HEALTHBRIDGE DPC

HAA

SAMPLE CERTIFICATES OF INSURANCE*

NEBRASKA

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Short Term Medical Insurance Disclosure:

IMPORTANT: This program provides short term medical insurance only. It does not provide basic hospital, basic medical, or comprehensive major medical coverage, and does not satisfy the "minimum essential coverage" requirements of the Patient Protection and Affordable Care Act.

This literature is descriptive only. All policy terms, conditions, and pricing is solely determined by Everest and all coverage is subject to the language of the policy as issued.

Not all products and product features may be available in all jurisdictions and availability may be subject to business and regulatory approval in each jurisdiction. Healthy America Association, HealthyAmerica or H A Partners, Inc. are not affiliated with Everest Insurance®. No employees, agents and/or representatives of Everest are involved in the operation of Companies.

**Upon enrollment and receipt of the initial payment, each member will receive a personalized certificate. The certificate provided here serves only as an example to illustrate the plan details, including the schedule of benefits, terms, conditions, limitations, and exclusions of the HealthBridge DPC plan.*

The sample Certificates of Insurance on the following page are for illustrative purposes only. Once you are enrolled, you will receive your actual certificate.

ATTENTION PLEASE

READ CAREFULLY FOR ALL LIMITATIONS, EXCLUSIONS, AGE LIMITS, DEFINITIONS AND SCHEDULE OF BENEFITS. CALL **866-438-4274** WITH ANY QUESTIONS.

EVEREST REINSURANCE COMPANY

Statutory Office: 251 Little Falls Drive, Wilmington, DE 19808
Administrative Office: Warren Corporate Center, 100 Everest Way, Warren, NJ 07059
800-438-4375

(hereafter referred to as "We", "Us", "Our" or "the Company")

SHORT TERM MEDICAL INSURANCE CERTIFICATE OF COVERAGE – NEBRASKA

This Certificate is evidence of insurance provided under, and forms part of, the Group Policy, which We will refer to as "the Policy." All benefits are paid according to the terms of the Policy. This Certificate describes the essential features of the insurance coverage. The Policy is on file with the Group Policyholder and may be examined at any reasonable time. The Policy and this Certificate may be changed or cancelled as stated in the Policy. Such action may be taken without the consent of or notice to any Covered Person. Only an authorized officer of the Company can approve a change. The approval must be in writing and endorsed on or attached to the Policy. No other person, including an agent, may change the Policy or Certificate or waive any of its provisions. The Group Policy was issued in Delaware.

CONSIDERATION – This Certificate is issued in consideration of the statements made in the Enrollment Form and payment of the initial premium. Coverage is not provided until the first full premium is paid. The first premium pays for the initial term of coverage. The initial term of coverage begins at 12:01 A.M., local time on the Certificate Effective Date at the Insured's Residence.

PREMIUMS – Premiums may be changed and are due as stated in the section titled "Premiums".

NONRENEWABLE CERTIFICATE – NO CONTINUOUS COVERAGE – This Certificate provides coverage on a short term basis. It is not renewable. Although this short-term plan may be rewritten for new and completely separate Coverage Periods (as long as You meet eligibility criteria), coverage does not continue from one Certificate to another. This means that a new Enrollment Form must be submitted, a new Certificate Effective Date is given, and a new Pre-Existing Condition exclusion period begins. Any medical condition which may have occurred and/or existed under a prior Certificate will be treated as a Pre-Existing Condition under the new Certificate. This Certificate will terminate on the earlier of the expiration of the Grace Period, if a monthly premium is due and unpaid, or 12:00 A.M., local time on the Certificate Termination Date at the Insured's residence.

10 DAY RIGHT TO EXAMINE CERTIFICATE. Within 10 days after the Insured receives the Certificate, or notice electronically that the Certificate is available, it may be returned in person or by regular mail to the Company, its agency office or the agent who sold it to the Insured for any reason. The Company will return the premium to the payee. Then the Insured and the Company will be in the same position as if a Certificate had never been issued. **LIMITED BENEFITS, PLEASE READ CAREFULLY.**

INTERNAL/EXTERNAL REVIEW. This Certificate is subject to internal and external review pursuant to Health Carrier Grievance Procedure Act, Neb. Rev. Stat. § 44-7301 et. seq. and the Health Carrier External Review Act, Neb. Rev. Stat. § 44-1301 et. seq.

For: Everest Reinsurance Company

Jill Beggs
President and Chief Executive Officer

Sylvia Semerdjian
Secretary

This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your Certificate carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental

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health and substance use disorder services). Your Certificate might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage.

LIMITED BENEFITS, PLEASE READ CAREFULLY. No benefits are payable for Sicknesses which arise during the first 5 days following a Covered Person's Effective Date. No Benefits are payable for cancer which arises during the first 30 days following a Covered Person's Certificate Effective Date. See **PART VII – EXCLUSIONS AND LIMITATIONS** for details.

Benefits are not provided for outpatient prescription drug coverage.

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IMPORTANT NOTICE CONCERNING STATEMENTS IN THE ENROLLMENT FORM

Please read the Enrollment Form and all documents attached to this Certificate. Omissions or misstatements in the Enrollment Form or any attached documents may cause Us to deny an otherwise valid claim or rescind coverage. Carefully check all documents. You must advise Our Underwriting Department at the address or numbers listed above within 10 days of the receipt of this Certificate, or notice electronically that the Certificate is available, if any information or medical history is incomplete, incorrect, or has changed since the date of the Enrollment Form.

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PART I – GENERAL DEFINITIONS

"**Accident**" means an act or event which: (a) is unforeseen, unexpected and unanticipated and is the direct cause of a loss covered under the Policy; (b) is definite as to time and place; (c) is not a Sickness; and (d) occurs on or after the Certificate Effective Date and while insurance is in effect for a Covered Person.

"**Advanced Diagnostic Studies**" means advanced radiological diagnostic testing, such as MRI; nuclear medicine scans and imaging, including PET scan; CT scan; and ultrasound guided procedures.

"**Certificate Effective Date**" is the date coverage begins under the Certificate. Each Covered Person's Effective Date is shown in the Schedule of Benefits. It will be different for a Covered Person added to the Certificate after the original date of issue or when a change in coverage for any Covered Person occurs.

"**Civil Union**" means a same sex relationship, similar like marriage, that is recognized by law.

"Coinsurance" means the percentage amount the Company will pay of the Eligible Expenses that the Insured and the Company share after the applicable Deductibles and Copayments are met. Coinsurance does not include Deductibles, Copayments, penalty coinsurance for failure to pre-certify required services or any charges in excess of the Maximum Allowable Expense.

"**Complications of Pregnancy**" means either of these two general types of conditions:

1. Conditions requiring Inpatient treatment (when pregnancy is not terminated);
2. Whose diagnoses are distinct from pregnancy but are adversely affected or caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity, but shall not include hyperemesis gravidarum, preeclampsia, false labor, occasional spotting, Doctor prescribed rest during the period of pregnancy, morning sickness, and other similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and
3. Non-elective or emergency cesarean section, ectopic pregnancy that is terminated, and spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible.

"**Congenital Condition**" means a disease or other anomaly existing at or before birth, whether acquired during development or by heredity.

"Copayment" means a designated amount that must be paid by a Covered Person for each medical service, including consultations and follow ups, that is subject to a Copayment amount. Copayments do not apply to any Deductible or to the Out-of-Pocket Maximum.

"**Cosmetic Treatment**" means treatments, procedures, services or supplies that change or improve appearance without significantly improving physiological function and without regard to any intended or actual improvement to the psychological consequences resulting from an Injury, Sickness or Congenital Condition.

"**Coverage Period**" means the length of time for which the Insured selected coverage in the Insured's Enrollment Form and approved by Us not to exceed a three-hundred-and-sixty-four (364) day period commencing as of the Certificate Effective Date.

"**Coverage Period Maximum Benefit**" means the total aggregate amount of benefits We will pay under this Certificate for each Covered Person which are incurred during the Coverage Period. The Coverage Period Maximum Benefit applies to all Eligible Expenses under this Certificate.

"**Covered Person**" means You and Your covered Dependents, listed as a Covered Person in the Schedule of Benefits and for whom premium has been paid.

"**Custodial or Convalescent Care**" means any care that is provided to a Covered Person who is disabled and needs help to support the essential activities of daily living when the Covered Person is not under active and specific medical, surgical,

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or psychiatric treatment that will reduce the disability to the extent necessary for the person to perform the essentials of daily living on his own.

"**Deductible**" means the amount of Eligible Expenses that must actually be paid by each Covered Person during any Coverage Period before any benefits are payable. The Deductible(s) are shown in the Schedule of Benefits and do not include any Copayment amounts.

"**Dental Expenses**" means treatment, procedures, services or supplies, including oral appliances, to diagnose, prevent, or correct any ailments or defects of the teeth and supporting tissue. Expenses for such treatment, procedures, services or supplies are considered Dental Expenses regardless of the reason they are provided.

"**Dependent**" means Your family as follows:
1. The lawful spouse*, if not legally separated or divorced who is under age 64 and 11 months and is not a full-time active duty member in the armed forces other than for reserve duty of 30 days or less;
2. Children (whether natural, stepchildren, adopted, or children placed for adoption) under the limiting age of 26 and is not a full-time active-duty member in the armed forces other than for reserve duty of 30 days or less; or
3. Children for whom You are required to provide insurance under a medical support order or an order enforceable by a court.

*The term "lawful spouse" as used throughout this Certificate will also mean Your legal Domestic Partner or Civil Union partner.

"**Domestic Partner**" means an opposite or same sex person with whom You maintain a committed relationship and share a familial relationship characterized by mutual caring and the sharing of a mutual residence and who has registered under state law as a domestic partner. Each partner must:
1. Be at least 18 years old and competent to contract
2. Be the sole domestic partner of the other person; and
3. Not be married.

"**Doctor**" means any duly licensed practitioner who is recognized by the law of the state in which treatment is received as qualified to perform the service for which claim is made and who is not a member of Your immediate family.

"**Eligible Expense**" means those expenses incurred for a covered Injury or Sickness:
1. which are for Medically Necessary services, supplies, or treatment, except for preventative services where expressly covered by this Certificate;
2. which are prescribed or provided by a Doctor;
3. which are incurred while coverage is in force for a Covered Person;
4. which are not in excess of the Maximum Allowable Expense;
5. for which a Covered Person is legally liable; and
6. which are not otherwise excluded by this Certificate or exceed any limits or amounts payable under this Certificate.

The Company reserves the right to interpret and determine coverage for Eligible Expenses. The fact that a Doctor has prescribed, recommended, approved, or provided a treatment, service or supply does not, in itself, make such treatment, service or supply a Medically Necessary covered Eligible Expense.

