

SAMPLE CERTIFICATES OF INSURANCE*

ARKANSAS



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	PAGE #S	SAMPLE GROUP CERTIFICATES OF INSURANCE
	02-27	Group Short Term Medical Insurance Certificate of Insurance (EAH 00 524 08 18) underwritten by: Everest Reinsurance Company
	28-34	Arkansas Rider (EAH 01 593 09 22)
	35-36	Consecutive STM Insurance Plan Amendment - Group (EAH 01 684 05 25)

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 VCS 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

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.

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

This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your Certificate carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your Certificate might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose

eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage. Also, this coverage is not “minimum essential coverage.” If you don’t have minimum essential coverage for any month in 2018, you may have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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.

SAMPLE

TABLE OF CONTENTS

TABLE OF CONTENTS	3
IMPORTANT NOTICE CONCERNING STATEMENTS IN THE ENROLLMENT FORM	3
PART I – GENERAL DEFINITIONS	4
PART II – ELIGIBILITY AND EFFECTIVE DATE OF INSURANCE	8
PART III - TERMINATION OF INSURANCE	9
PART IV - PREMIUMS	10
PART V – BENEFITS	10
PART VI – ELIGIBLE EXPENSES	11
Pre-Certification Requirements	14
PART VII – EXCLUSIONS AND LIMITATIONS	14
PART VIII – COORDINATION OF BENEFITS (COB)	18
PART IX - CLAIM PROVISIONS	20
PART X – GENERAL PROVISIONS	21
OPTIONAL BENEFIT RIDERS	

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.

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

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

“Complications of Pregnancy” means either of these two general types of conditions:

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

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

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

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

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

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

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

“Custodial or Convalescent Care” means any care that is provided to a Covered Person who is disabled and needs help to support the essential activities of daily living when the Covered Person is not under active and specific medical, surgical, or psychiatric treatment that will reduce the disability to the extent necessary for the person to perform the essentials of daily living on his own.

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

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

“Dependent” means Your family as follows:

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

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

“Domestic Partner” means an opposite or same sex person with whom You maintain a committed relationship and share a familial relationship characterized by mutual caring and the sharing of a mutual residence and who has registered under state law as a domestic partner. Each partner must:

1. Be at least 18 years old and competent to contract
2. Be the sole domestic partner of the other person; and
3. Not be married.

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

“Eligible Expense” means those expenses incurred for a covered Injury or Sickness:

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

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

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

“Experimental or Investigational Treatment” means in Our discretion a treatment, drug, device, procedure, supply or service and related services (or any portion thereof, including the form, administration or dosage) for a particular diagnosis or condition when any one of the following exists:

1. The treatment, drug, device, procedure, supply or service is in any clinical trial or a Phase I, II or III trial.
2. The treatment, drug, device, procedure, supply or service is not yet fully approved or recognized (for other than experimental, investigational, research or clinical trial purposes) by the National Cancer Institute (NCI), Food & Drug Administration (FDA), or other pertinent governmental agency or professional organization.
3. The results are not proven through controlled clinical trials with results published in peer-reviewed English language medical journals, to be of greater safety and efficacy than conventional treatment, in both the short and long term.

4. The treatment, drug, device, procedure, supply or service is not generally accepted medical practice in the state where the Covered Person resides or as generally accepted throughout the United States as determined in Our discretion, by reference to any one or more of the following: peer-reviewed English-language medical literature, consultation with physicians, authoritative medical compendia, the American Medical Association, or other pertinent professional organization or governmental agency.

5. The treatment, drug, device, procedure, supply or service is described as investigational, experimental, a study, or for research or the like in any consent, release or authorization which the Covered Person, or someone acting on his or her behalf, may be required to sign.

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

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

“Home Health Care Agency” means an entity licensed by state or local law operated primarily to provide skilled nursing care and therapeutic services in an individual’s home and:

1. Which maintains clinical records on each patient;
2. Whose services are under the supervision of a Doctor or a licensed graduate registered nurse (RN); and
3. Which maintains operational policies established by a professional group including at least one Doctor and one licensed graduate registered nurse (RN).

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

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

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

“Injury” means Accidental bodily Injury of a Covered Person:

1. Caused by an Accident; and
2. That results in covered loss directly and independently of all other causes.

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

“Inpatient” means a Covered Person who incurs medical expenses for at least one day’s room and board from a Hospital.

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

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

“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. The Company has discretionary authority to determine the Maximum Allowable Expense.

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

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

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

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

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

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

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

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

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

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

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

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

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

“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.

PART II – ELIGIBILITY AND EFFECTIVE DATE OF INSURANCE

Coverage will be effective for You and Your Covered Dependent(s), as of the approved Certificate Effective Date, provided:

1. You meet the eligibility requirements set forth in the Group Policyholder Application and the Policy;
2. Your Enrollment Form is approved by Us;
3. The first premium payment is received on or before the date Your Enrollment Form is approved by Us.

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

Adopted Children Coverage: Coverage for Injury or Sickness for a child adopted by You or a child placed with You for the purpose of adoption after the Certificate Effective Date will be effective for the first 31 days, or until this Policy terminates, whichever is sooner. Coverage for such child will be at either the date of placement of the child in the home, or the date of the final decree of adoption, whichever is earlier. To continue coverage beyond 31 days, an Insured must enroll the adopted

child and pay any required premium within 31 days from either the date of placement or the final decree of adoption. The coverage of such child will be the same as provided for other members of the Insured's family.

