HEALTHBRIDGE DPC

HAA

SAMPLE CERTIFICATES OF INSURANCE*

TEXAS

VISIT THE MEMBER PORTAL FOR YOUR CERTIFICATES OF INSURANCE.

https://members.haahub.com

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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.

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

IMPORTANT: This is a short-term, limited-duration certificate, NOT comprehensive health coverage

This is a temporary limited certificate that has fewer benefits and Federal protections than other types of health insurance options, like those on HealthCare.gov.

This certificate	Insurance on HealthCare.gov
Might not cover you due to preexisting health conditions like diabetes, cancer, stroke, arthritis, heart disease, mental health & substance use disorders	Can't deny you coverage due to preexisting health conditions
Might not cover things like prescription drugs, preventive screenings, maternity care, emergency services, hospitalization, pediatric care, physical therapy & more	Covers all essential health benefits
Might have **no limit on what you pay** out-of-pocket for care	Protects you with limits on what you pay each year out-of-pocket for essential health benefits
You **won't qualify** for Federal financial help to pay premiums & out-of-pocket costs	Many people qualify for Federal financial help
Doesn't have to meet Federal standards for comprehensive health coverage	All plans must meet Federal standards

SAMPLE

Looking for comprehensive health insurance?

- **Visit HealthCare.gov** or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this certificate?

For questions or complaints about this certificate, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (naic.org) under "Insurance Departments."

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SHORT TERM MEDICAL INSURANCE CERTIFICATE OF COVERAGE

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.

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. Texas laws will govern any Certificate issued to Texas residents.

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.**

For: Everest Reinsurance Company

Jill Beggs
President and Chief Executive Officer

Sylvia Semerdjian
Secretary

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.

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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.

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.

"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 364 days 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, 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.

SAMPLE

“**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 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, children placed for adoption or children for whom You are in a party in a suit which the adoption of such child by You is being sought, or grandchildren** who, at the time of application, can be claimed as a dependent on Your federal tax return) 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.

> **(Coverage for a grandchild may not be terminated solely because he or she is no longer a Dependent of the Insured for federal tax purposes).

“**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, age of majority or be legally emancipated;
2. Each is mentally competent to consent to contract;
3. Be the sole domestic partner of the other person; and
4. 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.

“**Emergency Care**” means bona fide emergency services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:
1. placing the patient’s health in serious jeopardy;
2. serious impairment to bodily functions; or
3. serious dysfunction of any bodily organ or part.

“**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.

SAMPLE

"**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.
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.

"**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.

SAMPLE

"**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.

"**Maximum Allowable Expense**" means the maximum charge that will be considered as an Eligible Expense will be the lesser of billed charges, the Usual and Customary Fee, the negotiated or contracted discount, the maximum benefit under this Policy, or 150% of the Medicare allowable charge.

"**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.

SAMPLE

“**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.

“**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 alcohol, 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.

“**Usual and Customary Fee” (or “Fees”)** means the usual, fair and reasonable fee for medical treatment provided to a Covered Person (or any other form of medical care, procedure, drug or supply). In determining a Usual and Customary Fee, the Company at its discretion, consults:
1. one (1) or more standard industry sources to calculate services of comparable severity and nature in the same geographical area, the cost of the goods and services reasonably required to produce and deliver such treatment and/or the charge most commonly paid for such treatment. The standard industry sources utilize cost-based formula methodology and/or pricing data (updated semi-annually) to produce replicable and consistent cost and/or pricing parameters.
2. the cost to the health care provider of performing or providing the medical treatment, including reasonable allowance for overhead and profit.
3. fee schedules used by third parties such as Medicare or Medicaid, including Medicare allowable charge data for Medicare Part B.
4. hospital cost data as submitted to Medicare, including Medicare allowable charge data for Medicare Part A.
5. prevailing negotiated fee schedules for same or similar services performed in the same geographical area.

“**You**” **(**or “**Your**” **or** “**Yours**”**)** means the Insured.

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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 and for administration of the newborn screening tests required by the Health and Safety Code, including the cost of a newborn screening test kit, in the amount published by the Department of State Health Services on its Internet website. 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; a child placed with You for the purpose of adoption or a child for whom the You are a party to a suit in which You seek to adopt such child, 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, the date the Insured becomes a party to a suit to adopt the child, 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. Such child's coverage will not be subject to any pre-existing conditions limitation provided by the Policy. Coverage for such minor child will continue unless the petition for adoption is dismissed or denied. A child for which the Insured is a party in a suit in which the adoption of child is sought shall be deemed an adopted child.

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;
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.

SAMPLE

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).

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.

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.

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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 Deductible(s, 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 Deductible(s), 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.

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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 appropriate immunizations (including but not limited to: diphtheria; haemophilus influenzae type b; hepatitis B; measles; mumps; pertussis; polio; rubella; tetanus; and varicella; and any other immunization that is required for the child by law) 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. Coverage for inpatient care will be provided for a minimum of 48 hours following a mastectomy; and 24 hours following a lymph node dissection for the treatment of breast cancer. We are not required to provide the minimum hours of coverage of inpatient care if your Doctor determines that a shorter period of inpatient care is appropriate. 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 coverage for a prescribed, orally administered anticancer medication that is used to kill or slow the growth of cancerous cells.

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

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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.

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;

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c. Are Experimental or Investigative;
d. Are not generally accepted by the medical community as an effective treatment for a covered Injury or Sickness.
e. Performed in a country that is known to have participated in forced organ harvesting;
f. The human organ to be transplanted was procured by a sale or donation originating in a country that is known to have participated in forced organ harvesting; or
g. Relate to a condition that is excluded under **PART VII – EXCLUSIONS AND LIMITATIONS.**

"Forced organ harvesting" means the removal of one or more organs from a living person by means of coercion, abduction, deception, fraud, or abuse of power or a position of vulnerability.

