



SAMPLE INSURANCE POLICY*

NORTH CAROLINA



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| | PAGE #S | SAMPLE INDIVIDUAL SHORT TERM MEDICAL INSURANCE POLICY DOCUMENTS |
|------------------------------------------------------------------------------------|---------|----------------------------------------------------------------------------------------------------------------|
|  | 02-32 | Individual Short Term Medical Insurance Policy (EAH 00 539 08 18) underwritten by: Everest Reinsurance Company |
|  | 33 | North Carolina Important Notice (EAH 99 00 03 10 15) |

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 NORTH CAROLINA and shall be governed by its laws. This Policy is a 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 READ YOUR POLICY CAREFULLY

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

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

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

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.

**REFER TO THE TERMINATION OF INSURANCE PROVISION FOR INFORMATION ON CANCELLATION.
THIS POLICY CONTAINS A PRE-EXISTING CONDITION LIMITATION**

Non-compliance with the Pre-Admission Certification procedure will result in a reduction in benefits of 50%.

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 | 9 |
| PART III - TERMINATION OF INSURANCE | 9 |
| PART IV - PREMIUMS | 10 |
| PART V – BENEFITS | 11 |
| PART VI – ELIGIBLE EXPENSES | 12 |
| PART VII – EXCLUSIONS AND LIMITATIONS | 17 |
| PART VIII - CLAIM PROVISIONS | 20 |
| PART IV – GENERAL PROVISIONS | 21 |
| PART X - SCHEDULE OF BENEFITS | 28 |
| OPTIONAL BENEFIT RIDERS | |

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 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.

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.

“Creditable Coverage” means the time spent under any of the following plans:

1. A group health plan as defined in G.S. 58-68-25(a)(4b);
2. Health insurance coverage without regard to whether the coverage is offered in the group market, the individual market, or otherwise;
3. Part A & B of title XVIII of the Social Security Act;
4. Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928;
5. Chapter 55 of title 10, United States Code;
6. A medical care program of the Indian Health Service or of a tribal organization;
7. A State health benefits risk pool;
8. A health plan offered under chapter 89 of title 5, United States Code;
9. A public health plan (as defined in federal regulation);
10. A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. s2504(e));
11. Title XXI of the Social Security Act (State Children’s Health Insurance Program); or
12. Short Term limited duration health insurance coverage.

“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.

“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, foster child, 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 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.

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity, including, but not limited to, severe pain, or by acute symptoms developing from a chronic condition that would lead a prudent layperson possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in any of the following:

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

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

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

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

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

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

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

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

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

“Hospital” means an institution operated by law for the care and treatment of Injuries or Sicknesses; has organized facilities for diagnosis and surgery or has a contract with another Hospital for these services; and has 24-hour nursing service. Hospital excludes any institution that is primarily a rest home, nursing home, assisted living facility, Custodial or Convalescent Care facility, Extended Care Facility, a home for the aged, an alcoholism or drug addiction treatment facility or a facility for treatment of Mental Disorders. A State tax-supported institution will not be excluded, even though it may not have an operating room and related equipment for surgery.

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

“Medically Necessary” means covered services or supplies that are:

1. Provided for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, or disease; and not for experimental, investigational, or cosmetic purposes.
2. Necessary for and appropriate to the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease, or its symptoms.
3. Within generally accepted standards of medical care in the community.
4. Not solely for the convenience of the insured, the insured's family, or the provider.

For Medically Necessary services, nothing precludes the Company from comparing the cost-effectiveness of alternative services or supplies when determining which of the services or supplies will be covered.

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.

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

"Sickness" means a Covered Person's illness, disease, Complication of Pregnancy, or condition that:

1. Is treated by a Doctor while the person is covered under the Policy; and
2. Results directly and independently of all other causes covered by the Policy.

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

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

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

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

"Usual and Customary Fee" (or "Fees") means the usual, fair and reasonable fee for medical treatment provided to a Covered Person (or any other form of medical care, procedure, drug or supply). In determining a Usual and Customary Fee, the Company at its discretion, consults:

1. one (1) or more standard industry sources to calculate services of comparable severity and nature in the same geographical area, the cost of the goods and services reasonably required to produce and deliver such treatment and/or the charge most commonly paid for such treatment. The standard industry sources utilize cost-based formula methodology and/or pricing data (updated semi-annually) to produce replicable and consistent cost and/or pricing parameters.
2. the cost to the health care provider of performing or providing the medical treatment, including reasonable allowance for overhead and profit.
3. fee schedules used by third parties such as Medicare or Medicaid, including Medicare allowable charge data for Medicare Part B.
4. hospital cost data as submitted to Medicare, including Medicare allowable charge data for Medicare Part A.
5. prevailing negotiated fee schedules for same or similar services performed in the same geographical area.

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

PART II – ELIGIBILITY AND EFFECTIVE DATE OF INSURANCE

Coverage will be effective for You and Your Covered Dependent(s), as of the approved 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. Any additional premium must be received by 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 the date of placement of the child in the home, regardless of whether a final degree of adoption has become final. To continue coverage beyond 31 days, an Insured must pay any required premium. The coverage of such child will be the same as provided for other members of the Insured's family.

Foster Children Coverage: A foster child over whom You have been appointed as guardian by the clerk of a superior court of any county in this state who has not attained 18 years of age, will become insured for coverage automatically as of the date of placement in the foster home. This includes coverage for a child for which a parent is required by a court or administrative order to provide coverage for such child. Such child's coverage will not be subject to any pre-existing conditions limitation provided by this Policy.

Court Ordered Custody: A child placed in court-ordered custody, including a foster child will be covered on the same basis as an adopted Child.