PART III - TERMINATION OF INSURANCE

Coverage under the Policy will cease at 12:01 a.m. for a Covered Person, based on the time zone in the place where the Insured resides, on the earliest of the following:

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

TERMINATION UPON INSURED'S DEATH

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

TERMINATION OF SPOUSE'S COVERAGE

The Insured's spouse will cease to be a Covered Person at the earlier of:

1. The date of their death;
2. The date the spouse and Insured become legally divorced or legally separated;
3. The date the spouse becomes eligible for Medicare; or
4. The date that the spouse enters full-time active duty in the armed forces of any country or international organization other than for reserve duty of 30 days or less.

TERMINATION OF A CHILD'S COVERAGE

A child's coverage will terminate on the at the earlier of:

1. The date the child ceases to meet the requirements of a Dependent; or
2. The date that the child enters full-time active duty in the armed forces of any country or international organization other than for reserve duty of 30 days or less.

CONTINUATION OF COVERAGE FOR AN INCAPACITATED CHILD

Coverage for a Dependent child, who reaches the limiting age as defined in the definition of Dependent, will continue if the child continues to be both:

1. Incapable of self-sustaining employment by reason of mental incapacity or physical handicap; and
2. Remains dependent upon the Insured for support and maintenance.

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

EXTENSION OF BENEFITS

If a Covered Person is Hospital confined on the date insurance ends, other than for failure to pay the required premium, benefits will be continued only for the condition causing the Hospital confinement until the earlier of:

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

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

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.

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.

WELLNESS BENEFIT COPAYMENT – A Copayment must be paid when Eligible Expenses are incurred for an annual Routine Physical Exam.

DOCTOR'S OFFICE OR URGENT CARE CENTER VISIT COPAYMENT - A Copayment must be paid for Eligible Expenses incurred for each Doctor's office or urgent care center visit with a Doctor or a Doctor consultation, not to exceed a maximum of 3 Doctor's Office or Urgent Care Center Visit Copayments per Covered Person. Any other services or tests performed as part of the office visit will be subject to the Advanced Diagnostic Studies Deductible (if applicable), 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.

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 a Doctor's office visit, consultation, or urgent care center visit. Charges for other covered services or tests performed as a part of the office visit will be subject to the Plan Deductible and Coinsurance.
 10. Wellness Benefit: Charges for one annual Routine Physical Exam performed by a Doctor as part of a regular check-up. This includes a health history, an exam of all systems including cardiovascular, respiratory, neurological, musculoskeletal, reproductive, and behavioral studies appropriate for age, risk and sex. This does not include blood work, radiology, Advanced Diagnostic Studies, and/or lab work.
 11. Charges for routine child health care for periodic visits that include a history, a physical examination, a development assessment, anticipatory guidance and appropriate immunizations 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.
 12. 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.
 13. Charges for diagnostic testing using radiology, ultrasonographic or laboratory services (psychometric, intelligence, behavioral and educational testing are not included).
 14. Charges for artificial eyes or larynx, breast prosthesis or basic functional artificial limbs, but not their replacement or repair.
 15. Charges for reconstructive surgery directly related to surgery which is covered under the Policy, including reconstructive breast surgery and prosthetic devices incident to a Mastectomy. Coverage will also include all stages of reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction on a non-diseased breast to establish symmetry with the diseased breast and prostheses and physical complications of mastectomy, including lymphedemas. As used in this benefit: "Mastectomy" means the surgical removal of all or part of a breast as a result of breast cancer. "Reconstructive breast surgery" means surgery performed as a result of a mastectomy to reestablish symmetry between the two breasts and includes augmentation mammoplasty, reductive mammoplasty and mastopexy.
 16. Charges for radiation therapy or treatment and chemotherapy.
 17. Charges for blood and blood products, administration of blood and blood processing.

18. Charges for an Extended Care Facility room and board accommodations; if:
- 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.
 - The confinement commences immediately following a period of at least three (3) continuous days of Hospital confinement; and
 - The confinement is for the same covered Injury or Sickness that was treated during the Covered Person's confinement in the Hospital.
19. 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:
- Part-time skilled nursing care;
 - Home Health aide services/supplies when under a R.N.'s direct supervision;
 - Physical, occupational and speech therapy;
 - Medical supplies; and
 - Respiratory therapy.

However, benefits will not be paid for charges made by a Home Health Care Agency for:

- Full-time nursing care at home;
- Meals delivered to the home;
- Homemaker services;
- 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
- Any transportation services.

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

20. 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:
- Inpatient and Outpatient care.
 - Part-time or intermittent home nursing care by, or under the direction of a nurse;
 - Physical, respiratory or speech therapy performed by a licensed therapist;
 - Nutrition counseling provided by or under the direction of a registered dietitian; and
 - 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:

- Under active management through an agency licensed or certified to provide hospice services and which is responsible for coordinating all such services; and
- 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 Medical Necessity may be periodically required.

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

21. 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.
22. 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.
23. 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.

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

Eligible Expenses do not include organ or tissue transplants which:

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

25. 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. 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.

26. 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.

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

Pre-Certification Requirements

- A. All Inpatient Hospitalizations and procedures done at an Outpatient Surgery Facility must be pre-certified.
- B. To comply with the pre-certification requirements, the Covered Person must:
 1. Contact the professional review organization at the following telephone number 1-800-641-5566 as soon as possible before the expense is to be incurred; and
 2. Comply with the instructions of the professional review organization and submit any information or documents they require; and
 3. Notify all Doctors, Hospitals and other providers that this insurance contains pre-certification requirements and ask them to fully cooperate with the professional review organization.
- C. If the Covered Person complies with the pre-certification requirements, and the expenses are pre-certified, the Company will pay Eligible Expenses subject to all terms, conditions, provisions and exclusions described in this Certificate.
- D. If the Covered Person does not comply with the pre-certification requirements, or if the expenses are not pre-certified, Eligible Expenses will be reduced by 50%.
- E. Emergency pre-certification: In the event of an emergency Hospital admission, pre-certification must be made within 48 hours after the admission, or as soon as is reasonably possible.
- F. Pre-certification Does Not Guarantee Benefits – The fact that expenses are pre-certified does not guarantee either payment of benefits or the amount of benefits. Eligibility for and payment of benefits are subject to all the terms, conditions, provisions and exclusions of this Certificate.
- G. Concurrent Review – For Inpatient stays of any kind, the professional review organization will pre-certify a limited number of days of confinement. Additional days of Inpatient confinement may later be pre-certified if a Covered Person receives prior approval.