23. Charges for temporomandibular joint disorder (TMJ) 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 developmental defect or pathology on the same basis as any other 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. Treatment, when under the order of the attending Doctor with concurrence of the attending dentist, will include that which is performed in a hospital or surgical center for an insured due to documented physical, mental, or medical reason.

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.
Benefits include treatment at one the following facilities in lieu of a Hospital Confinement, as certified by the Doctor:
a. Psychiatric Day Treatment Facility. The facility must be accredited by the Program of Psychiatric Facilities, or its successor, of the Joint Commission on Accreditation of Hospitals. Treatment must be for not more than eight hours in any 24 hour period.
b. Residential treatment center for children and adolescents. The facility must be accredited as a residential treatment center by the Council on Accreditation, the Joint Commission on Accreditation of Hospitals, or the American Association of Psychiatric Services for Children.
c. A crisis stabilization unit.
For the purpose of determining benefits and benefit maximums: (a) each full day of treatment in a Psychiatric Day Treatment Facility is the equivalent of one-half of one day of treatment of mental or emotional illness or disorder in a Hospital or inpatient program; and (b) each two days of treatment in a residential treatment center for children and adolescents is the equivalent of one day of treatment of mental or emotional illness or disorder in a Hospital or inpatient program.

Coverage is also provided for treatment rendered in a Crisis Stabilization Unit or a Residential Treatment Center for Children and Adolescents. Benefits will be paid on the same basis as Hospital confinement, subject to the following:
a. Treatment must be based on an Individual Treatment Plan;
b. Treatment must be provided in state licensed or certified facilities;
c. A Serious Mental Illness substantially impairs the Covered Person's thought, perception of reality, emotional process or judgment or grossly impairs behavior as manifested by recent disturbed behavior and which would otherwise necessitate confinement in a Hospital if care and treatment were not provided in the Crisis Stabilization Unit or Residential Treatment Center for Children and Adolescents.
For purposes of benefit payment, two days of treatment in a Crisis Stabilization Unit or Residential Treatment Center for children and adolescents will equal one day of treatment in a Hospital.

"Psychiatric Day Treatment Facility" means a mental health facility which provides treatment for individuals suffering from acute, mental and nervous disorders in a structured psychiatric program utilizing objectives appropriate both to the patient and the treatment modality of the program and that is clinically supervised by a doctor of medicine who is certified in psychiatry by the American Board of Psychiatry and Neurology.

25. Charges for treatment rendered in a Hospital or by a licensed treatment facility or other provider licensed to treat Substance Abuse. Benefits include treatment in a Chemical Dependency Treatment Center. "Chemical Dependency Treatment Center" means a facility which provides a program for the treatment of Chemical Dependency pursuant to a written treatment plan approved and monitored by a Doctor and which facility is also: (a)

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affiliated with a Hospital under a contractual agreement with an established system for patient referral; or (b) accredited as such a facility by the Joint Commission on Accreditation of Hospitals; or (c) licensed as a chemical dependency treatment program by the Texas Commission on Alcohol and Drug Abuse; or (d) licensed, certified, or approved as a chemical dependency treatment program or center by any other state agency having legal authority to so license, certify, or approved.

26. Charges for reconstructive surgery for craniofacial abnormalities for a child who is younger than 19 years of age. "Reconstructive surgery for craniofacial abnormalities" means surgery to improve the function of, or to attempt to create a normal appearance of an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease Benefits will be paid the same as any other Sickness.

27. Charges for a medically recognized screening examination for the detection of colorectal cancer for Covered Persons age 45 years of age or older and at normal risk for developing colon cancer. This includes: all colorectal cancer examinations, preventive services, and laboratory tests assigned a grade of "A" or "B" by the United States Preventive Services Task Force for average-risk individuals, including the services that may be assigned a grade of "A" or "B" in the future; and (b) an initial colonoscopy or other medical test or procedure for colorectal cancer screening and a follow-up colonoscopy if the results of the initial colonoscopy, test, or procedure are abnormal. 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.

28. Charges for an annual exam and prostate-specific antigen (PSA) for male insured Covered Person for the detection of prostate cancer who is: (a) at least 50 years of age and asymptomatic; or (b) at least 40 years of age with a family history of prostate cancer or another prostate cancer risk factor. 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.

29. Charges for an annual pap smear for women age 18 and over, when performed by a Doctor for the early detection of cervical cancer. Benefits will be paid for a conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the United States Food and Drug Administration, alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus and any other test or screening approved by the United States Food and Drug Administration for the detection of ovarian cancer. A screening test required under this benefit must be performed in accordance with the guidelines adopted by: (a) the American College of Obstetricians and Gynecologists; or (b) another similar national organization of medical professionals recognized by the commissioner. 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.

30. Charges for: (a) an annual screening by all forms of low-dose mammography for the presences of occult breast cancer for a female who is 35 years of age or older will be covered the same as any other Sickness; and (b) for a diagnostic imaging for the presence of occult breast cancer will be covered the same as a screening mammogram.

    "Diagnostic imaging" means an imaging examination using mammography, ultrasound imaging or magnetic resonance imaging that is designed to evaluate: (a) a subjective or objective abnormality detected by a Doctor in a breast; (b) an abnormality seen by a Doctor or patient on a screening mammogram; (c) an abnormality previously identified by a Doctor as probably benign in a breast for which follow-up imaging is recommended by a Doctor; or (d) an individual with a person history of breast cancer or dense breast tissue.

    "Low-dose mammography" means: (a) the x-ray examination of the breast using equipment dedicated specifically for mammography, including an x-ray tube, filter, compression device, screens, films, and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast; (b) digital imaging; or (c) breast tomosynthesis.

    "Breast tomosynthesis" means a radiologic mammography procedure that involves the acquisition of projection images over a stationary breast to produce cross-sectional digital three-dimensional images of the breast from which applicable breast cancer screening diagnoses may be determined.

    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.

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33. Charges for services otherwise covered under the Group Policy provided through telemedicine services and telehealth services will be covered the same as an in-person setting**.**

    "Telehealth service" means a health service, other than a telemedicine medical service, delivered by a licensed, certified, or otherwise entitled to practice in this state health professional acting within the scope of the health professional's license, certification or entitlement to a patient at a different physical location than the health professional using telecommunications or information technology.

