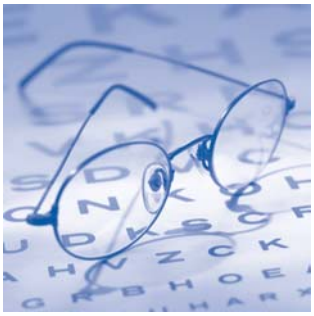
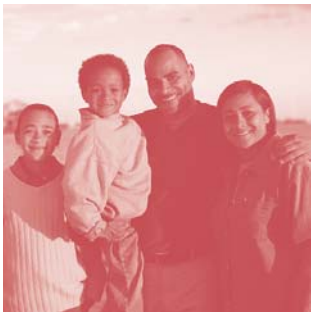
Advanced benefit solutions that enable your employees to make informed healthcare decisions!

Affordable health and supplemental benefit choices for companies with 2-50 employees





The Advantage Health Plans

Covered Charges

Covered charges are subject to applicable copayments, deductible and coinsurance. See plan overviews for details.

- Hospital room & board
- Physician services
- Licensed emergency ambulance
- Emergency room services
- Inpatient surgery
- Outpatient surgery
- Surgery performed in a physician's office
- Medical supplies/hospital services
- X-ray, laboratory & diagnostic tests
- Anesthetics, oxygen & their administration
- Mammography
- Radiation therapy
- Chemotherapy, antiobic therapy, infusion therapy
- Blood & its administration, but not the cost of blood and/or blood components if replaced by donation
- Rental (or at our option, lease or purchase) of a wheelchair, hospital bed, crutches, canes, and other durable medical equipment
- Initial supply but not replacement of casts, splints, trusses, crutches and braces (excluding dental braces and orthodontics which are not covered benefits)
- Initial supply of artificial limbs, larynx, & eyes due to loss of limbs, larynx and eyes the result of bodily injury sustained or sickness that begins while covered under the plan

These services must be medically necessary in order to be covered under the plan.

Limited Major Medical Benefits

Accidental Death & Dismemberment
The plan's life insurance benefit includes accidental death and dismemberment coverage for losses that are the direct result of accidental bodily injury occurring no more than 90 days before the loss was sustained.

Complications of Pregnancy
Covered the same as any other illness. However, normal pregnancy is not covered unless the optional maternity benefit is selected.

Emergency Treatment at Out-of-network Hospitals
Insured employees and dependents who are taken to an out-of-network hospital for a medical emergency will have covered services paid at in-network benefit levels. However, they must arrange for transfer to an in-network hospital within 48 hours or as soon as this transfer can take place without detriment to their health. Otherwise, covered services will be paid at out-of-network benefit levels.

Extended Care & Skilled Nursing Care
Limited to $100 daily benefit and 60 days per calendar year.

Home Health Care
Limited to 60 visits per calendar year.

Hospice Care
Plan pays 100% of covered charges for medically necessary hospice care, up to 6 months. Bereavement support services for the insured's family are also paid for up to 3 months after death, up to $250.

Life Insurance
A minimum of $10,000 of life insurance is required on the primary insured person, except in the states of AZ, GA, KS, NV, OK, PA, TN, TX, & WI, where life insurance coverage is available but not mandatory. Additional coverage may be purchased. See the Certificate of Life Insurance (C-1006) for details.

Mental & Nervous and Chemical Dependency
Maximum combined benefit of $10,000 per person while insured.

Outpatient Mental & Nervous and Chemical Dependency

Plan pays 50%. Limited to $50 daily plan maximum benefit, up to 25 visits per calendar year. Charges do not accumulate towards the plan's maximum out-of-pocket amount.

Inpatient Mental & Nervous

Maximum of 10 inpatient days, up to $2,500 per calendar year.

Inpatient Chemical Dependency

Benefits are not provided for inpatient chemical dependency treatment, unless otherwise mandated by law.

Non-surgical Back Treatment & Chiropractic Care
Maximum of $500 per person, per calendar year.

Occupational, Physical & Speech Therapies
Limited to 30 treatments per calendar year for any one type of therapy and up to 60 treatments per calendar year for all therapies combined.

Organ Transplants
United Resource Network Providers

Paid up to $1,000,000 while insured.

In-network Providers

Paid up to $400,000 while insured.

Out-of-network Providers

Paid up to $200,000 while insured.

Non-PPO Plans

Paid up to $200,000 while insured. Additional benefits may be available through the Health Care Coordination provision of the Certificate of Coverage.