PART III - TERMINATION OF INSURANCE

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

1. The date premiums are not paid in accordance with the terms of the Policy, subject to the Grace Period;
2. On the next premium due date after the Company receives a written request from the Insured to terminate coverage, or any later date stated in the request;
3. The date an Insured performs an act or practice that constitutes fraud, or is found to have made a misrepresentation of material fact, relating in any way to the Policy, including claims for benefits under the Policy;
4. The date of the Insured's death or the termination date of the Insured's coverage, if the Insured's spouse is not covered under the Policy;
5. The 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 days advance written notice.

If premiums have been paid beyond the termination date, the Company will refund the excess; or if premiums have been paid short of the termination date, the Policyholder will owe the Company the difference.

TERMINATION UPON INSURED'S DEATH

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

TERMINATION OF SPOUSE'S COVERAGE

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

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

TERMINATION OF A CHILD'S COVERAGE

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

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

CONTINUATION OF COVERAGE FOR AN INCAPACITATED CHILD

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

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

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

EXTENSION OF BENEFITS

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

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

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

PART IV - PREMIUMS

1. Unless the single payment option has been chosen, premium due dates for an Insured will be on the 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 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, not to exceed a maximum of 3 Doctor's Office or Urgent Care Center Visit Copayments per Covered Person. Any other services or tests performed as part of the office visit will be subject to the Advanced Diagnostic Studies Deductible (if applicable), Plan Deductible and Coinsurance.

COVERAGE PERIOD MAXIMUM BENEFIT

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

PART VI – ELIGIBLE EXPENSES

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

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

The following are Eligible Expenses under the Policy:

1. Charges for Inpatient Hospital services:
 - a. Daily room and board and nursing services not to exceed the average standard room rate. If a Hospital has only private rooms, Eligible Expenses will be limited to 90% of the private room charge;
 - b. Daily room and board and nursing services in an Intensive Care or Critical Care Unit;
 - c. Use of operating, treatment or recovery room; and
 - d. Miscellaneous tests, services and supplies.
2. Charges for Outpatient Hospital services.
3. Charges for care received in a Hospital emergency room or a free standing emergency room.
4. Charges for Surgery at an Outpatient Surgical Facility, including services and supplies.
5. Charges for Inpatient Doctor visits.
6. Charges made by a Doctor for surgery and other professional services.
7. Charges for a surgical assistance or a surgeon assistant up to 20% of the Maximum Allowable Expense allowance for the primary surgical procedure performed during the operative session.
8. Charges for the administration of anesthetics up to 20% of the Maximum Allowable Expense allowance for the primary surgical procedure performed during the operative session.
9. Charges for 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.
10. Charges for dressings, sutures, casts or other supplies which are administered by or under the supervision of a Doctor, but excluding nebulizers, oxygen tanks, supplies for use or application at home and all devices or supplies for repeat use at home.
11. Charges for diagnostic testing using radiology, ultrasonographic or laboratory services (psychometric, intelligence, behavioral and educational testing are not included).

12. Charges for artificial eyes or larynx, breast prosthesis or basic functional artificial limbs, but not their replacement or repair.
13. Charges for reconstructive surgery directly related to surgery which is covered under the Policy, including reconstructive breast surgery and prosthetic devices incident to a Mastectomy. The coverage shall include coverage for all stages and revisions of reconstructive breast surgery performed on a non-diseased breast to establish symmetry if reconstructive surgery on a diseased breast is performed, as well as coverage for prostheses and physical complications in all stages of mastectomy, including lymphedemas. The decision whether to discharge the Covered Person following a mastectomy must be made by the attending Doctor in consultation with the Covered Person. The length of post-mastectomy Hospital stay is based on the unique characteristics of each Covered Person taking into consideration the health and medical history of the Covered Person. 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 of the non-diseased breast.
14. Charges for radiation therapy or treatment and chemotherapy.
15. Charges for blood and blood products, administration of blood and blood processing.
16. Charges for an Extended Care Facility room and board accommodations; if:
 - a. The Covered Person is receiving skilled nursing care as an Inpatient in that facility on the certification of the attending Doctor that the confinement is Medically Necessary;
 - b. The confinement commences immediately following a period of at least three (3) continuous days of Hospital confinement; and
 - c. The confinement is for the same covered Injury or Sickness that was treated during the Covered Person's confinement in the Hospital.
17. Charges for treatment of a Covered Person by a Home Health Care Agency under a Home Health Care Plan. Eligible Expenses for Home Health Care are:
 - a. Part-time skilled nursing care;
 - b. Home Health aide services/supplies when under a R.N.'s direct supervision;
 - c. Physical, occupational and speech therapy;
 - d. Medical supplies; and
 - e. Respiratory therapy.

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

- a. Full-time nursing care at home;
- b. Meals delivered to the home;
- c. Homemaker services;
- d. Any services of an individual who ordinarily resides in the Covered Person's home or is a member of the Insured's immediate family; or
- e. Any transportation services.

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

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

Hospice services must be:

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

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

19. Charges for ambulance transport to the nearest Hospital qualified to treat Injuries or medical emergencies. In order for benefits to be payable, transportation due to Sickness must result in Inpatient Hospitalization.
20. Charges for the rental of a standard, basic Hospital bed and/or wheelchair, up to the purchase prices, not including expenses for customization and only for the portion of the cost equivalent to the Coverage Period.
21. Charges for Physical Therapy, Occupational Therapy and Speech Therapy from a licensed or registered provider to improve or restore lost function caused by a Sickness or Injury covered under this Policy when ordered by the attending Doctor.
22. Charges for organ or tissue transplants including all expenses related to the transplant before the transplant is performed, for the procurement of the donor organ or tissue, the Hospital expenses of the donor, and for follow-up care, including any complications while this coverage is in force.