    "Telemedicine medical service" means a health care service delivered by a Doctor licensed in this state or by a health professional acting under the delegation and supervision of a Doctor licensed in this state and acting within the scope of the Doctor's or health care professional's license to a patient at a different physical location than the Doctor or health care professional using telecommunications or information technology.

34. Charges for bone mass measurement to determine a risk of osteoporosis and fractures associated with osteoporosis for a Qualified Insured Person will be covered the same as any other Sickness. "Qualified Insured Person" means: (a) a postmenopausal woman who is not receiving estrogen replacement therapy;(b) an individual with (1) vertebral abnormalities; (2) primary hyperparathyroidis; or (3) a history of bone fractures; and (c) an individual who is: (1) receiving long-term glucocorticoid (steroid) therapy; or (2) being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

35. Charges for a screening test for hearing loss for a newborn child through the age of 30 days and the necessary diagnostic follow-up care related to the screening test for a newborn child through age 24 months.

36. Charges for coverage for the formulas necessary for the treatment of PKU or other heritable diseases to the same extent as for drugs available only on the orders of a Doctor. "Heritable disease" means an inherited disease that may result in mental or physical retardation or death. "Phenylketonuria" means an inherited condition that may cause severe mental retardation if not treated.

37. Charges for the screening a Dependent child for autism spectrum disorder at the ages of 18 and 24 months and treatment for a Dependent child from the date of diagnosis with autism spectrum disorder until the child completes nine years of age. Benefits will not exceed a maximum of $36,000 per year, for a Dependent child who is being treated for autism spectrum disorder and continues to need treatment beyond 10 years of age. Coverage will be provided for all generally recognized services prescribed in relation to autism spectrum disorder by the Dependent's primary care Doctor in the treatment plan recommended by that Doctor. An individual providing treatment must be a health care practitioner:
    a. who is licensed, certified, or registered by an appropriate agency of this state;
    b. whose professional credential is recognized and accepted by an appropriate agency of the United States; or
    c. who is certified as a provider under the TRICARE military health system.

    "Generally recognized services" may include services such as:
    a. evaluation and assessment services;
    b. applied behavior analysis;
    c. behavior training and behavior management;
    d. speech therapy;
    e. occupational therapy;
    f. physical therapy; or
    g. medications or nutritional supplements used to address symptoms of autism spectrum disorder.

38. Charges for screening for the early detection of cardiovascular disease a Covered Person (1) who is: (a) a male older than 45 years of age and younger than 65 years of age; or (b) a female older than 55 years of age and younger than 65 years of age; and (2) who: (a) is diabetic; or (b) has a risk of developing coronary heart disease, based on a score derived using the Farmingham Heart Study coronary prediction algorithm, that is intermediate or higher.

    Benefits will be payable not to exceed $200 for one of the following noninvasive screening tests for atherosclerosis and abnormal artery structure and function every five years, performed by a laboratory that is certified by a national organization recognized by the commissioner: (a) computed tomography (CT) scanning measuring coronary artery calcification; or (b) ultrasonography measuring carotid intima-media thickness and plaque. 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.

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39. Charges for prosthetic devices, orthotic devices and professional services related to the fitting and use of those devices that equals the coverage provided under federal laws for health insurance for the aged and disabled. Benefits will be provided the same as any other Sickness for the most appropriate model of prosthetic device or orthotic device that adequately meets the medical needs of the Covered Person as determined by the Covered Person's treating Doctor or podiatrist and prosthetist or orthotist, as applicable.

    Repair or replacement of a prosthetic device or orthotic device will not be covered if the repair or replacement is necessitated by misuse or loss. Coverage may be provided by a pharmacy that has employees who are qualified under the Medicare system and applicable Medicaid regulations to service and bill for orthotic services

40. Charges for routine patient care costs in connection with a phase I, phase II, phase III, or phase IV clinical trial will be covered the same as any other Sickness if the clinical trial is conducted in relation to the prevention, detection, or treatment of a life-threatening disease or condition and is approved by:
    a. the Centers for Disease Control and Prevention of the United States Department of Health and Human Services;
    b. the National Institutes of Health;
    c. the United States Food and Drug Administration;
    d. the United States Department of Defense;
    e. the United States Department of Veterans Affairs; or
    f. an institution review board of an institution in Texas that has an agreement with the Office for Human Research Protections of the United States Department of Health and Human Services.

    Benefits will not be payable to research institution conducting the clinical trial for the cost of routine patent care provided through the research institution unless the research institution, and each health care professional providing routine patient care through the research institution, agrees to accept reimbursement under this Policy as payment in full for the routine patient care provided in connection with the clinical trial. Benefits will not be payable for services that are a part of the subject matter of the clinical trial and that are customarily paid for by the research institution conducting the clinical trial.

    As used in this benefit,
    "Life threatening disease or condition" means a disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

    "Research institution" means the institution or other person or entity conducting a phase I, phase II, phase III, or phase IV clinical trial.

    "Routine patient care costs" means the costs of any Medically Necessary health care services for which benefits are provided under this Policy, without regard to whether the Covered Person is participating in a clinical trial. Routine patient care costs do not include:
    a. the cost of an investigational new drug or device that is not approved for any indication by the United States Food and Drug Administration, including a drug or device that is the subject of the clinical trial;
    b. the cost of a service that is not a health care service, regardless of whether the service is required in connection with participating in a clinical trial
    c. the cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
    d. a cost associated with managing a clinical trial; or
    e. the cost of a health care service that is specifically excluded under the Policy.

41. Charges for diabetic self-management training, equipment and supplies for a Qualified Insured Person. A Qualified Insured Person means an individual who has been diagnosed with:
    a. insulin dependent or non-insulin dependent diabetes;
    b. elevated blood glucose levels induced by pregnancy; or
    c. another medical condition associated with elevated blood glucose levels.

