

What is Liberty STM?

You don't want to go without health insurance for even a short time. It's just too risky, considering the high cost of medical care these days. That's why HPA offers a very affordable Short-Term Major Medical insurance plan designed specifically for people and families needing temporary coverage from 30 days to 180 days. If you don't have health insurance, consider applying for The Competitor Liberty Short Term Medical (STM). It protects you and your family against the financial hardship of unexpected medical expenses.

How benefits are covered?

The benefit options for covered expenses are per insured person per coverage period.

First, you meet your deductible. Choose from four options: \$250, \$500, \$1,000 or \$2,000

Then Liberty STM pays 80% of the next \$5,000 of covered expenses

After this, Liberty STM pays 100% of covered expenses up to your lifetime maximum of \$1 million

What payment options are available?

There are two payment options available. If you choose the Single Payment option, you pay for your coverage up front. You can pay for 30, 60, 90, 120, 150 or 180 days of coverage. If you choose the Monthly Payment option, you pay for your coverage in monthly installments, up to 6 months. When you choose the Monthly Payment option, if your need for short term medical insurance ends before the 6 month period is over, you can stop the coverage by not making any more monthly payments. You can pay by credit card, auto bank withdrawal or check.

Is there a free look period?

Once you receive your Policy, carefully review all information. If you are not satisfied for any reason, return the Policy (within 10 days of receipt) with your written request for cancellation to HPA. Coverage will be cancelled as of the effective date and you'll receive a full refund (less the administration fee) — no questions asked.

Can I continue coverage?

Liberty STM is issued on a temporary need and terminates at the end of the period applied for. If the need for temporary health insurance continues, you may apply for another new STM* coverage period. Your application is subject to the eligibility and underwriting requirements. Furthermore the coverage is not continuous. Any condition that incurred expense during the last coverage period will be treated as a Pre-Existing Condition, and excluded under the next coverage period. Applicants over the age of 64 are not eligible to re-apply for coverage.

**Only if an STM Plan is available in your resident state at that time; plan benefits, premium and features may vary. Not available in CO, GA or MN (cannot exceed 185 days).*

Is there coverage after termination?

If an Insured incurs medical expenses after the Termination Date from a covered Injury or Sickness for which benefits were paid before the Termination Date, Covered Medical Expenses for such Injury or Sickness will continue to be paid as long as the condition continues: 1.) When Hospital Confined on the Termination Date, not to exceed 90 days after the Termination Date; or 2.) When not Hospital Confined on the Termination Date, not to exceed 30 days after the Termination Date. The Insured Person must: a.) have met his or her Deductible during the Benefit Period; and b.) be being treated for complications of or follow-up treatment for an Injury or Sickness which commenced during the Benefit Period.

The total payments made in respect of the Insured for such condition both before and after the Termination Date will never exceed the Maximum Benefit. After this "Extension of Benefits After Termination" provision has been exhausted, all benefits cease to exist, and under no circumstances will further payments be made.

About the Insurance Company

Liberty Short Term Major Medical, under Policy Series STP-01 is underwritten by The Chesapeake Life Insurance Company (a UICI Company). Founded in 1956, The Chesapeake Life Insurance Company has protected millions of insureds and earned an "A-Excellent" rating from A.M. Best Company (as of 10/22/2002).

About the Administrator

HPA, Inc. is a fully licensed, full service Third Party Administrator transacting business worldwide. HPA is a third generation company dating back to 1939. Industry leading services include: professional customer service, state-of-the-art billing and reporting.

This brochure provides general information about Liberty Short Term Major Medical Insurance Plan. It is not a contract. The complete terms, provisions and conditions of coverage are described in the Policy issued by The Chesapeake Life Insurance Company and may vary by state.

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The Competitor

Liberty II STM

Short Term Major Medical Insurance

THE IDEAL SOLUTION FOR

- People between jobs
- New employee waiting periods
- Part-time or temporary employees
- Dependent child coverage
- College students or new graduates

SPECIAL FEATURES

- Coverage for prescription drugs
- Freedom to choose any doctor or hospital
- Convenient payment options

For use in: CO, CT, GA, ID, IN, KS, MD, MN, NV, OR, SD, WA

Underwritten by: The Chesapeake Life Insurance Company, a UICI Company
Rated A- (Excellent) by A.M. Best Reports

Administered by: Health Plan Administrators, Inc., Rockford, IL
Marketed by:

What medical expenses are covered?

