

New Generation Health Plans

Simple Solutions for Individuals and Families

Fully insured medical insurance



Underwritten by:



Administered by:



Marketed by:





Simple Solutions for Individuals and Families

Before you purchase health insurance, research your options to ensure you choose a company you can count on—one that cares about helping you select the best plan for your situation, and one that will provide you with exceptional service after the sale.

Insurers Administrative Corporation is that company.

Since 1978, Insurers Administrative Corporation (IAC) has been helping people just like you meet their health insurance needs by offering quality coverage solutions at affordable prices.

We offer health plans that are all about choice.

- Multiple options for copays and deductibles
- More than 70 PPO networks
- Choice of prescription drug benefits
- Value-added benefits included with every plan—use one or use them all, depending on your changing health needs
- Personalized customer support by telephone during normal business hours—or 24/7 online access at a time that's convenient for you

Put us to the test.

Our numbers tell the story when it comes to demonstrating our commitment to prompt service:

- We receive approximately 728,000 claims per year*
- We handle 95% of all claims within 10 days*
- We answer 90% of customer service calls in less than 30 seconds*

IAC is a member of the IHC Group, (NYSE: IHC). Our combined strength, stability, reputation and commitment to service will exceed your expectations.

We look forward to serving you!

*IAC internal reports, 2008.

Choose From Six Plan Designs

Deluxe Plan

- Most comprehensive plan
- Offers the lowest out-of-pocket options

Advantage Plan

- Provides lower premiums without sacrificing benefits
- Employs two separate out-of-pocket maximums to achieve reduced premiums: one for medical services and supplies, and a second for outpatient surgical services and inpatient confinement

Value Plan

- When affordability is your top priority
- Offers comprehensive coverage for hospitalization and surgery, and limited coverage for typical services like office visits and diagnostic exams

Copay Plan

- Creative use of copays, coinsurance, and deductible help make benefits economical
- An affordable option when you prefer the predictability of copays

Premier Plan

- A smart health plan designed to keep premiums low without exposing you to high deductibles
- Covered charges that exceed the daily deductible amount on any given day are covered at 100%

High Deductible Health Plan

- A consumer-directed health plan that offers lower premiums and is qualified for use with a Health Savings Account (HSA)
- Achieve premium savings through in-network 100% coinsurance with a single deductible, or choose the in-network 80% coinsurance option for even greater premium savings

See separate plan overviews for details and outpatient prescription drug options.



Consumer Directed Options

Premier Plan

The Premier Plan protects you and your pocketbook! Instead of a calendar-year deductible, this plan offers a choice of three daily maximums. Choose a daily in-network maximum of \$250 for individual coverage and your expenses will not exceed \$250 per day for any covered in-network expense. Plus, you still have a convenient \$40 copay option for an in-network physician office visit charge. All other covered medical services are subject to the daily maximum.

Example (In-Network)	Cost of Service	What You Pay* (Premier Plan)	What You Pay** (Traditional PPO Plan)
Day 1 Physician office visit	\$72	\$40 copay	\$40 copay
Day 2 X-ray taken	\$68	\$68 applied to out-of-pocket	\$68 applied to deductible
2 weeks later... Blood work, ultrasound and CT scan all on the same day	\$2,047	\$250 applied to out-of-pocket	\$2,047 applied to deductible
One month later... Outpatient gallbladder removal	\$4,000	\$250 applied to out-of-pocket	\$385 applied to deductible \$723 out-of-pocket
Later that year... Accident resulting in a four-day hospital stay	\$28,000	\$250 each day, for a total of \$1,000 applied to out-of-pocket	\$3,277 out-of-pocket
TOTAL COST	\$34,187	\$1,608	\$6,540

*Based on \$250 daily in-network maximum, \$4,000 calendar-year out-of-pocket and \$40 physician office visit charge copay. Other options available. Cost of services is after PPO network discount.

**Based on \$2,500 calendar-year deductible, 80% coinsurance, \$4,000 calendar-year out-of-pocket maximum. Other options available. Cost of services is after PPO network discount.

High Deductible Health Plan

The High Deductible Health Plan (HDHP) from New Generation can be used in conjunction with a tax-favored health savings account (HSA). You have the freedom to select New Generation's vendor to establish and administer your HSA and health plan or choose your own bank to use as your HSA custodian.