"**Enrollment Form**" means the form(s) that You (and Your spouse, if any) signed, or otherwise certified, in order to apply for coverage under the Policy. It also includes any other document approved by the Company that You use to change coverage under the Policy.

"**Experimental or Investigational Treatment**" means in Our discretion a treatment, drug, device, procedure, supply or service and related services (or any portion thereof, including the form, administration or dosage) for a particular diagnosis or condition when any one of the following exists:
1. The treatment, drug, device, procedure, supply or service is in any clinical trial or a Phase I, II or III trial.
2. The treatment, drug, device, procedure, supply or service is not yet fully approved or recognized (for other than experimental, investigational, research or clinical trial purposes) by the National Cancer Institute (NCI), Food & Drug Administration (FDA), or other pertinent governmental agency or professional organization.

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3. The results are not proven through controlled clinical trials with results published in peer-reviewed English language medical journals, to be of greater safety and efficacy than conventional treatment, in both the short and long term.
4. The treatment, drug, device, procedure, supply or service is not generally accepted medical practice in the state where the Covered Person resides or as generally accepted throughout the United States as determined in Our discretion, by reference to any one or more of the following: peer-reviewed English-language medical literature, consultation with physicians, authoritative medical compendia, the American Medical Association, or other pertinent professional organization or governmental agency.
5. The treatment, drug, device, procedure, supply or service is described as investigational, experimental, a study, or for research or the like in any consent, release or authorization which the Covered Person, or someone acting on his or her behalf, may be required to sign.

The fact that a procedure, service, supply, treatment, drug, or device may be the only hope for survival will not change the fact that it is otherwise experimental in nature.

"**Extended Care Facility**" means an institution, other than a Hospital, operated and licensed pursuant to law, that provides: (a) permanent and full-time facilities for the continuous skilled nursing care of three (3) or more sick or injured persons on an Inpatient basis during the convalescent stage of their Sicknesses or Injuries; (b) full-time supervision of a Doctor; (c) twenty-four (24) hour a day nursing service of one or more nurses; and (d) is not, other than incidentally, a rest home or a home for custodial care or for the aged. Extended Care Facility does not include an institution that primarily engages in the care and treatment of drug addiction or alcoholism.

"**Home Health Care Agency**" means an entity licensed by state or local law operated primarily to provide skilled nursing care and therapeutic services in an individual's home and:
1. Which maintains clinical records on each patient;
2. Whose services are under the supervision of a Doctor or a licensed graduate registered nurse (RN); and
3. Which maintains operational policies established by a professional group including at least one Doctor and one licensed graduate registered nurse (RN).

"**Home Health Care Plan**" means a program for continued care and treatment of an individual established and approved in writing by the individual's attending Doctor. As part of the plan, an attending Doctor must certify that proper treatment of the Injury or Sickness would require continued confinement in a Hospital in the absence of the services and supplies.

"**Hospital**" means an institution operated by law for the care and treatment of Injuries or Sicknesses; has organized facilities for diagnosis and surgery or has a contract with another Hospital for these services; and has 24-hour nursing service. Hospital excludes any institution that is primarily a rest home, nursing home, assisted living facility, Custodial or Convalescent Care facility, Extended Care Facility, a home for the aged, an alcoholism or drug addiction treatment facility or a facility for treatment of Mental Disorders.

"**Immediate Family**" means the parents, lawful spouse, children, or siblings of a Covered Person, or any person residing with a Covered Person.

"**Injury**" means Accidental bodily Injury of a Covered Person:
1. Caused by an Accident; and
2. That results in covered loss directly and independently of all other causes.

All Injuries sustained in one Accident, including all related conditions and recurring symptoms of the Injuries, will be considered one Injury.

"**Inpatient**" means a Covered Person who incurs medical expenses for at least one day's room and board from a Hospital.

"**Insured**" means the Applicant named in the attached Enrollment Form and to whom the Certificate is issued.

"**Intensive Care or Critical Care Unit**" means that part of a Hospital service specifically designed as an intensive care or critical care unit permanently equipped and staffed to provide the highest level of care for critically ill or Injured patients, including a Coronary Care Unit and Neonatal Intensive Care Unit. Coverage includes close observation by trained and qualified personnel whose duties are primarily confined to the part of the Hospital for which an additional charge is made.

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“**Maximum Allowable Expense**” means the maximum charge that will be considered as an Eligible Expense will be the lesser of billed charges, the maximum benefit under this Policy, or 150% of the Medicare allowable charge. Amounts in excess of the Maximum Allowable Expense may be subject to balance billing by the Doctor, Hospital or other medical provider.

“**Medically Necessary**” means that, based on generally accepted current medical practice, a service or supply is necessary and appropriate for the diagnosis or treatment of Injury or Sickness. We do not consider a service or supply as Medically Necessary if:

1. It is provided only as a convenience to the Covered Person or provider;
2. It is not appropriate treatment for the Covered Person’s diagnosis or symptoms;
3. It exceeds (in type, scope, site, duration or intensity) that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment;
4. It is Experimental or Investigational.

The fact that a Doctor may prescribe, order, recommend or approve a service or supply does not, of itself, make the service or supply Medically Necessary.

“**Mental Disorder**” means a serious “biologically-based” mental disorder, including Schizophrenia, Schizoaffective disorder, Major depressive disorder, Bipolar disorder, Paranoia and other psychotic disorders, Obsessive-compulsive disorder, Panic disorder, Delirium and dementia, Affective disorders, and any other "biologically-based" mental disorders appearing in the most recent edition of the Diagnostic and Statistical Manual of the American Psychiatric Association (the "DSM").

“**Occupational Therapy**” means constructive therapeutic activity designed and adapted to promote the restoration of useful physical function. Occupational Therapy does not include educational training or services designed and adapted to develop a physical function.

“**Out Of Pocket Maximum**” means an amount of allowable expenses that is the responsibility of each Covered Person to meet before the Company will begin paying the expenses at 100%. It does not include Deductibles, Copayments, penalty coinsurance for failure to pre-certify required services or charges in excess of the Maximum Allowable Expense. Once the Out-of-Pocket Maximum is met, the Policy will begin paying 100% of Eligible Expenses for the remainder of the Coverage Period, not to exceed Coverage Period Maximum Benefit and any applicable benefit limits.

“**Outpatient**” means a Covered Person who incurs medical expenses at Doctor’s offices and freestanding clinics, and at Hospitals when not admitted as an Inpatient.

“**Outpatient Surgical Facility**” means a licensed medical facility or a part of a Hospital:

1. With an organized staff of Doctors;
2. That is permanently equipped and operated primarily for the purpose of performing surgical procedures;
3. That does not provide accommodations for overnight stays; and
4. That provides continuous Doctor services and nursing services whenever a patient is in the facility.

The term “Outpatient Surgical Facility” does not include a:

1. Hospital emergency room or free-standing emergency room;
2. Trauma center;
3. Doctor’s office; or
4. Urgent care center.

“**Physical Therapy**” means the treatment of a disease, Injury or condition by physical means by a Doctor or a registered professional physical therapist under the supervision of a Doctor and which is designed and adapted to promote the restoration of a useful physical function. Physical Therapy does not include educational training or services designed and adapted to develop a physical function.

“**Prescription Drug**” means any medication or medicinal substance which has been approved by the U.S. Food and Drug Administration for general use and which can, under federal or state law, be dispensed only pursuant to a Prescription Order (a legend drug). Insulin and the syringes necessary for its injection are considered Prescription Drugs.

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"**Routine Physical Exam**" means examination of the physical body by a Doctor for preventive or informative purposes only, and not for the diagnosis or treatment of any condition.

"**Sickness**" means a Covered Person's illness, disease, Complication of Pregnancy, or condition that:
1. Is treated by a Doctor while the person is covered under the Policy; and
2. Results directly and independently of all other causes covered by the Policy.

"**Specialists**" means doctors who have completed advanced education and clinical training in a specific area of medicine.

"**Speech Therapy**" means the treatment for the correction of a speech impairment resulting from disease, trauma, congenital anomalies, previous therapeutic processes, psycho-social speech delay, behavioral problems, attention disorder, conceptual handicap or mental retardation and which is designed and adapted to promote the restoration of a useful physical function.

"**Substance Abuse**" means drug (whether prescribed by a Doctor or not) or chemical abuse, overuse or dependency and the resultant physiological and/or psychological effects requiring medical treatment, procedures, services or supplies, including detoxification.

"**Surgery or Surgical Procedure**" means an invasive diagnostic procedure; or the treatment of Injury or Sickness by manual or instrumental operations performed by a Doctor while the patient is under general or local anesthesia.

"**You**" **(**or "**Your**" **or** "**Yours**"**)** means the Insured.

PART II – ELIGIBILITY AND EFFECTIVE DATE OF INSURANCE

Coverage will be effective for You and Your Covered Dependent(s), as of the approved Certificate Effective Date, provided:
1. You meet the eligibility requirements set forth in the Group Policyholder Application and the Policy;
2. Your Enrollment Form is approved by Us;
3. The first premium payment is received on or before the date Your Enrollment Form is approved by Us.

Newborn Child Coverage: A child of the Insured born while the Policy is in force is covered for Injury and Sickness (including Medically Necessary care and treatment of a Congenital Condition, birth abnormality and premature birth), as well as routine newborn care, which includes any hearing loss screening tests of newborns and infants provided by the hospital before discharge. Coverage for a child born after the Certificate Effective Date will be effective from the moment of birth and will remain in force for 31 days, or until this Policy terminates, whichever is sooner. A notice of birth, together with any additional premium, must be submitted to us within 31 days of the birth in order to continue coverage for Injury and Sickness beyond the initial 31-day period.

Adopted Children Coverage: Coverage for Injury or Sickness for a child adopted by You or a child placed with You for the purpose of adoption after the Certificate Effective Date will be effective for the first 31 days, or until this Policy terminates, whichever is sooner. Coverage for such child will be at either the date of placement of the child in the home, or the date of the final decree of adoption, whichever is earlier. To continue coverage beyond 31 days, an Insured must enroll the adopted child and pay any required premium within 31 days from either the date of placement or the final decree of adoption. The coverage of such child will be the same as provided for other members of the Insured's family.

PART III – TERMINATION OF INSURANCE

Coverage under the Policy will cease at 12:01 a.m. for a Covered Person, based on the time zone in the place where the Insured resides, on the earliest of the following:
1. The date premiums are not paid in accordance with the terms of the Policy, subject to the Grace Period;
2. On the next premium due date after the Company receives a written request from the Insured to terminate coverage, or any later date stated in the request;

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3. The date an Insured performs an act or practice that constitutes fraud, or is found to have made a misrepresentation of material fact, relating in any way to the Policy, including claims for benefits under the Policy;
4. The date of the Insured's death or the termination date of the Insured's coverage, if the Insured's spouse is not covered under the Policy;
5. The Certificate Termination Date stated on Your Schedule of Benefits.
6. The date that You enter full-time active duty in the armed forces of any country or international organization other than for reserve duty of 30 days or less;
7. The date other major medical insurance coverage becomes effective for a Covered Person;
8. The date You become eligible for Medicare;
9. The date that insurance under the Policy is discontinued; or
10. The first day of any policy month We elect to terminate the Policy by giving the Group Policyholder at least 30 days advance written notice.

