Perq

A new perspective on employee benefits

Employer-sponsored fixed indemnity benefits for employees with or without major medical

- Reduce employee out-of-pocket with first-dollar benefits
- Enhance a Minimum Essential Coverage plan
- Provide an option for employees not eligible for other group benefits

Perq is a suite of employer group limited-benefit fixed-indemnity insurance plans underwritten by Madison National Life Insurance Company, Inc., a member of The IHC Group. For more information about Madison National Life and The IHC Group, visit www.ihcgroup.com.

This plan is not considered Minimal Essential Coverage (MEC) as defined by the Patient Protection and Affordable Care Act (ACA).

The world of employer-sponsored benefits is changing.

- In some instances it may benefit employers and their employees to move from employer-sponsored benefits to individual medical plans.
- Employers who have chosen to offer Minimum Essential Coverage, or MEC plans, may want to enrich their benefit offerings.
- Employees not eligible for traditional group benefits may be looking for coverage options.

Perq pays fixed benefit amounts for covered medical events such as hospitalization, surgery or outpatient services. All of the plans also include a critical care benefit paid in a lump sum upon the diagnosis of a covered illness such as life-threatening cancer, heart attack or stroke.

Employers can choose among six unique plans to find one best suited to the needs of their employees.

Critical Care

The costs associated with a serious condition such as a heart attack or cancer have the potential to stress family finances. This plan provides a one-time $25,000 critical care benefit that is paid in a lump sum at the first diagnosis of a specified health event. Critical Care is the only plan that also offers a preventive care benefit.

Ally

This plan provides carefully selected benefits to complement medical care with higher price tags. Ally has the highest hospital admission and confinement fixed-indemnity benefit levels in the Perq portfolio, and provides inpatient surgical, accident* and critical care benefits.

Base

The Base plan provides benefits for covered accidents, hospital admission and doctor office visits. A one-time critical care benefit of $5,000 is also included. The Base plan pairs well with a Bronze or Silver ACA health plan.

Base+

Base+ extends Base coverage to include inpatient confinement, mental illness, substance use and an emergency room visit. Doctor office visits and critical care benefits are included with the Base+ plan.

Base Pro

With higher fixed-benefit amounts and additional coverage, Base Pro broadens the coverage provided in the two previous plans. Base Pro includes benefits for inpatient and outpatient surgery, along with outpatient lab, X-ray and advanced studies. Base Pro may be a valuable option for employees without major medical coverage or those waiting for the next open enrollment period to purchase a major medical plan.

Annex

Designed to be paired with an employer-sponsored Minimum Essential Coverage plan, Annex provides fixed-benefit amounts for hospitalizations and surgeries, as well as coverage for common occurrences like lab tests and office visits. Annex also includes a critical care benefit.

Provider Choice: All of our plan levels include the freedom for employees to choose the provider that can offer the best treatment option.

*The accident benefit is not available in Florida, Nebraska, New Mexico, South Dakota, Tennessee or Texas.

Perq Plan Options

Select from the following six plan options. **Additional benefit details are available on the following page.**

	Critical Care	Ally	Base	Base+	Base Pro	Annex
First-day hospital admission	Not included	$2,000	$200	$500	$1,000	$1,000
Hospital inpatient confinement	Not included	$500	Not included	$200	$300	$300
Inpatient mental illness	Not included	Not included	Not included	$100	$200	Not included
Inpatient substance use	Not included	Not included	Not included	$100	$200	Not included
Emergency room	Not included	Not included	Not included	$100	$200	$200
Accident medical expense*	Not included	$1,000	$1,000	$1,000	$1,000	$1,000
Doctor office visit	Not included	Not included	$50	$50	$50	$50
Critical care	$25,000	$10,000	$5,000	$5,000	$10,000	$5,000
Outpatient lab	Not included	Not included	Not included	Not included	$30	$50
Outpatient X-ray	Not included	Not included	Not included	Not included	$125	Not included
Outpatient advanced studies	Not included	Not included	Not included	Not included	$500	Not included
Inpatient surgery	Not included	Not included	Not included	Not included	$500	$1,500
Inpatient surgical anesthesia	Not included	Not included	Not included	Not included	$125	$375
Outpatient surgery	Not included	Not included	Not included	Not included	$250	Not included
Outpatient minor surgery	Not included	Not included	Not included	Not included	$75	Not included
Outpatient surgical anethesia	Not included	Not included	Not included	Not included	$63	Not included
Preventive care	$50	Not included	Not included	Not included	Not included	Not included

*The accident benefit is not available in Florida, Nebraska, New Mexico, South Dakota, Tennessee or Texas.