The example below shows potential tax saving and a 50 percent savings on premium. Plus, any unused HSA funds roll over and can be used for next year's deductible!

	HDHP 80% \$5,450 deductible	Deluxe Plan \$1,500 deductible
Annual premium	\$2,397	\$4,777
Annual HSA deposit	\$2,000	\$0
Tax savings (28% tax bracket)	\$560	\$0
Total cost of annual health premiums after tax savings	\$1,837	\$4,777

Please see a financial advisor or attorney for individual tax and personal investment advice.

Covering More Than the Basics

Take charge of your health by taking advantage of all we have to offer!
New Generation Health Plans automatically include these benefits and services:

Optum® 24-Hour NurseLine

Provides 24/7 telephone access to registered nurses for guidance with treating various health-related conditions.

Personal Wellness Profile

This online tool takes lifestyle and health factors into consideration, and provides recommendations for health enhancement.

MyHealthCompass™

A health care tool that provides pricing and quality-of-care comparisons for medical services performed in various cities, states or regions.

LabOne Select®

Receive outpatient laboratory testing at a significant savings over other labs when your covered lab services are performed by LabOne, a fully accredited and certified laboratory.

Access to Chiropractors and Alternative Medicine* ^

Members receive a 25% discount on provider services through the American Specialty Health alternative health care network of nearly 20,000 credentialed providers.

*DISCLOSURE:

1. THIS PLAN IS NOT INSURANCE.

2. The plan provides discounts at certain health care providers for medical services.
3. The plan does not make payments directly to the providers of medical services.
4. Plan members are obligated to pay for all health care services but will receive a discount from those health care providers who have contracted with the discount medical plan organization.
5. Discount Medical Plan Organization and administrator: **Careington International Corporation**, 7400 Gaylord Parkway, Frisco, TX 75034; phone 800-441-0380.

^ Note to Texas Consumers: Regulated by the Texas Department of Licensing and Regulation, P.O. Box 12157, Austin, Texas 78711; telephone 800-803-9202 or 512-463-6599; Web site: www.license.state.tx.us/complaints.
This program is not available in Vermont and Montana.

Medical Care by Telephone

Offered with all New Generation Health Plans, TelaDoc is changing the way people access medical services. You can now receive a telephone consultation with a doctor 24/7 when you need non-emergency medical care.

TelaDoc is ideal for those times when you:

- Cannot reach your primary physician
- Are on vacation or a business trip
- Have a recurring prescription that needs to be filled and don't have time to go to your doctor's office (short-term refills only)
- Have any medical questions or concerns and want to speak with a doctor



These are just some of the benefits of using TelaDoc:

- On-demand access to health care 24/7
- Consultation with physicians who diagnose medical problems and prescribe medication when appropriate
- Low cost to you - only \$35 per consultation
- Access to a physician within three hours or the consultation is free
- Resolution of most minor routine medical issues from any remote location



- TelaDoc is not an insurance benefit.
- Prior to using TelaDoc the first time, you must complete a brief medical history disclosure.
- TelaDoc does not replace your primary care physician. TelaDoc is available when your physician is not.
- Services are available to you and your dependents age 10 or older; TelaDoc is not available for child-only plans.
- TelaDoc consulting physicians do not prescribe DEA-controlled substances.
- TelaDoc is not available to residents of or in the state of Oklahoma.

Optional Enhancements

In addition to the great benefits and services automatically included, the following optional benefits are also available:

Wellness/Preventive Care

Includes routine physicals, colorectal screening, well-child care, prostate cancer screening and flu shots. Covers 100% up to \$250 or \$500 per insured per calendar year at in-network providers.

Outpatient Prescription Drug Coverage

Choose an optional drug benefit to meet your needs.

Vision Insurance Benefit

Receive savings through EyeMed Vision Care® on eye care needs including frames, bifocals, non-disposable contact lenses and more. Choose from two options:

Option 1 - \$10 exam/\$25 lenses/\$100 frame allowance

Option 2 - \$20 exam/\$20 lenses/\$100 frame allowance

Refer to the EyeMed Vision Care overview for additional details and state availability.

