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HCC LIFE INSURANCE COMPANY
225 TownPark Drive, Suite 350
Kennesaw, Georgia 30144
866-400-7102

SHORT TERM MAJOR MEDICAL INSURANCE POLICY

HCC Life Insurance Company (hereinafter the Company, We, Our, or Us) agrees to pay the insurance benefits herein provided, subject to the terms and conditions of this policy. Benefits are payable in United States Dollars only.

This policy is issued to the Policyholder (hereinafter the Insured, You or Your) in consideration of the application and payment of premiums, to take effect as of the Effective Date. This policy will terminate as hereinafter provided.

The first premium is due on or before the Effective Date and future premiums are due as stated herein during the continuance of this policy.

All periods indicated herein begin and end at 12:01 A.M. Standard Time at the address of the Policyholder.

This policy is delivered in and is governed by the laws of Indiana.

The benefits and provisions set forth on the following pages, riders or endorsements are a part of this policy as if recited over the parties' signatures.

NOTICE OF RIGHT TO EXAMINE POLICY FOR 30 DAYS: The Policyholder may return this Policy within 30 days of its delivery if, after examination of the Policy, the Policyholder is not satisfied with it for any reason. Upon return, the Company will refund all Premium paid and any administrative fees charged where applicable. The Policy shall be void from the beginning and the parties shall be in the same position as if no policy had been issued.

Signed for HCC Life Insurance Company.

President

Vice President and General Counsel

LIMITED BENEFIT SHORT TERM MEDICAL INSURANCE

THIS POLICY A CONTRACT
BETWEEN THE POLICY HOLDER AND THE COMPANY
READ IT CAREFULLY

TABLE OF CONTENTS

NOTE: NO CONTINUOUS COVERAGE. This policy of insurance provides coverage for a short term duration only. It is not renewable.

Although this short term plan may be rewritten for new and completely separate Coverage Periods (as long as you meet the eligibility criteria described in the application), coverage does not continue from one policy to another. This means that a new application must be submitted, a new effective date is given, a new pre-existing condition exclusion period begins and a new deductible and out-of-pocket expense must be met. 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.

Questions regarding your policy or coverage should be directed to
HCC Life Insurance Company
866-400-7102

If you (a) need the assistance of the governmental agency that regulates insurance; or (b) have a complaint you have been unable to resolve with your insurer you may contact the Department of Insurance by mail, telephone or email:

State of Indiana Department of Insurance
Consumer Services Division
311 West Washington Street, Suite 300
Indianapolis, IN 46204

Consumer Hotline: (800) 622-4461; (317) 232-2395

Complaints can be filed electronically at *www.in.gov/idoi*

PART I – GENERAL DEFINITIONS

"Accident" means a sudden, unforeseeable event that causes injury to one or more Covered Persons.

"Complications of Pregnancy" means:
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 hyperemesis gravidarum, preeclampsia, acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity, but shall not include 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-scheduled 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.

"Coverage Period" means the length of time which the Insured selected in the Insured's application and approved by us, not to exceed a month period commencing on the Effective Date. The Insured's Coverage Period is shown in the Schedule of Benefits.

"Covered Person" means an Insured and his eligible dependents for whom coverage is in effect under this policy, as described in Part II – Eligibility and Effective Date of Insurance Provisions and the Schedule of Benefits.

"Custodial or Convalescence 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 covered expenses that must be paid by a Covered Person before benefits are payable under this policy. This amount applies separately to each Covered Person and must be satisfied as stated in the Schedule of Benefits.

"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.

"Eligible Dependent" means:
1. The Insured's lawful spouse under age 65; and
2. The Insured's children who are less than age 26.

Dependent children may include stepchildren, foster children, legally adopted children, children of adopting parents pending finalization of adoption procedures and children for whom coverage has been court-ordered.

"Durable Medical Equipment" means medical equipment that can withstand repeated use, is prescribed by a Doctor, and is appropriate for use in the home. Covered DME is limited to a standard basic Hospital bed and/or a standard basic wheel chair.