TERMINATION UPON INSURED'S DEATH

The Insured will cease to be a Covered Person on the date of their death. If the Insured's spouse is a Covered Person when the Insured dies, the spouse will become the Insured.

TERMINATION OF SPOUSE'S COVERAGE

The Insured's spouse will cease to be a Covered Person at the earlier of:
1. The date of their death;
2. The date the spouse and Insured become legally divorced or legally separated;
3. The date the spouse becomes eligible for Medicare; or
4. The date that the spouse enters full-time active duty in the armed forces of any country or international organization other than for reserve duty of 30 days or less.

TERMINATION OF A CHILD'S COVERAGE

A child's coverage will terminate on the at the earlier of:
1. The date the child ceases to meet the requirements of a Dependent; or
2. The date that the child enters full-time active duty in the armed forces of any country or international organization other than for reserve duty of 30 days or less.

CONTINUATION OF COVERAGE FOR AN INCAPACITATED CHILD

Coverage for a Dependent child, who reaches the limiting age as defined in the definition of Dependent, will continue if the child continues to be both:
1. Incapable of self-sustaining employment by reason of mental incapacity or physical handicap; and
2. Remains dependent upon the Insured for support and maintenance.

Coverage for such child will continue while the coverage is in force and so long as such incapacity continues and the applicable premium is paid.

EXTENSION OF BENEFITS

If a Covered Person is Hospital confined on the date insurance ends, other than for failure to pay the required premium, benefits will be continued only for the condition causing the Hospital confinement until the earlier of:
1. the date such Hospital confinement ends;
2. the date when treatment for the condition causing the Hospital confinement is no longer required;
3. the date following a time period equal to the number of days in the Covered Person's Coverage Period, with a minimum of thirty (30) days not to exceed a maximum of ninety (90) days;
4. the date the Covered Person becomes eligible for any other major medical plan, including Medicaid or Medicare, providing coverage for the same conditions causing the Hospital Confinement; or
5. the date the Coverage Period Maximum Benefit under the Policy has been reached.

Benefits payable due to the Extension of Benefits provision after the expiration date or when a Covered Person's coverage ends, are subject to new Deductible(s).

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PART IV – PREMIUMS

1. Unless the single payment option has been chosen, premium due dates for an Insured will be on the Certificate Effective Date and then the same date of each following calendar months. If a month has fewer days than the scheduled premium due date, premium will be due on the last day of the month. All insurance shall be charged from and to the premium due date.

2. Upon Your death, or when a change in benefits, change in Dependents, or clerical error affects premiums, an equitable adjustment in premiums shall be made on the premium due date next following the date of the change or the discovery of the error. Any premium adjustment that involves collecting earned premiums, or returning unearned premium shall be limited to the six (6) months immediately preceding the date of determination that the adjustment in premium should be made. A "change in Dependents" is when a Dependent is added pursuant to the terms of this Policy as a Covered Person or ceases to be a Covered Person pursuant to the terms of this Policy.

3. Premiums shall be payable in advance to Us at Administrator's Office.

4. Grace Period. You have a 31-day Grace Period for the payment of each premium due after the first premium. Your coverage will continue in force during the Grace Period unless You have given Us prior written notice of termination. If such a premium is not paid by the end of the Grace Period, all such insurance will end as of the due date of such premiums, and no expenses incurred during the Grace Period will be considered for benefits.

5. The Policy does not share in the surplus earnings of the Company and no refund or assessment shall be made to the Group Policyholder, Insured, or Dependent of any excess or deficit earnings of the Company.

6. Reinstatement. If the premium is not paid before the grace period ends, Your coverage will lapse. If the premium is received after the grace period ends but within 45 days of the premium due date, acceptance of such premium by Us (or by an agent authorized to accept payment) will reinstate this Certificate, as of the date of acceptance of the late premium. The reinstated Certificate will cover only Covered Expenses that result from an Injury sustained after the date of reinstatement or from Sickness that begins more than ten days after the date of reinstatement. In all other respects Your rights and Our rights will remain the same subject to any provisions noted on or attached to the reinstated Certificate.

7. Unearned Premium. Upon receipt of a request for a pro rata refund by a party legally entitled to claim such a refund, a refund of the unearned premium prorated to the month of the Insured's death if the request has been made within one year after the Insured's death. The refund of the premium and termination of the coverage shall be without prejudice to any claim originating prior to the date of the Insured's death.

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PART V – BENEFITS

This Part explains how We will pay benefits under the Policy. The section entitled **ELIGIBLE EXPENSES** lists the types of medical care that We cover and to what extent. In order for Us to pay benefits, You or the Covered Person must meet the following conditions:

1. You or a Covered Person must receive medical care while coverage under the Policy is in force for such person;
2. Medical care must not be excluded under **PART VII – EXCLUSIONS AND LIMITATIONS**; and
3. Medical care must consist of services or supplies that a Doctor has prescribed and that are Medically Necessary for the diagnosis or treatment of a covered Injury or Sickness.

WHAT WE PAY

Benefits are payable under the Policy after a Covered Person incurs charges for Eligible Expenses in excess of any applicable Additional Deductible, and then the Plan Deductible or Copayment, unless otherwise specified. Benefits will be paid at the Coinsurance amount shown in the Schedule of Benefits. Once the Out-of-Pocket Maximum amount is reached, the Coinsurance amount for the remainder of the Coverage Period is 100%. All benefits payable are subject to the Coverage Period Maximum Benefit. Your Schedule of Benefits shows Your Plan Deductible, Additional Deductibles, Copayment, Coinsurance amount, Out of Pocket Maximum amount and Coverage Period Maximum Benefit. Reimbursement is also

subject to any benefit limitations shown in the Schedule of Benefits. Eligible Expenses for the same treatment or service that are applicable to more than one benefit limitation shown in the Schedule of Benefits will be applied toward all applicable limitations.

PLAN DEDUCTIBLE
The Plan Deductible is the amount of Eligible Expenses a Covered Person must incur during a Coverage Period before We pay benefits.

FAMILY DEDUCTIBLE MAXIMUM
Once 3 Covered Persons have met their respective Plan Deductible in a Coverage Period, no further Plan Deductible will be required for the remainder of the Coverage Period. The Family Deductible Maximum does not apply to any additional Deductibles, which still must be satisfied if applicable.

ADDITIONAL DEDUCTIBLES:

FOREIGN TRAVEL DEDUCTIBLE - An additional Deductible must be paid for Eligible Expenses incurred in a foreign country for Sickness or Injury after which the Plan Deductible and Coinsurance will apply.

COPAYMENT AMOUNTS:

EMERGENCY ROOM COPAYMENT – A Copayment must be paid for Eligible Expenses incurred for use of an emergency room in the event of Sickness or Injury not to exceed a maximum of 3 Emergency Room Copayments per Covered Person. Emergency room visits in excess of the maximum number of visits will be subject to the Plan Deductible and Coinsurance. The Copayment is waived if the Covered Person is directly admitted as an Inpatient for further treatment after which the Plan Deductible and Coinsurance will apply.

ADVANCED DIAGNOSTIC STUDIES COPAYMENT – A Copayment must be paid per occurrence for Eligible Expenses incurred in a non-Hospital setting for Advanced Diagnostic Studies, not to exceed a maximum of 3 Advanced Diagnostic Studies Copayments per Covered Person. Occurrences in excess of the maximum number of Advanced Diagnostic Studies Copayments will be subject to the Plan Deductible and Coinsurance.

COVERAGE PERIOD MAXIMUM BENEFIT
All benefits under this Policy are subject to the Coverage Period Maximum Benefit shown in the Schedule of Benefits.

SAMPLE

PART VI – ELIGIBLE EXPENSES

The Policy covers the Eligible Expenses listed below. We apply these Eligible Expenses separately for each Covered Person.

An expense is “incurred” on the date a provider or facility performs the service or furnishes the supplies.

The following are Eligible Expenses under the Policy:

1. Charges for Inpatient Hospital services:
   a. Daily room and board and nursing services not to exceed the average standard room rate. If a Hospital has only private rooms, Eligible Expenses will be limited to 90% of the private room charge;

b. Daily room and board and nursing services in an Intensive Care or Critical Care Unit;
c. Use of operating, treatment or recovery room; and
d. Miscellaneous tests, services and supplies.

2. Charges for Outpatient Hospital services.

3. Charges for care received in a Hospital emergency room or a free standing emergency room.

4. Charges for Surgery at an Outpatient Surgical Facility, including services and supplies.

5. Charges for Inpatient Doctor visits.

6. Charges made by a Doctor for surgery and other professional services.

7. Charges for a surgical assistance or a surgeon assistant up to 20% of the Maximum Allowable Expense allowance for the primary surgical procedure performed during the operative session.

8. Charges for the administration of anesthetics up to 20% of the Maximum Allowable Expense allowance for the primary surgical procedure performed during the operative session.

9. Charges for routine child health care for periodic visits that include a history, a physical examination, a development assessment, anticipatory guidance and immunizations, including but not limited to measles, mumps, rubella, poliomyelitis, diphtheria, pertussis, tetanus, and haemophilus influenza type B, and laboratory tests consistent with the Recommendations of Preventative Pediatric Health Care of the American Academy of Pediatrics from the moment of birth to age 16. Immunizations are not subject to the Plan Deductible.

10. Charges for dressings, sutures, casts or other supplies which are administered by or under the supervision of a Doctor, but excluding nebulizers, oxygen tanks, supplies for use or application at home and all devices or supplies for repeat use at home.

11. Charges for diagnostic testing using radiology, ultrasonographic or laboratory services (psychometric, intelligence, behavioral and educational testing are not included).

12. Charges for artificial eyes or larynx, breast prosthesis or basic functional artificial limbs, but not their replacement or repair.

13. Charges for reconstructive surgery directly related to surgery which is covered under the Policy, including reconstructive breast surgery and prosthetic devices incident to a Mastectomy. Coverage will also include all stages of reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction on a non-diseased breast to establish symmetry with the diseased breast and prostheses and physical complications of mastectomy, including lymphedemas. As used in this benefit: “Mastectomy” means the surgical removal of all or part of a breast as a result of breast cancer. “Reconstructive breast surgery” means surgery performed as a result of a mastectomy to reestablish symmetry between the two breasts and includes augmentation mammoplasty, reductive mammoplasty and mastopexy.