Supplemental Accident Coverage

Choose either \$500 or \$1,000 maximum benefit. Plan pays 100% of each accident's covered charges up to the selected benefit per insured. Charges for the covered injury must be incurred within three months after the date of the injury and while coverage under the optional rider is in force. Covered charges incurred after the maximum benefit is paid, or three months after the accident, are subject to the plan's applicable copay, deductible and coinsurance. Benefit applies to both in- and out-of-network providers.

24-Hour Occupational Coverage

Available to qualified sole proprietors, partners or business owners who are eligible under state law to legally opt out of and are not covered by Workers' Compensation. Benefits may be payable for covered charges for work-related injuries or sickness.

18-Month Initial Rate Guarantee

Extend your plan's initial 12-month rate guarantee period for an additional six months.

Additional Life Insurance*

Up to \$100,000 of life insurance is available for the primary insured.

Not available in Florida, Georgia, Kansas or Texas.

*Term life insurance benefits are subject to a reduction schedule based on age. The life 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%. Death by suicide, while sane or insane, is not covered if the death occurs within 12 months of the effective date of coverage under this rider.

Health Empowerment Package

Enhance your New Generation Health Plan by adding our Health Empowerment Package.* These optional low-cost, high-value services will help you take control of your physical and financial well-being.

Optum® Care24SM

This resource offers access to master's-level counselors, attorneys, financial advisors and dependent-care resources. Using Care24, IAC members can address parenting challenges, relationship and marriage problems, work-related stress, addictions, dependent-care concerns, and more. Members also have access to legal consultations and financial advisors.

TravelGuard

Travel worry-free with TravelGuard! When traveling more than 100 miles away from home and faced with a serious injury, illness, or travel-related emergency, TravelGuard assists members with emergency services such as medical transportation, emergency message relay, travel document replacement, legal referrals, security and evacuation assistance.

Members also enjoy concierge services like flight re-booking, pre-trip travel advice, ground transportation and translation services.

Weight Watchers®

Weight Watchers offers a multidimensional, comprehensive way to learn how to achieve and maintain a healthy body weight for life by incorporating healthful eating, physical activity, behavior modification, a weight-maintenance phase, and group support. Members can choose from Local Meeting vouchers, an online subscription or the Deluxe Edition At-Home kit at a savings of more than 20 percent!

AskAFS Financial Counseling

AskAFS provides IAC members with personal, private and actionable solutions to their financial concerns through a confidential counseling helpline, online assistance and on-site seminars. AskAFS services include assistance with budgeting, taxes, savings and retirement planning, eldercare, home ownership, mortgages and bankruptcy debtor education.

*These services are not insurance. Services are not available in Nevada; other restrictions may apply.

Outpatient Prescription Drugs

Options for any Budget

New Generation Health Plans automatically include a Discount Drug Program through Express Scripts pharmacies. If you prefer insurance coverage for prescriptions, a variety of optional upgrades are available.

Mail Order, Telephonic and Internet Prescription Drug Purchases

If you select an optional prescription drug benefit, you can purchase up to a 90-day prescription supply through Express Scripts for the cost of a 60-day supply using their convenient mail order, telephone and Internet service.

Online Convenience

We make it easy for you to access your health plan benefits anytime by visiting www.iacusa.com. Using our convenient Web tool, you can:

- View claim payment status including an Explanation of Benefits
- Request a new health plan identification card or certificate of creditable coverage
- Submit name and address changes

PPO Networks

When you purchase a New Generation Health Plan, you are given the opportunity to select a primary PPO network from the numerous regional and national networks we offer. Services provided by an in-network provider are covered at discounted, pre-negotiated rates, which benefit you through lower out-of-pocket costs.

Regional networks are typically limited to providers in your area and often have greater name recognition locally, while national networks provide access to health care providers across the country, regardless of where you live, work or travel within the U.S. We offer three national networks: PHCS (Private Health Care Systems), First Health Network, and Great-West Healthcare, now part of CIGNA.

If you select a regional network, discounts are available through the PHCS Healthy Directions network for those times when you are traveling outside your regional network's coverage area.

The network you select as your primary PPO network may favorably impact the price you pay for your health insurance premium. Your agent will help you identify the most competitive and appropriate network for you.



Additional Provisions

Emergency Care at Out-of-Network Hospitals

If you are taken to an out-of-network hospital for emergency care, we will pay for covered services at in-network benefit levels subject to usual and reasonable charges. However, you must arrange for transfer to an in-network hospital within 48 hours or as soon as this transfer can take place without detriment to your health. Otherwise, covered services will be paid at out-of-network benefit levels.

