HEALTHBRIDGE VCS

Endorsed By HAA

SAMPLE INSURANCE POLICY*

KENTUCKY

VISIT THE MEMBER PORTAL FOR YOUR INSURANCE POLICY.

https://members.haahub.com

	PAGE #S	SAMPLE INDIVIDUAL SHORT TERM MEDICAL INSURANCE POLICY DOCUMENTS
	02-31	Individual Short Term Medical Insurance Policy (EAH 00 546 10 18) underwritten by: Everest Reinsurance Company
	32-33	Consecutive STM Insurance Plan Amendment - Ind (EAH 01 685 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 policy. The policy 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 policy documents on the following pages are for illustrative purposes only. Once you are enrolled, you will receive your actual policy.

ATTENTION PLEASE

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

EVEREST REINSURANCE COMPANY

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

SHORT TERM MEDICAL INSURANCE INDIVIDUAL POLICY

THIS POLICY IS ISSUED AND DELIVERED IN THE STATE OF Kentucky and shall be governed by its laws. This Policy is the legal contract between the Insured and Everest Reinsurance Company. This Policy contains the terms under which We agree to insure eligible persons and pay benefits, subject to the terms and conditions herein.

CONSIDERATION - This Policy 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 Policy Effective Date at the Insured's Residence.

PREMIUMS - Premiums are due as stated in the section titled "Premiums".

THIS POLICY PROVIDES NON-RENEWABLE SHORT TERM INSURANCE

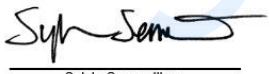
NO CONTINUOUS COVERAGE – This Policy provides coverage on a short term basis. It is not renewable. Although this short term plan may be rewritten for new and completely separate Coverage Periods (as long as You meet eligibility criteria), coverage does not continue from one Policy to another. This means that a new Enrollment Form must be submitted, a new 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 Policy will be treated as a Pre-Existing Condition under the new Policy. This Policy 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 Policy Termination Date at the Insured's residence.

10 DAY RIGHT TO RETURN THE POLICY

If for any reason the Insured is not satisfied with this Policy, the Insured may return it to Us within 10 days after the Insured receives it. We will refund any premium paid and the Policy will be deemed void, just as though it had not been issued.

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 Policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your Policy might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage.

COVERAGE FOR INSUREDS AND ANY DEPENDENTS WILL NOT BE RENEWED AT THE END OF THEIR COVERAGE PERIOD.

SAMPLE

READ YOUR POLICY CAREFULLY. The policy itself sets forth, in detail, the rights and obligations of both you and your insurance company. IT IS THEREFORE IMPORTANT THAT YOU READ YOUR POLICY.

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 Policy Effective Date. See **PART VII – EXCLUSIONS AND LIMITATIONS** for details.

SAMPLE

TABLE OF CONTENTS

The following provisions appear within this Policy in the following order:

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
PART VII – EXCLUSIONS AND LIMITATIONS	15
PART VIII – COORDINATION OF BENEFITS (COB)	18
PART IX - CLAIM PROVISIONS	22
PART X – GENERAL PROVISIONS	23
PART XI - SCHEDULE OF BENEFITS	27

IMPORTANT NOTICE CONCERNING STATEMENTS IN THE ENROLLMENT FORM

Please read the Enrollment Form and all documents attached to this Policy. Omissions or misstatements in the Enrollment Form or any attached documents that are fraudulent or material to the acceptance of the risk 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 Policy, or notice electronically that the Policy is available, if any information or medical history is incomplete, incorrect, or has changed since the date of the Enrollment Form.

SAMPLE

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 Policy 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.

"**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 Policy Effective Date.

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

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

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

SAMPLE

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

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

"**Dependent**" means Your family as follows:

1. The lawful spouse*, if not 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 Policy 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 (including a psychologist or clinical social worker) 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 Policy;
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 Policy or exceed any limits or amounts payable under this Policy.

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 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 by reference to any

SAMPLE

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 Policy 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.

SAMPLE

"**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.

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

"**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.

SAMPLE

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

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

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

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

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

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

"**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, 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 Policy Effective Date, provided:
1. You meet the eligibility requirements set forth in the Enrollment Form 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 Policy 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 Policy 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

SAMPLE

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 an intentional 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 Policy 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 Insured at least 30 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.