    Diabetes equipment and supplies includes:
    a. blood glucose monitors, including noninvasive glucose monitors and glucose monitors designed to be used by or adapted for the legally blind;
    b. test strips specified for use with a corresponding glucose monitor;
    c. lancets and lancet devices;

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d. visual reading strips and urine testing strips and tablets which test for glucose, ketones and protein;
e. insulin and insulin analog preparations;
f. injection aids, including devices used to assist with insulin injection and needleless systems;
g. insulin syringes;
h. biohazard disposal containers;
i. insulin pumps, both external and implantable, and associated appurtenances, which include: (i) insulin infusion devices; (ii) batteries; (iii) skin preparation items; (iv) adhesive supplies; (v) infusion sets; (vi) insulin cartridges; (vi) durable and disposable devices to assist in the injection of insulin; and (vii) other required disposable supplies;
j. repairs and necessary maintenance of insulin pumps not otherwise provided for under a manufacturer's warranty or purchase agreement, and rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which shall exceed the purchase price of a similar replacement pump;
k. prescription medications which bear the legend "Caution: Federal Law prohibits dispensing without a prescription" and medications available without a prescription for controlling the blood sugar level;
l. podiatric appliances, including up to two pairs of therapeutic footwear per year, for the prevention of complications associated with diabetes;
m. glucagon emergency kits; and
n. any new or improved diabetes supplies, including improved insulin or other prescription drugs, as approved by the U.S. Food and Drug Administration and determined by the Doctor as appropriate.

A Doctor or provider who is licensed, registered, or certified in the state of Texas and who is acting within the scope of practice authorized by the practitioner's or providers' license registration or certification to provide such training must provide diabetes self-management training. Self-management training includes:
a. Training provided to a Qualified Insured Person or caretaker after the initial diagnosis of diabetes in the care and management of that condition, including nutrition counseling and proper use of diabetes equipment and supplies;
b. Additional training authorized on the diagnosis of a Doctor or other health care practitioner of a significant change in the Qualified Insured Person's symptoms or condition that requires changes in the Qualified Insured Person's self-management regime; and
c. Periodic or episodic continuing education training when prescribed by an appropriate health care practitioner as warranted by the development of new techniques and treatments for diabetes.

Coverage for diabetes self-management training provided to a Qualified Insured Person will include coverage for the following if provided on the order of a Doctor, including the written order of a health care practitioner practicing under protocols jointly developed with a Doctor:
a. A diabetes self-management training program recognized by the American Diabetes Association;
b. Diabetes self-management training given by a multidisciplinary team:
    i. the non-physician members of which are coordinated by (1) a diabetes educator who is certified by the National Certification Board for Diabetes Educators; or (2) a person who has completed at least 24 hours of continuing education that meets guidelines established by the Texas Board of Health and that includes a combination of diabetes-related educational principles and behavioral strategies;
    ii. that consists of at least a licensed dietitian and a registered nurse and may include a pharmacists and a social worker; and
    iii. each member of which, other than a social worker, has recent didactic and experiential preparation in diabetes clinical and educational issues as determined by the member's licensing agency.
c. Diabetes self-management training provided by a diabetes education certified by the National Certification Board for Diabetes Educators; or
d. Diabetes self-management training in which one or more of the following components are provided:
    i. The nutrition counseling component provided by a licensed dietitian.
    ii. The pharmaceutical component provided by a pharmacist.
    iii. Any component of the training provided by a Doctor assistant or registered nurse, except that the Doctor assistant or registered nurse may not be paid for providing a nutrition counseling or pharmaceutical component unless a licensed dietitian or pharmacist is unavailable to provide that component; or
    iv. Any component of the training provided by a Doctor.

A person may not provide a component of a diabetes self-management training unless the subject matter of the component is within the scope of the person's practice and meets the education requirements.

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Emergency refills of diabetes equipment or diabetes supplies are covered in the same manner as nonemergency refills for diabetes equipment of diabetes supplies.

42. Charges for cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing or treatment, neurofeedback therapy, remediation, post-acute transition services, or community reintegration services necessary as a result of and related to an acquired brain injury. Benefits will be paid the same as any other Sickness.

    As used in this benefit,
    "Acquired brain injury" means a neurological insult to the brain, which is not hereditary, congenital, or degenerative. The injury to the brain has occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition, or psychosocial behavior.

    "Cognitive communication therapy" means services designed to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information.

    "Cognitive rehabilitation therapy" means services designed to address therapeutic cognitive activities, based on an assessment and understanding of the individual's brain-behavioral deficits.

    "Community reintegration services" means services that facilitate the continuum of care as an affected individual transitions into the community.

    "Neurobehavioral testing" means an evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and premorbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the individual, family, or others.

    "Neurobehavioral treatment" means interventions that focus on behavior and the variables that control behavior.

    "Neurocognitive rehabilitation" means services designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.

    "Neurocognitive therapy" means services designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities.

    "Neurofeedback therapy" means services that utilize operant conditioning learning procedure based on electroencephalography (EEG) parameters, and which are designed to result in improved mental performance and behavior, and stabilized mood.

    "Neurophysiological testing" means an evaluation of the functions of the nervous system.

    "Neurophysiological treatment" means interventions that focus on the functions of the nervous system.

    "Neuropsychological testing" means the administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning.

    "Neuropsychological treatment" means interventions designed to improve or minimize deficits in behavioral and cognitive processes.

    "Outpatient day treatment services" means structured services provided to address deficits in physiological, behavioral, and/or cognitive functions. Such services may be delivered in settings that include transitional residential, community integration, or non-residential treatment settings.

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"Post-acute care treatment services" means services provided after acute care confinement and/or treatment that are based on an assessment of the individual's physical, behavioral, or cognitive functional deficits, which include a treatment goal of achieving functional changes by reinforcing, strengthening, or re-establishing previously learned patterns of behavior and/or establishing new patterns of cognitive activity or compensatory mechanisms.

"Post-acute transition services" means services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.