Hospital Room and Board

Your New Generation Health Plan covers hospital room and board charges according to the plan you selected, on the basis of the average semi-private room rate. If the hospital does not have semi-private rooms, the plan will pay the usual and reasonable charge limited to 90% of that hospital's lowest-priced private room.

Intensive Care

Intensive care room and board provided through in-network hospitals will be paid at the most common rate for intensive care units. If provided through out-of-network facilities, they will be paid at up to three times the most common semi-private room rate. Observation room and intermediate care unit services will be paid at a rate of up to two times the most common semi-private room rate.

Non-Surgical Back Treatment (Chiropractic Care)

Covered expenses for outpatient non-surgical back treatment are payable up to the maximum benefit of \$250 per calendar year under the Copay and Value Plans; up to \$500 per calendar year under all other plans. Applicable copay, deductible and coinsurance apply.

Home Health Care

After applicable deductible has been satisfied, covered medical expenses will be paid at the coinsurance level you have selected, up to 21 visits per calendar year, per insured.

Routine Mammography, Breast Screening and PAP Smear

Covered at 100% in- and out-of-network.

Mental or Nervous and Chemical Dependency Disorders

The combined maximum lifetime benefit for mental and nervous and chemical dependency treatment is \$10,000 per insured. Covered outpatient charges **do not** accumulate towards the plan's maximum out-of-pocket amounts except on the High Deductible Health Plan.

Outpatient Mental or Nervous and Chemical Dependency Disorders

Applicable copay, deductible and coinsurance apply. Up to \$25 per visit, maximum of 50 visits or \$1,250 per insured, per calendar year, on all plans except Premier, Value and Copay plans. Premier plan is limited to \$1,250 per calendar year. Up to \$50 per visit, maximum 10 visits or \$500 calendar year for Value and Copay plans.

Inpatient Mental or Nervous Disorders

Applicable copay, deductible and coinsurance apply. Limited to 10 inpatient days and up to \$2,500 per insured per calendar year on all plans except Value and Copay. Limited to five inpatient days and up to \$1,000 per insured per calendar year for Value and Copay plans.

Inpatient Chemical Dependency Disorders

Benefits are not provided for inpatient chemical dependency treatment.

Complications of Pregnancy

Complications of pregnancy are covered the same as any other illness. Normal pregnancy is not a covered benefit.

Skilled Nursing Facility Care

After your applicable deductible and copays have been satisfied, covered medical expenses will be paid at the coinsurance level you have selected, up to a \$100 daily benefit, limited to 50 days per calendar year, per insured.

Hospice Care

The plan will pay covered medical expenses for hospice care for up to six months. The plan also covers bereavement support services for the insured person's family during the three-month period after death, up to \$250.

Organ Transplant Benefit

Center of Excellence Providers:

Covered transplant services are paid up to \$1 million lifetime maximum. If the \$100,000 calendar-year maximum is elected for the Deluxe Plan, covered transplant services are paid up to \$100,000 lifetime maximum. When the insured person uses a Center of Excellence, a lodging and transportation allowance of up to \$5,000 is available for one companion or two companions if the insured recipient is a minor.

In-Network Providers:

Covered transplant services are paid subject to a lifetime maximum benefit of \$250,000. If the \$100,000 calendar-year maximum is elected for the Deluxe plan, covered transplant services are paid up to \$100,000.

Out-of-Network Providers:

Covered transplant services are paid subject to a lifetime maximum benefit of \$175,000. If the \$100,000 calendar-year maximum is elected for the Deluxe plan, covered transplant services are paid up to \$100,000.

Occupational, Physical and Speech Therapies

Applicable copay, deductible, and coinsurance apply. Maximum of 30 treatments per calendar year for any one type of therapy and up to 60 treatments per calendar year for any combination of these therapies.

Additional Provisions

Initial Rate Guarantee

Premiums are based on several factors including, but not limited to: age, gender, spouse age, the number of children covered on the plan, home address, benefits selected, effective date and underwriting decisions. Rates will not change for the initial 12 months of coverage, or 18 months if elected, from the effective date unless one or more of the following events occur during that time: 1) A change of residence; 2) Administrative or PPO fees change 3) The number of dependents covered under the plan changes; or 4) A change in benefit options or PPO network.