Eligible Expenses do not include organ or tissue transplants which:

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

23. Charges for temporomandibular joint disorder (TMJ) 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, bridges, dentures, treatment for periodontal disease, dental root form implants, root canals or other dental care or procedures.
24. Charges for treatment rendered in a Hospital or by a licensed treatment facility or other provider licensed to treat Mental Disorders as defined in this Policy.
25. Charges for treatment rendered in a Hospital or by a licensed treatment facility or other provider licensed to treat Substance Abuse.
26. Charges for anesthesia and hospital or facility charges for services performed in a hospital or ambulatory surgical facility in connection with dental procedures for children below the age of nine years, persons with serious mental or physical conditions, and persons with significant behavioral problems, where the provider treating the patient involved certifies that, because of the patient's age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedures. The same Deductibles, Coinsurance, Medical Necessity provisions, and other limitations as apply to similar services covered under the Policy shall apply to this coverage.
27. Charges for a screening for the early detection of cervical cancer including examination, laboratory fees, and the Doctor's interpretation of the laboratory results. The laboratory must meet the accreditation standards adopted by the North Carolina Medical Care Commission in order for the laboratory fees to be covered. No benefit will be paid for services under this benefit if a benefit for this service has already been paid for under the Wellness Benefit.

28. Charges for a prostate specific antigen (PSA) test or equivalent tests for the presence of prostate cancer. Any prostate test must be recommended by a Doctor in order to be covered. No benefit will be paid for services under this benefit if a benefit for this service has already been paid for under the Wellness Benefit.
29. Charges for Medically Necessary and appropriate diabetes services, including diabetes outpatient self-management training and educational services, and equipment, supplies, medications, and laboratory procedures used to treat diabetes. Diabetes outpatient self-management training and educational services will be provided by a Doctor or a health care professional designated by the Doctor. We shall determine who shall provide and be reimbursed for the diabetes outpatient self-management training and educational services.
30. Charges for low-dose screening mammography as follows:
 - a. One or more mammograms a year, as recommended by a Doctor, for any female Covered Person who is at risk for breast cancer. A woman is at risk for breast cancer if any one or more of the following is true: (i) She has a personal history of breast cancer; (ii) She has a personal history of biopsy-proven benign breast disease; (iii) Her mother, sister, or daughter has or has had breast cancer; or (iv) She has not given birth prior to the age of 30;
 - b. One baseline mammogram for any female Covered Person 35 through 39 years of age, inclusive;
 - c. One mammogram every other year for any female Covered Person 40 through 49 years of age, inclusive, or more frequently upon recommendation of her Doctor; and
 - d. A mammogram every year for any female Covered Person 50 years of age or older.

"Low-dose screening mammography" means a radiologic procedure for the early detection of breast cancer provided to an asymptomatic woman using equipment dedicated specifically for mammography, including her doctor's interpretation of the results of the procedure. The facility in which the mammogram is performed must meet the mammography accreditation standards established by the North Carolina Medical Care Commission (unless such standards are not in effect, in which case standards established by the United States Department of Health and Human Services for Medicare/Medicaid coverage of screening mammography shall apply).

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.

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. 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.

A Covered Person is covered for Emergency Medical Conditions and may receive medical services to treat an Emergency Medical Condition without prior authorization if a prudent layperson acting reasonably would have believed that an Emergency Medical Condition existed. In order to ensure that a person receives proper care for their condition, the person should call the Professional Review Organization and inform them of their condition and the services they are receiving.

Certification and Appeals Process

If You or Your provider disagrees with Our decision, You have the right to a review of that decision. Submit a written appeal request to Us. Until such time as authorization may be granted, the service will be considered unauthorized.

Prospective and Concurrent Reviews: Necessary information includes the results of any patient examination, clinical evaluation, or second opinion that may be required. Prospective and concurrent determinations shall be communicated to Your provider within three business days after We obtain all necessary information about the admission, procedure, or health care service. If We certify a health care service, We will notify Your provider. For a noncertification, We will notify Your provider and send written or electronic confirmation of the noncertification to You. In concurrent reviews, We will remain liable for health care services until You have been notified of the noncertification.

Retrospective Reviews: Necessary information includes the results of any patient examination, clinical evaluation, or second opinion that may be required. For retrospective review determinations, We will make the determination within 30 days after receiving all necessary information. For a certification, We may give written notification to Your provider. For a noncertification, We will give written notification to You and Your provider within five business days after making the noncertification.

Notice of Noncertification: A written notification of a noncertification shall include all reasons for the noncertification, including the clinical rationale, the instructions for initiating a voluntary appeal or reconsideration of the noncertification, and the instructions for requesting a written statement of the clinical review criteria used to make the noncertification. We will provide the clinical review criteria used to make the noncertification to any person who received the notification of the noncertification and who follows the procedures for a request. We will also inform You in writing about the availability of assistance from Health Insurance Smart NC, including the telephone number and address of the Program.

Requests for Informal Reconsideration: We may establish procedures for informal reconsideration of noncertifications and, if established, the procedures will be in writing. After a written notice of noncertification has been issued, the reconsideration shall be conducted between Your provider and a medical doctor licensed to practice medicine in this State designated by Us. We will not require a You to participate in an informal reconsideration before You appeal a noncertification. If, after informal reconsideration, We uphold the noncertification decision, We will issue a new notice. If We are unable to render an informal reconsideration decision within 10 business days after the date of receipt of the request for an informal reconsideration, We will treat the request for informal reconsideration as a request for an appeal; providing the acknowledging of the request will apply beginning on the day We determine an informal reconsideration decision cannot be made before the tenth business day after receipt of the request for an informal reconsideration.

