What is Select STM?

Just because you don't have health insurance right now doesn't mean you won't have health problems. Select STM allows you and your family to purchase high quality, affordable medical coverage on a temporary basis. Coverage is provided for physician services, surgery, outpatient and inpatient care.

How are benefits covered?

Select STM pays benefits for each covered person in the following manner:

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

Then Select STM pays 80% or 50% of the next $5,000 of covered expenses

After this, Select STM pays 100% of covered expenses up to your lifetime maximum of $2 million

** There is a maximum requirment of three (3) deductibles per family.*

Who is eligible to apply for Select STM?

You and your spouse under age 65 (and not eligible for Medicare) and you and your spouse's unmarried dependent children under age 19 (or under age 25 if a full-time student) who have a social security number and can answer "No" to the seven health questions on the application. Children age 19 and over should apply separately. Child-only coverage is available for ages 2 through 18 (see the Monthly Rates chart for instructions).

Satisfaction guarantee
If you are not completely satisfied with this plan, and you have not filed a claim, you may return the Certificate of Insurance within 30 days and receive a premium refund.

About the UCSA Discount Plus Card
The United Consumers Savings Association 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.
(This optional program is not affiliated with TIG Premier Insurance Company/Ranger Insurance Company, nor is it part of the Select STM insurance plan.)

Limitations and exclusions continued:

vascular disease or an Injury sustained while coverage is in force; • Acne or varicose veins; • Weight loss programs, diets, or treatment for obesity; • Transportation charges, except as specifically covered; • Rehabilitation, Rest cures, extended care facility, nursing home, Skilled Nursing Facility, or home for the aged, unless specifically covered; • Personal comfort or convenience services, except as specifically covered; • Services or supplies furnished or provided by a member of your Immediate Family; • Sleep disorders; • Participation in skydiving, scuba diving, hang or ultra light gliding, riding an all terrain vehicle, dirt bike, snowmobile or go-cart, racing with a motorcycle, boat, aircraft, any participation in sports for pay or profit, or participation in rodeo contests; • Noninvasive osteogenesis stimulator (bone stimulator); • Exercise cycles, air or water purifiers, air conditioners, allergenic mattresses, or blood pressure kits; • Surgery during the first six (6) months after the Effective Date of coverage for a total or partial hysterectomy, unless it is Medically Necessary due to a diagnosis of carcinoma (subject to all other coverage provisions, including but not limited to, the Pre-existing Conditions exclusion); tonsillectomy; adenoidectomy; repair of deviated nasal septum or any type of surgery involving the sinus; myringotomy; tympanotomy; herniorraphy; or cholecystectomies. • Medical treatment, services or supplies outside of the United States or it s possessions. • Participating in interscholastic, Intercollegiate or Organized Competitive Sports.

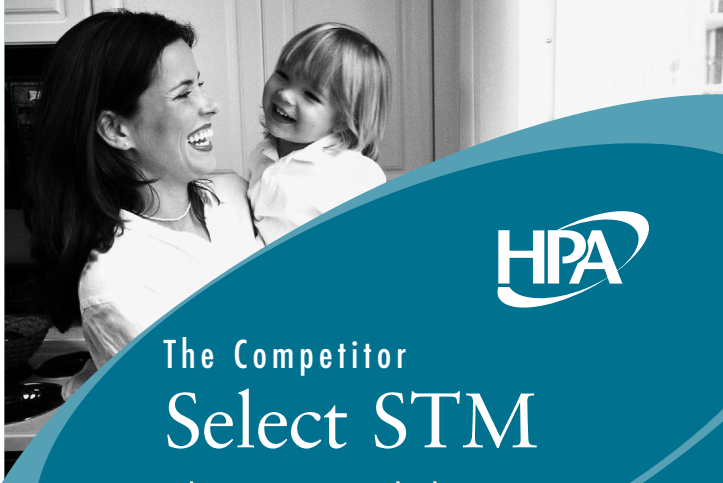
Detailed information about these and other plan limitations and exclusions are listed in the Policy / Certificate of Insurance and may vary by state.

