Filing at a Glance

Company: World Insurance Company

Product Name: Association Group Major Medical

SERFF Tr Num: AMRP-125470057

State: ArkansasLH

TOI: H16G Group Health - Major Medical

SERFF Status: Closed

State Tr Num: 38265

Sub-TOI: H16G.001A Any Size Group - PPO

Co Tr Num: AC4800W

State Status: Approved-Closed

Filing Type: Form

Co Status:

Reviewer(s): Rosalind Minor

Authors: Norm Von Seggern, Beverly Shuey

Disposition Date: 03/31/2008

Date Submitted: 02/26/2008

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name:

Status of Filing in Domicile: Pending

Project Number: AC4800W

Date Approved in Domicile:

Requested Filing Mode:

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Overall Rate Impact:

Group Market Type: Association, Other

Filing Status Changed: 03/31/2008

State Status Changed: 04/30/2008

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

Please refer to attached cover letter.

Company and Contact

Filing Contact Information

Norm Von Seggern, Product Analyst 4
P. O. Box 3160
Omaha, NE 68103-0160

norm.von.seggern@americanenterprise.com
(402) 496-8289 [Phone]
(402) 496-8040[FAX]

Filing Company Information

World Insurance Company	CoCode: 70629	State of Domicile: Nebraska
11808 Grant Street	Group Code: 3527	Company Type:
Omaha, NE 68103-8000	Group Name:	State ID Number:
(402) 496-8289 ext. [Phone]	FEIN Number: 47-0339860	

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
World Insurance Company	$50.00	02/26/2008	18170516

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	03/31/2008	03/31/2008

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	**Created By**	**Created On**	**Date Submitted**	**Responded By**	**Created On**	**Date Submitted**
Pending Industry Response	Rosalind Minor	02/29/2008	02/29/2008	Norm Von Seggern	03/03/2008	03/26/2008

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Your Note to Reviewer	Note To Filer	Rosalind Minor	03/03/2008	03/03/2008
A4800W	Note To Reviewer	Norm Von Seggern	03/03/2008	03/03/2008

Disposition

Disposition Date: 03/31/2008

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AMRP-125470057*	*State:*	*Arkansas*
Filing Company:	*World Insurance Company*	*State Tracking Number:*	*38265*
Company Tracking Number:	*AC4800W*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.001A Any Size Group - PPO*
Product Name:	*Association Group Major Medical*		
Project Name/Number:	*/AC4800W*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Supporting Document	Certification	Approved-Closed	Yes
Supporting Document	Association Membership and Association Documents	Approved-Closed	Yes
Form *(revised)*	Certificate of Coverage	Approved-Closed	Yes
Form	Certificate of Coverage	Withdrawn	No
Form	State Mandated Benefits Rider	Approved-Closed	Yes
Form	Optional	Approved-Closed	Yes
Form	Optional	Approved-Closed	Yes
Form	Optional	Approved-Closed	Yes
Form	Optional	Approved-Closed	Yes
Form	Optional	Approved-Closed	Yes
Form	Optional	Approved-Closed	Yes
Form	Optional	Approved-Closed	Yes
Form	Optional	Approved-Closed	Yes
Form	Optional	Approved-Closed	Yes
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Form	Optional	Approved-Closed	Yes
Form	Optional	Approved-Closed	Yes
Form	Optional	Approved-Closed	Yes
Form	Optional	Approved-Closed	Yes

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	02/29/2008
Submitted Date	02/29/2008
Respond By Date	

Dear Norm Von Seggern,

This will acknowledge receipt of the captioned filing.

Objection 1

- Certificate of Coverage (Form)

Comment: Under the language for Dependents and with respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-86-108(4) and Bulletin 14-81.

Objection 2

- Certificate of Coverage (Form)

Comment: Our Conversion Law, ACA 23-86-115 does not have a provision that the insured must be covered for 3-months prior to termination.

Objection 3

- Optional (Form)
- Optional (Form)
- Optional (Form)
- Optional (Form)

Comment: The co-pay for a participating mail order provider must be three (3) times the applicable prescription drug copayment.

Please feel free to contact me if you have questions.
Sincerely,
Rosalind Minor

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	03/03/2008
Submitted Date	03/26/2008

Dear Rosalind Minor,

Comments:

Response 1

Comments: Good morning, Rosalind

Thank you for your letter of March 3rd regarding the above-captioned filing. I will answer your questions in the order in which they were asked.

1) I have attached the answers to the specific questions asked in reference to the Association. The Association By-laws and other documentation are attached.
2) The certificate was amended to comply with the requirements of ACA 23-86-108(4) and Bulletin 14-81.
3) I have attached the certification required by Bulletin 9-85.
4) Exclusion #27 was amended to reference the "attachment of the Outpatient Prescription Drug Rider.
5) It appears that the 3 month requirement under the "continuation" section of the provision titled Continuation and Conversion would be permissible. I mention this pursuant to the requirements outlined in 23-86-114, and I quote:
"Group accident and health insurance -- Continuation of coverage beyond termination of employment, change in marital status, etc. (a) Every group accident and health insurance policy, contract, or certificate providing hospital, surgical, or major medical coverage, other than accident only or specified disease policies, shall contain a provision that any certificate holder, member, or spouse whose coverage under the policy would otherwise terminate due to termination of employment or membership or a change in marital status may continue coverage under the policy for themselves and their eligible dependents as provided in this section.

(b) The continued coverage need not include benefits for dental care, vision services, or prescription drug expenses.

(c) (1) Continuation of coverage shall be available only to individuals who have been insured continuously under the group policy during the three-month period prior to the termination of employment membership or change in marital status."
Such statute references the 3-month period noted in our provision.

Item 6b of the Conversion provision was amended to comply with ACA 23-86-115(a)(3).

Your continued review will be greatly appreciated.

Thanks, Norm

Related Objection 1

Applies To:

- Certificate of Coverage (Form)

Comment:

Under the language for Dependents and with respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-86-108(4) and Bulletin 14-81.

Related Objection 2

Applies To:

- Certificate of Coverage (Form)

Comment:

Our Conversion Law, ACA 23-86-115 does not have a provision that the insured must be covered for 3-months prior to termination.

Related Objection 3

Applies To:

- Optional (Form)
- Optional (Form)
- Optional (Form)
- Optional (Form)

Comment:

The co-pay for a participating mail order provider must be three (3) times the applicable prescription drug copayment.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Certification

Comment:

Satisfied -Name: Association Membership and Association Documents

Comment:

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Certificate of Coverage	AC4800W		Certificate	Initial		0	AC4800W

					(certbook for Arkansas) (03-25).pdf

Previous Version

Certificate of Coverage	*AC4800W*	*Certificate*	*Initial*	*0*	AC4800W (certbook for ARkansas).pdf

No Rate/Rule Schedule items changed.

Response 2

Comments: Good morning, Rosalind

Thank you for your letter of March 3rd regarding the above-captioned filing. I will answer your questions in the order in which they were asked.

1) I have attached the answers to the specific questions asked in reference to the Association. The Association By-laws and other documentation are attached.
2) The certificate was amended to comply with the requirements of ACA 23-86-108(4) and Bulletin 14-81.
3) I have attached the certification required by Bulletin 9-85.
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Item 6b of the Conversion provision was amended to comply with ACA 23-86-115(a)(3).

Your continued review will be greatly appreciated.

Thanks, Norm

Related Objection 1

Applies To:

- Certificate of Coverage (Form)

Comment:

Under the language for Dependents and with respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-86-108(4) and Bulletin 14-81.

Related Objection 2

Applies To:

- Certificate of Coverage (Form)

Comment:

Our Conversion Law, ACA 23-86-115 does not have a provision that the insured must be covered for 3-months prior to termination.

Related Objection 3

Applies To:

- Optional (Form)
- Optional (Form)
- Optional (Form)
- Optional (Form)

Comment:

The co-pay for a participating mail order provider must be three (3) times the applicable prescription drug copayment.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Sincerely,
Beverly Shuey, Norm Von Seggern

Note To Filer

Created By:

Rosalind Minor on 03/03/2008 02:39 PM

Subject:

Your Note to Reviewer

Comments:

As discussed in our telephone conversation on this date, please refer to my comments under my objection on american Republic Insurance Co. All comments under the American Republic filing will also apply to the World Insurance Company filing.

Thanks.

Note To Reviewer

Created By:

Norm Von Seggern on 03/03/2008 12:46 PM

Subject:

A4800W

Comments:

Hello, Rosalind ... thank you for your recent letter regarding the above-captioned filing.

I have one question, before providing a response to your letter. In your letter, you reference that the Mail order Copay on the RX riders should be 3 times ... it is our intent to only require 2 copays if RX is ordered via Mail. Please let me know if this is a specific requirement or if we can use the 2 times ... which would be a benefit to the insured.

Thanks, Norm

Form Schedule

Lead Form Number: AC4800W

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	AC4800W	Certificate	Certificate of Coverage	Initial		0	AC4800W (certbook for Arkansas)(03-25).pdf
Approved-Closed	R4800W-AR	Certificate Amendment, Insert Page, Endorsement or Rider	State Mandated Benefits Rider	Initial		0	R4800W-AR (State Mandated Benefits Rider).pdf
Approved-Closed	R4801W	Certificate Amendment, Insert Page, Endorsement or Rider	Optional	Initial		0	R4801W (Accident Exp Ben Rdr).pdf
Approved-Closed	R4802W	Certificate Amendment, Insert Page, Endorsement or Rider	Optional	Initial		0	R4802W (Accidental Death Ben Rdr).pdf
Approved-Closed	R4803W	Certificate Amendment, Insert Page, Endorsement or Rider	Optional	Initial		0	R4803W (Critical Illness Ben Rdr).pdf
Approved-Closed	R4804W	Certificate Amendment, Insert Page,	Optional	Initial		0	R4804W (Decreasing Deductible Rdr).pdf

		Endorsement or Rider				
Approved-Closed	R4805W	Certificate Amendment, Insert Page, Endorsement or Rider	Optional	Initial	0	R4805W (Good Health, Premium Discount Rdr).pdf
Approved-Closed	R4806W	Certificate Amendment, Insert Page, Endorsement or Rider	Optional	Initial	0	R4806W (Good Health, Refund of Prem Rdr).pdf
Approved-Closed	R4808W	Certificate Amendment, Insert Page, Endorsement or Rider	Optional	Initial	0	R4808W (Office Visit Benefit Rdr).pdf
Approved-Closed	R4808W-1	Certificate Amendment, Insert Page, Endorsement or Rider	Optional	Initial	0	R4808W-1 (Office Visit Ben Rdr, x-ray lab.pdf
Approved-Closed	R4809W	Certificate Amendment, Insert Page, Endorsement or Rider	Optional	Initial	0	R4809W (Convalescent Care Rdr).pdf
Approved-Closed	R4810W-AR	Certificate Amendment, Insert Page, Endorsement or Rider	Optional	Initial	0	R4810W-AR (Rx1-Deductible and Coins Rider).pdf

Approved-Closed	R4811W-AR	Certificate Amendment, Insert Page, Endorsement or Rider	Optional	Initial	0	R4811W-AR (Rx2-Generic Only Rider).pdf
Approved-Closed	R4812W-AR	Certificate Amendment, Insert Page, Endorsement or Rider	Optional	Initial	0	R4812W-AR (Rx3-Generic w-Specialty Rider).pdf
Approved-Closed	R4813W-AR	Certificate Amendment, Insert Page, Endorsement or Rider	Optional	Initial	0	R4813W-AR (Rx4-3T w-Specialty,Copay Rider).pdf
Approved-Closed	R4814W	Certificate Amendment, Insert Page, Endorsement or Rider	Optional	Initial	0	R4814W (Wellness Rider).pdf
Approved-Closed	R4815W	Certificate Amendment, Insert Page, Endorsement or Rider	Optional	Initial	0	R4815W-AR (Maternity Exp Ben Rdr).pdf
Approved-Closed	R4816W	Certificate Amendment, Insert Page, Endorsement or Rider	Optional	Initial	0	R4816W (Term Life Insurance Rider).pdf
Approved-Closed	R4817W-AR	Certificate Amendmen	Optional	Initial	0	R4817W-AR (Alcoholism-

t, Insert Page, Endorsement or Rider

Substance Abuse Trtmnt Ben Rdr).pdf

P.O. Box 3160
Omaha, NE 68103-0160
(402) 496-8000

Certificate of Coverage

World Insurance certifies that the Member is insured as of the Issue Date shown on the Validation of Coverage page, subject to the terms and conditions of the Group Insurance Policy issued to the Policyholder, shown on the Validation of Coverage.

When we use “we,” “us,” or “our,” we mean World Insurance Company; and when we use “you” or “your,” we mean the person named as Member on the Validation of Coverage page.

This Certificate explains, in general, the terms of your coverage. However, when reading this Certificate, remember that decisions regarding a Covered Person’s medical Treatment are between the Covered Person and his or her Physician.

This Certificate is not being sold as an employment benefit plan and the Member’s employer is not responsible, either directly or indirectly, for paying the premium or benefits.

This Certificate describes, in general terms, the principal features of the insurance. Nothing in this Certificate will waive or alter any of the terms or conditions of the Group Insurance Policy, and if any discrepancies, misprint of certificates, or change in benefits occur, the Group Insurance Policy will govern.

No statement made by any of our representatives if in conflict with this Certificate or the provisions of the Group Insurance Policy shall be binding on us.

Eligibility for the benefits provided by this Certificate is based on: a) your being a member of the Policyholder; and b) the information you provided on the Application.

Important Notice: This Certificate was issued on the basis of the information provided on your Application, a copy of which is attached. Please read the Application carefully. If there is any misstatement on the Application, or if any past medical history has been omitted, you must write to us within 10 days regarding the incorrect or omitted information; otherwise, this Certificate may not be valid.

Signed for World Insurance Company on the Policy Date

Michael E. Abbott
President

Mary K. Durand
Secretary

Table of Contents

Validation of Coverage

Schedule of Benefits

Section I. Definitions

Section II. Benefit Provisions

Section III. General Exclusions and Limitations

Section IV. Certificate Provisions

Section V. Claim Provisions

Section VI. Continuation and Conversion

[VALIDATION OF COVERAGE

POLICYHOLDER:	Association Name
MEMBER:	John Doe
CERTIFICATE NUMBER:	0001234567
ISSUE DATE:	02/01/2008
COVERED PERSONS	
COVERED MEMBER:	John Doe
COVERED DEPENDENTS:	Dependent 1 Name
	Dependent 2 Name
BENEFIT INFORMATION	See Schedule of Benefits
PREMIUM INFORMATION	
FIRST PREMIUM:	$500.00
PREMIUM FREQUENCY:	Monthly]

SCHEDULE OF BENEFITS

This Schedule of Benefits (Schedule) provides important information about the benefits you have selected and out-of-pocket expenses for which you are responsible when you Incur Covered Expenses under your Certificate.

SECTION 1. Maximum Benefits

Maximum Lifetime Benefit

Maximum cumulative amount we will ever pay in benefits for your Covered Expenses: ..... [$250,000-$25,000,000]

[Calendar Year Maximum Benefit

Maximum amount we will pay in benefits during a Calendar Year for your Covered Expenses: ..... [$None/$100,000/$250,000, $500,000/$1,000,000/$5,000,000]]

SECTION 2. Your Out-of-Pocket Expenses

Your out-of-pocket expenses are the amounts you must pay each Calendar Year before Covered Expenses are payable at 100% for the remainder of the Calendar Year. Depending on the benefit for which you are making a claim under this Certificate, you are responsible for paying one of (or a combination of) the following amounts before we have an obligation to pay benefits related to the claim.

Deductibles

Individual Deductible (per Calendar Year per Covered Person)

Participating Provider: ..... [0,$500, $1,000, $1,500, $2,000, $2,500, $3,000, $3,500, $4,000, $5,000, $6,000, $7,500, $10,000, $12,500, $15,000, $20,000, $25,000]

Nonparticipating Provider: ..... [0, $1,000, $2,000, $3,000, $4,000, $5,000, $6,000, $7,000, $8,000, $10,000, $12,000, $15,000, $20,000, $25,000, $30,000, $40,000, $50,000]

Family Deductible (per Calendar Year)

Participating Provider: ..... [$ *(Two/Three times the above Individual Deductible for Participating Provider)*]

Nonparticipating Provider: [$ *(Two/Three times the above Individual Deductible for Nonparticipating Provider)*]

When [two/three] family members have each satisfied a Calendar Year Deductible in a Calendar Year for a particular type of Provider (Participating or Nonparticipating), no further Deductible(s) will apply for the remainder of that Calendar Year for that type of Provider.

Coinsurance Percentage

Calendar Year Coinsurance Percentage

For Covered Expenses that are subject to the Certificate's Deductible and Coinsurance, after you have satisfied the appropriate Deductible, you are responsible for paying Coinsurance as follows. After you satisfy your Coinsurance obligation, we will pay 100% of the remainder of Covered Expenses through the end of the Calendar Year.

Participating Provider: ..... [30%/20%/10%/0%] of the next [$10,000/$20,000]

Nonparticipating Provider: ..... [50%/40%/30%/20%] of the next [$20,000/$40,000]

Copayment Amounts

(Copayment amounts do not apply toward satisfying the Deductible, Coinsurance Percentage amount or Out-of-Pocket Limit.)

Office Visit Copayment

Participating Provider: ..... [$30/$40/$50/N/A - Covered Expenses are subject to the Certificate's Participating Provider Deductible and Coinsurance Percentage [and number of waived Copayments]

Nonparticipating Provider: ..... N/A - Covered Expenses are subject to the Certificate's Nonparticipating Provider Deductible and Coinsurance Percentage

Access Fees

(Access Fees do not apply toward satisfying the Deductible, Coinsurance Percentage amount or Out-of-Pocket Limit.)

Emergency Room Access Fee

Participating and Nonparticipating Providers: ..... [$75]

(This Access Fee will be waived if the Covered Person is admitted directly from the emergency room into the Hospital as an Inpatient.)

Or

Emergency Benefit

Participating Provider

Emergency Room Access Fee per visit:..... [$150]*

Maximum amount we pay for an emergency room visit:..... [$1,000]

Covered Expense in excess of the Calendar Year Maximum is subject to the Certificate's Participating Provider Calendar Year Deductible and Coinsurance Percentage.

Nonparticipating Provider

Emergency Room Access Fee per visit: ..... [$150]*
Maximum amount we pay for an emergency room visit: ..... [$1,000]
Covered Expense in excess of the Emergency Room Access Fee is subject to the Certificate's Nonparticipating Provider Calendar Year Deductible and Coinsurance Percentage.

* The Emergency Benefit Access Fee amount will not be applied to the Certificate's Participating or Nonparticipating Provider Calendar Year Deductibles or to any Out-of-Pocket Limit.

[**Covered Diagnostic X-ray and Laboratory Access Fee**
(This Access Fee does not apply to Covered Expenses under any other benefit provision or limitation such as Treatment for Allergies; Spinal Manipulation; Occupational, Speech or Physical Therapy; and Mental or Nervous Disorders, if applicable. Any other services, such as office surgeries, processing, or reading charges are subject to the Certificate's Calendar Year Deductible and Coinsurance Percentage amount.)

Participating Provider: ..... [100% of the first $150 of Covered Expenses per Covered Person per Calendar Year; remainder subject to the Certificate's Participating Provider Calendar Year Deductible and Coinsurance Percentage.]

Nonparticipating Provider: ..... Covered Expenses are subject to the Certificate's Non-participating Provider Calendar Year Deductible and Coinsurance Percentage]

Your Out-of-Pocket Limit
Subject to the certificate's provisions, exclusions and limitations, the maximum amount a Covered Person will have to pay during a Calendar Year for Covered Expenses:

Participating Providers: ..... [$000000]

Nonparticipating Providers: ..... [$000000]

[(If product is an HSA, this statement must be included on Schedule)

PLEASE NOTE: ON EACH JANUARY 1ST, THE DEDUCTIBLE AND THE OUT-OF-POCKET LIMIT ARE INDEXED FOR INFLATION IN $50 INCREMENTS, BASED ON THE NATIONAL CONSUMER PRICE INDEX. A CHANGE IN THE DEDUCTIBLE AND THE OUT-OF-POCKET COVERED EXPENSE LIMIT MAY AFFECT THE DOLLAR AMOUNTS SHOWN UNDER THE SECTION TITLED "YOUR OUT-OF-POCKET LIMIT."]

SECTION 3. Our Maximum Obligation for Each Type of Benefit

Subject to the Certificate's provisions, exclusions and limitations, after you have satisfied your out-of-pocket obligation(s) in Section 2 above, our responsibility to pay for a particular benefit is described below.

INPATIENT TREATMENT

This benefit is subject to the certificate's Deductible and Coinsurance. Subject to other provisions, exclusions, and limitations in your certificate, once you have satisfied the applicable Deductible and Coinsurance Percentage, we will pay benefits for Inpatient Covered Expenses.

OTHER BENEFITS

Transplants
(This benefit subject to Certificate Deductible and Coinsurance.)

Transplants performed at a Center of Excellence (COE)

Maximum lifetime amount we pay for this benefit per Covered Person at a COE..... [$1,000,000 / N/A]

Maximum amount we pay per Covered Person per Transplant at a COE:..... [$500,000 / N/A]

[Maximum transportation and living expenses we pay per covered transplant:..... $5,000]

Transplants not performed at a COE

Maximum lifetime amount we pay for this benefit per transplant per Covered Person:..... [$100,000]

Maximum amount we pay per Covered Person per transplant at a Non-COE: ..... [$100,000]

Acute Rehabilitation..... This benefit subject to Certificate Deductible and Coinsurance.

Ambulance Service

[Local Ground Ambulance..... Included/Not Included]

[Air Ambulance..... $5,000]

(and – if applies) [per covered Illness or Injury]

(or – if applies) [per Covered Person per Calendar Year]

(and – if applies) [due to a life-threatening Illness or Injury]

(or) [Not Included]

(and – if applies) [Subject to Certificate's Deductible and Coinsurance]

[**Emergency Foreign Travel Benefit**
(This benefit subject to Certificate Deductible and Coinsurance)
[Maximum lifetime amount we pay for all
covered Illnesses and/or Injuries under this benefit: ..... $100,000]

Home Health Care
(This benefit subject to Certificate Deductible and Coinsurance)
Maximum number of Home Health Care Visits per Calendar Year: ... [40]

Hospice Treatment and Services
(This benefit subject to Certificate Deductible and Coinsurance)
Maximum we pay for Outpatient Hospice benefits, per day: ..... [$100]
Maximum we pay for Treatment and Room and Board Expenses
while an Inpatient in a Hospice Facility, per day: ..... [$200]
Maximum lifetime benefit we pay for Inpatient and Outpatient
Hospice Treatment (combined): ..... [$5,000]

Outpatient Occupational, Physical and Speech Therapy
(This benefit subject to Certificate Deductible and Coinsurance)
Maximum we pay per visit: ..... [$50]
Maximum we pay for all three types of therapy (combined),
per Covered Person per Calendar Year: ..... [$2,000]

Skilled Care Facility Benefit
(This benefit subject to Certificate Deductible and Coinsurance)
Maximum number of days we pay per Calendar Year: ..... [60]

Spinal Manipulation
(This benefit subject to Certificate Deductible and Coinsurance)
Maximum we pay per day of Treatment (does not include x-rays): ..... [$25]
Maximum for all Treatments and x-rays under this benefit,
per Covered Person, per Calendar Year: ..... [$500]

[Sterilization
(This benefit subject to Certificate Deductible and Coinsurance)
Maximum lifetime amount we pay for this benefit,
per Covered Person: ..... [$500]]

[Treatment of Allergies
(This benefit subject to Certificate Deductible and Coinsurance)
Maximum amount we pay for this benefit, per Covered Person,
per Calendar Year: ..... [$500]]

[**Treatment for Sleep Apnea**
(This benefit subject to Certificate Deductible and Coinsurance)
Maximum lifetime benefit we will pay, per Covered Person: ..... [$15,000]]

[**Treatment for Growth Disorders**
(This benefit subject to Certificate Deductible and Coinsurance)
Maximum lifetime benefit we will pay,
per Covered Dependent child ..... [$15,000]

OPTIONAL RIDERS

[Accident Expense Benefit
Maximum amount we pay for this benefit, per Covered Person,
per Calendar Year:..... [$500/$1,000/$1,500/$2,000/
$2,500/$3,000/$5,000]]

[Accidental Death Benefit
Maximum amount we pay for this benefit..... [$00000]]

[Convalescent Care Benefit (Short Term)
(This benefit subject to Certificate Deductible and Coinsurance)
Maximum Benefit Period
(number of days per Calendar Year for which we pay benefit): ..... [XX days]
Elimination Period:..... [XX days]
Daily Benefit Amount
(maximum amount per day we pay for this benefit): ..... [$00]]

[Critical Illness Benefit
Critical Illness Maximum Lifetime Benefit..... [$25,000]

Specified Critical Illness and Specified Surgeries	Percentage of Critical Illness Maximum Benefit Payable
Angioplasty	[10%]
Blindness	[100%]
Coronary Artery Bypass Surgery	[25%]
End Stage Renal Failure	[100%]
Heart Attack	[100%]
Life-Threatening Cancer	[100%]
Loss of Limbs	[100%]
Major Organ Transplant Surgery	[100%]
Multiple Sclerosis	[100%]
Permanent Paralysis	[100%]
Stroke	[100%]]

[Decreasing Deductible
First Certificate Year Decrease ..... [$000]
Second Certificate Year Decrease ..... [$000]]

[Maternity Expense Benefit
Maternity Waiting Period..... [00 days]
Maternity Benefit Deductible Amount..... [$000]
Maternity Benefit Percentage..... [00%]]

[**Office Visit Benefit**
Maximum benefit amount we pay,
per Covered Person, per visit (after Copayment) ..... [$25/$50/$75/$100/$125]
[Maximum number of visits for which we will pay,
per Covered Person, per Calendar Year: ..... [XX]]
Office Visit Waiting Period:..... [XX months]]

[Premium Discount for Good Health..... Included]

[Refund of Premium for Good Health]

Consecutive Calendar Years	Specified Percentage
First	[5%]
Second	[10%]
Third and thereafter	[15%]]

[Wellness Benefit

Wellness Services Annual Maximum
Maximum we pay per Covered Person per Calendar Year: ..... [$0000]

[Waiting Period before this benefit is available ..... [None, 6 months, 12 months]]

or

[Wellness Benefit

[Participating Provider
Covered Expenses are subject to the Participating Provider
Calendar Year Deductible and Coinsurance Percentage to: ..... [$500]]

[Nonparticipating Provider
Covered Expenses are subject to the Nonparticipating Provider
Calendar Year Deductible and Coinsurance Percentage]

[Preventive Dental Services ..... [$50/$75/$100 applied against Wellness Benefit Maximum

[Waiting Period before this benefit is available ..... [None, 6 months, 12 months]]

[Term Life Insurance Rider]

Life Insurance Benefit Amount

Insured	[$15,000/$25,000…]
Covered Dependent	[$7,500/$12,500
Covered Dependent Child - 14 days to 6 months old	[$250/$500]
Covered Dependent Child – 6 months to 18 years old	[$1,000/$2,000]

Persons named here are covered under the rider:

[Insured	Name]
[Covered Dependent]	Name]
[Covered Dependent Child/Children]	Child Name 1]
	[Child Name 2]
	[Child Name 3, etc.]

[

SCHEDULE OF BENEFITS
FOR
OUTPATIENT PRESCRIPTION DRUG BENEFIT

SECTION 1. Maximum Benefits

[Amounts we pay for Outpatient Prescription Drugs and Specialty Medications apply toward the Certificate's Calendar Year Maximum.]

or

[Amounts we pay for Outpatient Prescription Drugs and Specialty Medications apply toward the Certificate's Maximum Lifetime Benefit.]

SECTION 2. Your Out-of-Pocket Expenses

Prescription Drugs and Specialty Medications are subject to the Certificate's applicable Deductible and Coinsurance Percentage.

SECTION 3. Our Maximum Obligation for Prescription Drugs

For this benefit, once you have satisfied your certificate's Calendar Year Deductible and Coinsurance percentage, if any, charges for Prescription Drugs and Specialty Medications will be covered, during the same Calendar Year, according to the provisions of your certificate.]

[

SCHEDULE OF BENEFITS
FOR
OUTPATIENT PRESCRIPTION DRUG BENEFIT
(Generic Drugs Only)

SECTION 1. Maximum Benefits

Prescription Drug Maximum
[Maximum amount we will pay for Outpatient Prescription Drugs, per Covered Person, per Calendar Year: ..... [$0000]

or [Amounts we pay for Outpatient Prescription Drugs apply toward the Certificate's Calendar Year Maximum.]

or [Amounts we pay for Outpatient Prescription Drugs apply toward the Certificate's Maximum Lifetime Benefit.]

SECTION 2. Your Out-of-Pocket Expenses

For Outpatient Prescription Drugs, you are responsible for one of (or a combination of) the following amounts before we have any obligation to pay benefits.

Prescription Drug Deductible
[Amount of Covered Expenses each Covered Person must pay for Outpatient Prescription Drugs in a Calendar Year: ..... $100/$200/$300/$400/$500]
or
..... [This deductible does not apply to your certificate.]

Then

[Prescription Drug Copayment (and/or Prescription Drug Percentage)
Amount of Covered Expenses each Covered Person must pay to the pharmacy each time a Generic Drug prescription is filled or refilled before we pay benefits.
You pay the higher of: ..... [$10] Prescription Drug Copayment or [20%] Prescription Drug Percentage]

SECTION 3. Our Maximum Obligation for Prescription Drugs

For this benefit, we will pay 100% of Covered Prescription Expenses after applying the Prescription Drug Deductible, if any, and Prescription Drug Copayment [and/or Prescription Drug Percentage], if any, up to the Prescription Drug Maximum.]

[

SCHEDULE OF BENEFITS
FOR
OUTPATIENT PRESCRIPTION DRUG BENEFIT
(Generic Drugs and Specialty Medications)

SECTION 1. Maximum Benefits

Prescription Drug Maximum
[Maximum amount we will pay for Outpatient Prescription Drugs, per Covered Person, per Calendar Year: ..... [$0000]

or [Amounts we pay for Outpatient Prescription Drugs apply toward the Certificate's Calendar Year Maximum.]

or [Amounts we pay for Outpatient Prescription Drugs apply toward the Certificate's Maximum Lifetime Benefit.]

Section 2. Your Out-of-Pocket Expenses

For Outpatient Prescription Drugs, you are responsible for one of (or a combination of) the following amounts before we have any obligation to pay benefits.

Prescription Drug Deductible

Generic Prescription Drugs
[Amount of Covered Expenses each Covered Person must pay for Outpatient Prescription Drugs in a Calendar Year: ..... $100/$200/$300/$400/$500]
or
..... [This deductible does not apply to your certificate.]

Specialty Medications
Specialty Medications are subject to the **Certificate's** Deductible and Coinsurance Percentage.

[Prescription Drug Copayment (and/or Prescription Drug Percentage)

Generic Prescription Drugs
Amount of Covered Expenses each Covered Person must pay to the pharmacy each time a Generic Drug prescription is filled or refilled before we pay benefits.
You pay the higher of: ..... [$10] Prescription Drug Copayment or [20%] Prescription Drug Percentage]
or ..... [This copayment and/or percentage does not apply to your certificate.]

Specialty Medications
Specialty Medications are subject to the **Certificate's** Deductible and Coinsurance Percentage.

SECTION 3. Our Maximum Obligation for Prescription Drugs

Generic Prescription Drugs
For this benefit, we will pay 100% of Covered Prescription Expenses after applying the Prescription Drug Deductible, if any, and Prescription Drug Copayment [and/or Prescription Drug Percentage], if any, up to the Prescription Drug Maximum.

Specialty Medications
For this benefit, once you have satisfied your Certificate's Calendar Year Deductible and Coinsurance Percentage, charges for Specialty Medications will be covered, during the same Calendar Year, according to the provisions of your Certificate. Amounts we pay for this benefit are applied toward the Certificate's Maximum Lifetime Benefit.]

[

SCHEDULE OF BENEFITS
FOR
OUTPATIENT PRESCRIPTION DRUG BENEFIT
(3-Tier and Specialty Medications)

SECTION 1. Maximum Benefits

Prescription Drug Maximum

[Maximum amount we will pay for
Generic Prescription Drugs per Covered Person,
per Calendar Year: .....[None]

Brand Name Formulary/Brand Name Nonformulary
Prescription Drugs, per Covered Person,
per Calendar Year: .....[NA/$500, NA/$1,000, NA/$2000]]

or [Amounts we pay for Outpatient Prescription Drugs apply toward the Certificate's Calendar Year Maximum.]

or [Amounts we pay for Outpatient Prescription Drugs apply toward the Certificate's Maximum Lifetime Benefit.]

SECTION 2. Your Out-of-Pocket Expenses

For Outpatient Prescription Drugs, you are responsible for one of (or a combination of) the following amounts before we have any obligation to pay benefits.

Prescription Drug Deductible

[Amount of Covered Expenses each Covered Person must pay
in a Calendar Year:

Generic Prescription Drugs.....[$0]
Brand Name Formulary/Nonformulary Prescription Drugs .....[$0/$200, $0/$500, $250, $500, $1000]

or
.....[This deductible does not apply to your Certificate.]

Deductible for Specialty Medications

Specialty Medications are subject to the **Certificate's** Deductible and Coinsurance Percentage.

Then

[**Prescription Drug Copayment (and/or Prescription Drug Percentage)**

Amount of covered Expenses each Covered Person must pay
to the pharmacy each time a Prescription Drug is filled or refilled
before we pay benefits.

Tier 1

For Generic Prescription Drugs you pay the higher of:.....[$10] Prescription Drug Copayment or [20% Prescription Drug Percentage]

Tier 2

For Brand Name Formulary Prescription Drugs you pay the higher of: .....[$20] Prescription Drug Copayment or [50% Prescription Drug percentage]

Tier 3

For Brand Name Nonformulary Prescription Drugs you pay the higher of: .....[$30] Prescription Drug Copayment or [50% Prescription Drug Percentage]]

Section I. Definitions

Terms and provisions used at various points in your Certificate are defined in this section. The presence of a particular definition below does not necessarily mean that the term applies to your coverage. Certain definitions below may not apply to you because of the benefit selections you made when applying for this coverage. "You" and "your" as used in this Certificate refers to each person shown on the Validation of Coverage page as a "Covered Person". "We" and "Our" refers to the insurance company issuing this Certificate.