PART VII – EXCLUSIONS AND LIMITATIONS

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

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

- b. Pre-Existing Conditions includes conditions that produced any symptoms which would have caused a reasonable prudent person to seek diagnosis, care or treatment within the 60-month period immediately prior to the Covered Person's Certificate Effective Date of coverage under the Policy.

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. Acquired Immune Deficiency Syndrome (AIDS)/ Human Immuno-deficiency Virus (HIV)
 - f. Gallbladder Surgery
- 5. Charges which are not incurred by a Covered Person during his/her Coverage Period.
- 6. Charges which exceed any limits or limitations specified in this Certificate, including the Schedule of Benefits.
- 7. Charges for services of supplies in excess of the Maximum Allowable Expense.
- 8. Charges for services or supplies which are not administered by or under the supervision of a Doctor.
- 9. Mental, emotional or nervous disorders or counseling of any type, except as specifically covered as an Eligible Expense.
- 10. Marital counseling or social counseling.
- 11. Treatment for Substance Abuse, unless specifically covered under the Policy as an Eligible Expense.
- 12. Prescription Drugs, except those administered by a Doctor in an Inpatient or Outpatient setting covered under this Policy as an Eligible Expense.
- 13. Medications, vitamins, and mineral or food supplements including pre-natal vitamins, or any over-the-counter medicines, whether or not ordered by a Doctor.

14. Any drug, treatment or procedure that either promotes or prevents conception including but not limited to: artificial insemination, treatment for infertility or impotency, sterilization or reversal of sterilization.
15. Any drug, treatment or procedure that corrects impotency or non-organic sexual dysfunction.
16. Modifications of the physical body in order to improve the psychological, mental or emotional well-being of the Covered Person, such as sex-change surgery.
17. Cosmetic Treatment, except for reconstructive surgery where expressly covered under the Policy.
18. Weight modification or surgical treatment of obesity.
19. Eye surgery, including LASIK, when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism.
20. Dental Expenses, except as necessary to restore or replace sound and natural teeth lost or damaged as a result of an Injury. The Injury must be severe enough that the contact with the Doctor occurs within seventy-two (72) hours of the Accident, unless extenuating circumstances exist due to the severity of the Injury that prevent you from contacting the Doctor.
21. Expenses incurred in the treatment by any method for jaw joint problems including temporomandibular joint dysfunction (TMJ), TMJ pain syndromes, craniomandibular disorders, myofascial pain dysfunction or other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the joint, unless specifically covered under the Policy as an Eligible Expense.
22. Routine pre-natal care, Pregnancy, childbirth, 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.
28. Chronic fatigue or pain disorders.
29. Kidney or end stage renal disease.
30. Treatment or diagnosis of allergies, except for emergency treatment of allergic reactions.
31. Treatment for cataracts.
32. Treatment of sleep disorders.
33. Treatment required as a result of complications or consequences of a treatment or condition not covered under this Certificate.
34. Treatment incurred as a result of exposure to non-medical nuclear radiation and/or radioactive material(s).
35. Treatment for acne, moles, skin tags, diseases of sebaceous glands, seborrhea, sebaceous cyst, unspecified disease of sebaceous glands, hypertrophic and atrophic conditions of skin, nevus.

36. Treatment for or related to any Congenital Condition, except as it relates to a newborn child or newborn adopted child added as a Covered Person pursuant to the terms of this Certificate.
37. Treatment, medication or hormones to stimulate growth, or treatment of learning disorders, disabilities, developmental delays or deficiencies, including therapy.
38. Spinal manipulation or adjustment.
39. Biofeedback, acupuncture, recreational, sleep or MIST Therapy®, holistic care of any nature, massage and 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, eye refraction, visual therapy, orthoptics, visual eye training and any examination or fitting related to these devices, and all vision and hearing tests and examinations.
42. Care, treatment or supplies for the feet, orthopedic shoes, orthopedic prescription devices to be attached to or placed in shoes, treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions and treatment of corns, calluses or toenails.
43. Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Doctor.
44. Exercise programs, whether or not prescribed or recommended by a Doctor.
45. Telephone or Internet consultations and/or treatment or failure to keep a scheduled appointment.
46. Charges for travel or accommodations, except as expressly provided for local ambulance.
47. All charges incurred while confined primarily to receive Custodial or Convalescent Care.
48. Services received or supplies purchased outside the United States, its territories or possessions, or Canada, unless specifically covered under the Policy as an Eligible Expense.
49. Any services or supplies in connection with cigarette smoking cessation.
50. Any services performed or supplies provided by a member of a Covered Person's Immediate Family.
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.
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.
58. Charges incurred by a Covered Person while on active duty in the armed forces. Upon written notice to Us of entry into such active duty, the unused premium will be returned to the Covered Person on a pro-rated basis.
59. Costs for Routine Physical Exams or other services not needed for medical treatment, unless specifically covered under the Policy as an Eligible Expense.
60. Charges You or Your Covered Dependent are not required to pay, or which would not have been billed if no insurance existed.
61. Charges to the extent that they are paid or payable under other valid or collectible group insurance or medical prepayment plan.
62. Charges that are eligible for payment by Medicare or any other government program except Medicaid. Costs for care in government institutions unless You or Your Covered Dependent are obligated to pay for such care.
63. Charges related to Injury or Sickness arising out of or in the course of any occupation for compensation, wage or profit, if the Covered Person is insured, or is required to be insured, by occupational disease or workers' compensation insurance pursuant to applicable state or federal law, whether or not application for such benefits have been made.
64. Medical expenses which are payable under any automobile insurance policy without regard to fault (does not apply in any state where prohibited).