Fixed-indemnity benefit descriptions

The benefit amounts displayed in the charts and the maximums indicated below apply per insured person.

First-day hospital admission: Maximum benefit of one day per calendar year
The benefit is paid in a single sum for a hospital admission (first day of an inpatient hospital confinement).

Hospital inpatient: Maximum benefit of 10 days per calendar year
Benefits are paid as a fixed amount for each day of hospital inpatient confinement if a charge is made for room and board and the entire duration of the confinement is recommended and approved by a physician.

Inpatient mental illness disorders: Maximum benefit of 10 days per calendar year
Benefits are paid as a fixed amount for each day of inpatient confinement in a hospital or licensed institution that provides treatment for mental illness disorders. Mental illness disorder services are not payable under any other benefit within the Perq plan.

Inpatient substance use: Maximum benefit of 30 days per calendar year
Benefits are paid as a fixed amount for each day services are received as an inpatient in a facility accredited by the Joint Commission on accreditation of hospitals as a program for the treatment of alcoholism, substance use or chemical dependency. Inpatient detoxification is included in this benefit. Substance use services are not payable under any other benefit within the Perq plan.

Emergency room visit (illness only): Maximum benefit of one day per calendar year
The benefit is paid in a single sum when an insured person has an emergency room visit due to a non-occupational illness. Services must be provided on an emergency basis and cannot result in an inpatient confinement. The emergency room visit must occur within 72 hours of the onset of symptoms of the illness.

Doctor office visit: Maximum of three days per calendar year for Base+, Base Pro and Annex, and a maximum of two days per calendar year for Base
Benefits are paid as a fixed amount per day when an insured person visits the doctor's office. Routine exams, preventive care and immunizations are not included in this benefit.

Critical care: Maximum benefit of a one-time lump-sum payment
This benefit is paid upon the first occurrence of a specified health event including heart attack, stroke, life-threatening internal cancer, end-stage renal failure, major organ transplant, permanent paralysis or heart by-pass. The diagnosis must the first in the insured person's lifetime and be made by a doctor with documentation supported by clinical, radiological, histological and laboratory evidence. Please refer to the Policy for a detailed definition of each covered specified health event. Benefits are available after an initial 30-day waiting period. Once the benefit has been paid, no further critical care benefits are available under the Policy for the insured person.

A pre-existing condition limitation applies to the critical care benefit. Benefits are not payable in connection with a pre-existing condition during the initial 12 months the insured person has been covered under the plan. A pre-existing condition is any illness or injury for which any diagnosis, medical advice, treatment or prescription medication had been provided or taken in the 12 months immediately preceding the effective date of the insured person's coverage.

Outpatient diagnostic lab test: Maximum benefit of three days per calendar year
Benefits are paid as a fixed amount per day when an insured person receives outpatient lab tests. The benefit includes reading of the lab test. Routine and preventive lab tests are not covered under this benefit.

Outpatient diagnostic X-ray: Maximum benefit of one day per calendar year
The benefit is paid as a single sum when an insured person receives an outpatient X-ray. The benefit includes reading of the X-ray. Routine and preventive X-rays are not covered under this benefit.

Outpatient diagnostic advanced studies: Maximum benefit of three days per calendar year
Benefits are paid as a fixed amount per day when an insured person receives an outpatient advanced study. The benefit includes reading of the study. Advanced studies include but are not limited to angiogram, computer tomography scan (CT) and magnetic resonance imaging (MRI). Routine and preventive advanced studies are not covered under this benefit.

Inpatient surgery:* Maximum benefit of one day per calendar year
The benefit is paid in a single sum when an insured person has surgery while confined as an inpatient.

Inpatient anesthesiology: Maximum benefit of one day per calendar year
The benefit is paid in a single sum when an insured person receives anesthesia for a surgery performed inpatient.

Outpatient surgery:* Maximum benefit of one day per calendar year
The benefit is paid in a single sum when an insured person has surgery at an outpatient facility.