Appeals of Noncertifications: We will have written procedures for appeals of noncertifications by You or Your providers acting on Your behalf, including expedited review to address a situation where the time frames would reasonably appear to seriously jeopardize the life or health of You or jeopardize Your ability to regain maximum function. Each appeal shall be evaluated by a medical doctor licensed to practice medicine in this State who was not involved in the noncertification.

Nonexpedited Appeals: Within three business days after receiving a request for a standard, nonexpedited appeal, We will provide You with the name, address, and telephone number of the coordinator and information on how to submit written material. For standard, nonexpedited appeals, We will give written notification of the decision, in clear terms, to You and Your provider within 30 days after We receive the request for an appeal. If the decision is not in favor of You, the written decision shall contain:

1. The professional qualifications and licensure of the person or persons reviewing the appeal.
2. A statement of the reviewers' understanding of the reason for Your appeal.
3. The reviewers' decision in clear terms and the medical rationale in sufficient detail for You to respond further to Our position.
4. A reference to the evidence or documentation that is the basis for the decision, including the clinical review criteria used to make the determination, and instructions for requesting the clinical review criteria.
5. A statement advising You of Your right to request a second-level grievance review and a description of the procedure for submitting a second-level grievance as outlined in the Grievance Procedures.
6. Notice of the availability of assistance from Health Insurance Smart NC, including the telephone number and address of the Program.

Expedited Appeals: An expedited appeal of a noncertification may be requested by You or Your provider acting on Your behalf only when a non-expedited appeal would reasonably appear to seriously jeopardize the life or health of You or jeopardize Your ability to regain maximum function. We may require documentation of the medical justification for the expedited appeal. We will, in consultation with a medical doctor licensed to practice medicine in this State, provide expedited review, and We will communicate Our decision in writing to You and Your provider as soon as possible, but not later than four days after receiving the information justifying expedited review. If the expedited review is a concurrent review

determination, We will remain liable for the coverage of health care services until You have been notified of the determination. We are not required to provide an expedited review for retrospective noncertifications.

PART VII – EXCLUSIONS AND LIMITATIONS

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

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

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

This Policy does not give credit for any previous Creditable Coverage however, it is considered to be creditable coverage in North Carolina. A certification of creditable coverage will be provided automatically at the time a Covered Person ceases to be covered under the Policy and upon the request from a Covered Person provided the request is made no later than 24 months after the date coverage ended. The certification of creditable coverage is written certification of the period of creditable coverage of the Covered Person under this Policy.

We will provide a certification at the time a Covered Person ceases to be covered under this Policy, and on the request on behalf of a Covered Person made not later than 24 months after the date of cessation of coverage under this Policy, whichever is later. The certification is a written certification of the period of creditable coverage of the Covered Person under this Policy and any waiting period and affiliation period, if applicable, imposed with respect to the Covered Person for any coverage under this Policy.

2. Waiting Period:
 1. 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.
 2. 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. Herniorrhaphy; or
 - h. Cholecystectomy.

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

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

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

6. Charges which exceed any limits or limitations specified in this Policy, including the Schedule of Benefits.
7. Charges for services or supplies in excess of the Maximum Allowable Expense.
8. Charges for services or supplies which are not administered by or under the supervision of a Doctor.
9. Mental, emotional or nervous disorders or counseling of any type, except as specifically covered as an Eligible Expense.
10. Marital counseling or social counseling.
11. Treatment for Substance Abuse, unless specifically covered under the Policy as an Eligible Expense.
12. Prescription Drugs, except those administered by a Doctor in an Inpatient or Outpatient setting covered under this Policy as an Eligible Expense.
13. Medications, vitamins, and mineral or food supplements including pre-natal vitamins, or any over-the-counter medicines, whether or not ordered by a Doctor.
14. Any drug, treatment or procedure that either promotes or prevents conception including but not limited to: artificial insemination, treatment for infertility or impotency, sterilization or reversal of sterilization.
15. Any drug, treatment or procedure that corrects impotency or non-organic sexual dysfunction.
16. Modifications of the physical body in order to improve the psychological, mental or emotional well-being of the Covered Person, such as sex-change surgery.
17. Cosmetic Treatment, except for reconstructive surgery where expressly covered under the Policy. This does not apply to a newborn child, adopted child or foster child added as a Covered Person pursuant to the terms of this Policy.
18. Weight modification or surgical treatment of obesity.
19. Eye surgery, including LASIK, when the primary purpose is to correct nearsightedness, farsightedness or astigmatism.
20. Dental Expenses, except as necessary to restore or replace sound and natural teeth lost or damaged as a result of an Injury. The Injury must be severe enough that the contact with the Doctor occurs within seventy-two (72) hours of the Accident, unless extenuating circumstances exist due to the severity of the Injury that prevent you from contacting the Doctor.
21. Expenses incurred in the treatment by any method for jaw joint problems including temporomandibular joint dysfunction (TMJ), TMJ pain syndromes, craniomandibular disorders, myofascial pain dysfunction or other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the joint, except as specifically covered under the Policy as an Eligible Expense.
22. Routine pre-natal care, Pregnancy, child birth, and post natal care. (This exclusion does not apply to "Complications of Pregnancy" as defined.)
23. Charges for a Covered Dependent who is a newborn child not yet discharged from the Hospital, unless the charges are Medically Necessary to treat premature birth, congenital Injury or Sickness, or Sickness or Injury sustained during or after birth.
24. Sclerotherapy for veins of the extremities.
25. Abortions, except in connection with covered Complications of Pregnancy or if the life of the expectant mother would be at risk.
26. Joint replacement or other treatment of joints, spine, bones or connective tissue including tendons, ligaments and cartilage, unless related to a covered Injury.
27. Surgeries, treatments, services or supplies which are deemed to be Experimental Treatment.