About HPA
HPA is a fully licensed, full-service Third Party Administrator transacting business worldwide. Established in 1939, HPA is a third generation company providing state of the art industry leading insurance services, including customer service, claims payment, billing and reporting. HPA's speciality products division was founded by Michael Kosloske who now serves as company president.

www.hpa-inc.com 1-800-277-3323

This brochure provides a brief description of the benefits, limitations, exclusions and other provisions of the Short Term Medical Policy, Form AH27286 (or state variation) underwritten by TIG Premier Insurance Company/ Ranger Insurance Company. Benefits, benefit amounts, limitations, exclusions, and availability may vary by state. For complete details, read your coverage document immediately upon receipt.

TIG B-272866-12 11/04



HPA

The Competitor

Select STM

Select Temporary Medical Insurance

THE PERFECT SOLUTION FOR

- Those between health insurance plans
- College students and graduates
- Part-time or temporary employees
- Those unemployed or laid-off

SPECIAL FEATURES

- *Coverage for 1–6 or 12 months
- Choose any doctor or hospital
- Convenient payment options
- $2 million lifetime maximum per certificate

* (12 Month Plan not available in all states)

Insured by: TIG Premier Insurance Company/Ranger Insurance Company
Administered by: Health Plan Administrators, Inc., Rockford, IL
Michael Kosloske, President
Marketed by:

What medical expenses are covered?

After satisfying the deductible amount you have selected, Select STM will pay the coinsurance you selected for covered expenses, up to a lifetime maximum of $2,000,000 per policy period. Precertification is required prior to inpatient hospitalizations or surgery.

Hospital Charges: average semi-private room rate, medical care and treatment

Surgery in a Hospital or Ambulatory Surgical Center

Physician Services for diagnosis, treatment and surgery

Intensive Care: up to three times the average semi-private room rate

Skilled Nursing Facility: up to $30 per day for 30 days

X-Ray Exams, Laboratory tests and analyses

X-Ray and Radioactive isotope therapy, anesthesia, oxygen, casts, splints, crutches, braces, surgical dressings, artificial limbs or eyes, rental of medical supplies

Blood or blood plazma and their administration

Ambulance Services: $250 per emergency

Organ Transplants*: $50,000 lifetime maximum

Acquired Immune Deficiency Syndrome (AIDS)*: $10,000 lifetime maximum

Home Health Care: up to 40 visits

Hospice Care: up to $5,000

Spinal Manipulation/Adjustment*: up to $1,000

Mammography, pap smear and screens

Gallbladder Surgery: up to a $2,500 lifetime maximum

Knee injury or disorder: up to a $2,500 lifetime maximum for both left and right knees

**Benefits vary by state. Refer to your coverage document for specific terms and conditions.*

The benefit amount shown is the lifetime maximum per covered individual per policy period.

What is a usual, reasonable and customary charge?

A "usual, reasonable and customary charge" is the charge typically made by physicians or suppliers of medical services, medicines and supplies within a specific geographic area.

Do I need precertification?

Pre-admission certification prior to eligible inpatient hospitalization or surgery by the covered individual within 48 hours is required. This is not a guarantee of benefits. Failure to precertify will result in a benefit reduction of 50%. Call 1-800-367-9938 for precertification.

When does my coverage start?

Your coverage will begin as early as the day following the U.S. postmark stamp on your envelope. You can request a later effective date, but no more than 60 days after the application date. All coverage is subject to approval of your application and payment of the first premium.

How long will Select STM coverage last?

HPA's Select STM is specifically designed to fill temporary insurance needs and coverage stops at the end of the period applied for. Depending on the payment option you select, Select STM offers coverage for one to six months or even a full 12 months.*

What are my payment options?

You can pay by check, money order, credit card or automatic bank withdrawal in easy **monthly** payments for up to 6 or 12 months* of coverage. Receive a special reduced rate when you select the 1–6 Months of Coverage and make **payment in full** for 1, 2, 3, 4, 5 or 6 months.

If the 1–12 Months of Coverage payment option is selected and your need for insurance ends before the coverage period ends, you can stop your coverage by not making your monthly payment.

** (The 12 Month Coverage Option is not available in all states)*

Coverage Termination

Coverage ends when: the premium is not paid when due; you enter full-time active duty in the Armed Forces; you become eligible for Medicare; the policy terminates; the elected coverage period expires; The Insurance Company determines fraud or misrepresentation has been made in filing a claim for benefits; or a dependent ceases to be eligible.