PART VIII – COORDINATION OF BENEFITS (COB)

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

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

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

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

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

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

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

The term "plan" does not include:

1. Individual or family insurance or subscriber contracts;
2. Individual or family coverage through Health Maintenance Organizations (HMOs);
3. Individual or family coverage under other prepayment, group practice and individual practice plans;

4. School Accident-type coverages. (These contracts cover students for accidents only, including athletic injuries, either on a twenty-four-hour basis or on a to-and-from school basis);
5. Group or group-type hospital indemnity benefits of \$100 per day or less;
6. Medicare Supplement policies;
7. A state plan under Medicaid.

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

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

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

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

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

1. A plan which does not have a COB provision will always be the Primary Plan.
2. The benefits of a plan which covers the person on whose expenses the claim is based as other than a dependent will be determined before the benefits of a plan which covers the person as a dependent. However, if the person is also a Medicare beneficiary, and if the rule established under the Social Security Act of 1965, as amended, makes Medicare secondary to the plan covering the person as a dependent of an active employee, the order of benefit determination is:
 - a. First, benefits of a plan covering persons as an employee, member, or subscriber.
 - b. Second, benefits of a plan of an active worker covering persons as a dependent.
 - c. Third, Medicare benefits.
3. The benefits of a plan that covers a person for whom a claim is made as a dependent child will be determined under the following rules:
 - a. When the parents are married: the benefits of a plan which covers the child as a dependent of the parent whose birthday anniversary occurs earlier in the calendar year will be determined before the benefits of a plan which covers the child as a dependent of the parent whose birthday anniversary occurs later in the calendar year.
 - b. If both parents have the same birthday the benefits of the plan that covered the parent longer are determined before those of the plan that covered the other parent for a shorter period of time.
 - c. If the plans do not agree on the order of benefit rules because the other plan does not have the rule described in this section, but has a rule based upon the gender of the parent, the rule in the other plan will determine the order of benefits.
 - d. When the parents are separated or divorced and the parent with custody has not remarried the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.
 - e. When the parents are divorced and the parent who has custody of the child has remarried: (a) the benefits of a plan which covers the child as a dependent of the parent with custody will be determined before the benefits of a plan which covers the child as a dependent of the step-parent; and (b) the benefits of a plan that covers the child as a dependent of the step-parent will be determined before the benefits of a plan that covers the child as a dependent of the parent without custody.
 - f. Despite (2) and (3) above, if there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, the benefit payment of a plan which covers the child as a dependent of the parent with such financial responsibility will be determined before the benefit payment of any other plan that covers the child as a dependent child.
4. The benefits of a plan that covers a person as a primary insured who is neither laid off nor retired, or as that primary insured’s dependent, are determined before those of a plan that covers that person as a laid off or retired primary

insured or as that primary insured's dependent. This rule will not apply if the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits.

5. If a person whose coverage is provided under a right of continuation pursuant to federal or state law is covered under another plan, the following will be the order of benefit determination:
 - a. First, the benefits of a plan covering the person as an employee, member, or subscriber (or as that person's dependent);
 - b. Second, the benefits under the continuation coverage. If the other plan does not have the rule described above and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
6. When rules (2) through (5) above do not establish an order of benefit determination the benefits of a plan which has covered the person on whose expenses the claim is based for the longer period of time will be determined before the benefits of a plan which has covered the person the shorter period of time.

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

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

Right to Receive and Release Necessary Information. In order to carry out these COB rules:

1. We have the right, without the consent of or notice to any person, to exchange information with any person, insurance company or organization, as we deem necessary; and
2. Any person claiming benefits under this plan must give Us any information necessary to carry out this provision.

PART IX - CLAIM PROVISIONS

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

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.

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

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

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

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

PART X – GENERAL PROVISIONS

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

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 90 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.

No action at law or in equity may be brought against Us under the Policy for any reason unless You first complete all steps in any complaint/grievance procedures made available by Your state to resolve disputes under this Policy. After completing

the complaint/grievance process, if You choose to bring action at law or in equity against Us relating to that dispute, You must do so within three years (or the required statute of limitation by state law, if longer) of the date We notify You of the final decision on Your complaint/grievance.

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

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

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

Conformity With 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.

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
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Description of Eligible Classes:

- I. All active members of Healthy America 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.
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Advanced Diagnostic Studies Copayment	\$500 Copayment per occurrence for Advanced Diagnostic Studies in an Outpatient setting, not to exceed a maximum of 3 Advanced Diagnostic Studies Copayments per
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Wellness Benefit Copayment

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.

Doctor's Office or Urgent Care Center Visits Copayment

\$100 Copayment for one annual Routine Physical Exam. Coinsurance is 80% and benefits are not subject to the Plan Deductible.

\$50 Copayment per visit or consultation per Covered Person. Coinsurance is 80% of Eligible Expenses and benefits are not subject to the Plan Deductible. 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.

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

\$2,000 per Covered Person per Coverage Period

**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.

Coverage Period Maximum Benefit

\$1,000,000 per Covered Person

Penalty for failure to pre-certify

Eligible Expenses will be reduced 50%; any Deductible(s) will be subtracted from the remaining amount; and the Coinsurance will be applied.