Eligibility

If you are a dues-paying member of Communicating for America, Inc., under age 65 and a permanent resident of the United States, you and your eligible dependents may apply to purchase the IAC Personal Health Plans. You can apply by completing an application for insurance and by qualifying for coverage based on the plan's underwriting guidelines. Eligible dependents include: your lawful spouse under age 65 and your unmarried child(ren) primarily dependent upon you for support and maintenance under age 19 or under 25 only if enrolled as a full-time student actively attending an accredited college, vocational or high school. Full-time is defined as actively attending at least 12 hours of classes per week or, if less, attending the minimum hours of class the school considers full-time status.

Child(ren) Only Coverage

Child(ren) only coverage is available for child(ren) 2 months through 17 years of age. When covered children attain age 18, they can be issued coverage under their own individual plan and charged an appropriate adult rate if they reside in a state where the coverage is available. Premium is based on the rates applicable to the state in which the child resides. Children of foreign nationals with legal residency in the United States are not eligible for coverage.

Applications for child(ren) only coverage will be declined if either parent or legal guardian of the child(ren) to be included under the coverage is currently an expectant parent or has undergone infertility treatment within one (1) year of the date of application for the child(ren) only coverage.

Effective Date

You may request that your coverage become effective on either the 1st or 15th of the month. We must receive your application before the requested effective date. If your application is approved, your coverage will become effective on the requested effective date following approval. Your applicable premium must be paid before your coverage under the policy goes into effect. If the company is unable to approve your application within 60 days of the application date, the requested effective date will not be honored and a new, currently dated application may be required. If you or any dependent is confined as an inpatient or totally disabled, as defined by the policy, on the effective date, the approval of coverage is void and coverage will not take effect. A new application will be required to consider coverage in the future.

Covered Charges

Covered charges are the charges for services or supplies that are eligible for reimbursement under the policy. In order for a charge to be a covered charge, it must be: listed as a covered expense under the certificate; medically necessary; usual and reasonable; authorized or ordered by a physician; incurred while coverage under the policy is in force and not excluded by the policy. Covered charges are subject to applicable copays, deductibles, coinsurance amounts, limitation and maximums, unless otherwise noted in the schedule of benefits section of the certificate of coverage. The Usual and Reasonable Charge, as determined by us, is the reasonable charge made by most providers or other suppliers of medical services and supplies within a specific geographic area significant enough to establish a representative base of charges for treatment.

Pre-Certification and Pre-Determination of Benefits Requirement

Pre-certification and pre-determination are screening processes used to determine if the proposed hospital confinement, services, drugs or supplies are medically necessary. Failure to obtain the required pre-certification for inpatient confinement or specific medical treatment and services will result in a \$500 penalty. This pre-certification penalty is in addition to deductibles, copays and coinsurance. Pre-determination is required in order to receive benefits for certain charges including non-emergency care ambulance, durable medical equipment that exceeds \$1,000 and certain prescription medications. Failure to comply with the pre-determination requirement will result in no benefits being paid and no coverage for such charges. Pre-certification and pre-determination are not pre-authorization or pre-approval of coverage and do not guarantee payment of benefits.

Additional Provisions

Pre-Existing Conditions

A pre-existing condition is defined as a condition, whether physical or mental and regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was received within the 12 months immediately preceding the effective date of coverage. A pre-existing condition will be considered a covered charge at the end of a continuous 12-month period following the covered person's effective date of coverage if no medical advice, diagnosis, care or treatment in connection with the injury or sickness has been received. Otherwise, pre-existing conditions will be considered covered charges after two years of continuous coverage unless specifically excluded by the policy or by an endorsement or rider attached to the certificate.

Pre-Existing Conditions and Disclosed Health History

Health conditions that are fully disclosed in writing on the application for insurance are not subject to the pre-existing limitation and are covered from the effective date of coverage under the certificate unless the condition is specifically excluded under the policy or by an endorsement or health condition rider attached to the certificate of coverage.

Important: Failure to fully disclose health information on the application for insurance can result in rescission or reformation of coverage.

