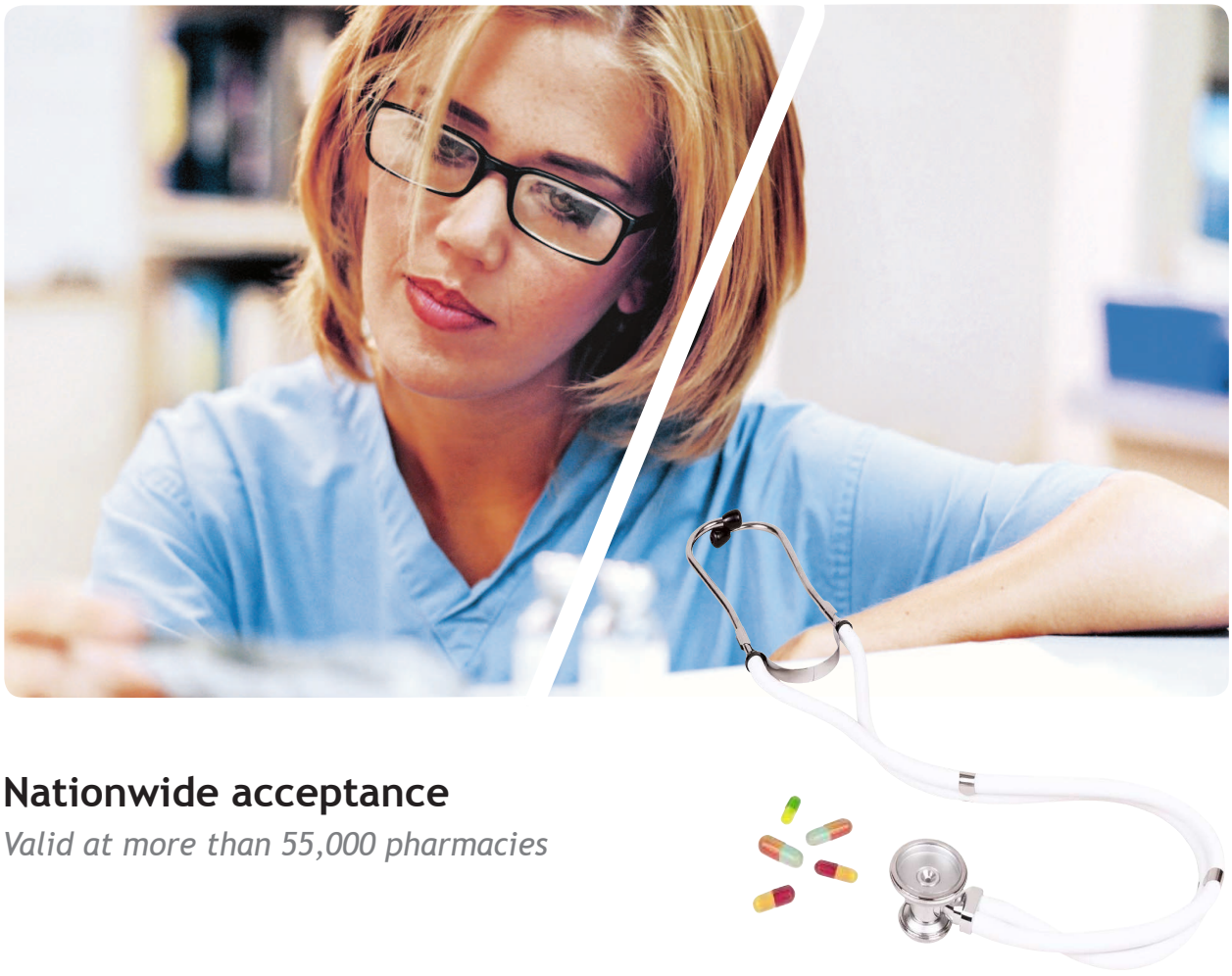
THE IHC GROUP
Independence Holding Company

Rx Pay Card

Prescription drug card program



Nationwide acceptance

Valid at more than 55,000 pharmacies

www.ihcbenefits.com

SAMPLE DRUG PRICES >>
See a complete list at www.ihcbenefits.com

What if the brand drug I am taking is not discounted?

If you are currently taking a medication that has similar active ingredients or is used to treat the same conditions as the preferred brand drugs on the Rx Pay Card product guide, it will still be discounted. You will pay the negotiated price for that drug. To take advantage of the potential program savings on listed preferred drugs, you should ask your pharmacist (where regulations permit) or a doctor to change your medication, where medically appropriate, to a less expensive product listed in the product guide.

Is the Rx Pay Card available for child-only use?