Access Fee: An Access Fee is the dollar amount that you must pay each time you receive certain Treatments, services and supplies. The Access Fee is subtracted from Covered Expenses before applying any Deductible or Coinsurance Percentage. An Access Fee will not be reimbursed by us nor does it count toward satisfying any Deductible, Coinsurance Percentage or other out-of-pocket limit. The Access Fee may be waived in certain situations. The primary difference between a Copayment (Copay) and an Access Fee is that: (a) when a Copay applies, Covered Expenses are not subject to Deductible and Coinsurance after you have paid the Copay; (b) when an Access Fee applies, Covered Expenses are subject to Deductible and Coinsurance Percentage after you have paid the Access Fee. Please refer to your Schedule of Benefits to determine if Access Fees apply to your coverage and, if so, the amount(s) of the Access Fees.

Acute Rehabilitation: A coordinated multidisciplinary physical restorative Treatment provided to Inpatients under the direction of a Physician.

Acute Rehabilitation Facility: A specialized Hospital or unit of a Hospital providing Acute Rehabilitation Treatment. Beds must be set up and staffed in a unit specifically designed for rehabilitation.

Age: Your age as of your most recent birthday.

Application: The form(s) used to apply for this Certificate that provides us with the relevant information upon which we rely in making our determination of whether to issue or amend a Certificate. The Application becomes part of your Certificate.

Benefit Maximums: The maximum amount of benefits allowable for a Covered Expense. The Benefit Maximums, if any, are shown on the Schedule of Benefits.

Benefit Percentage: The percentage of Covered Expenses we will pay:

1. after you have paid the Copayment and/or Access Fee, if any; and
2. after the Deductible has been satisfied.

The Benefit Percentage is shown on the Schedule of Benefits.

Calendar Year: A Calendar Year begins on January 1st and ends on December 31st of the same year.

Center of Excellence (COE): A COE is a Hospital that specializes in a specific type or types of transplants. The COE also has agreed, through a transplant network as designated by us, to provide quality care on a cost efficient basis.

Coinsurance Percentage: The percentage of Covered Expenses you must pay:

1. after you have paid the Copayment and/or Access Fee, if any; and
2. after the Deductible has been satisfied.

The Coinsurance Percentage is shown on the Schedule of Benefits.

Complications of Pregnancy:

1. Complications of Pregnancy include any of the following:
    a. Conditions (when the pregnancy is not terminated) that are caused by pregnancy, or are distinct from pregnancy but adversely affected by pregnancy, including, but not limited to:

(1) Severe dehydration requiring intravenous (IV) therapy;

(2) Acute nephritis or nephrosis;

(3) Cardiac decompensation;

(4) Premature labor or threatened abortion;

(5) Preeclampsia and eclampsia; and

(6) Abruptio placentae or placenta previa.

b. Emergency cesarean section;

c. Termination of ectopic pregnancy; and

d. Spontaneous termination of pregnancy occurring during a period of gestation in which a live birth is not possible.

2. The term Complications of Pregnancy does not include any of the following:

a. Nonemergency cesarean sections including, but not limited to, either or both of the following:

(1) Cesarean sections that don't satisfy the definition of "Emergency Care" under this Certificate; and/or

(2) Cesarean sections that are merely for the convenience of the patient or solely due to a previous cesarean section.

b. Conditions associated with the management of a difficult pregnancy including, but not limited to, any one or more of the following:

(1) Postpartum bleeding unless it requires Confinement in a Hospital beyond the normal period of Confinement for a normal childbirth;

(2) Morning sickness;

(3) Occasional spotting; and/or

(4) False labor.

c. Normal deliveries and associated services, even if the deliveries and associated services follow Complications of Pregnancy.

Confined or Confinement: A Hospital stay as a registered Inpatient because of Illness or Injury. The stay must last for a period of at least 12 consecutive hours. A Physician must recommend and supervise the stay.

Copayment (or Copay): A dollar amount that you must pay to the health care Provider each time certain visits take place or certain services are provided. Copayment amounts are shown on the Schedule of Benefits. A Copayment does not count toward satisfying the Deductible, Coinsurance Percentage, or the out-of-pocket limit.

Covered Dependent: A person:

1. Who meets the definition of a Dependent; and
2. For whom premiums are paid under this Certificate; and
3. Who is eligible to receive benefits under this Certificate.

Covered Expenses: Medical expenses you Incur for services that are all of the following:

1. The result of an Illness or Injury;
2. Ordered by a Provider;
3. Usual and Customary for the Treatment;

4. Medically Necessary;
5. Not Preexisting as defined by this Certificate; and
6. Not excluded elsewhere in this Certificate.

Covered Member: A person who is all of the following:

1. A Member with the Policyholder;
2. At least 16 years of age;
3. Approved by us for coverage under the terms of this Certificate and for whom premiums are paid; and
4. Named as a "Covered Member" on the Validation of Coverage page.

Covered Person: A Covered Member and/or Covered Dependent, as approved by us or as added to coverage by endorsement. If coverage is terminated, the person is no longer a Covered Person.

Custodial Care: Custodial Care means nonhealth-related services. Custodial Care includes assistance in activities of daily living or health-related services that: (a) do not seek to cure; or (b) are provided during periods when the medical condition of the patient is not changing; or (c) do not require continued administration by trained medical personnel. Examples of activities of daily living include, but are not limited to:

1. Bathing;
2. Getting dressed;
3. Eating;
4. Getting in and out of bed or a chair;
5. Getting to and back from the restroom; and
6. Administering oral medications or eye drops.

Deductible: Deductibles are amounts that you and/or a Covered Person must pay during a Calendar Year for Covered Expenses before benefits will be payable under this Certificate. [Separate Deductibles may be charged for Participating and Nonparticipating Providers.] All applicable Deductibles will be shown on your Schedule of Benefits.

One or more of the following Deductibles may apply to your Certificate:

1. **Individual Deductible:** An Individual Deductible is the dollar amount of Covered Expenses that each Covered Person must satisfy before benefits will be payable by us. When Covered Expenses equal to the Individual Deductible have been Incurred and processed by us, the Individual Deductible for that Covered Person will be satisfied for the remainder of the Calendar Year.
2. **Family Deductible:** Your Family Deductible will be one of the following:
   a. **Standard Family Deductible:** When the designated number of Covered Persons (as shown on the Schedule of Benefits) have each satisfied the Individual Deductible (per Covered Person) in any given Calendar Year, no further Deductibles will apply for the remainder of that Calendar Year.
   b. **Family Aggregate Deductible for Qualified High Deductible Health Plan**: If you have a Qualified High Deductible Health Plan certificate, you will have only one aggregate Deductible. Covered Expenses Incurred by all Covered Persons count toward satisfying the one aggregate Deductible. When Covered Expenses equal to the Family Aggregate Deductible have been Incurred and processed by us, the Family Aggregate Deductible for all Covered Persons will be satisfied for the remainder of the Calendar Year.

3. **Common Accident Deductible:** If two or more Covered Persons insured under the same Certificate Incur Covered Expenses due to injuries in the same accident, only one Deductible will be applied to all eligible charges Incurred as a result of such accident during the Calendar Year the accident occurs.

Other information about your Deductible(s) is shown in your Schedule of Benefits.

Dependent: A Dependent can be any of the following:

1. Your spouse under the age of 65 if said spouse is not legally separated from you;
2. Your domestic partner who is under the age of 65;
3. Someone with whom you have a civil union who is under the age of 65;
4. Your unmarried child under age 19, including:
   a. Your biological child; or
   b. Your legally adopted child or a child Placed for Adoption; or
   c. A stepchild who permanently resides with you; or
   d. A grandchild for whom you are legal guardian.
5. The term Dependent also will include your unmarried child age 19 or older who is:
   a. Incapable of self-sustaining employment because of the child's disability (including mental retardation, mental illness or disorder, or physical handicap). In order to be considered in this category, you must furnish proof of the child's incapacity prior to the date insurance would have otherwise terminated due to age. We may require proof of continued incapacity each year after the first two-year period that insurance has been extended;
   b. Fully dependent on you or other care providers for lifetime care and supervision. "Other care providers" means a community-integrated living arrangement, group home, supervised apartment, or other residential service licensed or certified by the Department of Human Services, the Department of Health, or the Department of Public Aide; and
   c. Insured on the date immediately preceding the day the insurance would have terminated due to age.
6. Your unmarried child who is:
   a. Age 19 or older but under the age of 27; and
   b. Enrolled as a full-time student in an accredited school; and
   c. Financially dependent on you.

Durable Medical Equipment and Personal Medical Equipment: Durable Medical Equipment and Personal Medical Equipment are the Medically Necessary apparatus needed for therapeutic use. Such apparatus must satisfy all of the following:

1. Be for the Medically Necessary care and Treatment of a covered Illness or Injury;
2. Be able to withstand repeated use;
3. Be primarily designated for medical purposes (not personal comfort or convenience);
4. Not be useful in the absence of Illness or Injury;
5. Be ordered by a Physician; and
6. Be Basic equipment. "Basic" means the most cost effective equipment that will meet the particular medical need.

Emergency Care: Treatment required immediately for a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson could reasonably expect the absence of immediate medical attention to result in:

1. Placing his or her health in serious jeopardy;
2. Serious impairment to bodily function; or
3. Serious dysfunction of any bodily organ or part.

Without limiting the foregoing, Treatment that is scheduled with a Physician more than 24 hours before the Treatment is to be provided is not considered Emergency Care for the purposes of this Certificate.

Evidence of Insurability: Satisfactory proof, as determined by us, that a person is acceptable for this insurance coverage.

Experimental/Investigational: A drug, device, procedure or Treatment will be considered Experimental or Investigational if any of the following exist:

1. Approval required by the FDA or another appropriate government agency has not been granted for marketing;
2. Recognized national medical specialty societies or governmental agencies have determined, in writing, that it is experimental, investigational or for research purposes;
3. It is a drug, device or Treatment that is the subject of a Phase I or Phase II clinical trial or the experimental or research arm of a Phase III clinical trial. The "phases" are those identified in regulations and other official actions and publications of the FDA and Department of Health and Human Services;
4. The written protocol or protocols that the treating facility uses, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or Treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or Treatment states that it is experimental, investigational or for research purposes;
5. Completed randomized Phase III Clinical Trials have not proven the relative effectiveness of the Treatment to be as good as or better than standard therapy or no therapy; and/or
6. There is insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the Illness or Injury involved.

Home Health Care Agency: An agency that has been:

1. Certified under Medicare as a Home Health Care Agency; or
2. Licensed by the proper state authority as a Home Health Care Agency.

Home Health Care Services: Medically Necessary services that a Home Health Care Agency provides to you. Such noncustodial services must be all of the following:

1. Part of a written home health care plan that a Physician orders for you;
2. Received while not Confined in a Hospital or Skilled Care Facility; and
3. Provided in lieu of Hospital or skilled care Confinement.

Home Health Care Services are limited to:

1. Nursing care provided by a registered nurse (RN); or Licensed practical nurse (LPN); and
2. Physical or speech therapy provided by a licensed therapist.

Home Health Care Services also can include services provided by a home health aide in conjunction with the services of an RN, LPN, physical therapist or speech therapist.

Home Health Care Visit: A Home Health Care Visit is up to four consecutive hours of Home Health Care Services in a 24-hour period. If a Home Health Care Visit extends beyond four hours, each additional four-hour increment into which that Home Health Care Visit extends will be considered an additional Home Health Care Visit.

Hospice: An organization that provides medical services in an Inpatient, Outpatient or home setting to support and care for persons who are terminally ill with a life expectancy of 6 months or less as certified by a Physician. A Hospice must meet all of the following requirements:

1. Comply with all state licensing requirements;
2. Be Medicare certified and/or accredited by the Joint Commission on Accreditation of Healthcare Organizations; and
3. Provide a Treatment plan and services under the direction of a Physician.

Hospice Facility: An organization that meets the definition of Hospice and, in addition, satisfies all of the following additional requirements:

1. Be a dedicated unit within a Skilled Care Facility or a separate facility that provides Hospice services on an Inpatient basis;
2. Be licensed to provide Inpatient Hospice services by the state in which the services are rendered;
3. Be staffed by an on-call Physician 24 hours per day;
4. Provide nursing services supervised by an on duty registered nurse 24 hours per day;
5. Maintain daily clinical records;
6. Admit patients who have a terminal illness; and
7. Not provide patients with services that involve active intervention for the terminal illness although ongoing care for comorbid conditions and palliative care for the terminal illness may be provided.

Hospice Treatment Program: A formal program to care for a terminally ill person. The program primarily will provide home care services. The program also may be provided through Confinement in a Hospice Facility.

Hospital: An institution that satisfies all of the following:

1. It provides Inpatient Treatment;
2. It is licensed as a Hospital by the proper state authority;
3. At a minimum, the services it provides must include services for emergencies, clinical laboratory, diagnostic x-ray and surgery;
4. It provides 24-hour nursing services under the supervision of a registered nurse (RN);
5. It is supervised by a staff of one or more Physicians; and
6. It maintains access to patient medical records on its premises.

The following are not considered Hospitals:

1. Skilled Care Facilities;
2. Assisted living facilities;
3. A facility that is primarily for the Treatment of substance abuse, although such services may be provided in a distinct section of a Hospital; and
4. Extended care or convalescent sections of a Hospital.

Illness: A sickness or disease, including all related conditions, symptoms, and occurrences, requiring medical Treatment. Illness does not include:

1. The presence or absence of a family history of a particular Illness; or
2. A genetic predisposition for the development of a future disease or Illness.

Immediate Family: The term Immediate Family includes all of the following:

1. You;
2. Your spouse;
3. The children, brothers, sisters, and parents of either you or your spouse; and
4. The spouses of children, brothers, and sisters of either you or your spouse.

Incur or Incurred: The date Treatment, services and/or supplies are provided or received.

In Force: The period of time we insure you. This Certificate is "In Force" as long as all premiums are paid when due and this Certificate has not been terminated (either voluntarily or involuntarily).

Injury: Accidental bodily damage, independent of disease or bodily infirmity, occurring unexpectedly and unintentionally. This Certificate must be In Force at the time of the Injury.

Inpatient: A person who is Confined and receives services and Treatment in a Hospital, Skilled Care Facility or Hospice Facility on an Inpatient basis as opposed to services and Treatment provided on an Outpatient basis.

Intoxication: Intoxication means the level of concentration of alcohol in your body that is considered illegal for the purpose of operating a motor vehicle in the state in which the Illness or Injury occurs.

Issue Date: The date coverage under this Certificate begins.

Maximum Lifetime Benefit: The cumulative amount of payments we will make for all Covered Expenses under this Certificate or any extension thereof, for all of your Illnesses and Injuries. Such expenses will never be more than the Maximum Lifetime Benefit that is set forth in the Schedule of Benefits. Regardless of the number of our certificates under which you may be covered over time, there is only one Maximum Lifetime Benefit.

Medical Transportation: Professional air and ground ambulance transportation to a Hospital or Skilled Care Facility in the surrounding area where your Medical Transportation originates. All of the following are required in order to qualify for this benefit:

1. No other method of transportation is appropriate;
2. The services required to treat your Illness or Injury are not available in the facility where you are currently receiving care if you are an Inpatient at a facility; and
3. You are transported to the nearest Hospital or Skilled Care Facility that has facilities that are adequate to treat your medical condition.

Medically Necessary Treatment (Medical Necessity): Medically Necessary Treatment means services or supplies that a Provider, exercising prudent clinical judgment, would provide to a person for the purpose of preventing, evaluating, diagnosing or treating an Illness and/or Injury, and that are all of the following:

1. Commonly accepted as proper care or Treatment of the condition consistent with generally accepted standards of good medical practice or published guidelines in the United States;
2. Not primarily for the personal comfort, social well-being or convenience of you, your family or the Provider, or part of or associated with your scholastic education or vocational training;
3. Clinically appropriate in terms of type, frequency, extent, site and duration and considered safe, adequate, and effective for the patient's Illness and/or Injury;

4. Reasonably expected to result in or contribute substantially to the improvement of a condition resulting from an Illness or Injury;
5. Not Experimental or Investigational in nature or otherwise limited by exclusions and limitations found elsewhere in this Certificate.

The fact that a Provider may prescribe, order, recommend or approve a Treatment, service or supply does not, of itself, make the Treatment, service or supply Medically Necessary for the purpose of determining eligibility for coverage under this Certificate.

Medicare: The provisions of Title XVIII of the Federal Social Security Act, as amended, or any federal law that replaces the foregoing Act.

Member: A person who has a membership with the Policyholder and is at least 16 years of age.

Mental or Nervous Disorders: Conditions listed in the Diagnostic and Statistical Manual of Mental Disorders, DSM IV, or current edition.

Never Event: Means a significant error that occurs in a Provider's delivery or failure to deliver medical services. The event must be identifiable and preventable. In determining whether an event is a "Never Event," we will take into consideration the complexity of the particular service and the fact that certain medical events are not always avoidable.

Other Insurance: A plan that provides insurance, reimbursement, or service benefits for hospital, surgical or medical expenses. The term "Other Insurance" includes coverage under any one of, or combination of, the following:

1. Individual or group insurance policies;
2. Group insurance certificates;
3. Nonprofit health service plans;
4. Health Maintenance Organization (HMO) subscriber contracts;
5. Preferred Provider Organization (PPO) subscriber contracts;
6. Self-insured group plans;
7. First-party medical expense coverage under automobile insurance;
8. Prepayment plans;
9. Medicare; and/or
10. Any state or federal mandated health insurance plan.

Outpatient: Services and Treatment provided to you on an Outpatient basis by a Hospital, Skilled Care Facility, Hospice, or other Outpatient Facility as opposed to Confinement as an Inpatient.

Outpatient Facility: An Outpatient department of a Hospital, an ambulatory surgical facility, or an Urgent Care center that is operated in accordance with the laws of the state in which it is located. In order to be considered an Outpatient Facility in this Certificate, the facility also must be licensed for the primary purpose of diagnosing and treating Illness or Injury on an Outpatient basis.

Physician: A person who:

1. Is a qualified doctor and/or surgeon licensed to practice, so long as the service provided or to be provided is within the scope of the license as a Medical Doctor (MD) or Doctor of Osteopathic Medicine (DO); and
2. Is not a member of your Immediate Family.

Placed for Adoption: For the purposes of this Certificate, the moment a child is "Placed for Adoption" with a person is the moment at which the person adopting the child assumes and retains a legal obligation to totally or partially support such child in anticipation of the adoption of such child. The child's "placement" with the person terminates upon the termination of such legal obligation.

Policyholder: The entity to which the Master Policy has been issued.

Preexisting Condition: A condition:

1. For which medical advice was given or Treatment was recommended by a Provider within a 12-month period prior to the Issue Date of coverage for that Covered Person; or
2. For which prescription medication was taken within a 12-month period prior to the Issue Date of coverage for that Covered Person.

A pregnancy that exists on the day before the Covered Person's Issue Date of coverage will be considered a Preexisting Condition.

Provider: A person or facility licensed by the state to treat or provide supplies for the kind of Illness or Injury for which a claim is made. A Provider must be practicing within the scope of their license and in the geographic area in which they are licensed. A Provider cannot be a member of your Immediate Family.

Rehabilitative Treatment: Treatment for purposes of restoring bodily function and independence that has been lost due to Illness or Injury. Care ceases to be considered "rehabilitative" when either:

1. You can perform the activities of daily living of someone of the same age and gender; or
2. You have reached maximum therapeutic benefit and further Treatment cannot reasonably be expected to restore bodily function beyond the current level of bodily function.

Room and Board Expenses: Charges from a Hospital or Skilled Care Facility for the room, meals, and nursing services it has provided to an Inpatient.

Skilled Care Facility: A facility that provides continuous skilled nursing services on an Inpatient basis for persons recovering from an Illness or an Injury. The facility must meet all of the following requirements:

1. Be licensed by the state to provide skilled nursing services;
2. Be staffed by an on-call Physician 24 hours per day;
3. Provide skilled nursing services supervised by an on duty registered nurse 24 hours per day;
4. Maintain daily clinical records; and
5. Not primarily be a place for rest, Custodial Care, or the Treatment of substance abuse, although any of the foregoing services may be provided in a distinct section of the same physical facility.

Total Disability or Totally Disabled: For the purposes of this Certificate, you have a Total Disability when, as a direct result of Illness or Injury:

1. You are unable to perform the essential and material activities of a person of like age and gender who is in good health; and
2. The Social Security Administration has made a formal determination that you are disabled.

Treatment: Any and all forms of care including, but not limited to, medical or surgical care, advice, consultation, diagnosis, cure, mitigation or prevention of disease, drugs (prescribed or nonprescribed), examination, observation, services, or testing. Treatment also includes equipment, devices and supplies that are Medically Necessary.

Urgent Care: Treatment or services provided for an Illness or an Injury that:

1. Develops suddenly and unexpectedly outside of a Physician's normal business hours; and
2. Requires immediate Treatment, but is not of sufficient severity to require Emergency Care.

Usual and Customary Allowance: The Usual and Customary Allowance is the amount determined to be eligible for any service, supply or Treatment in a geographic region. We will consider the lesser of the Provider's billed charge, the negotiated contractual amount agreed upon with the Participating Provider organization, or the Usual and Customary Allowance. We determine the Usual and Customary Allowance using payment methodologies that may include, but are not limited to, one or more of the following:

1. Negotiated Payment Arrangements made directly or indirectly between health care Providers and insurers;
2. The reimbursement made by Medicare for similar services, supplies or Treatment;
3. Charging protocols and billing practices generally accepted by the medical community;
4. The amount we would have paid to a Participating Provider in the same geographic region for the same or similar services;
5. Proprietary or commercially available fee or reimbursement data;
6. The expected or estimated charges of facilities of a similar type and/or in the same geographic area, when providing the same or similar goods and services defined by Current Procedural Terminology (CPT) codes or Healthcare Common Procedure Coding System (HCPCS) codes, or grouping of services as determined through standard Diagnosis-Related Group (DRG), refined DRG or other standard industry methodologies;
7. The amount derived by applying comparable markups from facilities of a similar type and/or in the same geographic area, to the estimated costs of the facility providing the goods and services reported on the claim, established utilizing the facility's most recently available cost reports submitted to The Centers for Medicare and Medicaid Services (CMS); and/or
8. In addition to the above methodologies, if you have a Prescription Rider that covers specialty medications, we may consider the Average Wholesale Price, Average Sales Price and/or other nationally recognized drug cost basis used by nationally contracted vendors.

We reserve the right to change our payment methodologies, update pricing profiles, and modify factors we use to calculate the Usual and Customary Allowance. Amounts billed in excess of the Usual and Customary Allowance by or on behalf of a Provider are not considered eligible expenses under this Certificate.

Negotiated Payment Arrangement: The dollar amount agreed to either directly or indirectly by a Provider as the total allowed amount for medical procedures, services and supplies.

Nonparticipating Provider: A Provider of health care services or supplies who has not agreed to participate in our Preferred Provider Network.

Participating Provider: A Provider of health care services or supplies who has agreed to participate in the network shown on your insurance identification card.

Preferred Provider Network: A selected network of Physicians, Hospitals, and other Providers. These Providers have an agreement with us to deliver health care services at negotiated prices.

Section II. Benefit Provisions

A. General Benefit Provisions

Payment of Benefits

Benefits will be paid if you Incur Covered Expenses during the Calendar Year that exceed any Deductible, Coinsurance Percentage, Copayment amounts and Access Fees (if any) that may apply as set forth on the Schedule of Benefits.

Determination of Benefits

Benefits will be determined by multiplying the Benefit Percentage times the amount of Covered Expenses that exceed:

1. The Deductible (and Copayments and Access Fees, if any); and
2. Any amount payable under any other benefit provision of this Certificate. If a service or Treatment is payable under more than one provision of this Certificate, the expenses will be considered under the provision that provides the higher benefit.

Out-of-Pocket Limit

The amount each Covered Person can be obligated to pay for Covered Expenses per Calendar Year. Expenses in excess of a specific dollar limit for any of the following cannot be used to satisfy any Benefit Percentage amount requirement or to meet the out-of-pocket limit:

1. Specific Benefit Provisions;
2. Covered Expenses Subject to Limitations provision;
3. Copayment amounts, if any, as shown in the Schedule of Benefits;
4. Penalties under the Utilization Review provision; or
5. Access Fees.

Your Benefits under this Certificate are not available to pay for Covered Expenses that are applied toward satisfying a Deductible, your Coinsurance Percentage, Copayment amount or Access Fee, if applicable. Such expenses are your responsibility.

Covered Expenses

The following are Covered Expenses under this Certificate:

1. Inpatient Hospital Confinement:
   a. Hospital daily Room and Board Expenses not to exceed the usual and customary semiprivate room charge of the Hospital.
   b. Other Medically Necessary Hospital services and supplies.
2. Anesthetics and their administration (includes the services of a certified nurse anesthetist).
3. Medical services and supplies furnished by an Outpatient department of a Hospital or an ambulatory surgical facility.
4. Medically Necessary services provided by a Provider.
5. Treatment in an Urgent Care facility licensed to provide Urgent Care.
6. Other Covered Expenses:
   a. Laboratory tests;

b. Radiologic exams and other diagnostic services (including but not limited to: x-rays; Positron Emission Tomography (PET); computerized transverse tomography (CAT scans); and magnetic resonance imaging (MRI)).

c. Radiation therapy and chemotherapy Treatment.

d. Medical Transportation within the 48 contiguous states. Air ambulance service must be:

   i. Required to transport the Covered Person to the nearest Hospital that provides the special medical Treatment not available in the immediate area; and

   ii. Ordered by a Physician; and

   iii. An aircraft used primarily for transporting ill and injured persons to the nearest Hospital providing the Medically Necessary Treatment.

   Air ambulance benefits are limited to the amount and terms set forth on the Schedule of Benefits.

e. Breast Reconstruction. Prosthetic devices or reconstructive surgery following the surgical procedure mastectomy. Coverage for prosthetic devices and reconstructive surgery is subject to the same Deductible and coinsurance applicable to the mastectomy and all other terms and conditions of this Certificate. Breast reconstruction following a Medically Necessary mastectomy will be provided in a manner determined in consultation with the attending Physician and the Covered Person, and will include:

   (1) Reconstruction of the breast on which the mastectomy has been performed;

   (2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

   (3) Expenses for physical complications from all stages of a mastectomy, including lymphedema. For the purposes of this provision, “mastectomy” means the removal of all or part of the breast for Medically Necessary reasons as determined by a Physician.

B. Covered Expenses Subject to Limitations

All Covered Expenses referenced in this provision are subject to the applicable Deductibles, Benefit Percentages (amounts), Benefit Maximums and Calendar Year or Lifetime Maximums, as set forth on the Schedule of Benefits. However, the Covered Expenses referenced in this provision are not subject to the office visit Copayments (if any) or any Access Fees. Expenses that exceed the Benefit Maximums shown on the Schedule of Benefits:

1. Will not be considered Covered Expenses under this Certificate; and
2. Will not apply to the out-of-pocket Covered Expense limit.

The following expenses are also subject to any applicable limitations set forth in the General Exclusions and Limitations Section.

Emergency Foreign Travel Benefit

We will pay the Benefit Percentage of the Covered Expenses Incurred for emergency Hospital, Physician, and medical care that you receive outside the United States. This benefit is subject to all of the following limitations and requirements:

1. Benefits are payable only for care that would be covered as Emergency Care under this Certificate had the care been provided in the United States;
2. Benefits are limited to care beginning during the first 60 consecutive days of each trip outside the United States;

3. An English language translation of the claims, medical records and proof of loss must be received by us. You are responsible for obtaining this information at your expense;
4. Benefits are not payable under this provision in a foreign country where travel warnings, issued by a state in the United States and/or by a United States federal governmental agency, exist for visitors from the United States at the time the services are received; and
5. Benefits are not payable under this provision if one of the purposes for traveling outside of the United States is to obtain medical care.

Home Health Care

Home Health Care must be provided by a Home Health Care Agency. Benefits under this provision are limited to the number of Home Health Care Visits per Calendar Year that are shown on the Schedule of Benefits. Such care must be provided pursuant to a written plan of Treatment ordered by a Physician and be in lieu of Hospital Confinement.

Hospice Treatment and Services

Hospice Treatment and Services, whether on an Inpatient or Outpatient basis, that are provided pursuant to a Hospice Treatment Program approved by us. Such Treatment and services must be provided within six months from the date you entered or reentered the Hospice Treatment Program or a Hospice Facility, as defined in this Certificate.

Benefits under this provision are subject to all of the following requirements and limitations:

1. The attending Physician must certify that you have a terminal illness and life expectancy of six months or less;
2. We will determine your eligibility for the Hospice Treatment and Services benefits and we also will administer your benefits; and
3. All Covered Expenses for this benefit must be billed by the Hospice Treatment Program or the approved Hospice Care Provider, and the Covered Expenses will be subject to all the terms of this Certificate. This benefit will be paid for Covered Expenses actually Incurred, not to exceed the Benefit Maximums set forth on the Schedule of Benefits.

Outpatient Occupational, Physical and Speech Therapy

Benefits will be paid for Covered Expenses per Covered Person per Calendar Year for each type of therapy combined, not to exceed the Benefit Maximums shown on the Schedule of Benefits. This benefit is subject to the following requirements and limitations:

1. Occupational, Physical or Speech Therapy must be ordered by a Physician, and such therapy must be directly related to and begin within six months following Illness, Injury or surgery;
2. We must determine that the occupational, physical or speech therapy is Medically Necessary prior to the beginning of any Treatment;
3. Therapy under this benefit must be performed by a licensed occupational, physical or speech therapist and be under the supervision of a Physician; and
4. Benefits under this provision will cease when measurable and significant progress toward expected and reasonable outcomes has been achieved or the results have plateaued.

Covered Expenses under this provision do not include Treatment of a learning disability or developmental delay even though therapy is recommended due to organic dysfunction (including, but not limited to, congenital deformity or birth trauma).

Acute Rehabilitation

Benefits under this provision will be paid for Covered Expenses when you receive Acute Rehabilitation services as an Inpatient at an Acute Rehabilitation Facility. This benefit is subject to all of the following requirements and limitations:

1. You must be Confined in an Acute Rehabilitation Facility;
2. Prior to your Confinement in the Acute Rehabilitation Facility, you must have been Confined in a Hospital or Skilled Care Facility; and
3. Your admission to the Acute Rehabilitation Facility must begin within seven days of discharge from the Hospital or Skilled Care Facility.

Skilled Care Facility Benefit

Benefits under this provision will be paid for Covered Expenses you Incur while you are an Inpatient at a Skilled Care Facility. These benefits are subject to all of the following requirements and limitations:

1. You must be an Inpatient at a Skilled Care Facility;
2. Admission to the Skilled Care Facility must begin within fourteen days of discharge from a Hospital;
3. The attending Physician must certify the Confinement as being Medically Necessary for your care and Treatment if you are Totally Disabled and if you otherwise would have been Confined to a bed in a Hospital; and
4. Confinement must be under the direct care of a Physician.

Durable Medical Equipment and Personal Medical Equipment Benefit

Rental or purchase, whichever is most cost effective, of the following items when prescribed by a Physician:

1. A Basic wheelchair;
2. A Basic Hospital bed; and
3. Basic crutches.

In addition, Durable Medical Equipment and Personal Medical Equipment include the following:

1. Orthopedic braces, excluding foot orthotics;
2. The temporary interim and initial permanent basic artificial limb or eye;
3. External breast prostheses needed because of surgical removal of all or part of the breast;
4. Oxygen and the equipment needed for the administration of oxygen; and
5. Other Durable Medical Equipment and supplies that are approved in advance by us.

Observation Room Expense

When you seek Treatment at a Hospital and are placed under observation for more than 24 hours, but are not admitted to the Hospital, we will pay benefits as if you had been admitted as an Inpatient, not to exceed the Hospital's standard semiprivate Room and Board rate.

Spinal Manipulation

Benefits will be paid for spinal manipulation including, but not limited to, manipulation for spinal subluxation and associated Treatment or services within the scope of the Provider’s license, not to exceed the Benefit Maximums shown on the Schedule of Benefits. Benefits under this provision will cease when measurable and significant progress toward an expected and reasonable outcome has been achieved, or the results have reached a plateau.

Sterilization

After you have been insured under this Certificate for a period of 12 consecutive months, benefits will be paid for sterilization. The benefits under this provision will not exceed the Benefit Maximum shown on the Schedule of Benefits.

Treatment of Allergies

Benefits will be paid for allergy testing and allergy injections including, but not limited to, injectable antigens and extracts, not to exceed the Benefit Maximum shown on the Schedule of Benefits.

Treatment of Sleep Apnea

Benefits will be paid for the Treatment of sleep apnea including, but not limited to, sleep study, Durable Medical Equipment (CPAP or BiPAP), and surgery. Benefits under this provision will not exceed the Benefit Maximum shown on the Schedule of Benefits.

Treatment of Growth Disorders

Benefits will be paid for Treatment of a growth disorder or abnormally short stature, including, but not limited to, growth hormone deficiency therapy (GHDT), not to exceed the Benefit Maximum shown on the Schedule of Benefits for each Covered Dependent child.

C. Center of Excellence (COE) Benefit

This section includes information about the non-Experimental and non-Investigational organ/tissue transplants that will be considered Covered Expenses.

Center of Excellence (COE) Transplants

The following are considered COE Transplants under this Certificate:

1. Heart transplant;
2. Heart/lung transplant;
3. Kidney transplant;
4. Liver transplant;
5. Bone marrow and/or stem cell transplant;
6. Kidney-pancreas transplant;
7. Lung transplant (unilateral or bilateral);
8. Pancreas; and
9. Small bowel transplant.

COE Enrollment

Your enrollment at a COE must satisfy all of the following:

1. The Covered Person must contact and work with one of our trained registered nurses to coordinate benefits for transplant services.
2. For us to consider you as a possible candidate for acceptance into the COE for any organ/tissue transplant services or procedure, you or your Physician (or a Physician's staff member) must contact the COE Coordinator to request a transplant evaluation. The decision as to whether or not you will be a transplant candidate in a COE is made by the COE medical staff and will be communicated by the COE Coordinator.

3. If you are denied a transplant procedure by the COE, you will be offered the opportunity to have a second COE evaluate you. If the second COE determines that you are not an acceptable candidate for the proposed organ/tissue transplant procedure, no further coverage under the COE Benefit will be provided for services or supplies that are related to the proposed organ/tissue transplant procedure.

COE Organ/Tissue Transplants

1. If you need an organ/tissue transplant that is a Covered Expense under this Certificate, you may request participation in the COE program. To be considered for a COE transplant, you must agree to use COE Providers for all Treatments related to an organ/tissue transplant in order for the Treatments to be Covered Expenses. The exception to this rule is that you are not required to use COE Providers for routine blood work or Emergency Care needs.
2. If you elect to participate in transplantation at a COE approved by us for the transplant services, Covered Expenses are subject to the limitations set forth in this Certificate. The Maximum Lifetime Benefit payable under the COE Benefit is set forth on the Schedule of Benefits.
3. Any Covered Expenses paid for organ/tissue transplant related expenses shall be cumulative for purposes of determining any maximum benefits under this Certificate.