Termination of Insurance

A covered person's insurance under the policy will remain in force until: written request to terminate coverage is received; premium due is not paid by the end of the grace period; fraud or intentional misrepresentation of material fact is determined to have been committed under the terms of the policy; the insurer lawfully discontinues offering coverage under the policy or lawfully discontinues offering all health insurance in the state where the certificate was issued (subject to advance notice); death or termination of the policy. A dependent spouse's coverage terminates on the premium due date following a divorce, legal separation or annulment of such marriage. A dependent child's coverage will terminate on the premium due date following the date the child marries or ceases to meet the definition of an eligible dependent. Coverage terminates for dependents on the date your coverage terminates.



IMPORTANT INFORMATION

If you are not completely satisfied with the health insurance coverage and you have not filed a claim, you may return the certificate of coverage within 10 days of your receipt and receive a premium refund. The information included in this brochure is an outline of features, plan provisions, benefits and other information about the New Generation Health Plans. Plans offered may be subject to change and are not available in all states. This brochure is not intended to serve as legal interpretation of the benefits, which are provided under the Master Policy (Policy #SSL 2008-CA) issued to Communicating for America, Inc. in the District of Columbia. The exact provisions governing the insurance contract are contained in the Master Policy (form #SSL GP 607-A) underwritten by Standard Security Life Insurance Company of New York. Some provisions, benefits, exclusions or limitations may vary depending on your state of residence. Certain terms and conditions apply. Any provision of this policy that is in conflict with any applicable federal or state law is hereby amended to meet the minimum requirements of such law. For complete details about the New Generation Health Plans, please refer to the health insurance Certificate of Coverage (SSL GC 607-A). Applicants should not cancel any existing insurance until they have been notified in writing that their new insurance is in effect.

Vision benefits described in this brochure are underwritten by Fidelity Security Life Insurance Company, Kansas City, MO; Policy form M-9004 issued to the Multiple Unit Security Trust II.

New Generation Health Plans



New Generation, a forward-thinking marketing company, is opening new doors to affordable health care. Whether your health insurance decisions are guided by budget, lifestyle or both, New Generation is committed to meeting the ever-changing needs of individuals and families. The New Generation team, with more than 50 years of combined experience, is ready to assemble the best plan for you at a price you can afford.



Standard Security Life Insurance Company of New York is the insurer for health and life insurance benefits described in this brochure. Standard Security Life Insurance Company of New York, a member of the IHC Group, is rated A- (Excellent) by A.M. Best Company, a widely recognized rating agency that rates the relative financial strength of insurance companies and their ability to meet policyholder obligations.



The IHC Group is an insurance organization comprised of Independence Holding Company (NYSE: IHC), its operating subsidiaries and affiliates. With more than \$1.3 billion in assets, the IHC Group serves more than one million customers through its operating companies, which include three A- (Excellent) A.M. Best-rated insurance carriers, third-party administrators, managing general underwriters and marketing organizations.* The IHC Group has been providing life, health and stop-loss insurance solutions for over 25 years.



Communicating for America, Inc. endorses the New Generation Health Plans and is a national non-profit association founded in 1972. Originally founded as an advocate for the self-employed and rural members, CA has evolved into one of the largest and most respected associations in the country with members in communities of all sizes. Along with a legislative voice on important issues in Washington, D.C., CA provides high quality, valuable member benefits. CA, Inc. is not compensated by Standard Security Life Insurance Company of New York for its endorsement. Association membership not required or available in Colorado, Georgia, Kansas, Montana and South Dakota.

Services provided by TravelGuard, Optum®, Weight Watchers®, AskAFS, Express Scripts, personal wellness, LabOne, MyHealthCompass™ or TelaDoc® are not insurance benefits and are not underwritten by Standard Security Life Insurance Company of New York. Information contained herein regarding the advantages of an HSA should in no way be construed as providing legal or tax advice. Always consult your tax or legal advisors with any questions about tax or legal matters. Please consult your financial advisor when selecting an HSA custodian. Refer to Internal Revenue Code (IRC) Section 213(d) for a complete list of eligible expenses and maximum contributions. In addition, the HSA is not an insurance product and is not provided, administered or guaranteed by Standard Security Life Insurance Company of New York.

*IHC assets and number of customers as of 9-30-08.



Opening
new doors to
Affordable
health care

 **New Generation**
HEALTH PLANS