SAMPLE

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 Policy 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 Our 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 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 Deductibles, Copayment, Coinsurance amount, Out of Pocket Maximum amount and Coverage Period Maximum Benefit. Reimbursement is also subject to any benefit limitations shown in the Schedule of Benefits. Eligible Expenses for the same treatment or service

SAMPLE

that are applicable to more than one benefit limitation shown in the Schedule of Benefits will be applied toward all applicable limitations.

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

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

ADDITIONAL DEDUCTIBLES:

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

COPAYMENT AMOUNTS:

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

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

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

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

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 by an Ambulatory Surgical Center for medical care, but only if the charges are made for a condition that would normally require Hospital care.

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

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

6. Charges for Inpatient Doctor visits.

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

8. 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.

9. 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.

10. 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.

11. 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.

12. 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.

13. 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.

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

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

16. 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.

17. Charges for radiation therapy or treatment and chemotherapy.

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

19. Charges for an Extended Care Facility room and board accommodations; if:
    a. The Covered Person is receiving skilled nursing care as an Inpatient in that facility on the certification of the attending Doctor that the confinement is Medically Necessary;

SAMPLE

b. The confinement commences immediately following a period of at least three (3) continuous days of Hospital confinement; and
c. The confinement is for the same covered Injury or Sickness that was treated during the Covered Person's confinement in the Hospital.

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

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

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

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

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

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

22. 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.

23. 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.

24. 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.

25. 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:

SAMPLE

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.**

26. 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.

27. 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 Policy. Coverage will be paid the same as any other Sickness.

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

29. Coverage for the treatment of alcoholism will require:
    a. That the Covered Person be under the supervision of a physician licensed to practice in the Commonwealth or a professional designated by such physician, and who is a recognized staff member of a treatment facility licensed by the office or accredited by the Joint Commission on the Accreditation of Hospitals; and
    b. That the Covered Person receive appropriate emergency detoxification treatment, residential treatment and outpatient treatment at facilities licensed by the office or accredited by the Joint Commission on the Accreditation of Hospitals, for alcoholism treatment.

30. Charges for low-dose mammography screening for persons who have no sign or symptom of breast cancer and when performed on dedicated equipment which meets the guidelines established by the American College of Radiology and upon self-referral or on referral by Doctor as follows:
    a. one screening mammogram to persons age thirty-five (35) through thirty-nine (39);
    b. one mammogram every two (2) years for persons ages forty (40) through forty-nine (49); and
    c. one mammogram per year for a person fifty (50) years of age and over and may be limited to a benefit of fifty dollars ($50) per screening mammogram.

    This includes mammograms, performed on dedicated equipment that meets the guidelines established by the American College of Radiology, for any Covered Person, regardless of age, who has been diagnosed with breast disease upon referral by a Doctor.

    "Mammogram" means an x-ray examination of the breast using equipment dedicated specifically for mammography, including, but not limited to, the x-ray tube, filter, compression device, screens, film, and cassettes, with two (2) views of each breast and with an average radiation exposure at the current recommended level as set forth in guidelines of the American College of Radiology. Benefits will be subject to any applicable Plan Deductible, Copayment and Coinsurance. No benefit will be paid for services under this benefit if a benefit for this service has already been paid for under the Wellness Benefit.

31. Charges for the treatment of breast cancer by high-dose chemotherapy with autologous bone marrow transplantation or stem cell transplantation. The administration of high-dose chemotherapy with autologous bone marrow transplantation or stem cell transplantation shall only be covered when performed in institutions that comply with the guidelines of the American Society for Blood and Marrow Transplantation or the International Society of Hematotherapy and Graft Engineering, whichever has the higher standard. Treatment of breast cancer by high-dose chemotherapy with autologous bone marrow transplantation or stem cell transplantation shall not be considered experimental or investigational.

32. Charges for bone density testing for women age 35 and older, as required by a Doctor, in accordance with standard medical practices to obtain baseline data for the purpose of early detection of osteoporosis.

33. Chargers for the diagnosis and treatment of endometriosis and endometritis when hysterectomies are covered under the Policy.

