

HCC LIFE INSURANCE COMPANY
225 TownPark Drive, Suite 145
Kennesaw, Georgia 30144
866-400-7102

CERTIFICATE OF INSURANCE
PROVIDING SHORT TERM MAJOR MEDICAL INSURANCE

Group Policy No. STM600-1 ("the policy"), has been issued to Consumer Benefits of America which we will refer to as "the Policyholder". We will refer to HCC Life Insurance Company as "the Company", "we", "us", "our".

The policy was delivered in Missouri and will be governed by the laws thereof.

This Certificate of Insurance is evidence of the Insured's insurance under the policy and of its benefits. Everything contained in this Certificate of Insurance is subject to the provisions, definitions, and exceptions in the policy. The policy is on file with the Policyholder and may be examined at any reasonable time. Only one of our executive officers can authorize a change of the policy.

This Certificate replaces all Certificates and Certificate Riders, if any, previously issued to the Insured under the policy.

Signed for HCC Life Insurance Company.



President

THIS CERTIFICATE IS EVIDENCE OF A CONTRACT
BETWEEN THE POLICY HOLDER AND THE COMPANY
READ IT CAREFULLY

For service or complaints about this policy, please address any inquiries to the address shown above or call 866-400-7102.

TEXAS NOTICE

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call HCC Life Insurance Company's toll-free telephone number for information or to make a complaint at:
1-866-400-7102

You may write to HCC Life Insurance Company:
225 TownPark Drive, Suite 145
Kennesaw, GA 30144

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:
1-800-252-3439

You may write the Texas Department of Insurance at:
P.O. Box 149104
Austin, TX 78714-9104
FAX #(512) 475-1771
Web : <http://www.tdi.state.tx.us>
Email :
ConsumerProtection@tdi.state.tx.us

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your premium or about a claim you should contact the company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY: This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Usted puede llamar al numero de telefono gratis de HCC Life Insurance Company para informacion o para someter una queja al:
1-866-400-7102

Usted puede escribir a HCC Life Insurance Company:
225 TownPark Drive, Suite 145
Kennesaw, GA 30144

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al:
1-800-252-3439

Puede escribir al Departamento de Seguros de Texas:
P.O. Box 149104
Austin, TX 78714-9104
FAX #(512) 475-1771
Web : <http://www.tdi.state.tx.us>
Email :
ConsumerProtection@tdi.state.tx.us

DISPUTAS SOBRE PRIMAS O RECLAMOS: Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con la compania primero. Si no se resuelve la disputa, puede entonces comunicarse con el Departamento de Seguros de Texas.

UNA ESTE AVISO A SU POLIZA: Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

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NOTE: NO CONTINUOUS COVERAGE. This Certificate 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 Certificate of insurance 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 within the previous 12 months and existed under a prior Certificate will be treated as a pre-existing condition under the new Certificate.

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 [six(6)/twelve(12)] 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 the 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 the policy. This amount applies separately to each Covered Person and must be satisfied each Coverage Period.

“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; and
2. the Insured’s unmarried children who are less than age 25.

Dependent children may include stepchildren, foster children, legally adopted children, children of adopting parents pending finalization of adoption procedures, children who are medically certified as disabled and children for whom the Insured is required to insure under a medical support order issued under Chapter 154, Family Code, or enforceable by a court of this state.

Dependent children may also include a grandchild of the Insured who is less than age 25 and is a dependent on the Insured for federal income tax purposes at the time application for coverage is made. (Coverage for a grandchild may not be terminated solely because he or she is no longer a Dependent of the Insured for federal tax purposes).

Newborn Child Coverage: A child of the Insured born while the 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 is placed for adoption by the Insured or for whom the Insured is a party to a suit in which the Insured seeks to adopt such child while the 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 from the date of placement in the Insured's home or the date the Insured becomes a party to a suit to adopt the child. For coverage to continue beyond the initial 31-day period, the Insured must apply for coverage and pay any required premium within 31 days after the date of placement or the date that the Insured becomes a party in a suit in which adoption is sought or the adoption becomes final. However, coverage shall begin at the moment of birth if the petition for adoption, application for coverage and payment of premium occurs within 31 days after the child's birth. Such child's coverage will not be subject to any pre-existing conditions limitation provided by the policy. Coverage for such minor child will continue unless the petition for adoption is dismissed or denied. A child for which the Insured is a party in a suit in which the adoption of child is sought shall be deemed an adopted child.