14. Charges for radiation therapy or treatment and chemotherapy, including orally administered chemotherapy that is used to kill or slow the growth of cancerous cells on the same basis that intravenously administered or injected anticancer medications is covered. Pre-Certification may apply.

SAMPLE

15. Charges for blood and blood products, administration of blood and blood processing.

16. Charges for an Extended Care Facility room and board accommodations; if:
    a. The Covered Person is receiving skilled nursing care as an Inpatient in that facility on the certification of the attending Doctor that the confinement is Medically Necessary.
    b. The confinement commences immediately following a period of at least three (3) continuous days of Hospital confinement; and
    c. The confinement is for the same covered Injury or Sickness that was treated during the Covered Person's confinement in the Hospital.

17. Charges for treatment of a Covered Person by a Home Health Care Agency under a Home Health Care Plan. Eligible Expenses for Home Health Care are:
    a. Part-time skilled nursing care;
    b. Home Health aide services/supplies when under a R.N.'s direct supervision;
    c. Physical, occupational and speech therapy;
    d. Medical supplies; and
    e. Respiratory therapy.

    However, benefits will not be paid for charges made by a Home Health Care Agency for:
    a. Full-time nursing care at home;
    b. Meals delivered to the home;
    c. Homemaker services;
    d. Any services of an individual who ordinarily resides in the Covered Person's home or is a member of the Insured's immediate family; or
    e. Any transportation services.

    Benefits for Home Health Care are in lieu of any similar benefits provided under any other provision of the Certificate.

18. Charges for hospice care and services incurred for a terminally ill Covered Person with a life expectancy of 6 months or less. Eligible Expenses include charges incurred for care and services when provided by an agency licensed or certified to provide hospice services, including the following:
    a. Inpatient and Outpatient care.
    b. Part-time or intermittent home nursing care by, or under the direction of a nurse;
    c. Physical, respiratory or speech therapy performed by a licensed therapist;
    d. Nutrition counseling provided by or under the direction of a registered dietitian; and
    e. Counseling by a licensed social worker, pastoral counselor for the Covered Person or a member of the Immediate Family, the primary care giver and individuals with significant personal ties to a Covered Person who is terminally ill.

    Hospice services must be:
    a. Under active management through an agency licensed or certified to provide hospice services and which is responsible for coordinating all such services; and
    b. Provided only if the Doctor submits written certification to Us that the Covered Person is terminally ill with a life expectancy of 6 months or less. Review of Medically Necessity may be periodically required.

    This benefit does not include the services of volunteers or persons who do not regularly charge for their services.

19. Charges for ambulance transport to the nearest Hospital qualified to treat Injuries or medical emergencies. In order for benefits to be payable, transportation due to Sickness must result in Inpatient Hospitalization.

20. Charges for the rental of a standard, basic Hospital bed and/or wheelchair, up to the purchase prices, not including expenses for customization and only for the portion of the cost equivalent to the Coverage Period.

21. Charges for Physical Therapy, Occupational Therapy and Speech Therapy from a licensed or registered provider to improve or restore lost function caused by a Sickness or Injury covered under this Policy when ordered by the attending Doctor.

SAMPLE

22. Charges for organ or tissue transplants including all expenses related to the transplant before the transplant is performed, for the procurement of the donor organ or tissue, the Hospital expenses of the donor, and for follow-up care, including any complications while this coverage is in force.

    Eligible Expenses do not include organ or tissue transplants which:
    a. Are animal-to-human transplants;
    b. Use artificial or mechanical organs;
    c. Are Experimental or Investigative; or
    d. Are not generally accepted by the medical community as an effective treatment for a covered Injury or Sickness.
    e. Relate to a condition that is excluded under **PART VII – EXCLUSIONS AND LIMITATIONS.**

23. Charges for temporomandibular joint disorder (TMJ) and Craniomandibular Disorder procedures involving any bone or joint of the jaw, face, or head, so long as the procedure is Medically Necessary to treat a condition which prevents normal functioning of the particular bone or joint involved and the condition is caused by congenital deformity, disease, or traumatic Injury. Authorized therapeutic procedures include splinting and the use of intraoral prosthetics applied to reposition the bones. However, this does not include coverage for orthodontic braces, crowns, dentures, treatment for periodontal disease, dental root form implants or root canals.

24. Charges for treatment rendered in a Hospital or by a licensed treatment facility or other provider licensed to treat Mental Disorders as defined in this Certificate.

25. Charges for treatment rendered in a Hospital or by a licensed treatment facility or other provider licensed to treat Substance Abuse.

26. Charges for Primary treatment and Outpatient Treatment for alcoholism consisting of not less than:
    a. thirty (30) days of Inpatient treatment for the Primary Treatment of alcoholism in any 365 day period; and
    b. sixty (60) Outpatient Treatment visits during any Coverage Period.

    "Primary Treatment" means Inpatient treatment rendered in a structured and scheduled setting to prevent further ingestion of alcoholic beverages, to relieve the pain of the withdrawal syndrome, and to provide intensive therapy or rehabilitation, when such treatment is rendered in a Hospital or a substance abuse treatment center which is certified or accredited to render such care.

    "Outpatient Treatment" means counseling and therapy provided on a nonresidential basis when such treatment is rendered in or through a hospital, a substance abuse treatment center, or an Outpatient Program which is certified or accredited to render such care.

    "Outpatient Program" means a program that is licensed or certified by the Department of Health and Human Services or the Division of Behavioral Health of the Department of Health and Human Services to provide specified services to persons suffering from the disease of alcoholism.

    "Substance abuse treatment center" means an institution licensed as a substance abuse treatment center by the Department of Health and Human Services, which provides a program for the inpatient or outpatient treatment of alcoholism pursuant to a written treatment plan approved and monitored by a physician and which is affiliated with a hospital under a contractual agreement with an established system for patient referral.

27. Charges for the screening, diagnosis and treatment of an autism spectrum disorder in a Covered Person under twenty-one (21) years of age. Benefits will be covered the same as any other Sickness. However, behavioral health treatment, including applied behavior analysis, will not exceed twenty-five (25) hours per week until the Covered Person reaches twenty-one (21) years of age.

    "Autism spectrum disorder" means any of the pervasive developmental disorders or autism spectrum disorder as defined by the Diagnostic and Statistical Manual of Mental Disorders.
    "Diagnosis" means a Medically Necessary assessment, evaluation, or test to diagnose if an individual has an autism spectrum disorder.

SAMPLE

“Treatment” means evidence-based care, including related equipment, that is prescribed or ordered for an individual diagnosed with an autism spectrum disorder by a Doctor or a licensed psychologist, including: (a) behavioral health treatment; (b) psychiatric care; (c) psychological care; and (d) therapeutic care.

“Behavioral health treatment” means counseling and treatment programs, including applied behavior analysis, that are: (a) necessary to develop, maintain, or restore, to the maximum extent practicable, the functioning of an individual; and (b) provided or supervised, either in person or by telehealth, by a behavior analyst certified by a national certifying organization or a licensed psychologist if the services performed are within the boundaries of the psychologist's competency.

“Applied behavior analysis” means the design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

“Psychiatric care” means a direct or consultative service provided by a psychiatrist licensed in the state in which he or she practices;

“Psychological care” means a direct or consultative service provided by a psychologist licensed in the state in which he or she practices.

“Therapeutic care” means a service provided by a licensed speech-language pathologist, occupational therapist, or physical therapist.

28. Charges for diabetes equipment, supplies, medication, and outpatient self-management training and patient management, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin-using diabetes if prescribed by a Doctor legally authorized by law to prescribe such items.

    This benefit includes: blood glucose monitors; blood glucose monitors for the legally blind; test strips for glucose monitors; urine testing strips; insulin; injection aids; lancet and lancet devices; syringes; insulin pumps and all supplies for the pump; insulin infusion devices; oral agents for controlling blood sugars; glucose agents and glucagon kits; insulin measurement and administration aids for the visually impaired; patient management materials that provide essential diabetes self-management information; and podiatric appliances for the prevention of complications associated with diabetes.

    Benefits will be provided for the patient upon the diagnosis of diabetes, when a significant change occurs in the patient's symptoms or condition that necessitates changes in a patient's self-management, or when refresher patient management is necessary. This includes home visits when Medically Necessary and prescribed by a Doctor legally authorized by law to prescribe such items. Patient management may be conducted individually or in a group setting as long as there is Medical Necessity.

    Diabetes self-management training and patient management, including medical nutrition therapy, shall be provided by an American Diabetes Association Recognized Diabetes Self-Management Education Program or a health care professional that is a diabetes educator certified by the National Certification Board for Diabetes Educators.

    Doctor-prescribed diabetes self-management training and patient management will be covered at diagnosis, when symptoms or conditions change, and when new medications or treatments are prescribed. Diabetes self-management education must be deemed to be Medically Necessary by a Doctor to be eligible. Benefits for such coverage will not exceed $500 in a two-year period.

29. Charges for a screening mammography as follows: (1) one baseline mammogram for a female Covered Person for ages 35 through 39; one mammogram every 2 years for ages 40 through 49 (or more frequently if recommended by a Doctor) and one mammogram for 50 years of age or older. “Screening mammography” means radiological examination of the breast of asymptomatic women for the early detection of breast cancer, which examination shall include a cranio-caudal and a medial lateral oblique view of each breast, and a licensed radiologist's interpretation

SAMPLE

of the results of the procedure. Screening mammography shall not include diagnostic mammography, additional projections required for lesion definition, breast ultrasound, or any breast interventional procedure. Screening mammography shall be performed by a mammogram supplier who meets the standards of the federal Mammography Quality Standards Act of 1992.

30. Charges for telehealth will be provided on the same basis as if it were provided through in person consultation between the Covered Person and the provider. "Telehealth" means the use of medical information electronically exchanged from one site to another, whether synchronously or asynchronously, to aid a health care provider in the diagnosis or treatment of a patient. Telehealth includes services originating from a patient's home or any other location where such patient is located, asynchronous services involving the acquisition and storage of medical information at one site that is then forwarded to or retrieved by a health care provider at another site for medical evaluation, and telemonitoring. "Telemonitoring" means the remote monitoring of a patient's vital signs, biometric data, or subjective data by a monitoring device which transmits such data electronically to a health care provider for analysis and storage.

31. **Applicable only to Covered Persons with a Policy Term of more than six months:** Charges for a screening for colorectal cancer examination and laboratory tests for cancer for any nonsymptomatic person fifty (50) years of age and older. This includes a maximum of one screening fecal occult blood test annually and a flexible sigmoidoscopy every five (5) years, a colonoscopy every ten (10) years, or a barium enema every five (5) to ten (10) years, or any combination, or the most reliable, medically recognized screening test available. The screens selected shall be deemed appropriate by a Doctor and the Covered Person. Benefits will be subject to any applicable Plan Deductible, Copayment and Coinsurance. No benefit will be paid for services under this benefit if a benefit for this service has already been paid for under the Wellness Benefit.