SAMPLE

Pre-Certification Requirements

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

A. 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.

B. 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 Policy.

C. 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%.

D. 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.

E. 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 Policy.

F. 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 Policy 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 Policy 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 Policy 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 Policy Effective Date of coverage under the Policy.

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

SAMPLE

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

4. The benefits payable for the following conditions or procedures are limited to the specified amounts shown in the Schedule of Benefits:
   a. Kidney stones
   b. Appendectomy
   c. Joint or tendon Surgery
   d. Knee Injury or disorder
   e. Gallbladder Surgery

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

6. Charges which exceed any limits or limitations specified in this Policy, 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; artificial insemination, treatment for infertility or impotency, sterilization or reversal of sterilization.

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

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

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

18. Weight modification or surgical treatment of obesity.

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

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

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

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

SAMPLE

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. Elective abortions. "Elective abortion" means an abortion for any reason other than to preserve the life of the female upon whom the abortion is performed.

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 Policy.

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 Policy.

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

38. Spinal manipulation or adjustment.

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

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

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

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

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

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

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

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

SAMPLE

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.

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 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, if the person is eligible to receive such benefits.

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.

SAMPLE

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

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

Definitions.
"Allowable expense" means a health care service or expense including deductibles, coinsurance or copayments, that is covered in full or in part by any of the plans covering the person.

"Benefit reserve" means the savings recorded by a plan for claims paid for a covered person as a secondary plan rather than as a primary plan.

"Claim" means a request that benefits of a plan be provided or paid, and the benefits claimed may be in the form of:
1. Services including supplies;
2. Payment for all or a portion of the expenses incurred;
3. A combination of paragraphs (a) and (b) of this subsection; or
4. An indemnification.

"Complying plan" means a plan with benefit determination requirements that comply with the requirements of this administrative regulation.

"Coordination of benefits" means a provision establishing an order in which plans pay their claims, and permitting secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses.

"Claim determination period" means a period of at least twelve (12) consecutive months, over which allowable expenses shall be compared with total benefits payable in the absence of coordination of benefits, to determine whether overinsurance exists and how much each plan will pay or provide.

"Custodial parent" means the parent awarded custody of a child by a court decree, or with whom the child resides more than one-half (1/2) of the calendar year.

"Plan" means a form of coverage with which coordination of benefits is allowed and health benefit plans as defined in KRS 304.17A-005(22):
1. "Plan" shall not include the medical benefits coverage in a group, group-type, and individual motor vehicle "no-fault" and traditional automobile "fault" type contracts;
2. "Plan" may include Medicare benefits pursuant to 42 USC 1395, or other governmental benefits; and
3. "Plan" shall not include school accident-type coverages which cover elementary, high school, and college students for accidents only, including athletic injuries, either on a twenty-four (24) hour basis or on a "to-and-from school" basis.

“Primary Plan (Primary)” means a plan whose benefits for a person's health care coverage shall be determined without taking the existence of any other plan into consideration if:
1. The plan either has no order of benefit determination requirements, or its requirements differ from those permitted by this administrative regulation; or
2. All plans that cover the person use the order of benefit determination requirements required by this administrative regulation, and under those requirements the plan determines its benefits first..

“Secondary Plan (Secondary)” means a plan that is not a primary plan..

Requirements for Coordination of Benefits. If a person is covered by two (2) or more plans, the requirements for determining the order of benefit payments are as follows:
1. The primary plan shall pay or provide its benefits as if the secondary plan or plans did not exist;
2. A plan that does not contain a coordination of benefits provision that is consistent with this administrative regulation is always primary except that coverage obtained by virtue of membership in a group and designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be considered secondary to the basic package of benefits provided by the contract holder; and

SAMPLE

3. A plan may take the benefits of another plan into account only when it is secondary to that other plan.

The first of the following requirements that describes which plan pays its benefits before another plan is the requirement to use:

1. Nondependent or dependent. The plan that covers the person other than as a dependent is primary and the plan that covers the person as a dependent is secondary unless the person is a Medicare beneficiary, in which case the order of benefits is determined in accordance with 42 USC 1395.
2. A child, including a newborn, covered under more than one (1) plan.

a. The primary plan is the plan of the parent whose birthday is earlier in the year if:
   i. The parents are married;
   ii. The parents are not separated (whether or not they ever have been married); or
   iii. A court decree awards joint custody without specifying that one (1) parent has the responsibility to provide health care coverage.

b. If both parents have the same birthday, the plan that has covered either of the parents longer is primary.

c. If a court decree states that one (1) parent is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's spouse does, the spouse's plan is primary.

d. If the parents are not married or are separated or divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and the parents' spouses (if any) is:
   i. The plan of the custodial parent;
   ii. The plan of the spouse of the custodial parent;
   iii. The plan of the noncustodial parent; and then
   iv. The plan of the spouse of the noncustodial parent.