Outpatient minor surgery:* Maximum benefit of one day per calendar year
The benefit is paid in a single sum when an insured person has an outpatient minor surgical procedure at an outpatient facility. A minor surgical procedure includes but is not limited to incision and drainage, small lesions, excision of benign lesions, surgical injections, application of casts, and catheterizations.

Outpatient anesthesiology: Maximum benefit of one day per calendar year
The benefit is paid as a single sum when an insured person receives anesthesia for a surgery performed at an outpatient facility.

Preventive care: Maximum benefit of one day per calendar year
The benefit is paid as a single sum for a routine examination, immunization or screening provided by a doctor. The benefit is available for a service including but not limited to a routine physical examination, routine gynecological or cytological screening, a prostate-specific antigen test, a mammogram, an immunization, or a routine chest X-ray or lab service. Please refer to the Policy for a complete list of well-baby, well-child and adult preventive services.

*The inpatient, outpatient and minor surgical benefits are not available for dentistry or oral surgery except for the excision of impacted third molars, reduction of fractures, or dislocation of the jaw.

Accident medical expense benefit

Maximum benefit of up to $1,000 per accident
Benefits are paid based on the lesser of actual expenses or $1,000 per accident when an unexpected event causes loss or injury that is not due to any fault or misconduct by the insured person. Initial charges for the covered injury must be incurred within 90 days of the date of the injury and while the person is covered under the Perq plan. The per-accident benefit is available for any number of accidents, and benefits are paid for up to 52 consecutive weeks from the date of the accidental bodily injury. (This accident benefit is not available in Kansas, Nebraska, Ohio, South Dakota, Tennessee or Texas.)

Eligibility

Employer groups
A business with at least five participating employees is eligible for a Perq group limited medical plan. If 1099 employees are considered eligible employees, a minimum of two W-2 employees must participate in coverage for the group to be eligible.

Employees and dependents
An adult employee must be 18-99 years of age. The definition of an eligible employee, as determined by the employer, may include full-time, part-time, temporary, contract and seasonal employees. An eligible employee must be compensated for services on a regular periodic wage or salary that is subject to FICA and Federal tax income withholding by the employer. Or, 1099 employees can be considered eligible if they obtain 80 percent of their income from the employer group and provide a recent 1099 form. Coverage is available to United States residents. A legal resident lives in the United States on a full-time basis and is a citizen, or has been issued a green card or permanent visa.

A spouse under the age of 99 and unmarried dependent children under age 26 are eligible for coverage.

Enrollment

Initial enrollment period

Initial enrollment is the period of time during which an employee or dependent are first eligible to enroll under the Policy. After initial enrollment, employees or dependents may enroll in coverage or only during the annual open enrollment period, unless a special enrollment period applies. Benefit options may only be changed during the annual open enrollment period.

Open enrollment period

Open enrollment is an annual period during which an employee and his/her dependents are eligible to enroll in coverage or change benefit plan options.

Late enrollee

If an employee submits an application after the initial enrollment period, and does not qualify for a special enrollment period, he/she is considered a late enrollee and must wait until the following open enrollment period.

Special enrollee

If employees or dependents do not enroll during the initial enrollment period, they may enroll in coverage outside of an open enrollment period and not be considered a late enrollee if they meet the following criteria:

1. At the time of the initial enrollment period, the employee or dependent was covered under another health insurance policy and lost that coverage for one or more of the reasons listed below:
   - dependent termination of employment;
   - employee or dependent termination of eligibility, or change from full-time to part-time status;
   - termination of the other policy's coverage due to death of a spouse;
   - legal separation or divorce; or
   - termination of the employer's contribution toward coverage.
2. A person becomes a dependent of an employee or an employee's spouse through marriage, birth, adoption or placement for adoption.

For both special enrollment criteria, an enrollment application for coverage must be received within 31 days of the loss of coverage or family event.

Coordination of benefits

The Perq employer group limited medical fixed-indemnity Policy does not coordinate benefits with other insurance coverage.