Can I continue coverage?

If your need for temporary health insurance continues, you may be able to apply for another Select STM plan. Your application is subject to eligibility, underwriting requirements and state availability of the plan. The next coverage period is not continuous and any condition that incurred during the last coverage period will be excluded as a pre-existing condition.

Is there a pre-existing condition limitation?

Pre-existing conditions are not covered. This includes any condition or complication that was treated or produced symptoms five years prior to your Select STM effective date.

The pre-existing condition limitation may vary by state.

What are the plans limitations and exclusions?

The Select STM will not pay for expenses for diagnosis, treatment or supplies resulting from any the following:

• Expenses incurred prior to the Effective Date of a Covered Person s coverage or incurred after the Expiration Date, regardless of when the condition originated, except in accordance with the Extension of Benefits provision; • Complications resulting conditions which are not covered; • Experimental or Investigative services; • Determined to be educational; • Amounts in excess of the Usual, Reasonable and Customary charges; • Expenses you are not required to pay; • Payable under group insurance or medical prepayment plan; • Eligible for payment by Medicare charges or any other government program except Medicaid; • Care in government institutions unless you are obligated to pay for such care; • Benefits are received under workers compensation or employers liability laws;• Medical expenses payable under any automobile insurance policy (does not apply in any state where prohibited); • Charges while on active duty in the armed forces; Declared or undeclared war; • While engaging in an illegal act or occupation or during the commission of a felony or assault; • Normal pregnancy or childbirth; • Newborn Covered Dependant child not yet discharged from the Hospital, except as specifically covered; •Termination of normal pregnancy, normal childbirth or elective cesarean section; • Conceptions;• Infertility;• Sterilization; • Sex transformation, dysfunction or inadequacies; • Physical exams or services not medically necessary, unless specifically covered; • Prophylactic surgery or diagnostic testing, except as specifically covered;•Mental Illness or Nervous Disorders, including but not limited to neurosis, psychoneurosis, psychopathy, psychosis, attention deficit disorder, autism, or hyperactivity or any emotional or mental disease or disorder, unless specifically covered; • Alcoholism or abuse, chemical dependency, substance abuse or drug addiction, unless specifically covered; • Any Injury or Sickness occurring while intoxicated or under the influence of illegal drugs or hallucinogenic's, except as specifically covered; • Tobacco use cessation; • Suicide or attempted suicide or intentionally self-inflicted Injury, whether while sane or insane (only while sane in Missouri); • Dental care, except as specifically covered; •Jaw joint problems including but not limited to temporomandibular joint dysfunction (TMJ), craniomandibular disorders or myofacial pain; • Eye care or exams, eyeglasses, contact lenses, treatment of cataracts, radial keratotomy or correction of refractive error; • Hearing exams or hearing aids; • Cosmetic procedures, except as specifically covered; • Breast reduction or augmentation and complications thereof; • Out-patient Prescription or Legend Drugs, vitamins, minerals or food supplements; • Hair loss; • Any foot care, unless for the treatment of a metabolic or peripheral

Select Short Term Medical Application (Generic)

TIG Premier Insurance Company / Ranger Insurance Company

A. TELL US ABOUT YOURSELF

Applicant Name _____

Date of Birth ___/___/___ Age _____ Sex _____

Social Security # ___–___–___ Telephone (___) ___–_____

Occupation _____

Street Address _____

City _____ State _____ Zip _____

Billing Address (if different) _____

City _____ State _____ Zip _____

Email _____

Complete if spouse and / or children will also be covered:

Spouse's Name _____

Date of Birth ___–___–___ Age _____ Sex _____

Social Security # ___/___/___

Occupation _____

Child's Name _____ Age _____

Social Security # ___–___–___ Date of Birth ___/___/___

Child's Name _____ Age _____

Social Security # ___–___–___ Date of Birth ___/___/___

Child's Name _____ Age _____

Social Security # ___–___–___ Date of Birth ___/___/___

AGENT USE ONLY

Agent Name _____

SS# _____ HPA # 640000000

Address _____

City _____ State _____ Zip _____

Phone _____ Fax _____

Email _____

GA Name _____ MGA Name _____

Include a current copy of your license and a completed HPA appointment form with your first application.