Benefits may vary by plan. For complete details, refer to the Certificate of Coverage (C-MUST I).

Additional Provisions

Necessary, Reasonable & Customary
"Necessary, reasonable and customary" means the usual charge made for necessary medical services and supplies generally furnished for sickness or injuries of comparable severity and nature in the geographic area in which the services or supplies are furnished. Necessary also means charges for services and supplies that are necessary for the therapeutic treatment of an injury or sickness.

Allowable Charges
Allowable charges include provider network contracted charges or necessary, reasonable and customary charges for out-of-network providers for covered expenses that are necessary for the treatment of injury or sickness.

Out-of-network Providers at In-network Facilities
Certain providers such as radiologists, pathologists, anesthesiologists, and emergency room personnel may have relationships with network facilities but are not included in the provider network. Covered services from these providers will be considered at the in-network coinsurance percentage rate and the resulting benefits will be based on usual, customary, and reasonable charges if both the hospital and admitting physician are in the group's selected provider network.

Pre-existing Conditions
A pre-existing condition is a condition, whether physical or mental and regardless of cause, for which medical advice, diagnosis, care or treatment was recommended or received within the six-month period ending on the enrollment date of the insured person. A pre-existing condition will not be covered for a period of 12 months after the enrollment date.

Pre-existing Condition Limitation Credit
An insured person who has creditable coverage as defined in the Health Insurance Portability and Accountability Act (HIPAA) to a date no more than 63 days (or more, if required by state law) prior to the enrollment date under this plan will be given credit for the full or partial satisfaction of a pre-existing condition limitation waiting period by such creditable coverage. The pre-existing condition limitation waiting period will be reduced to the extent of the insured person's

Premium Rates and Rating Practices

Employer Class

This group medical insurance plan marketed and administered by Insurers Administrative Corporation is available only to a distinct class comprised of eligible Employers which elect to participate and adopt the Multiple Unit Security Trust for the purpose of establishing a group insurance plan for their eligible Employees and their eligible Dependents. Employers are considered to be Plan Administrators, as defined by ERISA, for the insurance plan selected by them for their Employees. The Trust is the Policyholder of this plan of insurance.

Premium Rates and Rate Guarantee

The Insurance Company has the right to determine the premium rates available to new participating employers applying for the plan's health benefits each month. Each Employer who joins the Trust and is accepted for insurance under the Group Policy has an initial 6-month rate table guarantee or an initial 12-month rate table guarantee.

Premiums may change during a rate guarantee period if: the Employer adds or deletes Employees • existing Employees move into a higher age bracket • the business moves to another geographic area • the Employer modifies the plan of benefits • the Provider Access or other Administrative fees change.

The manual rate table developed during each rating period which is used to calculate premiums is predicated upon the then current combined claims experience of all Employers participating in the Plan, adjusted for future utilization and medical inflation. Additional premium may be required due to industry or health status of an Employer Group within the rating practice of the state of issue. Renewal premiums that are developed from this manual rate table will vary from Employer to Employer because of benefit options or other characteristics such as geographic location, age, gender, or a change in Employer census. Also, characteristics of an Employer's claims experience, the changing health status of its Employees (or their Dependents), or the Employer's length of participation in the Plan may further increase renewal premiums for any such Employer up to an additional 15% per year or more if permitted by State law.

When Premiums are Due and Grace Period

The first premium payment is due with the submission of the application for insurance and must be a business check from the employer. Subsequent premiums are due on the first of each succeeding month. A Grace Period of 31 days will be allowed for the payment of any premium due after the initial premium. If not paid within that period, coverage will terminate automatically as of the due date of the unpaid premium.

Renewability of Coverage

We guarantee the Employer the right to renew coverage under the Group Policy on a monthly basis, at the Employer's option. However, we may refuse the coverage provided under the Group Policy if any of the following circumstances has occurred:

• non-payment of required premiums, or if we do not receive a premium payment by the last day of the Grace Period • the Employer or Employee has performed an act or practice that constitutes fraud or intentional misrepresentation of material fact under the terms of the Group Policy • failure on the part of the Employer to comply with a material group Policy provision related to premium contributions or group participation rules • in the case of an Employer issued coverage under a Preferred Provider Network Plan, there are no Employees who live, reside or work in the service area of that Preferred Provider Network (or the service area for which we are authorized to conduct business) • we elect to discontinue offering this type of group health insurance coverage, or elect to discontinue all health insurance coverage, in accordance with applicable State and Federal laws.