Termination of an eligible employee's coverage

Coverage for an eligible person shall automatically terminate on the earliest of the following dates: 1) the date of termination of the Policy; 2) the date of termination of any section or part of the Policy with respect to insurance under such section or part; 3) the last day of the month in which you are no longer eligible for insurance under the Policy; 4) the date you or the Policyholder fail to pay the required premium; 5) the date you enter the armed forces of any country, state or international organization, other than for reserve duty of 30 days or fewer or as provided under the Statement of Uniform Services Employment and Reemployment Rights Act of 1994 provision; or 6) the date you are no longer in an eligible class under the Policy.

Termination of a dependent's coverage

Coverage for an eligible dependent shall terminate on the earliest of the following dates: 1) the date of termination of the Policy; 2) the date of termination of any section or part of the Policy with respect to insurance under such section or part, including the date that insurance coverage for dependents is no longer offered under the Policy; 3) the date your insurance terminates; 4) the date you or the Policyholder fail to pay the required premium; 5) the last day of the month in which a dependent ceases to meet the definition of a dependent; 6) the date the dependent enters the armed forces of any country, state or international organization, other than for reserve duty of 30 days or fewer or as provided under the Uniform Services Employment and Reemployment Rights Act of 1994; 7) with respect to an eligible person's dependent spouse, the premium due date coinciding with, or next following, the date on which the eligible person is divorced or legally separated from such spouse; or 8) the date of the dependent's death.

Exclusions

The following is a list of the Perq group limited medical Policy exclusions. Please consult the Policy for a complete description of the charges, services and supplies excluded from coverage. Except as specifically provided for in the Policy, Schedule of Benefits or Benefit Riders, the plan does not provide any benefits for the following charges, treatment, confinements, visits, services, or supplies for or related to:

- Any services (including preventive services) which are not medically necessary, except as specified in the Preventive Care Fixed Indemnity Benefit, if included in the Schedule of Benefits
- Treatment, services or supplies which are not due to a sickness or injury, or are not recommended by a doctor
- Treatment, services or supplies for which no charge is made or for which the insured person is not required to pay
- Treatment, services or supplies provided by a government-owned or -operated facility, or by government-employed healthcare providers, unless the insured person is legally required to pay the charges incurred
- Hospital and doctor charges for weekend admission occurring between noon on Friday and noon the following Sunday for non-emergency procedures, unless medically necessary or surgery is scheduled for the next day
- A sickness or injury which arises out of or in the course of any employment for wage or profit, or for which the insured person has or had a right to recovery under any worker's compensation or occupational disease law
- Physical or psychological examinations required by any third party
- An illness or injury incurred while on active duty with the military
- A sickness or injury resulting from war or any act of war (declared or undeclared), or participation in a riot or insurrection
- A sickness or injury incurred during the commission or attempted commission of a crime or felony, while engaged in an illegal act, or while imprisoned
- Treatments, services or supplies for any loss sustained, incurred due to, or contracted as a consequence of an insured person being intoxicated or being under the influence of any illegal drug, unless administered by a doctor and taken in accordance with the prescribed dosage
- Treatments, services or supplies to improve the appearance or self-perception of an insured person that do not restore a bodily function including, but not limited to cosmetic or plastic surgery, hair loss or skin wrinkling, or the complications of any such treatment
- Treatment, services or supplies for breast augmentation, the removal of breast implants, or breast reduction unless medically necessary due to a sickness
- Surgery to correct refractive errors, such as radial keratotomy or radial keratectomy, routine eye exams, glasses, visual therapy, or contact lenses
- Routine hearing exams to assess the need for, or change to, hearing aids and the purchase, fittings or adjustments of hearing aids
- Penile implants and fertility and sterility studies; treatment, services or supplies to restore or enhance fertility; voluntary sterilization, including vasectomy or tubal ligation, or to reverse sterilization
- Impregnation techniques such as artificial insemination or in vitro fertilization
- Voluntary abortion or complications of voluntary abortion, except if the life of the mother would be in danger if the fetus were carried to term
- Mental illness disorders, except as specified in the Inpatient Mental Illness Disorders Indemnity Benefit, if such benefit is included in the Schedule of Benefits
- Substance abuse, except as specified in the Inpatient Substance Abuse Indemnity Benefit if such benefit is included in the Schedule of Benefits
- Treatment, services or supplies to eliminate or reduce a dependency on or an addiction to tobacco
- Marriage or family counseling, recreational therapy, equine therapy, educational therapy, social therapy, or sex therapy
- Sexual reassignments or sexual dysfunctions or inadequacies
- Meridian therapy (acupuncture)
- Treatment, services or supplies related to paring or removal of corns, calluses, bunions or toenails (other than partial or complete removal of nail roots)
- Treatment, services or supplies related to the feet by means of posting or strapping, range-of-motion studies, or orthotics
- Treatment, services or supplies for obesity, morbid obesity, weight reduction, or any complications resulting from such weight-reduction surgeries
- Treatment, services or supplies received from a doctor or other provider if such person ordinarily resides in your household, is a close relative, or is the Policyholder
- Custodial care, regardless of who prescribes or renders such care
- Treatment, services or supplies received or purchased outside the United States unless the charges are incurred while traveling on business or for pleasure, for a period not to exceed 90 days, and the charges are incurred for an emergency, provided the treatment, services or supplies used in connection with the emergency are approved for use in the United States
- Telephone and email consultations, missed appointment fees, fees for completing claim forms, and fees related to the costs of obtaining medical records as necessary under the Required Information provision
- Treatment, services or supplies for complications of conditions that are not covered under the Policy
- Outpatient prescription medications
- Treatment, services or supplies related to the teeth, gums and any associated structures except for tumors, cuts and injuries; the prevention or correction of teeth irregularities and malocclusion of jaws; and dental implants, regardless of the cause
- Treatment, services or supplies as the result of prognathism, retrognathism, microtrognathism, or any treatment, services or supplies to reposition the maxilla (upper jaw) mandible (lower jaw), or both maxilla and mandible, unless due to injury that occurs while covered under the Policy to sound, natural teeth, provided that such treatment is received within 12 months following the date of injury
- Treatment, services or supplies provided for temporomandibular joint (TMJ) dysfunction
- Physical, speech and occupational therapy
- Hospice care or home healthcare

