


SAMPLE INSURANCE POLICY*

NEVADA



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	PAGE #S	SAMPLE INDIVIDUAL SHORT TERM MEDICAL INSURANCE POLICY DOCUMENTS
	02-32	Individual Short Term Medical Insurance Policy (EAH 00 537 09 18) underwritten by: Everest Reinsurance Company

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, DE 19808
Administrative Office: Warren Corporate Center, 100 Everest Way, Warren, NJ 07059
800-438-4375

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

SHORT TERM MEDICAL INSURANCE INDIVIDUAL POLICY

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

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

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

THIS POLICY PROVIDES NON-RENEWABLE SHORT TERM INSURANCE

NO CONTINUOUS COVERAGE – This Policy provides coverage on a short term basis. It is not renewable. You are not eligible for more than 185 days of coverage within a 365 day period, regardless of the number of policies written. 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 INSURED 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. Also, this coverage is not "minimum essential coverage." If you don't have minimum essential coverage for any month in 2018, you may have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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

TABLE OF CONTENTS

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

PART I – GENERAL DEFINITIONS 3
PART II – ELIGIBILITY AND EFFECTIVE DATE OF INSURANCE 7
PART III – TERMINATION OF INSURANCE 8
PART IV – PREMIUMS 9
PART V – BENEFITS 9
PART VI – ELIGIBLE EXPENSES 10
PART VII – EXCLUSIONS AND LIMITATIONS 16
PART VIII – COORDINATION OF BENEFITS (COB) 20
PART IX – CLAIM PROVISIONS 22
PART X – GENERAL PROVISIONS 23
PART XI – 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.

“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 6 month 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, 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 two persons desiring to enter into a domestic partnership that have furnished proof satisfactory to Nevada’s Office of the Secretary of State that:

1. Both persons have a common residence;
2. Neither person is married or a member of another domestic partnership;
3. The two persons are not related by blood in a way that would prevent them from being married to each other in this State;
4. Both persons are at least 18 years of age; and
5. Both persons are competent to consent to the domestic partnership.

“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.

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

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

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

reference to any one or more of the following: peer-reviewed English-language medical literature, consultation with physicians, authoritative medical compendia, the American Medical Association, or other pertinent professional organization or governmental agency.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

“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. A notice of birth, together with any additional premium, must be submitted to us within 31 days of the birth in order to continue coverage for Injury and Sickness beyond the initial 31-day period.

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

PART III – TERMINATION OF INSURANCE

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

1. The date premiums are not paid in accordance with the terms of the Policy, subject to the Grace Period;
2. On the next premium due date after the Company receives a written request from the Insured to terminate coverage, or any later date stated in the request;
3. The date an Insured performs an act or practice that constitutes fraud, or is found to have made a misrepresentation of material fact, relating in any way to the Policy, including claims for benefits under the Policy;
4. The date of the Insured's death or the termination date of the Insured's coverage, if the Insured's spouse is not covered under the Policy;
5. The 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 60 days advance written notice.

TERMINATION UPON INSURED'S DEATH

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

TERMINATION OF SPOUSE'S COVERAGE

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

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

TERMINATION OF A CHILD'S COVERAGE

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

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

CONTINUATION OF COVERAGE FOR AN INCAPACITATED CHILD

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

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

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

EXTENSION OF BENEFITS

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

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

5. the date the Coverage Period Maximum Benefit under the Policy has been reached.

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

PART IV – PREMIUMS

1. Unless the single payment option has been chosen, premium due dates for an Insured will be on the 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. Coverage will also include all stages of reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction on a non-diseased breast to establish symmetry with the diseased breast and prostheses and physical complications of mastectomy, including lymphedemas. As used in this benefit: "Mastectomy" means the surgical removal of all or part of a breast as a result of breast cancer. "Reconstructive breast surgery" means surgery performed as a result of a mastectomy to reestablish symmetry between the two breasts and includes augmentation mammoplasty, reductive mammoplasty and mastopexy.
14. Charges for radiation therapy or treatment and chemotherapy, including orally administered chemotherapy. The combined amount of Copayment, Deductible and Coinsurance for chemotherapy administered orally by means of a Prescription Drug shall not exceed \$100 per prescription.
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, dentures, treatment for periodontal disease, dental root form implants or root canals.