"Effective Date" means the date the Insured's (and Eligible Dependents' if applicable) coverage under this policy is effective.

"Experimental 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 Doctors, 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:

1. 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 illnesses or injuries;
2. Full-time supervision of a Doctor;
3. Twenty-four (24) hour a day nursing service of one or more Nurses; and
4. 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 injured or sick persons; 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, convalescent home, 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, spouse, children, or siblings of a Covered Person, or any person residing with a Covered Person.

"Incident" means all Sicknesses that exist simultaneously and which are due to the same or related causes are considered to be one Incident. Further, if a Sickness is due to causes which are the same as or related to the causes of a prior Sickness, the Sickness will be deemed to be a continuation of the prior Sickness and not a separate Incident. All Injuries due to the same Accident shall be deemed to be one Incident.

"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 person who incurs medical expenses for at least one day's room and board from a Hospital.

"Insured" means a person who meets the eligibility requirements for an Insured in the Application and this policy, and whose coverage under this policy has become effective and has not terminated.

"Medically Necessary" means the care, service or supply is:
1. Prescribed by a Doctor for the diagnosis or treatment of an Injury or Sickness; and
2. Appropriate, according to conventional medical practice for the Injury or Sickness in the locality in which the care, service or supply, is given.

"Mental and Nervous Disorder" means a "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").

"Outpatient" means a person who incurs medical expenses at Doctor's offices and freestanding clinics, and at Hospitals when not admitted as an Inpatient.

"Regular and Customary Activities" means an Insured Person can carry on a substantial part of the standard and commonly practiced activities of a person in good health of the same sex and age. Activities performed while confined in a Hospital or other medical institution may not be used to meet this requirement.

"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 Sickness or disease of a Covered Person that:
1. Is treated by a Doctor while the person is covered under this policy; and
2. Results directly and independently of all other causes in loss covered by this policy.

"Substance Abuse" means the overindulgence in and dependence on a psychoactive leading to effects that are detrimental to the individual's physical health or mental health, or the welfare of others.

"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.

"Total Disability" (or "Totally Disabled") means the Insured is disabled and prevented from performing the material and substantial duties of his or her occupation. For Dependents, "Totally Disabled" means the inability to perform a majority of the normal activities of a person of like age in good health.

"Urgent Care Center" means a medical facility separate from a hospital emergency department where ambulatory patients can be treated on a walk-in basis without an appointment and receive immediate, non-routine urgent care for an Injury or Sickness presented on an episodic basis.

"Usual and Customary" charges means the following:
1. A usual fee is defined as the charge made for a given service by a Doctor to the majority of his or her patients; and
2. A customary fee is one that is charged by the majority of Doctors within a community for the same services. All benefits are limited to Usual and Customary charges.

PART II – ELIGIBILITY AND EFFECTIVE DATE OF INSURANCE

An Insured must meet the following eligibility requirements:

1. Must be at least age 2 and under age 65;
2. Must not be pregnant, an expectant father, or planning on adopting;
3. Must not be covered under other hospital, major medical, group health or other medical insurance coverage;
4. Must not be a member of the armed forces of any country, state or international organization, other than on reserve duty for 30 days or less; and
5. Must submit an Application, and if required, provide satisfactory evidence of insurability to the Company.

The Insured's Dependents may apply for coverage under the Policy, if each such person:

1. Qualifies as an Eligible Dependent as defined in this Policy;
2. Is not pregnant, an expectant father, or planning on adopting;
3. Is not covered under other hospital, major medical, group health or other medical insurance coverage;
4. Is not a member of the armed forces of any country, state or international organization, other than on reserve duty for 30 days or less; and
5. Submits an Application, and if required, provides satisfactory evidence of insurability to the Company.

Coverage will be effective for an Insured and his Eligible Dependent(s) as of the approved Effective Date, provided:

1. The Insured and his/her Dependent(s) meets the eligibility requirements set forth in the Application and this policy;
2. The Insured's Application is approved by Us;
3. The first premium payment is received on or before the date the Insured's Application is approved by Us;
4. The Insured is not confined at home or in a Hospital or medical institution as of the Effective date; and
5. The Insured is engaging in his Regular and Customary Activities as of the Effective date.