About Madison National Life Insurance Company, Inc.

Madison National Life Insurance Company, Inc. was founded in 1961 and is domiciled in Wisconsin and licensed to sell insurance products in 49 states, the District of Columbia, Guam, American Samoa and the U.S. Virgin Islands. Its core products and services are group life and disability income and specialty health insurance. It is rated A- (Excellent) for financial strength by A.M. Best Company, a widely recognized rating agency that rates insurance companies on their relative financial strength and ability to meet policyholder obligations (an A++ rating from A.M. Best is its highest rating).

About The IHC Group

Independence Holding Company (NYSE: IHC) is a holding company that is principally engaged in underwriting, administering and/or distributing group and individual disability, specialty and supplemental health, pet, and life insurance through its subsidiaries since 1980. The IHC Group owns three insurance companies (Standard Security Life Insurance Company of New York, Madison National Life Insurance Company, Inc. and Independence American Insurance Company) and IHC Specialty Benefits, Inc., which is a technology-driven insurance sales and marketing company that creates value for insurance producers, carriers and consumers (both individuals and small businesses) through a suite of proprietary tools and products (including ACA plans and small group medical stop-loss). All products are placed with highly rated carriers.

"IHC" and "The IHC Group" are the brand names for plans, products and services provided by one or more of the subsidiaries and affiliate member companies of The IHC Group ("IHC Entities"). Plans, products and services are solely and only provided by one or more IHC Entities specified on the plan, product or service contract, not The IHC Group. Not all plans, products and services are available in each state.

Important Information

This brochure provides a very brief description of the important features of the Perq plan. This brochure is not the Policy or Certificate of Coverage and only the actual Policy or Certificate provisions will control. The Policy itself sets forth, in detail, the rights and obligations of both the policyholder and the insurance company. It is, therefore, important that you READ THE POLICY and CERTIFICATE CAREFULLY. For complete details, refer to the Group Limited Benefit Fixed Indemnity Insurance Certificate of Coverage (form MNL LMB CERT 0115).

THIS IS NOT QUALIFYING HEALTH COVERAGE (MINIMUM ESSENTIAL COVERAGE) THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.

THE TERMINATION OR LOSS OF THIS POLICY DOES NOT ENTITLE YOU TO A SPECIAL ENROLLMENT PERIOD TO PURCHASE A HEALTH BENEFIT PLAN THAT QUALIFIES AS MINIMUM ESSENTIAL COVERAGE OUTSIDE OF AN OPEN ENROLLMENT PERIOD.

THE IHC GROUP