24. Charges for treatment rendered in a Hospital or by a licensed treatment facility or other provider licensed to treat Mental Disorders for hospitalization as an inpatient or outpatient. Two visits for partial or respite care, or a combination thereof, may be substituted for each 1 day of hospitalization not used by the Covered Person. Payment for treatment provided under this benefit shall be made directly to the provider of health care that provides the treatment if the provider has obtained and delivered to Us or Our authorized representative, including, without limitation, a third-party administrator, a written assignment of benefits pursuant to which the Covered Person has assigned to the provider the Covered Person's benefits with regard to the treatment..
25. Charges for the treatment of Substance Abuse for the following:
- Treatment for withdrawal from the physiological effects of alcohol or drugs.
 - Treatment for a patient admitted to a facility.
 - Counseling for a person, group or family who is not admitted to a facility.

The Covered Person is entitled to these benefits if treatment is received in any:

- Facility for the treatment of abuse of alcohol or drugs which is certified by the health division of the Department of Human Resources.
- Hospital or other medical facility or facility for the dependent which is licensed by the health division of the Department of Human Resources, accredited by the Joint Commission on Accreditation of Healthcare Organizations and provides a program for the treatment of abuse of alcohol or drugs as part of its accredited activities.

Payment for treatment provided under this benefit shall be made directly to the provider of health care that provides the treatment if the provider has obtained and delivered to Us or Our authorized representative, including, without limitation, a third-party administrator, a written assignment of benefits pursuant to which the Covered Person has assigned to the provider the Covered Person's benefits with regard to the treatment.

26. Charges for medication, equipment, supplies and appliances that are Medically Necessary for the management and treatment of diabetes, including type I, type II, and gestational diabetes, and including, without limitation, coverage for the self-management of diabetes. Coverage for the self-management of diabetes includes:
- The training and education provided to the Covered Person after he or she is initially diagnosed with diabetes which is Medically Necessary for the care and management of diabetes, including, without limitation, counseling in nutrition and the proper use of equipment and supplies for the treatment of diabetes.
 - Training and education which is Medically Necessary as a result of a subsequent diagnosis that indicates a significant change in the symptoms or condition of the Covered Person and which requires modification of his or her program of self-management of diabetes.
 - Training and education which is Medically Necessary because of the development of new techniques and treatment for diabetes.
27. Charges for colorectal cancer screening in accordance with (a) the guidelines concerning colorectal cancer screening which are published by the American Cancer Society; or (b) other guidelines or reports concerning colorectal cancer screening which are published by nationally recognized professional organizations and which include current or prevailing supporting scientific data. No benefit will be paid for services under this benefit if a benefit for this service has already been paid for under the Wellness Benefit.
28. Charges for an annual cytologic screening test for women 18 years of age or older; and a mammogram every two years; or annually if ordered by a provider of health care for women 40 years of age or older. 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 prostate cancer screening in accordance with: (a) the guidelines concerning prostate cancer screening which are published by the American Cancer Society; or (b) other guidelines or reports concerning prostate cancer screening which are published by nationally recognized professional organizations and which include current or prevailing supporting scientific data. No benefit will be paid for services under this benefit if a benefit for this service has already been paid for under the Wellness Benefit.
30. Charges for outpatient health care related to contraceptives or hormone replacement therapy. This Benefit covers only the coinsurance percentage payable for Doctor services.
31. Charges for enteral formulas for use at home that are prescribed or ordered by a Doctor as Medically Necessary for the treatment of inherited metabolic diseases characterized by deficient metabolism, or malabsorption originating from congenital defects or defects arising shortly after birth, of amino acid, organic acid, carbohydrate or fat.

Benefits will not exceed \$2,500 per year for special food products which are prescribed or ordered by a Doctor as Medically Necessary. Coverage will be provided whether or not the condition existed when this policy was purchased.