Yes, if the Rx Pay Card is for a child only (no adults will be using the card), list the child's name and information as the applicant. The parent or legal guardian must sign the enrollment form.

A. TELL US ABOUT YOURSELF

Applicant Name _____
Date of Birth ___ /___ /_____ Age ____ Sex _____
Social Security # ____ -____ - ____ Phone ( ) ____-_____
Occupation _____
Street Address _____
City _____ ST ____ ZIP _____
Billing Address (if different) _____
City _____ ST ____ ZIP _____
Email* _____

** You must list an email address since your kit and ID card are sent via email.*

Complete if spouse and/or children are included

Spouse's Name _____ Date of Birth ___ /___ /____
Child's Name _____ Date of Birth ___ /___ /____
Child's Name _____ Date of Birth ___ /___ /____
Child's Name _____ Date of Birth ___ /___ /____

B. CHOOSE YOUR DESIRED COVERAGE

□ Member □ Member + One Dependent
□ Member + 2 or More Dependents

SOLICITOR USE ONLY

Solicitor Name _____
IHC # _____
Address _____
City _____ ST ____ ZIP _____
Phone _____ Fax _____
Email _____
GA Name _____ IHC# _____
MGA Name _____ IHC# _____

$10 FIRST TIER UP TO $10 PAYMENT

Glyburide 2.5 mg	30 Tabs
Allopurinol 100mg	30 Tabs
Digoxin .125mg	30 Tabs
Amoxicillin 250mg	30 Caps
Penicillin VK 250mg	30 Tabs
Tetracycline 250mg	30 Caps
Estradiol 1mg	30 Tabs
Propranolol 40mg	30 Tabs
Trazodone 100mg	30 Tabs
Alprazolam .25mg	30 Tabs
Hydrocortisone 2.5%	30 gm
E.E.S. 400 Tabs	30 Tabs
Atenolol 50mg	30 Tabs
Lisinopril 10mg	30 Tabs
Furosemide 40mg	30 Tabs

$20 SECOND TIER UP TO $20 PAYMENT

Minocycline 50 mg	30 Caps
Sulfasalazine EC 500mg	30 Tabs
Naproxen EC 375mg	30 Tabs
Amoxil Chw 400mg	30 Tabs
Enalapril 5 mg	30 Tabs
Piroxicam 20 mg	30 Caps
Amaryl 1 mg	30 Tabs
Lanoxin .25 mg	30 Tabs
Synthroid 100 mcg	30 Tabs
Ranitidine 300 mg	30 Tabs
Etodolac 200 mg	30 Caps
Zolpidem 10 mg	30 Tabs
Fluoxetine 20 mg	30 Caps
Dilantin 100 mg	30 Caps
Glucotrol XL 2.5 mg	30 Tabs

$50 THIRD TIER UP TO $50 PAYMENT

Accoloate 10 mg	30 Tabs
Buspar 5 mg	30 Tabs
Bactroban Cream 2%	15 gm
Diovan 40mg	30 Tabs
Cardene 30mg	30 Caps
Lortab 10mg	30 Tabs
Kenalog Lotion .01%	60 gm
Paroxetine Hcl 20mg	30 Tabs
Ramipril 5mg	30 Tabs
Cytomel Tab 50mcg	30 Tabs
Macrodantin 25mg	30 Caps
Topicort LP Cream .05%	15 gm
Allegra 60mg	30 Tabs
Premarin .625mg	30 Tabs
Glucophage XR 750mg	30 Tabs

FOURTH TIER DISCOUNTS

Actos	Avinza
Actonel	Cipro XR
Crestor	Abilify
Lipitor	Atacand/HCTZ
Nexium	Detrol LA
Novolog	Cozaar
Lumigan	Ketek
Avandia	Travatan
Zoloft	Hyzaar
Paxil	Foradil
Amerge	Mobic
Zetia	Zithromax Z-pak
Valtrex	Lotrel
Ambien	Viagra
Lexapro	Concerta

Save time! Apply online @ www.ihcbenefits.com

CALCULATE YOUR MONTHLY COST*

Eligible member and/or spouse age 64 years old.
Rx Pay Card is not available to anyone 65 or older.

Member or Child Only: $19.99
Member + One Dependent/2 Children Only: $28.99
Member + 2 or More Dependents/3 + Children Only: $34.99

- Select your monthly cost from above $ _____
- If you are prepaying more than 1 month, multiply the number of months by the monthly rate (quarterly = x 3, semi-annual = x 6 or annually = x 12)
  x_____ (months) = $ _____
- Add the one-time enrollment fee + $15.00

TOTAL _____

**Not available in California*

C. SELECT YOUR PAYMENT OPTIONS

Total Due (from calculation section)

Select your payment plan:

□ Monthly □ Quarterly □ Semi-Annually □ Annually

IMPORTANT: If you choose to pay monthly, you must pay by electronic bank draft or credit card only.