If the Insured is not engaged in his Regular and Customary Activities or is confined in a Hospital or medical institution on the Effective Date, coverage will begin the first day he can engage in his Regular and Customary Activities and is not confined in a Hospital or medical institution.

The Company will require satisfactory evidence of insurability for each Insured and Eligible Dependent.

Newborn Child Coverage: A child of the Insured born while this policy is in force is covered for Injury and Sickness (including necessary care and treatment of congenital defects, birth abnormality and premature birth), as well as routine newborn care for the first 31 days. The child is covered from the moment of birth until the 31st day of age. A notice of birth together with 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: A minor child who comes under the charge, care and control of the Insured while this policy is in force is covered for Injury and Sickness. The coverage of such child will be the same as provided for other members of the Insured's family. Such child shall be covered for 31 days from the earlier of the date of adoption or placement or the date of the

entry of an order granting the adoptive parent custody of the child for purpose of adoption. Such child's coverage will not be subject to any pre-existing conditions limitation provided by this policy. Coverage for such minor child will continue unless the petition for adoption is dismissed or denied.

PART III - TERMINATION OF INSURANCE

Coverage of a Covered Person under this policy shall automatically terminate on the earliest of the following dates:

1. The date the Coverage Period expires;
2. The first day of the month coinciding with or following the date other hospital, major medical, group health or other medical insurance coverage becomes effective for a Covered Person;
3. The end of the last period for which the last required premium payment was made for the Insured's or Covered Person's insurance;
4. The date a Covered Person receives the Coverage Period Maximum Benefit Amount;
5. The date the Covered Person enters the armed forces of any country, state or international organization, other than for reserve duty of 30 days or less;
6. The premium due date that coincides with or next follows the date on which the Insured is no longer eligible;
7. For a Dependent spouse, the first day of the month following the date of divorce or legal separation from the Insured; or
8. The date We specify that the Covered Person's insurance is terminated because of:
    A. Failure to provide any signed release, consent, assignment or other documents requested by Us;
    B. Failure to fully cooperate with Us in the administration of this policy;
    C. Material misrepresentation, fraud, or omission of information on any application form, or in requesting the receipt of benefits under this policy; or
    D. Misuse of the Covered Person's identification card.

Coverage will not be terminated for an Eligible Dependent child who becomes incapable of self-support because of mental retardation or physical handicap before reaching the limiting age for dependent children. The Company must receive proof of incapacity and dependency within 31 days of the child reaching the age limit. This policy will continue for as long as the Insured's insurance stays in force and the child remains incapacitated.

At the death of an Insured, all rights and privileges as a Covered Person under this policy will transfer to the surviving Dependent spouse. The Dependent spouse will then be considered an Insured instead of a Dependent. In the event the Dependent spouse remarries, coverage under this policy for the Dependent Spouse and Dependent child(ren), if any, will end on the first day of the month following the date of that marriage. If no surviving Dependent spouse, or at the death of a surviving Dependent spouse, all rights and privileges as a Covered Person under this policy will transfer to each Dependent child, if any, and he will be considered the Insured instead of a Dependent.

If the Insured selected the Pay In Advance option in the Insured's Application, We received all required premium for the Coverage Period, and coverage terminates because other insurance is secured or due to divorce or legal separation, premium will be reimbursed to the Insured for the

period of time, if any, between the later of: (1) the date coverage terminates in accordance with the above provisions or (2) the date we are notified of ineligibility, and the end of that Coverage Period.

If the Insured selected the Pay in Advance option in the Insured's Application, the Company will refund any unused premiums upon the death of the Insured during the contract period. The amount of premium refund shall be prorated from the date following the date of death of the Insured to the end of the contract period for which the premium has been paid. If a person other than the Insured paid the premium, unused premiums will be refunded to that person. A person entitled to a refund must: (1) submit a written request for the refund; (2) furnish proof of payment to the Company; and (3) furnish proof of the Insured's death.