32. Charges for Medically Necessary hearing aids for a Dependent child under the age of 19, for each ear affected by a hearing impairment. Benefits are subject to the same Deductible, Coinsurance and Copayment as similar covered items but will not exceed $3,000 every 48 months. Coverages includes the following items and services for each ear affected by a hearing impairment:
    1. A hearing aid purchased from a licensed audiologist with the medical clearance form an otolaryngologist and costs related for dispensing;
    2. Evaluation for, fitting an programing, probe microphone measurements for verification of that hearing aid gain and output meet the prescribed targets;
    3. Repairs, follow-up adjustments, servicing, and maintenance;
    4. Ear mold impressions;
    5. Ear molds;
    6. Auditory rehabilitation and training; and
    7. Replacement of a hearing aid and the associated services within 3 months of the dispensing date if the hearing aid gain and output fail to meet prescribed target or it is unable to be repaired or adjusted.

    As used in this benefit "Hearing aid" means an ear level or bone conduction hearing device intended to aid or improve the sense of hearing for a person with a hearing impairment. The term includes all parts, replacement parts, parts for repair, tubing, and ear molds. "Hearing impairment" means a hearing impairment diagnosed by an otolaryngologist with an auditory assessment completed by a licensed audiologist.

Pre-Certification Requirements

A. All Inpatient Hospitalizations and procedures done at an Outpatient Surgery Facility must be pre-certified.
B. To comply with the pre-certification requirements, the Covered Person must:
    1. Contact the professional review organization at the following telephone number 1-800-641-5566 as soon as possible <u>before</u> the expense is to be incurred; and
    2. Comply with the instructions of the professional review organization and submit any information or documents they require; and
    3. Notify all Doctors, Hospitals and other providers that this insurance contains pre-certification requirements and ask them to fully cooperate with the professional review organization.
C. If the Covered Person complies with the pre-certification requirements, and the expenses are pre-certified, the Company will pay Eligible Expenses subject to all terms, conditions, provisions and exclusions described in this Certificate.

SAMPLE

D. If the Covered Person does not comply with the pre-certification requirements, or if the expenses are not pre-certified, Eligible Expenses will be reduced by 50%.
E. Emergency pre-certification: In the event of an emergency Hospital admission, pre-certification must be made within 48 hours after the admission, or as soon as is reasonably possible.
F. Pre-certification Does Not Guarantee Benefits – The fact that expenses are pre-certified does not guarantee either payment of benefits or the amount of benefits. Eligibility for and payment of benefits are subject to all the terms, conditions, provisions and exclusions of this Certificate.
G. Concurrent Review – For Inpatient stays of any kind, the professional review organization will pre-certify a limited number of days of confinement. Additional days of Inpatient confinement may later be pre-certified if a Covered Person receives prior approval.

PART VII – EXCLUSIONS AND LIMITATIONS

Loss caused by, contributed to or resulting from the following is excluded or otherwise limited as specified:

1. Pre-Existing Conditions: Charges resulting directly or indirectly from a condition for which a Covered Person received medical treatment, diagnosis, care or advice, including diagnostic tests or medications, within the 60-month period immediately preceding such person's Certificate Effective Date are excluded for the first 12 months of coverage hereunder.

   This exclusion does not apply to a newborn child or newborn adopted child who is added to coverage in accordance with PART II – ELIGIBILITY AND EFFECTIVE DATE OF INSURANCE.

2. Waiting Period:
   a. Covered Persons will only be entitled to receive benefits for Sicknesses that begin, by receipt of treatment, more than 5 days following the Covered Person's Certificate Effective Date of coverage under the Policy.
   b. Covered Persons will only be entitled to receive benefits for Cancer that begins, by receipt of treatment more than 30 days following the Covered Person's Certificate Effective Date of coverage under the Policy.

3. Charges during the first 6 months after the Certificate Effective Date of coverage for a Covered Person for the following:
   a. Total or partial hysterectomy, unless it is Medically Necessary due to a diagnosis of carcinoma;
   b. Tonsillectomy;
   c. Adenoidectomy;
   d. Repair of deviated nasal septum or any type of surgery involving the sinus;
   e. Myringotomy;
   f. Tympanotomy;
   g. Herniorraphy; or
   h. Cholecystectomy.

   However, if such condition is a Pre-Existing Condition, any benefit consideration will be in accordance with the Pre-Existing Conditions limitation.

4. The benefits payable for the following conditions or procedures are limited to the specified amounts shown in the Schedule of Benefits:
   a. Kidney stones
   b. Appendectomy
   c. Joint or tendon Surgery
   d. Knee Injury or disorder
   e. Acquired Immune Deficiency Syndrome (AIDS)/ Human Immuno-deficiency Virus (HIV)
   f. Gallbladder Surgery

5. Charges which are not incurred by a Covered Person during his/her Coverage Period.

6. Charges which exceed any limits or limitations specified in this Certificate, including the Schedule of Benefits.

7. Charges for services of supplies in excess of the Maximum Allowable Expense.

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8. Charges for services or supplies which are not administered by or under the supervision of a Doctor.

9. Mental, emotional or nervous disorders or counseling of any type, except as specifically covered as an Eligible Expense.

10. Marital counseling or social counseling.

11. Treatment for Substance Abuse, unless specifically covered under the Policy as an Eligible Expense.

12. Prescription Drugs, except those administered by a Doctor in an Inpatient or Outpatient setting covered under this Policy as an Eligible Expense.

13. Medications, vitamins, and mineral or food supplements including pre-natal vitamins, or any over-the-counter medicines, whether or not ordered by a Doctor.

14. Any drug, treatment or procedure that either promotes or prevents conception including but not limited to: artificial insemination, treatment for infertility or impotency, sterilization or reversal of sterilization.

15. Any drug, treatment or procedure that corrects impotency or non-organic sexual dysfunction.

16. Modifications of the physical body in order to improve the psychological, mental or emotional well-being of the Covered Person, such as sex-change surgery.

17. Cosmetic Treatment, except for reconstructive surgery where expressly covered under the Policy.

18. Weight modification or surgical treatment of obesity.

19. Eye surgery, including LASIK, when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.

20. Dental Expenses, except as necessary to restore or replace sound and natural teeth lost or damaged as a result of an Injury. The Injury must be severe enough that the contact with the Doctor occurs within seventy-two (72) hours of the Accident, unless extenuating circumstances exist due to the severity of the Injury that prevent you from contacting the Doctor.

21. Expenses incurred in the treatment by any method for jaw joint problems including temporomandibular joint dysfunction (TMJ), TMJ pain syndromes, craniomandibular disorders, myofacial pain dysfunction or other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the joint, unless specifically covered under the Policy as an Eligible Expense.

22. Routine pre-natal care, Pregnancy, child birth, and post-natal care. (This exclusion does not apply to “Complications of Pregnancy” as defined.)

23. Charges for a Covered Dependent who is a newborn child not yet discharged from the Hospital, unless the charges are Medically Necessary to treat premature birth, congenital Injury or Sickness, or Sickness or Injury sustained during or after birth.

24. Sclerotherapy for veins of the extremities.

25. Abortions, except in connection with covered Complications of Pregnancy or if the life of the expectant mother would be at risk.

26. Joint replacement or other treatment of joints, spine, bones or connective tissue including tendons, ligaments and cartilage, unless related to a covered Injury.

27. Surgeries, treatments, services or supplies which are deemed to be Experimental Treatment.

SAMPLE

28. Chronic fatigue or pain disorders.

29. Kidney or end stage renal disease.

30. Treatment or diagnosis of allergies, except for emergency treatment of allergic reactions.

31. Treatment for cataracts.

32. Treatment of sleep disorders.

33. Treatment required as a result of complications or consequences of a treatment or condition not covered under this Certificate.

34. Treatment incurred as a result of exposure to non-medical nuclear radiation and/or radioactive material(s).

35. Treatment for acne, moles, skin tags, diseases of sebaceous glands, seborrhea, sebaceous cyst, unspecified disease of sebaceous glands, hypertrophic and atrophic conditions of skin, nevus.

36. Treatment for or related to any Congenital Condition, except as it relates to a newborn child or newborn adopted child added as a Covered Person pursuant to the terms of this Certificate.

37. Treatment, medication or hormones to stimulate growth, or treatment of learning disorders, disabilities, developmental delays or deficiencies, including therapy.

38. Spinal manipulation or adjustment.

39. Biofeedback, acupuncture, recreational, sleep or MIST Therapy®, holistic care of any nature, massage and kinestherapy, excepted as provided for under Home Health Care.

40. Hypnotherapy when used to treat conditions that are not recognized as Mental Disorders by the American Psychiatric Association, and non-medical self-care or self-help programs.

41. Eyeglasses, contact lenses, hearing aids, hearing implants, eye refraction, visual therapy, orthoptics, visual eye training and any examination or fitting related to these devices, and all vision and hearing tests and examinations.

42. Care, treatment or supplies for the feet, orthopedic shoes, orthopedic prescription devices to be attached to or placed in shoes, treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions and treatment of corns, calluses or toenails.

43. Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Doctor.

44. Exercise programs, whether or not prescribed or recommended by a Doctor.

45. Telephone or Internet consultations and/or treatment or failure to keep a scheduled appointment.

46. Charges for travel or accommodations, except as expressly provided for local ambulance.

47. All charges incurred while confined primarily to receive Custodial or Convalescent Care.

48. Services received or supplies purchased outside the United States, its territories or possessions, or Canada, unless specifically covered under the Policy as an Eligible Expense.

49. Any services or supplies in connection with cigarette smoking cessation.

50. Any services performed or supplies provided by a member of a Covered Person's Immediate Family.

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51. Services received for any condition caused by a Covered Person's commission of or attempt to commit a felony, whether charged or not, or to which a contributing cause was the Covered Person being engaged in an illegal occupation.

52. Services or supplies which are not included as Eligible Expenses as described herein, to include charges for a Doctor's office visit, consultation, or urgent care center visit.

53. Participating in hazardous occupations or other activity including participating, instructing, demonstrating, guiding or accompanying others in the following: operation of a flight in an aircraft other than a regularly scheduled flight by a commercial airline, professional or semi-professional sports, extreme sports, parachute jumping, hot-air ballooning, hang-gliding, base jumping, mountain climbing, bungee jumping, scuba diving, sail gliding, parasailing, parakiting, rock or mountain climbing, cave exploration, parkour, organized racing including stunt show or speed test of any motorized or non-motorized vehicle, or rodeo activities. Also excluded is Injury received while practicing, exercising, undergoing conditional or physical preparation for such activity.