"Psychophysiological testing" means an evaluation of the interrelationships between the nervous system and other bodily organs and behavior.

"Psychophysiological treatment" means interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors.

"Remediation" means the process(es) of restoring or improving a specific function.

"Services" means the work of testing, treatment, and providing therapies to an individual with an acquired brain injury.

"Therapy" means the scheduled remedial treatment provided through direct interaction with the individual to improve a pathological condition resulting from an acquired brain injury

43. Charges for hearing aids or cochlear implants and related services and supplies for a covered Dependent who is 18 years of age or younger. This includes: (a) fitting and dispensing services and the provision of ear molds as necessary to maintain optimal fit of hearing aids; (b) any treatment related to hearing aids and cochlear implants, including coverage for habilitation and rehabilitation as necessary for educational gain; and (c) for a cochlear implant, an external speech processor and controller with necessary components replacement every three years. Benefits are limited to one hearing aid in each ear every three years and one cochlear implant in each ear with internal replacement as audiologically or Medically Necessary.

44. Charges for fertility preservation for professional services provided by a Doctor will be covered the same as any other Sickness for a Covered Person who receives Medically Necessary treatment for cancer, including surgery, chemotherapy, or radiation, while insured under the Policy, that the American Society of Clinical Oncology or the American Society for Reproductive Medicine has established may directly or indirectly cause impaired fertility. Fertility preservation services must be standard procedures to preserve fertility consistent with established medical practices or professional guidelines published by the American Society of Clinical Oncology or the American Society for Reproductive Medicine. As used in this benefit, "fertility preservation services" means the collection and preservation of sperm, unfertilized oocytes, and ovarian tissue. It does not include the storage of such unfertilized genetic materials.

45. Charges for biomarker testing for the purpose of diagnosis, treatment, appropriate management or ongoing monitoring of a Covered Person's disease or condition to guide treatment when the test is supported by the following kinds of medical scientific evidence will be covered the same as any other Sickness for the following:
    a. A labeled indication for a test approved or cleared by the United States Food and Drug Administration (FDA);
    b. An indicated test for a drug approved by the FDA;
    c. A national coverage determination made by the Centers for Medicare and Medicaid Services or a local coverage determination made by a Medicare administrative contractor;
    d. Nationally recognized clinical practice guidelines; or
    e. Consensus statements.

    Eligible Expenses will include biomarker testing when use of biomarker testing provides clinical value because use of the test for the condition:
    a. Is evidence-based;
    b. Is scientifically valid based on the medical and scientific evidence described above;
    c. Informs a Covered Person's outcome and a Doctor's clinical decision; and
    d. Predominantly addresses the acute or chronic issue for which the test is being ordered, except that a test may include some information that cannot be immediately used in the formulation of a clinical decision.

SAMPLE

Benefits will be provided in a manner that limits disruption in care, including limiting the number of biopsies and biospecimen samples.

As used in this benefit,
"Biomarker" means a characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes, or pharmacologic responses to a specific therapeutic intervention. Biomarkers include gene mutations and protein expression.

"Biomarker testing" means the analysis of a patient's tissue, blood, or fluid biospecimen for the presence of a biomarker. Biomarker testing includes single-analyte tests, multi-plex panel tests, and whole genome sequencing.
"Consensus statements" means statements that: (a) address specific clinical circumstances based on the best available evidence for the purpose of optimizing clinical care outcomes; and (b) are developed by an independent, multidisciplinary panel of experts that uses a transparent methodology and reporting structure and is subject to a conflict of interest policy.

"Nationally recognized clinical practice guidelines" means evidenced-based clinical practice guidelines that: (a) establish a standard of care informed by a systematic review of evidence and an assessment of the benefits and costs of alternative care options; (b) include recommendations intended to optimize patient care; and (c) are developed by an independent organization of medical professional society that uses a transparent methodology and reporting structure and is subject to a conflict of interest policy.

Pre-Authorization Requirements

All Inpatient Hospitalizations and procedures done at an Outpatient Surgery Facility must be pre-authorized.

A. To comply with the pre-authorization 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-authorization requirements and ask them to fully cooperate with the professional review organization.

B. If the Covered Person complies with the pre-authorization requirements, and the expenses are pre-authorized, the Company will pay Eligible Expenses subject to all terms, conditions, provisions and exclusions described in this Certificate.

C. If the Covered Person does not comply with the pre-authorization requirements, or if the expenses are not pre-authorized, Eligible Expenses will be reduced by 50% or $500 whichever is less.

D. Emergency pre- authorization: In the event of an Emergency Care Hospital admission, pre- authorization must be made within 48 hours after the admission, or as soon as is reasonably possible.

E. Pre-authorization Does Not Guarantee Benefits – The fact that expenses are pre-authorized 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.

F. Concurrent Review – For Inpatient stays of any kind, the professional review organization will pre-authorize a limited number of days of confinement. Additional days of Inpatient confinement may later be pre-authorized if a Covered Person receives prior approval.

G. Pre-authorization Renewal: Renewal of an existing pre-authorization must be requested by a Doctor or provider at least 60 days before the date the pre-authorization expires. The professional review organization will review the request and issue a determination indicating whether the service is pre-authorized before the existing pre-authorization expires.

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, or advice, including diagnostic tests or medications, within the 12 month period immediately preceding such person's Certificate Effective Date are excluded for the first 12 months of coverage hereunder.

SAMPLE

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 occurrence of symptoms and/or 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 occurrence of symptoms or 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. Herniorrhaphy; 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. 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.

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.

SAMPLE

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, except as 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. The Covered Person has a right to contact an independent review organization for any denials of Experimental Treatment.

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.

SAMPLE

38. Spinal manipulation or adjustment.

39. Biofeedback, acupuncture, recreational, sleep or MIST Therapy®, holistic care of any nature, massage and kinesitherapy, 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, (except as specifically covered under the Policy as an Eligible Expense) 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 except as specifically covered under the Policy as an Eligible Expense.