Dependent Pursuant to Medical Support Order: Children for whom a parent is required to insure under a medical support order shall be covered for 31 days after receipt of such order or notice of such order from the Policyholder. For such child to be covered beyond the initial 31-day period, the parent, if not already enrolled, must enroll for coverage within 31 days after receipt of the medical support order or notice of such order from the Policyholder.

"Durable Medical Equipment" means medical equipment that can withstand repeated use, is prescribed by a Physician, 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 the policy is effective.

"Emergency" means the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

"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 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:

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.

“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 as stated in the Master Application and the policy, and whose coverage under the 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 the policy; and
2. Results directly and independently of all other causes in loss covered by the policy.

“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 complete inability of the Insured to perform all of the substantial and material duties and functions of the Insured's occupation and any other gainful occupation in which the Insured earns substantially the same compensation earned

before the disability. For Dependents, "Totally Disabled" means being confined as a bed patient in a hospital.

"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

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

1. The Insured meets the eligibility requirements set forth in the Master Application and the 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.

PART III - TERMINATION OF INSURANCE

Coverage of a Covered Person under the 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 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 the Policy;
 - C. Material misrepresentation, fraud, or omission of information on any application form, or in requesting the receipt of benefits under the Policy; or
 - D. Misuse of the Covered Person's identification card.

At the death of an Insured, all rights and privileges as a Covered Person under the 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 the 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 the 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 and We received all required premium for the Coverage Period, premium will be reimbursed to the Insured for the period of time, if any, between the date coverage terminates in accordance with the above provisions and the end of that Coverage Period.

Extension of Benefits

If a covered Bodily Injury or Sickness commences while the Policy is in force as to a Covered Person, benefits otherwise payable under the 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.

SPECIMEN

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 Administrative 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. However, if a claim is incurred during the Grace Period, such claim will be paid following a deduction for the applicable premium due.
5. The Policy does not share in the surplus earnings of the Company and no refund or assessment shall be made to the Policyholder, Insured, or Dependent of any excess or deficit earnings of the Company.

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 certificate, including reconstructive breast surgery and prosthetic devices incident to a Mastectomy, regardless of when the mastectomy was performed. 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.Coverage for a Medically Necessary mastectomy will include inpatient care for a Covered Person for a minimum of:
 - A. 48 hours following a mastectomy; or
 - B. 24 hours following a lymph node dissection for the treatment of breast cancer, unless the Covered Person and their Doctor agree that a shorter period of time is appropriate.
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 the 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 certificate;
 - 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 certificate.
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 certificate.
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 HCC Life Insurance Company at the telephone number contained in the Insured's certificate as soon as possible before the expense is to be incurred; and
 - B. Comply with the instructions of HCC Life Insurance 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 HCC Life Insurance 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 certificate. 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, HCC Life Insurance 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.

State Mandated Benefits.

The following benefits are mandated by applicable state law. All benefits will be subject to any inside benefit limitations set forth below, as well as the Coverage Period Maximum Benefit amounts shown on the Schedule of Benefits.

1. **Colorectal Cancer Screenings** - Coverage shall be provided for a medically recognized screening examination for the detection of colorectal cancer for each Covered Person who is 50 years of age or older and at normal risk for developing colon cancer. Benefits shall include:
 - A. A fecal occult blood test performed annually and a flexible sigmoidoscopy performed every 5 years; or
 - B. A colonoscopy performed every 10 years.
2. **Diabetic Supplies/Equipment and Self-Management Education** – Coverage shall be provided for equipment, supplies and related services for the treatment of Type I, Type II and gestational diabetes when recommended or prescribed by a Doctor for a Covered Person or the caretaker of a Covered Person:
 - A. Visual reading and urine testing strips and tablets which test for glucose, ketones and protein;