54. Injuries or Sicknesses resulting from participation in interscholastic, intercollegiate or organized competitive sports. This does not include dependent children participating in local community sports activities.

55. Injury resulting from being under the influence of or due wholly or partly to the effects of alcohol or drugs, other than drugs taken in accordance with treatment prescribed by a Doctor.

56. Intentionally self-inflicted Injury or Sickness (whether the Covered Person is sane or insane).

57. Charges resulting from a declared or undeclared war, or from voluntary participation in a riot or insurrection.

58. Charges incurred by a Covered Person while on active duty in the armed forces. Upon written notice to Us of entry into such active duty, the unused premium will be returned to the Covered Person on a pro-rated basis.

59. Costs for Routine Physical Exams or other services not needed for medical treatment, unless specifically covered under the Policy as an Eligible Expense.

60. Charges You or Your Covered Dependent are not required to pay, or which would not have been billed if no insurance existed.

61. Charges to the extent that they are paid or payable under other valid or collectible group insurance or medical prepayment plan.

62. Charges that are eligible for payment by Medicare or any other government program except Medicaid. Costs for care in government institutions unless You or Your Covered Dependent are obligated to pay for such care.

63. Charges related to Injury or Sickness arising out of or in the course of any occupation for compensation, wage or profit, if the Covered Person is insured, or is required to be insured, by occupational disease or workers' compensation insurance pursuant to applicable state or federal law, whether or not application for such benefits have been made.

64. Medical expenses which are payable under any automobile insurance policy without regard to fault (does not apply in any state where prohibited).

PART VIII – COORDINATION OF BENEFITS (COB)

Some people have health care coverage through more than one medical insurance plan at the same time. COB allows these plans to work together so the total amount of all benefits will never be more than 100 percent of the allowable expenses during any coverage year. This helps to hold down the costs of health coverage.

COB does not apply to life insurance or accidental death and dismemberment benefits. COB also does not apply to major medical insurance as coverage hereunder ceased for a Covered Person as of the date major medical insurance became effective.

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The term “plan” applies separately to each policy, contract agreement or other arrangements for benefits or services. The term “plan” also applies separately to that part of any policy, contract, agreement or other arrangements for benefits or services that coordinates its benefits with other plans and to that part that does not.

When a plan provides benefits in the form of services rather than cash payment the reasonable cash value of each service rendered will be considered to be both: (1) an allowable expense; and (2) a benefit paid.

Definitions. “Plan” – means any of the following which provides benefits or services for medical expenses:

1. Any group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, or group practice coverage.
2. Any federal, state or local governmental programs, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time.)

Each contract or other arrangement for coverage under the above paragraphs is a separate plan. Also, if an arrangement has two parts and COB rules apply to one of the two, each of the parts is construed to mean a separate Plan.

The term “plan” does not include:

1. Individual or family insurance or subscriber contracts;
2. Individual or family coverage through Health Maintenance Organizations (HMOs);
3. Individual or family coverage under other prepayment, group practice and individual practice plans;
4. School Accident-type coverages. (These contracts cover students for accidents only, including athletic injuries, either on a twenty-four-hour basis or on a to-and-from school basis);
5. Group or group-type hospital indemnity benefits of $100 per day or less;
6. Medicare Supplement policies;
7. A state plan under Medicaid.

“**Primary Plan (Primary)**” – means the Plan which determines its benefits before those of the other Plan. When there are more than two (2) Plans, This Plan may be Primary as to one and Secondary as to another.

“**Secondary Plan (Secondary)**” – means the Plan which determines its benefits after those of the other Plan. When there are more than 2 Plans, This Plan may be Secondary as to one and Primary as to another.

“**This Plan**” – means the benefits provided under this group Policy.

Effect on Benefits. Plans use COB to decide which plan should pay first for a covered expense. If the Primary Plan’s payment is less than the charge for the allowable expense, then the Secondary Plan will apply its benefit payment to the balance.

The following rules will be used to establish the order of benefit determination:

1. A plan which does not have a COB provision will always be the Primary Plan.

2. The benefits of a plan which covers the person on whose expenses the claim is based as other than a dependent will be determined before the benefits of a plan which covers the person as a dependent. However, if the person is also a Medicare beneficiary, and if the rule established under the Social Security Act of 1965, as amended, makes Medicare secondary to the plan covering the person as a dependent of an active employee, the order of benefit determination is:
   a. First, benefits of a plan covering persons as an employee, member, or subscriber.
   b. Second, benefits of a plan of an active worker covering persons as a dependent.
   c. Third, Medicare benefits.

3. The benefits of a plan that covers a person for whom a claim is made as a dependent child will be determined under the following rules:
   a. When the parents are married: the benefits of a plan which covers the child as a dependent of the parent whose birthday anniversary occurs earlier in the calendar year will be determined before the benefits of a plan which covers the child as a dependent of the parent whose birthday anniversary occurs later in the calendar year.

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b. If both parents have the same birthday the benefits of the plan that covered the parent longer are determined before those of the plan that covered the other parent for a shorter period of time.
c. If the plans do not agree on the order of benefit rules because the other plan does not have the rule described in this section, but has a rule based upon the gender of the parent, the rule in the other plan will determine the order of benefits.
d. When the parents are separated or divorced and the parent with custody has not remarried the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.
e. When the parents are divorced and the parent who has custody of the child has remarried: (a) the benefits of a plan which covers the child as a dependent of the parent with custody will be determined before the benefits of a plan which covers the child as a dependent of the step-parent; and (b) the benefits of a plan that covers the child as a dependent of the step-parent will be determined before the benefits of a plan that covers the child as a dependent of the parent without custody.
f. Despite (2) and (3) above, if there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, the benefit payment of a plan which covers the child as a dependent of the parent with such financial responsibility will be determined before the benefit payment of any other plan that covers the child as a dependent child.

4. The benefits of a plan that covers a person as a primary insured who is neither laid off nor retired, or as that primary insured's dependent, are determined before those of a plan that covers that person as a laid off or retired primary insured or as that primary insured's dependent. This rule will not apply if the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits.

5. If a person whose coverage is provided under a right of continuation pursuant to federal or state law is covered under another plan, the following will be the order of benefit determination:
   a. First, the benefits of a plan covering the person as an employee, member, or subscriber (or as that person's dependent);
   b. Second, the benefits under the continuation coverage. If the other plan does not have the rule described above and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

6. When rules (2) through (5) above do not establish an order of benefit determination the benefits of a plan which has covered the person on whose expenses the claim is based for the longer period of time will be determined before the benefits of a plan which has covered the person the shorter period of time.

Facility of Payment. If another plan makes a benefit payment that should have been made by us, We have the right to pay the other plan any amount We deem necessary to satisfy Our obligation under these COB rules.

Right of Recovery. If the amount of Our benefit payment is more than the amount needed to satisfy Our obligation under these COB rules, We have the right to recover the excess amount from: (A) any persons to or for whom, or with respect to whom, the payments were made; (B) any insurance companies; or (C) any other organizations.

Right to Receive and Release Necessary Information. In order to carry out these COB rules:
1. We have the right, without the consent of or notice to any person, to exchange information with any person, insurance company or organization, as we deem necessary; and
2. Any person claiming benefits under this plan must give Us any information necessary to carry out this provision.

PART IX – CLAIM PROVISIONS

Notice of Claim: Written notice of claim must be given within 31 days after a covered loss begins (or longer, if required by state law) or as soon as is reasonably possible. Failure to give notice within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible. The notice must be given to the Administrator named on the Schedule of Benefits. Notice should include information that identifies the claimant and the Policy.

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Claim Forms: When the Administrator or We receive notice of claim, forms for filing proof of loss will be sent to the claimant. If claim forms are not supplied within 15 days a claimant can give proof as follows:

1. In writing;
2. Setting forth the nature and extent of the loss; and
3. Within the time stated in the Proof of Loss provision.

(If the Insured resides in Georgia, the reference to 15 days is changed to 10 working days.) If such forms are not furnished before the expiration of 15 days after the insurer receives notice of any claim under the Policy, the person making such claim shall be deemed to have complied with the requirements of the Policy as to proof of loss upon submitting, within the time fixed in the Policy for filing proof of loss, written proof covering the occurrence, character and extent of the loss for which claim is made.

Proof of Loss: Written proof of loss must be given to the Administrator named on the Schedule of Benefits within 90 days after the loss begins. We will not deny nor reduce any claim if it was not reasonably possible to give proof of loss in the time required. In any event, proof must be given to the Administrator within one year, or as otherwise specified by state law, after it is due unless the Insured is legally incapable of doing so.

Time of Payment of Claim: Benefits for loss covered by the Policy will be paid immediately upon receipt of proper written proof of such loss.

Payment of Claims: All benefits will be paid to the Insured, if living, unless an Assignment of Benefits has been requested by the Insured. Any other benefits due and unpaid at the Insured's death will be paid to the Insured's estate. If a benefit is to be paid to the Insured's estate, or to an Insured or beneficiary who is not competent to give a valid release, the Company may pay up to $5,000 of such benefit to one of the Insured's relatives who is deemed by the Company to be justly entitled to it. Such payment, made in good faith, fully discharges the Company to the extent of the payment.

Physical Examination: At Our expense, We may have a person claiming benefits examined as often as reasonably necessary while the claim is pending and also the right and opportunity to make an autopsy in the case of death where it is not prohibited by law.

Third Party Liability: No benefits are payable to or for a Covered Person for any Sickness, Injury, or other condition for which a third party may be liable or legally responsible by reason of negligence, an intentional act or omission, or breach of any legal obligation on the part of such third party. Nevertheless, the Company may elect to advance the benefits of this Policy to or for a Covered Person. If the Company determines it will advance the benefits of this Policy, such advance(s) will be subject to the following:

1. The Covered Person agrees to advise Us, in writing, within 60 days of any Covered Person's claim against the third party and to take such action, provide such information and assistance, and execute such paper as We may require to facilitate enforcement of the claim. The Covered Person and Insured, if other than the Covered Person, also agree to take no action that may prejudice Our rights or interests under this Policy. Failure to provide notice of a claim or to cooperate with Us, or actions that prejudice Our rights or interests, will be material breach of this Policy and will result in the Covered Person and/or the Insured, if other than the Covered Person, being personally responsible for reimbursing Us.
2. We will automatically have a lien, to the extent of benefits advanced, upon any recovery that any Covered Person receives from the third party, the third party's insurer, or the third party's guarantor. Recovery may be by settlement, judgment or otherwise. The lien will be in the amount of benefits paid by Us under this Policy for the treatment of the Sickness or Injury for which the third party is liable.