Extension of Benefits

If a covered Bodily Injury or Sickness commences while this policy is in force as to a Covered Person, benefits otherwise payable under this policy for the Injury or Sickness causing the Total Disability will also be paid for any Eligible Expenses incurred after the termination of insurance for a Covered Person if, from the date of such termination to the date such expenses are incurred, the Covered Person is Totally Disabled by reason of such Injury or Sickness. Such benefits shall be payable only during the continuance of such disability until the earlier of:

1. The date the Total Disability ends;
2. The date when treatment for the Total Disability is no longer required;
3. The date following a time period equal to 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 group insurance plan providing coverage for the same conditions causing the Total Disability; or
5. The date the Coverage Period Maximum Benefit amount has been reached.

PART IV - PREMIUMS

1. Unless the Pay In Advance option has been chosen, premium due dates for an Insured will be on the Effective Date and then the same date of each following calendar month. 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. If any change 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.

3. Premiums shall be payable in advance to Us at Our Home Office.

4. If the Insured has not given written notice to Us that insurance is to be terminated prior to the premium due date, a grace period of thirty-one (31) days beginning from the premium due date will be allowed for any premium after the first premium. If the Insured

fails to pay premium before the grace period expires all coverage shall lapse as of the premium due date.

5. This policy does not share in the surplus earnings of the Company and no refund or assessment shall be made to this policyholder, Insured, or Dependent of any excess or deficit earnings of the Company.

Reinstatement

If any renewal premium is not paid within the time granted the Insured for payment, a subsequent acceptance of premium by the Company or by any agent authorized by the Company to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the Policy. Provided, 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 Insured and the Company shall have the same rights as they had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

PART V – DESCRIPTION OF MEDICAL EXPENSES

Subject to the Deductible, Coinsurance and other limits set forth in PART X – SCHEDULE OF BENEFITS, the Company will pay the following expenses incurred while this insurance is in effect:

1. Charges made by a Hospital for:
   - A. Daily room and board and nursing services not to exceed the average semi-private room rate;
   - B. Daily room and board and nursing services in Intensive Care Unit;
   - C. Use of operating, treatment or recovery room;
   - D. Services and supplies which are routinely provided by the Hospital to persons for use while Inpatients;
   - E. Emergency treatment of an Injury, even if Hospital confinement is not required; and
   - F. Emergency treatment of a Sickness; however, an additional $250 Deductible will apply to emergency room charges unless the Covered Person is directly admitted to the Hospital as an Inpatient for further treatment of that Sickness.
2. For Surgery at an Outpatient surgical facility, including services and supplies.
3. For charges made by a Doctor for professional services, including Surgery. Charges for an assistant surgeon are covered up to 20% of the Usual and Customary charge of the primary surgeon. (Standby availability will not be deemed to be a professional service and therefore is not covered).
4. For dressings, sutures, casts or other supplies which are Medically Necessary and administered by or under the supervision of a Doctor, but excluding nebulizers, oxygen tanks, diabetic supplies, other supplies for use or application at home, and all devices or supplies for repeat use at home, except Durable Medical Equipment as herein defined.
5. For diagnostic testing using radiology, ultrasonographic or laboratory services (psychometric, intelligence, behavioral and educational testing are not included).
6. For artificial limbs, eyes or larynx, breast prosthesis or basic functional artificial limbs, but not the replacement or repair thereof.
7. For reconstructive surgery when the surgery is directly related to surgery which is covered under this policy, including reconstructive breast surgery and prosthetic devices incident to a Mastectomy. Coverage will also be extended to include surgery on a non-diseased breast to establish symmetry with the diseased breast. As used in this benefit:
   - A. “Mastectomy” means the surgical removal of all or part of a breast as a result of breast cancer.
   - B. “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.
8. For radiation therapy or treatment and chemotherapy.
9. For hemodialysis and the charges by the Hospital for processing and administration of blood or blood components but not the cost of the actual blood or blood components.
10. For oxygen and other gasses and their administration by or under the supervision of a Doctor.
11. For anesthetics and their administration by a Doctor, subject to a maximum of 20% of the benefit payable for the primary surgeon.
12. Extended Care Facility charges for room and board accommodations; if:
    - A. The Insured is 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. That confinement is for the same covered Injury or Sickness that was treated during the Covered Person's confinement in the Hospital.