- B. Insulin pumps, both external and implantable, and associated appurtenances, which include: (a) batteries; (b) skin preparation items; (c) adhesive supplies; (d) infusion sets; (e) insulin cartridges; (f) durable and disposable devices to assist in the injection of insulin; and (g) other required disposable supplies;
- C. Insulin infusion devices;
- D. Podiatric appliances, including up to two pairs of therapeutic footwear, for prevention of complications associated with diabetes;
- E. Blood glucose monitors, including noninvasive glucose monitors and blood glucose monitors for the legally blind;
- F. Lancets and lancet devices;
- G. Test strips for glucose monitors;
- H. Insulin and insulin analog preparations;
- I. Injection aids, including devices used to assist with insulin injection and needleless systems;
- J. Glucagon emergency kits;
- K. Insulin syringes;
- L. Prescriptive and nonprescriptive oral agents for controlling blood sugar;
- M. Biohazard disposal containers;
- N. Repairs and necessary maintenance of insulin pumps not otherwise provided for under a manufacturer's warranty or purchase agreement, and rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which shall exceed the purchase price of similar replacement pump; and
- O. prescription drugs (bears the legend "Caution: Federal law prohibits dispensing without a prescription") and medications available without a prescription for controlling the blood sugar level.

Coverage shall also include diabetes self-management training prescribed by a Doctor, including Medically Necessary medical nutrition therapy relating to diet, caloric intake and diabetes management (excluding programs whose only purpose is weight reduction) only if that therapy is provided by a licensed health care professional with specialized training in diabetes management, including a licensed registered dietician or a licensed certified nutritionist, and that is limited to the following:

- A. Visits upon the diagnosis of diabetes;
- B. Medically Necessary changes in a Covered Person's self-management based on a Doctor's diagnosis representing a significant change in the Covered Person's symptoms or condition; and
- C. Visits for Medically Necessary re-education or refresher training.

Coverage shall also be provided for:

- A. Office visits and consultations with Doctors and practitioners for monitoring and treatment of diabetes, including office visits and consultations with appropriate specialists;
- B. Immunizations required by Insurance Code Article 21.53F, Coverage for Childhood Immunizations;
- C. Immunizations for influenza and pneumococcus;
- D. Inpatient services, and Doctor and practitioner services when the Covered Person is confined to a Hospital, rehabilitation facility, or a skilled nursing facility; and
- E. Inpatient and outpatient laboratory and diagnostic imaging services.

3. **Prostate Screening Tests** – Coverage shall be provided for an annual medically recognized diagnostic examination for the detection of prostate cancer for male Covered Persons as follows:
 - A. A physical examination for the detection of prostate cancer; and
 - B. A prostate-specific antigen test used for the detection of prostate cancer for each male Covered Person who is:
 - a. At least 50 years of age and asymptomatic; or
 - b. At least 40 years of age with a family history of prostate cancer or another prostate cancer risk factor.

4. **Telehealth Services and Telemedicine Medical Services** – Coverage shall be provided for telehealth services and telemedicine medical services, as defined below:

“Telehealth service” means a health service, other than a telemedicine medical service, delivered by a licensed or certified health professional acting within the scope of the health professional’s license or certification who does not perform a telemedicine medical service that requires the use of advanced telecommunications technology, other than by telephone or facsimile, including:

 - A. Compressed digital interactive video, audio, or data transmission;
 - B. Clinical data transmission using computer imaging by way of still-image capture and store and forward; and
 - C. Other technology that facilitates access to health care services or medical specialty expertise.

“Telemedicine medical service” means a health care service initiated by a Doctor provided by a health professional acting under Doctor delegation and supervision, for purposes of patient assessment by a health professional, diagnosis or consultation by a Doctor, treatment, or the transfer of medical data, that requires the use of advanced telecommunications technology, other than by telephone or facsimile, including:

 - A. Compressed digital interactive video, audio, or data transmission;
 - B. Clinical data transmission using computer imaging by way of still-image capture and store and forward; and
 - C. Other technology that facilitates access to health care services or medical specialty expertise.