Covered Expenses

The following Treatments are eligible for the COE Organ/Tissue Transplants benefits under this section:

1. Pretransplant services;
2. Pretransplant harvesting;
3. Pretransplant stabilization. “Pretransplant stabilization” means an Outpatient Treatment or Inpatient stay to medically stabilize the Covered Person for the purpose of, or preparation for, a later transplant, whether or not the transplant occurs;
4. The transplant itself; and
5. Post-transplant care and Treatment for a period of 180 days after the date of the transplant procedure. Such care or Treatment must be provided within 180 days of the date of the transplant.

Covered Expenses under this section also include the following, which will be included in determining the maximum transplant benefits:

1. The costs involved in the procurement of the donor organ;
2. The costs involved in the donor search; and
3. The Hospital expenses of the donor.

In order to be Covered Expenses under this section, the Treatments also must satisfy the definition of “Covered Expenses” set forth in the Definitions Section of this Certificate.

Transplants Not Performed at a COE

1. If you elect not to participate in the COE program or are denied a transplant procedure by the COE, benefits for any Covered Expenses under this section will be paid subject to the following: Covered Expenses for organ/tissue transplants that are neither Experimental nor Investigational Treatment are payable, but not to exceed the Maximum Lifetime Benefit shown on the Schedule of Benefits, per transplant per Covered Person (includes the immediate 180-day post-transplant follow-up).
2. Included within the maximum lifetime allowance for organ/tissue transplant are Covered Expenses for or related to:
   a. Initial testing and diagnostic work-up;
   b. Complications resulting from a transplant surgery or procedure;

c. Complications resulting from organ/tissue rejection or failure;

d. Expenses related to anticipated organ/tissue rejection or failure;

e. Any repeat transplants of the same type of organ/tissue within 180 days of the first transplant;

f. All other Covered Expenses for or related to organ/tissue transplant; and

g. High dose chemotherapy, and/or radiation therapy, done in conjunction with a transplant.

3. Expenses for or related to the transplant of an artificial or animal organ are excluded from coverage.

Transportation and Living Expenses

1. If a COE transplant is performed at a designated COE, we will provide the following as Covered Expenses subject to the Maximum Lifetime Benefit.

   a. The reasonable travel and living expenses Incurred by:

      (1) A live donor, if applicable; and

      (2) You and one companion or, if the Covered Person is a dependent child, two parents.

   b. Round trip transportation to the COE (including round trip coach airfare, train, or other commercial carrier). Reimbursement for transportation in a private auto shall be based on the IRS allowance per mile for medical travel.

   c. The cost of meals and hotel accommodations for you and/or the donor if Treatment is required in an Outpatient setting.

   d. The cost of meals and hotel accommodations for one companion (or two parents if the Covered Person is a dependent child) while accompanying you during hospitalization and Outpatient Treatment.

2. Any benefit payable under this travel and living expense provision shall be subject to our approval for reimbursement.

3. Transportation and living benefits will be limited to the amount shown on the Schedule of Benefits, per covered transplant at a COE

Section II. Benefit Provisions

A. General Benefit Provisions

Payment of Benefits

Benefits will be paid if you Incur Covered Expenses during the Calendar Year that exceed any Deductible, Coinsurance Percentage, Copayment amounts and Access Fees (if any) that may apply as set forth on the Schedule of Benefits.

Determination of Benefits

Benefits will be determined by multiplying the Benefit Percentage times the amount of Covered Expenses that exceed:

1. The Deductible (and Copayments and Access Fees, if any); and
2. Any amount payable under any other benefit provision of this Certificate. If a service or Treatment is payable under more than one provision of this Certificate, the expenses will be considered under the provision that provides the higher benefit.

Out-of-Pocket Limit

The amount each Covered Person can be obligated to pay for Covered Expenses per Calendar Year. Expenses in excess of a specific dollar limit for any of the following cannot be used to satisfy any Benefit Percentage amount requirement or to meet the out-of-pocket limit:

1. Specific Benefit Provisions;
2. Covered Expenses Subject to Limitations provision;
3. Copayment amounts, if any, as shown in the Schedule of Benefits;
4. Penalties under the Utilization Review provision; or
5. Access Fees.

Your Benefits under this Certificate are not available to pay for Covered Expenses that are applied toward satisfying a Deductible, your Coinsurance Percentage, Copayment amount or Access Fee, if applicable. Such expenses are your responsibility.

Covered Expenses

The following are Covered Expenses under this Certificate:

1. Inpatient Hospital Confinement:
   a. Hospital daily Room and Board Expenses not to exceed the usual and customary semiprivate room charge of the Hospital.
   b. Other Medically Necessary Hospital services and supplies.
   c. Medically Necessary services provided by a Provider.
   d. Anesthetics and their administration (includes the services of a certified nurse anesthetist).
2. Other Covered Expenses:
   a. Outpatient Surgical Expenses, as follows:
      (1) Surgery by a Physician in an Outpatient facility;

(2) Charges for services (including laboratory tests and x-rays), supplies, prescription drugs, oxygen and Durable Medical Equipment for which an Outpatient facility charges when related to and provided on the same day as the Outpatient surgery; and

(3) Anesthesiologist's service for a covered surgery in an Outpatient facility.

b. Radiation therapy and chemotherapy Treatment.

c. Medical Transportation within the 48 contiguous states. Air ambulance service must be:

(1) Required to transport the Covered Person to the nearest Hospital that provides the special medical Treatment not available in the immediate area; and

(2) Ordered by a Physician; and

(3) An aircraft used primarily for transporting ill and injured persons to the nearest Hospital providing the Medically Necessary Treatment.

Air ambulance benefits are limited to the amount and terms set forth on the Schedule of Benefits.

d. Breast Reconstruction. Prosthetic devices or reconstructive surgery following the surgical procedure mastectomy. Coverage for prosthetic devices and reconstructive surgery is subject to the same Deductible and coinsurance applicable to the mastectomy and all other terms and conditions of this Certificate. Breast reconstruction following a Medically Necessary mastectomy will be provided in a manner determined in consultation with the attending Physician and the Covered Person, and will include:

(1) Reconstruction of the breast on which the mastectomy has been performed;

(2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(3) Expenses for physical complications from all stages of a mastectomy, including lymphedema. For the purposes of this provision, "mastectomy" means the removal of all or part of the breast for Medically Necessary reasons as determined by a Physician.

B. Covered Expenses Subject to Limitations

All Covered Expenses referenced in this provision are subject to the applicable Deductibles, Benefit Percentages (amounts), Benefit Maximums and Calendar Year or Lifetime Maximums, as set forth on the Schedule of Benefits. However, the Covered Expenses referenced in this provision are not subject to the office visit Copayments (if any) or any Access Fees. Expenses that exceed the Benefit Maximums shown on the Schedule of Benefits:

1. Will not be considered Covered Expenses under this Certificate; and
2. Will not apply to the out-of-pocket Covered Expense limit.

The following expenses are also subject to any applicable limitations set forth in the General Exclusions and Limitations Section.

Home Health Care

Home Health Care must be provided by a Home Health Care Agency. Benefits under this provision are limited to the number of Home Health Care Visits per Calendar Year that are shown on the Schedule of Benefits. Such care must be provided pursuant to a written plan of Treatment ordered by a Physician and be in lieu of Hospital Confinement.

Hospice Treatment and Services

Hospice Treatment and Services, whether on an Inpatient or Outpatient basis, that are provided pursuant to a Hospice Treatment Program approved by us. Such Treatment and services must be provided within six months

from the date you entered or reentered the Hospice Treatment Program or a Hospice Facility, as defined in this Certificate.

Benefits under this provision are subject to all of the following requirements and limitations:

1. The attending Physician must certify that you have a terminal illness and life expectancy of six months or less;
2. We will determine your eligibility for the Hospice Treatment and Services benefits and we also will administer your benefits; and
3. All Covered Expenses for this benefit must be billed by the Hospice Treatment Program or the approved Hospice Care Provider, and the Covered Expenses will be subject to all the terms of this Certificate. This benefit will be paid for Covered Expenses actually Incurred, not to exceed the Benefit Maximums set forth on the Schedule of Benefits.

Acute Rehabilitation

Benefits under this provision will be paid for Covered Expenses when you receive Acute Rehabilitation services as an Inpatient at an Acute Rehabilitation Facility. This benefit is subject to all of the following requirements and limitations:

1. You must be Confined in an Acute Rehabilitation Facility;
2. Prior to your Confinement in the Acute Rehabilitation Facility, you must have been Confined in a Hospital or Skilled Care Facility; and
3. Your admission to the Acute Rehabilitation Facility must begin within seven days of discharge from the Hospital or Skilled Care Facility.

Skilled Care Facility Benefit

Benefits under this provision will be paid for Covered Expenses you Incur while you are an Inpatient at a Skilled Care Facility. These benefits are subject to all of the following requirements and limitations:

1. You must be an Inpatient at a Skilled Care Facility;
2. Admission to the Skilled Care Facility must begin within fourteen days of discharge from a Hospital;
3. The attending Physician must certify the Confinement as being Medically Necessary for your care and Treatment if you are Totally Disabled and if you otherwise would have been Confined to a bed in a Hospital; and
4. Confinement must be under the direct care of a Physician.

Durable Medical Equipment and Personal Medical Equipment Benefit

Rental or purchase, whichever is most cost effective, of the following items when prescribed by a Physician:

1. A Basic wheelchair;
2. A Basic Hospital bed; and
3. Basic crutches.

In addition, Durable Medical Equipment and Personal Medical Equipment include the following:

1. Orthopedic braces, excluding foot orthotics;
2. The temporary interim and initial permanent basic artificial limb or eye;
3. External breast prostheses needed because of surgical removal of all or part of the breast;
4. Oxygen and the equipment needed for the administration of oxygen; and
5. Other Durable Medical Equipment and supplies that are approved in advance by us.

Observation Room Expense

When you seek Treatment at a Hospital and are placed under observation for more than 24 hours, but are not admitted to the Hospital, we will pay benefits as if you had been admitted as an Inpatient, not to exceed the Hospital's standard semiprivate Room and Board rate.

C. Center of Excellence (COE) Benefit

This section includes information about the non-Experimental and non-Investigational organ/tissue transplants that will be considered Covered Expenses.

Center of Excellence (COE) Transplants

The following are considered COE Transplants under this Certificate:

1. Heart transplant;
2. Heart/lung transplant;
3. Kidney transplant;
4. Liver transplant;
5. Bone marrow and/or stem cell transplant;
6. Kidney-pancreas transplant;
7. Lung transplant (unilateral or bilateral);
8. Pancreas; and
9. Small bowel transplant.

COE Enrollment

Your enrollment at a COE must satisfy all of the following:

1. The Covered Person must contact and work with one of our trained registered nurses to coordinate benefits for transplant services.
2. For us to consider you as a possible candidate for acceptance into the COE for any organ/tissue transplant services or procedure, you or your Physician (or a Physician's staff member) must contact the COE Coordinator to request a transplant evaluation. The decision as to whether or not you will be a transplant candidate in a COE is made by the COE medical staff and will be communicated by the COE Coordinator.
3. If you are denied a transplant procedure by the COE, you will be offered the opportunity to have a second COE evaluate you. If the second COE determines that you are not an acceptable candidate for the proposed organ/tissue transplant procedure, no further coverage under the COE Benefit will be provided for services or supplies that are related to the proposed organ/tissue transplant procedure.

COE Organ/Tissue Transplants

1. If you need an organ/tissue transplant that is a Covered Expense under this Certificate, you may request participation in the COE program. To be considered for a COE transplant, you must agree to use COE Providers for all Treatments related to an organ/tissue transplant in order for the Treatments to be Covered Expenses. The exception to this rule is that you are not required to use COE Providers for routine blood work or Emergency Care needs.
2. If you elect to participate in transplantation at a COE approved by us for the transplant services, Covered Expenses are subject to the limitations set forth in this Certificate. The Maximum Lifetime Benefit payable under the COE Benefit is set forth on the Schedule of Benefits.

3. Any Covered Expenses paid for organ/tissue transplant related expenses shall be cumulative for purposes of determining any maximum benefits under this Certificate.

Covered Expenses

The following Treatments are eligible for the COE Organ/Tissue Transplants benefits under this section:

1. Pretransplant services;
2. Pretransplant harvesting;
3. Pretransplant stabilization. "Pretransplant stabilization" means an Outpatient Treatment or Inpatient stay to medically stabilize the Covered Person for the purpose of, or preparation for, a later transplant, whether or not the transplant occurs;
4. The transplant itself; and
5. Post-transplant care and Treatment for a period of 180 days after the date of the transplant procedure. Such care or Treatment must be provided within 180 days of the date of the transplant.

Covered Expenses under this section also include the following, which will be included in determining the maximum transplant benefits:

1. The costs involved in the procurement of the donor organ;
2. The costs involved in the donor search; and
3. The Hospital expenses of the donor.

In order to be Covered Expenses under this section, the Treatments also must satisfy the definition of "Covered Expenses" set forth in the Definitions Section of this Certificate.

Transplants Not Performed at a COE

1. If you elect not to participate in the COE program or are denied a transplant procedure by the COE, benefits for any Covered Expenses under this section will be paid subject to the following: Covered Expenses for organ/tissue transplants that are neither Experimental nor Investigational Treatment are payable, but not to exceed the Maximum Lifetime Benefit shown on the Schedule of Benefits, per transplant per Covered Person (includes the immediate 180-day post-transplant follow-up).
2. Included within the maximum lifetime allowance for organ/tissue transplant are Covered Expenses for or related to:
   a. Initial testing and diagnostic work-up;
   b. Complications resulting from a transplant surgery or procedure;
   c. Complications resulting from organ/tissue rejection or failure;
   d. Expenses related to anticipated organ/tissue rejection or failure;
   e. Any repeat transplants of the same type of organ/tissue within 180 days of the first transplant;
   f. All other Covered Expenses for or related to organ/tissue transplant; and
   g. High dose chemotherapy, and/or radiation therapy, done in conjunction with a transplant.
3. Expenses for or related to the transplant of an artificial or animal organ are excluded from coverage.

Transportation and Living Expenses

1. If a COE transplant is performed at a designated COE, we will provide the following as Covered Expenses subject to the Maximum Lifetime Benefit.
   a. The reasonable travel and living expenses Incurred by:

(1) A live donor, if applicable; and

(2) You and one companion or, if the Covered Person is a dependent child, two parents.

b. Round trip transportation to the COE (including round trip coach airfare, train, or other commercial carrier). Reimbursement for transportation in a private auto shall be based on the IRS allowance per mile for medical travel.

c. The cost of meals and hotel accommodations for you and/or the donor if Treatment is required in an Outpatient setting.

d. The cost of meals and hotel accommodations for one companion (or two parents if the Covered Person is a dependent child) while accompanying you during hospitalization and Outpatient Treatment.

2. Any benefit payable under this travel and living expense provision shall be subject to our approval for reimbursement.

3. Transportation and living benefits will be limited to the amount shown on the Schedule of Benefits, per covered transplant at a COE

Section III. General Exclusions and Limitations

A. General Benefit Provisions

This Certificate does not cover any of the following expenses or charges:

1. For Treatment, services and/or supplies not covered under this Certificate.
2. Incurred before the Issue Date.
3. Incurred after this Certificate terminates, regardless of when the condition originated, except as provided in the Extension of Benefits provision.
4. Preexisting Conditions are not covered during the first 12 months. After 12 months, benefits are payable unless specifically excluded from coverage. Conditions fully disclosed on the Application and not excluded from coverage by name or specific description are covered, subject to the provisions of this Certificate. Any period of time that a Covered Person was covered under qualifying creditable coverage will be applied to this 12-month period.
5. In excess of the Usual and Customary Allowance for Treatment, services or supplies covered under this Certificate.
6. Applied to a Deductible, Coinsurance Percentage, Copayment or Access Fee amount for any benefit of this Certificate.
7. For office visits including evaluation and management services as defined in the most recent edition of Current Procedural Terminology, except as specifically provided elsewhere in this Certificate.
8. For any drug or other item used for Treatment of hair loss.
9. For Treatment of acne or rosacea and related conditions.
10. For any of the following:
    a. Routine vision care;
    b. Glasses;
    c. Contact lenses, except when used to aid in healing an eye or eyes due to an Illness or an Injury;
    d. Vision therapy, exercise or training; and
    e. Surgery including any complications arising therefrom to correct visual acuity including, but not limited to, lasik and other laser surgery, radial keratotomy services or surgery to correct astigmatism, nearsightedness (myopia) and/or farsightedness (presbyopia).
11. For surgical repair of the eyelids, including, but not limited to, blepharoplasty or “eyebrow lifts”, except when required as a result of the following events or conditions that occurred while this Certificate is In Force and for which expenses are otherwise eligible under the terms of this Certificate:
    a. Accidental bodily Injury;
    b. Surgery; or
    c. Congenital ptosis (drooping) of the eyelid that was first diagnosed while you were insured under this Certificate.
12. For any of the following:
    a. Hearing care that is routine;
    b. Any artificial hearing device;

c. Cochlear implant;

d. Auditory prostheses; or

e. Other electrical, digital, mechanical or surgical means of enhancing, creating or restoring auditory comprehension.

13. For any of the following types of dental care:

a. Routine dental care, except as specifically provided elsewhere;

b. Dental charges, except as specifically provided elsewhere;

c. Bridges, crowns, caps, dentures, dental implants or other dental prostheses;

d. Dental braces or dental appliances;

e. Extraction of teeth;

f. Orthodontic charges;

g. Odontogenic cysts;

h. Any other expenses for Treatment or complications of teeth and gum tissue;

i. Dental extraction that is a pre-Treatment for any Illness.

This exclusion is not applicable to dental care or Treatment required as a result of a covered Injury. Such Treatment must be provided within 90 days of the date of the Injury.

14 For any appliance, medical or surgical expenses for:

a. Malocclusion or protrusion or recession of the mandible;

b. Maxillary or mandibular hyperplasia;

c. Maxillary or mandibular hypoplasia.

15. For Treatment of Temporomandibular Joint Dysfunction and Craniomandibular Joint Dysfunction that includes, but is not limited to:

a. Any electronic diagnostic modalities;

b. Occlusal analysis;

c. Surgery;

d. Splints;

e. Imaging; and/or

f. Muscle testing.

16. For the first six months this Certificate is In Force, surgeries for any of the following conditions are not covered unless such conditions satisfy the definition of Emergency Care:

a. Hernia;

b. Removal of adenoids and/or tonsils;

c. Varicose veins;

d. Hemorrhoids;

e. Middle ear disorders; or

f. Disorders of the reproductive organs.

17. For any of the following:
    a. Bunions;
    b. Removal of one or more corns, calluses or toenails;
    c. Foot inserts;
    d. Orthopedic shoes or supportive devices for the feet; or
    e. Treatment of toenail fungus that is not associated with bacterial infection or diabetes.
18. For any of the following:
    a. Any diagnosis, supplies, Treatment or regimen, whether medical or surgical, for purposes of controlling the Covered Person's weight or related to obesity, including Morbid Obesity, whether or not weight reduction is Medically Necessary or appropriate and regardless of potential benefits for comorbid conditions;
    b. Weight reduction or weight control surgery, Treatment or programs;
    c. Any type of gastric bypass surgery;
    d. Suction lipectomy;
    e. Physical fitness programs, exercise equipment or exercise therapy, including health club membership fees or services; or
    f. Nutritional counseling.
19. For cosmetic services. This exclusion includes any surgery, procedure, injection, medication or Treatment primarily designed to improve appearance, self-esteem or body image and/or to relieve or prevent social, emotional, or psychological distress. Cosmetic services and services for complications from cosmetic services are not covered regardless of whether the initial surgery occurred while this Certificate is In Force or under any previous coverage.
20. For chemical peels, reconstructive or plastic surgery that does not alleviate a functional impairment.
21. For breast reduction or augmentation or complications arising from these procedures, except as specifically provided elsewhere in this Certificate.
22. For cranial orthotic devices that are used to redirect growth of the skull bones or reduce cranial asymmetry.
23. For growth hormone therapy, including growth hormone medication and its derivatives or other drugs used to stimulate, promote or delay growth or to delay puberty to allow for increased growth.
24. For home traction units.
25. For home defibrillators.
26. For programs, Treatment, or procedures to help you stop using tobacco products.
27. For any drug (including birth control pills), supply, Treatment, or procedure for males or females, used for prevention of conception and/or childbirth, unless an Outpatient Prescription Drug Benefit Rider is attached to this Certificate.
28. For any of the following:
    a. Genetic testing or counseling;
    b. Genetic services and related procedures for screening purposes including, but not limited to, amniocentesis and chorionic villi testing.

29. For any of the following:
    a. Infertility diagnosis and Treatment for males or females including, but not limited to, drugs and medications regardless of intended use, artificial insemination, in vitro fertilization, reversal of reproductive sterilization and related tests, services or procedures and any Treatment to promote conception;
    b. Family planning;
    c. Cryopreservation of sperm or eggs;
    d. Surrogate pregnancy; or
    e. Umbilical cord stem cell or other blood component harvest and storage.
30. For pregnancy, prenatal care, or normal childbirth, except for covered Complications of Pregnancy.
31. Incurred for termination of pregnancy, except to protect the health of the mother.
32. For services, supplies and/or Treatment related to any of the following conditions, regardless of underlying causes:
    a. Sex transformation;
    b. Gender dysphoric disorder;
    c. Gender reassignment;
    d. Sexual function, dysfunction or inadequacy; or
    e. To enhance, restore or improve sexual energy, performance or desire.
33. For Treatment of a developmental delay.
34. For Treatment of Mental or Nervous Disorders, except as provided elsewhere in this Certificate.
35. For expenses resulting from suicide, attempted suicide or self-inflicted Illness or Injury, while sane or insane.
36. For transportation, except as specifically provided in this Certificate.
37. For living expenses, except as specifically provided in this Certificate.
38. For any over-the-counter or prescription products, drugs or medications, including, but not limited to, the following categories, whether or not prescribed by a Physician:
    a. Herbal or homeopathic medicines or products.
    b. Minerals.
    c. Health and beauty aids.
    d. Batteries.
    e. Appetite suppressants.
    f. Dietary or nutritional substances or dietary supplements.
    g. Nutraceuticals.
    h. Infant formulas.
    i. Vitamins.

    This exclusion also excludes from coverage the intentional taking of over-the-counter medications not in accordance with recommended dosage and warning instructions.

39. For prophylactic Treatment, services or surgery including, but not limited to, prophylactic mastectomy or any other Treatment, services or surgery performed to prevent a disease process from becoming evident in the organ or tissue at a later date.
40. For any of the following:
    a. Behavior modification or behavioral (conduct) problems;
    b. Learning disabilities;
    c. Educational testing, training or materials;
    d. Cognitive enhancement or training;
    e. Vocational programs; or
    f. Transitional living.
41. For services or supplies for personal convenience, including Custodial Care or homemaker services, except as specifically provided in this Certificate.
42. For Custodial Care, except as specifically covered elsewhere in this Certificate.
43. For Illness or Injury caused by, contributed to, or resulting from your Intoxication or use of alcohol, illegal drugs, voluntary use of any controlled substance (as defined by statute), or use of legal prescription or over-the-counter drugs that are not taken in the dosage or for the purpose prescribed or recommended by your Physician. This exclusion shall apply even if no traffic or criminal charges are filed or proposed.
44. For voluntarily taking, absorbing, or inhaling any gas, poison or other hazardous items.
45. Incurred while participating in the military service of any country or international organization, including nonmilitary units supporting such forces. This exclusion also includes expenses resulting from your participation in war, whether war has been declared or not.
46. For Illness or Injury sustained during your voluntary participation in an assault, strike, civil disorder, or riot.
47. For Illness or Injury resulting, either directly or indirectly, from your participation in a high risk activity for pay, profit or other commercial purposes including, but not limited to:
    a. Skydiving;
    b. Hang gliding;
    c. Parachuting;
    d. Piloting experimental or ultralight aircraft;
    e. Riding in any aircraft not licensed to carry passengers or not operated by a duly licensed pilot;
    f. Riding in a hot air balloon;
    g. Bungee jumping;
    h. Professional mountain and/or rock climbing;
    i. Rodeo participation; and
    j. Organized contests including, but not limited to, organized contests of speed, go-cart racing, dirt bike racing, demolition derbies, and mountain bike racing. This exclusion also includes the practice, qualification and/or testing for such activities
48. Incurred for Illness or Injury that result from:
    a. Engaging in an illegal act or occupation, as defined by statute; or

b. Committing, attempting to commit, or participating in a felony, as defined by statute.

49. For Treatment of complications from a noncovered service.
50. For Treatment, services or supplies that are not Medically Necessary.
51. For private duty nursing.
52. For having a Provider on standby.
53. For services, supplies and/or Treatment not ordered by a Provider;
54. For Treatment, supplies or services that are Experimental or Investigational as defined in this Certificate;
55. For Treatment, services, supplies, or drugs designed or used to diagnose, treat, alter, impact, or differentiate your genetic make-up or genetic predisposition.
56. For free Treatment provided in a federal, veteran's, state or municipal medical facility or through a school system.
57. Payable or reimbursable by Medicare Part A, Part B, or Part D, or any other governmental law or program when permitted by law, except Medicaid. If a Covered Person at any time was eligible to enroll in the Medicare program (including Part B and Part D) but did not do so, any benefits otherwise allowed under this Certificate will be reduced by any amount that would have been reimbursed by Medicare.
58. For Treatment, services and/or supplies for which you have no legal obligation to pay or for which no charge would be made if you did not have a health plan or insurance coverage.
59. For free services provided in a student health center.
60. For work-related Illness or Injury eligible for benefits under worker's compensation, employers' liability or similar laws even when you do not file a claim for those benefits.
61. For work hardening programs;
62. For Treatment, services or supplies that are covered under an extension of group health benefits provision by a previous employer-related health plan, health insurance plan, or other coverage arrangement. Such services and supplies will not be covered by this Certificate until the extension of benefits under the prior plan ends.
63. That are payable under any motor vehicle no-fault law insurance policy or certificate.
64. For Treatment, services or supplies received outside the United States or for drugs obtained from pharmacy provider sources outside the United States, except as specifically provided in this Certificate.
65. For Treatment, services and/or supplies provided by any of the following:
    a. A person who ordinarily resides in your home;
    b. A member of your Immediate Family; or
    c. Your employer or business partner.
66. For Treatment of hyperhidrosis (excessive sweating).
67. For Never Events as defined in this Certificate.
68. For services that are not documented in the Provider's records.
69. That are related to the supervision of laboratory services that do not involve written consultation by a Provider including, but not limited to, laboratory interpretation.
70. For complications resulting from leaving a licensed medical facility against the advice of the Covered Person's Provider.

71. For routine physical exams, premarital examination, or other services or supplies not needed for medical Treatment, except as specifically provided elsewhere in this Certificate.
72. For routine newborn or well-child care, except as otherwise covered in this Certificate.
73. For prescription drugs or medicines, except as specifically provided elsewhere in this Certificate. This exclusion also excludes from coverage the intentional misuse of prescription drugs or medicines.

Section III. General Exclusions and Limitations

A. General Benefit Provisions

This Certificate does not cover any of the following expenses or charges:

1. For Treatment, services and/or supplies not covered under this Certificate.
2. Incurred before the Issue Date.
3. Incurred after this Certificate terminates, regardless of when the condition originated, except as provided in the Extension of Benefits provision.
4. Preexisting Conditions are not covered during the first 12 months. After 12 months, benefits are payable unless specifically excluded from coverage. Conditions fully disclosed on the Application and not excluded from coverage by name or specific description are covered, subject to the provisions of this Certificate. Any period of time that a Covered Person was covered under qualifying creditable coverage will be applied to this 12-month period.
5. In excess of the Usual and Customary Allowance for Treatment, services or supplies covered under this Certificate.
6. Applied to a Deductible, Coinsurance Percentage, Copayment or Access Fee amount for any benefit of this Certificate.
7. For office visits including evaluation and management services as defined in the most recent edition of Current Procedural Terminology, except as specifically provided elsewhere in this Certificate.
8. For any drug or other item used for Treatment of hair loss.
9. For Treatment of acne or rosacea and related conditions.
10. For any of the following:
    a. Routine vision care;
    b. Glasses;
    c. Contact lenses, except when used to aid in healing an eye or eyes due to an Illness or an Injury;
    d. Vision therapy, exercise or training; and
    e. Surgery including any complications arising therefrom to correct visual acuity including, but not limited to, lasik and other laser surgery, radial keratotomy services or surgery to correct astigmatism, nearsightedness (myopia) and/or farsightedness (presbyopia).
11. For surgical repair of the eyelids, including, but not limited to, blepharoplasty or “eyebrow lifts”, except when required as a result of the following events or conditions that occurred while this Certificate is In Force and for which expenses are otherwise eligible under the terms of this Certificate:
    a. Accidental bodily Injury;
    b. Surgery; or
    c. Congenital ptosis (drooping) of the eyelid that was first diagnosed while you were insured under this Certificate.
12. For any of the following:
    a. Hearing care that is routine;
    b. Any artificial hearing device;

c. Cochlear implant;

d. Auditory prostheses; or

e. Other electrical, digital, mechanical or surgical means of enhancing, creating or restoring auditory comprehension.

13. For any of the following types of dental care:

a. Routine dental care, except as specifically provided elsewhere;

b. Dental charges, except as specifically provided elsewhere;

c. Bridges, crowns, caps, dentures, dental implants or other dental prostheses;

d. Dental braces or dental appliances;

e. Extraction of teeth;

f. Orthodontic charges;

g. Odontogenic cysts;

h. Any other expenses for Treatment or complications of teeth and gum tissue;

i. Dental extraction that is a pre-Treatment for any Illness.

This exclusion is not applicable to dental care or Treatment required as a result of a covered Injury. Such Treatment must be provided within 90 days of the date of the Injury.

14 For any appliance, medical or surgical expenses for:

a. Malocclusion or protrusion or recession of the mandible;

b. Maxillary or mandibular hyperplasia;

c. Maxillary or mandibular hypoplasia.

15. For Treatment of Temporomandibular Joint Dysfunction and Craniomandibular Joint Dysfunction that includes, but is not limited to:

a. Any electronic diagnostic modalities;

b. Occlusal analysis;

c. Surgery;

d. Splints;

e. Imaging; and/or

f. Muscle testing.

16. For the first six months this Certificate is In Force, surgeries for any of the following conditions are not covered unless such conditions satisfy the definition of Emergency Care:

a. Hernia;

b. Removal of adenoids and/or tonsils;

c. Varicose veins;

d. Hemorrhoids;

e. Middle ear disorders; or

f. Disorders of the reproductive organs.

17. For any of the following:
    a. Bunions;
    b. Removal of one or more corns, calluses or toenails;
    c. Foot inserts;
    d. Orthopedic shoes or supportive devices for the feet; or
    e. Treatment of toenail fungus that is not associated with bacterial infection or diabetes.
18. For any of the following:
    a. Any diagnosis, supplies, Treatment or regimen, whether medical or surgical, for purposes of controlling the Covered Person's weight or related to obesity, including Morbid Obesity, whether or not weight reduction is Medically Necessary or appropriate and regardless of potential benefits for comorbid conditions;
    b. Weight reduction or weight control surgery, Treatment or programs;
    c. Any type of gastric bypass surgery;
    d. Suction lipectomy;
    e. Physical fitness programs, exercise equipment or exercise therapy, including health club membership fees or services; or
    f. Nutritional counseling.
19. For cosmetic services. This exclusion includes any surgery, procedure, injection, medication or Treatment primarily designed to improve appearance, self-esteem or body image and/or to relieve or prevent social, emotional, or psychological distress. Cosmetic services and services for complications from cosmetic services are not covered regardless of whether the initial surgery occurred while this Certificate is In Force or under any previous coverage.
20. For chemical peels, reconstructive or plastic surgery that does not alleviate a functional impairment.
21. For breast reduction or augmentation or complications arising from these procedures, except as specifically provided elsewhere in this Certificate.
22. For cranial orthotic devices that are used to redirect growth of the skull bones or reduce cranial asymmetry.
23. For growth hormone therapy, including growth hormone medication and its derivatives or other drugs used to stimulate, promote or delay growth or to delay puberty to allow for increased growth.
24. For home traction units;
25. For home defibrillators;
26. For programs, Treatment, or procedures to help you stop using tobacco products.
27. For any drug (including birth control pills), supply, Treatment, or procedure for males or females, used for prevention of conception and/or childbirth, unless an Outpatient Prescription Drug Benefit Rider is attached to this Certificate.
28. For any of the following:
    a. Genetic testing or counseling;
    b. Genetic services and related procedures for screening purposes including, but not limited to, amniocentesis and chorionic villi testing.

29. For any of the following:
    a. Infertility diagnosis and Treatment for males or females including, but not limited to, drugs and medications regardless of intended use, artificial insemination, in vitro fertilization, reversal of reproductive sterilization and related tests, services or procedures and any Treatment to promote conception;
    b. Family planning;
    c. Cryopreservation of sperm or eggs;
    d. Surrogate pregnancy; or
    e. Umbilical cord stem cell or other blood component harvest and storage.
30. For pregnancy, prenatal care, or normal childbirth, except for covered Complications of Pregnancy.
31. Incurred for termination of pregnancy, except to protect the health of the mother.
32. For services, supplies and/or Treatment related to any of the following conditions, regardless of underlying causes:
    a. Sex transformation;
    b. Gender dysphoric disorder;
    c. Gender reassignment;
    d. Sexual function, dysfunction or inadequacy; or
    e. To enhance, restore or improve sexual energy, performance or desire.
33. For Treatment of a developmental delay.
34. For Treatment of Mental or Nervous Disorders, except as provided elsewhere in this Certificate.
35. For expenses resulting from suicide, attempted suicide or self-inflicted Illness or Injury, while sane or insane.
36. For transportation, except as specifically provided in this Certificate.
37. For living expenses, except as specifically provided in this Certificate.
38. For any over-the-counter or prescription products, drugs or medications, including, but not limited to, the following categories, whether or not prescribed by a Physician:
    a. Herbal or homeopathic medicines or products.
    b. Minerals.
    c. Health and beauty aids.
    d. Batteries.
    e. Appetite suppressants.
    f. Dietary or nutritional substances or dietary supplements.
    g. Nutraceuticals.
    h. Infant formulas.
    i. Vitamins.

    This exclusion also excludes from coverage the intentional taking of over-the-counter medications not in accordance with recommended dosage and warning instructions.