13. Treatment of a Covered Person by a Home Health Care Agency under a Home Health Care Plan. Up to four (4) consecutive hours in a twenty-four (24) hour period of Home Health Care services shall be considered as one Home Health Care visit. Eligible Expenses for Home Health Care are the Maximum Allowable Charges made for the following:
    A. Part-time skilled nursing care;
    B. Physical therapy;
    C. Speech therapy;
    D. Medical supplies, drugs and medicines prescribed by a Doctor;
    E. Laboratory services by or on behalf of the Hospital but only to the extent benefits for those services would have been paid under this policy had the Insured Person remained Hospitalized;
    F. Occupational therapy; and
    G. Respiratory therapy.

    However, benefits will not be paid for charges made by a Home Health Care Agency for:
    A. Any charges excluded under the Exclusions of the policy;
    B. Full-time nursing care at home;
    C. Meals delivered to the home;
    D. Homemaker services;
    E. Any services of an individual who ordinarily resides in the Insured's home or is a member of the Insured's immediate family; or
    F. Any transportation services.

    Benefits for Home Health Care are in lieu of any similar benefits provided under any other provision of the policy.
14. Local Ambulance transport necessarily incurred in connection with Injury, and Local Ambulance transport necessarily incurred in connection with Sickness resulting in Inpatient hospitalization.
15. Dental treatment and dental surgery necessary to restore or replace natural teeth lost or damaged as a result of an Injury covered under this policy.
16. Medically Necessary rental of Durable Medical Equipment (limited to a standard basic hospital bed and/or a standard basic wheelchair) up to the purchase prices, not including expenses for customization and only for the portion of the cost equivalent to the Coverage Period.
17. Physical Therapy if prescribed by a Doctor who is not affiliated with the Physical Therapy practice, necessarily incurred to continue recovery from a covered Injury or Sickness.

Pre-Certification Requirements

1. All hospitalizations, other Inpatient care, and Surgeries or Surgical Procedures must be Pre-certified.
2. To comply with the Pre-certification requirements, the Covered Person must:
    A. Contact the Company at the telephone number contained in the Insured's policy as soon as possible before the expense is to be incurred; and
    B. Comply with the instructions of the Company and submit any information or documents they require; and
    C. Notify all Doctors, Hospitals and other providers that this insurance contains Pre-certification requirements and ask them to fully cooperate with the Company**.**
3. If the Covered Person complies with the Pre-certification requirements, and the expenses are Pre-certified, the Company will pay Eligible Medical Expenses subject to

all terms, conditions, provisions and exclusions described in this policy. If the Covered Person does not comply with the Pre-certification requirements or if the expenses are not Pre-certified:

A. Eligible Medical Expenses will be reduced by 50%; and
B. The Deductible will be subtracted from the remaining amount; and
C. The Coinsurance will be applied.

4. 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.
5. 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 herein.
6. Concurrent Review – For Inpatient stays of any kind, the Company 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 VI – EXCLUSIONS

Charges for the following treatments and/or services and/or supplies and/or conditions are excluded from coverage:

1. Pre-existing Conditions – Charges resulting directly or indirectly from a pre-existing condition are excluded from coverage hereunder. A pre-existing condition is a condition: (1) for which medical advice, diagnosis, care, or treatment (includes receiving services and supplies, consultations, diagnostic tests or prescription medicines) was recommended or received within the 60 months immediately preceding the Effective Date; or (2) that had manifested itself in such a manner that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment (includes receiving services and supplies, consultations, diagnostic tests or prescription medicines) within the 12 months immediately preceding such person's Effective Date. This exclusion does not apply to a newborn or newly adopted child who is added to coverage under this policy in accordance with PART II – ELIGIBILITY AND EFFECTIVE DATE OF INSURANCE.
2. Waiting Period – If coverage was purchased within 3 days of the Covered Person's Effective Date, then in respect to Sickness, Covered Persons will only be entitled to receive benefits for Sicknesses that begin, by occurrence of symptoms and/or receipt of treatment, at least 72 hours following the Covered Person's Effective Date of coverage under this policy.
3. Outpatient Prescription Drugs, medications, vitamins, and mineral or food supplements including pre-natal vitamins, or any over-the-counter medicines, whether or not ordered by a Doctor.
4. Routine pre-natal care, Pregnancy, childbirth, and postnatal care. (This exclusion does not apply to "Complications of Pregnancy" as defined.)
5. Alcoholism.
6. Substance abuse.
7. Charges which are not incurred by a Covered Person during his/her Coverage Period.
8. Treatment, services or supplies, which are not administered by or under the supervision of a Doctor.
9. Treatment, services or supplies which are not Medically Necessary as defined.
10. Treatment, services or supplies provided at no cost to the Covered Person.

11. Charges which exceed Usual and Customary charge as defined.
12. Telephone consultations or failure to keep a scheduled appointment.
13. Consultations and/or treatment provided over the Internet.
14. Surgeries, treatments, services or supplies which are deemed to be Experimental Treatment.
15. All charges Incurred while confined primarily to receive Custodial or Convalescence Care.
16. Weight modification or surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass surgery.
17. 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.
18. Surgeries, treatments, services or supplies for cosmetic or aesthetic reasons, except for reconstructive surgery which is expressly covered under this policy.
19. Any drug, treatment or procedure that either promotes or prevents conception including but not limited to: artificial insemination, treatment for infertility or impotency, sterilization or reversal of sterilization.
20. Any drug, treatment or procedure that either promotes, enhances or corrects impotency or sexual dysfunction.
21. Abortions, except in connection with covered Complications of Pregnancy or if the life of the expectant mother would be at risk.
22. Dental treatment, except for dental treatment that is expressly covered under this policy.
23. Eyeglasses, contact lenses, hearing aids, hearing implants, eye refraction, visual therapy, and any examination or fitting related to these devices, and all vision and hearing tests and examinations.
24. Eye surgery, such as radial keratotomy, when the primary purpose is to correct nearsightedness, farsightedness or astigmatism.
25. Treatment for cataracts.
26. Treatment of the temporomandibular joint.
27. Injuries resulting from participation in any form of skydiving, scuba diving, auto racing, bungee jumping, hang or ultra light gliding, parasailing, sail planing, flying in an aircraft (other than as a passenger on a commercial airline), rodeo contests or as a result of participating in any professional, semi-professional or other non-recreational sports including boating, motorcycling, skiing, riding all-terrain vehicles or dirt-bikes, snowmobiling or go-carting.
28. Injuries or Sicknesses resulting from participation in interscholastic, intercollegiate or organized competitive sports.
29. Willfully self-inflicted Injury or Sickness.
30. Venereal disease, including all sexually transmitted diseases and conditions.
31. Immunizations and Routine Physical Exams.
32. Services received for any condition caused by a Covered Person's commission of or attempt to commit a felony or to which a contributing cause was the Covered Person being engaged in an illegal occupation.
33. Speech, vocational, occupational, biofeedback, acupuncture, recreational, sleep or music therapy, holistic care of any nature, massage and kinestherapy.
34. Any services performed or supplies provided by a member of the Insured's Immediate Family.
35. Orthoptics and visual eye training.
36. Services or supplies which are not included as Eligible Expenses as described herein.
37. 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.

38. Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Doctor.
39. Treatment of sleep disorders.
40. Hypnotherapy when used to treat conditions that are not recognized as Mental or Nervous Disorders by the American Psychiatric Association, and biofeedback, and non-medical self-care or self-help programs.
41. Any services or supplies in connection with cigarette smoking cessation.
42. Exercise programs, whether or not prescribed or recommended by a Doctor.
43. Treatment required as a result of complications or consequences of a treatment or condition not covered under this policy.
44. Charges for travel or accommodations, except as expressly provided for local ambulance.
45. Treatment incurred as a result of exposure to non-medical nuclear radiation and/or radioactive material(s).
46. Organ or Tissue Transplants or related services.
47. 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.
48. Services received or supplies purchased outside the United States, its territories or possessions, or Canada.
49. Treatment for or related to any congenital condition, except as it relates to a newborn or adopted child added as a Covered Person to this policy.
50. Spinal manipulation or adjustment.
51. Sclerotherapy for veins of the extremities.
52. Expenses during the first 6 months after the Effective Date of coverage for a Covered Person for the following (subject to all other coverage provisions, including but not limited to the Pre-existing Condition exclusion):
    A. Total or partial hysterectomy, unless it is Medically Necessary due to a diagnosis of carcinoma;
    B. Tonsillectomy;
    C. Adenoidectomy;
    D. Repair of deviated nasal septum or any type of surgery involving the sinus;
    E. Myringotomy;
    F. Tympanotomy;
    G. Herniorraphy; or
    H. Cholecystectomy.
53. Chronic fatigue or pain disorders.
54. Treatment or diagnosis of allergies, except for emergency treatment of allergic reactions.
55. Treatment, medication or hormones to stimulate growth, or treatment of learning disorders, disabilities, developmental delays or deficiencies, including therapy.
56. Kidney or end stage renal disease.
57. Joint replacement or other treatment of joints, spine, bones or connective tissue including tendons, ligaments and cartilage, unless related to a covered Injury.
58. Expenses resulting from a declared or undeclared war, or from voluntary participation in a riot or insurrection.
59. Expenses 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.

PART VII – 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.

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. Group or group-type hospital indemnity benefits of $100 per day or less;
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.

"This Plan" – means the benefits provided under this policy.

Effect on Benefits. Plans use COB to decide which plan should pay first for a covered expense. If the Primary Plan's payment is less than the charge for the allowable expense, then the Secondary Plan will apply its benefit payment to the balance.
The following rules will be used to establish the order of benefit determination:

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

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

5. If a person whose coverage is provided under a right of continuation pursuant to federal or state law is covered under another plan, the following will be the order of benefit determination:
   A. First, the benefits of a plan covering the person as an employee, member, or subscriber (or as that person's dependent);
   B. Second, the benefits under the continuation coverage. If the other plan does not have the rule described above and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.
6. When rules 2 through 5 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 VIII - CLAIM PROVISIONS

Notice of Claim: Written notice of claim must be given within 31 days after a covered loss begins (60 days in Kentucky; six months in Montana) or as soon as is reasonably possible. The notice must be given to the Company named on the Schedule of Benefits. Notice should include information that identifies the claimant and this policy.

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

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

(If the Insured resides in Georgia, the reference to 15 days is changed to 10 working days.)

Proof of Loss: Written proof of loss must be given to the Company 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 Company within one year after it is due unless the Insured is legally incapable of doing so.

Time of Payment of Claim: Benefits for loss covered by this policy will be paid as soon as we receive proper written proof of such loss. The Company will pay or deny each clean claim within 45 days after receipt if the claim is filed on paper, and 30 days after receipt if the claim is filed electronically. If the Company fails to pay or deny a clean claim in this time period, and the Company subsequently pays the claim, the Company will pay interest on such claim at the annual percentage rate specified by state law. If interest is due, the accrual will begin 31 days after the date the claim is filed if it is an electronic claim and 46 days after the date the claim in filed if it is a paper claim. Accrual of interest stops when the claim is paid. As used here, a "clean claim" means a claim submitted by a provider for payment that has no defect, impropriety, or particular circumstance requiring special treatment preventing payment. If a submitted claim has deficiencies, the Company will notify the provider of such deficiencies not more that 45 days after receipt of the claim if filed on paper, and 30 days if the claim is filed electronically, with a description of any remedy necessary to establish a clean claim.

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 $1,000.00 of such benefit to one of the Insured's relatives who is deemed by the Company to be justly entitled to it. Such payment, made in good faith, fully discharges the Company to the extent of the payment.