"Inherited metabolic disease" means a disease caused by an inherited abnormality of the body chemistry of a person. "Special food product" means a food product that is specially formulated to have less than one gram of protein per serving and is intended to be consumed under the direction of a Doctor for the dietary treatment of an inherited metabolic disease. The term does not include a food that is naturally low in protein.

32. Charges for expenses incurred for: (a) administering the human papillomavirus vaccine as recommended for vaccination by a competent authority, including, without limitation, the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the Food and Drug Administration or the manufacturer of the vaccine and (b) deoxyribonucleic acid testing for high-risk strains of human papillomavirus every 3 years for women 30 years of age or older. "Human papillomavirus vaccine " means the Quadrivalent Human Papillomavirus Recombinant Vaccine or its successor which is approved by the Food and Drug Administration for the prevention of human papillomavirus infection and cervical cancer. 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.
33. Charges for services provided to a Covered Person through Telehealth to the same extent as though provided in person or by other means. "Telehealth" means the delivery of services from a provider of health care to a patient at a different location through the use of information and audio-visual communication technology, not including standard telephone, facsimile or electronic mail.
34. Charges for the following are payable without any Coinsurance, Copayment and with the same Deductible and Waiting Period applicable to any other benefit under the Policy:
- a. Counseling, support and supplies for breastfeeding, including breastfeeding equipment, counseling and education during the antenatal, perinatal and postpartum period for not more than one year;
 - b. Screening and counseling for interpersonal and domestic violence for women at least annually with intervention services consisting of education, strategies to reduce harm, supportive services or a referral for any other appropriate services;
 - c. Behavioral counseling concerning sexually transmitted diseases from a provider of health care for sexually active women who are at increased risk for such diseases;
 - d. Such prenatal screenings and tests as recommended by the American College of Obstetricians and Gynecologists or its successor organization;
 - e. Screening for blood pressure abnormalities and diabetes, including gestational diabetes, after at least 24 weeks of gestation or as ordered by a provider of health care;
 - f. Screening for cervical cancer at such intervals as are recommended by the American College of Obstetricians and Gynecologists or its successor organization;
 - g. Screening for depression;
 - h. Screening and counseling for the human immunodeficiency virus consisting of a risk assessment, annual education relating to prevention and at least one screening for the virus during the lifetime of the Covered Person or as ordered by a provider of health care;
 - i. Smoking cessation programs for an insured who is 18 years of age or older consisting of not more than two cessation attempts per year and four counseling sessions per year;
 - j. All vaccinations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention of the United States Department of Health and Human Services or its successor organization; and
 - k. Such well-woman preventative visits as recommended by the Health Resources and Services Administration, which must include at least one such visit per year beginning at 14 years of age.
- No benefit will be paid for services under this benefit if a benefit for this service has already been paid for under another benefit.
35. Charges for medical treatment which a Covered Person receives as part of a clinical trial or study if:
- a. The medical treatment is provided in a Phase I, Phase II, Phase III or Phase IV study or clinical trial for the treatment of cancer or in a Phase II, Phase III or Phase IV study or clinical trial for the treatment of chronic fatigue syndrome;
 - b. The clinical trial or study is approved by:
 - i. An agency of the National Institutes of Health;
 - ii. A cooperative group;

- iii. The Food and Drug Administration as an application for a new investigational drug;
- iv. The United States Department of Veterans Affairs; or
- v. The United States Department of Defense;
- c. In the case of:
 - i. A Phase I clinical trial or study for the treatment of cancer, the medical treatment is provided at a facility authorized to conduct Phase I clinical trials or studies for the treatment of cancer; or
 - ii. A Phase II, Phase III or Phase IV study or clinical trial for the treatment of cancer or chronic fatigue syndrome, the medical treatment is provided by a provider of health care and the facility and personnel for the clinical trial or study have the experience and training to provide the treatment in a capable manner;
- d. There is no medical treatment available which is considered a more appropriate alternative medical treatment than the medical treatment provided in the clinical trial or study;
- e. There is a reasonable expectation based on clinical data that the medical treatment provided in the clinical trial or study will be at least as effective as any other medical treatment;
- f. The clinical trial or study is conducted in this state; and
- g. The Covered Person has signed, before his or her participation in the clinical trial or study, a statement of consent indicating that he or she has been informed of, without limitation:
 - i. The procedure to be undertaken;
 - ii. Alternative methods of treatment; and
 - iii. The risks associated with participation in the clinical trial or study, including, without limitation, the general nature and extent of such risks.