39. For prophylactic Treatment, services or surgery including, but not limited to, prophylactic mastectomy or any other Treatment, services or surgery performed to prevent a disease process from becoming evident in the organ or tissue at a later date.
40. For any of the following:
    a. Behavior modification or behavioral (conduct) problems;
    b. Learning disabilities;
    c. Educational testing, training or materials;
    d. Cognitive enhancement or training;
    e. Vocational programs; or
    f. Transitional living.
41. For services or supplies for personal convenience, including Custodial Care or homemaker services, except as specifically provided in this Certificate.
42. For Custodial Care, except as specifically covered elsewhere in this Certificate.
43. For Illness or Injury caused by, contributed to, or resulting from your Intoxication or use of alcohol, illegal drugs, voluntary use of any controlled substance (as defined by statute), or use of legal prescription or over-the-counter drugs that are not taken in the dosage or for the purpose prescribed or recommended by your Physician. This exclusion shall apply even if no traffic or criminal charges are filed or proposed.
44. For voluntarily taking, absorbing, or inhaling any gas, poison or other hazardous items.
45. Incurred while participating in the military service of any country or international organization, including nonmilitary units supporting such forces. This exclusion also includes expenses resulting from your participation in war, whether war has been declared or not.
46. For Illness or Injury sustained during your voluntary participation in an assault, strike, civil disorder, or riot.
47. For Illness or Injury resulting, either directly or indirectly, from your participation in a high risk activity for pay, profit or other commercial purposes including, but not limited to:
    a. Skydiving;
    b. Hang gliding;
    c. Parachuting;
    d. Piloting experimental or ultralight aircraft;
    e. Riding in any aircraft not licensed to carry passengers or not operated by a duly licensed pilot;
    f. Riding in a hot air balloon;
    g. Bungee jumping;
    h. Professional mountain and/or rock climbing;
    i. Rodeo participation; and
    j. Organized contests including, but not limited to, organized contests of speed, go-cart racing, dirt bike racing, demolition derbies, and mountain bike racing. This exclusion also includes the practice, qualification and/or testing for such activities
48. Incurred for Illness or Injury that result from:
    a. Engaging in an illegal act or occupation, as defined by statute; or

b. Committing, attempting to commit, or participating in a felony, as defined by statute.

49. For Treatment of complications from a noncovered service.
50. For Treatment, services or supplies that are not Medically Necessary.
51. For private duty nursing.
52. For having a Provider on standby.
53. For services, supplies and/or Treatment not ordered by a Provider;
54. For Treatment, supplies or services that are Experimental or Investigational as defined in this Certificate;
55. For Treatment, services, supplies, or drugs designed or used to diagnose, treat, alter, impact, or differentiate your genetic make-up or genetic predisposition.
56. For free Treatment provided in a federal, veteran's, state or municipal medical facility or through a school system.
57. Payable or reimbursable by Medicare Part A, Part B, or Part D, or any other governmental law or program when permitted by law, except Medicaid. If a Covered Person at any time was eligible to enroll in the Medicare program (including Part B and Part D) but did not do so, any benefits otherwise allowed under this Certificate will be reduced by any amount that would have been reimbursed by Medicare.
58. For Treatment, services and/or supplies for which you have no legal obligation to pay or for which no charge would be made if you did not have a health plan or insurance coverage.
59. For free services provided in a student health center.
60. For work-related Illness or Injury eligible for benefits under worker's compensation, employers' liability or similar laws even when you do not file a claim for those benefits.
61. For work hardening programs;
62. For Treatment, services or supplies that are covered under an extension of group health benefits provision by a previous employer-related health plan, health insurance plan, or other coverage arrangement. Such services and supplies will not be covered by this Certificate until the extension of benefits under the prior plan ends.
63. That are payable under any motor vehicle no-fault law insurance policy or certificate.
64. For Treatment, services or supplies received outside the United States or for drugs obtained from pharmacy provider sources outside the United States, except as specifically provided in this Certificate.
65. For Treatment, services and/or supplies provided by any of the following:
    a. A person who ordinarily resides in your home;
    b. A member of your Immediate Family; or
    c. Your employer or business partner.
66. For Treatment of hyperhidrosis (excessive sweating).
67. For Never Events as defined in this Certificate.
68. For services that are not documented in the Provider's records.
69. That are related to the supervision of laboratory services that do not involve written consultation by a Provider including, but not limited to, laboratory interpretation.
70. For complications resulting from leaving a licensed medical facility against the advice of the Covered Person's Provider.

71. For routine physical exams, premarital examination, or other services or supplies not needed for medical Treatment, except as specifically provided elsewhere in this Certificate.
72. For routine newborn or well-child care, except as otherwise covered in this Certificate.
73. For prescription drugs or medicines, except as specifically provided elsewhere in this Certificate. This exclusion also excludes from coverage the intentional misuse of prescription drugs or medicines.
74. For care received outside the United States.
75. For sterilization or the reversal of sterilization.
76. For spinal manipulation, including, but not limited to, manipulation for spinal subluxation and any associated Treatment or services;
77. For Outpatient occupational, physical, and speech therapy.
78. For Treatment of allergies.
79. For Treatment of growth disorders.

Adding Dependent Coverage

1. For newborns:
   a. Coverage will be effective for a period of 90 days following the "eligibility date." In order for coverage to continue beyond this initial 90-day period, we must receive a written request from you to add the newborn child within 90 days following the eligibility date.
   b. The "eligibility date" for a newborn is the newborn's date of birth.
2. For newly adopted children:
   a. Coverage will be effective for a period of 60 days following the "eligibility date." In order for coverage to continue beyond this initial 60-day period, we must receive a written request from you to add the newborn or adopted child within 60 days following the eligibility date.
   b. The "eligibility date" for an adopted child is the earlier of the date Placed for Adoption, or the date of legal adoption.
3. Other Dependents (not a newborn or adopted child):

   When you request coverage for a new family member you must complete an Application. Each dependent will be considered independently and, if approved by us, we will determine the Issue Date of coverage for that person.
4. The additional premium charge for the new Dependent, if any, will be added to your next premium statement and must be paid with that premium when due.
5. No dependent coverage will become effective for a Dependent before the Member's coverage is effective. Insurance for a Dependent Confined in a Hospital or Skilled Care Facility on the date that his or her coverage would otherwise have become effective will become effective on the day after the final discharge from the Hospital or the Skilled Care Facility. This provision will not apply to a newborn Hospital-Confined on his or her Issue Date.
6. Following written approval by us to the Member's Application, we will determine the Issue Date of coverage for a Dependent who was previously rejected for coverage by us.

Certificate/Premium Changes

1. The Group Policyholder may request in writing a change in this Certificate at any time without your consent or the consent of any other interested party. Any such change is subject to our approval and requires the signature of the Group Policyholder and an officer of ours in order to be effective. We will provide any such change to your Certificate and the required notice to you according to the Certificate provisions.
2. We may increase or otherwise adjust the premium rates on any premium due date with 30 days advance written notice to the Member.
3. If a Preferred Provider Organization (PPO) is used in conjunction with this Certificate, the list of Participating Providers is subject to change without advance notice to you. If the agreement between us and the PPO is terminated for any reason, we will offer you a substitute plan of our choice.

Coverage Exclusion

We reserve the right to exclude from coverage by name or specific description any condition or any organ, system, part or area of the body, or high risk activity as we deem necessary. We may require you to sign an amendment to this Certificate that specifically excludes from coverage the condition or the organ, system, part or area of the body, or high risk activity, as applies to you, your spouse, or your other Dependents. We further reserve the right to decline to insure you, your spouse or your other Dependents if you do not sign the amendment to this Certificate.

Issue Date of Insurance if Totally Disabled

If you have been approved in writing by us and are Totally Disabled on the date your coverage would have otherwise taken effect, your coverage will not become effective until the second consecutive day you are no longer Totally Disabled.

Eligibility

The following provisions apply to a person's eligibility for coverage:

1. An association Member who is between the ages of 16 and 64½ is eligible to apply for coverage. However, any Member who has coverage under a similar, employer-sponsored major medical plan is not eligible for coverage under this Certificate.
2. No individual will be eligible as a Covered Dependent of more than one Member or be eligible as both a Member and a Covered Dependent. In addition, any Dependent who has coverage under a similar employer-sponsored major medical plan is not eligible for coverage under this Certificate.

Extension of Benefits

If the Covered Person is Totally Disabled on the date this coverage terminates (for reasons other than nonpayment of the required premium payment), we will extend benefits only for the Illness or Injury that caused the Total Disability. Benefits are subject to all the terms, limits and conditions in this Certificate. Premium payment will not be required during the Extension of Benefits period. These benefits will be extended under this Certificate until the earliest of:

1. 12 months after coverage terminates;
2. The date the Maximum Lifetime Benefit is reached; or
3. The end of the Total Disability.

Grace Period

A grace period of 31 days will be provided for the payment of each premium falling due after the first premium. This Certificate will stay In Force during the grace period unless you have given advance written notice to us that this Certificate will terminate prior to the end of the grace period. Benefits will be provided for any eligible claim Incurred during the 31-day grace period only if the required premium payment is received on or before the end of the 31-day grace period.

Individual Exclusion

We reserve the right to exclude you, your spouse, or another of your Dependents from coverage as we deem necessary, based on that person's health history. We may require you to sign an amendment to this Certificate that specifically excludes a spouse or another Dependent from coverage. Another offer of coverage may be made to Dependents.

Misstatement of Age

If the Age of any Covered Person has been misstated, the premiums may be adjusted. If the amount of insurance would be affected by such misstatement, it will be changed to the amount the Covered Person would have had at the correct age, and the premium will be adjusted based on the corrected age.

Modifications or Discontinuance of Coverage

1. Uniform Modification of Coverage. At the time of coverage renewal, we may modify this Certificate to a product offered to an individual in the individual market, provided such modification is consistent with state law and effective on a uniform basis among all individuals with that product.
2. Discontinuation of Coverage.
   a. Discontinuation of a Particular Type of Coverage. If we decide to discontinue offering a particular type of health insurance coverage offered in the individual market, all coverage of that type will be discontinued uniformly by us by providing:
      (1) Notice to each Covered Person at least 90 days prior to the date of the discontinuation of the particular type of coverage; and
      (2) An offer to each Covered Member of the option to purchase any other individual health insurance coverage currently being offered by us for individuals in such market.
   b. Discontinuance of All Coverage.
      (1) If we elect to discontinue offering all health insurance coverage in the individual market in a particular state, health insurance coverage may be discontinued by us if:
         (a) We provide notice to the applicable state authority and to each Covered Person covered under such coverage at least 180 days prior to the date of the discontinuation of such coverage; and
         (b) Such coverage is not renewed.
      (2) If we discontinue all coverage in the individual market in a particular state, we may not issue any health insurance coverage in the individual market and state involved during the five-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

Other Insurance With Us

You may only have one certificate with us that is comparable to this Certificate. If, through an error, we issue you more than one certificate, you may select which certificate will remain In Force. We will refund the money you paid on any other certificate, less claims paid.

Our Right to Cancel, Rescind or Reform

1. We reserve the right to cancel, rescind or reform your coverage under this Certificate in the event of fraud or misrepresentation by you or your representative including, but not limited to, fraud or misrepresentation related to any of the following:
   a. Applying for coverage, including the initial qualification for coverage or any subsequent requalification;
   b. Telephone verification of submitted information;
   c. The filing or processing of a claim; or
   d. Any other similar process or procedure.
2. In the absence of fraud, all statements made by you will be deemed representations and not warranties. No such statement will be used to deny a claim or reduce benefits unless it is stated in the Application for coverage.

Payment of Premium

1. All required premiums due are to be paid on or before the due date. Each premium payment must be received by us to be considered paid. The payment of any premium will not maintain this Certificate In Force beyond the date when the next premium is due.
2. Continued premium payments beyond the termination date will not have the effect of continuing any insurance coverage.

Renewal Agreement

We will renew this coverage or continue this coverage In Force at your option, unless any of the following occurs:

1. Nonpayment of premiums. You failed to pay premiums in accordance with the terms of this Certificate, or we have not received timely premium payments.
2. Fraud. You or your Dependents have performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact related to this Certificate or your coverage under this Certificate.
3. Loss of Eligibility. We may terminate this Certificate in any of the following situations:
   a. You are no longer a Member.
   b. The Covered Dependent, if applicable, ceases to meet the definition of a Covered Dependent.
   c. You moved to a state in which we do not hold a Certificate of Authority to issue insurance or you have moved to a state in which we do not actively market health insurance because we have discontinued all types of plans within that state.
4. Termination of Coverage. Based on the "Modifications or Discontinuance of Coverage" provision in this Certificate, we either: (a) cease to offer coverage; or (b) terminate this Certificate in its entirety.
5. Movement Outside of Service Area. If you elected Preferred Provider Organization (PPO) coverage and you no longer live, reside, or work in the service area, you may be switched to another PPO or you will be subject to Nonparticipating Provider benefits.
6. You may elect not to renew coverage by providing written notice to us. The earliest date that coverage will be terminated is on the last day of the month during which we receive written notice.

The Contract

The entire contract includes the Group Insurance Policy, this Certificate, the Application (a copy of which is attached to this Certificate), and any attached papers. We may use misstatements or omissions in your Application to contest the validity of your insurance coverage, reduce coverage, or deny a claim. Before we take any of the foregoing actions, we must first furnish you with a copy of the Application. All statements in an Application will, in the absence of fraud, be deemed representations and not warranties.

Section V. Claim Provisions

Most Providers will file claims directly with us. However, you are responsible for filing a claim with us if the Provider does not file it. The following provisions give you the information you need in order to properly file claims with us.

Notice of Loss/Claim

1. In order to properly file a claim, you must send us: a) a notice of the loss or notice of your claim; and at a later time b) a proof of loss. In the following paragraphs we describe these notices, what is required for each one, and the deadlines for submitting them.
2. We must receive your written notice of loss or claim within 20 days after the date of any covered loss. "Loss" as used in this context means the medical expenses you Incur resulting from a covered Illness or Injury. We do not require that the written notice be on a particular form; rather, you can simply send us a letter in which you inform us that you have Incurred medical expenses that you believe are Covered Expenses under this Certificate. If we have not received the written notice within 20 days of the date of loss, we will not deny or reduce a claim as long as you send us the notice as soon as is reasonably possible.
3. Within 15 days of our receipt of the notice of a claim, we will send you the forms you will need for filing a proof of loss. If we fail to provide the necessary forms within the stated time, you will be considered to have satisfied the proof of loss requirements if written proof of loss is submitted within the time requirements as stated in the Proof of Loss provision below.

Proof of Loss

1. Proof of loss as required in this Certificate means evidence of loss satisfactory to us. Our receipt, acknowledgment or investigation of a claim will not waive our rights to defend against any claim.
2. The proof of loss must include all of the following:
   a. Your name and Certificate number.
   b. The name of the Covered Person who Incurred the claim.
   c. The name and address of the Provider of the services.
   d. An itemized bill from the Provider of the services that includes all of the following (as applies):
      (1) International Classification of Diseases (ICD) diagnosis codes;
      (2) International Classification of Diseases (ICD) procedures;
      (3) Current Procedural Terminology (CPT) codes;
      (4) Healthcare Common Procedure Coding System (HCPCS) level II codes; and
      (5) National Drug Codes (NDC).
   e. A statement indicating whether the Covered Person has coverage for the services related to the Illness or Injury under any Other Insurance plan or program. If the Covered Person has other coverage, include the name and certificate or policy number of the other coverage.
3. We must receive written proof of loss no later than 90 days after the date of the loss ("Written Notice Period").
4. If we have not received written proof of loss within the Written Notice Period, we will not deny or reduce a claim as long as you send us the proof of loss as soon as is reasonably possible. Except in the case of documented legal incapacity, in no event will we accept proof of loss beyond one year after the end of the Written Notice Period.

5. After we receive written proof of loss, we may require additional information from you in order to evaluate your claim. You must furnish all such information pursuant to the Right to Collect Information provision below. We will not pay benefits if the required information, or an authorization for its release, is not furnished to us.

Right to Collect Information

To determine our liability, we may request additional information from a Covered Person, Provider, facility, or other individual or entity. A Covered Person must cooperate with us, and assist us by obtaining the following information within 30 days of our request. Charges will be denied if we are unable to determine our liability because a Covered Person, Provider, facility, or other individual or entity fails to do any of the following:

1. Authorize the release of all medical records to us and/or fails to authorize the release of other information we request;
2. Provide us with information we request about pending claims, Other Insurance coverage or proof of creditable coverage;
3. Provide us with information as required by any contract with us or a network including, but not limited to, repricing information;
4. Provide us with information that is accurate and complete;
5. Have any examination completed as requested by us; or
6. Reasonably cooperate with any requests made by us.

Such charges may be considered for Benefits upon receipt of the requested information, provided that we receive all necessary information before the expiration of the time allowed for submission of claim information as set forth in this Claims Provisions section.

Examination

We have the right to require that you be examined by a Physician of our choice, at our own expense, as often as we may require. In the event of your death, we have the right to require an autopsy, unless otherwise prohibited by law.

Payment of Claim

1. Benefits will be paid to you unless benefits have been assigned to the Provider. We are not responsible for verifying the validity of the assignment.
2. If we determine that you are not legally able to receive such payment, we may at our option pay the Benefits to:
   a. Providers; or
   b. Your estate; or
   c. Your closest living relative.
3. We reserve the right to allocate any Covered Expenses to any Deductible and to apportion the benefits to you and to any assignees. Such actions will be binding on you and the assignees.
4. Upon receipt of the required written proof of loss, we normally will pay claims within 30 days of our receipt of the written proof of loss.

Overpayment or Erroneous Payment

If a benefit is paid under this Certificate and it is later determined that a lesser amount or no amount should have been paid, we are entitled to recover the excess amount from you, the beneficiary or the Provider. We may offset the overpayment or erroneous payment against future benefit payments.

Utilization Review Process

You must call the toll-free number on your identification (ID) card to obtain our authorization for the services listed in the "When to Call" provision below. Benefits will be reduced as described in the "Reduction of Payment" provision below if a Covered Person does not comply with this Utilization Review Process and does not obtain authorization.

A review by the Utilization Review Manager does not guarantee that benefits will be paid. Payment of benefits will be subject to all other terms, limits and conditions in this Certificate.

1. **Utilization Review Procedures**.
   a. In order to obtain authorization for the services, the Covered Person must contact our Utilization Review Manager by calling the toll free number on the ID card. Please have all of the following information on hand before calling:
      (1) Your Certificate number for this Certificate;
      (2) The Provider's name and telephone number;
      (3) The service, procedure and diagnosis;
      (4) The proposed date of admission or date the service or procedure will be performed; and
      (5) The facility's name and phone number.
   b. The Utilization Review Manager may review a proposed service or procedure to determine any of the following:
      (1) Medical Necessity;
      (2) Whether it is a Cosmetic service or an Experimental or Investigational service;
      (3) Location of the Treatment; and
      (4) Length of stay for an Inpatient Confinement.
2. **When to Call.**
   a. **Contact the Utilization Review Manager for authorization of the following services:**
      (1) **Inpatient Confinements:** Call us to obtain authorization for an admission to an Inpatient facility, or transfer between Inpatient facilities, or any other Inpatient Confinement that will exceed 24 hours as follows:
         (a) ***Non-Emergency Confinements:*** Call at least 3 business days prior to an Inpatient admission for a nonemergency Confinement that will exceed 24 hours in length.
         (b) ***Emergency Care Confinements:*** Call within 24 hours, or as soon as reasonably possible, after admission for an Emergency Care Confinement that will exceed 24 hours in length. The Covered Person must provide or make available to the Utilization Review Manager the full details of the Emergency Care Confinement.
         (c) ***Extended Confinement for Complication of Pregnancy:*** In the event of a Complication of Pregnancy that results in an Inpatient Confinement exceeding 48 hours following a normal, vaginal delivery or 96 hours following a caesarean section delivery, the Covered Person must call prior to the end of the Confinement, or as soon as reasonably possible. Any other Inpatient Confinements because of Complications of Pregnancy that occur during a pregnancy must be authorized in accordance with the Non-Emergency Confinements and Emergency Confinements provisions above.

(d) ***Continued Stay Review:*** We may request additional clinical information during an Inpatient Confinement. Failure of the Physician or facility to provide the requested information will result in nonauthorization of benefits for continued Inpatient Confinement. No benefits will be considered until we receive the additional information. No benefits will be paid for the days of Inpatient Confinement beyond the originally scheduled discharge date if the continued stay would not have been authorized by the Utilization Review Manager based on review of the additional information provided.

(2) **Outpatient Procedures:** Call us to obtain authorization for the following procedures that are performed in an Outpatient setting. Call at least 3 business days before receiving any of the following nonemergency Outpatient services (if you have the particular benefit):

(a) Surgical procedures;

(b) Home Health Care;

(c) Home infusion;

(d) Hospice care;

(e) Physical medicine including physical therapy, occupational therapy or speech therapy.

(3) **Transplants:** Call at least 7 business days prior to any transplant evaluation, testing, preparative Treatment or donor search.

b. The review process must be repeated if Treatment is received more than 30 days after review by our Utilization Review Manager or if the type of Treatment, admitting Physician or facility differs from what the Utilization Review Manager authorized. A determination by the Utilization Review Manager does not alter, limit or restrict in any manner the attending Provider's ultimate patient care responsibility.

3. **Reduction of Payment**. If you do not obtain authorization from us for the course of Treatment for the services listed in the When to Call provision above, benefits will be reduced for otherwise Covered Expenses by 25% if any of the following occur:

a. The Covered Person does not contact the Utilization Review Manager within the required time frame;

b. The type of Treatment, admitting Physician or facility differs from what was authorized by the Utilization Review Manager; or

c. The Treatment is Incurred more than 30 days after review by the Utilization Review Manager.

The reduced amount, or any portion thereof, under this section will not count toward satisfying any Access Fee, Coinsurance, Copayment, Deductible or Out-of-Pocket Limit.

Case Management Program

1. You may be referred to our Case Management Program if you have a complex Illness or Injury requiring ongoing medical care. Our Case Management Program is a voluntary program. If you participate in the Case Management Program, one of our trained registered nurses ("a Care Manager") will coordinate with you and your Provider in the development of a health care treatment plan that is intended to:

a. Respond to your health care needs; and

b. Be cost-effective and promote efficient use of Certificate benefits.

2. The proposed health care treatment plan must be approved by us to ensure that any care provided pursuant to the treatment plan is Medically Necessary, cost-effective and involves efficient use of Certificate benefits. The health care treatment plan is also subject to approval by you and your Physician.

3. The Case Management Program may be initiated by:

a. You;

b. Your family members;

c. Your Physician or Provider; or

d. Us.

4. It is your decision whether or not to participate in our Case Management Program. Our Case Management Program does not replace the care received from your Physician. You and your Physician remain in charge of your health care treatment plan.

5. Through Case Management we may agree on a limited basis to modify certain terms or conditions of this Certificate. Providing benefits under the Case Management Program in a particular case does not commit us to do so in another case, nor does it waive or modify the terms and conditions of this Certificate, render them unenforceable or prevent us from strictly applying the benefits, limitations and exclusions of this Certificate at any other time or for any other insured person, whether or not the circumstances are similar or the same.

Coordination of Benefits

1. Coordination of Benefits (COB) may limit benefits when you are insured under more than one plan (certificate or policy). The Benefits payable under this Certificate may be reduced, under the rules shown below, so that you will receive no more than 100% of Covered Expenses from all plans combined.

2. The plans with which this Certificate coordinates benefits are:

   a. Group insurance;

   b. Individual insurance;

   c. Other arrangements, whether insured or uninsured, covering individuals in a group;

   d. Blue Cross and Blue Shield plans on an individual or group basis;

   e. Plans of Hospital or medical service organizations on a group basis;

   f. Group practice plans;

   g. Group prepayment plans;

   h. Federal government plans or programs;

   i. Medicare Parts A and B;

   j. Coverage required or provided by law;

   k. Student insurance, except that COB will not apply to accident-only coverage for elementary, middle, or high school students;

   l. Group auto insurance, including group no-fault auto insurance; and

   m. Individual no-fault auto insurance, by whatever name called.

3. We will pay the regular benefits if we are determined to be the primary plan. If we are determined to be the secondary plan, we will pay the excess of Covered Expenses after the primary plan pays its regular benefits. In any event, we will not pay more than the regular benefits of our Certificate.

4. The following rules determine which plan is primary and which is secondary:

   a. Any plan that does not have a COB provision will be the primary plan and pay first.

   b. For a plan having a COB provision, the following rules apply:

      (1) The plan that covers the Covered Person as an employee, member or nondependent will pay its benefits first.

(2) The plan that covers the Covered Person as a dependent (spouse or children) will be considered the secondary plan and pay after any other plan.

(3) For covered dependent children:

(a) The benefits of the plan of the parent whose birthday (month and day only) falls earlier in a year will apply for the covered dependent children before those of the plan of the parent whose birthday falls later in that year.

(b) If both parents have the same birthday (month and day only), the benefits of the plan that covered the parent longer will apply for the covered dependent children before those of the plan which covered the other parent for a shorter period of time.

(c) If the other plan does not have the birthday rule described above, but instead has a rule based upon the gender of the parent and if, as a result, the plans do not agree on the order of benefits, the rule based upon the gender of the parent will determine the order of benefits.

c. If the natural parents of the covered dependent child are divorced or otherwise separated, the following coordination of benefit rules apply:

(1) If the parent with custody of the child has not remarried, the plan which covers the child as a dependent of that parent will be considered before the plan that covers the child as the dependent of the parent without custody.

(2) If the parent with custody of the child has remarried, the plan which covers the child as a dependent of that parent will be considered before the plan that covers the child as a dependent of the current stepparent. The plan that covers the child as a dependent of the parent without custody will be considered last.

(3) If there is a court decree that establishes financial responsibility for the medical, dental or other health care expenses with respect to the child, (i) and (ii) above will not apply. The plan that covers the child as a dependent of the parent with such financial responsibility will be considered before any other plan that covers the child as a dependent.

d. When the rules above do not apply, the plan that has insured the person the longest will be primary, except that a plan insuring the individual as a retired or laid off employee will pay as secondary plan.

5. An allowable expense is a Medically Necessary expense under this Certificate and covered, at least in part, by one of the other plans. If a plan provides benefits in the form of services rather than cash payments, we will determine a reasonable cash value for each service that is provided and that cash value will be considered the allowable expense and the amount paid by the other plan.

6. Benefits will be coordinated on a Calendar Year basis or any portion of a Calendar Year in which the person was insured by us.

7. For purposes of this COB provision, any or all of the following may apply:

a. You are required to furnish us with complete information concerning all plans and benefits paid or payable from other plans.

b. As permitted by law, we may without your consent:

(1) Obtain information from all plans involved;

(2) Reimburse such other plans, if we determine that benefits have been paid by another plan that should have been paid by us. Such reimbursement will be a valid payment under the terms of this Certificate.

c. We may obtain reimbursement from any other plan, and/or from you, if we have paid benefits that should have been paid by any other plan. Such reimbursement is a valid payment under the other plan.

d. We may obtain a refund of any amount that exceeded 100% of Covered Expenses as a result of our payment as a secondary plan.

Cost Containment

We reserve the right to initiate, conduct and maintain, or to contract for, various programs and procedures directed at containing medical costs. Such programs and procedures include, but are not limited to:

1. Utilization Review;
2. Continued stay review;
3. Retrospective review;
4. Auditing of expenses including, but not limited to, the review of coding and payment. We will pay appropriate medical claims when coded according to the latest editions of the Current Procedural Terminology (CPT) manual or International Classification of Diseases (ICD) manual. We will not pay for any of the following:
   a. Charges that are billed separately as professional services when the procedure requires only a technical component;
   b. Charges that are billed incorrectly or billed separately but are an integral part of another billed service;
   c. Other claims that are improperly billed; or
   d. Duplicates of previously received or processed claims.
5. Our auditing process also includes adjustments when a Physician bills for a secondary or tertiary procedure. A secondary or tertiary procedure is a procedure that is separate and distinct from the primary procedure, but which is performed by the same Physician during the same operative session. A procedure is considered secondary or tertiary because the patient only requires anesthesia or analgesia one time, the procedure room is used only one time, and set up for the separate procedure is done at the same time. For secondary or tertiary procedures performed during the same operative session, the Covered Expenses for the Physician's bill will be:
   a. One hundred percent of the Usual and Customary Charge for the primary procedure;
   b. Fifty percent of the Usual and Customary Charge for the secondary procedure; and
   c. Twenty-five percent of the Usual and Customary Charge for each additional procedure.
6. Negotiated Payment Arrangements.

Workers' Compensation

This Certificate is not a workers' compensation policy. This Certificate does not satisfy any governmental requirements for coverage by workers' compensation insurance.

Time Limit on Certain Defenses

After 2 years from the Issue Date, no misstatements made by the applicant in the Application for this Certificate, except fraudulent misstatements, shall be used to void the Certificate or to deny a claim for loss Incurred or Total Disability commencing after the expiration of such 2 year period. No claim for loss Incurred or Total Disability commencing after 2 years from the Issue Date shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the Issue Date.

Appeal of (Claim) Decision

"Grievance" means a written complaint submitted by or on behalf of a Covered Person ("you" or "your") regarding the:

1. Availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review:
2. Claims payment, handling or reimbursement for health care services; or
3. Matters pertaining to the contractual relationship between you and us.

The following grievance process is voluntary to you.

***Informal Reconsideration* —** If you have a problem or complaint concerning a claim, certificate provision, decision or action, you may attempt to resolve the problem immediately by contacting the Customer Service Department at this toll-free telephone number [1-800-786-7557]. An attempt will be made to solve the problem to your satisfaction during the initial telephone call.

If you are not satisfied, you may voluntarily submit a written grievance with us at:

[World Insurance Company
P.O. Box 2155
Omaha, Nebraska 68103-0155
ATTN: Grievance Coordinator]

Your state department of insurance is available to assist insurance consumers with insurance-related problems and questions.

You may inquire in writing to:

[Arkansas Insurance Department
Consumer Services Division
Third and Cross Streets
Little Rock, AR 72201
(501) 371-2640
Fax: (501) 371-2749
or call: 1-800-852-5494]

Internal Grievance Procedure

First-Level Grievance Review — The grievance may be submitted by you, your representative or your health care Provider ("Provider") acting on your behalf.

You must submit written material for consideration by the first-level reviewers.

Upon receipt of a request for the first-level grievance review, we will:

1. Within three business days after receiving a grievance, provide you with the name, address and telephone number of the grievance coordinator and information on how to submit written material;
2. Within 20 business days after receiving a grievance, issue a written decision to you or your representative. If we cannot make a decision within 20 business days due to circumstances beyond our control, we may take up to an additional 10 business days to issue a written decision. The person(s) reviewing the grievance shall not be the same person(s) who initially handled the matter that is the subject of the grievance; and if the issue is a clinical one, at least one of whom shall be a medical doctor with appropriate expertise to evaluate the matter. The written decision issued in a first-level grievance review will contain:
    a. The professional qualifications and licensure of the person or persons reviewing the grievance.
    b. A statement of the reviewers' understanding of the grievance.

c. The reviewers' decision in clear terms and the contractual basis or medical rationale in sufficient detail for you to respond further to our position.

d. A reference to the evidence or documentation used as the basis for the decision.

e. A statement advising you of your right to request a second-level grievance review and a description of the procedure for submitting a second-level grievance.

Second-Level Grievance Review — A second-level grievance review process is available for you if you are dissatisfied with the first-level grievance review decision or a Utilization Review (UR) appeal decision.

We will, within 10 business days after receiving a request for a second-level grievance review, provide the following information to you:

1. Name, address and telephone number of grievance review coordinator;
2. Statement of your rights, including the right to:
   a. Request and receive from us all information relevant to the case;
   b. Present your case to the review panel;
   c. Submit supporting material prior to and at the review meeting;
   d. Ask questions of any member of the panel; and
   e. Be assisted or represented by a person of your choosing; including a family member, authorized representative or attorney.

Second-Level Grievance Review Procedures — The second-level grievance review will include:

1. The review panel will schedule and hold a review meeting within 45 business days after receiving a request for a second-level review.
2. You will be notified in writing at least 15 working days before the review meeting date.
3. Your right to a full review will not be conditioned on your appearance at the review meeting.

Second-Level Grievance Review Decisions — We will issue a written decision to you and, if applicable, to your Provider within seven business days after completing the review meeting. The decision will include:

1. The professional qualifications and licensure of the members of the review panel;
2. A statement of the review panel's understanding of the nature of the grievance and all pertinent facts;
3. The review panel's recommendation to us and the rationale behind that recommendation;
4. A description of or reference to the evidence or documentation considered by the review panel in making the recommendation;
5. In the review of a noncertification or other clinical matter, a written statement of the clinical rationale, including the clinical review criteria, that was used by the review panel to make the recommendation;
6. The rationale for our decision if it differs from the review panel's recommendation;
7. A statement that the decision is our final determination in the matter; and
8. Notice of the availability of the Commissioner's office for assistance, including the telephone number and address of the Commissioner's office.

Expedited Second-Level Review Procedures

An expedited second-level review will be made available where medically justified, whether or not the initial review was expedited. We are not required to provide an expedited review for retrospective adverse determinations. The provisions of Second-Level Grievance Review, Second-Level Grievance Review

Procedures, and Second-Level Grievance Review Decisions apply to expedited review except for the following timetable:

1. Review proceeding must take place and the decision communicated to you within four business days of receiving all the necessary information.
2. Review meeting must take place by way of a telephone conference call or through the exchange of written information.

We will not discriminate against any Provider based on any action taken under this provision or under the UR provisions on your behalf.

Standard External Review

At the time we receive a request for an external review, we shall assign an independent review organization (IRO) from the list of approved IRO's compiled and maintained by the commissioner to conduct a preliminary review of the request to determine if:

1. Tthe report for external review meets the applicability standards for external review;
2. You have exhausted our internal grievance process unless you are not required to; and
3. You have provided all the information and forms required to process an external review, including the authorization form.

Within five (5) business days after receipt of the request for external review, the IRO assigned shall complete the preliminary review and notify us, you, and your treating health care professional in writing whether: a) the request is complete; and b) the request has been accepted for external review. The assigned IRO shall include in the notice a statement that we, you, and your treating health care professional may submit in writing to the IRO within seven (7) business days following the date of receipt of the notice, additional information and supporting documentation that the IRO shall consider when conducting the external review.

If the request: a) is not complete, the assigned IRO shall, within five (5) business days, inform us, you, and your treating health care professional what information or materials are needed to make the request complete; or b) is not accepted for external review, the assigned IRO shall inform you, your treating health care professional and us in writing within five (5) business days, of the reasons for its non-acceptance.

Upon receipt of any information submitted by you, the assigned IRO immediately shall forward copies of the information to us.

In reaching a decision to accept or reject a matter for external review, the assigned IRO is not bound by any decisions or conclusions reached during our internal grievance procedure or utilization review procedure.