5. **Osteoporosis** – Coverage shall be provided for bone mass measurement for the detection of low bone mass and to determine a “qualified individual’s” risk of osteoporosis and fractures associated with osteoporosis. As used here, a “qualified individual” means:
 - A. A postmenopausal woman who is not receiving estrogen replacement therapy;
 - B. An individual with:
 - a. Vertebral abnormalities;
 - b. Primary hyperparathyroidism; or
 - c. A history of bone fractures; or
 - C. An individual who is:
 - a. Receiving long-term glucocorticoid therapy; or
 - b. Being monitored to assess the response to or the efficacy of an approved osteoporosis drug therapy.

6. **Cranio Facial Abnormalities of a Child** – Coverage shall be provided for reconstructive surgery for craniofacial abnormalities for a child who is younger than 19 years of age. As used here, “reconstructive surgery for craniofacial abnormalities”

means surgery to improve the function of, or to attempt to create a normal appearance of an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.

7. **Acquired Brain Injury** – Coverage shall be provided for cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing or treatment, neurofeedback therapy, remediation, post-acute transition services, or community reintegration services necessary as a result of and related to an acquired brain injury.

For purposes here, the following definitions shall apply:

Cognitive communication therapy – Services designated to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information.

Cognitive rehabilitation therapy – Services designed to address therapeutic cognitive activities, based on an assessment and understanding of the individual's brain-behavioral deficits.

Community reintegration services – Services that facilitate the continuum of care as an affected individual transitions into the community.

Neurobehavioral testing – An evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and premorbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the individual, family, or others.

Neurobehavioral treatment – Interventions that focus on behavior and the variables that control behavior.

Neurocognitive rehabilitation – Services designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.

Neurocognitive therapy – Services designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities.

Neurofeedback therapy – Services that utilize operant conditioning learning procedure based on electroencephalography (EEG) parameters, and which are designed to result in improved mental performance and behavior, and stabilized mood.

Neurophysiological testing – An evaluation of the functions of the nervous system.

Neurophysiological treatment – Interventions that focus on the functions of the nervous system.

Neuropsychological testing – The administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning.

Neuropsychological treatment – Interventions designed to improve or minimize deficits in behavioral and cognitive processes.

Post-acute transition services – Services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.

Psychophysiological testing – An evaluation of the interrelationships between the nervous system and other bodily organs and behavior.

Psychophysiological treatment – Interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors.

8. **Chemical Dependency** – Coverage shall include expenses incurred for the treatment of Chemical Dependency on an outpatient or inpatient basis at a Chemical Dependency Treatment Facility, subject to a lifetime maximum of 3 separate series of treatments for each Covered Person. A series of treatments is a planned, structured, and organized program to promote chemical and alcohol free status which may include different facilities or modalities and is complete when the Covered Person is discharged on medical advice from inpatient detoxification, inpatient rehabilitation/treatment, partial hospitalization or intensive outpatient or series of these levels of treatments without a lapse in treatment or when a person fails to materially comply with the treatment program for a period of 30 days. As used here, "Chemical Dependency" means the abuse of, a psychological or physical dependence on, or an addiction to alcohol or a controlled substance.
9. **Serious Mental Illness** – Coverage shall be provided for the treatment of "serious mental illness," subject to the following calendar year limits:
 - A. 45 days of inpatient treatment; and
 - B. 60 visits for outpatient treatment, including group and individual outpatient treatment.As used here, "serious mental illness" means: schizophrenia; paranoid and other psychotic disorders; bipolar disorders (hypomaniac, manic, depressive, and mixed); major depressive disorders (single episode or recurrent); schizo-affective disorders (bipolar or depressive); pervasive developmental disorder; obsessive-compulsive disorders; and depression in childhood and adolescence.
Outpatient visits that relate to medication management will not count against the maximum number of outpatient visits allowed in a calendar year.
10. **Hearing Screening Tests** – Coverage shall be provided for screening tests for hearing loss from birth through the date the child is 30 days old, including any necessary diagnostic follow-up care related to the screening test from birth through the date the child is 24 months old. (This covered charge is not subject to any Deductible, but is subject to payment of any applicable coinsurance).