Services of licensed Physicians, Registered Nurses, Surgeons, Assistant Surgeon, and Anesthetist

Prescription drugs up to \$500 and injections

X-rays and laboratory tests

Ground ambulance service

Pre-admission testing

Hospital emergency room services

Hospital services including outpatient department or ambulatory surgical facility services

Hospital room and board and general nursing care while confined in a semi-private room

Intensive care

Chemotherapy and radiation therapy

Intensive, cardiac, burn or other specialized care unit

Physiotherapy

Braces and appliances

Detailed information about these and additional Covered Expenses is listed in the Policy. Not all covered expenses apply in every state, and additional expenses might be covered in your state. Consult the Policy for provisions in your state.

How do I apply?

To apply for Liberty STM insurance, simply:

- 1.) Complete and sign the attached application.
- 2.) Attach a check in the amount of the total premiums for the coverage you've selected (30, 60, 90, 120, 150 or 180 days). Monthly payment is available for up to 6 months. Just attach your check for 1 month premium and fees, and complete the monthly payment section on the Rate Calculation Sheet.
- 3.) Mail the completed application and payment to:

Health Plan Administrators, Inc.
P.O. Box 15250
Rockford, IL 61132-5250
www.hpa-inc.com
1-800-277-3323

Who is eligible to apply?

You and your spouse (to 64 years and 11 months) and your unmarried dependent children (between age 15 days to 19 or 23 if a full-time student) that live with you may apply for coverage. To be considered for coverage, proposed Insureds must not: a.) have other hospital, major medical, health, governmental, or medical insurance coverage in force that will not terminate prior to the Effective Date of the plan; b.) be pregnant or the expectant father of an unborn child on the Effective Date; c.) have been declined for insurance due to health reasons; or d.) have received consultation or treatment, within the past five years, for any conditions identified on the application.

When does my coverage start?

Your coverage begins at 12:01 a.m. (where you live) on the Policy date listed on the application or the day after the postmark date on your application envelope, whichever is later. If your envelope is not postmarked by the U.S. Postal Service or the postmark is illegible, your Policy date will be the later of the date you request or the date HPA, Inc. receives the application.

Is there a Pre-Existing Condition limitation?

Yes, Pre-Existing Conditions are not covered. A Pre-Existing Condition is defined as a condition: 1.) for which the Insured received medical treatment or advice from a Physician within the five (5) year period immediately preceding the Effective Date of coverage; or, 2.) which produced signs or symptoms within the five (5) year period immediately preceding the Effective Date of Coverage.

The signs or symptoms must have been significant enough to establish manifestation or onset by one of the following tests: (a) The signs or symptoms would have allowed one learned in medicine to make a diagnosis of the disorder; or (b) The signs or symptoms should have caused an ordinarily prudent person to seek diagnosis or treatment.

What is a usual and customary charge?

This plan provides benefits based on Usual and Customary Charges, defined as the lesser of: 1.) the actual charge; 2.) what the provider would accept for the same service or supply in the absence of insurance; or 3.) the reasonable charge as determined by the Company, based on factors such as: a.) the most common charge for the same or comparable service or supply in a community similar to where the service or supply is furnished; b.) charging protocols and billing practices generally accepted by the medical community or specialty; or c.) inflation trends by geographic region.

When does coverage terminate?

Coverage will terminate on the earlier of: 1.) the Benefit Period termination date; 2.) the last day of the period through which the plan cost is paid; 3.) the date the Insured Person attains age 65 or becomes Medicare eligible; or 4.) if a dependent child, the date on which his/her eligibility terminates.

What are the plan exclusions and limitations?