Active or inactive employee. The plan that covers a person as an employee who is neither laid off nor retired, or as that employee's dependent, is primary.

Continuation coverage. If a person whose coverage is provided under a right of continuation pursuant to federal or state law is also covered under another plan, the plan covering the person as an employee, member, subscriber or retiree, or as that person's dependent, is primary and the continuation coverage is secondary.

Longer or shorter length of coverage. If the preceding requirements do not determine the order of benefits, the plan that covered the person for the longer period of time is primary:

1. To determine the length of time a person has been covered under a plan, two (2) plans shall be treated as one (1) if the covered person was eligible under the second within twenty-four (24) hours after the first ended;
2. Changes during a coverage period that do not constitute the start of a new plan include:

a. A change in scope of a plan's benefits;
b. A change in the entity that pays, provides or administers the plan's benefits; or
c. A change from one (1) type of plan to another.

3. The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a member of the group shall be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.

If none of the preceding requirements determines the primary plan, the allowable expenses shall be shared equally between the plans.

Procedure to be Followed by Secondary Plan. A secondary plan shall reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than 100 percent of total allowable expenses.

The secondary plan shall calculate its savings by subtracting the amount that it paid as a secondary plan from the amount it would have paid had it been primary and any savings shall be:

1. Recorded as a benefit reserve for the covered person; and

SAMPLE

2. Used by the secondary plan to pay any allowable expenses, not otherwise paid, that are incurred by the covered person during the claim determination period.

By the end of the claim determination period, the secondary plan shall:

1. Determine whether a benefit reserve has been recorded for the covered person;
2. Determine whether there are any unpaid allowable expenses for that claims determination period; and
3. Pay any unpaid allowable expenses for that claim determination period.

The secondary plan shall use the covered person's recorded benefit reserve, if any, to pay up to 100 percent of total allowable expenses incurred during the claim determination period, at the end of which:

1. The benefit reserve shall return to zero; and
2. A new benefit reserve shall be created for each new claim determination period.

The benefits of the secondary plan shall be reduced when the sum of the benefits payable under the secondary plan, in the absence of this coordination of benefits provision, and the benefits that would be payable under the other plans, in the absence of a coordination of benefits provision, whether or not a claim is made, exceeds the allowable expenses in a claim determination period, with a reduction of benefits as follows:

1. The benefits of the secondary plan shall be reduced so that they and the benefits payable under the other plans do not total more than the allowable expenses; and
2. Each benefit is reduced in proportion and charged against any applicable benefit limit of the plan.

If a person is covered by more than one secondary plan, the order of benefit determination requirements of this administrative regulation decide the order in which secondary plans benefits are determined in relation to each other. Each secondary plan shall take into consideration the benefits of the primary plan or plans and the benefits of any other plan which, under the requirements of this administrative regulation, has its benefits determined before those of that secondary plan.

Notice to Covered Persons. A plan shall, in its explanation of benefits provided to covered persons, include the following language: "If you are covered by more than one (1) health benefit plan, you should file all your claims with each plan."

Miscellaneous Provisions. A secondary plan that provides benefits in the form of services may recover the reasonable cash value of the services from the primary plan, to the extent that benefits for the services are covered by the primary plan and have not already been paid or provided by the primary plan.