Within seven (7) business days after the date of receipt of the notice, we shall provide to the assigned IRO, you, and your treating health care professional, the documents and any information considered in making the adverse determination or final adverse determination, together with any additional information we submit. Failure by us or our utilization review organization to provide the documents and information within the time specified shall not delay the conduct of the external review. If we or our utilization review organization fail to provide the documents and information within the time specified, the assigned IRO may terminate the external review and make a decision to reverse the adverse determination or final adverse determination. Immediately upon making the decision, IRO shall notify you, your treating health care professional, and us.

The assigned IRO shall review all of the information and documents submitted by you, your treating health care professional, and us. Upon receipt of the information, if any, required to be forwarded, we may reconsider its adverse determination or final adverse determination that is the subject of the external review. Reconsideration by us of our adverse determination or final adverse determination shall not delay or terminate the external review. The external review may only be terminated if we

decide, upon completion of our reconsideration, to reverse its adverse determination or final adverse determination and provide coverage or payment for the health care services that is the subject of the adverse determination or final adverse determination. Immediately upon making the decision to reverse its adverse determination or final adverse determination, we shall notify you, your treating health care professional, and the assigned IRO in writing of our decision. The assigned IRO shall terminate the external review upon receipt of the notice from us.

In exercising its independent medical judgment in reviewing an adverse determination, in additional to the documents and information provided, the assigned IRO, to the extent the information or documents are available, shall consider the following in reaching a decision:

1. Your medical records;
2. The treating health care professional's recommendation;
3. Consulting reports from appropriate health care professionals and other documents submitted by us, you, or your treating health care professional;
4. The applicable terms of coverage under your health benefit plan to ensure that the IRO's decision is not contrary to the terms of coverage;
5. The most appropriate practice guidelines, which may include generally accepted practice guidelines, evidence-based practice guidelines or any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;
6. Any applicable written screening procedures, decision abstracts, clinical protocols and practice guidelines used by us to determine the necessity and appropriateness of health care services;
7. If the adverse determination involves a denial of coverage based on a determination that the recommended or requested health care services is "Experimental" or "Investigational," the IRO shall also consider whether:
    a. The recommended or requested health care service or Treatment has been approved by the federal Food and Drug Administration for the condition, while realizing that Treatments or services are often legitimately used for purposes other than those listed in the FDA approval; or
    b. Medical or scientific evidence demonstrates that the expected benefits of the recommended or requested health care service or Treatment is more likely than not, to be more beneficial to you than any available standard health care service or Treatment, and the adverse risks of the recommended or requested health care service or Treatment would not be substantially increased over those of available standard health care services or Treatments.

Within 45 calendar days after the date of receipt of the request for an external review, the assigned IRO shall provide written notice of its decision to uphold, reverse, or partially uphold or reverse, the adverse determination or the final adverse determination to you, your treating health care professional, and us. The IRO shall include in the notice sent:

1. A general description of the reason for the request for external review;
2. The date the IRO received the assignment from us to conduct the preliminary review of the external review request;
3. The date the external review was conducted, if appropriate;
4. the date of its decision;
5. The principal reason or reasons for its decision;
6. The rationale for its decision; and

7. References to the evidence or documentation, including the practice guidelines, considered in reaching its decision.

If the adverse determination involves a denial of coverage based on a determination that the recommended or requested health care services is “experimental” or “investigational,” the IRO shall also consider whether:

1. Aa description of the indicators relevant to determining whether there is sufficient evidence to demonstrate that the recommended or requested health care service or Treatments is more likely than not, to be more beneficial to you than any available standard health care services or Treatments, and the adverse risks of the recommended or requested health care service or Treatment would not be substantially increased over those of available standard health care services or Treatments; and
2. A description and analysis of any medical or scientific evidence, considered in reaching the opinion.

Upon receipt of a notice of a decision reversing the adverse determination or final adverse determination, we immediately shall approve the coverage that was the subject of the adverse determination or final adverse determination.

Expedited External Review

You may make a request for an expedited external review with us at the time you receive an adverse determination if the criteria for an external review, as noted above, is met. At the time you make a request for an expedited external review, you or your treating health care professional shall submit additional information and supporting documentation that the IRO shall consider when conducting the expedited external review.

At the time we receive a request for an expedited external review, we immediately shall assign an IRO from the list compiled and maintained, to determine whether the request meets the reviewability requirements set forth in this provision, and conduct the external review if the request meets the reviewability requirements. In reaching a decision, the assigned IRO is not bound by any decisions or conclusions reached during our utilization review process or our internal grievance process.

At the time we assign an IRO to conduct the expedited external review, we shall immediately provide or transmit all documents and information considered in making the adverse determination or final adverse determination, as well as any additional information and supporting documentation, to the assigned IRO, you, and your person’s treating health care professional via electronically, facsimile or any other available expeditious method. We shall also submit to the IRO any information you submit, in addition to the documents and information provided or transmitted, to the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate.

As expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the date of receipt of the request for an expedited external review that meets the reviewability requirements, the assigned IRO shall:

1. Make a decision to uphold or reverse the adverse determination; and
2. Notify you, your treating health care professional, and us of the decision.

If the notice provided was not in writing within two (2) days after the date of providing that notice, the assigned IRO shall:

1. Provide a written or electronic media confirmation of the decision to you and us; and
2. Include the information set forth above under the standard external review requirements.

Upon receipt of notice of a decision reversing the adverse determination or final adverse determination, we immediately shall approve the coverage that was the subject of the adverse determination or final adverse determination.

An expedited external review may not be provided for adverse or final adverse determinations involving a retrospective review.

Binding Nature of External Review Decision

An external review decision is binding on us except to the extent we have other remedies available under applicable federal or state law. An external review decision is binding on you except to the extent you have other remedies available under applicable federal or state law. You may not file a subsequent request for external review involving the same adverse determination or final adverse determination for which you have already received an external review decision

Legal Actions

All of the following limitations apply to your ability to file an action at law or equity relating to this Certificate:

1. You cannot file such an action at law or equity before the expiration of 60 days after proof of loss has been furnished to us in accordance with the requirements of this Certificate;
2. You cannot file such an action at law or equity unless you have fully complied with this Certificate's appeal procedures; and
3. You cannot bring an action at law or equity unless you bring it within three years from the expiration of the time by which proof of loss is required under the terms of this Certificate.

Right of Reimbursement

1. If a Covered Person Incurs expenses for an Illness or Injury that occurred due to the negligence of a third party:
   a. We have the right to reimbursement for all Benefits we paid if damages are collected from the third party for those same expenses. This right of reimbursement exists regardless of whether such damages are recovered by action at law, settlement, or compromise, by you, your parents if you are a minor, or your legal representative; and
   b. We are assigned the right to recover from the third party or his or her insurer, to the extent of the benefits we paid for the Illness or Injury.
2. We shall have the right to first reimbursement out of all funds you, the Covered Person's parents (if the Covered Person is a minor) or the Covered Person's legal representative, are or were able to obtain for the same expenses we paid as a result of that Illness or Injury.
3. You are required to furnish any information or assistance or provide any documents that we may reasonably require in order to exercise our rights under this provision. This provision applies whether or not the third party admits liability.
4. You must provide us with timely written notification in the event that a Covered Person suffers an Illness or an Injury in which a third party might be responsible and the Covered Person seeks recourse against any person, entity or Other Insurance coverage by suit, settlement, judgment or otherwise. Such a notice must inform us of all of the following:
   a. The nature of the Illness or Injury;
   b. The names, addresses and phone numbers of any insurance companies or other third parties who may be responsible for payment of damages suffered by the Covered Person;
   c. A description of the accident or occurrence that the Covered Person reasonably believes was responsible for the Illness or Injury at issue and the approximate date(s) on which such accident or occurrence happened; and
   d. The name of any legal counsel retained by a Covered Person in connection with any such accident or occurrence.
5. If a Covered Person brings a lawsuit or other proceeding to recover damages in connection with any such accident or occurrence, you or your attorney must provide us with copies of all pleadings, notices and other documents and papers that are related to our right to reimbursement under this Certificate. We

reserve the right to intervene in any proceeding in which a Covered Person is a party to the extent that such intervention is reasonably necessary to protect our right to reimbursement under this Certificate.

6. Upon recovery of any portion of our reimbursement interest by way of settlement or judgment, we will not be required, under any circumstances, to pay a fee to the Covered Person's attorney or share in any costs Incurred by the Covered Person and/or the Covered Person's attorney in obtaining the settlement or judgment.
7. A Covered Person is not obligated by this provision to seek legal action against any person or entity for recovery of Benefits paid under this Certificate.

Section VI. Continuation and Conversion

Continuation of Coverage

You and Covered Dependents may be eligible to have the medical coverage continued under this Certificate after coverage otherwise would terminate if such termination is the result of your loss of membership. However, to have coverage continued under this provision, you and the Covered Dependents must continue to satisfy the other conditions of this Certificate. The following provisions apply to the continuation of coverage for you and Covered Dependents.

1. For you and your Covered Dependents.
   a. You may continue coverage under this Certificate for yourself and your Covered Dependents for as long as nine months when both of the following have occurred:
      (1) Your coverage ends because your membership in the association ends; and
      (2) You have been insured under this Certificate for at least three months before your coverage ends.
   b. If you elect to continue coverage under this Certificate, you must send to us:
      (1) Written notice that you want to continue coverage; and
      (2) The first monthly premium.
   c. If we provide you with written notice of your right to continue coverage, you must make your election to continue coverage on or before the later of the following dates:
      (1) Ten days after your membership in the association ends; or
      (2) Ten days after we have provided written notice of your right to continue coverage.
   d. If we do not provide you with the written notice, you must make your election to continue coverage no later than 60 days after your membership in the association ends (not when any applicable extension of benefits ends).
   e. You must continue to make premium payments to us throughout the period of continued coverage. During the period in which your coverage is continued, we are not required to send you any notification that your premium is due.
   f. Your continued coverage under this Certificate will end at 12:01 a.m. local time at your state of residence on the earliest of the following dates:
      (1) The day any premium is due but unpaid;
      (2) The date 9 months after the date you make your continuation election;
      (3) The day you become insured under similar group coverage that was not in effect on the day your membership in the association ended;
      (4) The date you become entitled to Medicare coverage;
      (5) The day you enter the armed forces;
      (6) The day you are no longer an eligible Dependent; or
      (7) The day continued coverage becomes conversion coverage.

2. For your Covered Dependents, covered spouse, former spouse, domestic partner, or person with whom you have a civil union ("civil union partner") if the forgoing were covered under this Certificate.

   a. Your current spouse, domestic partner or civil union partner (if covered under this Certificate), former covered spouse, domestic partner or civil union partner (in the event you die, your marriage is ended in divorce or annulment, or your domestic partnership or civil union ends) and any other Covered Dependents may continue this coverage until the earliest of:

      (1) The day any premium is due but unpaid, including any grace period provided by the Certificate;

      (2) The day coverage under the Certificate would end if you or your former spouse were still married;

      (3) The day coverage under the Certificate would end if you or your former domestic partner were still domestic partners;

      (4) The day coverage under the Certificate would end if you or your former civil union partner still were civil union partners;

      (5) The day a Dependent no longer meets the definition of a Covered Dependent under this Certificate;

      (6) The day your former spouse remarries;

      (7) The day your current or former spouse, current or former domestic partner, or current or former civil union partner becomes insured under any other group health plan;

      (8) The day continued coverage becomes Conversion Coverage.

   b. To elect to continue coverage under this Certificate, your current or former spouse, current or former domestic partner, current or former civil union partner, or another Covered Dependent must notify us of their desire to continue coverage within 30 days following your death, divorce, annulment, or the date that person no longer meets the definition of "Dependent" under this Certificate. Within 30 days after we receive such notice, we will send the following materials to your current or former spouse, current or former domestic partner, current or former civil union partner, or other Covered Dependent by certified mail, return receipt requested:

      (1) A form on which your current or former spouse, current or former domestic partner, current or former civil union partner, or other Covered Dependent can elect to continue coverage under this Certificate;

      (2) The dollar amount of the premiums that must be paid for coverage to continue and when such premium payments will be due;

      (3) The method and place of payment;

      (4) Instructions for returning the election form.

      If your former or current spouse, current or former domestic partner, or current or former civil union partner fails to return the election form and the required premium payment to us within the required time period, his or her rights of continuation and continued benefits will end. **We require that your current or former spouse, current or former domestic partner, current or former civil union partner or other Covered Dependent return the election form by certified mail, return receipt requested, within 30 days after the date on which we mail the election form to them.**

   c. If we fail to send the notification as described above, all premiums will be waived and benefits will continue under the terms of the Certificate. Such waiver of premiums and continuation of benefits will be limited to the period between the date such notice is required through the date such notice ultimately is sent. The foregoing waiver of premiums and continuation of benefits will not occur if the benefits that existed, at the time such notice was to be sent, end for all Covered Persons under the group policy.

Conversion Coverage

1. This Conversion Coverage provision sets forth the rules and processes for Covered Persons who want to obtain conversion coverage. In providing conversion coverage, please be advised that we may provide different benefit levels, covered services and premium rates.
2. Conversion coverage is available to you if your coverage under this Certificate ends unless your coverage ends for any one of the following reasons:
   a. You fail to make any required premium payment;
   b. The group policy is terminated;
   c. You have similar individual or group coverage; or
   d. You are eligible for or have Medicare coverage.
3. Conversion coverage is available to your Covered Dependents if their coverage ends because:
   a. Your coverage ends;
   b. You die;
   c. Your marriage is ended by divorce or annulment;
   d. Your domestic partnership ends;
   e. Your civil union partnership ends; or
   c. A covered dependent child is no longer an eligible Dependent.
4. Conversion coverage is not available to a Covered Dependent when any one of the following occurs:
   a. You fail to make the required premium payment;
   b. The group policy is terminated;
   c. The Covered Dependent has similar individual or group coverage; or
   d. The Covered Dependent is eligible for or has Medicare coverage.
5. Option to Obtain Conversion Coverage. If application and the first premium payment are made within the required time period, conversion coverage will be issued in accordance with our rules and the conversion law in effect when application is made.
6. If we provide you with written notice of the right to convert coverage, application and the first premium payment must be received by us by the later of:
   a. 31 days after coverage under this Certificate ends; or
   b. 31 days after we provide you with written notice of the right to convert coverage.

   If we do not provide you with written notice of the right to convert coverage, application and the first premium payment must be received by us no later than 60 days after coverage under this Certificate ends (not when any applicable extension of benefits ends).
7. Application to convert coverage may be made:
   a. By you:
      (1) For yourself;
      (2) For yourself and any Covered Dependent whose coverage under this Certificate ends because your coverage under this Certificate ends; or
      (3) For any Covered Dependent who does not have the legal capacity to apply.

b. By any Covered Dependent to whom conversion coverage is available.

8. Conditions. Conversion coverage begins immediately after coverage under this Certificate ends. Covered Expenses for which Benefits are payable under this Certificate will not be paid under the conversion coverage. Coverage for conditions that are excluded under this Certificate may be excluded under the conversion coverage.

Arkansas

State Mandated Benefits Rider

This rider is made a part of the Certificate to which it is attached. It is subject to all the provisions of the Certificate not in conflict with the provisions of this rider.

The provisions described in this rider are applicable when the Certificate, to which this rider is attached, is issued to residents of the state of Arkansas.

The following Covered Expenses are added to the Certificate:

1. General anesthesia and Hospital or ambulatory surgical facility charges for services performed in connection with dental procedures in such facilities, if the Provider treating the Covered Person certifies that, because of the person's Age or condition or problem, Hospitalization or general anesthesia is required in order to safely and effectively perform the procedures and the patient is:
   a. A child under 7 years of Age who is determined by 2 dentists to require, without delay, necessary dental Treatment in a Hospital or ambulatory surgical center for a significantly complex dental condition;
   b. A Covered Person with a diagnosed serious mental or physical condition; or
   c. A Covered Person with a significant behavioral problem as determined by the Covered Person's Physician.
2. Colorectal cancer examinations and laboratory tests for Covered Persons who are 50 years of Age or older; less than 50 years of Age and at high risk for colorectal cancer; and Covered Persons experiencing bleeding from the rectum or blood in the stool or a change in bowel habits such as diarrhea, constipation, or narrowing of the stool that lasts more than 5 days.
3. Screening shall include the following examinations and laboratory tests: Annual fecal occult blood test utilizing the take-home sample method or an annual fecal immunochemical test in conjunction with a flexible sigmoidoscopy every 5 years; double contrast barium enema every 5 years; or a colonoscopy every 10 years.
4. Medically Necessary equipment, supplies, and services for the Treatment of Type I, Type II, and gestational diabetes when prescribed by a licensed Physician. Diabetes self-management training is also a benefit under this provision. Medically Necessary and Physician-prescribed diabetes self-management training is limited to 1 per lifetime.
5. Diabetes self-management training. Shall offer, in addition to the required 1 per lifetime training program, additional diabetes self-management training in the event the Physician prescribes Medically Necessary additional training because of a significant change in the Covered Person's symptoms or condition.
6. Postmastectomy care. Inpatient coverage for a period up to 48 hours following a mastectomy.
7. Mammography screening for the presence of occult breast cancer as follows:
   a. For women 35 to 40 years of Age – a baseline mammogram;
   b. For women 40 to 49 years of Age, inclusive, one mammogram every 1 to 2 years based on recommendation of the woman's Physician;
   c. For women Age 50 and older – one mammogram each year or more frequent mammograms if recommended by the woman's Physician;
   d. This covered expense is limited to not less than $50 for each screening mammogram, which shall include payment for both the professional and technical components. In the case of Hospital Outpatient screening mammography, when there is a claim for the professional services separate from the claim for technical services, the claim for the professional component will not be less than 40% of the total fee.

8. Treatment of loss or impairment of speech or hearing. “Loss or impairment of speech or hearing” shall include those communicative disorders generally treated by a speech pathologist or audiologist licensed by the Board of Examiners in Speech-Language Pathology and Audiology and which fall within the scope of his or her area of certification. Coverage provided for loss or impairment of speech or hearing does not include hearing instruments or devices.

9. Child preventive health care services on a periodic basis. Such services shall include 20 visits at approximately the following Age intervals: birth; 2 weeks; 2 months; 4 months; 6 months; 9 months; 12 months; 15 months; 18 months; 2 years; 3 years; 4 years; 5 years; 6 years; 8 years; 10 years; 12 years; 14 years; 16 years; and 18 years. Services rendered during a periodic review shall only be covered to the extent that those services are provided by or under the supervision of a single Physician during the course of one visit. Benefits for immunization services are exempt from any Coinsurance, Deductible, Copayment or dollar limit of the certificate.

   “Children’s Preventive Health Care Services” means Physician-delivered or Physician-supervised services for covered dependent children from birth through Age 18, with periodic preventive care visits, including medical history, physical examination, developmental assessment, anticipatory guidance and appropriate immunizations and laboratory tests, in keeping with prevailing medical standards.

10. Medical foods and low protein modified food products for the Medically Necessary Treatment of phenylketonuria, galactosemia, organic acidemias, and disorders of amino acid metabolism when administered under the direction of a licensed Physician. The cost of the medical food or low protein modified food products for a Covered Person must exceed the income tax credit of $2,400 per person per year.

11. Off-label prescription medication. Coverage for any drug approved by the United States Food and Drug Administration (FDA) for use in the Treatment of cancer, if the drug has been recognized as safe and effective for Treatment of that specific type of cancer in: The American Hospital Formulary Service drug information; The United States Pharmacopoeia dispensing information; or the drug has been recognized as safe and effective for Treatment of that specific type of cancer in 2 articles from medical literature that have not had their recognition of the drug's safety and effectiveness contradicted by clear and convincing evidence presented in another article from medical literature. Coverage includes Medically Necessary services associated with the administration of the drug, provided that such services are covered by the Certificate.

12. Reconstructive breast surgery following a mastectomy. Coverage provided for reconstruction of the breast on which the mastectomy has been performed as well as surgery and reconstruction of the nondiseased breast to produce a symmetrical appearance. We will also pay for prostheses and coverage of physical complications at all stages of a mastectomy, including lymphedemas. This benefit is subject to any Deductible, Copayment and Coinsurance amounts under the policy.

13. Medical Treatment of musculoskeletal disorders affecting any bone or joint in the face, neck, or head, including temporomandibular joint disorder and craniomandibular disorder. Treatment will include both surgical and nonsurgical procedures. Coverage will be provided for Medically Necessary diagnosis and Treatment of these conditions whether they are the result of accident, trauma, congenital defect, developmental defect, or pathology. This coverage shall be the same as that provided for any other musculoskeletal disorder in the body and will be provided whether prescribed or administered by a Physician or dentist.

14. Medically Necessary care and Treatment of a newborn child(ren) in the same manner as such care and Treatment is provided to other Covered Persons. This coverage includes care and Treatment of: Illness; Injury; congenital defects; premature birth; hypothyroidism; phenylketonuria; galactosemia; tests for sickle-cell anemia; testing of newborn infants mandated by law; and routine nursery care and pediatric charges for a well newborn child not to exceed 5 full days in a Hospital nursery, or until the mother is discharged, whichever is the lesser period of time.

Mary K. Durand
Secretary

ACCIDENT EXPENSE BENEFIT RIDER

This rider is made a part of the Certificate to which it is attached. This rider is subject to all of the provisions in the Certificate not in conflict with the provisions in this rider.

Covered Expenses

Expenses that you Incur as a result of an Injury (as that term is defined in the Certificate) are Covered Expenses under this rider. Such expenses must be Incurred within 90 days of the Injury.

Administration of Benefits

If expenses are Covered Expenses under this rider, we will pay the lowest of the following amounts:

1. The amount charged;
2. The amount of the Accident Expense Benefit shown on your Schedule of Benefits (per Covered Person per Calendar Year); or
3. The amount agreed to in a Negotiated Payment Arrangement.

Exclusions and Limitations

In addition to the Exclusions and Limitations in your Certificate, the following Exclusions and Limitations also apply to this rider:

1. This benefit is not subject to any Deductible, Copayment, Coinsurance Percentage or Access Fee.
2. No benefits paid under this rider will be used to satisfy any Deductible or Coinsurance amount.
3. Benefits provided by this rider will count toward the Certificate's Maximum Lifetime Benefit limit.
4. Benefits provided by this rider will not duplicate benefits provided under the Certificate to which this rider is attached.
5. Benefits will not be paid for expenses related to a work-related Illness or Injury eligible for benefits under worker's compensation, employers' liability or similar laws even when you do not file a claim for those benefits.
6. In addition to the other provisions in the Certificate that apply to this rider, the Right of Reimbursement provision in the Claim Provisions section of the Certificate also applies to this rider.

Termination of This Rider

This rider will terminate on the earlier of:

a. The date on which the Certificate terminates; or

b. The premium due date following the date on which we receive your written request to cancel this rider.

Mary K. Durand
Secretary

ACCIDENTAL DEATH BENEFIT RIDER

This rider is made a part of the Certificate to which it is attached. It is subject to all of the Certificate provisions not in conflict with the provisions of this rider.

We will pay the Accidental Death Benefit amount when the Covered Person dies as a result of an accidental bodily Injury. In order for the Accidental Death Benefit to be payable, death must occur within 90 days of the covered Injury. The Accidental Death Benefit amount is shown on the Schedule of Benefits.

This rider will terminate on the earlier of:

a. The date on which the Certificate terminates; or

b. The premium due date following the date on which we receive your written request to cancel this rider.

Mary K. Durand
Secretary

CRITICAL ILLNESS BENEFIT RIDER

This rider is made a part of the Certificate to which it is attached. It is subject to all of the provisions in the Certificate not in conflict with the provisions of this rider.

Additional Definitions for this Rider

In addition to the Definitions in the Certificate, the following Definitions also apply to this rider:

Activities of Daily Living. Activities such as bathing, dressing, toileting, transferring, continence and eating.

"Bathing" means cleaning the body by tub, shower or sponge bath, including getting a basin of water, managing faucets, getting in and out of the tub or shower, reaching head and body parts for soaping, rinsing, and drying.

"Dressing" means putting on and taking off, fastening and unfastening garments and undergarments and special devices such as back or leg braces, corsets, elastic stockings/ garments and artificial limbs or splints.

"Toileting" means getting on and off the toilet or commode and emptying the commode, managing clothing and wiping and cleaning body after toileting, and assistance with using and emptying bedpans and urinals.

"Transferring" means moving from one sitting or lying position to another sitting or lying position, e.g., from bed to wheelchair or sofa, coming to a standing position or repositioning to promote circulation and prevent skin breakdown.

"Continence" means the ability to control bowel and bladder as well as use of ostomy or catheter receptacles, and apply diapers and disposable barrier pads.

"Eating" means reaching for, picking up, grasping utensil and cup; getting food on utensil, bringing food, utensil, cup to mouth; manipulating food on plate; and cleaning face and hands as necessary following meal.

Beneficiary. Any person named in our records to receive the benefits of this coverage upon your death. The Beneficiary is as named in the Application for coverage, unless later changed as provided in this rider. Any benefit unpaid at death may be paid to either the Insured's Beneficiary or estate.

Covered Critical Illness Condition. Only those health conditions set out in the Covered Expenses and Administration of Benefits sections of this rider and defined in this Definitions section, and resulting from Illness or Injury.

Diagnosis. The conclusive determination of the Covered Critical Illness Condition through the use of clinical and/or laboratory findings. When payment of benefits under this rider is contingent upon the surgical Treatment of covered conditions (as in benefits for the First Coronary Artery Bypass Surgery or Major Organ Transplant Surgery), we will consider the conclusive determination to be the date the Covered Person has such surgical Treatment.

Eligible Person. You or any Covered Dependent who is 19 years of age or older at the time coverage is issued or when added to the base coverage at a later date.

End-Stage Renal Failure Diagnosis. The first ever Diagnosis of chronic irreversible failure of the function of both kidneys requiring regular hemodialysis or peritoneal dialysis at least weekly. The End-Stage Renal Failure Diagnosis must be made by a Physician who is a board-certified nephrologist.

First Angioplasty. The first ever balloon Angioplasty, endarterectomy, insertion of stents or laser Treatment to correct narrowing or blockage of one or more coronary arteries. Such procedure must be at the direction of a Physician who is a board-certified cardiologist.

First Coronary Artery Bypass Surgery. The first ever coronary artery revascularization surgery by way of thoracotomy to correct the narrowing or blockage of one or more coronary arteries with bypass grafts. First Coronary Artery Bypass Surgery does not mean balloon Angioplasty, insertion of stents, laser relief or any other heart or vascular procedure not specifically meeting the above criteria.

Heart Attack Diagnosis (Acute Myocardial Infarction, Coronary Thrombosis or Occlusion). The first ever Diagnosis of the death of a portion of the heart muscle as a result of inadequate blood supply. Such Diagnosis must be established by all of the following criteria: clinical history; confirmatory new electrocardiogram (ECG) changes; and diagnostic elevation of the cardiac enzyme CK/MB. Elevated levels of Troponin will not be considered to be diagnostic evidence of a Heart Attack. The definition of Heart Attack Diagnosis shall not be construed to mean congestive heart failure, atherosclerotic heart disease, angina, coronary artery disease or any other dysfunction of the cardiovascular system.

Life-Threatening Cancer Conditions Diagnosis. Types of cancer manifested by the presence of a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and invasion of tissue. The term Life-Threatening Cancer includes leukemia (other than low risk or intermediate risk chronic lymphocytic leukemia or less than Stage 3 of Modified Rai staging system) and Hodgkin's disease (except Stage 1 Hodgkin's).

The following types of cancer are not considered Life-Threatening Cancer:

1. Premalignant conditions or conditions with malignant potential;
2. Carcinoma in situ;
3. Cervical dysplasia CIN-1, CIN-2, CIN-3;
4. Benign tumors or polyps;
5. All skin cancer, including hyperkeratosis, basal cell carcinoma, squamous cell carcinoma, and melanoma that is Diagnosed as Clark's Level I or II or Breslow less than 1.5 mm, unless there is evidence of metastasis;
6. Prostatic cancers which are histologically described as TNM classification T1 or are of another equivalent or lesser classification;
7. Papillary micro carcinoma of the thyroid;
8. Stage 0 transitional carcinoma of the bladder;
9. Intraductal noninvasive carcinoma of the breast;
10. Kaposi's sarcoma.

We will require a pathological Diagnosis. When a pathological Diagnosis cannot be made, a clinical Diagnosis may be accepted. However, you must provide medical evidence that sustains the clinical Diagnosis.

Loss of Limbs. The total and permanent loss of the use of two or more limbs as a result of dismemberment. Dismemberment means the severance of an arm above the elbow or a leg above the knee.

Major Organ Transplant Surgery. Clinically definitive evidence of the failure of a Covered Person's liver, kidney, lung, entire heart, pancreas, or bone marrow that requires the malfunctioning organ to be replaced with an organ from a suitable human donor under generally accepted medical procedures. Services must be performed by a Physician who is board-certified to provide such services.

Multiple Sclerosis Diagnosis. Clinically definitive evidence of the occurrence of two or more episodes of well-defined neurological abnormalities (from medical history and neurological examination) resulting in the impairment of motor or sensory function. Diagnosis must be supported by modern imaging and investigative techniques confirming lesions at more than one site within the central nervous system and no other neurological disease better explains the findings. Neurological abnormalities in this context must be evidenced by the typical symptoms of demyelination with resultant impairment of the brain stem or spinal cord. A Physician who is a board-certified neurologist must make the definitive Diagnosis of Multiple Sclerosis.

Permanent Paralysis Diagnosis (Hemiplegia, Paraplegia or Quadriplegia). The complete and permanent loss of the use of one leg and one arm on one side of the body (hemiplegia) or both legs and/or both arms (paraplegia or quadriplegia) due to a covered Injury. The loss of use must be deemed to be permanent and must be supported by appropriate neurological evidence. A Physician who is a board-certified neurologist must make the definitive Diagnosis of Permanent Paralysis.

Stroke. A cerebrovascular event resulting in permanent neurological damage including infarction of brain tissue, hemorrhage, or embolization from an extracranial source. The Stroke must be positively Diagnosed by a Physician based upon documented neurological deficits and confirmatory neuroimaging studies. Such neurological deficits must persist for at least 30 days following the occurrence of the Stroke. Stroke does not mean cerebral symptoms due to transient ischemic attack, reversible neurological deficit, migraine, cerebral Injury resulting from trauma or hypoxia, and vascular disease affecting the eye, optic nerve, or vestibular functions or other cerebrovascular insufficiency.

Covered Expenses under This Rider

Covered Expenses under this rider are expenses a Covered Person Incurs after first being Diagnosed with, or having surgery for, a Covered Critical Illness Condition that first manifests while this coverage is In Force.

Administration of Benefits

1. We will pay the following benefits for Covered Critical Illness Conditions.
   a. 10% of the Critical Illness Lifetime Maximum Benefit Amount (shown on the Schedule of Benefits) for the First Angioplasty. If a benefit is paid under this provision, no further benefits will be paid for subsequent Angioplasties. The Critical Illness Lifetime Maximum Benefit Amount will then be reduced by the amount of this payment.
   b. 25% of the Critical Illness Lifetime Maximum Benefit Amount for the First Coronary Artery Bypass Surgery. Subsequent Coronary Artery Bypass Surgeries will not be covered under this provision. The Critical Illness Lifetime Maximum Benefit Amount will then be reduced by the amount of this payment.
   c. 100% of the Critical Illness Lifetime Maximum Benefit Amount, less any amount previously paid, when for the first time a Covered Person:
      (1) Is Diagnosed with End-Stage Renal Failure;
      (2) Is Diagnosed as having a Heart Attack (Acute Myocardial Infarction, Coronary Thrombosis or Occlusion);
      (3) Undergoes Major Organ Transplant Surgery;
      (4) Is Diagnosed as having Multiple Sclerosis with neurological abnormalities that have existed for a period of at least 180 days and which result in the inability to perform one or more Activities of Daily Living;
      (5) Is Diagnosed as having Permanent Paralysis (Hemiplegia, Paraplegia, or Quadriplegia) due to a covered Injury. The Paralysis must have existed for a period of at least 180 days;
      (6). Is Diagnosed as having a Stroke;
      (7) Is Diagnosed with a Life-Threatening Cancer Condition;
      (8) Suffers Loss of Limbs as a result of dismemberment.
2. Reduction of Benefits. When a Covered Person attains age 70, the applicable Critical Illness Lifetime Benefit Amount is reduced to 50% of the amount that otherwise would be payable. Benefits are paid based on the Critical Illness Lifetime Maximum Benefit Amount in effect on the date of Diagnosis or date of surgery.
3. Any preauthorization requirement in the Certificate does not apply to the benefits in this rider.
4. The Coordination of Benefits provision in the Certificate does not apply to the benefits provided in this rider.
5. Change of Beneficiary. You may change the Beneficiary of the benefits of this rider at any time while this Certificate and rider are in force. The change must be made in writing and sent to us. The Beneficiary's consent is not required for this or any other change in the Certificate, unless the designation of the Beneficiary is irrevocable. The change will take effect on the date you sign it. However, a change will not apply to any payment or other action we may have taken before we receive the change. A change cancels all prior Beneficiary designations.

6. Loss of life benefits are payable in accordance with the Beneficiary designation in effect at the time of payment. Any other benefit unpaid at death may be paid to either the insured's Beneficiary or estate.

Exclusions and Limitations

1. The Critical Illness Lifetime Maximum Benefit Amount for each Covered Person is shown on the Schedule of Benefits. In no event shall the benefits paid for any one Covered Person exceed the Critical Illness Lifetime Maximum Benefit Amount, regardless of the number of Covered Critical Illness Conditions.
2. We will not pay benefits under the rider for loss incurred as a result of any condition not specifically listed as a Covered Critical Illness Condition in the this rider.

Termination of this Rider

This rider will terminate on the earlier of:

1. The date on which the Certificate to which this rider is attached terminates; or
2. The premium due date following the date on which we receive your written request to cancel this rider; or
3. The date the Critical Illness Lifetime Maximum Benefit amount has been paid for a Covered Person.

Mary K. Durand
Secretary

DECREASING DEDUCTIBLE RIDER

This rider is made a part of the Certificate to which it is attached. It is subject to all of the provisions in the Certificate that do not conflict with the provisions in this rider.

Additional Definitions for This Rider

In addition to the Definitions in the Certificate, the following Definitions also apply to this rider:

Certificate Year: For the purposes of this rider: (a) the first Certificate Year eligibility period is measured as a period of 9 months beginning on the Certificate Issue Date; and (b) the second Certificate Year eligibility period is measured as a 12-month period from the end of the first Certificate Year.

Claim: A Claim is the payment we make, after applying the Deductible amount if any, for Covered Expenses for any Covered Person under the Certificate or any attached riders. For the purposes of this rider, benefits for Wellness Services are not considered Claims.

[Preventive Dental Services: Preventive Dental Services are routine dental checkups and routine dental cleanings.**]**

Wellness Services: Wellness Services are routine physicals, screenings and immunizations from a Provider that are all of the following:

1. Appropriate for the age and gender of the Covered Person; and
2. Based on generally accepted standards of medical practice.