Make personal check or money order payable to:
Health Plan Administrators, Inc.

B. ANSWER THE FOLLOWING MEDICAL QUESTIONS

NOTE: IF "YES" IS ANSWERED ON ANY QUESTION 1 THROUGH 7, COVERAGE CANNOT BE ISSUED.

1. Will there be any other health insurance in force on the policy date? ❑ Yes ❑ No
2. Is the proposed insured, spouse, or any dependent child now pregnant? ❑ Yes ❑ No
3. Is any proposed insured currently eligible for Medicaid? ❑ Yes ❑ No
4. Has any person proposed for coverage been declined for health insurance in the past 12 months? (Missouri residents do not have to answer) ❑ Yes ❑ No
5. Within the past five years have you been aware of, diagnosed, treated by a member of the medical profession, or taken medication for cancer or tumor, stroke, heart disease including heart attack, chest pain or had heart surgery, COPD (chronic obstructive pulmonary disease) or emphysema, liver disorder, degenerative disc disease or herniation / bulge, rheumatoid arthritis, degenerative joint disease of the knee, insulin-dependent diabetes (not applicable to DC residents), alcohol abuse or chemical dependency? ❑ Yes ❑ No
6. Have you been diagnosed or treated for AIDS, AIDS-related complex, or any other immune system disorder? ❑ Yes ❑ No
7. Has any person proposed for coverage not been a legal resident of the United States for the last 12 consecutive months? ❑ Yes ❑ No

E. SIGN THE APPLICATION

Any material misstatement or omission of information made on this form will be considered a misrepresentation and may be the basis for later rescission of my coverage or that of my dependents. In the event of rescission or termination for any reason, the insurer shall have the right to setoff premium paid by or on behalf of me and my dependents against any claims paid to or on behalf of my dependents or me after the effective date of such rescission or termination.

1.) I agree that coverage will not become effective for any person whose medical history changes prior to coverage approval, such that the person's answer would be "Yes" to any of the medical questions in this application. If such person is the applicant, coverage is automatically declined for all persons included in this application; 2.) I hereby request and understand that if the coverage applied for becomes effective, I agree to all terms of the coverage. I understand that health insurance benefits are excluded for pre-existing conditions; 3.) I hereby authorize any hospital, clinic, physician, surgeon, practitioner or insurance company to furnish the insurer or its representative any and all information concerning any sickness or injury I or my dependents may have suffered and also copies of all hospital or medical records. A copy of this authorization shall be considered as valid as the original and remains in effect for two years from the date of my signature; 4.) I understand that the broker who solicited this application was acting as an independent contractor and not an agent of TIG Premier Insurance Company / Ranger Insurance Company. I further acknowledge that the person who solicited this application and upon whose explanation of benefits, limitations or exclusions we relied, was retained by me as my agent, and that such person has no right to bind or approve coverage or alter any terms or conditions of the policy; 5.) I have read this application and have verified that all of the information provided in it is complete, true and correct, and is all within my personal knowledge. I agree to immediately notify the insurer of of any changes in any of the information contained in this form which may occur prior to the approval of coverage.

Fraud Warning: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading may be guilty of insurance fraud and subject to criminal and / or civil penalties.

I understand that this coverage will not pay benefits for a disease or physical condition that I now have or have had in the past.

Applicant's Signature _____ Date _____

Spouse's Signature _____ Date _____

AHU27286

C. CHOOSE YOUR DESIRED COVERAGE

Requested Effective Date:

❑ 12:01 a.m. of the day following postmark

❑ Later Effective Date ___/___/___

Deductible: ❑ $250 ❑ $500 ❑ $1,000 ❑ $2,500

Co-insurance: ❑ 80 / 20 up to $5,000 ❑ 50 / 50 up to $5,000

D. SELECT YOUR PAYMENT OPTIONS

Total Due (from calculation section on opposite page) $ _____

Select your payment mode:

❑ Single Payment for 1, 2, 3, 4, 5 or 6 months: Enter # of months _____

❑ Monthly Payments ❑ up to 6 months ❑ up to 12 months

Select your payment method:

❑ Check or money order. Enclose initial payment to HPA, Inc., with application.