A plan with order of benefit determination requirements that comply with this administrative regulation may coordinate its benefits with a plan that is "excess" or "always secondary" or that uses order of benefit determination requirements that do not comply with those contained in this administrative regulation on the following basis:

1. If the complying plan is the primary plan, it shall pay or provide its benefits first;
2. If the complying plan is the secondary plan, it shall pay or provide its benefits first, but the amount of the benefits payable shall be determined as if the complying plan were the secondary plan. In that situation, the payment shall be the limit of the complying plan's liability; and
3. If the noncomplying plan does not provide the information needed by the complying plan to determine its benefits within a reasonable time after it is requested to do so, the complying plan shall assume that the benefits of the noncomplying plan are identical to its own, and shall pay its benefits accordingly. If, within two (2) years of payment, the complying plan receives information as to the actual benefits of the noncomplying plan, it shall adjust payments accordingly.

If the noncomplying plan reduces its benefits so that the covered person receives less in benefits than he would have received had the complying plan paid or provided its benefits as the secondary plan and the noncomplying plan paid or provided its benefits as the primary plan, and governing state law allows the right of subrogation set forth below, then the complying plan shall advance to or on behalf of the covered person an amount equal to the difference.

The complying plan shall not advance more than the complying plan would have paid had it been the primary plan less any amount it previously paid for the same expense or service, and:

1. In consideration of the advance, the complying plan shall be subrogated to all rights of the covered person against the noncomplying plan; and

SAMPLE

2. The advance by the complying plan shall also be without prejudice to any claim it may have against a noncomplying plan in the absence of subrogation.

Coordination of benefits differs from subrogation. Provisions for one (1) may be included in health care benefits contracts without compelling the inclusion or exclusion of the other.

If the plans cannot agree on the order of benefits within thirty (30) calendar days after the plans have received all of the information needed to pay the claim, the plans shall immediately pay the claim in equal shares and determine their relative liabilities following payment, except that no plan shall be required to pay more than it would have paid had it been primary.

PART IX - CLAIM PROVISIONS

Notice of Claim: Written notice of claim must be given within 60 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 such forms are not furnished before the expiration of 15 days after the insurer receives notice of any claim under the Policy, the person making such claim shall be deemed to have complied with the requirements of the Policy as to proof of loss upon submitting, within the time fixed in the Policy for filing proof of loss, written proof covering the occurrence, character and extent of the loss for which claim is made.

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

Time of Payment of Claim: Benefits for loss covered by the Policy will be paid as soon as We receive proper written proof of such loss but not more than 30 days after receipt of proof of loss.

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

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:

SAMPLE

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

Entire Contract: The entire contract consists of the Policy, the Enrollment Form, Riders and any other documents requested and accepted by Us. No change in this Policy is valid unless approved by an officer of the Company. Such approval must be signed by Our officer and attached to this Policy. No broker, agent or producer can change or waive any provision of this Policy.

Amendments: Any change in this Policy will be made by amendment and approved by Us. Such amendment will not require the consent of any Covered Person. The effective time for any amendments shall be 12:01 A.M. Standard Time at the address of the Insured.

Time Limit on Certain Defenses: All material 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 that is fraudulent or material to the acceptance of the risk made on Your Enrollment Form or on any other materials on which We relied to issue, change or increase coverage will be considered a fraudulent misrepresentation or omission 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 Policy Effective Date, except for fraudulent misstatements.

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

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

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

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 Policy which, on the Policy Effective Date, is in conflict with the statutes of the jurisdiction in which the Insured 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.

SAMPLE

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 fraudulent or material misrepresentation 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 Policy 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.

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

Reinstatement: If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the Company or by any agent duly authorized by the Company to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the policy: provided, however, that if the Company or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the policy will be reinstated upon approval of such application by the Company or, lacking such approval, upon the forty-fifth day following the date of such conditional receipt unless the Company has previously notified the Insured in writing of its disapproval of such application. The reinstated policy shall cover only loss resulting from such Accidental Injury as may be sustained after the date of reinstatement and loss due to such Sickness as may begin more than ten (10) days after such date. In all other respects the insured and the Company shall have the same rights thereunder as they had under the policy immediately before the due date of the defaulted premium, subject to any provisions indorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than sixty (60) days prior to the date of reinstatement.

Kentucky Appeals Procedures: When you submit a claim and that claim is denied, we will provide a written statement containing the reasons for the Adverse Determination. You have the right to request a review of any Company decision or action pertaining to our contractual relationship and to appeal any adverse claim determination we've made.