[Wellness Services also include Preventive Dental Services as defined above.]

Administration of Benefits

1. Subject to any additional limitations provided elsewhere in your Certificate, if no Covered Person Incurs a Claim in a Certificate Year, we will decrease the individual Calendar Year Deductible amounts shown on the Schedule of Benefits.
2. If you Incur a claim, the individual Calendar Year Deductible will revert back to the initial individual Calendar Year Deductible amount shown on the Schedule of Benefits. In this case, this rider becomes null and void.

Termination of This Rider

This rider will terminate on the earlier of:

1. The date on which the Certificate to which this rider is attached terminates; or
2. The premium due date following the date on which we receive your written request to cancel this rider.

Mary K. Durand
Secretary

PREMIUM DISCOUNT FOR GOOD HEALTH RIDER

This rider is made a part of the Certificate to which it is attached. It is subject to all of the provisions in the Certificate that do not conflict with the provisions in this rider.

Additional Definitions for This Rider

In addition to the Definitions in the Certificate, the following Definitions also apply to this rider:

Claim: A Claim is the payment we make, after applying the Deductible amount if any, for Covered Expenses for any Covered Person under the Certificate or any attached riders. For the purposes of this rider, benefits we pay for Wellness Services [and Preventive Dental Services] are not considered Claims.

Premium: Premium is the dollar amount for the Certificate and any attached riders that is applicable to the Calendar Year prior to the date the discount is paid.

Wellness Services: Wellness Services are routine physicals, screenings and immunizations from a Provider that are all of the following:

1. Appropriate for the age and gender of the Covered Person; and
2. Based on generally accepted standards of medical practice.

[Wellness Services also include Preventive Dental Services as defined below.]

[Preventive Dental Services: Preventive Dental Services are routine dental checkups and routine dental cleanings.**]**

Administration of Benefits

1. If no Covered Person Incurs a Claim in a Calendar Year, we will discount the specified percentage (shown in your Schedule of Benefits) of the Premium for the next Calendar Year.
2. If we pay benefits for a Covered Expense Incurred during the Calendar Year, you are not eligible for a discount for the next Calendar Year. In order to again become eligible for the Premium discount, you will have to requalify (at the first Calendar Year specified percentage shown on your Schedule of Benefits) for any future Premium discount.
3. Any discount you receive that we later determine to have been unearned may be deducted from any future Claim payment or Premium Discount.

Termination of This Rider

This rider will terminate on the earlier of:

1. The date on which the Certificate to which this rider is attached terminates; or
2. The premium due date following the date on which we receive your written request to cancel this rider.

Mary K. Durand
Secretary

REFUND OF PREMIUM FOR GOOD HEALTH RIDER

This rider is made a part of the Certificate to which it is attached. It is subject to all of the provisions in the Certificate that do not conflict with the provisions in this rider.

Additional Definitions for This Rider

In addition to the Definitions in the Certificate, the following Definitions also apply to this rider:

Claim: A Claim is the payment we make, after applying the Deductible amount if any, for Covered Expenses for any Covered Person under the Certificate or any attached riders. For purposes of this rider, benefits we pay for Wellness Services [and Preventive Dental Services] are not considered Claims.

Premium: Premium is the dollar amount for the Certificate and any attached riders that is applicable to the Calendar Year prior to the date the refund is paid.

Wellness Services: Wellness Services are routine physicals, screenings and immunizations from a Provider that are all of the following:

a. Appropriate for the age and gender of the Covered Person; and

b. Based on generally accepted standards of medical practice.

[Wellness Services also include Preventive Dental Services as defined below.]

[Preventive Dental Services: Preventive Dental Services are routine dental checkups and routine dental cleanings.**]**

Administration of Benefits

1. If no Covered Person Incurs a Claim in a Calendar Year, we will refund the Specified Percentage (shown in your Schedule of Benefits) of the Premium due and paid in a Calendar Year.
2. If we pay benefits for a Covered Expense Incurred during the Calendar Year, you are not eligible for a refund for that Calendar Year. In order to again become eligible for the Premium refund, you will have to requalify (at the first Calendar Year Specified Percentage shown on your Schedule of Benefits) for any future Premium refund.
3. If you are eligible for the Premium refund, we will send it to you no later than July 15th for refunds for which you qualified in the previous Calendar Year.
4. Your Certificate must be In Force at the time we pay the refund.
5. Any refund we pay to you that we later determine to have been unearned may be deducted from any future Claim payment or Premium refund.

Termination of This Rider

This rider will terminate on the earlier of:

1. The date on which the Certificate to which this rider is attached terminates; or
2. The premium due date following the date on which we receive your written request to cancel this rider.

Mary K. Durand
Secretary

OFFICE VISIT BENEFIT RIDER

This rider is made a part of the Certificate to which it is attached. It is subject to all of the provisions in the Certificate not in conflict with the provisions in this rider.

Additional Definition for This Rider

In addition to the Definitions in the Certificate, the following Definition also applies to this rider:

Office Visit. Office Visit includes evaluation and management services as defined in the most recent edition of Current Procedural Terminology. This rider provides coverage only for the examination that is performed during the visit.

Administration of Benefits

1. Your [Copayment/Deductible and Coinsurance Percentage] amount for Office Visits are described in the Schedule of Benefits.
2. Office Visit charges that you Incur are payable as described in the Schedule of Benefits.
3. This benefit will become effective after the applicable Office Visit Waiting Period, if any, has passed. The Office Visit Waiting Period, if any, is shown on your Schedule of Benefits.

Exclusions and Limitations

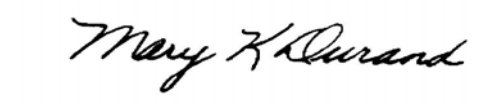
1. The benefits per Covered Person per Calendar Year under this rider will not exceed the Office Visit Annual Maximum Benefit shown on the Schedule of Benefits.
2. The following are not Covered Expenses for this benefit:
   a. Routine physical examinations;
   b. Laboratory and other diagnostic services;
   c. Radiological exams;
   d. Surgical procedures;
   e. Chemotherapy;
   f. Allergy testing;
   g. Treatment of behavioral health and substance abuse;
   h. Spinal manipulation or subluxation;
   i. Occupational, physical and speech therapy;
   j. Any other service not specifically listed as a Covered Expense in the Schedule of Benefits.

   The above services that are excluded in this rider may be Covered Expenses under a separate provision in your Certificate. Please review your Certificate to determine whether a particular service is specifically covered elsewhere.
3. All of the exclusions, limitations, terms and conditions set forth in your Certificate apply to this rider unless the terms of this rider specifically provide otherwise.
4. Benefits provided by this rider will count toward the Maximum Lifetime Benefit Limit of the Certificate.
5. Benefits provided by this rider will not duplicate benefits provided under the Certificate to which this rider is attached.
6. Please review your Schedule of Benefits for any additional limitations for this benefit.

Termination of This Rider

This rider will terminate on the earlier of:

1. The date on which the Certificate to which this rider is attached terminates; or
2. The premium due date following the date on which we receive your written request to cancel this rider.



Mary K. Durand
Secretary

OFFICE VISIT BENEFIT RIDER

This rider is made a part of the Certificate to which it is attached. It is subject to all of the provisions in the Certificate not in conflict with the provisions in this rider.

Additional Definition

In addition to the Definitions in the Certificate, the following Definition also applies to this rider:

Office Visit. Office Visit includes evaluation and management services as defined in the most recent edition of Current Procedural Terminology. It also includes diagnostic x-ray and/or laboratory services received by a Covered Person in a Physician's office. This rider provides coverage only for the examination, diagnostic x-ray and/or laboratory services that are performed during the office visit.

Administration of Benefits

1. Your [Copayment/Deductible and Coinsurance Percentage] amount for Office Visits are described in the Schedule of Benefits.
2. Office Visit charges that you Incur are payable as described in the Schedule of Benefits.
3. This benefit will become effective after the applicable Office Visit Waiting Period, if any, has passed. The Office Visit Waiting Period, if any, is shown on your Schedule of Benefits.

Exclusions and Limitations

1. The benefits per Covered Person per Calendar Year under this rider will not exceed the Office Visit Annual Maximum Benefit shown on the Schedule of Benefits.
2. The following are not Covered Expenses for this benefit:
   a. Routine physical examinations;
   b. Laboratory and other diagnostic services, except as specifically provided above;
   c. Radiological exams;
   d. Surgical procedures;
   e. Chemotherapy;
   f. Allergy testing;
   g. Treatment of behavioral health and substance abuse;
   h. Spinal manipulation or subluxation;
   i. Occupational, physical and speech therapy;
   j. Any other service not specifically listed as a Covered Expense in the Schedule of Benefits.

   The above services that are excluded in this rider may be Covered Expenses under a separate provision in your Certificate. Please review your Certificate to determine whether a particular service is specifically covered elsewhere.
3. All of the exclusions, limitations, terms and conditions set forth in your Certificate apply to this rider unless the terms of this rider specifically provide otherwise.
4. Benefits provided by this rider will count toward the Maximum Lifetime Benefit Limit of the Certificate.
5. Benefits provided by this rider will not duplicate benefits provided under the Certificate to which this rider is attached.
6. Please review your Schedule of Benefits for any additional limitations for this benefit.

Termination of This Rider

This rider will terminate on the earlier of:

1. The date on which the Certificate to which this rider is attached terminates; or
2. The premium due date following the date on which we receive your written request to cancel this rider.

Mary K. Durand
Secretary

SHORT TERM CONVALESCENT CARE RIDER

This rider is made a part of the Certificate to which it is attached. It is subject to all of the provisions in the Certificate that do not conflict with the provisions in this rider.

Additional Definitions for this Rider

In addition to the Definitions in the attached Certificate, the following Definitions also apply to this rider:

Activities of Daily Living: Activities of Daily Living include but are not limited to:

1. Bathing;
2. Getting dressed;
3. Eating;
4. Getting in and out of bed or a chair;
5. Getting to and back from the restroom; and
6. Administering oral medications or eye drops.

Assisted Living Facility: An institution that satisfies all of the following:

1. It provides 24-hour care and related services to resident Inpatients in support of their needs that are the result of their Cognitive Impairment or their inability to perform the Activities of Daily Living;
2. It provides Inpatient Treatment; and
3. It is licensed as an Assisted Living Facility by the proper state authority. If it is not recognized by the state as an Assisted Living Facility, we still will consider it an Assisted Living Facility if it provides all the following:
   a. A trained employee on site at all times to provide care and supervision;
   b. Three (3) meals a day and accommodates special dietary needs; and
   c. Appropriate methods and procedures for handling and administering prescribed medications.

None of the following are considered Assisted Living Facilities:

1. An individual residence;
2. An independent living unit or apartment;
3. A Hospital;
4. A clinic
5. A boarding home; or
6. A facility that is primarily for the Treatment of substance abuse.

Cognitive Impairment: Cognitive Impairment means confusion or disorientation resulting from a deterioration or loss of intellectual capacity that is not related to or a result of mental illness but which can result from Alzheimer's disease or similar forms of senility or irreversible dementia. This deterioration or loss of intellectual capacity is established through use of standardized tests that reliably measure impairment in the following areas:

1. Short-term or long-term memory;
2. Orientation as to person, place, and time; and
3. Deductive or abstract reasoning.

Cognitive Impairment must result in the individual requiring 24-hour-a-day supervision or direct assistance to maintain the individual's safety.

Elimination Period: Elimination Period is the number of consecutive days the Covered Person must be continuously Confined to a Nursing or Assisted Living Facility before benefits will be paid. For each day of Confinement to apply toward satisfaction of the Elimination Period, the Confinement must otherwise be an eligible covered stay under this coverage. When benefits do begin, they will not be retroactive to the beginning of the Elimination Period. Any Elimination Period of this Certificate is found on the Schedule of Benefits and must be satisfied for each Confinement in a Nursing Facility or Assisted Living Facility.

Functional Incapacity: Functional Incapacity means the inability to perform at least two (2) of the specified Activities of Daily Living.

Licensed Health Care Practitioner: A Licensed Health Care Practitioner is a Physician, registered nurse (RN), or social worker, who is licensed by the state and, for purposes of this rider, is acting within the lawful scope of their license.

Licensed Nursing Facility Administrator: A Licensed Nursing Facility Administrator is a person who:

1. Is licensed as a Nursing Facility Administrator (or equivalent) by the state in which the Nursing Facility is located; and
2. Has the authority to organize and implement the day-to-day operations of a Nursing Facility.

Nursing Facility: An institution that satisfies all of the following:

1. It is licensed as a Nursing Facility by the proper state authority;
2. It provides continuous room and board accommodations for its patients;
3. It is under the supervision of a Licensed Nursing Facility Administrator who is not a member of your Immediate Family; and
4. It has a Physician on call or available for consultation at all times.

None of the following are considered Nursing Facilities:

1. An individual residence;
2. An independent living unit or apartment;
3. A Hospital;
4. A clinic;
5. A boarding home; or
6. A facility that is primarily for the Treatment of substance abuse.

Substantial Assistance: Substantial Assistance means continual supervision, standby assistance or hands-on assistance.

1. *"Continual supervision"* is supervision that is needed to protect a severely Cognitively Impaired Covered Person from threats to health or safety, such as what may result from wandering and may include cueing by verbal prompting, gestures, or other demonstrations.
2. *"Standby assistance"* is the physical presence of another person within arm's reach who is necessary to prevent Injury by physical intervention while the Covered Person is performing any of the Activities of Daily Living.
3. *"Hands-on assistance"* is the physical assistance by another person, without which assistance the Covered Person would be unable to perform Activities of Daily Living.

Rider's Benefits and their Administration

1. After the Elimination Period has been satisfied, we will provide the Daily Benefit Amount shown on the Schedule of Benefits. The Daily Benefit Amount will be paid each day the Covered Person is Confined in a Nursing Facility or Assisted Living Facility, up to the Maximum Benefit Period. In order for services to be eligible for benefits under this rider, the care must be certified by a Licensed Health Care Practitioner as necessary due to Cognitive Impairment requiring Substantial Assistance or proof of Functional Incapacity.
2. Claim Forms. When we receive your notice of claim for benefits, we will send you forms to complete. If these forms are not sent to you within 15 days after we receive your notice of claim for benefits, you will have satisfied the requirements of your proof of claim if you notify us in writing, about the expenses for which you are making a claim, within 90 days after the expenses were Incurred.
3. Coordination of Benefits. The Coordination of Benefits provision in the Certificate does not apply to the benefits provided under this rider.
4. Continuation of Coverage. For the purposes of this rider, the Continuation of Coverage section is changed to read as follows: Should you die, your covered spouse will become the Insured. Should your spouse not be covered, your oldest child covered under this rider will become the Insured.

Exclusions and Limitations

In addition to the Exclusions and Limitations listed in your Certificate, the following Exclusions and Limitations also apply to this rider:

1. A charge or expense related to a loss that is not specifically included in the Benefits provision of this rider is not a Covered Expense under this rider;
2. The Daily Benefit under this rider will be provided only to the extent the same services are not covered under the Certificate to which it is attached; and
3. The benefits in this rider will not duplicate any benefit provided under the base Certificate.

Termination of this Rider

This rider will terminate on the earlier of:

1. The date of the Covered Person's death;
2. The date the Maximum Benefit Period has been paid for a Covered Person;
3. The date the Certificate to which this rider is attached terminates.

Mary K. Durand
Secretary

OUTPATIENT PRESCRIPTION DRUG BENEFIT RIDER

Prescription Drugs Plus Specialty Medications
***** Deductible and Coinsurance Plan *****

This rider is made a part of the Certificate to which it is attached. It is subject to all of the provisions in the Certificate that do not conflict with the provisions in this rider.

THE DRUG BENEFITS IN THIS RIDER ARE SUBJECT TO YOUR CERTIFICATE'S DEDUCTIBLE AND COINSURANCE PERCENTAGE.

SECTION 1. BENEFITS FOR PRESCRIPTION DRUGS

A. Definitions for this Section. In addition to the Definitions in the Certificate, the following Definitions also apply:

Ancillary Charge: When a Generic Drug substitute exists but a Brand Name Drug is dispensed, the Ancillary Charge is the difference in cost between the Brand Name Drug and what we would have paid for the Generic Drug substitute.

Brand Name Drug: A Prescription Drug:

1. That is included on our Drug List; and
2. For which a pharmaceutical company has received a patent or trade name; and
3. That is only available for purchase from one pharmaceutical company.

Generic Drug: A Prescription Drug that:

1. Has the same active ingredients as an equivalent Brand Name Drug; and
2. Does not carry any drug manufacturer's brand name on the label; and
3. Is not protected by a patent.

Nonparticipating Pharmacy: A retail or mail order pharmacy that is not under contract with the Pharmacy Benefit Manager to fill prescription orders.

Participating Mail Order Pharmacy: A pharmacy that is under contract with the Pharmacy Benefit Manager to dispense prescription orders through the mail.

Participating Pharmacy: A retail or mail order pharmacy that is under contract with the Pharmacy Benefit Manager to fill prescription orders when presented with prescription drug cards.

Pharmacy Benefit Manager: The organization or entity, with which we have contracted, that administers the processing of prescription claims under this rider.

Prescription Drug: Any medication or medicinal substance that has been approved by the Food and Drug Administration (FDA) and which, under federal or state law, only can be dispensed by a prescription order.

Retail Pharmacy: A licensed establishment where a wide variety of Prescription Drugs are dispensed by a licensed pharmacist in accordance with all applicable state and federal laws.

B. Covered Prescription Expenses Under This Section

The following drugs provided on an Outpatient basis are covered under this section of the rider:

1. Prescription Drugs.
2. The following items on prescription:
   a. Insulin;
   b. Insulin needles and syringes;

c. Sugar test tablets and tape, including chemstrips, Acetone tablets and Benedict's Solution or equivalent; and

d. Compounded medication of which at least one ingredient is a Prescription Drug.

3. Contraceptives. Prescription drugs or devices approved by the FDA for use as a contraceptive.

C. Administration of Benefits

All of the following rules and procedures apply to benefits for the above Covered Expenses:

1. Prescription Drugs are subject to the Certificate's applicable Deductible and Coinsurance Percentage.
2. When obtaining Prescription Drugs at a Participating Pharmacy, you must present your prescription drug card to the pharmacy staff.
3. You are required to pay the cost of the medication at the time of purchase.
4. Once you have satisfied the applicable Calendar Year Certificate Deductible and Coinsurance Percentage, charges for Prescription Drugs will be covered during the same Calendar Year according to the provisions of your Certificate.
5. Retail Pharmacies are able to fill up to a 30-day supply for one prescription. For certain Prescription Drugs, you may be able to obtain a prescription order in excess of a 30-day supply (up to a 90-day supply) from a Participating Mail Order Pharmacy.
6. If you fail to present your prescription drug card at a Participating Pharmacy: (a) you are required to pay the pharmacy the full cost for the Prescription Drug; and (b) in order for us to reimburse you, you must send a claim form to the Pharmacy Benefit Manager. You will then be reimbursed, based on the amount we would have paid if you initially had presented your prescription drug card to the pharmacy.
7. If you obtain a Prescription Drug from a Nonparticipating Pharmacy: (a) you are required to pay the pharmacy the full charge for the Prescription Drug; and (b) in order to be reimbursed, you must send the Pharmacy Benefit Manager the receipt for the Prescription Drugs along with a prescription drug claim form. Any reimbursement will be based on the amount we would have paid if you had obtained the Prescription Drug from a Participating Pharmacy.
8. We may require that you try a Generic Drug before we will cover a higher cost Brand Name Drug. When you are first prescribed a particular Prescription Drug, we will guide you to a first-step, lower cost, clinically effective drug for the therapy group. Evidence-based clinical protocols are used to select first-step therapy. If you cannot tolerate or do not receive the desired health improvement effect from the first-step drug therapy, the prescribing Physician may request authorization for a drug in a following step to be dispensed. If we do not provide such authorization, the Prescription Drug benefit may be reduced or denied.
9. For certain Prescription Drugs, we may require that you obtain prior authorization for the drug before benefits will be available. Your pharmacist will notify you if prior authorization is required. Please see Section 3 of this rider for more information on prior authorization.

SECTION 2. BENEFITS FOR SPECIALTY MEDICATIONS

A. Definitions for this Section. In addition to the Definitions in the Certificate and in Section 1 of this Rider, the following Definitions also apply:

Participating Specialty Pharmacy: Participating Specialty Pharmacies are pharmacies that focus on the sale of Specialty Medications and which have contracted with the Pharmacy Benefit Manager to fill prescription orders for Specialty Medications. Such pharmacies have expertise in the storing, handling and administering of Specialty Medications.

Specialty Medications: Specialty Medications are drugs that normally have more than one of the following key characteristics:

1. Not available at Retail Pharmacies;
2. Requires specialized product handling and/or administrative requirements;
3. Requires frequent dosing adjustments and intensive clinical monitoring to decrease the potential for drug toxicity, and increase the probability for beneficial treatment outcomes;
4. Requires intensive patient training and compliance assistance to facilitate therapeutic goals;
5. Requires refrigeration and/or distinct safety protocols;
6. Cost in excess of [$500] for a 30-day supply;
7. Is injectable and administered or supervised by a Provider.

Specialty Medication List: A listing of Specialty Medications that we designate as eligible for reimbursement. We compile the Specialty Medication List and we reserve the right to periodically review and modify the Specialty Medication List. To obtain information about the drugs included on our Specialty Medication List, please visit our website or call the telephone number shown on your insurance identification card. When a Specialty Medication is new to the market, we will add it to our Specialty Medication List within a reasonable time.

B. Covered Expenses Under This Section

Specialty Medications that are included on our Specialty Medication List and provided on an Outpatient basis are Covered Expenses under this section.

C. Administration of Benefits

All of the following rules and procedures apply to benefits for the Covered Expenses in this section:

1. Specialty Medications are subject to the Certificate's Deductible and Coinsurance Percentage.
2. You may initially purchase a Specialty Medication at a Retail Pharmacy if the Retail Pharmacy carries the particular Specialty Medication. If so, you must pay the Retail Pharmacy the entire charge for the Specialty Medication. After you obtain your Specialty Medication, you must send us receipt of your purchase and we will process your claim for benefits. Your claim is subject to possible reimbursement as described below.
3. For subsequent refills, we will coordinate with you in selecting a Participating Specialty Pharmacy from which you must obtain the Specialty Medication. If you elect to obtain Specialty Medications from a pharmacy other than a Participating Specialty Pharmacy, any reimbursement to you will be based on the dollar amount we would have paid if you had obtained the Specialty Medication from a Participating Specialty Pharmacy.
4. Once you have satisfied your Calendar Year Certificate Deductible and Coinsurance Percentage, charges for Specialty Medications will be covered, during the same Calendar Year, according to the provisions of your Certificate.
5. For certain Specialty Medications, we may require that you obtain prior authorization for the drug before benefits will be available. Please see Section 3 below for more information on prior authorization.

SECTION 3. PROVISIONS THAT APPLY TO BOTH PRESCRIPTION DRUGS AND SPECIALTY MEDICATIONS

A. Prescription Utilization Review

Prior authorization may be required for certain Prescription Drugs and Specialty Medications before they are considered for coverage under this rider. Because the list of drugs requiring prior authorization is subject to change, please access our website to obtain information on which drugs require prior authorization. If a drug is purchased without prior authorization when prior authorization is required, you will be responsible for the full cost of the drug at the time of purchase. If a prescription for a drug that requires prior authorization is requested at the pharmacy, the pharmacy should work with the prescribing Physician to obtain medical information for the prior authorization.

B. Exclusions and Limitations

In addition to the Exclusions and Limitations listed in your Certificate, the following Exclusions and Limitations also apply to this rider:

1. All of the exclusions, limitations, terms and conditions set forth in your Certificate apply to this rider unless the terms of this rider specifically provide otherwise.
2. Benefits provided by this rider will count toward the Maximum Lifetime Benefit Limit of the Certificate.
3. Benefits provided by this rider will not duplicate benefits provided under the Certificate to which this rider is attached.
4. Any applicable benefit maximum for this rider is shown on your Schedule of Benefits.
5. If you use a prescription drug card after the card's termination date, we will bill you directly for any benefits we pay after the termination date or we will deduct from any pending claim the amount we paid for the drug.
6. All expenses for covered drugs are subject to the drug manufacturer's recommendation for dosage and dispensing and will be limited based on those recommendations.
7. **This Rider does <u>not</u> cover any of the following:**
    a. Contraceptives, oral or otherwise, whether medication or device, not approved by the FDA, regardless of intended use;
    b. Any drug for the treatment of sexual and/or erectile dysfunction;
    c. Nonprescription Drugs except as specifically covered in this rider;
    d. Therapeutic devices or appliances including, but not limited to, training and education on how to use such devices or appliances, except as specifically covered in this rider;
    e. Prescriptions that you are entitled to receive without charge under any Worker's Compensation Laws;
    f. Drugs that are considered Experimental or Investigational;
    g. Immunization agents, biological sera or blood plasma products;
    h. Medication that is to be taken by you or administered to you while you are an Inpatient in a medical care facility;
    i. Any prescription filled or refilled in excess of the number specified by the Physician, or any refill dispensed after one year from the Physician's original order;
    j. Charges for more than a 30-day supply of any medication at a Retail Pharmacy;
    k. Nicorette, nicotine patches, or any other drug, preparation, or device designed to help you quit tobacco use;
    l. Any drug for which there is no charge to you;

m. Any type of equipment or device used to administer a drug effectively, except as otherwise specifically covered in this rider;

n. TPN (Total Parenteral Nutrition);

o. Retin-A or its therapeutic equivalent or any drugs used in the treatment of acne;

p. Drugs prescribed for cosmetic purposes;

q. Drugs prescribed for the treatment of hair loss;

r. Preparations, drugs or devices designed to assist in diet or weight control, including appetite suppressant drugs;

s. Vitamins, minerals, fluoride or other dietary supplements;

t. Prescriptions for mental and nervous disorders;

u. Growth Hormone therapy;

v. Medication not dispensed in the United States;

w. Medication obtained through the Internet, or through other sources, that are not regulated by the United States Food and Drug Administration;

x. Medications used in the treatment of infertility or with the intent of facilitating pregnancy;

y. Durable medical equipment, devices or appliances including, but not limited to, blood glucose testing devices, support garments, bandages or other medical supplies unless specified in this endorsement.

C. Termination of This Rider

This rider will terminate on the earlier of:

1. The date on which the Certificate to which this rider is attached terminates; or
2. The premium due date following the date on which we receive your written request to cancel this rider.

Mary K. Durand
Secretary

OUTPATIENT PRESCRIPTION DRUG BENEFIT RIDER

Generic Drugs Only

This rider is made a part of the Certificate to which it is attached. It is subject to all of the provisions in the Certificate that do not conflict with the provisions in this rider.

THE ONLY DRUGS COVERED UNDER THIS RIDER ARE GENERIC DRUGS. BRAND NAME DRUGS AND SPECIALTY MEDICATIONS ARE NOT COVERED EXPENSES IN THIS RIDER.

Additional Definitions for this Rider. In addition to the Definitions in the attached Certificate, the following Definitions also apply to this rider:

Brand Name Drug: Brand Name Drugs are not Covered Expenses in this rider. A Brand Name Drug is a Prescription Drug:

1. That is included on our Drug List; and
2. For which a pharmaceutical company has received a patent or trade name; and
3. That is only available for purchase from one pharmaceutical company.

Generic Drug: A Prescription Drug that:

1. Has the same active ingredients as an equivalent Brand Name Drug; and
2. Does not carry any drug manufacturer's brand name on the label; and
3. Is not protected by a patent.

Nonparticipating Pharmacy: A retail or mail order pharmacy that is not under contract with the Pharmacy Benefit Manager to fill prescription orders.

Participating Mail Order Pharmacy: A pharmacy that is under contract with the Pharmacy Benefit Manager to dispense prescription orders through the mail.

Participating Pharmacy: A retail or mail order pharmacy that is under contract with the Pharmacy Benefit Manager to fill prescription orders when presented with prescription drug cards.

Pharmacy Benefit Manager: The organization or entity, with which we have contracted, that administers the processing of prescription claims under this rider.

Prescription Drug: A medication or medicinal substance that has been approved by the Food and Drug Administration (FDA) and which, under federal or state law, only can be dispensed by a prescription order.

Prescription Drug Copayment (or Prescription Drug Percentage): The amount of Covered Expenses under this rider that each Covered Person must pay to the pharmacy each time a Generic Drug prescription is filled or refilled before we pay benefits. The Prescription Drug Copayment (or Percentage) amount per prescription is shown on the Schedule of Benefits.

Prescription Drug Deductible: The amount of Covered Expenses under this rider that each Covered Person must pay in a Calendar Year before the applicable Prescription Drug Copayment is applied and before we pay benefits for covered Generic Drugs.

Prescription Drug Maximum: The maximum benefit amount we will pay under this rider per Covered Person per Calendar Year. The Prescription Drug Maximum is shown on the Schedule of Benefits.

Retail Pharmacy: A licensed establishment where a wide variety of Prescription Drugs are dispensed by a licensed pharmacist in accordance with all applicable state and federal laws.

Specialty Medications: Specialty Medications are drugs that normally have more than one of the following key characteristics:

1. Not available at Retail Pharmacies;
2. Requires specialized product handling and/or administrative requirements;
3. Requires frequent dosing adjustments and intensive clinical monitoring to decrease the potential for drug toxicity, and increase the probability for beneficial treatment outcomes;
4. Requires intensive patient training and compliance assistance to facilitate therapeutic goals;
5. Requires refrigeration and/or distinct safety protocols;
6. Cost in excess of [$500] for a 30-day supply;
7. Is injectable and administered or supervised by a licensed/certified Provider.

Covered Prescription Expenses Under This Section

The following drugs provided on an Outpatient basis are covered under this rider:

1. Generic Drugs.
2. The following items on prescription:
   a. Insulin;
   b. Insulin needles and syringes;
   c. Sugar test tablets and tape, including chemstrips, Acetone tablets and Benedict's Solution or equivalent.
3. Contraceptives. Prescription drugs or devices approved by the FDA for use as a contraceptive.

Administration of Benefits

All of the following rules and procedures apply to benefits for the above Covered Expenses:

1. When obtaining Generic Drugs at a Participating Pharmacy, you must present your prescription drug card to the pharmacy staff.
2. **The Prescription Drug Copayment amounts and/or Prescription Drug Percentage for Generic Drugs are shown on your Schedule of Benefits.**
3. You may call the Pharmacy Benefit Manager to find out whether a particular drug is a Generic Drug or if a particular Prescription Drug has a generic equivalent.
4. You must pay the applicable Prescription Drug Deductible and Prescription Drug Copayment (and/or Prescription Drug Percentage) for each new and refill prescription. If the Covered Expense for a particular Generic Drug is less than the applicable Prescription Drug Copayment and/or Prescription Drug Percentage amount, you will be responsible for the full cost of the Generic Drug.
5. Retail Pharmacies are able to fill up to a 30-day supply for one prescription. For certain Generic Drugs, you may be able to obtain a prescription order in excess of a 30-day supply (up to a 90-day supply) from a Participating Mail Order Pharmacy. For any 90-day supply you obtain from a Participating Mail Order Pharmacy, your Prescription Drug Copayment will be **two** times the applicable Prescription Drug Copayment shown on your Schedule of Benefits.
6. All benefits are subject to the Calendar Year Prescription Drug Maximum, when applicable.
7. We may change the Prescription Drug Deductible, Copayment amounts or Coinsurance Percentage and maximum benefit, but only on a renewal date or at the end of a Calendar Year. Such changes will be made for all riders with this form number on a class as determined by us, but such change will not be made on an individual basis.

8. If you fail to present your prescription drug card at a Participating Pharmacy, you are required to pay the pharmacy the full cost for the Generic Drug. In order for us to reimburse you, you must send a claim form to the Pharmacy Benefit Manager. You will then be reimbursed, based on the amount we would have paid if you initially had presented your prescription drug card to the pharmacy.
9. If you obtain a Generic Drug from a Nonparticipating Pharmacy, you are required to pay the pharmacy the full charge for the Generic Drug. In order to be reimbursed, you must send the Pharmacy Benefit Manager the receipt for the Generic Drugs along with a prescription drug claim form. Any reimbursement will be based on the amount we would have paid if you had obtained the Generic Drug from a Participating Pharmacy.
10. For certain Generic Drugs, we may require that you obtain prior authorization for the drug before benefits will be available. Your pharmacist should notify you if prior authorization is required. Please refer to the next section of this rider for more information on prior authorization.
11. **Prescription Utilization Review. Prior authorization may be required for certain Generic Drugs before they are considered for coverage under this rider. Because the list of drugs requiring prior authorization is subject to change, please access our website to obtain information on which drugs require prior authorization. If a drug is purchased without prior authorization when prior authorization is required, you will be responsible for the full cost of the drug at the time of purchase. If a prescription for a drug that requires prior authorization is requested at the pharmacy, the pharmacy should work with the prescribing Physician to obtain medical information for the prior authorization.**

Exclusions and Limitations

In addition to the Exclusions and Limitations listed in your Certificate, the following Exclusions and Limitations apply:

1. The benefits per Covered Person per Calendar Year under this rider will not exceed the Prescription Drug Maximum benefit.
2. All of the exclusions, limitations, terms and conditions set forth in your Certificate apply to this rider unless the terms of this rider specifically provide otherwise.
3. Benefits provided by this rider will count toward the Maximum Lifetime Benefit Limit of the Certificate.
4. Benefits provided by this rider will not duplicate benefits provided under the Certificate to which this rider is attached.
5. Any applicable benefit maximum for this rider is shown on your Schedule of Benefits.
6. If you use a prescription drug card after the card's termination date, we will bill you directly for any benefits we pay after the termination date or we will deduct from any pending claim the amount we paid for the drug.
7. All expenses for covered drugs are subject to the drug manufacturer's recommendation for dosage and dispensing and will be limited based on those recommendations.
8. **This Rider does <u>not</u> cover any of the following:**
   a. Brand Name Drugs;
   b. Specialty Medications;
   c. Contraceptives, oral or otherwise, whether medication or device, not approved by the FDA, regardless of intended use;
   d. Any drug for the treatment of sexual and/or erectile dysfunction;
   e. Nonprescription Drugs except as specifically covered in this rider;
   f. Therapeutic devices or appliances including, but not limited to, training and education on how to use such devices or appliances, except as specifically covered in this rider;
   g. Prescriptions that you are entitled to receive without charge under any Worker's Compensation Laws;

h. Drugs that are considered Experimental or Investigational;

i. Immunization agents, biological sera or blood plasma products;

j. Medication that is to be taken by you or administered to you while you are an Inpatient in a medical care facility;

k. Any prescription filled or refilled in excess of the number specified by the Physician, or any refill dispensed after one year from the Physician's original order;

l. Charges for more than a 30-day supply of any medication at a Retail Pharmacy;

m. Nicorette, nicotine patches, or any other drug, preparation, or device designed to help you quit tobacco use;

n. Any drug for which there is no charge to you;

o. Any type of equipment or device used to administer a drug effectively, except as otherwise specifically covered in this rider;

p. TPN (Total Parenteral Nutrition);

q. Retin-A or its therapeutic equivalent or any drugs used in the treatment of acne;

r. Drugs prescribed for cosmetic purposes;

s. Drugs prescribed for the treatment of hair loss;

t. Preparations, drugs or devices designed to assist in diet or weight control, including appetite suppressant drugs;

u. Vitamins, minerals, fluoride or other dietary supplements;

v. Prescriptions for Mental or Nervous disorders;

w. Growth Hormone therapy;

x. Medication not dispensed in the United States;

y. Medication obtained through the Internet, or through other sources, that are not regulated by the United States Food and Drug Administration;

z. Medications used in the treatment of infertility or with the intent of facilitating pregnancy;

aa. Durable medical equipment, devices or appliances including, but not limited to, blood glucose testing devices, support garments, bandages or other medical supplies unless specified in this endorsement.