Physical Examination: At our expense, we may have a person claiming benefits examined as often as reasonably necessary while the claim is pending.

Legal Action: No legal action may be brought to recover on this policy before 60 days after written proof of loss has been furnished as required by this policy. No such action may be brought after three years (five years in Kansas, six years in South Carolina and the applicable statute of limitation in Florida) from the time written proof of loss is required to be furnished.

Third Party Liability: No benefits are payable 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 breach of any legal obligation on the part of such third party. Nevertheless, the Company will advance the benefits of this policy to the Insured subject to the following**:**

1. The Insured 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 Insured and 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 Insured 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, disease, Injury or condition for which the third party is liable.

PART IX – GENERAL PROVISIONS

Time Limit on Certain Defenses: The validity of coverage issued under this policy with respect to an Insured or his Eligible Dependents may not be contested after two years from this policy's effective date, except for nonpayment of premiums.

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: This 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.

Entire Contract: This policy, riders, endorsements and the Policyholder's application, a copy of which is attached hereto, shall constitute the entire contract between the parties. All statements made by the policyholder and any other Covered Persons shall be deemed representations and not warranties. No such statement, in the absence of fraud, shall be used in any contest under this policy unless it is contained in a written instrument and a copy of the instrument is or has been furnished to the person or his beneficiary, if any.

Authority, Amendment and Alteration: None of the terms of this policy may be modified, except by an agreement in writing signed by the President, a Vice President or the Secretary of the Company. The authority for this purpose cannot be delegated. This policy may be amended or changed at any time, subject to the laws of the jurisdiction in which it is delivered. No agent or person, other than as stated above, shall have the authority to change this policy or otherwise waive any requirements or provisions of this policy. No change in this policy shall be valid unless evidenced by endorsement on this policy or by an amendment to this policy signed by Us.

Non-Renewability of Insurance: Insurance for an Insured and his Eligible Dependents, if any, does not renew and shall terminate at the end of the Coverage Period selected by the Insured and approved by Us, unless earlier terminated as provided in this policy.

Conformity with Law: If any provision of this policy is contrary to any law to which it is subject, this provision is hereby amended to conform thereto.

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

PART X – SCHEDULE OF BENEFITS

INSURED INFORMATION:

Name:

Policy Effective Date:

COVERAGE PERIOD:

ELIGIBILE DEPENDENTS COVERED

COVERAGE AND BENEFIT AMOUNTS:

Deductible	per Covered Person per Coverage Period. Maximum of 3 Deductibles per family per Coverage Period. An additional Deductible of $250 per visit will be applied to charges for use of emergency room in the event of Sickness unless the Covered Person is directly admitted as an Inpatient for further treatment.
Coinsurance	During a Coverage Period, the Company will pay of the next $5,000 of Eligible Expenses after the Deductible, then 100% of Eligible Expenses to the Overall Maximum Limit.
Urgent Care Center	For each visit, the Covered Person shall be responsible for a $50 co-payment, after which Coinsurance will apply. Not subject to Deductible
Hospital Room and Board	Average Semi-private room rate, including nursing services.
Local Ambulance	Injury: Usual and Customary charges to a Maximum of $250 per trip, when related to a covered Injury. Sickness: Usual and Customary charges to a maximum of $250 per trip, when covered Sickness results in hospitalization as Inpatient
Intensive Care Unit	Usual and Customary charges
Physical Therapy	$50 Maximum per visit per day
Mental and Nervous Disorders	Outpatient Treatment: $50 Maximum per visit, Maximum 10 visits per Coverage Period Inpatient Treatment: $100 Maximum per

	day, Maximum 31 days per Coverage Period
Home Health Care	Maximum 1 visit per day. Maximum of 40 visits during a Coverage Period
Extended Care Facility	Not to exceed a daily rate of $150 nor a maximum of 60 days
All Other Eligible Medical Expenses	Usual and Customary charges
Penalty for Failure to Pre-certify	50% of Eligible Medical Expenses
Overall Maximum Limit per Coverage Period	

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