The coverage for medical treatment under this benefit is limited to:

- a. Coverage for any drug or device that is approved for sale by the Food and Drug Administration without regard to whether the approved drug or device has been approved for use in the medical treatment of the Covered Person.
- b. The cost of any reasonably necessary health care services that are required as a result of the medical treatment provided in a Phase II, Phase III or Phase IV clinical trial or study or as a result of any complication arising out of the medical treatment provided in a Phase II, Phase III or Phase IV clinical trial or study, to the extent that such health care services would otherwise be covered under this policy.
- c. The cost of any routine health care services that would otherwise be covered under this policy for a Covered Person participating in a Phase I clinical trial or study.
- d. The initial consultation to determine whether the Covered Person is eligible to participate in the clinical trial or study.
- e. Health care services required for the clinically appropriate monitoring of the Covered Person during a Phase II, Phase III or Phase IV clinical trial or study.
- f. Health care services which are required for the clinically appropriate monitoring of the Covered Person during a Phase I clinical trial or study and which are not directly related to the clinical trial or study.

Particular medical treatment described above and provided to a Covered Person is not covered if that particular medical treatment is provided by the sponsor of the clinical trial or study free of charge to the Covered Person.

The coverage for medical treatment under this benefit does not include:

- a. Any portion of the clinical trial or study that is customarily paid for by a government or a biotechnical, pharmaceutical or medical industry.
- b. Coverage for a drug or device which is paid for by the manufacturer, distributor or provider of the drug or device.
- c. Health care services that are specifically excluded from coverage under this policy, regardless of whether such services are provided under the clinical trial or study.
- d. Health care services that are customarily provided by the sponsors of the clinical trial or study free of charge to the participants in the trial or study.
- e. Extraneous expenses related to participation in the clinical trial or study including, without limitation, travel, housing and other expenses that a Covered Person may incur.
- f. Any expenses incurred by a person who accompanies the Covered Person during the clinical trial or study.
- g. Any item or service that is provided solely to satisfy a need or desire for data collection or analysis that is not directly related to the clinical management of the Covered Person.
- h. Any costs for the management of research relating to the clinical trial or study.

In order for coverage to be provided, we will require copies of the approval or certification issued, the statement of consent signed by the Covered Person, protocols for the clinical trial or study and any other materials related to the scope of the clinical trial or study relevant to the coverage of medical treatment under this benefit.

“Cooperative group” means a network of facilities that collaborate on research projects and has established a peer review program approved by the National Institutes of Health. The term includes the Clinical Trials Cooperative Group Program; and the Community Clinical Oncology Program.

“Facility authorized to conduct Phase I clinical trials or studies for the treatment of cancer” means a facility or an affiliate of a facility that:

- a. Has in place a Phase I program which permits only selective participation in the program and which uses clear-cut criteria to determine eligibility for participation in the program;
- b. Operates a protocol review and monitoring system which conforms to the standards set forth in the Policies and Guidelines Relating to the Cancer-Center Support Grant published by the Cancer Centers Branch of the National Cancer Institute;
- c. Employs at least two researchers and at least one of those researchers receives funding from a federal grant;
- d. Employs at least three clinical investigators who have experience working in Phase I clinical trials or studies conducted at a facility designated as a comprehensive cancer center by the National Cancer Institute;
- e. Possesses specialized resources for use in Phase I clinical trials or studies, including, without limitation, equipment that facilitates research and analysis in proteomics, genomics and pharmacokinetics;
- f. Is capable of gathering, maintaining and reporting electronic data; and
- g. Is capable of responding to audits instituted by federal and state agencies.