Covered Services

Benefit Limits

Inpatient Hospital services:

Average Standard Room Rate

Average Standard room rate. Benefits including nursing services and all miscellaneous medical charges are limited to \$5,000 per day.

Intensive Care or Critical Care Unit

The benefit payable for each day of confinement in an Intensive Care or Critical Care Unit. Benefits including nursing services and all miscellaneous medical charges are limited to \$5,000 per day.

Outpatient Miscellaneous Hospital Expenses

The benefit payable for miscellaneous Outpatient Hospital expenses, excluding Outpatient Surgery. Benefits are limited to \$5,000 per Covered Person per Coverage Period for all Eligible Expenses combined.

Emergency Room

(This includes the emergency room physician charge, 24 hour surveillance and all miscellaneous medical charges)

After the Copayment shown above, The benefit payable for each emergency room visit, including professional and facility services will not exceed \$2,500.

Outpatient Surgical Facility

The benefit payable per day including all miscellaneous expenses is limited to \$5,000.

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.

Doctor's Office Visit or Urgent Care Center

After the Copayment shown above, Coinsurance is 80% of Eligible Expenses and benefits are not subject to the Plan Deductible.

Any other covered services or tests performed as part of the office visit will be subject to the Plan Deductible and Coinsurance.

Office or urgent care center visits or consultations in excess of the maximum number of Doctor's Office Visit or Urgent Care Center Copayments will be subject to the Plan Deductible and Coinsurance.

Wellness Benefit

After the Copayment shown above, Coinsurance is 80% of Eligible Expenses and benefits are not subject to the Plan Deductible.

Home Health Care

\$100 per visit. There is a limit of 1 visit per day not to exceed a maximum 40 Home Health Care visits per Covered Person per Coverage Period.

Ambulance

Injury:

\$1,000 per transport.

Sickness:

\$1,000 per transport.

Physical, Occupational and Speech Therapy

\$100 per day and 10 visits combined per Covered Person per Coverage Period.

Organ or tissue transplants

\$100,000 per Covered Person per Coverage Period.

Foreign Travel

\$50,000 per Covered Person per Coverage Period.

Temporomandibular Joint Disorder (TMJ):	\$2,000 per Covered Person per Coverage Period
Kidney Stones	\$5,000 per Covered Person per Coverage Period
Appendectomy	\$5,000 per Covered Person per Coverage Period
Joint or Tendon Surgery	\$5,000 per Covered Person per Coverage Period
Knee Injury or Disorders	\$5,000 per Covered Person per Coverage Period
Acquired Immune Deficiency Syndrome (AIDS) Human Immunodeficiency Virus (HIV)	\$5,000 per Covered Person per Coverage Period
Gallbladder Surgery	\$5,000 per Covered Person per Coverage Period
Mental Disorders	
Inpatient:	\$100 per day, 31 days maximum per Covered Person per Coverage Period.
Outpatient:	\$50 per visit, 10 visit maximum per Covered Person per Coverage Period
Substance Abuse	
Inpatient:	\$100 per day, 31 days maximum per Covered Person per Coverage Period.
Outpatient:	\$50 per visit, 10 visit maximum per Covered Person per Coverage Period
Pre-Existing Conditions Allowance	Notwithstanding the Pre-Existing Conditions exclusion under Part VII of the Certificate, Eligible Expenses not to exceed \$500 per Coverage Period will be allowed. Payment of any benefits, including application to the Deductible and 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

EVEREST REINSURANCE COMPANY

Statutory Office: 251 Little Falls Drive, Wilmington, Delaware 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")

ARKANSAS 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.

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

A. The following is added to the face page of the Certificate:

Any certificates issued in Arkansas will be governed by the State of Arkansas.

Policyholder Service Office of Company:

251 Little Falls Drive, Wilmington, DE 19808

Toll-Free Telephone Number: 800-438-4375

If we fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department

Consumer Services Division

1 Commerce Way, Suite 102 Little Rock, Arkansas 72202

Telephone: (501) 371-2640 or Toll-Free: 800-852-5494

B. The following definition under **PART I – GENERAL DEFINITIONS** is replaced with the following:

"Experimental or Investigational Treatment" means 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.

- C. The Newborn Child and Adopted Children provisions under **PART II – ELIGIBILITY AND EFFECTIVE DATE OF INSURANCE** are 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. Coverage for a child born after the Certificate Effective Date will be effective from the moment of birth and will remain in force for 90 days. A notice of birth, together with any additional premium, must be submitted to us within 90 days of the birth in order to continue coverage for Injury and Sickness beyond the initial 90-day period.

Coverage for your child will be for Injury or Sickness the same as provided for any other member of the Insured's family, including a Congenital Condition, premature birth and tests for hypothyroidism, phenylketonuria, galactosemia, and sickle-cell anemia and all other genetic disorders for which screening is performed by or for the State of Arkansas.

Adopted Children Coverage: Coverage for Injury or Sickness for a child adopted by You or a child placed with You for the purpose of adoption after the Certificate Effective Date will be effective for the first 60 days from 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 60 days, an Insured must enroll the adopted child and pay any required premium within 60 days from either the date of placement or the final decree of adoption. The coverage of such child will be the same as provided for other members of the Insured's family.

- D. The Extension of Benefits provision under **PART III - TERMINATION OF INSURANCE** is replaced with the following:

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 Covered Person's Coverage Period, with a
4. minimum of thirty (30) days not to exceed a maximum of ninety (90) days; 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 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 a new Deductible.

An extension of benefits will also be provided if a Covered Person who is hospitalized on the date the entire Policy is terminated, if the Policy is terminated and replaced by a group health insurance policy issued by another insurer or by a self-funded health care plan. Termination must be for reasons other than nonpayment of premium, fraud or material misrepresentation. We will temporarily extend the coverage, only for treatment of the condition causing the Hospitalization. Benefits will be paid until the earlier of (1) the date Hospital Confinement ends (2) the date premium payment is not paid when due; or (3) the date the any maximum benefit has been reached.