❑ Credit Card: ❑ VISA ❑ MC ❑ Discover

Account # _____ Expiration _____

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

Signature _____ Date _____

❑ Automatic bank withdrawal. Enclose initial payment and a voided check with application.

Your TIG Insurance Company monthly premium 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 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 _____ Date _____

Mail your application and initial payment to: HPA, Inc., P.O. Box 15250, Rockford, IL 61132-5250

Rate Calculations (Generic)

Please refer to rate charts and zip code factor table.

	Single Pay 2-6 mos.	One Month or Monthly Pay
Applicant Rate		
Spouse Rate	+	+
Per Child Rate x number of children *Maximum rate: for more than three children, use rate for three children*	+	+
Subtotal:	=	=
Enter Number of Months of Coverage	x	x
Subtotal:	=	=
Enter and Multiply by **1.35** for Monthly Pay up to 12 months	N/A	x
Subtotal:	=	=
Enter and Multiply by **.83** for Single Pay Option 1-6 months	x	N/A
Subtotal:	=	
Enter and Multiply by **.80** for 50% Coinsurance Option	x	x
Subtotal:	=	=
Administration Fee: Single Pay Option 2-6 months	+ $25.00	
1 Month Single/or Monthly Pay		+ $12.50
Subtotal:	=	=
Enrollment Fee *(non-refundable)*	+ $10.00	+ $10.00
Total Amount Due	=	=

Save time and postage if you pay by credit card. Just fax the completed application toll free to **1-888-329-4721.**

*Only dependent children age 19 or younger (or 25 if full-time student) are eligible. The minimum age for children-only coverage is 2 years old. A parent or legal guardian must sign and date the application.

SELECT SHORT TERM MEDICAL MONTHLY RATES EFFECTIVE 1/1/05*

MONTHLY PAYMENT 1 TO 6 MONTHS • 80% COINSURANCE UP TO $5,000

$250 Deductible

Area	A	B	C	D	E	F	G	H	I	J	K	L	M	N
Male														
2 - 24	64.21	74.17	84.14	88.83	93.51	98.79	103.48	109.34	112.27	119.31	125.17	132.20	139.82	144.51
25 - 29	72.25	83.57	94.89	100.21	105.54	111.53	116.86	123.52	126.85	134.84	141.50	149.49	158.14	163.47
30 - 34	81.27	93.27	105.26	110.91	116.55	122.90	128.55	135.61	139.13	147.60	154.66	163.13	172.30	177.94
35 - 39	103.08	118.75	134.41	141.79	149.16	157.45	164.83	174.04	178.65	189.71	198.92	209.98	221.96	229.34
40 - 44	119.11	137.48	155.84	164.48	173.13	182.85	191.49	202.30	207.70	220.66	231.46	244.43	258.47	267.11
45 - 49	146.30	169.24	192.18	202.98	213.77	225.92	236.71	250.21	256.95	273.15	286.64	302.84	320.38	331.18
50 - 54	196.17	227.51	258.84	273.59	288.33	304.92	319.67	338.10	347.32	369.44	387.87	409.99	433.95	448.70
55 - 59	266.59	309.77	352.96	373.28	393.61	416.47	436.80	462.20	474.90	505.39	530.79	561.28	594.30	614.63
60 - 64	400.08	465.74	531.40	562.30	593.19	627.95	658.85	697.47	716.78	763.13	801.75	848.10	898.31	929.21
Female														
2 - 24	64.72	74.77	84.82	89.55	94.28	99.60	104.33	110.24	113.20	120.29	126.21	133.30	140.99	145.72
25 - 29	77.55	89.76	101.97	107.72	113.46	119.93	125.67	132.86	136.45	145.07	152.25	160.87	170.21	175.96
30 - 34	95.97	110.44	124.91	131.72	138.53	146.19	153.00	161.51	165.77	175.98	184.49	194.71	205.77	212.58
35 - 39	110.25	127.12	143.99	151.93	159.87	168.80	176.75	186.67	191.63	203.54	213.47	225.38	238.28	246.22
40 - 44	125.62	145.08	164.54	173.70	182.86	193.16	202.32	213.77	219.49	233.23	244.68	258.42	273.30	282.46
45 - 49	149.57	173.07	196.56	207.62	218.67	231.11	242.16	255.98	262.89	279.48	293.30	309.88	327.84	338.90
50 - 54	186.14	215.78	245.43	259.38	273.33	289.03	302.98	320.42	329.14	350.07	367.51	388.43	411.11	425.06
55 - 59	235.43	273.38	311.32	329.18	347.03	367.12	384.98	407.30	418.46	445.24	467.56	494.35	523.36	541.22
60 - 64	283.25	329.24	375.24	396.88	418.52	442.87	464.52	491.57	505.10	537.56	564.62	597.08	632.25	653.90
Per Child	53.00	61.41	69.83	73.79	77.75	82.20	86.16	91.11	93.59	99.53	104.48	110.42	116.85	120.81