Pre-Certification Requirements

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

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

PART VII – EXCLUSIONS AND LIMITATIONS

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

1. Pre-Existing Conditions:
 - a. Charges resulting directly or indirectly from a condition for which a Covered Person received medical treatment, diagnosis, care or advice, including diagnostic tests or medications, within the 60 month period immediately preceding such person’s Policy Effective Date are excluded for the first 12 months of coverage hereunder.
 - b. Pre-Existing Conditions includes conditions that produced any symptoms which would have caused a reasonable prudent person to seek diagnosis, care or treatment within the 60 month period immediately prior to the Covered Person’s Policy Effective Date of coverage under the Policy.

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

2. Waiting Period:
 - a. Covered Persons will only be entitled to receive benefits for Sicknesses that begin, by occurrence of symptoms and/or receipt of treatment, more than 5 days following the Covered Person's Policy Effective Date of coverage under the Policy.
 - b. Covered Persons will only be entitled to receive benefits for Cancer that begins, by occurrence of symptoms or receipt of treatment more than 30 days following the Covered Person's Policy Effective Date of coverage under the Policy.
3. Charges during the first 6 months after the Policy Effective Date of coverage for a Covered Person for the following:
 - a. Total or partial hysterectomy, unless it is Medically Necessary due to a diagnosis of carcinoma;
 - b. Tonsillectomy;
 - c. Adenoidectomy;
 - d. Repair of deviated nasal septum or any type of surgery involving the sinus;
 - e. Myringotomy;
 - f. Tympanotomy;
 - g. Herniorrhaphy; or
 - h. Cholecystectomy.

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

4. The benefits payable for the following conditions or procedures are limited to the specified amounts shown in the Schedule of Benefits:
 - a. Kidney stones
 - b. Appendectomy
 - c. Joint or tendon Surgery
 - d. Knee Injury or disorder
 - e. Acquired Immune Deficiency Syndrome (AIDS)/ Human Immuno-deficiency Virus (HIV)
 - f. Gallbladder Surgery
5. Charges which are not incurred by a Covered Person during his/her Coverage Period.
6. Charges which exceed any limits or limitations specified in this Policy, including the Schedule of Benefits.
7. Charges for services of supplies in excess of the Maximum Allowable Expense.
8. Charges for services or supplies which are not administered by or under the supervision of a Doctor.
9. Mental, emotional or nervous disorders or counseling of any type, except as specifically covered as an Eligible Expense.
10. Marital counseling or social counseling.
11. Treatment for Substance Abuse, except as 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, male sterilization or reversal of sterilization.
15. Any drug, treatment or procedure that corrects impotency or non-organic sexual dysfunction.

16. Modifications of the physical body in order to improve the psychological, mental or emotional well-being of the Covered Person, such as sex-change surgery.
17. Cosmetic Treatment, except for reconstructive surgery where expressly covered under the Policy.
18. Weight modification or surgical treatment of obesity.
19. Eye surgery, including LASIK, when the primary purpose is to correct nearsightedness, farsightedness or astigmatism.
20. Dental Expenses, except as necessary to restore or replace sound and natural teeth lost or damaged as a result of an Injury. The Injury must be severe enough that the contact with the Doctor occurs within seventy-two (72) hours of the Accident, unless extenuating circumstances exist due to the severity of the Injury that prevent you from contacting the Doctor.
21. Expenses incurred in the treatment by any method for jaw joint problems including temporomandibular joint dysfunction (TMJ), TMJ pain syndromes, craniomandibular disorders, myofascial pain dysfunction or other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the joint, 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 or newborn adopted child added as a Covered Person pursuant to the terms of this Policy.

37. Treatment, medication or hormones to stimulate growth, or treatment of learning disorders, disabilities, developmental delays or deficiencies, including therapy.
38. Biofeedback, acupuncture, recreational, sleep or MIST Therapy®, holistic care of any nature, massage and kinestherapy, excepted as provided for under Home Health Care.
39. 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.
40. 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.
41. 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.
42. Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Doctor.
43. Exercise programs, whether or not prescribed or recommended by a Doctor.
44. Charges for travel or accommodations, except as expressly provided for local ambulance.
45. All charges incurred while confined primarily to receive Custodial or Convalescent Care.
46. Services received or supplies purchased outside the United States, its territories or possessions, or Canada.
47. Any services or supplies in connection with cigarette smoking cessation, except as specifically covered under the Policy as an Eligible Expense.
48. Any services performed or supplies provided by a member of a Covered Person's Immediate Family.
49. 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.
50. Services or supplies which are not included as Eligible Expenses as described herein.
51. 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.