Unless specifically listed as a Covered Expense in the Policy (or as may be provided by an Amendment Rider), no benefits will be paid for loss or expense caused by, contributed to, or resulting from: • A Pre-Existing Condition, • Addiction and codependency; • Biofeedback; • Complications of any treatment or surgery for an excluded service or procedure; • Congenital conditions; circumcision; • Cosmetic procedures; • Custodial care or rehabilitation care service and supplies; • Dental treatment; • Elective surgery, treatment and abortion; • Expenses incurred outside of the United States, its possessions, territories or Canada; • Health services and supplies from or at a health spa or similar facility; • Hearing examinations, hearing aids, eye exams, glasses or contacts; • Hypnosis; patient controlled analgesia (PCA); • Immunizations services and supplies; • Injury caused by, contributed to, or resulting from the use of alcohol, intoxicants, hallucinogens, illegal drugs, or any drugs or medications that are not taken in the dosage or for the purpose prescribed by the Insured Person's Physician; • Injury or Sickness for which benefits are paid or payable under any Workers' Compensation or Occupational Disease Law or Act, or similar legislation; • Injury or Sickness to the extent that benefits are paid by Medicare or any other government law or program (except Medicaid); or medical coverage under any automobile insurance; • Lipetomy services and supplies related to surgical or suction-assisted lipectomy; • Mental and behavioral problems; • Normal pregnancy, maternity services or supplies; • Organ transplants; • Pain services; • Participation in a riot or civil disorder; commission of or attempt to commit a felony or fighting; • Prescription Drug Services – no benefits will be payable for: a.) Therapeutic devices or appliances, including hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use; b.) Contraceptives; c.) Immunization agents, biological sera, blood or blood products administered on an outpatient basis; d.) Drugs labeled, Caution – limited by federal law to investigational uses or experimental drugs; e.) Products used for unapproved cosmetic indications; f.) Drugs used to treat or cure baldness, and anabolic steroids used for body building; g.) Anorexia – drugs used for the purpose of weight control; h.) Fertility agents or sexual enhancement drugs; i.) Growth hormones; or j.) Refills in excess of the number specified or dispensed after one (1) year of date of the prescription; • Psychotherapy; • Rehabilitation services; • Reproductive/infertility services; • Research for examinations relating to research studies; • Routine Newborn infant care; • Routine physical examinations and routine testing; preventive testing or treatment; screening exams or testing in the absence of Injury or Sickness, except as specifically provided in the Policy; • Services rendered or supplies purchased from your immediate family; • Skydiving, parachuting, hang gliding, glider flying, parasailing, sail planning, bungee jumping, or flight in any kind of aircraft (except while riding as a passenger on a regularly scheduled flight of a commercial airline); • Sleep disorders, supplies, treatment, or testing related to sleep disorders; • Suicide or attempted suicide while sane or insane; intentionally self-inflicted Injury; • Supplies, except as specifically provided in the Policy; • Surgical breast reduction, breast augmentation; • Taxes; provider administrative expenses; • Treatment in a Government hospital; • Treatment or removal or repair of tonsils or adenoids, except for a Medical Emergency; • Sclerotherapy for veins of the extremities; • Services, supplies or treatment of acne, acupuncture, allergy (including testing); Nasal, sinus surgery, deviated nasal septum, skeletal irregularities of jaws; • War or any act of war, declared or undeclared; or while in the armed forces of any country; • Weight management services; • Vision services and supplies.

Detailed information about these and other plan limitations and exclusions are listed in the Policy and may vary by state. **The Policy is deemed amended to conform to the minimum requirements of the laws of the state in which coverage is issued.**



Liberty II STM (GEORGIA)

The Chesapeake Life Insurance Company
Short Term Medical Insurance Application
THIS POLICY IS NON-RENEWABLE

INSURED'S NAME (Print last, first., Middle)

SEX / BIRTHDATE (M-D-Y) / SOCIAL SECURITY NUMBER

RESIDENCE / STREET ADDRESS

CITY / STATE / ZIP CODE

PHONE NUMBER / E-MAIL ADDRESS

SPOUSE'S NAME (If to be insured)

SEX / BIRTHDATE (M-D-Y) / SOCIAL SECURITY NUMBER

CHILD NAME (Full name if to be insured) BIRTHDATE (M-D-Y)

CHILD NAME (Full name if to be insured) BIRTHDATE (M-D-Y)

CHILD NAME (Full name if to be insured) BIRTHDATE (M-D-Y)

ANSWER THE FOLLOWING QUESTIONS COMPLETELY AND ACCURATELY:

- Do you or any applicant to be insured have any hospital, major medical, group health, government or medical insurance coverage in force that will not terminate prior to the effective date of this coverage? YES NO
a) Will this plan replace existing coverage? YES NO (If Yes, the applicable replacement form must be signed.)
b) When will existing coverage expire? ____/____/____
- To your knowledge, are you, your spouse, or any dependent (whether listed on the application or not) now pregnant or are you an expectant father of any unborn child? YES NO
- Have you or any person to be insured been declined for insurance due to health reasons? YES NO
- Have you or any applicant to be insured in the past five years received any treatment, medications, or medical or surgical advice for heart or circulatory system disorder, including heart attack or chest pain, stroke, diabetes, cancer or tumor, leukemia or any blood disorder, alcohol or drug abuse or dependency, immune system disorder or been tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection? YES NO