Select your payment method:

□ Check or money order

Enclose initial payment to IHC Health Solutions, Inc. with the application.

□ Credit Card: □ Visa □ Mastercard

Account # _____ Expiration _____

I authorize IHC Health Solutions, Inc. to charge the above credit card for the premium listed according to the payment mode selected.

Signature_____ Date _____

□ Automatic bank withdrawal. Your Rx Pay Card monthly fee will automatically be withdrawn from your checking account.

I request that (bank name), _____

(address) _____

Pay and charge my account debits drawn from my account by IHC Health Solutions, 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 IHC Health Solutions, 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 Rx Pay Card membership.

Applicant's Signature _____ **Date** _____

I hereby apply for coverage. I understand that acceptance of this application is guaranteed. I understand that the earliest my enrollment can become effective is the day after receipt of the completed enrollment form and the first month's payment. I also understand that by participating in this program external factors may force a change in monthly fee, benefits and/or preferred drug list at any time. I will be entitled to negotiated and funded discounts on eligible prescription drugs purchased from any participating pharmacy. We understand that your trust in us is one of our most important assets. In order to preserve that trust, we want you to understand our information practices and your rights to ask us not to share certain information about you. As a member of this plan we want you to know the following: "THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY." Rx Options, Inc. will without your consent or authorization submit online pharmacy claim data to manufacturers, with NO member identification, for the payment of the rebates. Online claims data will also be provided to employers and pharmacies regarding invoicing and payments in the standard NCPDP claims billing format. If you have signed up for the email online reminders regarding refills of your current medications, emails will be sent to you directly at the email address you list on your enrollment application. If you wish to revoke the right for us to use your personal health information (PHI), you must do so in writing to IHC Health Solutions, Inc., P.O. Box 15250, Loves Park, IL, 61132-5250. Your request will be processed within 60 days upon receipt. Revoking the right for us to use your personal health information may also terminate your benefit.

Applicant's Signature _____ **Date** _____

Signature authorizes release of information and enrollment into the program. The enrollment kit is sent via email. We do not have preprinted materials.

PLEASE NOTE: Not all FDA-approved generic, preferred or brand name drugs are included in Tiers 1, 2, 3 or 4. A complete list of all drugs included in this plan is listed at www.ihcbenefits.com. Pricing and tier position are subject to change without notice. Tier position and pricing are only for quantities stated; additional quantities may result in higher costs.
THIS IS NOT AN INSURANCE PRODUCT.

This brochure provides a brief description of the Rx Pay Card. Plan may not include all drugs. The drug list is subject to additions or deletions without notice. THIS PLAN IS NOT AN INSURANCE PLAN.

The Rx Pay card formulary program has the following benefit tiers:

What is the Rx Pay Card?

A hassle-free prescription drug card program—with no health questions to answer; it has no limitations for pre-existing conditions, and is accepted at over 55,000 pharmacies throughout the United States.

This program is designed to save you money on prescription drug costs! We will help you find low cost medications within the same therapeutic class as a drug you may currently be taking.

To get the most out of this program, you should ask your doctor to prescribe a drug within Tiers 1, 2 or 3 if possible. Often drugs within the same therapeutic class can be prescribed in place of an expensive brand name drug. Of course, if you choose the higher price brand name drug, we have negotiated a discount to you.

FREQUENTLY ASKED QUESTIONS

When can I begin saving on my prescriptions?

The effective date is the day after IHC Health Solutions' administrative office receives your application and your first month's payment. Your identification card and discount drug card kit are instantly issued online. A complete drug list is available at **www.ihcbenefits.com.**

Is the Rx Pay Card available in all states?

The Rx Pay card is available in all states except California.

How will I know if a generic equivalent is available?

Simply ask your local pharmacist or call the customer service department to find out about generic equivalents for your prescription. Also ask your doctor to prescribe generics whenever possible and appropriate. (Your new member packet will include helpful materials you can share with your doctor.)

Who is the administrator?

IHC Health Solutions Inc., the administrator of this health plan, is headquartered in Minneapolis, Minn.

Right to return

If you are not completely satisfied with this plan for any reason and have not used your membership, you may return the Rx Pay Card within 10 days and receive a full refund of the plan cost.

www.ihcbenefits.com · 800.277.3323 x 3

 Rx Pay Card Bro. 06/11