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. This does not include Emergency Care services.

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, except a dentist.

51. Services received for any condition caused by a Covered Person's commission of or attempt to commit an assault, battery, or 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, racing including stunt show or speed test of any motorized or non-motorized vehicle, rodeo activities, or similar hazardous 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.

SAMPLE

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. The Company will not exclude expenses of a nonindigent patient incurred in a hospital facility that: (a) is owned or controlled by the state or by a unit of local government; and (b) regularly and customarily demands and collects from nonindigent persons payment for those expenses.

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.

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.
"Allowable expense" means any health care expense, including coinsurance or copayments and without reduction for any applicable deductible, that is covered in full or in part by any of the Plans covering the person. An expense that is not covered by any plan covering the person is not an allowable expense.

"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, group practice, or individual practice coverage.
2. The medical benefits coverage in automobile insurance contracts.
3. Limited benefit policies, excluding Disability Income Protection Coverage.
4. 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.)

SAMPLE

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. The Texas Health Insurance Pool;
2. Workers' compensation insurance coverage;
3. Individual or family insurance or subscriber contracts;
4. Individual or family coverage through Health Maintenance Organizations (HMOs);
5. Individual or family coverage under other prepayment, group practice and individual practice plans;
6. 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);
7. Group or group-type hospital indemnity benefits or other fixed indemnity; specified disease coverage, or supplement benefit coverage;
8. Accident-only or specified accident coverage;
9. Benefits provided in long-term care insurance contracts for nonmedical services;
10. Medicare Supplement policies;
11. A state plan under Medicaid
12. A governmental plan which, by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan; or
13. An individual accident and health insurance policy that is designed to fully integrate with other policies through a variable deductible.

"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:

A. The Primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

B. Except as provided in the next paragraph, a Plan that does not contain a coordination of benefits provision that is consistent with this provision is always primary unless the provisions of both Plans state that the complying plan is primary.

   Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be in excess of any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed Panel Plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.

D. Each Plan determines its order of benefits using the first of the following rules that apply:

   1. Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary Plan and the Plan that covers the person as a dependent is the Secondary Plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the two Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary Plan and the other Plan is the Primary Plan.

SAMPLE

2. Dependent Child Covered Under More Than One Coverage Plan. Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

   (a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

      (1) The Plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or

      (2) If both parents have the same birthday, the Plan that covered the parent longest is the Primary Plan.

   (b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

      (1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the Primary Plan. This shall not apply with respect to any plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision.

      (2) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph a) above shall determine the order of benefits.

      (3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph a) above shall determine the order of benefits.

      (4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

         (a) The Plan covering the Custodial Parent.

         (b) The Plan covering the Custodial Parent's spouse.

         (c) The Plan covering the non-Custodial Parent.

         (d) The Plan covering the non-Custodial Parent's spouse.

   (c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under subparagraph a) or b) above as if those individuals were parents of the child.

3. Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired is the Primary Plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and, as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.

4. COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the Primary Plan, and the COBRA or state or other federal continuation coverage is the Secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.1. can determine the order of benefits.

5. Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary Plan and the Plan that covered the person the shorter period of time is the Secondary Plan.

6. If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, This Plan will not pay more than it would have paid had it been the Primary Plan.

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.

SAMPLE

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. The amount of the payments made includes the reasonable cash value of any benefits provided in the form of services.

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.

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 as soon as We receive proper written proof of such loss but not more than 60 days after receipt of proof of 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. All benefits paid on behalf of children must be paid to the Texas Department of Human Services whenever: (1) the Texas Department of Human Services is paying benefits under the Human Resources Code, Chapter 31 or Chapter 32; and (2) the parent who is insured under the Policy has possession or access to the child pursuant to a court order, or is not entitled to access or possession of the child and is required by the court to pay child support and (3) the Company receives written notice at its Administrative Office affixed to the benefit claim when the claim is first submitted, that the benefits claimed must be paid directly to the Texas Department of Human Services. All Eligible Expenses paid on behalf of the Covered Person must be paid to the Texas Department of Human resources for the actual cost of medical expenses the department pays through medical assistance.

SAMPLE

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 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 nonpayment of premiums.

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 (or the required statute of limitation by state law, if longer) from the time written proof of loss is required to be furnished.

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.

SAMPLE

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 Statutes: Any provision of this Certificate which, on the Group Policyholder Effective Date, is in conflict with the statutes of the jurisdiction in which the Group Policyholder is located is hereby amended to conform to the minimum requirements of such statutes.

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 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.

SAMPLE

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: Deductible(s), 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.
Advanced Diagnostic Studies Copayment	$500 Copayment per occurrence for Advanced Diagnostic Studies in an Outpatient setting, not to exceed a maximum

SAMPLE

	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
Penalty for failure to pre-authorize	Eligible Expenses will be reduced by 50% or $500 whichever is less; 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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Benefit	Limit
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.
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:	The greater of 45 days or the number of days that would be payable for any other Sickness, per Covered Person per Coverage Period.
Outpatient:	The greater of: 60 visits or the number of visits that would be payable for any other Sickness, per Covered Person per Coverage Period.
Substance Abuse	
Inpatient:	Eligible Expenses will be paid the same as any other Sickness.

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Outpatient:	Eligible Expenses will be paid the same as any other Sickness.
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 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

SAMPLE

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”)

TEXAS AMENDMENT

This Amendment becomes a part of the Policy/Certificate to which it is attached. The provisions of this Amendment will expire concurrently with the Policy/Certificate unless otherwise terminated.

Benefits will be payable either under the Policy/Certificate or these mandated benefits, whichever provides the greater benefit.

A. The Newborn Child Coverage provision under **PART II - ELIGIBILITY AN DEFFECTIVE DATE OF INSURANCE** is replaced with the following:

   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 and for administration of the newborn screening tests required by the Health and Safety Code, including the cost of a newborn screening test kit, in the amount published by the Department of State Health Services on its Internet website. Coverage for a child born after the Certificate Effective Date will be effective from the moment of birth and will remain in force for 60 days, or until this Certificate terminates, whichever is sooner. A notice of birth, together with any additional premium, must be submitted to us not later than 60 days after the date of birth in order to continue coverage for Injury and Sickness beyond the initial 60-day period.