- E. The Reconstructive Surgery benefit under **PART VI – ELIGIBLE EXPENSES** is changed with the addition of the following:

Medical and surgical benefits for any hospital stay in connection with a mastectomy shall be provided for not less than forty-eight (48) hours unless the decision to discharge the patient before the expiration of the minimum length of stay is made by an attending Doctor in consultation with Covered Person.

- F. The following benefits are added to **PART VI – ELIGIBLE EXPENSES**:

1. Coverage for the necessary care and treatment of **loss or impairment of speech or hearing**, subject to the same durational limits, dollar limits, deductibles, and coinsurance as other covered services in the Policy. The benefit does not apply to hearing instruments or devices. Loss or impairment of speech or hearing includes those communicative disorders generally treated by a speech pathologist or audiologist licensed by the Board of Examiners in Speech-Language Pathology and Audiology and which fall within the scope of his or her area of

certification.

2. Coverage for corrective surgery and related medical care for a Covered Person of any age who is diagnosed as having a **craniofacial anomaly** if the surgery and treatment are Medically Necessary to improve a functional impairment that results from the craniofacial anomaly as determined by a nationally accredited cleft-craniofacial team, approved by the American Cleft Palate-Craniofacial Association in Chapel Hill, North Carolina. This includes Eligible Expenses for reconstructive surgery, dental care, and vision care.

Coverage for the following for a craniofacial patient, if Medically Necessary:

1. On an annual basis: Sclera contact lenses, including coatings; Office visits; an ocular impression of each eye; and any additional tests or procedures that are Medically Necessary;
2. Every two years: two hearing aids and two hearing aid molds for each ear. Hearing aids include behind the ear, in the ear, wearable bone conductions, surgically implanted bone conduction services, and cochlear implants; and
3. Every four years: a dehumidifier.

For Eligible Expenses to be performed by a nationally approved cleft-craniofacial team, a request for written authorization or approval shall be reviewed by the Administrator: (1) Within two working days from the request by a nationally approved cleft-craniofacial surgical team member, for a non-urgent case; or (2) Within twenty-four hours from the request by a nationally approved cleft-craniofacial surgical team member, for an urgent case.

For Eligible Expenses that are recommended by a surgical member of a nationally approved cleft-craniofacial team that are to be performed by a medical provider that is not on a nationally approved cleft-craniofacial team, a request for written authorization or approval shall be reviewed: (1) Within two working days from the request by a nationally approved cleft-craniofacial surgical team member, for a non-urgent case; or (2) Within twenty-four hours from the request by a nationally approved cleft-craniofacial surgical team member, for an urgent case.

"Reconstructive surgery" means the use of surgery to alter the form and function of the cranial facial tissues due to a congenital or acquired musculoskeletal disorder, including surgery to alter the form and function of the skull and face. "Craniofacial anomaly" means the abnormal development of the skull and face.

3. Coverage for one (1) annual **prostate cancer screening** for men 40 years of age and older according to the National Comprehensive Cancer Network guidelines, as in effect on January 1, 2009. The prostate cancer screening must be performed by a qualified medical professional. If a medical practitioner recommends that a Covered Person undergo a prostate specific antigen blood test, this benefit will not be denied on the ground that the Covered Person has already had a digital rectal examination and the examination result was negative. The coverage for prostate cancer screening is not subject to the Deductible. 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.
4. Coverage for Medically Necessary equipment, supplies, and services for the treatment of Type I **diabetes**, Type II diabetes, and gestational diabetes, when prescribed by a Doctor. This includes one (1) training program per Covered Person per lifetime for diabetes self-management training when Medically Necessary as determined by a Doctor and when provided by an appropriately licensed health care professional upon certification by the health care professional providing the training that the insured patient has successfully completed the training. "Diabetes self-management training" means instruction in an inpatient or outpatient setting including medical nutrition therapy relating to diet, caloric intake and diabetes management, excluding programs the primary purposes of which are weight reduction, which enables diabetic patients to understand the diabetic management process and daily management of diabetic therapy as a method of avoiding frequent hospitalizations and complications when the instruction is provided in accordance with a program in compliance with the National Standards for Diabetes Self-Management Education and Support as developed by the American Diabetes Association.
5. Coverage for **medical foods** and low protein modified food products for the Medically Necessary treatment of phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism, if administered under the direction of a licensed Doctor. The cost of the medical food or low protein modified food products for a Covered Person must exceed the income tax credit of \$2,400 per person per year.
6. Coverage for gastric pacemakers for Covered Persons with **gastroparesis**. Eligible Expenses will be based on Medically Necessity or the Policy's coverage criteria for other medical services. This benefit is subject to any Deductible, Copayment and Coinsurance under the Certificate. Coverage is subject to Pre-Certification.

"Gastric pacemaker" means a medical device that uses an external programmer and implanted electrical leads to the stomach; and transmits low-frequency, high-energy electrical stimulation to the stomach to entrain and pace the gastric slow waves to treat gastroparesis.

"Gastroparesis" means a neuromuscular stomach disorder in which food empties from the stomach more slowly than normal.

7. Covered Expenses will include diagnosis and treatment of **autism spectrum disorders** that are not already covered under another benefit of the Policy. Treatment includes:
- a. The following care prescribed, provided, or ordered for a specific individual diagnosed with an autism spectrum disorder by a licensed physician or a licensed psychologist who determines the care to be medically necessary and evidence-based, including without limitation:
 - i. Applied behavior analysis when provided by or supervised by a board-certified behavior analyst;
 - ii. Pharmacy care;
 - iii. Psychiatric care;
 - iv. Psychological care;
 - v. Therapeutic care; and
 - b. Equipment determined necessary to provide evidence-based treatment; and any care for an individual with autism spectrum disorder that is determined by a licensed physician to be: medically necessary and evidence-based.