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, adopted child or foster 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. This exclusion does not apply to treatments with growth hormones due to congenial defects or anomalies.
38. Spinal manipulation or adjustment.
39. Biofeedback, acupuncture, recreational, sleep or MIST Therapy®, holistic care of any nature, massage and kinstherapy, 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. This does not apply to any Eligible Expenses covered under the diabetic benefit.
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. Charges for travel or accommodations, except as expressly provided for local ambulance.
46. All charges incurred while confined primarily to receive Custodial or Convalescent Care.
47. Services received or supplies purchased outside the United States, its territories or possessions, or Canada.
48. Any services or supplies in connection with cigarette smoking cessation.
49. Any services performed or supplies provided by a member of a Covered Person's Immediate Family.
50. 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.
51. Services or supplies which are not included as Eligible Expenses as described herein.

52. 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.
53. 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.
54. Intentionally self-inflicted Injury or Sickness (whether the Covered Person is sane or insane).
55. Charges resulting from a declared or undeclared war, or from voluntary participation in a riot or insurrection.
56. 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.
57. Charges You or Your Covered Dependent are not required to pay, or which would not have been billed, if no insurance existed.
58. Charges to the extent that they are paid or payable under other valid or collectible group insurance or medical prepayment plan.
59. Charges that are eligible for payment by Medicare or any other government program except Medicaid. Costs for care in government institutions unless You or Your Covered Dependent are obligated to pay for such care.
60. 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 insurance or the North Carolina Workers' Compensation Act only to the extent such services or supplies are the liability of the employee, employer or workers' compensation insurance carrier according to a final adjudication under the North Carolina' Worker's Compensation Act or an order of the North Carolina Industrial Commission approving a settlement agreement under the North Carolina Worker's Compensation Act.

PART VIII - CLAIM PROVISIONS

Notice of Claim: Written notice of claim must be given within 31 days after a covered loss begins (or longer, if required by state law) or as soon as is reasonably possible. Failure to give notice within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably possible. The notice must be given to the Administrator, an authorized agent of the Company, 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 180 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, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal capacity of the Covered Person, later than one year from the time proof is otherwise required.

Time of Payment of Claim: Benefits for loss covered by the Policy will be paid as soon as We receive proper written proof of such loss.

Payment of Claims: All benefits will be paid to the Insured, if living, unless an Assignment of Benefits has been requested by the Insured. Any other benefits due and unpaid at the Insured's death will be paid to the Insured's estate. If a benefit is to be paid to the Insured's estate, or to an Insured or beneficiary who is not competent to give a valid release, the Company may pay up to \$3,000 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.

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

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.

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

Rescission: A misrepresentation or omission in the Enrollment Form or other documents provided to Us may be the basis for later rescission of all coverage of all Covered Persons. Rescission voids all coverage as of the 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: The right to change of beneficiary is reserved to the Covered Person 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 the renewal premium is not paid before the Grace Period ends, coverage under this Policy will lapse. The Policy may be reinstated during the 45 days following the premium due date. If it is lapsed for nonpayment of premium, if You submit written application to the Company, the Company accepts the application and You make payment of all overdue premiums.

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 10 days after such date. In all other respects the Covered Person and the Company shall have the same rights as they had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed 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 45 days prior to the date of reinstatement.

Grievance Procedures: THIS GRIEVANCE PROCESS IS VOLUNTARY. THE NORTH CAROLINA DEPARTMENT OF INSURANCE IS AVAILABLE TO ASSIST INSURANCE CONSUMERS WITH INSURANCE RELATED PROBLEMS AND QUESTIONS. YOU MAY INQUIRE IN WRITING TO THE DEPARTMENT AT 1201 MAIL SERVICE CENTER, RALEIGH, NC 27699 OR BY TELEPHONE AT 1-855-408-1212.

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 by filing a Grievance. These procedures have been developed to ensure a full investigation of a Grievance through a formal process.

"Grievance" means a written complaint submitted by a Covered Person about any of the following:

1. Our decision, policies, or actions related to availability, delivery, or quality of health care services. A written complaint submitted by a Covered Person about a decision rendered solely on the basis that the health benefit plan contains a benefits exclusion for the health care service in question is not a grievance if the exclusion of the specific service requested is clearly stated in the Policy.
2. Claims payment or handling; or reimbursement for services.
3. The contractual relationship between a Covered Person and an insurer.
4. The outcome of an appeal of an Utilization Review Non-certification under this section.

An **"Adverse Determination"(Non-Certification)** is a determination by the Company or its designated utilization review organization that an admission, availability of care, continued stay, or other health care service, treatment, drug, or device, has been reviewed and based upon the information provided does not meet Our contractual requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, or does not meet the prudent layperson standard for coverage of emergency services, and the benefit coverage is denied, reduced, or terminated in whole or in part.

An "Adverse Determination" (Non-Certification) is not a decision rendered solely on the basis that the health benefit plan does not provide benefits for the health care service in question, if the exclusion of the specific service requested is clearly stated in the certificate of coverage. An "Adverse Determination" (Non-Certification) includes any situation in which an insurer or its designated agent makes a decision about a Covered Person's condition to determine whether a requested treatment is experimental, investigational, or cosmetic, and the extent of coverage under the health benefit plan is affected by that decision.

Formal Grievance Procedure

A formal grievance may be submitted by you, your authorized representative, or in the event of an adverse determination, by a provider acting on your behalf.

If you file a formal grievance, you will have the opportunity to submit written comments, documents, records and other information you feel are relevant to the grievance, regardless of whether those materials were considered in the initial adverse determination.