Definition of Employer

An employer is a sole proprietorship, partnership, or corporation that is actively pursuing business interests and is applying for coverage in connection with its own employee welfare benefit plan. An employer must complete a Trust Adoption and Participation Agreement agreeing to all the terms specified by us, meet our underwriting requirements, meet and maintain the trust and policy participation requirements and meet all other requirements of the state in which the Agreement is signed. The employer will be deemed the plan administrator for the purposes of compliance with and duties arising under the Employee Retirement Income Security Act (ERISA) and Consolidated Omnibus Budget Reconciliation Act (COBRA).

Ineligible Small Employer Groups

- Employee leasing companies
- Seasonal, part-time, or temporary employment situations

Minimum Employer Contribution

Employers are required to contribute a portion of the premiums under their Advantage Health Plan. The minimum contribution is 50% of the employee cost or 25% of the employee and dependent cost.

Definition of Employee

An employee is an individual who is:

- Working at least thirty (30) hours per week in the service of the employer at its usual place of business
- Compensated for such service by a regular periodic wage or salary that is subject to FICA and federal income tax withholding by the employer
- Not a seasonal or temporary employee and is scheduled to work at least 9 months per year
- A partner or proprietor actively engaged in the business of the employer on a full-time basis and
- Those new employees who are added from time to time as they become eligible
- 1099 employees are also eligible if they meet all of the above criteria and are solely and actively engaged in the business of the employer on a full-time basis.

No director of a corporation shall be deemed an employee solely because of such a directorship.

Definition of dependent

Eligible dependents are an insured employee's:

- Lawful spouse.
- Unmarried children dependent upon the insured employee for support and maintenance and are:

- less than nineteen (19) years of age or
- less than twenty-five (25) years of age and a full-time student.

Refer to the Certificate of Coverage for additional definitions of eligible dependents.

Pre-certification Requirements

Pre-certification is a screening process that uses established medical criteria to determine whether a proposed length of an inpatient hospital confinement, a proposed treatment plan, or proposed services and supplies are medically necessary and appropriate. It may also include proposing alternative treatment plans, concurrent length of stay reviews and discharge planning.

Services Requiring Pre-certification

• Proposed inpatient confinements in a hospital of more than 23 hours • An existing pregnancy within 30 days from the date of diagnosis • Prescription drug orders for growth hormones, immuno-suppressants, AZT or HIV anti-retroviral medication, "off-label" use, orphan drugs, and Group C cancer drugs • *In addition, all outpatient tests and surgeries should be pre-certified*

Emergency Situations

In emergency situations, an insured person should go directly to the hospital for immediate care. In the event of an emergency condition that results in hospitalization, the pre-certification service must be contacted within 48 hours of admission to the hospital (or as soon as reasonably possible). The insured's doctor must verify that an emergency situation existed.

Non-emergency Situations

In non-emergency situations the pre-certification service must be contacted by the insured at least 7 days prior to incurring charges on account of any of the above occurrences by calling the pre-certification service indicated on the health plan identification card.
The pre-certification service will contact the insured's doctor to obtain necessary information.

IMPORTANT: *Additional Deductible for Failure to Pre-certify*

Failure to pre-certify an inpatient confinement, pregnancy or complications of pregnancy will result in an additional deductible amount of $500 per occurrence and, if the prescription drugs specified above are not pre-certified, no benefits will be payable toward their cost.

Pre-certification is not a guarantee of payment. Determination of eligibility, covered charges and benefits to be paid is made by Insurers Administrative Corporation in accordance with the terms of the Master Policy. If the insured complies with pre-certification requirements, the additional $500 pre-certification deductible amount(s) will be waived.

Major Medical Exclusions

Expenses for any of the following are excluded from coverage:

Confinement, treatment, service, supply or prescription not necessitated by sickness or injury, not recommended by a physician, or not medically necessary • Bodily injury or sickness arising out of or in the course of employment for which the employee has or has had a right to compensation under any Workers' Compensation or occupational disability law • Any confinement, treatment, service or supply provided by a government-owned or operated facility, unless the insured person is legally required to pay for such charges • Injury or sickness resulting from war or any act of war • Charges incurred while on active duty with any military, naval or air force of any country or international organization • Services or supplies for treatment of the teeth and gums (other than for tumors), unless due to an injury, which occurs while covered under this plan, to sound natural teeth, provided such treatment is received within 12 months of the date of injury • Treatment or surgery as the result of prognathism, retrognathism, microtrognathism, or any treatment or surgery to reposition the maxilla (upper jaw), mandible (lower jaw), or both, unless due to an injury which occurs while covered under this plan, to sound natural teeth, provided such treatment is received within 12 months of the date of injury • Charges for treatment of temporomandibular joint (TMJ) dysfunction • Services or supplies to improve the appearance or self-perception of an insured person which does not restore a bodily function, including but not limited to cosmetic or plastic surgery, hair loss, or skin wrinkling • Routine eye exams, glasses, visual therapy, or contact lenses • Hearing aids • Birth control pills and contraceptive devices except if specified in the validation of coverage face page or schedule of benefits • Charges incurred as a result of participation in a riot or insurrection or the commission of a felony or while imprisoned • Non-therapeutic release of nuclear energy • Charges for radial keratotomy and radial keratectomy • Hypnosis or acupuncture, except when used in lieu of anesthesia • Physical exams, immunizations and check-ups which are not necessary for the treatment of injury or sickness, except if specified in the validation of coverage face page that the optional wellness benefits have been selected and are available • Charges for routine treatment, paring or removal of corns, calluses or toenails • Treatments for obesity or weight reduction including wiring of the teeth and all forms of intestinal bypass surgery • Charges for services rendered by a physician or other provider who is a close relative of the insured person, or who lives in the same household, except for charges rendered while a hospital inpatient • Charges incurred as the result of attempted suicide or intentionally self-inflicted injury or sickness while sane or insane • Treatment for mental, nervous or chemical dependency disorders except as indicated in the schedule of benefits • Experimental medical treatment • Voluntary abortion, unless necessary to protect the life of the mother for insureds without such coverage or if specified in the validation of coverage face page that the optional pregnancy benefits have been selected and are available • Charges related to or in connection with procedures to restore or enhance fertility, reversal of sterilization, penile implants, fertility and sterility studies • Impregnation techniques such as but not limited to artificial insemination, invitro fertilization, intrafallopian transfers, genetic counseling, etc. • Hospital and physician charges for weekend admissions for non-emergency procedures, unless medically justified or unless surgery is scheduled for the next day • Sexual reassignments, dysfunctions or inadequacies • Custodial care • Charges related to or in connection with pregnancy of a dependent child • Services or supplies for which the insured is not required to pay • Services received or supplies purchased outside the United States unless charges are incurred while traveling

(continued next page)

Major Medical Exclusions (continued)

• Education or training materials • Equipment, other than durable medical equipment, including but not limited to modifications to motor vehicles or homes, including such items as wheelchair lifts or ramps, water therapy devices, exercise equipment, etc. • Smoking or tobacco cessation programs and supplies • Any surgical removal of an organ or tissue unless medically necessary • Private duty nursing • Artificial organ implant • Personal convenience services or supplies • Non-prescription medication • Pap smears, unless coverage is specifically noted on the validation of coverage face page as available under the wellness benefit • Maternity benefits, unless coverage is specifically noted as available under the optional maternity benefit on the validation of coverage face page as having been selected and being available

Refer to the Schedule of Benefits and Certificate of Coverage for additional details.

Other Exclusions

Accidental Death & Dismemberment Exclusions

Benefits under this coverage are not payable for any loss caused by or contributed to or which resulted directly from:

Any act of war, whether declared or undeclared, riot or insurrection, or as a result of service in the military, naval or air forces of any country or in any auxiliary or civilian non-combatant unit auxiliary to or service with such forces • Travel or flight in, or descent from, any aircraft except as a fare-paying passenger on a licensed commercial aircraft operating on a regular schedule between established airports • suicide, attempted suicide or intentionally self-inflicted injuries while sane or insane • Sickness, disease, or mental infirmity, or medical or surgical treatment thereof or diagnosis thereof, or bacterial or other infection (except infection which occurs through and as a result of a visible wound caused by accidental bodily injury) • Participation in or commission of, or attempting to commit an assault or a felony, or a loss to which a contributing cause was the insured employee's being engaged in an illegal occupation • Bodily injury sustained as a consequence of intoxification or influence of any narcotic unless administered on the advice of a legally qualified physician • The voluntary ingestion of poison, or inhaling of gas, or asphyxiation • The ingestion of any drug, sedative, or narcotic unless prescribed by a physician

Refer to the Certificate of Coverage for additional details.