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

For: Everest Reinsurance Company

Jill Beggs
President and Chief Executive Officer

SAMPLE

EVEREST REINSURANCE COMPANY

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TEXAS MANDATED OFFER RIDER

This Rider becomes a part of the Policy to which it is attached. The provisions of this Rider will expire concurrently with the Policy unless otherwise terminated.

If the Group Policyholder elects coverage for this benefit and any required additional premium is paid, the following coverage will apply to Texas residents while coverage is in force:

1. **Speech or Hearing Therapy** rendered by a licensed speech therapist; licensed speech pathologist; or qualified licensed audiologist for a Covered Person who incurs expenses for the Medically Necessary care and treatment of loss or impairment of speech or hearing. Examination for and the fitting of hearing aids is not a covered expense.

The Group Policyholder had indicated below whether or not they have accepted or rejected this optional benefit:

☐ Accept ☐ Reject

2. **Home Health Care.** The benefit range shown in the Schedule is replaced with the following:

   $50 per visit. There is a limit of 1 visit per day not to exceed a maximum 60 Home Health Care visits per Covered Person per Coverage Period.

The Group Policyholder had indicated below whether or not they have accepted or rejected this optional benefit:

☐ Accept ☐ Reject

Rejection of any of this optional benefit means there is NO COVERAGE for that benefit.

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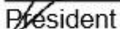
______________________________ ________________
Signed for the Group Policyholder Date

______________________________ ________________
Printed Name Title

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

For: Everest Reinsurance Company


President

Secretary

Is this short-term health insurance plan right for me?

You must read and sign this form.

Plan name:

Offered by: Everest Reinsurance Company

This plan does not need to follow federal Affordable Care Act (ACA) rules. Unlike ACA plans, this short-term plan:

- May not cover all injuries or sicknesses, including any you have before applying.
- May not pay for some medical care you might need.
- Doesn't allow you to get federal help with premiums or out-of-pocket costs (tax credits and cost-sharing reductions).

Carefully read the information below so you know this plan's coverage limits and your rights under this plan.

How long with this plan cover me?

Can I renew or extend this plan?

No.

When this plan ends, can I sign up for another insurance plan?

- **If you want to sign up for another short-term health plan or another plan not covered by ACA laws:** You can sign up for another plan at any time. But a short-term health plan can deny you for health reasons. The amount of your premium payment might change.
- **If you want to sign up for a health plan covered by ACA laws:** You can signed up for another plan only during open enrollment or if you have a qualifying life event (like losing coverage from your job or having a baby). To find out if you have a qualifying life event, talk to your insurance agent or go to HealthCare.gov.
  - The next open enrollment dates for ACA plans are:
    - **2025:** November 1 – December 15
    - **2026:** November 1 – December 15
    - **2027:** November 1 – December 15

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- When you sign up for a plan during HealthCare.gov open enrollment dates, your insurance coverage will start January 1.
- **The end of this plan is not a qualifying life event. You may have to wait until the next open enrollment period to sign up for an ACA plan.**

Am I covered for an injury, illness or disease I had before I applied for this plan (a preexisting condition)?

No.

- You must tell the truth when answering questions about your health.
- We can deny claims for any injury, illness or disease you had before signing up for this plan (whether or not you tell us about your condition).

What is the most (maximum) this plan will pay for services?

$ per Covered Person

What is the deductible (the amount I must pay for services before this plan starts paying)?

You must pay $ (plus your premiums) per Covered Person per Coverage Period before the plan will start paying for services.

The following services are exempt from the deductible amount:

- Benefits subject to a copayment (as noted below in "What type of care will this plan cover?").

The following services have an Additional Deductible:

- Outpatient Surgery Deductible - $500 per Surgery for Surgery performed in an Outpatient Surgical Facility after which Plan Deductible and Coinsurance will apply. Maximum of 3 Outpatient Surgery Deductibles per Covered Person. Surgeries in excess of the maximum number of Outpatient Surgery Deductibles will remain subject to the Plan Deductible and Coinsurance.
- Emergency Room Deductible - $500 per visit for use of emergency room in the event of Sickness or Injury after which the Plan Deductible and Coinsurance will apply. The Emergency Room Deductible 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 Deductible - $500 per occurrence for Advanced Diagnostic Studies in an Outpatient setting after which the Plan Deductible and Coinsurance will apply.

Does this plan use a network of doctors / providers?

No. Your coverage is the same, no matter what doctor / provider you use. But the amounts the plan will pay might be less than providers charge for care. Doctors / providers can bill you directly for any amount the plan does not pay.

What type of care will this plan cover?

Review the chart below to know which benefits are covered by this plan. ACA plans cover all listed benefits with few limits, but this plan limits coverage for some types of care.

Any copayment amounts are listed in the chart below. The chart below does not include your coinsurance amounts. Ask your agent or the plan for this information. All benefits under your plan are subject to the Plan Deductible, any Additional Deductibles, and coinsurance unless a copayment applies or unless specifically stated otherwise. The plan pays up to the Maximum Allowable Expense as defined in the Certificate. Amounts the plan will pay might be less than providers charge for care. Doctors / providers can bill you directly for any amount the plan does not pay.