First Level Review

Within 3 working business days after receiving the grievance, we must acknowledge the grievance and provide you, your authorized representative or a provider with the name, address, and telephone number of the coordinator handling the grievance and information on how to submit written material. The person(s) who reviews the grievance will not be the same person(s) who made the initial adverse determination. During the review, all information, documents, and other materials submitted relating to the claim will be considered, regardless of whether they were considered in making the previous claim decision. The insured will not be allowed to attend, or have a representative attend, a first level review. The insured may, however, submit written material for consideration by the reviewer(s).

When the grievance is based in whole or in part on a medical judgment, the review will be conducted by, or in consultation with, a medical physician with appropriate training and expertise to evaluate the matter.

Following Our review of Your Grievance, We must issue a written decision to You and, if applicable, to Your representative or provider, within 20-days after receiving the Grievance. The written decision must include:

1. The name(s), title(s) professional qualifications and licensure of any person(s) participating in the First Level Review process.
2. A statement of the reviewer's understanding of the Grievance.
3. The specific reason(s) for the reviewer's decision in clear terms and the contractual basis or medical rationale used as the basis for the decision in sufficient detail for the Insured to respond further to Our position.
4. A reference to the evidence or documentation used as the basis for the decision.
5. If the claim denial is based on medical necessity, experimental treatment or similar exclusion, instructions for requesting an explanation of the scientific or clinical rationale used to make the determination.
6. A statement advising You of Your right to request a Second Level Review, if applicable, and a description of the procedure and timeframes for requesting a Second Level Review.
7. A statement advising You of Your right to request an External Review by an independent review organization (IRO) and information on how to contact Health Insurance Smart NC is shown below.

For grievances concerning the quality of clinical care delivered by the Covered Person's Physician, We shall acknowledge the grievance within 10 business days. The acknowledgement shall advise the Covered Person that (i) We will refer the grievance to its quality assurance committee for review and consideration of any appropriate action against the provider and (ii) State law does not allow for a second-level grievance review for grievances concerning quality of care.

Second Level Review

The Second Level Review process is available if You are not satisfied with the outcome of the First level Review for an Adverse Determination. Within 10 business days after receiving a request for a Second Level Review, We will advise You of the following:

1. The name, address, and telephone number of a person designated to coordinate the Grievance review for the Company;
2. A statement of Your rights, including the right to:
 - a. Attend the Second Level Review;
 - b. Present his/her case to the review panel;
 - c. Submit supporting materials before and at the review meeting;
 - d. Ask questions of any member of the review panel;
 - e. Be assisted or represented by a person of his/her choice, including a provider, family member, employer representative, or attorney;
 - f. Request and receive from us free of charge, copies of all relevant documents, records and other information that is not confidential or privileged that were considered in making the Adverse Determination.

We must convene a review panel and hold a review meeting within 45-days after receiving a request for a Second Level Review. We will notify You in writing of the meeting date at least 15-days prior to the date. The review meeting will be held during regular business hours at a location reasonable accessible to You. In cases where a face-to-face meeting is not practical for geographic reasons, We will offer You the opportunity to communicate with the review panel at Our expense by conference call or other appropriate technology. Your right to a full review may not be conditioned on whether or not You appear at the meeting.

If You choose to be represented by an attorney, We may also be represented by an attorney. If We choose to have an attorney present to represent Our interests, We will notify You at least 15 working days in advance of the review that an attorney will be present and that You may wish to obtain legal representation of Your own.

The panel must be comprised of persons who:

1. Were not previously involved in any matter giving rise to the Second Level Review;
2. Are not employees of the Company or Utilization Review Organization; and
3. Do not have a financial interest in the outcome of the review.

A person previously involved in the Grievance may appear before the panel to present information or answer questions.

All persons reviewing a Second Level Grievance involving a Utilization Review non-certification or a clinical issue will be providers who have appropriate expertise, including at least one clinical peer. If We use a clinical peer on an appeal of a Utilization Review non-certification or on a First Level Review, We may use one of Our employees on the Second Level Review panel if the panel is comprised of 3 or more persons.

We must issue a written decision to You and, if applicable, to Your representative or provider, within 7 business days after completing the review meeting. The decision must include:

1. The name(s), title(s) and qualifying credentials of the members of the review panel;
2. A statement of the review panel's understanding of the nature of the Grievance and all pertinent facts;
3. The review panel's recommendation to the Company and the rationale behind the recommendation;
4. A description of, or reference to, the evidence or documentation considered by the review panel in making the recommendation;
5. In the review of a Utilization Review non-certification or other clinical matter, a written statement of the clinical rationale, including the clinical review criteria, that was used by the review panel to make the determination;
6. The rationale for the Company's decision if it differs from the review panel's recommendation;
7. A statement that the decision is the Company's final determination in the matter;
8. Notice of the availability of the Commissioner's office for assistance in requesting an External Review, or in contacting Health Insurance Smart NC, including the telephone number and address of the Commissioner's office is shown below.

Expedited Review

You are eligible for an expedited review when the timeframes for a formal First Level review or Second Level review would reasonably appear to seriously jeopardize Your life or health, or Your ability to regain maximum function. An expedited review is also available for all Grievances concerning an admission, availability of care, continued stay or health care service including Utilization Review Non-certification for a person who has received emergency services, but who has not been discharged from a facility.

A request for an expedited review may be submitted orally or in writing. An expedited review must be evaluated by an appropriate clinical peer in the same or similar specialty as would typically manage the case being reviewed. If We don't have the information necessary to decide an appeal, We will send You notification of precisely what is required within 24-hours of Our receipt of Your Grievance. All necessary information, including Our decision, will be transmitted by telephone, facsimile, or the most expeditious method available. Provided We have enough information to make a decision, You, Your authorized representative, or a provider acting on Your behalf will be notified of the determination as expeditiously as the medical condition requires, but in no event more than 72-hours after the review has commenced. Written confirmation of Our decision will be provided within 2 working business days of the decision and will contain the same items described in the written decision requirements contained within the section titled First Level reviews above.