PART X – GENERAL PROVISIONS

Time Limit on Certain Defenses: All statements made by You or Your Dependents shall be deemed representations and not warranties, and no statement made by any person insured shall be used in any contest unless a copy of the instrument containing the statement is or has been furnished to such person or, in the event of the death or incapacity of the Covered Person, to the individual's beneficiary or personal representative. Any misstatement or omission of information made on Your Enrollment Form or on any other materials on which We relied to issue, change or increase coverage will be considered

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a misrepresentation and may be the basis for later rescission of coverage. The validity of coverage issued under the Policy with respect to an Insured or his Dependents may not be contested after two years from the Certificate Effective Date, except for fraud or nonpayment of premiums.

Change of Beneficiary: Unless the Insured makes an irrevocable designation of beneficiary, the right to change of beneficiary is reserved to the Insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of the policy, to any change of beneficiary or beneficiaries, or to any other changes in the policy.

Complaint/Grievance: You or someone acting on Your behalf may appeal any coverage or claim determination made by Us to deny, reduce, or terminate the provision or payment for Eligible Expenses under Your Certificate.

You have one year after the receipt of the adverse decision to request an appeal. Include in Your request any additional medical information that You feel is pertinent to Your case. We will send You written acknowledgement of Your request.

The appeal will be completed and a written notification of Our decision will be sent to You within 15 working days of initiation of the appeal process.

Internal appeal of an adverse determination will be conducted by individuals that were not involved in the original determination. If the appeal involves a medical judgment, We will consult with appropriate medical personnel necessary to make the determination.

If you have not yet received the services you are appealing:
For pre-service appeals will be completed within 15 calendar days of receipt of the appeal request. "Pre-service" means any claim for a benefit under a group health plan with respect to which the terms of the plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

Our internal appeals process will be exhausted upon completion of the pre-service appeal or the Appeal decision.

Urgent Care: You and Your Doctor have a right to request an expedited review verbally or by fax if, in the judgment of Your treating Doctor, Your health could be harmed if standard timeframes are followed. Submit requests for expedited review to: Claims@InsuranceTPA.com, Appeals Department .

Expedited appeal determinations will be rendered within seventy-two (72) hours of receipt of the request. If additional information is necessary for Us to conduct the review, we will contact you within 24 hours of the request and specify the information which is necessary to complete the review. You will have 48 hours to provide the required information. A determination will be made within 48 hours of receiving the information or the expiration of the time afforded for You to provide the information to Us, whichever is earlier.

If Your request for an expedited review is to extend the course of treatment beyond the approved time or number of treatments, Your request must be received 24 hours prior to the expiration of the approved course of treatment. We will make our determination and You will be notified within 24 hours of Your request.

Request can be submitted by telephone, in writing, or via fax to:

Everest Reinsurance Company (InsuranceTPA.com)
Telephone: 1-800-279-2290
FAX: 608-501-1068, Attention: Appeals Department

When we have made an adverse claim determination based on a judgment as to Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of the health care service, You have the right to have Our decision reviewed by an independent review organization external to Us. A request for an external independent review must be submitted to the:

Nebraska Department of Insurance
P.O. Box 95087
Lincoln, NE 68509-5087
402-471-2201
www.doi.nebraska.gov

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within 4 months from the date You received notice of the adverse determination through Our internal appeal process.

For standard external reviews, a decision will be made within 45 days of receiving your request. Except when a Covered Person's life or health would be seriously jeopardized, You must first exhaust Our internal appeal process before we will grant Your request for an external independent review. Appeals must be submitted in accordance with Our appeal policy and required timeframes, as set forth in Your Certificate. If the Covered Person's life or health would be seriously jeopardized due to a delay, and our denial to provide or pay for health care services or course of treatment is based on a determination that the service or treatment is experimental or investigational, you may be entitled to file a request for expedited external review of our denial, upon certification by the Covered Person's treating physician. The Covered Person may not have to complete the internal appeals process to request an expedited external review.

The Nebraska Department of Insurance may be contacted for assistance at any time during the appeal process at:

Nebraska Department of Insurance
P.O. Box 95087
Lincoln, NE 68509-5087
402-471-2201
Toll free: 877-564-7323

Conditions Precedent to Legal Action: Litigation is an expensive and time-consuming way to resolve disagreements we may have related to the coverage, benefits and premiums under this Policy and should be the last resort in dispute resolution. In order to provide an opportunity to resolve such dispute without the need for litigation, You must give Us at least thirty (30) days written notice of Your intent to sue Us as a condition precedent to bringing any action at law or in equity. Such notice must, at a minimum, (1) identify the coverage, benefits or premiums or other aspects of the Policy over which We have a disagreement; (2) identify the specific Policy provision(s) at issue; and (3) include all relevant facts and information that support Your position.

Unless prohibited by law, You agree to waive an action for statutory or common law extra-contractual or punitive damages that You may have if the disputed claims are paid, or the issues giving rise to the disagreement are resolved or corrected within thirty (30) days after We received Your written notice of intention to sue.

Legal Action: No action at law or in equity may be brought to recover on the Policy before 60 days after written proof of loss has been furnished as required by the Policy. No such action may be brought after three years from the time written proof of loss is required to be furnished.

The Company recommends that You first complete all steps in any complaint/grievance procedures made available by Your state to resolve disputes under this Policy before bringing suit against the Company. After completing the complaint/grievance process, if You choose to bring action at law or in equity against Us relating to that dispute, You must do so within three years of the date We notify You of the final decision on Your complaint/grievance.

Misstatement of Age: If the age of any Covered Person is incorrectly stated, We will make a fair adjustment of the premiums, benefits or both. The adjustment will be based on the premiums and benefits that would have been payable had We known the correct information.

Not in Lieu of Workers' Compensation: The Policy is not in lieu of and does not affect requirements for coverage under workers' compensation laws.

Pronouns: Whenever a personal pronoun in the masculine gender is used, it will be deemed to include the feminine also, unless the context clearly indicates to the contrary.

Conformity With State and Federal Law: Any provision of this Certificate which, on its Effective Date, is in conflict with the laws of the federal government or the state in which the Insured resides on such date is hereby amended to conform to the minimum requirements of such law.

Clerical Error: Clerical errors that We or Our authorized Administrator make in Your Schedule of Benefits, the issuance of a Policy, or in record keeping will not afford You benefits or validate insurance for which You have not applied and paid the

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appropriate premium and been approved by Us. We have the right to offset or recover from You any overpayment of benefits made due to such errors.

Non-Waiver: If We or You fail to enforce or to insist on strict compliance with any of the terms, conditions, limitations or exclusions of this Policy, that will not be considered a waiver of any rights under the Policy. A past failure to strictly enforce the Policy will not be a waiver of any rights in the future, even in the same situation or set of facts.

Rescission: A misrepresentation or omission in the Enrollment Form or other documents provided to Us may be the basis for later rescission of all coverage of all Covered Persons. Rescission voids all coverage as of the Certificate Effective Date and means that no benefits will be paid to any person for any claim submitted. We will refund to You premiums paid after deduction for any claims We paid.

Medical Records: The Company shall have access to medical and treatment records of the Covered Persons to determine benefits, process claims, utilization review, quality assurance, or for any other purpose reasonably related to the Policy benefits. Each Covered Person shall complete and submit to the Company such additional consents, releases and other documents as may be requested by the Company in order to determine or provide benefits under the Policy. The Company reserves the right to reject or suspend a claim based on lack of supporting medical information or records.

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PART XI – SCHEDULE OF BENEFITS

INSURED:

MONTHLY PREMIUM:

CERTIFICATE NUMBER:

CERTIFICATE EFFECTIVE DATE:

CERTIFICATE TERMINATION DATE:

COVERAGE PERIOD:

COVERED PERSONS	RELATIONSHIP	AGE	DATE OF BIRTH

Description of Eligible Classes:

I. All active members of HealthyAmerica Association in the member class as determined by the bylaws or charter of the Association.

II. Dependents of the Insured as defined in the Policy.

COVERAGE AND BENEFIT AMOUNTS: Deductibles, Copayments, Coinsurance, Out of Pocket Maximum and the Coverage Period Maximum Benefit apply to each Covered Person and for ALL Eligible Expenses, unless otherwise stated.

Plan Deductible**	per Covered Person per Coverage Period. Maximum of 3 Deductibles per family per Coverage Period.
Additional Deductibles**	
Foreign Travel Deductible	$500 per Covered Person after which the Plan Deductible and Coinsurance will apply.

Copayments**

Copayments do not apply towards the Plan Deductible or Out of Pocket Maximum

Emergency Room Copayment	$500 Copayment per visit for use of emergency room in the event of Sickness or Injury, not to exceed a maximum of 3 Emergency Room Copayments per Covered Person. Coinsurance is 80% of Eligible Expenses and benefits are not subject to the Plan Deductible. Emergency room visits in excess of the maximum number of Emergency Room Copayments will be subject to the Plan Deductible and Coinsurance. The Copayment is waived if the Covered Person is directly admitted as an Inpatient for further treatment after which the Plan Deductible and Coinsurance will apply.

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Advanced Diagnostic Studies Copayment	$500 Copayment per occurrence for Advanced Diagnostic Studies in an Outpatient setting, not to exceed a maximum of 3 Advanced Diagnostic Studies Copayments per Covered Person. Coinsurance is 80% of Eligible Expenses and benefits are not subject to the Plan Deductible. Occurrences in excess of the maximum number of Advanced Diagnostic Studies will be subject to the Plan Deductible and Coinsurance.
Coinsurance Amount	80% of Eligible Expenses after the Plan Deductible and any Additional Deductibles, up to the Out of Pocket Maximum, then 100% of Eligible Expenses up to the overall Coverage Period Maximum Benefit.
Out of Pocket Maximum **The Deductible(s), Copayments, pre-certification penalties and amounts in excess of the Maximum Allowable Expense do not apply towards the Out-of-Pocket Maximum.	$2,000 per Covered Person per Coverage Period.
Coverage Period Maximum Benefit	$1,000,000 per Covered Person.
Lifetime Maximum Benefit	N/A
Penalty for failure to pre-certify	Eligible Expenses will be reduced 50%; any Deductible(s) will be subtracted from the remaining amount; and the Coinsurance will be applied.

Covered Services	Benefit Limits
Inpatient Hospital services:	
Average Standard Room Rate	Average Standard room rate. Benefits including nursing services and all miscellaneous medical charges are limited to $5,000 per day.
Intensive Care or Critical Care Unit	The benefit payable for each day of confinement in an Intensive Care or Critical Care Unit. Benefits including nursing services and all miscellaneous medical charges are limited to $5,000 per day.
Outpatient Miscellaneous Hospital Expenses	The benefit payable for miscellaneous Outpatient Hospital expenses, excluding Outpatient Surgery. Benefits are limited to $5,000 per Covered Person per Coverage Period for all Eligible Expenses combined.
Emergency Room **(This includes the emergency room physician charge, 24 hour surveillance and all miscellaneous medical charges)**	After the Copayment shown above, The benefit payable for each emergency room visit, including professional and facility services will not exceed $2,500.
Outpatient Surgical Facility	The benefit payable per day including all miscellaneous expenses is limited to $5,000.