DEFINITIONS

Internal Appeals: A Covered Person, the Covered Person's Authorized Representative, or a provider acting on behalf of the Covered Person, may initiate an internal appeal. An appeal is a request for review of an Adverse Determination or a Coverage Denial as defined below. An internal appeal may also be initiated if We fail to make a timely utilization review determination.

Adverse Determination means a determination by an insurer or its designee that the health care services furnished or proposed to be furnished to a Covered Person are:

1. Not medically necessary, as determined by the insurer, or its designee or experimental or investigational, as determined by the insurer, or its designee; and
2. Benefit coverage is therefore denied, reduced, or terminated.

Coverage Denial means an insurer's determination that a service, treatment, drug, or device is specifically limited or excluded under the Covered Person's health benefit plan.

Initiating an Appeal

A request for an internal appeal must be submitted within sixty (60) calendar days of receipt of a denial letter and include the initial denial letter, the number of claims in question, the date(s) of service, a summary of any previous communication You have had with Us regarding this denial, and any pertinent medical information.

Internal appeal of an Adverse Determination shall only be conducted by a licensed physician who did not participate in the initial review and denial. However, in the case of a review involving a medical or surgical specialty or subspecialty, a Covered Person, the Covered Person's Authorized Representative, or a provider may request a board eligible or certified Physician in the appropriate specialty or subspecialty area to conduct the internal appeal relating to an Adverse Determination.

Within thirty (30) days of receipt of the internal appeal request, We will send a written decision to the Covered Person or their authorized representative, and if applicable, the Covered Person's provider.

An expedited appeal is deemed necessary when the Covered Person is hospitalized, or in the opinion of the treating provider, a review under a standard timeframe could, in the absence of immediate medical attention; result in any of the following:

1. Placing the health of the Covered Person or, with respect to a pregnant woman, the health of the Covered Person or the unborn child in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of a bodily organ or part.

An expedited appeal may be requested orally and followed up by an abbreviated written request by a Covered Person, the Covered Person's Authorized Representative or a provider acting on behalf of a Covered Person. An internal appeal decision will be rendered not later than (three) 3 business days after the receipt of the request for an expedited internal appeal.

Any additional pertinent information may be submitted for consideration during the internal appeal process. If You or Your provider has new clinical information regarding Your appeal, You may provide it prior to the initiation of an External Review. We will then have five (5) business days from the date of receipt of the new information to render a decision based on the new information. Following that decision, You have sixty (60) calendar days to initiate an external review of an Adverse Determination.

If Our decision is to uphold a Coverage Denial, the Covered Person, the Covered Person's Authorized Representative, or a provider may contact the Kentucky Department of Insurance (DOI), Health and Life Division, P.O. Box 517, Frankfort, Kentucky 40602, and request a review of Our decision. The DOI will make a determination as to whether the service should or should not be covered. If the DOI determines the disputed service should be covered, they may direct Us to either cover the service or offer external review to resolve the issue.

External Review by an Independent Review Entity (IRE)

The Covered Person, the Covered Person's Authorized Representative, or a provider acting on behalf of and with the consent of the Covered Person may request an external review of an Adverse Determination if:

1. The internal appeal process outlined above was completed or jointly waived by You and Us or We failed to make a timely determination or notification;
2. The Covered Person was covered under this Certificate on the date of service or, if a prospective denial, the Covered Person was enrolled and eligible to receive covered benefits under this Certificate on the date the proposed service was requested; and
3. The entire course of treatment or service would cost the Covered Person at least one hundred dollars ($100) if the Covered Person had no insurance.

The request for an external review must be sent to Us within sixty (60) calendar days of receiving Our written decision rendered under the internal appeal process. As part of the request, the Covered Person shall provide written consent authorizing the independent review entity to obtain all medical records from Us and any provider utilized for review purposes. All medical records involved in the external review process shall be deemed confidential.

The Covered Person will be responsible for a twenty-five dollar ($25) filing fee to be paid to the IRE, which may be waived in case of financial hardship, or refunded if the IRE finds in favor of the Covered Person.

An external review of an "Adverse Determination" shall not be afforded if:

1. The subject of the Covered Person's adverse determination has previously gone through the external review process and the independent review entity found in favor of Us; and

SAMPLE

2. No relevant new clinical information has been submitted to Us since the independent review entity found in favor of Us.