If the expedited review does not resolve the situation, You, Your representative or a provider acting on Your behalf may submit a written Grievance.

External Review

North Carolina law provides for review of noncertification decisions by an external, Independent Review Organization (IRO). The North Carolina Department of Insurance (NCDOI) administers this service at no charge to you, arranging for an IRO to review your case once the NCDOI establishes that your request is complete and eligible for review. You or someone you have authorized to represent you may request an external review. The Company will notify you in writing of your right to request an external review each time you:

1. receive a noncertification decision, or
2. receive an appeal decision upholding a noncertification decision, or
3. receive a second-level grievance review decision upholding the original noncertification.

In order for your request to be eligible for external review, the NCDOI must determine the following:

1. that your request is about a medical necessity determination that resulted in a noncertification decision;
2. that you had coverage with the Company in effect when the noncertification decision was issued;
3. that the service for which the noncertification was issued appears to be a covered service under your policy; and
4. that you have exhausted the Company's internal review process as described below.

External review is performed on a standard and expedited timetable, depending on which is requested and on whether medical circumstances meet the criteria for expedited review.

For a standard external review, you will be considered to have exhausted the internal review process if you have:

1. completed the Company's appeal and second level grievance review and received a written second level determination from the Company, or
2. filed a second level grievance and except to the extent that you have requested or agreed to a delay, have not received the Company's written decision within 60 days of the date can demonstrate that a grievance was filed with the insurer, or
3. received notification that the Company has agreed to waive the requirement to exhaust the internal appeal and/or second level grievance process.

If your request for a standard external review is related to a retrospective noncertification (a noncertification which occurs after you have received the services in question), you will not be eligible to request a standard review until you have completed the Company's internal review process and received a written final determination from the Company.

If you wish to request a standard external review, you (or your representative) must make this request to NCDOI within 120 days of receiving the Company's written notice of final determination that the services in question are not approved. When processing your request for external review, the NCDOI will require you to provide the NCDOI with a written, signed authorization for the release of any of your medical records that may need to be reviewed for the purpose of reaching a decision on the external review.

Within 10 business days of receipt of your request for a standard external review, the NCDOI will notify you and your provider of whether your request is complete and whether it is accepted. If the NCDOI notifies you that your request is incomplete, you must provide all requested additional information to the NCDOI within 150 days of the date of the Company's written notice of final determination. If the NCDOI accepts your request, the acceptance notice will include:

1. the name and contact information for the Independent Review Organization (IRO) assigned to your case;
2. a copy of the information about your case that the Company has provided to the NCDOI;
3. notice that the Company will provide you or your authorized representative with a copy of the documents and information considered in making the denial decision (which will also be sent to the IRO); and
4. notification that you may submit additional written information and supporting documentation relevant to the initial noncertification to the assigned IRO within 7 after receipt of the notice of acceptance.

If you choose to provide any additional information to the IRO, you must also provide that same information to the Company at the same time using the same means of communication (e.g., you must fax the information to the Company if you faxed it to the IRO). When faxing information to the Company, send it to 1-608-501-1068. If you choose to mail your information, send it to:

InsuranceTPA.com
P.O. Box 241869

Please note that you may also provide this additional information to the NCDOI within the 7-day deadline rather than sending it directly to the IRO and the Company. The NCDOI will forward this information to the IRO and the Company within two business days of receiving your additional information.

The IRO will send you written notice of its determination within 45 days of the date the NCDOI received your standard external review request. If the IRO's decision is to reverse the noncertification, the Company will, reverse the noncertification decision within 3 business days of receiving notice of the IRO's decision, and provide coverage for the requested service or supply that was the subject of the noncertification decision. If you are no longer covered by the Company at the time the Company receives notice of the IRO's decision to reverse the noncertification, the Company will only provide coverage for those services or supplies you actually received or would have received prior to disenrollment if the service had not been noncertified when first requested.

An expedited external review of a noncertification decision may be available if you have a medical condition where the time required to complete either an expedited internal appeal or second level grievance review or a standard external review would reasonably be expected to seriously jeopardize your life or health or would jeopardize your ability to regain maximum function. If you meet this requirement, you may make a written request to the NCDOI for an expedited review after you:

1. receive a noncertification decision from the Company AND file a request with the Company for an expedited appeal, or
2. receive an appeal decision upholding a noncertification decision AND file a request with the Company for an expedited second level grievance review, or
3. receive a second-level grievance review decision upholding the original noncertification.

You may also make a request for an expedited external review if you receive an adverse second-level grievance review decision concerning a noncertification of an admission, availability of care, continued stay or emergency care, but have not been discharged from the inpatient facility.

In consultation with a medical professional, the NCDOI will review your request and determine whether it qualifies for expedited review. You and your provider will be notified within 2 days if your request is accepted for expedited external review. If your request is not accepted for expedited review, the NCDOI may: (1) accept the case for standard external review if the Company's internal review process was already completed, or (2) require the completion of the Company's internal review process before you may make another request for an external review with the NCDOI. An expedited external review is not available for retrospective noncertifications.

The IRO will communicate its decision to you within 3 days of the date the NCDOI received your request for an expedited external review. If the IRO's decision is to reverse the noncertification, the Company will, within one day of receiving notice of the IRO's decision, reverse the noncertification decision for the requested service or supply that is the subject of the noncertification decision. If you are no longer covered by the Company at the time the Company receives notice of the IRO's decision to reverse the noncertification, the Company will only provide coverage for those services or supplies you actually received or would have received prior to disenrollment if the service had not been noncertified when first requested.