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Type of care	Is it covered?
Emergency Room Visit	Yes, but there are some limits. Emergency Room Deductible will apply.
Urgent Care	Yes, but there are some limits. Urgent Care Center Visits subject to $50 Copayment per visit or consultation per Covered Person. Doctor’s office or urgent care visits or doctor consultations in excess of the maximum number of Doctor’s Office or Urgent Care Center Visits Copayments will be subject to the Plan Deductible and Coinsurance**.**
Ambulance	Yes, but there are some limits. Benefits are limited to $250 per transport for Injury and $250 per transport for Sickness.
Hospital stay – facility fee (inpatient – overnight stay)	Yes, but there are some limits. The plan pays up to the Maximum Allowable Expense as defined in the Certificate. Amounts the plan will pay might be less than providers charge for care. Doctors / providers can bill you directly for any amount the plan does not pay.
Hospital stay – doctor services (inpatient – overnight stay)	Yes, but there are some limits. N/A per day. Surgeon benefits are limited to N/A per surgery, for all Eligible Expenses combined Assistant Surgeon and Surgical Assistant benefits are limited to N/A per surgery, for all Eligible Expenses combined. Administrator of Anesthetics benefits are limited to N/A per surgery, for all Eligible Expenses combined.
Day surgery – facility fee (outpatient – no overnight stay)	Yes, but there are some limits. The benefit payable per day for Outpatient Surgical Facility is limited to N/A. The benefit payable for miscellaneous Outpatient Hospital expenses are limited to N/A per Covered Person per Coverage Period for all Eligible Expenses combined.

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Day surgery – doctor services (outpatient – no overnight stay)	Yes, but there are some limits. Surgeon benefits are limited to N/A per surgery, for all Eligible Expenses combined.
Mental health services (inpatient – overnight stay)	Yes, but there are some limits. Benefits are limited to 45 day or the number of visits that would be payable for any other Sickness, whichever is greater, per Covered Person per Coverage Period.
Mental health services (outpatient – no overnight stay)	Yes, but there are some limits. Benefits are limited to 60 visit or the number of visits that would be payable for any other Sickness, whichever is greater, per Covered Person per Coverage Period.
Alcohol / drug / substance abuse services (inpatient – overnight stay)	Benefits will be paid the same as any other Sickness.
Alcohol / drug / substance abuse services (outpatient – no overnight stay)	Benefits will be paid the same as any other Sickness.
Preventative care (includes regular checkups, and some screenings and vaccines)	Yes, but there are some limits. One annual Routine Physical Exam is covered subject to a $50 Copayment. Benefits are not subject to the Plan Deductible. Other wellness benefits are covered for only listed services, including prostate-specific antigen testing; mammography screening; pap smear; colorectal cancer screenings; and children's preventative health screenings. Childhood immunizations are not subject to coinsurance or the Plan Deductible. See certificate for specific details.

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Primary care (office visit to treat an injury or illness)	Yes, but there are some limits. Doctor's Office Visits subject to $50 Copayment per visit or consultation per Covered Person. Benefits are not subject to the Plan Deductible.
Specialist care office visit (Doctors who treat one type of health issue. Examples: cancer, skin issues, allergies, heart issues, or kidney issues.)	Yes, but there are some limits. Limitations are same as primary care benefit above.
Drugs ordered by your doctor (outpatient prescription drugs)	No.
Services for a pregnant woman: prenatal office visits	No. Covers Complications of Pregnancy only.
Services for a pregnant woman: delivery – doctor services	No. Covers Complications of Pregnancy only.
Services for a pregnant woman: delivery – facility fee	No. Covers Complications of Pregnancy only.

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You must confirm you read and understand this form:

Did you read and understand the limited benefits offered by this plan before you applied or paid for coverage?

- ☐ Yes, I read and understand the benefits and limits of this plan. I was not required to make a payment or apply for this policy before getting this disclosure form.

Don't sign this document if you don't understand

it. No firme este documento si no lo comprende.

Type or sign your name:

____

Date:

____

Have a complaint or need help?

To check if an agent has a license or to file a complaint, go to the Texas Department of Insurance's website at **www.tdi.texas.gov** or call 1-800-252-3439.

Federal notice: 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 policy 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 health and substance use disorder services). Your policy 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.

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Have a complaint or need help?

If you have a problem with a claim or your premium, call your insurance company first. If you can't work out the issue, the Texas Department of Insurance may be able to help.

Even if you file a complaint with the Texas Department of Insurance, you should also file a complaint or appeal through your insurance company. If you don't, you may lose your right to appeal.

InsuranceTPA.com
To get information or file a complaint with your insurance company:

Call: Department of Appeals at 1-800-279-2290
Toll-free: 1-800-279-2290
Email: claims@insurancetpa.com
Mail: PO Box 998 Janesville, WI 53547

The Texas Department of Insurance
To get help with an insurance question or file a complaint with the state:

Call with a question: 1-800-252-3439
File a complaint: www.tdi.texas.gov
Email: ConsumerProtection@tdi.texas.gov
Mail: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

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¿Tiene una queja o necesita ayuda?

Si tiene un problema con una reclamación o con su prima de seguro, llame primero a su compañía de seguros. Si no puede resolver el problema, es posible que el Departamento de Seguros de Texas (Texas Department of Insurance, por su nombre en inglés) pueda ayudar.

Aun si usted presenta una queja ante el Departamento de Seguros de Texas, también debe presentar una queja a través del proceso de quejas o de apelaciones de su compañía de seguros. Si no lo hace, podría perder su derecho para apelar.

InsuranceTPA.com
Para obtener información o para presentar una queja ante su compañía de seguros:

Llame a: Departamento de Apelaciones al 1-800-279-2290
Teléfono gratuito: 1-800-279-2290
Correo electrónico: claims@insurancetpa.com
Dirección postal: PO Box 998 Janesville, WI 53547

El Departamento de Seguros de Texas
Para obtener ayuda con una pregunta relacionada con los seguros o para presentar una queja ante el estado:

Llame con sus preguntas al: 1-800-252-3439
Presente una queja en: www.tdi.texas.gov
Correo electrico: ConsumerProtection@tdi.texas.gov
Direcci postal: MC 111-1A, P.O. Box 149091, Austin, TX 78714-9091

EVEREST REINSURANCE COMPANY

Statutory Office: 251 Little Falls Drive, Wilmington, Delaware 19808
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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 Policy with respect to an Insured or his Dependents may not be contested after two years from the Certificate Effective Date, except for 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.

SAMPLE

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

SAMPLE