Applied behavior analysis services is limited to children under eighteen (18) years of age and will not exceed \$50,000 per Policy year.

Coverage for treatment under this benefit will not be denied on the basis that the treatment is habilitative in nature. If an Insured Person is receiving treatment for an autism spectrum disorder, the Company will not request a review of the medical necessity of the treatment for autism spectrum disorder to a greater extent than it does for other illnesses covered in the Policy. The cost of obtaining the review shall be borne by the Company.

"Applied behavior analysis" means the design, implementation, and evaluation of environmental modifications by a board-certified behavior analyst using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior;

"Autism services provider" means a person, entity, or group that provides diagnostic evaluations and treatment of autism spectrum disorders, including licensed physicians, licensed psychiatrists, licensed speech therapists, licensed occupational therapists, licensed physical therapists, licensed psychologists, and board-certified behavior analysts.

"Autism spectrum disorder" means any of the pervasive developmental disorders as defined by the most recent edition of the "Diagnostic and Statistical Manual of Mental Disorders", including: (1) autistic disorder; (2) asperger's disorder; and (3) pervasive developmental disorder not otherwise specified.

"Board-certified behavior analyst" means an individual certified by the nationally accredited Behavior Analyst Certification Board, a nationally accredited nongovernmental agency that certifies individuals who have completed academic, examination, training, and supervision requirements in applied behavior analysis.

"Diagnosis" means medically necessary assessment, evaluations, or tests to diagnose whether or not an individual has an autism spectrum disorder. Diagnostic evaluations do not need to be completed concurrently to diagnose autism spectrum disorder.

"Evidence-based treatment" means treatment subject to research that applies rigorous, systematic, and objective procedures to obtain valid knowledge relevant to autism spectrum disorders.

"Medically necessary" means reasonably expected to do the following: (1) prevent the onset of an illness, condition, injury, or disability; (2) reduce or ameliorate the physical, mental, or developmental effects of an illness, condition, injury, or disability; or (3) assist to achieve or maintain maximum functional capacity in performing daily activities, taking into account both the functional capacity of the individual and the functional capacities that are appropriate for individuals of the same age.

"Pharmacy care" means medications prescribed by a licensed physician and any health-related services deemed medically necessary to determine the need or effectiveness of the medications.

"Psychiatric care" means direct or consultative services provided by a psychiatrist licensed in the state in which the psychiatrist practices.

"Psychological care" means direct or consultative services provided by a psychologist licensed in the state in which the psychologist practices.

"Therapeutic care" means services provided by licensed speech therapists, occupational therapists, or physical therapists.

8. Coverage for colorectal cancer screening for a Covered Person who is:
- a. age 45 years of age or older;
 - b. less than 45 years of age who is at high risk for colorectal cancer according to the colorectal cancer screening guidelines as they existed on January 1, 2021; or
 - c. experiencing the following symptoms of colorectal cancer as determined by a Doctor: (i) bleeding from the rectum or blood in the stool or (ii) a change in bowel habits, such as diarrhea, constipation, or narrowing of the stool that last more than five days; or (c) the need for a follow-up colonoscopy.

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.

A colorectal cancer screening includes an examination of the entire colon, including: all examinations, lab tests, or preventive screening tests assigned either a grade of "A" or "B" by the United States Preventive Services Task Force (USPSTF); and any additional medically recognized screening tests determined by the USPSTF.

The Deductible and Coinsurance will not apply to a colonoscopy performed as a result of a positive result on a non-colonoscopy preventive screening test; or any additional non-colonoscopy preventive screening tests for colorectal cancer required by the Secretary of the Department of Health in consultation with the University of Arkansas for Medical Sciences and consistent with guidelines issued by the USPSTF).

As used in this benefit "follow-up colonoscopy" means a colonoscopy that is performed as a follow-up to a colorectal cancer screening test, other than a colonoscopy, the result of which is positive and assigned either a grade "A" or "B" by the USPSTF.

"Person at high risk of colorectal cancer" means (a) the presence of one or more adenomatous polyps on a previous colonoscopy, or flexible sigmoidoscopy; (b) a family history of colorectal cancer; (c) genetic alterations of hereditary nonpolyposis colon cancer or familial adenomatous polyposis; (d) a personal history of colorectal cancer, ulcerative colitis, or Crohn's disease; or (e) the presence of any appropriate recognized gene markers for colorectal cancer or other predisposing factors. It also includes any additional or expanded definition as expanded by the medical science and determined by the Secretary of the Department of Health in consultation with the University of Arkansas for Medical Sciences and consistent with the guidelines issued by the USPSTF.

9. Charges for healthcare services provided through telemedicine.

"Telemedicine" means the use of electronic information and communications technology to deliver health care services, including without limitation the assessment, diagnosis, consultation, treatment, education, care management, and self-management of a patient. It also includes store-and-forward technology and remote patient monitoring. It does not include the use of:

1. Audio-only communication, unless the audio-only communication is real-time, interactive, and substantially meets the requirements of a service normally covered under the Certificate;
2. A facsimile machine;
3. Text messaging;
4. Electronic mail systems; or
5. Email.

"Distant site" means the location of the healthcare professional delivering healthcare services through telemedicine at the time the services are provided. "Originating site" means a site at which a patient is located at the time healthcare services are provided to him or her by means of telemedicine. "Remote patient monitoring" means the

use of synchronous or asynchronous electronic information and communication technology to collect personal health information and medical data from a patient at an originating site that is transmitted to a healthcare professional at a distant site for use in the treatment and management of medical conditions that require frequent monitoring. "Store-and-forward technology" means the asynchronous transmission of a patient's medical information from a healthcare professional at an originating site to a healthcare professional at the distant site.

