbox"/> alcohol abuse or chemical dependency
		<input type="checkbox"/> hemophilia

- Have you or any person proposed for coverage been diagnosed or treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS-related complex, or any other immune system disorder? Answer this question "no" if you have tested positive for HIV but have not developed symptoms of the disease AIDS..... Yes  No
- Has any person proposed for coverage not been a legal resident of the United States for the last 12 consecutive months?..... Yes  No

**NOTE: IF "YES" IS ANSWERED ON ANY QUESTION 1 THROUGH 8, COVERAGE CANNOT BE ISSUED.**

- I agree that coverage will not become effective for any person whose medical history changes prior to coverage approval, such that the person's answer would be "yes" to any of the Medical History questions in this application. If such person is the Applicant, coverage is automatically declined for all persons included in this application.
- I hereby request coverage issued to the group policyholder by the insurer and understand that if the coverage applied for becomes effective, I agree to all terms of the group policy. I understand that health insurance benefits are excluded for pre-existing conditions.
- I understand that the broker who solicited this application was acting as an independent contractor and not as an agent of the Insurance Company. I further acknowledge that the person who solicited this application and upon whose explanation of benefits, limitations or exclusions we relied, was retained by me as my agent, and that such person has no right to bind or approve coverage or alter any of the terms or conditions of the policy.
- I have read this application and have verified that all of the information provided in it is complete, true and correct, and is all within my personal knowledge. I agree to immediately notify the insurer of any changes in any of the information contained in this form which may occur prior to the approval of coverage.
- All information provided will be held in strictest confidence. My personal health information is protected at all times and may only be released with my express written authorization to do so.

**I understand that this coverage will not pay benefits for a disease or physical condition that I now have or have had within 5 years of my application for coverage**

**Signature of Applicant:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**Signature of Spouse:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Fraud Warning:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading may be guilty of insurance fraud and subject to criminal and/ or civil penalties.

*The Credit Card / Automatic Bank Withdrawal request forms and rate calculation instructions are on the reverse side. (SSL Secure STM App 11-07)*

**Arkansas Residents:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**District of Columbia Residents:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**Ohio and Pennsylvania Residents:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

**New Mexico Residents:** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

**Oklahoma Residents:** WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**Tennessee Residents:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.

**If you selected payment by credit card or monthly bank draft, please complete the applicable request form below:**

**CREDIT CARD PAYMENT REQUEST:**

I authorize Health Plan Administrators, Inc. to charge my credit card premium and fees once for Single Pay Option; or the 1st month and each month thereafter for the Monthly Pay Option.

VISA     MASTER CARD     DISCOVER CARD

Account Number \_\_\_\_\_ / \_\_\_\_\_  
Expiration Date

Print Accountholders Name (As it appears on the card.) \_\_\_\_\_

Signature of Cardholder \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Date

**AUTOMATIC CHECK WITHDRAWAL REQUEST:**

**Attach a voided check and a check for the first month premium and fees.**

Your Standard Security Life Insurance Company of New York monthly premium and fees will automatically be withdrawn from your checking account until the term of insurance expires.

Print Name of Bank or Institution \_\_\_\_\_

Address of Bank or Institution \_\_\_\_\_

I request that you pay and charge my account debits drawn from my account by Health Plan Administrators, Inc. to its order. This authorization will stay in effect until I revoke it in writing. Until you receive such notice, I agree that you shall be fully protected in honoring any such debits. I also agree that you may at any time end this agreement by giving 30 days advanced written notice to me. You are to treat such debit as if it were signed by me. If you dishonor such debit with or without cause, I will not hold you liable even if it results in loss of my insurance.

Signature of Premium Payer \_\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Date

**STM RATE CALCULATION INSTRUCTIONS:**

Complete the calculations based on the coverage options you selected on the application. Note, after the 10 day free look period, premiums are not refundable.

	SINGLE PAY (Daily Rates Minimum of 30, Maximum of 180)	MONTHLY PAY (Monthly Rates)
1. Applicant:	\$	\$
2. Spouse:	\$	\$
3. Child:                      Multiply (x) by # ____ of children (Pay for a maximum of 3)	\$	\$
4. Subtotal:                      Add lines 1, 2 and 3	\$	\$
5. Single Payment Option:      Multiply (x) daily rate by # ____ of Days (Minimum of 30 days)	\$	NA
6. Add Monthly Administration Fee:	<b>\$15.00</b>	<b>\$15.00</b>
7. Add Association Dues:      (This is paid once per year.)	<b>\$10.00</b>	<b>\$10.00</b>
8. Final Total:	\$	\$

**FOR AGENTS USE ONLY:**

Include a current copy of your license and the completed HPA License Request Form with your 1st application.

\_\_\_\_\_  
Ziehler Insurance Group, LLC

Agent's Full Name \_\_\_\_\_

HPA # \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone # \_\_\_\_\_ Fax # \_\_\_\_\_

Email **BGA** / **591800000**

GA Name \_\_\_\_\_ HPA # \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone # \_\_\_\_\_ Fax # \_\_\_\_\_ Email \_\_\_\_\_

MGA Name \_\_\_\_\_ HPA # \_\_\_\_\_

Phone # \_\_\_\_\_ Fax # \_\_\_\_\_ Email \_\_\_\_\_

**Make personal check or money order payable to:  
Health Plan Administrators, Inc.**

**Mail your application and initial payment to :  
HPA, Inc. , P.O. Box 15250 Rockford, IL 61132-5250**

**Save time and postage, if you pay by credit card, fax both sides of the application to: 1-815-633-0277**