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Inpatient Doctor visits	$100 per day Benefits for all Hospital visits during a Hospital stay are limited to $2,500 per Covered Person per Coverage period.
Surgeon	$20,000 per surgery, for all Eligible Expenses combined, not to exceed $40,000 per Covered Person per Coverage Period.
Assistant Surgeon and Surgical Assistant	$4,000 per surgery for all Eligible Expenses combined, not to exceed $8,000 per Covered Person per Coverage Period.
Administration of Anesthetics	$2,500 per surgery for all Eligible Expenses combined, not to exceed $5,000 per Covered Person per Coverage Period.
Home Health Care	$100 per visit. There is a limit of 1 visit per day not to exceed a maximum 40 Home Health Care visits per Covered Person per Coverage Period.
Ambulance	
Injury:	$1,000 per transport.
Sickness:	$1,000 per transport.
Physical, Occupational and Speech Therapy	$100 per day and 10 visits combined per Covered Person per Coverage Period.
Organ or tissue transplants	$100,000 per Covered Person per Coverage Period.
Foreign Travel	$50,000 per Covered Person per Coverage Period.
Temporomandibular Joint Disorder (TMJ):	$2,000 per Covered Person per Coverage Period
Kidney Stones	$5,000 per Covered Person per Coverage Period
Appendectomy	$5,000 per Covered Person per Coverage Period
Joint or Tendon Surgery	$5,000 per Covered Person per Coverage Period
Knee Injury or Disorders	$5,000 per Covered Person per Coverage Period
Acquired Immune Deficiency Syndrome (AIDS) Human Immunodeficiency Virus (HIV)	$5,000 per Covered Person per Coverage Period
Gallbladder Surgery	$5,000 per Covered Person per Coverage Period
Mental Disorders	
Inpatient:	$100 per day, 31 days maximum per Covered Person per Coverage Period.
Outpatient:	$50 per visit, 10 visit maximum per Covered Person per Coverage Period
Substance Abuse	
Inpatient:	$100 per day, 31 days maximum per Covered Person per Coverage Period.
Outpatient:	$50 per visit, 10 visit maximum per Covered Person per Coverage Period
Pre-Existing Conditions Allowance	Notwithstanding the Pre-Existing Conditions exclusion under Part VII of the Certificate, Eligible Expenses not to exceed $500 per Coverage Period will be allowed. Payment of any benefits, including application to the Deductible and

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Coinsurance, under this allowance does not waive, or in any manner whatsoever affect, any of the Covered Person's exclusions or limitations, including the Pre-Existing Conditions exclusion.

OPTIONAL RIDERS

Waiver of Pre-Existing Conditions Rider Included: ☐ Yes ☒No

COMPANY'S ADMINISTRATOR/AUTHORIZED REPRESENTATIVE(S):

Send Notice of Claim, Claim Forms, Proof of Loss and any other documents relating to claims to:

Name:	InsuranceTPA.com
Address:	P.O. Box 241869
City, State and ZIP:	Apple Valley, MN 55124

Send all other (non-Claim) notices or documentation to:

Name:	InsuranceTPA.com
Address:	PO Box 998
City, State and ZIP:	Janesville, WI 53547

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EVEREST REINSURANCE COMPANY

Statutory Office: 251 Little Falls Drive, Wilmington, DE 19808
Administrative Office: Warren Corporate Center, 100 Everest Way, Warren, NJ 07059
800-438-4375

(hereafter referred to as “We”, “Us”, “Our” or “the Company”)

CONSECUTIVE SHORT TERM MEDICAL INSURANCE PLAN AMENDMENT

This Amendment is attached to and made a part of Certificate to which it is attached.

The provisions of this Amendment are effective on the same date as the Certificate to which it is attached and will expire concurrently with the Certificate, which You may cancel at any time. This Amendment is issued as a convenience for Covered Person(s) under the Initial and Subsequent Period(s) of Coverage, subject to the following:

A. Any component of your Certificate that accumulates per Coverage Period will begin to accumulate anew on the effective date of each Subsequent Coverage Period with us. This includes any applicable deductible amounts, coinsurance out-of-pocket maximum amounts, number of days limits, visit limits, and maximum dollar limits.

B. The **NO CONTINUOUS COVERAGE** provision is removed and replaced with the following:

   NO CONTINUOUS COVERAGE – This Certificate provides coverage on a short term basis. It is not renewable. Although this short term plan may be rewritten for new and completely separate Coverage Periods (as long as You meet eligibility criteria), coverage does not continue from one Certificate to another. This means that a new Enrollment Form must be submitted, a new Certificate Effective Date is given, and a new Pre-Existing Condition exclusion period begins. Any medical condition which may have occurred and/or existed under a prior Certificate will be treated as a Pre-Existing Condition under the new Certificate. This Certificate will terminate on the earlier of the expiration of the Grace Period, if a monthly premium is due and unpaid, or 12:00 A.M., local time on the Certificate Termination Date at the Insured’s residence.

   The Company will waive the requirement for a new Enrollment Form for each Subsequent Coverage Period if the Certificate for the Initial or Subsequent Coverage Period was issued with this Consecutive Short Term Medical Insurance Plan Amendment.

C. The **Time Limit on Certain Defenses** provision is removed and replaced with the following:

   All statements made by You or Your Dependents shall be deemed representations and not warranties, and no statement made by any person insured shall be used in any contest unless a copy of the instrument containing the statement is or has been furnished to such person or, in the event of the death or incapacity of the Covered Person, to the individual’s beneficiary or personal representative. Any misstatement or omission of information made on Your Enrollment Form for the Initial Coverage Period or on any other materials on which We relied to issue, change or increase coverage will be considered a misrepresentation and may be the basis for later rescission of coverage. The validity of coverage issued under the Certificate with respect to an Insured or Dependents may not be contested after two years from the Initial Certificate Effective Date, except for fraud or nonpayment of premiums.

D. Any Dependent who qualified and was added as an eligible Dependent under the Initial Coverage Period with Us must continue to meet the eligibility requirements set forth in the Certificate for any Subsequent Coverage Period with Us.

E. For each Subsequent Coverage Period, You will be issued a new Certificate with this Consecutive Short Term Medical Insurance Plan Amendment, a new Certificate Number and Your premium may change due to a change in age or a change in the Covered Persons or due to a premium trend adjustment approved by the state. Your premium deductions will continue uninterrupted from one Certificate to the next unless You contact Us to cancel coverage.

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GENERAL DEFINITIONS

"Initial Coverage Period" means a period of coverage that begins when a Covered Person first becomes insured by Us under a Short Term Medical Insurance Certificate issued with the Consecutive Short Term Medical Insurance Plan Amendment.

"Subsequent Coverage Period(s)" means a period of coverage that begins when a Covered Person becomes insured by Us under a second or subsequent Short Term Medical Insurance Certificate without a break in coverage between the Initial Coverage Period and Subsequent Coverage Period(s). The total number of consecutive months for Initial and Subsequent Coverage Periods shall not exceed 36 months.

Nothing contained in this Amendment will be held to vary, alter, waive or extend any of the terms, conditions, agreements or limitations of this or any Certificate other than as stated above.

For: Everest Reinsurance Company

Jill Beggs
President and Chief Executive Officer

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NEBRASKA COMPARISON SUMMARY

COMPARISON OF ACA-COMPLIANT HEALTH PLANS AND SHORT-TERM MEDICAL INSURANCE

The following chart summarizes some of the differences between Affordable Care Act ("ACA") plans and your Short-Term Medical Insurance coverage. **Please refer to your Certificate for complete terms, conditions, limitations and exclusions**.

Coverage/Feature	ACA-Compliant Plans	Short-Term Medical Insurance
Deny applicants due to pre-existing conditions	No. ACA plans will not deny benefits due to your preexisting conditions.	Yes.
Coverage of pre-existing conditions	Yes.	No. Rider available at an additional cost for conditions that received treatment during a prior consecutive coverage period.
Prescription Drug Coverage	Yes. Covered as an essential health benefit.	No, unless administered by a Doctor in an Inpatient or Outpatient setting and covered under your Certificate. Outpatient prescription drugs are not covered.
Preventive or Wellness Care	Yes. Covered as an essential health benefit.	Yes for routine child health care and one annual Routine Physical Exam.
Maternity Coverage	Yes. Covered as an essential health benefit.	No, except for Complications of Pregnancy.
Mental Health and Substance Abuse	Yes. Covered as an essential health benefit.	Yes but coverage limits may apply. Refer to your Certificate Schedule of Benefits for limits on the number of covered days and the amount of benefit.
Rehabilitative and Habilitative Services	Yes. Covered as an essential health benefit.	Physical, Occupational and Speech Therapy are covered but have maximums on the number of covered days and amount of benefit.
Coverage availability	Apply only during Open Enrollment or Special Enrollment.	Apply at any time.
Type of Coverage	Comprehensive medical insurance coverage. All plans include the 10 essential health benefits required by the ACA.	Short term medical insurance coverage. Coverage varies by plan, and plans are NOT required to include the 10 essential health benefits required by the ACA.

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Coverage/Feature	ACA-Compliant Plans	Short-Term Medical Insurance
Coverage Duration	Entire Year.	364-day maximum.
Coverage immediately following Effective Date	Yes.	Yes for accidents. No for sickness (5 day waiting period) or cancer (30 day waiting period).
Healthcare provider networks - Doctors	Yes. When Insured uses in-network providers, they are not subject to balance billing.	No. Allowed expenses limited to 150% of the rates that Medicare would typically pay your hospital or facility. This is a fair payment but may be less than what your Doctor charges or is willing accept. If your Doctor does not accept this rate, you may be subject to balance billing by your Doctor.
Healthcare provider networks - Hospitals	Yes. When Insured uses in-network providers, they are not subject to balance billing.	No. Allowed expenses limited to 150% of the rates that Medicare would typically pay your hospital or facility. This is a fair payment but may be less than what your Hospital or facility charges or is willing accept. If your Hospital or facility does not accept this rate, you may be subject to balance billing by your Hospital or facility.
Maximum Benefit	Unlimited.	Yes. Maximum benefit per coverage duration period is available from $250,000 to $1,500,000.
Deductible and Coinsurance	Generally, you must pay all of the costs from providers up to the deductible amount you elected before the plan begins to pay. The coinsurance percentage is your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. This will vary based on the plan you pick.	Generally, you must pay all of the costs from providers up to the deductible amount you elected before the plan begins to pay. The coinsurance percentage is your share of the costs of a covered health care service, calculated as a percentage (for example, 20%) of the allowed amount for the service. This will vary based on the plan you pick.

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