10. Charges for **orthotic and prosthetic devices** are payable at no less than 80% of Medicare allowable as defined by the Centers for Medicare and Medicaid Services, Healthcare Common Procedure Coding System for the following:
- An orthotic device;
 - An orthotic service;
 - A prosthetic device; and
 - A prosthetic service.

Charges must be based on Medical Necessity and the information and recommendation from the treating Doctor in consultation with the Insured and the results of a functional limit test.

"Functional limit test" includes without limitation the Insured's:

- Medical history, including prior use of orthotic devices or prosthetic devices if applicable;
- Current condition, including the status of the musculoskeletal system and the nature of other medical problems; and
- Desire to ambulate with respect to lower-limb orthotic devices or prosthetic devices; or maximize upper-limb function with respect to upper-limb orthotic devices or prosthetic devices.

This Benefit is not available for an orthotic device or service, or a prosthetic device or service for a replacement that occurs more frequently than once every three years unless Medically Necessary.

An orthotic device, orthotic service, a prosthetic device, or a prosthetic service must be prescribed by a licensed doctor of medicine, doctor of osteopathy, or doctor of podiatric medicine and provided by a doctor of medicine, a doctor of osteopathy, a doctor of podiatric medicine, a licensed orthotist, or a licensed prosthetist.

Pre-Certification is required as outlined in the Pre-Certification Requirements provision.

11. Charges for Eligible Expenses for off-label drug use of **intravenous immunoglobulin**, also known as IVIG, to treat individuals diagnosed with pediatric acute-onset neuropsychiatric (PANS) and pediatric autoimmune neuropsychiatric disorders associated with streptococcal infection (PANDAS), or both, under a patient-specific treatment plan established by the Childhood Post-Infectious Autoimmune Encephalopathy Clinic established by the University of Arkansas for Medical Sciences in collaboration with Arkansas Children's Hospital. Benefits may be subject to Prior-Certification as outlined in the Pre-Certification Requirements provision

As used in this benefit: "PANS" means a clinically defined disorder characterized by the sudden onset of obsessive-compulsive symptoms or eating restrictions, accompanied by two or more symptoms of acute behavioral deterioration or motor and sensory changes or both. "PANDAS" means a subset of symptoms affecting children and adolescents within the broader PANS classification.

- G. The following exclusion under **PART VII – EXCLUSIONS** is replaced with the following:

41. Eyeglasses, contact lenses, hearing aids (unless specifically covered under the Policy as an Eligible Expense), hearing implants, eye refraction, visual therapy, orthoptics, visual eye training and any examination or fitting related to these devices, and all vision and hearing tests and examinations, except as specifically covered as an Eligible Expense.

- H. The Time Of Payment of Claim provision under **PART IX CLAIMS PROVISIONS** is replaced with the following:

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 30 calendar days after receipt of proof of loss submitted electronically or within 45 days by any other method.

If the resolution of a claim requires additional information, We will, within 30 calendar days after receipt of the claim, give You a full explanation of what additional information is needed. If You and the provider have provided all such

additional information necessary to resolve the claim, the claim shall be paid, denied, or settled within 30 calendar days after receipt.

If We fail to pay, settle or deny a clean claim or take other required actions within 30 or 45 calendar days (excluding the time waiting for additional information), We will pay interest at the rate of 12% annually on the amount ultimately allowed on the claim, accruing from the date payment was due.

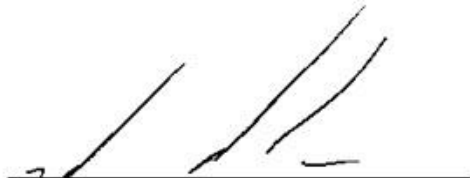
I. The following provisions under **PART X – GENERAL PROVISIONS** are replaced with the following:

Time Limit on Certain Defenses: In the absence of fraud, all statements made by the Policyholder or by the person insured shall be deemed representations and not warranties, and no statement made for the purpose of effecting insurance shall void the insurance or reduce benefits unless contained in a written instrument signed by the Policyholder or by the insured person, a copy of which has been furnished to the policyholder or to the person, or to the individual's beneficiary or personal representative. Any misstatement of a material fact 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 fraud or nonpayment of premiums.

Rescission: A material 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.

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

EVEREST REINSURANCE COMPANY

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

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

CONSECUTIVE SHORT TERM MEDICAL INSURANCE PLAN AMENDMENT

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

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

- A. Any component of your Certificate that accumulates per Coverage Period will begin to accumulate anew on the effective date of each Subsequent Coverage Period with us. This includes any applicable deductible amounts, coinsurance out-of-pocket maximum amounts, number of days limits, visit limits, and maximum dollar limits.
- B. The **NO CONTINUOUS COVERAGE** provision is removed and replaced with the following:

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

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

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

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

- D. Any Dependent who qualified and was added as an eligible Dependent under the Initial Coverage Period with Us must continue to meet the eligibility requirements set forth in the Certificate for any Subsequent Coverage Period with Us.
- E. For each Subsequent Coverage Period, You will be issued a new Certificate with this Consecutive Short Term Medical Insurance Plan Amendment, a new Certificate Number and Your premium may change due to a change in age or a change in the Covered Persons or due to a premium trend adjustment approved by the state. Your premium deductions will continue uninterrupted from one Certificate to the next unless You contact Us to cancel coverage.

GENERAL DEFINITIONS

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

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

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

For: Everest Reinsurance Company



Jill Beggs
President and Chief Executive Officer

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