52. 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.
53. Intentionally self-inflicted Injury or Sickness (whether the Covered Person is sane or insane).
54. Charges resulting from a declared or undeclared war, or from voluntary participation in a riot or insurrection.
55. 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.
56. Charges You or Your Covered Dependent are not required to pay, or which would not have been billed, if no insurance existed.
57. Charges to the extent that they are paid or payable under other valid or collectible group insurance or medical prepayment plan.
58. 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.
59. Charges related to Injury or Sickness arising out of or in the course of any occupation for compensation, wage or profit, if the Covered Person is insured, or is required to be insured, by occupational disease or workers' compensation insurance pursuant to applicable state or federal law, whether or not application for such benefits have been made.
60. Medical expenses which are payable under any automobile insurance policy without regard to fault (does not apply in any state where prohibited).

PART VIII – COORDINATION OF BENEFITS (COB)

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

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

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

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

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

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

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

The term "plan" does not include:

1. Individual or family coverage through Health Maintenance Organizations (HMOs);
2. Individual or family coverage under other prepayment, group practice and individual practice plans;
3. School Accident-type coverages. (These contracts cover students for accidents only, including athletic injuries, either on a twenty-four hour basis or on a to-and-from school basis);
4. Policies with coverage limited to specified illnesses or accidents;
5. Medicare Supplement policies;
6. A state plan under Medicaid.

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

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

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

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

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

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

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

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

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

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

PART IX – CLAIM PROVISIONS

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

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

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

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

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

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

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

We will make direct reimbursement for covered ambulance services to the provider of services if that provider does not receive direct reimbursement from any other source. The Covered Person or the provider may submit the claim for reimbursement. An ambulance service provider may not demand payment from the Covered Person until after that reimbursement has been granted or denied.

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

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

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

PART X – GENERAL PROVISIONS

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 three years from the Policy Effective Date, except for fraud or nonpayment of premiums.

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

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

Legal Action: No action at law or in equity may be brought to recover on the Policy before 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.

No action at law or in equity may be brought against Us under the Policy for any reason unless You first complete all steps in any complaint/grievance procedures made available by Your state to resolve disputes under this Policy. After completing the complaint/grievance process, if You choose to bring action at law or in equity against Us relating to that dispute, You must do so within three years (or the required statute of limitation by state law, if longer) of the date We notify You of the final decision on Your complaint/grievance.

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

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

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

Conformity With Statutes: Any provision of this 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.

Reinstatement: If any renewal premium be not paid within the time granted the insured for payment, a subsequent acceptance of premium by the Company or by any agent duly authorized by the Company to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the Policy; provided, however, that if the Company or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by the Company or, lacking such approval, upon the 45th day following the date of such conditional receipt unless the Company has previously notified the insured in writing of its disapproval of such application. The reinstated Policy shall cover only loss resulting from such accidental Injury as may be sustained after the date of reinstatement and loss due to such Sickness as may begin more than 10 days after such date. In all other respects the Covered Person and Company shall have the same rights thereunder as they had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed herein 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 60 days prior to the date of reinstatement.

Grievance Procedures: When you submit a claim and that claim is denied, We will provide a written statement containing the reasons for the Adverse Determination. You have the right to request a review of any Company decision or action pertaining to our contractual relationship and to appeal any adverse claim determination we've made by filing a Grievance. These procedures have been developed to ensure a full investigation of a Grievance through a formal process.

A "**Grievance**" is a written complaint requesting a change to a previous claim decision, claims payment, the handling or reimbursement of health care services, or other matters pertaining to your coverage and our contractual relationship.