11. **Temporomandibular Joint** – Coverage shall be provided for diagnostic or surgical treatment of conditions affecting the temporomandibular joint if the treatment is Medically Necessary as a result of:
 - A. an accident;
 - B. a trauma;
 - C. a congenital defect;
 - D. a developmental defect; or
 - E. a pathology.
12. **Mammography Exam** – Coverage shall be provided for mammography screening, subject to the same terms and conditions as a Sickness covered under the policy (including the application of deductible amounts, benefit percentages, and benefit maximums), for a Covered Person age 35 and over.
13. **Childhood Immunizations** – Coverage shall be provided from birth through the date of a Dependent child's sixth birthday coverage for immunization against: (1) diphtheria; (2) haemophilus influenzae type b; (3) hepatitis B; (4) measles; (5) mumps; (6) pertussis; (7) polio; (8) rubella; (9) tetanus; (10) varicella; and (11) any other immunization that is required for the child by law. Coverage for childhood immunizations shall not be subject to any Deductible, coinsurance or co-payment.
14. **Papillomavirus and Cervical Cancer Testing** – Coverage shall be provided for an annual medically recognized diagnostic examination for the early detection of cervical cancer for female Covered Persons age 18 and older. Coverage includes a conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the United States Food and Drug Administration, alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus.

A screening test must be performed in accordance with the guidelines adopted by the American College of Obstetricians and Gynecologists or another similar national organization of medical professionals.

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 condition for which a Covered Person received medical treatment, diagnosis, care or advice within the twelve-month period immediately preceding such person's Effective Date are excluded for the first 12 months of coverage hereunder. This exclusion does not apply to a newborn or newly adopted child who is added to coverage under this certificate 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 the 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, child birth, and post natal care. (This exclusion does not apply to "Complications of Pregnancy" as defined.)
5. Alcoholism, except as provided under the State Mandated Benefit pertaining to Chemical Dependency.
6. Substance abuse, except as provided under the State Mandated Benefit pertaining to Chemical Dependency.
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 certificate.
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 certificate.

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, except as provided under the State Mandated Benefit pertaining to TMJ.
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. Injury resulting from being under the influence of or due wholly or partly to the effects of alcohol or drugs, other than drugs taken in accordance with treatment prescribed by a Doctor, but not for the treatment of Substance Abuse.
30. Willfully self-inflicted Injury or Sickness.
31. Venereal disease, including all sexually transmitted diseases and conditions (This exclusion will not be applicable to AIDS).
32. Immunizations (except as provided under the State Mandated Benefit pertaining to Childhood Immunizations or Diabetes) and Routine Physical Exams.
33. 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.
34. Speech, vocational, occupational, biofeedback, acupuncture, recreational, sleep or music therapy, holistic care of any nature, massage and kinestherapy.
35. Any services performed or supplies provided by a member of the Insured's Immediate Family.
36. Orthoptics and visual eye training.
37. Services or supplies which are not included as Eligible Expenses as described herein.
38. 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.
39. Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Doctor.
40. Treatment of sleep disorders.
41. 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.
42. Any services or supplies in connection with cigarette smoking cessation.
43. Exercise programs, whether or not prescribed or recommended by a Doctor.
44. Treatment required as a result of complications or consequences of a treatment or condition not covered under this certificate.
45. Charges for travel or accommodations, except as expressly provided for local ambulance.
46. Treatment incurred as a result of exposure to non-medical nuclear radiation and/or radioactive material(s).

47. Organ or Tissue Transplants or related services.
48. 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.
49. Services received or supplies purchased outside the United States, its territories or possessions, or Canada.
50. 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 certificate.
51. Spinal manipulation or adjustment.
52. Sclerotherapy for veins of the extremities.
53. 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. Herniorrhaphy; or
 - H. Cholecystectomy.
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. Any group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice, or individual practice coverage.
2. Any federal, state or local governmental programs, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time.)

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

The term "plan" does not include:

1. Individual or family insurance or subscriber contracts;
2. Individual or family coverage through Health Maintenance Organizations (HMOs);
3. Individual or family coverage under other prepayment, group practice and individual practice plans;
4. School accident-type coverages. (These contracts cover students for accidents only, including athletic injuries, either on a twenty-four hour basis or on a to-and-from school basis);
5. Group or group-type hospital indemnity benefits of \$100 per day or less;
6. Medicare Supplement policies;
7. A state plan under Medicaid.