The IRO's external review decision is binding on the Company and you, except to the extent you may have other remedies available under applicable federal or state law. You may not file a subsequent request for an external review involving the same noncertification decision for which you have already received an external review decision.

For further information about External Review or to request an external review, contact the NCDOI at:

By Mail:
NC Department of Insurance
Health Insurance Smart NC
1201 Mail Service Center
Raleigh, NC 27699-1201
(fax) 919-807-6865

In Person:
NC Department of Insurance
EAH 00 539 09 15 (08/18)

3200 Beechleaf Court
Raleigh NC 27604

855-408-1212 (toll-free)
www.ncdoi.com/Smart for External Review information and Request Form

The Health Insurance Smart NC Program is also available to provide assistance to consumers who wish to file an appeal or grievance with their health plan.

If you believe you are eligible for and request an expedited appeal from the Company, you may be eligible to request an expedited external review from NCDOL. Expedited external review is available if you have a medical condition where the time frame for completion of an expedited appeal with us would reasonably be expected to seriously jeopardize your life or health or jeopardize your ability to regain maximum function. However, you must have also filed a request for an expedited appeal (even if you have not yet received a decision on the appeal) before NCDOL can accept your request for expedited external review.

SAMPLE

PART X - 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.

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

Inpatient Hospital services:

Average Standard Room Rate

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

Intensive Care or Critical Care Unit

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

Outpatient Miscellaneous Hospital Expenses

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

Emergency Room

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

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

| | |
|----------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Outpatient Surgical Facility | The benefit payable per day including all miscellaneous expenses is limited to \$5,000. |
| Inpatient Doctor visits | \$100 per day Benefits for all Hospital visits during a Hospital stay are limited to \$2,500 per Covered Person per Coverage period. |
| Surgeon | \$20,000 per surgery, for all Eligible Expenses combined, not to exceed \$40,000 per Covered Person per Coverage Period. |
| Assistant Surgeon and Surgical Assistant | \$4,000 per surgery for all Eligible Expenses combined, not to exceed \$8,000 per Covered Person per Coverage Period. |
| Administration of Anesthetics | \$2,500 per surgery for all Eligible Expenses combined, not to exceed \$5,000 per Covered Person per Coverage Period. |
| Doctor's Office Visit or Urgent Care Center | <p>After the Copayment shown above, Coinsurance is 80% of Eligible Expenses and benefits are not subject to the Plan Deductible.</p> <p>Any other covered services or tests performed as part of the office visit will be subject to the Plan Deductible and Coinsurance.</p> <p>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.</p> |
| 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): | \$3,500 per Covered Person per Coverage Period |
| Kidney Stones | \$5,000 per Covered Person per Coverage Period |
| Appendectomy | \$5,000 per Covered Person per Coverage Period |
| Joint or Tendon Surgery | \$5,000 per Covered Person per Coverage Period |

| | |
|--------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Knee Injury or Disorders | \$5,000 per Covered Person per Coverage Period |
| Acquired Immune Deficiency Syndrome (AIDS) Human Immunodeficiency Virus (HIV) | \$5,000 per Covered Person per Coverage Period |
| Gallbladder Surgery | \$5,000 per Covered Person per Coverage Period |
| Mental Disorders | |
| Inpatient: | \$100 per day, 31 day maximum per Covered Person per Coverage Period. |
| Outpatient: | \$50 per visit, 10 visit maximum per Covered Person per Coverage Period |
| Substance Abuse | |
| Inpatient: | \$100 per day, 31 day maximum per Covered Person per Coverage Period. |
| Outpatient: | \$50 per visit, 10 visit maximum per Covered Person per Coverage Period |
| Pre-Existing Conditions Allowance | Notwithstanding the Pre-Existing Conditions exclusion under Part VII of the Certificate, Eligible Expenses not to exceed \$500 per Coverage Period will be allowed. Payment of any benefits, including application to the Deductible and Coinsurance, under this allowance does not waive, or in any manner whatsoever affect, any of the Covered Person's exclusions or limitations, including the Pre-Existing Conditions exclusion. |

OPTIONAL RIDERS

Waiver of Pre-Existing Conditions Rider Included: Yes No

COMPANY'S ADMINISTRATOR/AUTHORIZED REPRESENTATIVE(S):

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

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

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

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

EVEREST REINSURANCE COMPANY

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

NORTH CAROLINA REASON FOR ADVERSE UNDERWRITING DECISIONS

Recently you applied for coverage under our Short Term Medical Insurance Plan. Your coverage was denied due to your answer of "Yes" to one of the questions shown on the application. A "Yes" answer to any of the named questions makes you ineligible for coverage.

You have the right to request information regarding the specific reason(s) for our decision.

You may call our Customer Service Department at 800-438-4375. When an adverse underwriting decision results solely from an oral request or inquiry, the explanation of reasons and summary of rights required by this section may be given orally.

Or you may send a written request to us within ninety (90) business days of the date of this notice.

Send the request to:

Everest Reinsurance Company, Warren Corporate Center, 100 Everest Way, Warren, NJ 07059

Within twenty-one (21) business days after we receive your written request, we will provide the specific reason(s) for our decision.

Within 30 business days from the date of receipt of a written request from you to correct, amend or delete any recorded personal information, we will notify you in writing if: (a) the information in dispute has been corrected, amended or deleted; or (b) we refuse to make the requested correction, amendment or deletion. If we refuse to make the requested changes, we will notify you of the reasons for the refusal. If you disagree with our refusal to correct, amend or delete the recorded personal information, you may file with us a concise statement of what you think is the correct, relevant or fair information, including a concise statement of the reasons why you disagree with our decision. Your statements will always be a part of any future disclosure of the disputed recorded personal information.