An "**Adverse Determination**" is a determination by the Company or its designated utilization review organization that (1) a service, treatment, drug, or device, is experimental, investigational, specifically limited or excluded by your coverage; or (2) a facility admission, the availability of care, continued stay or other health care services proposed or furnished have been reviewed and, based upon the information provided, does not meet the contractual requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness and therefore, the benefit coverage is denied, reduced or terminated in whole or in part.

Informal Grievance Procedure: You, your authorized representative, or a provider acting on your behalf may submit an oral complaint to us within 60-days after an event that causes a dispute. Telephoning allows you to discuss your complaint or concerns and gives us the opportunity to immediately resolve the problem.

If we don't have all the information necessary to review your complaint, we will request any additional information within 5 business days of receiving your complaint. After we receive all the necessary information, we will provide you, your authorized representative, or a provider acting on your behalf with our written decision within 30-days after receiving the complaint and all necessary information.

If the problem cannot be resolved in this manner, you still have the right to submit a written request for the complaint to be reviewed through the Formal Grievance Procedure, as outlined below.

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 doctor 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) and professional qualifications 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.

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 ten 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 10 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, including the telephone number and address of the Commissioner's office.

Expedited Review: You are eligible for an expedited review when the timeframes for an Informal, 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 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 for First Level reviews.

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

We will not provide an expedited review for retrospective reviews of Adverse Determinations.

PART XI – SCHEDULE OF BENEFITS

INSURED:

MONTHLY PREMIUM:

POLICY NUMBER:

POLICY EFFECTIVE DATE:

POLICY TERMINATION DATE:

COVERAGE PERIOD:

COVERED PERSONS

RELATIONSHIP

AGE DATE OF BIRTH

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

Plan Deductible**

per Covered Person per Coverage Period.
Maximum of 3 Deductibles per family per Coverage Period.

Additional Deductibles**

Foreign Travel Deductible

\$500 per Covered Person after which the Plan Deductible and Coinsurance will apply.

Copayments**

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

Emergency Room Copayment

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

Advanced Diagnostic Studies Copayment

\$500 Copayment per occurrence for Advanced Diagnostic Studies in an Outpatient setting, not to exceed a maximum of 3 Advanced Diagnostic Studies Copayments per Covered Person. Coinsurance is 80% of Eligible Expenses and benefits are not subject to the Plan Deductible. Occurrences in excess of the maximum number of Advanced Diagnostic Studies will be subject to the Plan Deductible and Coinsurance.

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	After the Copayment shown above, Coinsurance is 80% of Eligible Expenses and benefits are not subject to the Plan Deductible. Any other covered services or tests performed as part of the office visit will be subject to the Plan Deductible and Coinsurance. Office or urgent care center visits or consultations in excess of the maximum number of Doctor's Office Visit or Urgent Care Center Copayments will be subject to the Plan Deductible and Coinsurance.
Wellness Benefit	After the Copayment shown above, Coinsurance is 80% of Eligible Expenses and benefits are not subject to the Plan Deductible.
Home Health Care	\$100 per visit. There is a limit of 1 visit per day not to exceed a maximum 40 Home Health Care visits per Covered Person per Coverage Period.
Ambulance	
Injury:	\$1,000 per transport.
Sickness:	\$1,000 per transport.
Physical, Occupational and Speech Therapy	\$100 per day and 10 visits combined per Covered Person per Coverage Period.
Organ or tissue transplants	\$100,000 per Covered Person per Coverage Period.
Foreign Travel	\$50,000 per Covered Person per Coverage Period.
Temporomandibular Joint Disorder (TMJ):	50% of Eligible Expenses after the Plan Deductible and any additional Deductibles
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

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

Mental Disorders

Inpatient:

40 day maximum per Covered Person per Coverage Period.

Outpatient:

40 visit maximum per Covered Person per Coverage Period, excluding visits for the management of medication.

Substance Abuse

Treatment for withdrawal from the physiological effects of alcohol or drugs:

\$1,500 maximum per Covered Person per Coverage Period.

Treatment for a patient admitted to a facility:

\$9,000 maximum per Covered Person per Coverage Period.

Individual, group or family counseling on an outpatient basis:

\$2,500 maximum per Coverage Period

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