Termination of This Rider

This rider will terminate on the earlier of:

1. The date on which the Certificate to which this rider is attached terminates; or
2. The premium due date following the date on which we receive your written request to cancel this rider.

Mary K. Durand
Secretary

OUTPATIENT PRESCRIPTION DRUG BENEFIT RIDER

Generic Drugs Plus Specialty Medications

This rider is made a part of the Certificate to which it is attached. It is subject to all of the provisions in the Certificate that do not conflict with the provisions in this rider.

THE ONLY DRUGS COVERED UNDER THIS RIDER ARE GENERIC DRUGS AND SPECIALTY MEDICATIONS. BRAND NAME DRUGS ARE NOT COVERED EXPENSES IN THIS RIDER.

The administration of your benefits for Generic Drugs is described in Section 1 of this rider. **Because Benefits for Specialty Medications are administered differently than other drugs, we discuss Specialty Medications in their own section of this rider (Section 2). The primary difference in administering Specialty Medication Benefits is that their benefits are subject to your Certificate's Deductible and Coinsurance Percentage.** Your payment obligation is typically lowest with a Generic Drug and highest with a Specialty Medication.

SECTION 1. BENEFITS FOR GENERIC DRUGS

A. Definitions for this Section. In addition to the Definitions in the Certificate, the following Definitions also apply to your benefits for drugs in Category 1:

Brand Name Drug: Brand Name Drugs are not Covered Expenses in this rider. A Brand Name Drug is a Prescription Drug:

1. That is included on our Drug List; and
2. For which a pharmaceutical company has received a patent or trade name; and
3. That is only available for purchase from one pharmaceutical company.

Generic Drug: A Prescription Drug that:

1. Has the same active ingredients as an equivalent Brand Name Drug; and
2. Does not carry any drug manufacturer's brand name on the label; and
3. Is not protected by a patent.

Nonparticipating Pharmacy: A retail or mail order pharmacy that is not under contract with the Pharmacy Benefit Manager to fill prescription orders.

Participating Mail Order Pharmacy: A pharmacy that is under contract with the Pharmacy Benefit Manager to dispense prescription orders through the mail.

Participating Pharmacy: A retail or mail order pharmacy that is under contract with the Pharmacy Benefit Manager to fill prescription orders when presented with prescription drug cards.

Pharmacy Benefit Manager: The organization or entity, with which we have contracted, that administers the processing of prescription claims under this rider.

Prescription Drug: A medication or medicinal substance that has been approved by the Food and Drug Administration (FDA) and which, under federal or state law, only can be dispensed by a prescription order.

Prescription Drug Copayment (or Prescription Drug Percentage): The amount of Covered Expenses under this rider that each Covered Person must pay to the pharmacy each time a Generic Drug prescription is filled or refilled before we pay benefits. The Prescription Drug Copayment (or Percentage) amount per Generic Drug prescription is shown on the Schedule of Benefits.

Prescription Drug Deductible: The amount of Covered Expenses under this rider that each Covered Person must pay in a Calendar Year before the applicable Prescription Drug Copayment is applied and before we pay benefits for covered Generic Drugs.

Prescription Drug Maximum: The maximum benefit amount we will pay under this rider per Covered Person per Calendar Year. The Prescription Drug Maximum is shown on the Schedule of Benefits.

Retail Pharmacy: A licensed establishment where a wide variety of Prescription Drugs are dispensed by a licensed pharmacist in accordance with all applicable state and federal laws.

B. Covered Prescription Expenses Under This Section

The following drugs provided on an Outpatient basis are covered under this section of the rider:

1. Generic Drugs.
2. The following items on prescription:
   a. Insulin;
   b. Insulin needles and syringes;
   c. Sugar test tablets and tape, including chemstrips, Acetone tablets and Benedict's Solution or equivalent.
3. Contraceptives. Prescription drugs or devices approved by the FDA for use as a contraceptive.

C. Administration of Benefits

All of the following rules and procedures apply to benefits for the above Covered Expenses:

1. When obtaining Generic Drugs at a Participating Pharmacy, you must present your prescription drug card to the pharmacy staff.
2. **The Prescription Drug Copayment amounts and/or Prescription Drug Percentage for Generic Drugs are shown on your Schedule of Benefits.**
3. You may call the Pharmacy Benefit Manager to determine if a particular drug is a Generics Drug or if a particular Brand Name Drug has a generic equivalent.
4. You must pay the applicable Prescription Drug Deductible and Prescription Drug Copayment (and/or Prescription Drug Percentage), if any for each new and refill Generic Drug prescription. If the Covered Expense for a particular Generic Drug is less than the Prescription Drug Copayment amount, you will be responsible for the full cost of the Generic Drug.
5. Brand Name Drugs are not Covered Expenses under this rider.
6. Retail Pharmacies are able to fill up to a 30-day supply for one prescription. For certain Generic Drugs, you may be able to obtain a prescription order in excess of a 30-day supply (up to a 90-day supply) from a Participating Mail Order Pharmacy. For any 90-day supply you obtain from a Participating Mail Order Pharmacy, your Prescription Drug Copayment will be **two** times the applicable Prescription Drug Copayment shown on your Schedule of Benefits.
7. A Prescription Drug Deductible may be applicable for Generic Drugs. All benefits are subject to the Calendar Year Prescription Drug Maximum, when applicable
8. We may change the Prescription Drug Deductible, Copayment amounts and maximum benefit, but only on a renewal date or at the end of a Calendar Year. Such changes will be made for all riders with this form number on a class as determined by us, but such change will not be made on an individual basis.
9. If you fail to present your prescription drug card at a Participating Pharmacy, you are required to pay the pharmacy the full cost for the Generic Drug. In order for us to reimburse you, you must send a claim form to the Pharmacy Benefit Manager. You will then be reimbursed, based on the amount we would have paid if you initially had presented your prescription drug card to the pharmacy.
10. If you obtain a Generic Drug from a Nonparticipating Pharmacy, you are required to pay the pharmacy the full charge for the Generic Drug. In order to be reimbursed, you must send the Pharmacy Benefit Manager the receipt for the Generic Drugs along with a prescription drug claim form. Any reimbursement will be based on the amount we would have paid if you had obtained the Generic Drugs from a Participating Pharmacy.

11. For certain Generic Drugs, we may require that you obtain prior authorization for the drug before benefits will be available. Your pharmacist will notify you if prior authorization is required. Please see Section 3 of this rider for more information on prior authorization.

SECTION 2. BENEFITS FOR SPECIALTY MEDICATIONS

A. Definitions for this Section. In addition to the Definitions in the attached Certificate, the following Definitions also apply to your Specialty Medication benefits:

Participating Specialty Pharmacy: Participating Specialty Pharmacies are pharmacies that focus on the sale of Specialty Medications and which have contracted with the Pharmacy Benefit Manager to fill prescription orders for Specialty Medications. Such pharmacies have expertise in the storing, handling and administering of Specialty Medications.

Specialty Medications: Specialty Medications are drugs that normally have more than one of the following key characteristics:

1. Not available at Retail Pharmacies;
2. Requires specialized product handling and/or administrative requirements;
3. Requires frequent dosing adjustments and intensive clinical monitoring to decrease the potential for drug toxicity, and increase the probability for beneficial treatment outcomes;
4. Requires intensive patient training and compliance assistance to facilitate therapeutic goals;
5. Requires refrigeration and/or distinct safety protocols;
6. Cost in excess of [$500] for a 30-day supply;
7. Is injectable and administered or supervised by a Provider.

Specialty Medication List: A listing of Specialty Medications that we designate as eligible for reimbursement. We compile the Specialty Medication List and we reserve the right to periodically review and modify the Specialty Medication List. To obtain information about the drugs included on our Specialty Medication List, please visit our website or call the telephone number shown on your insurance identification card. When a Specialty Medication is new to the market, we will add it to our Specialty Medication List within a reasonable time.

B. Covered Expenses Under This Section

Specialty Medications that are included on our Specialty Medication List and provided on an Outpatient basis are Covered Expenses.

C. Administration of Benefits

All of the following rules and procedures apply to benefits for the Covered Expenses in this section:

1. **Your Prescription Drug Copayment and Prescription Drug Deductible, if any, do not apply to Specialty Medications. Instead, Specialty Medications are subject to the Certificate's Deductible and Coinsurance Percentage.**
2. You may initially purchase a Specialty Medication at a Retail Pharmacy if the Retail Pharmacy carries the particular Specialty Medication. If so, you must pay the Retail Pharmacy the entire charge for the Specialty Medication. After you obtain your Specialty Medication, you must send us receipt of your purchase and we will process your claim for benefits. Your claim is subject to possible reimbursement as described below.
3. For subsequent refills, we will coordinate with you in selecting a Participating Specialty Pharmacy from which you must obtain the Specialty Medication. If you obtain Specialty Medications from a pharmacy other than a Participating Specialty Pharmacy, any reimbursement to you will be based on the dollar amount we would have paid if you had obtained the Specialty Medication from a Participating Specialty Pharmacy.

4. Once you have satisfied your Calendar Year Certificate Deductible and Coinsurance Percentage, charges for Specialty medications will be covered, during the same Calendar Year, according to the provisions of your Certificate.
5. For certain Specialty Medications, we may require that you obtain prior authorization for the drug before benefits will be available. Please see Section 3 below for more information on prior authorization.

SECTION 3. PROVISIONS THAT APPLY TO CATEGORY 1 (GENERIC MEDICATIONS AND SPECIALTY MEDICATIONS)

A. Prescription Utilization Review

Prior authorization may be required for certain Generic Drugs and Specialty Medications before they are considered for coverage under this rider. Because the list of drugs requiring prior authorization is subject to change, please access our website to obtain information on which drugs require prior authorization. If a drug is purchased without prior authorization when prior authorization is required, you will be responsible for the full cost of the drug at the time of purchase. If a prescription for a drug that requires prior authorization is requested at the pharmacy, the pharmacy should work with the prescribing Physician to obtain medical information for the prior authorization.

B. Exclusions and Limitations

In addition to the Exclusions and Limitations listed in your Certificate, the following Exclusions and Limitations apply:

1. Prescription Drug benefits per Covered Person per Calendar Year under this rider will not exceed the Prescription Drug Annual Maximum benefit shown on the Schedule of Benefits.
2. All of the exclusions, limitations, terms and conditions set forth in your Certificate apply to this rider unless the terms of this rider specifically provide otherwise.
3. Benefits provided by this rider will count toward the Maximum Lifetime Benefit Limit of the Certificate.
4. Benefits provided by this rider will not duplicate benefits provided under the Certificate to which this rider is attached.
5. Any applicable benefit maximum for this rider is shown on your Schedule of Benefits.
6. If you use a prescription drug card after the card's termination date, we will bill you directly for any benefits we pay after the termination date or we will deduct from any pending claim the amount we paid for the drug.
7. All expenses for covered drugs are subject to the drug manufacturer's recommendation for dosage and dispensing and will be limited based on those recommendations.
8. **This Rider does <u>not</u> cover any of the following:**
   a. Brand Name Drugs;
   b. Contraceptives, oral or otherwise, whether medication or device, not approved by the FDA, regardless of intended use;
   c. Any drug for the treatment of sexual and/or erectile dysfunction;
   d. Nonprescription Drugs except as specifically covered in this rider;
   e. Therapeutic devices or appliances including, but not limited to, training and education on how to use such devices or appliances, except as specifically covered in this rider;
   f. Prescriptions that you are entitled to receive without charge under any Worker's Compensation Laws;
   g. Drugs that are considered Experimental or Investigational;
   h. Immunization agents, biological sera or blood plasma products;

i. Medication that is to be taken by you or administered to you while you are an Inpatient in a medical care facility;

j. Any prescription filled or refilled in excess of the number specified by the Physician, or any refill dispensed after one year from the Physician's original order;

k. Charges for more than a 30-day supply of any medication at a Retail Pharmacy;

l. Nicorette, nicotine patches, or any other drug, preparation, or device designed to help you quit tobacco use;

m. Any drug for which there is no charge to you;

n. Any type of equipment or device used to administer a drug effectively, except as otherwise specifically covered in this rider;

o. TPN (Total Parenteral Nutrition);

p. Retin-A or its therapeutic equivalent or any drugs used in the treatment of acne;

q. Drugs prescribed for cosmetic purposes;

r. Drugs prescribed for the treatment of hair loss;

s. Preparations, drugs or devices designed to assist in diet or weight control, including appetite suppressant drugs;

t. Vitamins, minerals, fluoride or other dietary supplements;

u. Prescriptions for mental and nervous disorders;

v. Growth Hormone therapy;

w. Medication not dispensed in the United States;

x. Medication obtained through the Internet, or through other sources, that are not regulated by the United States Food and Drug Administration;

y. Medications used in the treatment of infertility or with the intent of facilitating pregnancy;

z. Durable medical equipment, devices or appliances including, but not limited to, blood glucose testing devices, support garments, bandages or other medical supplies unless specified in this endorsement.

C. Termination of This Rider

This rider will terminate on the earlier of:

1. The date on which the Certificate to which this rider is attached terminates; or
2. The premium due date following the date on which we receive your written request to cancel this rider.

Mary K. Durand
Secretary

OUTPATIENT PRESCRIPTION DRUG BENEFIT RIDER

(3 Tier Plus Specialty Medications)

This rider is made a part of the Certificate to which it is attached. It is subject to all of the Certificate provisions not in conflict with the provisions in this rider.

The drugs available for benefits under this rider are split into 3 tiers plus a 4th category, Specialty Medications. Please refer to the Schedule of Benefits to determine which of these drugs are included in your coverage. The categories are:

Tier 1: Generic Drugs;

Tier 2: Brand Name Formulary Drugs;

Tier 3: Brand Name Nonformulary Drugs; and

Other: Specialty Medications

The administration of your benefits for Tier 1, Tier 2 and Tier 3 is described in Section 1 of this rider. **Because Specialty Medication benefits are administered differently than the drugs in the three tiers, we discuss Specialty Medications in their own section of this rider (Section 2). The primary difference in administering Specialty Medications is that their benefits are subject to your Certificate's Deductible and Coinsurance Percentage.** Your payment obligation is typically lowest with a Tier 1 drug and highest with a Specialty Medication. Most drugs on the market fall into Tiers 1, 2 and 3.

SECTION 1. BENEFITS FOR TIER 1, TIER 2 AND TIER 3

A. Definitions for this Section.

In addition to the Definitions in the attached Certificate, the following Definitions also apply to your benefits for drugs in Tiers 1, 2 and 3:

Ancillary Charge: When a Generic Drug substitute exists but a Brand Name Drug is dispensed, the Ancillary Charge is the difference in cost between the Brand Name Drug and what we would have paid for the Generic Drug substitute.

Brand Name Drug: A Prescription Drug:

1. That is included on our Drug List; and
2. For which a pharmaceutical company has received a patent or trade name; and
3. That is only available for purchase from one pharmaceutical company.

Brand Name Formulary Drug: A Brand Name Prescription Drug that is included on our list of preferred Brand Name Drugs.

Brand Name Nonformulary Drug: A Prescription Drug that is not included on our list of preferred Brand Name Drugs.

Drug List: A list of Prescription Drugs that we designate as eligible for coverage under this rider. The Drug List is subject to change at any time without notice to you.

Generic Drug: A Prescription Drug that:

1. Has the same active ingredients as an equivalent Brand Name Drug; and
2. Does not carry any drug manufacturer's brand name on the label; and
3. Is not protected by a patent.

Nonparticipating Pharmacy: A retail or mail order pharmacy that is not under contract with the Pharmacy Benefit Manager to fill prescription orders.

Participating Mail Order Pharmacy: A pharmacy that is under contract with the Pharmacy Benefit Manager to dispense prescription orders through the mail.

Participating Pharmacy: A retail or mail order pharmacy that is under contract with the Pharmacy Benefit Manager to fill prescription orders when presented with prescription drug cards.

Pharmacy Benefit Manager: The organization or entity, with which we have contracted, that administers the processing of prescription claims under this rider.

Prescription Drug: Any Tier 1, 2 or 3 medication or medicinal substance that has been approved by the Food and Drug Administration (FDA) and which, under federal or state law, only can be dispensed by a prescription order.

Prescription Drug Copayment (or Prescription Drug Percentage): The amount of Covered Expenses under this rider that each Covered Person must pay to the pharmacy each time a prescription is filled or refilled before we pay benefits. The Prescription Drug Copayment (and/or Percentage) amount per prescription is shown on the Schedule of Benefits.

Prescription Drug Deductible: The amount of Covered Expenses under this rider that each Covered Person must pay in a Calendar Year before the applicable Prescription Drug Copayment (or Percentage) is applied and before we pay benefits for covered Prescription Drugs.

Prescription Drug Maximum: The maximum benefit amount we will pay under this rider per Covered Person per Calendar Year. The Prescription Drug Maximum is shown on the Schedule of Benefits.

Retail Pharmacy: A licensed establishment where a wide variety of Prescription Drugs are dispensed by a licensed pharmacist in accordance with all applicable state and federal laws.

B. Covered Prescription Expenses Under This Section

The following drugs provided on an Outpatient basis are covered:

1. Prescription Drugs.
2. The following items on prescription:
   a. Insulin;
   b. Insulin needles and syringes;
   c. Sugar test tablets and tape, including chemstrips, Acetone tablets and Benedict's Solution or equivalent; and
   d. Compounded medication of which at least one ingredient is a Prescription Drug.
3. Contraceptives. Prescription drugs or devices approved by the FDA for use as a contraceptive.

C. Administration of Benefits

All of the following rules and procedures apply to benefits for the above Covered Expenses:

1. When obtaining Prescription Drugs at a Participating Pharmacy, you must present your prescription drug card to the pharmacy staff.
2. The amount of the Prescription Drug Copayment and/or Coinsurance varies depending on which of the following tiers the drug being dispensed falls into:
   a. *Tier 1:* Generic Drug;
   b. *Tier 2:* Brand Name Formulary Drug; or
   c. *Tier 3:* Brand Name Nonformulary Drug.
3. You may call the Pharmacy Benefit Manager to determine if a particular drug is included on our Drug List and in which tier the drug is located.

4. You must pay the applicable Prescription Drug Deductible and Prescription Drug Copayment (and/or Coinsurance Percentage) for each new and refill prescription. If the Covered Expense for a particular Prescription Drug is less than the Prescription Drug Copayment amount, you will be responsible for the full cost of the Prescription Drug.
5. The Covered Expense for a Brand Name Drug dispensed when a Generic Prescription Drug substitute is available is the cost of the drug up to the amount that would have been a Covered Expense for the Generic Drug substitute. The Ancillary Charge is not a Covered Expense and you are responsible for paying that amount to the pharmacy.
6. Retail Pharmacies are able to fill up to a 30-day supply for one prescription. For certain Prescription Drugs, you may be able to obtain a prescription order in excess of a 30-day supply (up to a 90-day supply) from a Participating Mail Order Pharmacy. For any 90-day supply you obtain from a Participating Mail Order Pharmacy, your Prescription Drug Copayment will be **two** times the applicable Prescription Drug Copayment shown on your Schedule of Benefits.
7. Separate Prescription Drug Deductibles may be applicable for Brand Name and Generic Drugs. All benefits are subject to the Calendar Year Prescription Drug Maximum, when applicable (See Schedule of Benefits to determine whether applicable).
8. We may change the Prescription Drug Deductible, Copayment amounts and maximum benefit, but only on a renewal date or at the end of a calendar year. Such changes will be made for all riders with this form number on a class as determined by us, but such change will not be made on an individual basis.
9. If you fail to present your prescription drug card at a Participating Pharmacy, you are required to pay the pharmacy the full cost for the Prescription Drug. In order for us to reimburse you, you must send a claim form to the Pharmacy Benefit Manager. You will then be reimbursed, based on the amount we would have paid if you initially had presented your prescription drug card to the pharmacy.
10. If you obtain a Prescription Drug from a Nonparticipating Pharmacy, you are required to pay the pharmacy the full charge for the Prescription Drug. In order to be reimbursed, you must send the Pharmacy Benefit Manager the receipt for the Prescription Drugs along with a prescription drug claim form. Any reimbursement will be based on the amount we would have paid if you had obtained the Prescription Drug from a Participating Pharmacy.
11. We may require that you try a Generic Drug before we will cover a higher cost Brand Name Drug. When you are first prescribed a particular Prescription Drug, we will guide you to a first-step, lower cost, clinically effective drug for the therapy group. Evidence-based clinical protocols are used to select first-step therapy. If you cannot tolerate or do not receive the desired health improvement effect from the first-step drug therapy, the prescribing Physician may request authorization for a drug in a following step to be dispensed. If we do not provide such authorization, the Prescription Drug benefit may be reduced or denied.
12. For certain Prescription Drugs, we may require that you obtain prior authorization for the drug before benefits will be available. Your pharmacist should notify you if prior authorization is required. Please see Section 3 of this rider for more information on prior authorization.

SECTION 2. BENEFITS FOR SPECIALTY MEDICATIONS

A. **Definitions for this Section.**

In addition to the Definitions in the attached Certificate, the following Definitions also apply to your Specialty Medication benefits:

Participating Specialty Pharmacy: Participating Specialty Pharmacies are pharmacies that focus on the sale of Specialty Medications and which have contracted with the Pharmacy Benefit Manager to fill prescription orders for Specialty Medications. Specialty Pharmacies have expertise in the storing, handling and administering of Specialty Medications.

Specialty Medications: Specialty Medications are drugs that normally have more than one of the following key characteristics:

1. Not available at retail pharmacies;
2. Requires specialized product handling and/or administrative requirements;
3. Requires frequent dosing adjustments and intensive clinical monitoring to decrease the potential for drug toxicity, and increase the probability for beneficial treatment outcomes;
4. Requires intensive patient training and compliance assistance to facilitate therapeutic goals;
5. Requires refrigeration and/or distinct safety protocols;
6. Cost in excess of [$500] for a 30-day supply;
7. Is injectable and administered or supervised by a Provider.

Specialty Medication List: A listing of Specialty Medications that we designate as eligible for reimbursement. We compile the Specialty Medication List and we reserve the right to periodically review and modify the Specialty Medication List. To obtain information about the drugs included on our Specialty Medication List, please visit our website or call the telephone number listed on your insurance identification card. When a Specialty Medication is new to the market, we will add it to our Specialty Medication List within a reasonable time.

B. Covered Expenses Under This Section

Specialty Medications that are included on our Specialty Medication List and provided on an Outpatient basis are Covered Expenses under this section.

C. Administration of Benefits

All of the following rules and procedures apply to benefits for the Covered Expenses in this section:

1. **Your Prescription Drug Copayment and Prescription Drug Deductible do not apply to Specialty Medications. Instead, Specialty Medications are subject to the Certificate's Deductible and Coinsurance Percentage.**
2. You may initially purchase a Specialty Medication at a Retail Pharmacy if the Retail Pharmacy carries the particular Specialty Medication. If so, you must pay the Retail Pharmacy the entire charge for the Specialty Medication. After you obtain your Specialty Medication, you must send us receipt of your purchase and we will process your claim for benefits. Your claim is subject to possible reimbursement as described below.
3. For subsequent refills, we will coordinate with you in selecting a Participating Specialty Pharmacy from which you must obtain the Specialty Medication. If you elect to obtain Specialty Medications from a pharmacy other than a Participating Specialty Pharmacy, any reimbursement to you will be based on the dollar amount we would have paid if you had obtained the Specialty Medication from a Participating Specialty Pharmacy.
4. Once you have satisfied your Calendar Year Certificate Deductible and Coinsurance Percentage, charges for Specialty medications will be covered, during the same Calendar Year, according to the provisions of your Certificate.
5. For certain Specialty Medications, we may require that you obtain prior authorization for the drug before benefits will be available. Please see Section 3 below for more information on prior authorization.

SECTION 3. PROVISIONS THAT APPLY TO BOTH PRESCRIPTION DRUGS AND SPECIALTY MEDICATIONS

A. Prescription Utilization Review

Prior authorization may be required for certain Prescription Drugs and Specialty Medications before they are considered for coverage under this rider. Because the list of drugs requiring prior authorization is subject to change, please access our website to obtain information on which drugs require prior authorization. If a drug is purchased without prior authorization when prior authorization is required, you will be responsible for the full cost of the drug at the time of purchase. If a prescription for a drug that requires prior authorization is requested at the pharmacy, the pharmacy should work with the prescribing Physician to obtain medical information for the prior authorization.

B. Exclusions and Limitations

In addition to the Exclusions and Limitations listed in your Certificate, the following Exclusions and Limitations also apply:

1. Prescription Drug benefits per Covered Person per Calendar Year under this rider will not exceed the Prescription Drug Annual Maximum benefit, if any, shown on the Schedule of Benefits.
2. All of the exclusions, limitations, terms and conditions set forth in your Certificate apply to this rider unless the terms of this rider specifically provide otherwise.
3. Benefits provided by this rider will count toward the Maximum Lifetime Benefit Limit of the Certificate.
4. Benefits provided by this rider will not duplicate benefits provided under the Certificate to which this rider is attached.
5. Any applicable benefit maximum for this rider is shown on your Schedule of Benefits.
6. If you use a prescription drug card after the card's termination date, we will bill you directly for any benefits we pay after the termination date or we will deduct from any pending claim the amount we paid for the drug.
7. All expenses for covered drugs are subject to the drug manufacturer's recommendation for dosage and dispensing and will be limited based on those recommendations.
8. **This Rider does <u>not</u> cover any of the following:**
    a. Contraceptives, oral or otherwise, whether medication or device, not approved by the FDA, regardless of intended use;
    b. Any drug for the treatment of sexual and/or erectile dysfunction;
    c. Nonprescription Drugs except as specifically covered in this rider;
    d. Therapeutic devices or appliances including, but not limited to, training and education on how to use such devices or appliances, except as specifically covered in this rider;
    e. Prescriptions that you are entitled to receive without charge under any Worker's Compensation Laws;
    f. Drugs that are considered Experimental or Investigational;
    g. Immunization agents, biological sera or blood plasma products;
    h. Medication that is to be taken by you or administered to you while you are an Inpatient in a medical care facility;
    i. Any prescription filled or refilled in excess of the number specified by the Physician, or any refill dispensed after one year from the Physician's original order;
    j. Charges for more than a 30-day supply of any medication at a Retail Pharmacy;
    k. Nicorette, nicotine patches, or any other drug, preparation, or device designed to help you quit tobacco use;

l. Any drug for which there is no charge to you;

m. Any type of equipment or device used to administer a drug effectively, except as otherwise specifically covered in this rider;

n. TPN (Total Parenteral Nutrition);

o. Retin-A or its therapeutic equivalent or any drugs used in the treatment of acne;

p. Drugs prescribed for cosmetic purposes;

q. Drugs prescribed for the treatment of hair loss;

r. Preparations, drugs or devices designed to assist in diet or weight control, including appetite suppressant drugs;

s. Vitamins, minerals, fluoride or other dietary supplements;

t. Prescriptions for mental and nervous disorders;

u. Growth Hormone therapy;

v. Medication not dispensed in the United States;

w. Medication obtained through the Internet, or through other sources, that are not regulated by the United States Food and Drug Administration;

x. Medications used in the treatment of infertility or with the intent of facilitating pregnancy;

y. Durable medical equipment, devices or appliances including, but not limited to, blood glucose testing devices, support garments, bandages or other medical supplies unless specified in this endorsement.

C. **Termination of This Rider**

This rider will terminate on the earlier of:

1. The date on which the Certificate to which this rider is attached terminates; or
2. The premium due date following the date on which we receive your written request to cancel this rider.

Mary K. Durand
Secretary

WELLNESS BENEFIT RIDER

This rider is made a part of the Certificate to which it is attached. It is subject to all of the Certificate provisions not in conflict with the provisions of this rider.

Definitions for This Rider

In addition to the Definitions in the Certificate, the following Definitions also apply to this rider:

Wellness Services: Wellness Services are routine physicals, screenings and immunizations from a Provider that are all of the following:

a. Appropriate for the age and gender of the Covered Person; and

b. Based on generally accepted standards of medical practice.

[Wellness Services also include Preventive Dental Services as defined below.]

[Preventive Dental Services: Preventive Dental Services are routine annual dental checkups and routine dental cleanings. Further information and limitations concerning this Wellness Services benefit are shown on your Schedule of Benefits.]

[Supervised or Prescribed by Physician: The following services are included in the definition of Wellness Services if they are supervised or prescribed by a Physician:

a. Smoking cessation services or products; and

b. Weight loss services or products.]

Administration of Benefits

After you satisfy the Copayment amount, if any, we will pay for expenses you Incur for Wellness Services not to exceed the Wellness Service Annual Maximum benefit. Any applicable Copayment amount and Wellness Service Annual Maximum benefit are shown on the Schedule of Benefits.

Exclusions and Limitations

1. The terms and benefits under this rider will become effective after the applicable Wellness Waiting Period, if any, has passed. The Wellness Waiting Period is shown on your Schedule of Benefits.
2. Benefits provided by this rider will count toward the Maximum Lifetime Benefit Limit of the Certificate.
3. This benefit is not subject to any Deductible amount, Coinsurance Percentage or Access Fee. No benefits paid under this rider will be used to satisfy any Deductible or coinsurance amount.
4. Benefits provided by this rider will not duplicate benefits provided under the Certificate to which this rider is attached.

Termination of This Rider

This rider will terminate on the earlier of:

1. The date on which the Certificate terminates; or
2. The premium due date following the date on which we receive your written request to cancel this rider.

Mary K. Durand
Secretary

MATERNITY EXPENSE BENEFIT RIDER

This rider is made a part of the Certificate to which it is attached. It is subject to all Certificate provisions not in conflict with the provisions of this rider.

Additional Definition for This Rider

In addition to the Definitions in the Certificate, the following Definition also applies to this rider:

Maternity Covered Expenses. Maternity Covered Expenses are:

1. Prenatal care;
2. Delivery;
3. The following duration of Inpatient care unless the attending Physician, in consultation with the mother, recommends a shorter Hospital stay:
   a. A minimum of 48 hours of Inpatient care following a vaginal delivery; and
   b. A minimum of 96 hours of Inpatient care following a cesarean section delivery.

   The minimum stay requirement excludes the day of delivery;
4. Postpartum care; and
5. Nursery charges from the moment of birth until the mother's Confinement ends.

Administration of Benefits

1. After application of the Maternity Waiting Period and the Maternity Benefit Deductible Amount, we will pay the Maternity Benefit Percentage of the Maternity Covered Expenses Incurred for a Covered Person's pregnancy. The Maternity Waiting Period; Maternity Benefit Deductible Amount and Maternity Benefit Percentage are shown on the Schedule of Benefits.
2. In order for benefits to be payable, your attending Physician must have determined that your pregnancy began after the Maternity Waiting Period.
3. Covered Expenses Incurred for Complications of Pregnancy will be considered Covered Expenses under the Certificate. Such expenses are payable on the same basis as any other Illness.

In Vitro Fertilization Benefit

Benefits for in vitro fertilization are payable on the same basis as benefits provided for Maternity Expenses, but are limited to a lifetime maximum benefit of $15,000. (Cryopreservation, the procedure whereby embryos are frozen for later implantation, shall be included as an in vitro fertilization procedure.)

Benefits for in vitro fertilization procedures will be provided when:

1. The patient is a Covered Person under the Certificate to which this rider is attached.
2. The Covered Person's oocytes are fertilized with the sperm of her spouse, and
3. a. The Covered Person has a history of unexplained infertility of at least two years' duration; or
   b. The infertility is associated with one or more of the following medical conditions:
      (1) Endometriosis;
      (2) Exposure in utero to Diethylstilbestrol, commonly know as DES;
      (3) Blockage of or removal of one or both fallopian tubes (lateral or bilateral salpingectomy) not a result of voluntary sterilization; or
      (4) Abnormal male factors contributing to the infertility; and

4. The in vitro fertilization procedures are performed at a medical facility, licensed or certified by the Arkansas Department of Health, those performed at a facility certified by the Arkansas Department of Health which conform to the American College of Obstetricians and Gynecologists' guidelines for in vitro fertilization clinics, or those performed at a facility certified by the Arkansas Department of Health which meet the American Fertility Society's minimal standards for programs of in vitro fertilization.
5. The Covered Person has been unable to obtain successful pregnancy through any less costly applicable infertility treatment.

Exclusions and Limitations

1. All of the exclusions, limitations, terms and conditions set forth in your Certificate apply to this rider unless the terms of this rider specifically provide otherwise.
2. Maternity Covered Expense Benefits will count towards the Certificate Maximum Lifetime Benefit limit. The Certificate Maximum Lifetime Benefit is shown on the Schedule of Benefits.
3. Maternity Covered Expenses Incurred for a pregnancy that begins after the Certificate Issue Date and during the Maternity Waiting Period will not be considered Maternity Covered Expenses;
4. The "General Exclusions and Limitations" section of the Certificate is amended by deleting the following; "For pregnancy, prenatal care, or normal childbirth, except for covered Complications of Pregnancy."
5. The Maternity Benefit Deductible Amount is separate from and cannot be used to satisfy the Certificate Deductible or the annual maximum out of pocket limit. Benefits provided by this rider cannot be used to satisfy the Deductible and Coinsurance amounts of the Certificate.
6. Benefits provided by this rider will not duplicate benefits provided under the Certificate to which this rider is attached.

General Information Statement

If this rider is attached to a High Deductible Health Plan issued in conjunction with a Health Savings Account (HSA), it must meet certain minimum Deductibles set by federal law. These set Deductibles may be adjusted in any given year. If at any time this coverage does not satisfy the minimum HSA Deductibles, we will automatically adjust the Maternity Deductible Amount to one currently offered by us that satisfies the requirement. However, you may notify us in writing to not adjust the Deductible amount. We must receive your notification within 30 days of the date we notify you of any change in the Deductible amount. The Maternity Deductible Amount will count towards satisfying the annual maximum out-of-pocket limit of that High Deductible Health Plan.