$500 Deductible

Area	A	B	C	D	E	F	G	H	I	J	K	L	M	N
Male														
2 - 24	42.89	49.27	55.65	58.65	61.65	65.03	68.03	71.78	73.65	78.16	81.91	86.41	91.29	94.29
25 - 29	48.04	55.28	62.53	65.94	69.35	73.18	76.59	80.85	82.98	88.10	92.36	97.47	103.01	106.42
30 - 34	57.04	64.96	72.87	76.60	80.33	84.52	88.24	92.90	95.23	100.82	105.47	111.06	117.12	120.84
35 - 39	73.29	83.95	94.60	99.61	104.63	110.27	115.28	121.55	124.68	132.20	138.47	145.99	154.14	159.15
40 - 44	86.38	99.23	112.09	118.14	124.19	130.99	137.04	144.61	148.39	157.46	165.02	174.10	183.93	189.98
45 - 49	109.50	126.24	142.99	150.87	158.75	167.62	175.50	185.35	190.28	202.10	211.95	223.77	236.58	244.46
50 - 54	151.49	175.30	199.12	210.33	221.53	234.14	245.35	259.36	266.36	283.17	297.18	313.99	332.20	343.41
55 - 59	207.57	240.83	274.08	289.73	305.38	322.98	338.63	358.19	367.97	391.45	411.01	434.48	459.91	475.56
60 - 64	310.36	360.92	411.48	435.27	459.06	485.82	509.62	539.35	554.22	589.91	619.65	655.34	694.00	717.79
Female														
2 - 24	43.22	49.65	56.08	59.11	62.14	65.54	68.57	72.36	74.25	78.79	82.57	87.11	92.03	95.06
25 - 29	51.43	59.25	67.06	70.74	74.42	78.55	82.23	86.83	89.13	94.64	99.24	104.76	110.73	114.41
30 - 34	66.74	76.29	85.84	90.33	94.83	99.88	104.38	110.00	112.81	119.55	125.16	131.91	139.21	143.70
35 - 39	78.17	89.64	101.11	106.51	111.91	117.99	123.39	130.14	133.51	141.61	148.36	156.46	165.23	170.63
40 - 44	90.94	104.56	118.18	124.59	131.00	138.21	144.62	152.64	156.65	166.26	174.27	183.89	194.31	200.72
45 - 49	111.89	129.04	146.19	154.26	162.33	171.41	179.48	189.57	194.61	206.72	216.81	228.91	242.03	250.10
50 - 54	143.86	166.40	188.93	199.53	210.13	222.06	232.67	245.92	252.55	268.45	281.71	297.61	314.84	325.44
55 - 59	183.58	212.80	242.02	255.77	269.52	284.98	298.73	315.92	324.51	345.14	362.32	382.95	405.29	419.04
60 - 64	220.40	255.82	291.23	307.90	324.56	343.31	359.98	380.81	391.22	416.22	437.06	462.05	489.14	505.80
Per Child	36.00	41.55	47.10	49.72	52.33	55.27	57.89	61.15	62.79	66.71	69.97	73.89	78.14	80.75