If a dispute arises between Us and a Covered Person regarding the right to an external review, the Covered Person may file a complaint with the DOI. The DOI shall render a decision within five (5) days of receipt of the complaint.

We will be responsible for the cost of the external review. We will assign external reviews to IREs on a rotating basis such that We do not utilize the same IRE for two consecutive reviews.

An expedited external review process is available if the Covered Person is hospitalized or, in the opinion of the treating provider, a review under a standard timeframe could, in the absence of immediate medical attention; result in any of the following:

1. Placing the health of the Covered Person or, with respect to a pregnant woman, the health of the Covered Person or her unborn child in serious jeopardy;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of a bodily organ or part.

An expedited external review may be requested orally and followed up by an abbreviated written request In the case of an expedited external review, the IRE will make a decision within twenty-four (24) hours from receiving all of the information required from Us. An extension of up to twenty-four (24) hours may be allowed if the Covered Person and the Company agree.

The IRE will send a written decision to the Covered Person within twenty-one (21) calendar days of receiving the request for external review. An extension of up to fourteen (14) calendar days may be allowed if the Covered Person and the Company are in agreement.

The request for an internal appeal or an external review and any supporting documentation must be submitted to the following address: Appeals Coordinator, 651 Perimeter Drive, Suite 300, Lexington, Kentucky 40517.

SAMPLE

PART XI - SCHEDULE OF BENEFITS

INSURED:

MONTHLY PREMIUM:

POLICY NUMBER:

POLICY EFFECTIVE DATE:

POLICY TERMINATION DATE:

COVERAGE PERIOD:

COVERED PERSONS	RELATIONSHIP	AGE	DATE OF BIRTH

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

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

Copayments**

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

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

SAMPLE

Wellness Benefit Copayment	$100 Copayment for one annual Routine Physical Exam. Coinsurance is 80% and benefits are not subject to the Plan Deductible.
Doctor's Office or Urgent Care Center Visits Copayment	$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 **The Deductibles, Copayments, pre-certification penalties and amounts in excess of the Maximum Allowable Expense do not apply towards the Out-of-Pocket Maximum.	$2,000 per Covered Person per Coverage Period
Coverage Period Maximum Benefit	$1,000,000 per Covered Person
Penalty for failure to pre-certify	Eligible Expenses will be reduced by 50%; any Deductible(s) will be subtracted from the remaining amount; and the Coinsurance will be applied.

Covered Services	Benefit Limits
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.

SAMPLE

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
Injury or Disorders	$5,000 per Covered Person per Coverage Period

SAMPLE

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:	Same as any other Sickness
Outpatient:	Same as any other Sickness
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
Treatment for Alcoholism	
Emergency detoxification:	$40 per day not to exceed 3 days
Residential treatment:	$50 per day not to exceed 10 days
Outpatient treatment:	$10 per visit not to exceed 10 visits

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:	PO Box 15953
City, State and ZIP:	Lubbock, TX 79490-5953

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

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

SAMPLE

EVEREST REINSURANCE COMPANY

Statutory Office: 251 Little Falls Drive, Wilmington, 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 becomes a part of the Policy to which it is attached.

The provisions of this Amendment are effective on the same date as the Policy to which it is attached and will expire concurrently with the Policy, 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 Policy 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 Policy 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 Policy to another. This means that a new Enrollment Form must be submitted, a new Policy 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 Policy will be treated as a Pre-Existing Condition under the new Policy. This Policy 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 Policy 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 Policy for the Initial or Subsequent Coverage Period was issued with this Consecutive Short Term Medical Insurance Plan Amendment.

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

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

E. For each Subsequent Coverage Period, You will be issued a new Policy with this Consecutive Short Term Medical Insurance Plan Amendment, a new Policy 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 Policy to the next unless You contact Us to cancel coverage.

SAMPLE

GENERAL DEFINITIONS

"Initial Coverage Period" means a period of coverage that begins when a Covered Person first becomes insured by Us under a Short Term Medical Insurance Policy 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 Policy 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 Policy other than as stated above.

For: Everest Reinsurance Company

Jill Beggs
President and Chief Executive Officer

SAMPLE