NOTE - The plan cannot be issued if YES is answered on any of the above questions, 2, 3 or 4. Under no circumstances can coverage become effective prior to the date this application is signed and the day after the envelope is postmarked.

stp-ind-app-GA

COVERAGE INFORMATION

A. Coverage Effective Date*:

- Day after the U.S. Postmark Date Stamp
- Later Effective Date: _____

B. Deductible per Person (choose one):

- \$250 \$500 \$1,000 \$2,000

C. Select Coverage:

- Pay Monthly (30 days up to a 180 day maximum)
- Single Payment (indicate the number of days below)
 - 30 days 60 days 90 days
 - 120 days 150 days 180 days

D. Payment Method:

- Check/Money Order
- Credit Card
- Monthly Automatic Bank Withdrawal

*Coverage cannot be effective prior to termination of any other insurance coverage in force.

AGREEMENT - I have read this application and represent that each of the above statements and answers are complete and true to the best of my knowledge and belief, and I understand that the answers to the above questions shall be the basis of any coverage issued, and that any untrue answer may operate to void this coverage.

Any material misstatement or omission of information made on this form will be considered a misrepresentation and may be the basis of claim denial or later rescission of coverage issued on the basis of the above information. Such rescission and termination of coverage will apply to the Named Insured and his or her Dependents without liability to the Company. Coverage is not effective until approved and issued by The Chesapeake Life Insurance Company.

I understand that the Company will not pay benefits during the term of coverage for loss due to any medical condition or illness I or any person to be insured may now have or had.

RIGHT TO EXAMINE POLICY FOR 10 DAYS:

If the named Insured is not satisfied, return the Policy to the Administrator within 10 days after it is delivered. All premiums will then be refunded. If the Policy is returned, it shall be void from the beginning. The parties shall be in the same position as if no Policy had been issued.

NO RECOVERY FOR PRE-EXISTING CONDITIONS:

No Benefits will be provided during the term of the Policy for any Pre-existing Condition as defined in the Policy.

I hereby authorize any insurance company, organization, employer, hospital, physician, pharmacist, educational institution, or other person to release to the Company such information as it may require to process claims.

APPLICANT SIGNATURE _____ / _____ / _____ DATE

The Chesapeake Life Insurance Company

CREDIT CARD PAYMENT REQUEST:

I authorize Health Plan Administrators, Inc. to bill my:

VISA MC DISCOVER CARD

Monthly for up to 180 days of premium and fees

For # _____ days of Single Payment premium and fees

ACCOUNT NUMBER _____ / _____ EXP. DATE

PRINT ACCOUNT HOLDERS NAME (As it appears on the card.) _____

SIGNATURE OF CARDHOLDER _____ / _____ DATE

AUTOMATIC CHECK WITHDRAWAL REQUEST:

By selecting automatic check withdrawal, your Chesapeake Life Insurance Company monthly premium and fees will automatically be withdrawn from your checking account until the term of insurance expires. **Complete the form below and include a voided check, with the STM Application and a check or money order for the initial premium due.**

PRINT NAME OF BANK OR INSTITUTION _____

ADDRESS _____

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 and to Health Plan Administrators, Inc. 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

FOR AGENTS USE ONLY:

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

AGENTS FULL NAME _____

SOCIAL SECURITY # _____ / _____ HPA # _____

ADDRESS _____ CITY _____ ST _____ ZIP CODE _____

PHONE # _____ FAX # _____ E-MAIL ADDRESS _____

GA NAME _____ HPA # _____

ADDRESS _____ CITY _____ ST _____ ZIP CODE _____

PHONE # _____ FAX # _____ E-MAIL ADDRESS _____

MGA NAME _____ HPA # _____

MAKE CHECK PAYABLE AND MAIL TO:
HPA, INC.
P.O. BOX 15250
ROCKFORD, IL 61132-5250



**Liberty II STM
CALCULATION INSTRUCTIONS**

- Find your age (and spouse's age) on the **30 DAY RATE** chart.
- Go to the column for the deductible you have chosen enter the rates on lines 1 and 2.
- Enter the per child rate (if child coverage requested) on line 3, enter the number of children, multiply and enter the amount on line 3.
- Subtotal lines 1, 2, 3 and enter subtotal on line 4.
- Locate your state and zip code on the **STATE ZIP CODE AREA FACTOR CHART**. Enter your zip code area factor in the space on line 5, multiply the subtotal on line 4 by the area factor and enter amount on line 5.
- Add the UCSA Discount Card Monthly Dues of 12.50 on line 6 and enter subtotal on line 7. (This benefit is optional.)
- If Single Payment coverage selected, enter the number of months on line 8. If Monthly Payment coverage selected, enter 1 on line 8. Multiply the number entered on line 8 by the subtotal on line 7, and enter the total on line 8.
- Add the Administration Fee of \$12.50 on line 9 and enter your **Final Total** on line 10.
- If payment by credit card, complete the **CREDIT CARD PAYMENT REQUEST** on the application. We do not need a check or money order with the application for this form of payment. This payment method can be used for Single Payment or Monthly Payment options.
- If payment by check or money order, attach your initial payment for one month to the application.
- If Monthly Payment by automatic check withdrawal, complete the **AUTOMATIC CHECK WITHDRAWAL REQUEST** on the application. Attach a check for one monthly payment and a voided check payable to HPA, Inc.
- Mail the completed and signed application with the initial payment to the agent listed on the brochure. If none listed, mail to:

**HPA, INC.
P.O. BOX 15250
ROCKFORD, IL 61132-5250**

RATE CALCULATION CHART

- Applicant: \$ _____
- Spouse: \$ _____
- Child: \$ _____ X # _____ \$ _____
- Subtotal of lines 1,2,and 3: \$ _____
- Multiply by area factor: _____ \$ _____
- Add the optional UCSA Monthly Fee: \$ 12.50
- Subtotal: \$ _____
- Multiply by # Months: _____ \$ _____
- Add the Administration Fee: \$ 12.50
- Final Total:** \$ _____

Save time and your postage!

If you pay by credit card just fax the completed, signed & dated application and Rate Calculation Chart **Toll Free: 1-888-FAX-HPA1 (329-4721)**



Liberty II STM
Underwritten by: The Chesapeake Life Insurance Company
Administered by: Health Plan Administrators, Inc. (HPA)

**30 DAY RATE - GEORGIA
EFFECTIVE AUGUST 1, 2003**

Deductible Age	\$250	\$250	\$500	\$500
	Male	Female	Male	Female
0-29	\$60	\$73	\$53	\$64
30-34	79	99	70	88
35-39	99	128	88	114
40-44	126	149	111	132
45-49	165	172	146	152
50-54	192	198	170	176
55-59	265	245	234	217
60-64	384	324	340	287

Per Child 53 53 47 47

Deductible Age	\$1,000	\$1,000	\$2,000	\$2,000
	Male	Female	Male	Female
0-29	\$47	\$56	\$31	\$37
30-34	56	70	34	47
35-39	70	91	43	55
40-44	89	106	54	64
45-49	117	122	71	74
50-54	136	141	83	85
55-59	187	173	114	105
60-64	272	230	165	139

Per Child 42 42 28 28

This STM plan rates are calculated and paid in 30 day increments. The Monthly Payment Plan rate is based on the 30 day rate shown. If you select the Single Payment option, use this chart to determine the number of 30 days rates you'll need to pay.

Days	# Months	Days	# Months
30	1	120	4
60	2	150	5
90	3	180	6

INSTRUCTIONS FOR CHILD ONLY COVERAGE

The minimum is 15 days old for child only coverage. Use the 0-29 monthly rate for either the male or female, based on the gender of the oldest child; then use the per child rate for each of the other siblings to be insured. The parent or legal guardian must sign and date the application.



Liberty II STM

**GEORGIA
ZIP CODE & AREA CHART**

Zip Prefix	Area Factor
314, 311.....	1.07
303, 305, 307, 308, 312.....	1.00
313, 318.....	1.00
300, 301, 309, 319, 399.....	0.93
All other.....	0.88

The Liberty STM is available in other states, not listed above. The benefits, brochure, rates and application may be different.
**Please call HPA Sales Support for information.
1-800-277-3323, ext. 3**

**THE UNITED CONSUMERS SAVINGS ASSOCIATION
DISCOUNT PLUS CARD
(Optional)**

The UCSA provides members with numerous quality benefits that include money saving discounts for: Retail cost of prescription drugs; Dental services; Eye and vision care; Chiropractic services; Vitamin & Nutritional supplements; 24 Hour Nurse Help Line; Accudiet.com, an on-line interactive exercise and diet program; National Health Survey, discounts for Health & Lifestyle Assessment. The UCSA membership fee is \$12.50 per month. A complete UCSA fulfillment kit will be mailed shortly following your enrollment. (The UCSA is not affiliated with The Chesapeake Life Insurance Company.) Please enroll me today.

Signed: _____