$1,000 Deductible

Area	A	B	C	D	E	F	G	H	I	J	K	L	M	N
Male														
2 - 24	32.97	37.68	42.39	44.61	46.82	49.32	51.53	54.30	55.69	59.01	61.78	65.10	68.70	70.92
25 - 29	36.78	42.12	47.47	49.99	52.51	55.34	57.85	61.00	62.57	66.35	69.49	73.27	77.36	79.88
30 - 34	44.42	50.22	56.01	58.74	61.47	64.53	67.26	70.67	72.37	76.46	79.87	83.96	88.39	91.12
35 - 39	54.96	62.52	70.09	73.65	77.21	81.22	84.78	89.23	91.46	96.80	101.25	106.59	112.38	115.94
40 - 44	64.99	74.25	83.50	87.86	92.22	97.12	101.47	106.92	109.64	116.17	121.62	128.15	135.23	139.59
45 - 49	81.56	93.60	105.64	111.31	116.98	123.36	129.02	136.11	139.65	148.15	155.24	163.74	172.95	178.62
50 - 54	111.65	128.76	145.87	153.92	161.97	171.03	179.08	189.14	194.18	206.25	216.32	228.39	241.48	249.53
55 - 59	152.79	176.82	200.86	212.17	223.48	236.20	247.51	261.65	268.72	285.68	299.82	316.79	335.16	346.47
60 - 64	231.18	268.41	305.63	323.15	340.67	360.38	377.90	399.80	410.75	437.03	458.92	485.20	513.67	531.19
Female														
2 - 24	33.22	37.97	42.71	44.95	47.18	49.70	51.93	54.73	56.12	59.48	62.27	65.62	69.25	71.49
25 - 29	39.28	45.05	50.82	53.53	56.25	59.30	62.02	65.41	67.11	71.18	74.58	78.65	83.06	85.78
30 - 34	51.52	58.51	65.50	68.79	72.08	75.78	79.07	83.18	85.23	90.17	94.28	99.21	104.56	107.85
35 - 39	58.42	66.57	74.72	78.55	82.39	86.70	90.54	95.33	97.73	103.48	108.28	114.03	120.26	124.10
40 - 44	68.27	78.08	87.89	92.51	97.12	102.31	106.93	112.70	115.58	122.51	128.28	135.20	142.70	147.32
45 - 49	83.28	95.61	107.94	113.75	119.55	126.08	131.89	139.14	142.77	151.48	158.73	167.44	176.87	182.67
50 - 54	106.17	122.36	138.55	146.16	153.78	162.35	169.97	179.49	184.25	195.68	205.20	216.63	229.00	236.62
55 - 59	135.45	156.57	177.69	187.62	197.56	208.74	218.68	231.10	237.31	252.21	264.63	279.54	295.69	305.62
60 - 64	164.93	191.01	217.09	229.36	241.63	255.44	267.71	283.05	290.72	309.13	324.47	342.88	362.82	375.09
Per Child	27.15	31.21	35.28	37.19	39.10	41.25	43.17	45.56	46.75	49.62	52.01	54.88	57.99	59.90