Outpatient Prescription Drug Benefit Exclusions

The following are excluded from coverage under the optional outpatient prescription drug benefit:

• Contraceptive devices (unless specifically required by state mandate) • Over-the-counter drugs and products • Fertility agents • Sexual performance enhancement drugs (i.e., Viagra) • Vitamins (other than pre-natal) • Anti-smoking aids • Hair loss medications • Immunization agents, biological sera, blood or blood plasma • Investigative or experimental drugs • Charges for administration of injectable insulin • Drugs covered under Workers' Compensation • Anorectic drugs • Medication while an inpatient at a hospital or similar institution • Therapeutic devices, appliances or support garments • Homeopathic medications • Drugs purchased outside the U.S. • Any drug requiring pre-certification which is not pre-certified (see Pre-certification Requirements section of this brochure)

Important Information

Information included in this brochure is an outline of features, plan provisions, benefits and other information about the Advantage Health Plans. It is not intended to serve as legal interpretation of benefits, which are provided under the Master Policies issued to the Multiple Unit Security Trust I. The exact provisions governing the insurance contract are contained in the Master Policy underwritten by Avemco Insurance Company of Frederick, Maryland. Some of the provisions, benefits, exclusions or limitations may vary depending upon the insured person's state of residence. These health plans may not be available in every state. Check with your agent for availability. Certain terms and restrictions apply. Any provision of this plan that is in conflict with applicable state law is hereby amended to meet the minimum requirements of such law.

For complete details about the Advantage Health plans, consult the following materials. For the health plan, please refer to the Certificate of Coverage C-MUST-I, Policy number IAC-9800, underwritten by Avemco Insurance Company; Frederick, Maryland. Life, accidental death and dismemberment, dental and vision coverage are underwritten by Fidelity Security Life Insurance Company, Kansas City, Missouri. For details on life, accidental death and dismemberment, refer to Certificate of Coverage C-1006, Policy number TL-70. For details on dental, refer to Certificate of Coverage C-9040, Policy number DT-134. For details on vision, refer to Certificate of Coverage C-9004 and Policy numbers VC-37, VC-38 and VC-20.

Medical benefits described in this brochure are underwritten by Avemco Insurance Company in all states where the Advantage Health Plans are available. Dental, vision, life and accidental death and dismemberment benefits are underwritten by Fidelity Security Life Insurance Company. Provisions, benefits, and limitations described herein may vary according to the insured's state of residence. For additional details, see the Certificate of Coverage.

The Advantage Health Plans may include access to services provided by MEDEX, Optum®, Express Scripts, Lab*One,* or My Health Compass™. Services provided by MEDEX, Optum®, Express Scripts, Lab*One,* or My Health Compass™ are not insurance benefits and are not underwritten by Avemco Insurance Company or Fidelity Security Life Insurance Company.

Advantage Health Plans

Health plans that work to your advantage!

AVEMCO INSURANCE COMPANY
A SUBSIDIARY OF HCC INSURANCE HOLDINGS, INC.

Avemco Insurance Company, Frederick MD, is the insurer for health benefits described in this brochure except for life, accidental death and dismemberment.

Avemco Insurance Company has been **rated A+ (Superior)** by A.M. Best Company, which rates an insurer on its relative financial strength and ability to meet its obligations to insureds.

While the Superior rating reflects the company's outstanding financial performance and capitalization, it is not a warranty of the company's present or future financial position. A.M. Best reports that companies rated A+ (Superior) *"have a very strong ability to meet their obligations to policyholders over a long period of time."*

FSL FIDELITY SECURITY LIFE INSURANCE COMPANY

Fidelity Security Life Insurance Company, Kansas City, MO, is the insurer for the life, accidental death & dismemberment, vision, and dental benefits described in this brochure.

Fidelity Security Life Insurance Company has been **rated A- (Excellent)** by A.M. Best Company. A.M. Best reports that companies rated A- (Excellent) *"have strong ability to meet their obligations to policyholders over a long period of time."* While the Excellent rating is not a warranty of the company's present or future financial position, the rating reflects Fidelity Security Life Insurance Company's balance sheet and overall favorable performance.

1978 INSURERS ADMINISTRATIVE CORPORATION 2003
Celebrating 25 Years of Service

Insurers Administrative Corporation (IAC), Phoenix, AZ, is a licensed and bonded third-party administrator who is now celebrating its 25th year in business.

IAC offers total services of underwriting, billing and claims administration for the Advantage Health Plans. IAC is one of the largest third-party administrators in the nation with more than 400 employees serving the insurance needs of individuals and employers in the areas of medical, dental, vision, life and AD&D, critical care coverage, self-funding, 401K and Section 125 plans.

In Mississippi, these plans are administered by IAC of Mississippi.