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

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

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

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

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

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

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

Claim Forms: When the Administrator 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.

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 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 later than 60 days after our receipt of written 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 \$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 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 (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.

Payment to the Texas Department of Human Services: All benefits paid on behalf of the child or children under the policy must be paid to the Texas Department of Human Services whenever:

1. The Texas Department of Human Services is paying benefits under the Human Resources Code, Chapter 31, or Chapter 32, i.e. financial and medical assistance service programs administered pursuant to the Human Resources Code; and
2. The parent who is covered by the policy has possession or access to the child pursuant to a court order, or is not entitled to access or possession of the child and is required by the court to pay child support. We must receive at our home office written notice affixed to the insurance claim when the claim is first submitted stating that all benefits paid must be paid directly to the Texas Department of Human Services.

Benefits will not be reduced or denied because such benefits are covered by the Medical Assistance Act of 1967, as amended. Benefits will be paid to the Texas Department of Human Resources for the actual cost of medical expenses it pays through medical assistance for a person insured by the policy, if the Covered Person would otherwise be entitled to payment of benefits for such medical expenses. Benefits so paid, in no event, will exceed benefits otherwise payable under the policy. Any benefits payable for expenses not paid by such Department will be paid as provided in the policy.

Payment to Possessory or Managing Conservator of Dependent Child: For a minor child who otherwise qualifies as a Dependent of the Insured, benefits may be paid on behalf of the child to a person who is not the Insured if an order issued by a court of competent jurisdiction in this or any other state names such person the possessory or managing conservator of the child.

To be entitled to receive benefits, a possessory or managing conservator of a child must submit to us with the claim form, written notice that such person is the possessory or managing conservator of the child on whose behalf the claim is made and submit a certified copy of a court order establishing the person as the possessory or managing conservator. This will not apply in the case of any unpaid medical bill for which a valid assignment of benefits has been exercised or to claims submitted by the Insured where the Insured had paid any portion of a medical bill that would be covered under the terms of the policy.

PART IX – GENERAL PROVISIONS

Time Limit on Certain Defenses: The validity of coverage issued under the Policy with respect to an Insured or his Eligible Dependents may not be contested after two years from each certificate'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: 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.

PART X – SCHEDULE OF BENEFITS

INSURED INFORMATION:

Name: John Doe

Policy Effective Date: January 1, 2008

COVERAGE PERIOD: [1-12 months]

ELIGIBLE DEPENDENTS COVERED [Janet Doe, Junior Doe, Juniorette Doe]

COVERAGE AND BENEFIT AMOUNTS:

Deductible	<p>[\$250, \$500, \$1,000, \$2,500, \$5,000 or \$7,500] per Covered Person per Coverage Period. Maximum of 3 Deductibles per family per Coverage Period.</p> <p>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.</p>
Coinsurance	<p>During a Coverage Period, the Company will pay [50 - 80%] of the next \$5,000 of Eligible Expenses after the Deductible, then 100% of Eligible Expenses to the Overall Maximum Limit.</p>
Urgent Care Center	<p>For each visit, the Covered Person shall be responsible for a \$50 co-payment, after which Coinsurance will apply. Not subject to Deductible</p>
Hospital Room and Board	<p>Average Semi-private room rate, including nursing services.</p>
Local Ambulance	<p><u>Injury</u>: Usual and Customary charges to a Maximum of \$250 per trip, when related to a covered Injury. <u>Sickness</u>: Usual and Customary charges to a maximum of \$250 per trip, when covered Sickness results in hospitalization as Inpatient</p>
Intensive Care Unit	<p>Usual and Customary charges</p>
Physical Therapy	<p>\$50 Maximum per visit per day</p>

Mental and Nervous Disorders	<u>Outpatient Treatment:</u> \$50 Maximum per visit, Maximum 10 visits per Coverage Period <u>Inpatient Treatment:</u> \$100 Maximum per day, Maximum 31 days per Coverage Period
Home Health Care	Maximum 1 visit per day. Maximum of 60 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	\$1,000,000, \$1,500,000, or \$2,000,000

Optional Riders:

Hospital Confinement Indemnity Benefit \$75.00 per day, subject to a maximum of [30] days per Coverage Period