$2,500 Deductible

Area	A	B	C	D	E	F	G	H	I	J	K	L	M	N
Male														
2 - 24	26.31	29.90	33.49	35.18	36.87	38.76	40.45	42.56	43.62	46.15	48.26	50.79	53.54	55.22
25 - 29	29.21	33.28	37.36	39.28	41.19	43.35	45.27	47.67	48.86	51.74	54.14	57.01	60.13	62.05
30 - 34	35.66	39.98	44.29	46.33	48.36	50.65	52.68	55.22	56.49	59.54	62.08	65.13	68.43	70.46
35 - 39	43.51	49.15	54.79	57.44	60.10	63.08	65.74	69.05	70.71	74.69	78.01	81.99	86.31	88.96
40 - 44	53.64	60.99	68.34	71.79	75.25	79.14	82.60	86.92	89.08	94.26	98.59	103.77	109.39	112.85
45 - 49	65.88	75.29	84.69	89.12	93.55	98.53	102.95	108.49	111.25	117.89	123.42	130.06	137.26	141.68
50 - 54	88.19	101.35	114.51	120.71	126.90	133.87	140.06	147.80	151.67	160.96	168.71	178.00	188.06	194.25
55 - 59	117.77	135.90	154.04	162.58	171.12	180.72	189.25	199.92	205.26	218.06	228.73	241.54	255.41	263.94
60 - 64	177.74	205.97	234.20	247.49	260.77	275.72	289.01	305.61	313.92	333.85	350.45	370.38	391.97	405.26
Female														
2 - 24	26.50	30.12	33.73	35.44	37.14	39.06	40.76	42.89	43.95	46.51	48.63	51.19	53.96	55.66
25 - 29	31.12	35.51	39.91	41.98	44.05	46.37	48.44	51.03	52.32	55.42	58.01	61.11	64.48	66.54
30 - 34	40.95	46.16	51.37	53.82	56.27	59.03	61.48	64.54	66.08	69.75	72.82	76.49	80.48	82.93
35 - 39	46.09	52.16	58.24	61.10	63.95	67.17	70.03	73.60	75.39	79.68	83.25	87.54	92.18	95.04
40 - 44	56.25	64.03	71.82	75.48	79.14	83.27	86.93	91.51	93.80	99.29	103.87	109.37	115.32	118.98
45 - 49	67.23	76.86	86.49	91.02	95.56	100.65	105.19	110.85	113.69	120.49	126.15	132.95	140.32	144.85
50 - 54	83.98	96.43	108.88	114.74	120.60	127.19	133.05	140.38	144.04	152.83	160.15	168.94	178.46	184.32
55 - 59	104.68	120.62	136.55	144.05	151.55	159.99	167.49	176.87	181.55	192.80	202.18	213.43	225.61	233.11
60 - 64	127.50	147.27	167.05	176.36	185.66	196.13	205.44	217.08	222.89	236.85	248.49	262.45	277.57	286.88
Per Child	21.00	24.03	27.06	28.48	29.91	31.51	32.94	34.72	35.61	37.75	39.53	41.67	43.99	45.41

Benefit Options Rate Factors:

Monthly Pay - 1 to 6 months:	**1.0**
Monthly Pay - 1 to 12 months:	**1.35**
Single Pay 1 to 6 months:	**0.83**
50% Coinsurance to $5,000:	**0.80**
80% Coinsurance to $5,000:	**1.0**

* The rates include the UCSA Discount Plus Card fee of $3 per child, $5 per rate for ages 2 through 29 and $10 per rate for ages 30 through 64 years old. The UCSA is not affiliated with TIG Premier / Ranger Ins. Co. nor is it a part of the STM insurance plan.

Child Only Coverage: The minimum age for child only coverage is 2 years old. Use the adult rate 2 -24. If more than one child, use adult 2-24 rate for the oldest and the per child rate for each of the other children to be insured.

State Zip Code Area Chart

STATE	ZIP CODE	AREA
Alabama	350-352	L
	All others	I
Alaska	All zips	K
Arizona	850-853	D
	All others	B
Arkansas	716-723, 728	E
	All others	C
California (6 Month Max)	Use CA application	
Connecticut	068-069	E
	All others	C
DC	All zips	K
Delaware	All zips	G
Georgia	300-303	J
	All others	I
Hawaii	All zips	G
Illinois	609, 613-629	G
	600, 601, 604, 605	I
	602, 603, 607	J
	606, 608	M
	All other	D
Indiana (6 Month Max)	462-463, 465-466	B
	464	G
	All others	A
Iowa	All zips	D
Kentucky	402	K
	All others	G
Maine	Use ME application	
Michigan (6 Month Max)	480, 481, 483, 482	G
	All others	E
Mississippi	All zips	C
Missouri	All zips	E
Nebraska	681	C
	All others	B
Ohio (6 Month Max)	436, 440, 442-445	E
	441	G
	All others	C
Oklahoma	730, 741	G
	731	H
	All others	F
Pennsylvania	190, 191, 194	N
	151, 152, 189, 193	K
	All others	I
Rhode Island	All zips	J
South Carolina	299	D
	All others	C
Tennessee	370-372, 381	C
	All others	B
Texas	Use TX application	
Utah	All zips	B
Virginia	222,223	K
	All zips	G
West Virginia	Use WV application	
Wisconsin	531, 532, 533, 534	I
	All others	H
Wyoming	All zips	I

For states not listed call HPA:
1-800-277-3323, ext. 3

Select STM rates/zips eff. 1/1/05