Termination of This Rider

This rider will terminate on the earlier of:

1. The date on which the Certificate terminates; or
2. The premium due date following the date on which we receive your written request to cancel this rider.

Mary K. Durand
Secretary

TERM LIFE INSURANCE RIDER

This rider is made a part of the Certificate to which it is attached. It is subject to all the provisions of the Certificate not in conflict with the provisions of this rider.

EFFECTIVE DATE (same as Issue Date if no date shown):_____

PREMIUM (included in the Certificate Premium if no amount shown): _____

Definitions

In addition to the definitions in the Certificate, the following definitions apply to this rider.

Beneficiary: A person named to receive benefits if the life insurance benefit becomes payable due to your death. You may change your Beneficiary at any time by filing the change with us on a form or in writing in a manner that we have approved. If we make any payment before we receive a change of Beneficiary notice, that payment will fully discharge our obligation. Any payment of a life insurance benefit due to the death of the Covered Dependent or a Covered Dependent Child will be paid to you.

Covered Dependent (other than Dependent Children): Includes any of the following:

1. Your spouse under the Age of 65 if said spouse is not legally separated from you;
2. Your domestic partner who is under the Age of 65; or
3. Someone with whom you have a civil union who is under the Age of 65.

To be eligible for coverage, each Covered Dependent must be named as one of the Covered Dependents on the Schedule of Benefits or added as such at a later date.

Covered Dependent Child: Includes any of the following:

1. Your unmarried child under Age 19, including:
   a. Your biological child; or
   b. Your legally adopted child or a child Placed for Adoption; or
   c. A stepchild who permanently resides with you; or
   d. A grandchild for whom you are legal guardian.
2. Your unmarried child under the Age of 65 who is:
   a. Incapable of self-sustaining employment because of the child's disability (including mental retardation, mental illness or disorder, or physical handicap). In order to be considered in this category, you must furnish proof of the child's incapacity within 31 days of the date insurance would have otherwise terminated due to age. We may require proof of continued incapacity each year after the first two-year period that insurance has been extended;
   b. Fully dependent on you or other care providers for lifetime care and supervision. "Other care providers" means a community-integrated living arrangement, group home, supervised apartment, or other residential service licensed or certified by the Department of Human Services, the Department of Health, or the Department of Public Aid; and
   c. Insured on the date immediately preceding the day the insurance would have terminated due to age.
3. Your unmarried child who is:
   a. Age 19 or older but under the age of 27; and
   b. Enrolled as a full-time student in an accredited school; and
   c. Financially dependent on you.

To be eligible for coverage, each child must: (a) be named as one of the Dependent Children on the Schedule of Benefits or added as a dependent child at a later date; and (b) not have been removed from coverage under the Certificate; and (c) not be less than 14 days old.

Family Coverage: Coverage for you and your Covered Dependents listed on the Schedule of Benefits.

Individual Coverage: Coverage only for you.

Insured: The person listed as the Covered Member on the Validation of Coverage page of the Certificate.

Evidence of Insurability: Satisfactory proof, as determined by us, that a person is acceptable for insurance.

Life Insurance Benefit

1. **Payment of Benefits For Loss of Life – Insured.** We will pay the life insurance benefit on the Insured in one lump sum to your Beneficiary. If any Beneficiary dies before you die, that Beneficiary's share will pass to the other surviving Beneficiaries equally. If you fail to name a Beneficiary, or if no Beneficiary survives you, we will pay the life insurance benefits to your estate. If you apply for a life conversion policy and die before the conversion is complete, any claims payable will be paid to the most recently named Beneficiary under the application for the life conversion policy. The life insurance benefit amount will be the maximum amount of insurance that you might have converted.
2. **Payment of Benefits for a Covered Dependent's or Covered Dependent Child's Loss of Life.** We will pay benefits to you if your Covered Dependent or Covered Dependent Child dies while eligible for life insurance coverage. If you die before your Covered Dependent or Covered Dependent Child there is a 31-day conversion period. If your Covered Dependent or Covered Dependent Child dies during the 31-day conversion period and we have not received an application for conversion, the life insurance benefit will be paid to your estate. If we have received the completed application, any claim payable will be paid to the most recently named Beneficiary under the application for the life conversion policy.

Incontestability

Except for nonpayment of premiums and except as otherwise provided in this section, the validity of this rider will not be contestable after it has been in force during the lifetime of the Covered Person for 2 years from the Date of Issue or the date of reinstatement. We may contest the validity of this rider after 2 years from the Date of Issue or the date of reinstatement if the Covered Person made a fraudulent misstatement or material omission to us. Such statement or omission may be used to contest the validity of this rider only if it is part of your application or in a separate document that was signed by the Covered Person or a person who had the authority to sign for the Covered Person. We must provide you with a copy of anything on which we base a decision to contest the validity of this rider.

Benefits in Event of Suicide

We will limit the proceeds we pay if the Insured, the Covered Dependent or Covered Dependent Child commits suicide, while sane or insane, within 2 years from the issue date of this rider or from the last date this rider was reinstated, whichever is later. The limited amount for the Insured will equal all premiums paid for the Insured's portion of the coverage from the later of the issue date or the date of the last reinstatement. The limited amount for the Covered Dependent or any Covered Dependent Child will equal a portion of all premiums paid from the later of the issue date or the date of the last reinstatement in those years when the only individual covered under this rider (other than the Insured) was the person who committed suicide. The portion of premium used to calculate the limited benefit for the Insured is the cost of Individual Coverage. The portion of premium used to calculate the limited benefit amount for the Covered Dependent or Covered Dependent Child is the premium for Family Coverage, less the cost of Individual Coverage.

Conversion

1. The coverage provided under this rider can be converted to a permanent life insurance policy offered specifically for this conversion privilege. The conversion of this coverage will be completed without Evidence of Insurability:

a. If you request conversion prior to the time the coverage under this rider ends, you can convert the full coverage amount on everyone who has a life insurance benefit under this rider. When the conversion is completed, this rider will end.

b. If you, your Covered Dependent or any Covered Dependent Child dies while this rider is being converted, we will pay the maximum amount of insurance that you might have converted. The death benefit will be paid under this rider and not the individual life insurance policy. Any premiums paid for the individual life insurance policy will be refunded.

2. If the life insurance benefit under this rider ends, and coverage has not been converted, you, your Covered Dependent and Covered Dependent Child can each convert the lesser of $2,000 or the coverage provided under this rider. We must receive a request for conversion and the first premium payment within 31 days from the following events:

   a. The coverage under this rider ending because you have reached your 65th birthday; or

   b. The coverage under this rider ending because your coverage under the Certificate is ending; or

   c. This rider terminating due to your death; or

   d. In addition to a., b., and c. above, your Covered Dependent and each Covered Dependent Child may convert their coverage when it ends because they have reached the limiting Age set out in the definition of Covered Dependent or Covered Dependent Child.

3. If you, your Covered Dependent, or any Covered Dependent Child dies during the 31-day conversion period, we will pay the maximum amount of insurance that the individual might have converted. The death benefit will be paid under this rider and not the individual life insurance policy. Any premiums paid for the individual life insurance policy will be refunded.

4. The individual life insurance policy will:

   a. Take effect on the date this rider is terminated due to a conversion under 1. above; or

   b. Take effect at the end of the 31-day application period due to a conversion in 2. above.

5. The individual life insurance policy also will:

   a. Be issued using the same premium class as the one used when this rider was issued;

   b. Be based on the attained Age of the person obtaining the coverage; and

   c. Be issued without any other benefits.

Termination

This rider will end on the date one of the following occurs:

1. The date the Certificate ends; or
2. The date a life insurance benefit is paid due to your death; or
3. The date you convert your coverage under this rider; or
4. The date requested by you in writing, to end this rider; or
5. The renewal date following your 65th birthday.

Mary K. Durand
Secretary

ALCOHOLISM/SUBSTANCE ABUSE TREATMENT BENEFITS RIDER

This rider is made a part of the Certificate to which it is attached. It is subject to all of the provisions in the Certificate that do not conflict with the provisions in this rider.

EFFECTIVE DATE (Same as Issue Date if no date shown): _____

PREMIUM (Included in the Certificate Premium if no amount shown): _____

Definitions

In addition to the definitions in the Definitions section of the Certificate, the following definitions apply to this rider:

Alcohol or drug dependency means the pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces impairment in persona, social, or occupational functioning and that may include a pattern of tolerance and withdrawal.

Alcohol or drug dependency facility means a public or private facility, or unit in a facility, that is engaged in providing Treatment 24 hours a day for alcohol or drug dependency or substance abuse, that provides a program for the Treatment of alcohol or drug dependency pursuant to a written treatment plan approved and monitored by a Physician, and that is also properly licensed or accredited to provide those services by the Bureau of Alcohol and Drug Abuse Prevention of the Department of Health.

Benefits

We will pay benefits for the Treatment of alcohol and other drug dependency in an alcohol or drug dependency facility or a Hospital. Such benefits are limited to:

1. Up to $6,000 for the Medically Necessary care and Treatment of alcohol or drug dependency, during a 24-month period (No more than one-half of this benefit can be provided in any 30-consecutive-day period); and
2. A lifetime maximum of $12,000 for each recipient of alcohol or drug dependency Treatment.

Termination of this Rider

This rider will terminate on the earlier of:

1. The date on which the Certificate terminates;
2. The premium due date following the date on which we receive your written request to cancel this rider.

Mary K. Durand
Secretary

Rate Information

Rate data does NOT apply to filing.

Supporting Document Schedules

Satisfied -Name: Certification/Notice

Review Status: Approved-Closed 03/31/2008

Comments:

Attachment:

FLESCH SCORE CERTIFICATION - wic.pdf

Satisfied -Name: Application

Review Status: Approved-Closed 03/31/2008

Comments:

G4800W - Application
G4800W-Eapp - E-Application
M1184W - Preferred Rating Guidelines
G4820W - Application for Internal Substitution

Attachments:

g4800w sec 2 - norm.pdf
g4800w-eapp.pdf
M1184W (06-117-0055-0108-US with brackets for filing).pdf
g4820w.pdf

Satisfied -Name: Cover Letter

Review Status: Approved-Closed 03/31/2008

Comments:

Cover letter includes list of forms.
Please corss-reference with AMRP-125470085 for American Republic Insurance Company -- forms are identical except for any reference to Company.

Attachment:

Letter,AR,WIC 2-26-08.pdf

Satisfied -Name: Certification

Review Status: Approved-Closed 03/31/2008

Comments:

Attachment:

Certification-World.pdf

Satisfied -Name: Association Membership and Association Documents

Review Status: Approved-Closed 03/31/2008

Comments:

Attachments:

AR Answers WIC.pdf
AR-M355N_20070724_090506aea.pdf
AR-M355N_20080314_155801aca.pdf
AR-M355N_20080314_155952nca.pdf
AR-M355N_20080314_160220sba.pdf
AR-M355N_20080314_160547chsa.pdf
AR-M355N_20080314_160655abba.pdf
AR-M355N_20070801_093501.pdf

FLESCH SCORE CERTIFICATION

FORM NUMBER	FLESCH SCORE
AC4800W*	48

(*Includes all forms combined – certificate, mandated benefits rider and optional riders.)

THIS FLESCH READING EASE SCORE WAS BASED ON THE ENTIRE TEXT OF THE FORMS.

I CERTIFY THAT THE FORMS SHOWN ABOVE ACHIEVED THE SCORES INDICATED.

SIGNED _____

Norman Von Seggern, Product Analyst 4

Application to World Insurance Company
(herein called the Company) for Health Coverage
P.O. Box 3160 • Omaha, NE 68103-0160

Complete & Submit

To be completed by Agent	*Home Office Use Only*
Agent #	Application #

A. General Information *(please print)*

1. Your Information

Name *(First, Middle, Last)*

Address *(Street, City, State, ZIP)*

Home Phone Number | Cell Phone Number

Best Time to Call: ☐AM ☐PM ☐Home ☐Work ☐Cell

Email Address *(It may be used to send you important notices.)*

Employer *(Name, Street, City, State, ZIP)*

Occupation/Duties | Work Phone Number

If unemployed or employed part-time, are you seeking full-time employment? ☐Yes ☐No

Driver's License Number/State _____

2. Your Spouse's Information *(where different)*

Name *(First, Middle, Last)*

Address *(Street, City, State, ZIP)*

Home Phone Number | Cell Phone Number

Best Time to Call: ☐AM ☐PM ☐Home ☐Work ☐Cell

Email Address *(It may be used to send you important notices.)*

Employer *(Name, Street, City, State, ZIP)*

Occupation/Duties | Work Phone Number

If unemployed or employed part-time, are you seeking full-time employment? ☐Yes ☐No

Driver's License Number/State _____

3. Persons proposed for insurance.

	List first, MI, and last names.	Birthdate Mo./Day/Yr.	State of Birth	Ht. ft., in.	Wt. lbs.	Sex	Full-time Student	Social Security Number
You						☐M ☐F	☐Yes ☐No	
Spouse						☐M ☐F	☐Yes ☐No	
Dependent						☐M ☐F	☐Yes ☐No	
Dependent						☐M ☐F	☐Yes ☐No	
Dependent						☐M ☐F	☐Yes ☐No	
Dependent						☐M ☐F	☐Yes ☐No	

4. Residency Information

a. Do all people requesting coverage live in the same household? ☐Yes ☐No

b. Are all of you U.S. citizens, have established permanent resident status, and have been in the U.S. a minimum of two years? ☐Yes ☐No

If "No" to a. or b., explain: _____

c. Are any of you planning to live, work or attend school outside the U.S. for more than 60 consecutive days? ☐Yes ☐No

If "Yes" to c., explain: _____

5. Please complete if Life Benefit selected: *(Not available in Ohio.)*

Beneficiary *(First, Middle Initial, Last)*	Address *(Street, City, State, ZIP Code)*	Social Security Number	Relationship

B. HIPAA Eligible Individual Determination

You may be eligible for guaranteed issue health coverage if you qualify under the rules of the Health Insurance Portability and Accountability Act (HIPAA). The information you provide in this section will help determine whether you qualify under HIPAA. Please answer the following questions for all applicants.

1. Was there any period of 63 days or more during the past 18 months when you were not continuously covered by group or individual health insurance, Medicare, Medicaid or any other health insurance? ☐Yes ☐No
2. If you answered "Yes" to question 1, were you offered coverage under COBRA or a similar state program, and
   a. refused coverage? ☐Yes ☐No
   b. were not covered through COBRA for the full allowable period of coverage available? ☐Yes ☐No
   c. are presently eligible for such coverage? ☐Yes ☐No
3. Are you presently eligible for, or will you be eligible for health coverage provided by an employer? ☐Yes ☐No
4. Was your most recent health insurance coverage terminated for non-payment of premium, misrepresentation or fraud? ☐Yes ☐No
5. Do you currently have health insurance in force? ☐Yes ☐No
6. Was your most recent health insurance coverage through an employer-sponsored group plan? ☐Yes ☐No

If you answered "No" to questions 1-5, and "Yes" to question 6, you meet the definition of an Eligible Individual.

☐ I elect to apply as a HIPAA Eligible Individual and understand the rates for this plan will be substantially higher than underwritten-plan rates.

☐ I am a HIPAA Eligible Individual, but elect to be underwritten and waive any available rights as an Eligible Individual. I understand I will be subject to pre-existing condition exclusions.

C. General Medical Overview

1. **Within the past 5 years,** have you or any applicant been treated for, been diagnosed as having, or had symptoms of any of the following medical conditions?
   a. Heart attack, angina, congestive heart failure, heart surgery, bypass or angioplasty? ☐Yes ☐No
   b. Rheumatoid arthritis, connective tissue disorders or psoriatic arthritis? ☐Yes ☐No
   c. Addison's Disease, Cushing's Syndrome or pheochromocytoma (tumor of the adrenal gland)? ☐Yes ☐No
   d. Diabetes, including hyperglycemia, insulin resistance or impaired glucose tolerance? ☐Yes ☐No
   e. Inflammatory bowel disease including ulcerative colitis or Crohn's disease? ☐Yes ☐No
   f. Chronic obstructive pulmonary disease (COPD) requiring oxygen, emphysema requiring oxygen or cystic fibrosis? ☐Yes ☐No
   g. Schizophrenia, psychoses, Alzheimer's disease or dementias? ☐Yes ☐No
   h. Stroke/TIA, Parkinson's disease? ☐Yes ☐No
   i. Liver failure, kidney failure/dialysis? ☐Yes ☐No
   j. Amyotrophic lateral sclerosis (ALS), multiple sclerosis (MS), muscular dystrophy (MD) or lupus (systemic)? ☐Yes ☐No
   k. Major organ transplant, including heart, lung, kidney or liver? ☐Yes ☐No
   l. Cancer including, but not limited to, cancer of any organ, melanoma, sarcoma, leukemia, Hodgkin's or other lymphoma, but excluding basal or squamous cell skin cancers? ☐Yes ☐No
2. Are any of you now pregnant, an expectant father, in the process of adopting a child, or planning to serve as a surrogate? ☐Yes ☐No
3. Are any of you eligible for Medicare due to a disability? ☐Yes ☐No
4. a. Have you or any applicant ever been diagnosed as having, or been treated by a member of the medical profession as having AIDS (acquired immune deficiency syndrome), ARC (AIDS-related complex), or any other disease or disorder of the immune system? ☐Yes ☐No
   b. Have you or any applicant ever tested positive for AIDS/HIV (limited to FDA licensed tests)? ☐Yes ☐No

Note: Applicant(s) who answers "Yes" to any questions in this section is not eligible for coverage. Please indicate individual(s): _____

D. Comprehensive Medical and Additional History

Please indicate "YES" or "NO" for each category. If you answer "YES", check (✓) the applicable condition and provide details in the space provided in the Explanation of Health Section. Categories do not necessarily include all the conditions related to that category, so please indicate "Other" for any conditions not listed.

Within the last 10 years, have you or any applicant been treated for, diagnosed with or had symptoms of any of the following:

1. Ears/Eyes/Nose/Throat ☐Yes ☐No

☐ Ear infections/otitis	☐ Otosclerosis	☐ Double vision	☐ Retinal detachment
☐ Hearing loss	☐ Cochlear implant	☐ Loss of vision	☐ Rhinitis
☐ Meniere's disease	☐ Strabismus/lazy eye	☐ Macular degeneration	☐ Optic Neuritis
☐ Ear tubes	☐ Cataracts	☐ Glaucoma/Increased eye pressure	☐ Sinusitis
☐ Enlarged tonsils/Adenoids	☐ Tonsillitis		☐ Other _____

2. Lungs and Respiratory ☐Yes ☐No

☐ Allergic rhinitis	☐ Reactive airway disease	☐ Chronic lung disease	☐ Chronic obstructive pulmonary disease
☐ Allergic sinusitis	☐ Bronchitis	☐ Tuberculosis	☐ Other _____
☐ Asthma	☐ Pneumonia	☐ Sleep apnea	
☐ Emphysema	☐ Chronic cough		

3. Heart/Circulatory ☐Yes ☐No

☐ Chest pain	☐ Heart surgery (stent placement, coronary artery bypass, angioplasty, valve)	☐ High blood pressure/ hypertension	☐ Claudication
☐ Heart valve disorders	☐ Heart murmurs	☐ Phlebitis	☐ High lipid (cholesterol or triglycerides)
☐ Coronary artery disease	☐ Peripheral vascular disease	☐ Thrombophlebitis	☐ Other _____
☐ Angina	☐ Edema	☐ Varicose veins	
☐ Heart attack		☐ Aneurysm	
☐ Irregular heart beat			

4. Blood/Lymph/Anemia ☐Yes ☐No

☐ Anemia	☐ Thrombocytopenia	☐ Bleeding disorders	☐ Other _____
☐ Hemophillia	☐ Hyperglycemia (high blood sugar)		

5. Digestive ☐Yes ☐No

☐ Esophagitis	☐ Ulcers	☐ Ulcerative colitis	☐ Rectal bleeding
☐ Gastric reflux/GERD	☐ Gastritis	☐ Crohn's disease	☐ Other _____
☐ Hernia	☐ Recurrent indigestion	☐ Hemorrhoids	
☐ Irritable bowel	☐ Diverticulosis	☐ Chronic diarrhea	

6. Liver/Gallbladder/Pancreas ☐Yes ☐No

☐ Cirrhosis	☐ Fatty liver	☐ Pancreatitis	☐ Other _____
☐ Hepatitis	☐ Gallstones	☐ Spleen/pancreas disease	

7. Urologic/Kidney/Bladder ☐Yes ☐No

☐ Bladder infections	☐ Overactive bladder	☐ Interstitial cystitis	☐ Nephritis
☐ Incontinence	☐ Kidney stones	☐ Pyelonephritis	☐ Other _____

D. Comprehensive Medical and Additional History (Cont'd.)

8. Reproductive/Breast ☐Yes ☐No

- ☐ Prostate disorder
- ☐ Impotence
- ☐ Abnormal Prostate Specific Antigen (PSA)
- ☐ Abnormal PAP smear
- ☐ Uterine fibroids
- ☐ Ovarian disorders
- ☐ Infertility
- ☐ Sexually transmitted disease
- ☐ Complications of pregnancy
- ☐ Human papillomavirus (HPV)
- ☐ Mastitis
- ☐ Cesarean section delivery
- ☐ Breast cysts/lumps
- ☐ Abnormal mammogram
- ☐ Gynecomastia
- ☐ Endometriosis
- ☐ Menstrual disorders (painful, excessive or irregular bleeding
- ☐ Other _____

9. Skin ☐Yes ☐No

- ☐ Acne/rosacea
- ☐ Hemangioma
- ☐ Eczema
- ☐ Psoriasis
- ☐ Shingles
- ☐ Herpes
- ☐ Keratosis
- ☐ Other _____

10. Bone/Muscular/Connective Tissue ☐Yes ☐No

- ☐ Arthritis
- ☐ Gout
- ☐ Back/spine conditions
- ☐ Herniated, bulging or degenerative discs
- ☐ Osteoarthritis
- ☐ Joint replacement
- ☐ Back pain
- ☐ Scoliosis
- ☐ Degenerative joint disease
- ☐ Joint pain
- ☐ Curvature subluxation
- ☐ Osteopenia/osteoporosis
- ☐ Rheumatoid arthritis
- ☐ Muscular pain
- ☐ Sciatica
- ☐ Fracture(s)
- ☐ Fibromyalgia
- ☐ Other _____

11. Prosthetic Devices/Plates, Pins, Screws ☐Yes ☐No

- ☐ Plates, pins, screws
- ☐ Rods
- ☐ Artificial limb
- ☐ Pacemakers
- ☐ Shunts
- ☐ Valve/joint replacement
- ☐ Other _____

12. Nervous System ☐Yes ☐No

- ☐ Dizziness/syncope
- ☐ Cerebral palsy
- ☐ Neuropathy
- ☐ Muscular weakness
- ☐ Restless leg syndrome
- ☐ Carpal tunnel syndrome
- ☐ Headaches/migraines
- ☐ Paralysis
- ☐ Seizures
- ☐ Epilepsy
- ☐ Tourette's syndrome
- ☐ Convulsions
- ☐ Other _____

13. Endocrine/Thyroid ☐Yes ☐No

- ☐ Diabetes
- ☐ Goiter
- ☐ Hyperthyroid
- ☐ Hypothyroid
- ☐ High blood sugar
- ☐ Insulin resistance
- ☐ Impaired glucose tolerance
- ☐ Other _____

14. Cancer/Tumors ☐Yes ☐No

- ☐ Of internal organ
- ☐ Leukemia
- ☐ Melanoma
- ☐ Hodgkin's disease
- ☐ Sarcoma
- ☐ Other lymphoma
- ☐ Adenoma
- ☐ Basal or squamous cell skin cancer
- ☐ Breast cancer
- ☐ Neoplasm
- ☐ Other _____

15. Psychological ☐Yes ☐No

- ☐ Emotional disorder
- ☐ Anxiety
- ☐ Depression
- ☐ Attention deficit disorder
- ☐ Eating disorder
- ☐ Chemical imbalance
- ☐ Bipolar (manic depression)
- ☐ Psychiatric treatment or counseling
- ☐ Obsessive compulsive disorder
- ☐ Other _____

16. Congenital Disorders/Birth Defects/Developmental Disorders ☐Yes ☐No

- ☐ Down's syndrome
- ☐ Mental retardation
- ☐ Autism
- ☐ Club foot
- ☐ Cleft lip/palate
- ☐ Delayed development
- ☐ Speech impairment
- ☐ Other _____

17. Other Conditions

a. In the past 10 years, have you or any applicant required an emergency room visit, hospital stay, surgery, or treatment? ☐Yes ☐No

b. In the past 10 years, have you or any applicant been recommended to have surgery or to receive treatment from a physician, chiropractor or other practitioner? ☐Yes ☐No

c. Do you or any applicant have any medical conditions/symptoms for which you have not seen a health care provider? ☐Yes ☐No

d. Have you or any applicant had any tests or procedures recommended that have not yet been performed? ☐Yes ☐No

18. Medication Use

a. Have you or any applicant taken or been recommended to take any prescription medication in the last 2 years? ☐Yes ☐No

b. In the last two years have you or any applicant taken any herbal or over-the-counter medication more often than once a week? ☐Yes ☐No

19. Substance Abuse/Advice to Reduce or Eliminate Use

a. In the past 5 years, have you or any applicant ever been evaluated or treated for alcoholism, frequently used alcoholic beverages to excess or intoxication, or been advised to modify drinking habits for any reason? ☐Yes ☐No

b. In the past 5 years, have you or any applicant ever used non-prescribed sedatives, tranquilizers, cocaine, marijuana, hallucinogenic, other narcotic drugs or controlled substances, or received treatment or evaluation for drug abuse or chemical dependency? ☐Yes ☐No

20. Tobacco Use

In the past 12 months, has anyone used cigarettes, cigars, pipes, oral tobacco or nicotine replacements? ☐Yes ☐No

If "YES", list name(s): _____

21. High Risk Activities

In the past 2 years, has anyone participated in hazardous activities, including activities like hang-gliding, scuba diving, rodeoing or racing (including automobile, motorcycle, etc.)? ☐Yes ☐No

If "YES", list name(s): _____

Activity: _____ Frequency: _____

D. Comprehensive Medical and Additional History (Cont'd.)

22. Driving Violations

In the past 2 years, has anyone been convicted of any driving violation, including DUI, DWI, license suspension or revocation, or 3 or more speeding violations? ..... ☐Yes ☐No

Name: _____ Date: _____ Violation _____

Name: _____ Date: _____ Violation _____

23. Insurance Declination

In the past 5 years, has anyone's health insurance been declined, rescinded, rated or issued with waivers? ..... ☐Yes ☐No

Name(s) _____

Insurance Company(ies) _____ Date(s) _____

Reason(s) _____ Details _____

24. Complete ONLY if applying for [Critical Illness/Cancer Care]

Has any applicant's biological parents, brothers or sisters, either living or deceased, been diagnosed prior to age 55 with any of the following: diabetes, heart disease, stroke, kidney disease, internal cancer or MS, Alzheimer's, Parkinson's?..... ☐Yes ☐No

Name	Family member's relationship	Condition	Age at onset	Current age/ Age at death

Explanation of Health

Provide details for all questions 1 through 19 with "YES" answers. If you need additional space, please include a separate sheet and sign, date and attach to this application.

a. Name	Medical Condition	Date of Onset
Dates of Treatment	Treatment *(prescription drugs, herbal or over-the-counter medications, office visits, therapy, or surgery)*	
Physician's Name	Physician's Location (City/State)	Phone Number
b. Name	Medical Condition	Date of Onset
Dates of Treatment	Treatment *(prescription drugs, herbal or over-the-counter medications, office visits, therapy, or surgery)*	
Physician's Name	Physician's Location (City/State)	Phone Number
c. Name	Medical Condition	Date of Onset
Dates of Treatment	Treatment *(prescription drugs, herbal or over-the-counter medications, office visits, therapy, or surgery)*	
Physician's Name	Physician's Location (City/State)	Phone Number
d. Name	Medical Condition	Date of Onset
Dates of Treatment	Treatment *(prescription drugs, herbal or over-the-counter medications, office visits, therapy, or surgery)*	
Physician's Name	Physician's Location (City/State)	Phone Number

Physician Information

	Name of Primary Physician	Location City/State	Phone Number	Date Last Seen	Reason for Visit	Results
Primary						
Spouse						
Dependent						
Dependent						
Dependent						
Dependent						

Please add any additional information you feel will be helpful in evaluating your application on a separate sheet and sign, date and attach to this application.

E. Other Coverage

1. Is any person applying for coverage covered by another plan? ☐Yes ☐No
   If "Yes", list name(s):_____
   If "Yes", check all that apply: ☐ COBRA ☐ Individual ☐ Medicare/Medicaid ☐ Other Coverage _____
2. Will the plan applied for replace the existing coverage(s)? ☐Yes ☐No
   Effective date of other coverage(s): _____
   Paid-to-date(s) or expected termination date(s) of their coverage(s): _____
   _____
   Name(s), certificate number(s) and telephone number(s) of other carrier(s): _____
   _____

Please Note: Other coverage should not be terminated until a new certificate is issued and accepted.

Please Read, Sign and Date

I have read and agree:

- **No insurance exists unless and until coverage is approved by the Company, the first premium is paid and a certificate is delivered.**
- The information furnished is complete, true and correctly recorded to the best of my knowledge.
- Any false statement or misrepresentation may result in loss or reduction of coverage or an increase in premium.
- *(Where applicable)* Association membership and dues may be required to purchase and continue this insurance.
- If requested, I will complete a recorded telephone call with a Company representative as part of the underwriting process.
- I must tell the Company if the health of any applicant changes prior to delivery of the certificate.
- The certificate, if issued, will cover accidents that occur and illnesses, the symptoms of which manifest after the date the certificate is issued.
- Health conditions present before the application is signed will be covered only if listed on this application and not excluded from coverage.
- I will be informed of the status of coverage within 90 days.

For Iowa Residents: Is the applicant HIPAA eligible? *(If yes, explain Iowa alternative mechanism.)* ☐Yes ☐No

I represent that the following information is correct and true as it relates to the health insurance being applied for:

1. no portion of the premium will be paid, during the period the certificate is in force, by or on behalf of my employer, either directly, or through wage adjustments or other means of reimbursement;
2. neither I, nor my spouse, nor my dependents, nor my employer intends to treat the certificate, during the period the certificate is in force, as part of a plan or program under Section 162 (other than Section 162(1)), Section 125, or Section 106 of the United States Internal Revenue Code.

Please Note: Any person who knowingly and with intent to defraud or damage, files a claim containing false, incomplete or misleading information, may be in violation of state law. Use of the mail to defraud is a violation of federal law.

For New Mexico Residents Only: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

For Ohio Residents Only: Any person who, with intent to defraud or knowingly that he or she is facilitating a fraud against insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud,

For Pennsylvania Residents Only: Any person who knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subject such person to criminal and civil penalties,

For Tennessee Residents Only: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Signed at _____ this _____ day of _____ , _____.
(City/State) *(Date)* *(Month)* *(Year)*

X _____
Your Signature

X _____
Your Spouse's Signature, if applying

X _____
Dependent's Signature, if 18 or older

X _____
Dependent's Signature, if 18 or older

X _____
Dependent's Signature, if 18 or older

WORLD INSURANCE
Omaha, Nebraska

Please indicate "YES" or "NO" for each category. If you answer "YES", check (✓) the applicable condition and provide details in the space provided in the Explanation of Health Section on page 4. Categories do not necessarily include all the conditions related to that category, so please indicate "Other" for any conditions not listed.

Within the last 10 years, have you or any applicant been treated for, diagnosed with or had symptoms of any of the following:

1. Ears/Eyes/Nose/Throat ..... ☐Yes ☐No

a. Which of the following conditions have any of you been treated for? *(check all that apply)*

☐ Ear infections/otitis
☐ Hearing loss
☐ Meniere's disease
☐ Ear tubes
☐ Enlarged tonsils/Adenoids
☐ Otosclerosis
☐ Cochlear implant
☐ Strabismus/lazy eye
☐ Cataracts
☐ Tonsillitis
☐ Double vision
☐ Loss of vision
☐ Macular degeneration
☐ Glaucoma/Increased eye pressure
☐ Retinal detachment
☐ Rhinitis
☐ Optic Neuritis
☐ Sinusitis
☐ Other _____

b. Which family member has been treated for this condition? *(pop up list)*

c. How long ago was the diagnosis? ☐ 0-6 months ☐ 7-12 months ☐ 13-24 months ☐ 2-5 years ago ☐ 6-10 years ago

d. When was your last treatment? ☐ Current ☐ 0-6 months ☐ 7-12 months ☐ 13-24 months ☐ 2-5 years ago ☐ 6-10 years ago

e. Have the cataracts been removed? ..... ☐Yes ☐No

f. How many times have you been treated in the last year? ☐ 1-2 times ☐ 3 or more times

g. What Medical Professional treated the condition? _____

h. What treatment, tests, procedures or medications were prescribed or performed? _____

_____

i. What were the results of the treatment? _____

2. Lungs and Respiratory ..... ☐Yes ☐No

a. Which of the following conditions have any of you been treated for? *(check all that apply)*

☐ Allergic rhinitis
☐ Allergic sinusitis
☐ Asthma
☐ Emphysema
☐ Reactive airway disease
☐ Bronchitis
☐ Pneumonia
☐ Chronic cough
☐ Chronic lung disease
☐ Tuberculosis
☐ Sleep apnea
☐ Other _____
☐ Chronic obstructive pulmonary disease

b. Which family member has been treated for this condition? *(pop up list)*

c. How long ago was the diagnosis? ☐ 0-6 months ☐ 7-12 months ☐ 13-24 months ☐ 2-5 years ago ☐ 6-10 years ago

d. When was your last treatment? ☐ Current ☐ 0-6 months ☐ 7-12 months ☐ 13-24 months ☐ 2-5 years ago ☐ 6-10 years ago

e. How often do you take prescription medication? ☐ Never ☐ 1-2 months a year ☐ 3-6 months a year ☐ Daily ☐ Other _____

f. What Medical Professional treated the condition? _____

g. What treatment, tests, procedures or medications were prescribed or performed? _____

_____

h. What were the results of the treatment? _____

3. Heart/Circulatory ..... ☐Yes ☐No

a. Which of the following conditions have any of you been treated for? *(check all that apply)*

☐ Chest pain
☐ Heart valve disorders
☐ Coronary artery disease
☐ Angina
☐ Heart attack
☐ Irregular heart beat
☐ Heart surgery (stent placement, coronary artery bypass, angioplasty, valve)
☐ Heart murmurs
☐ Peripheral vascular disease
☐ Edema
☐ High blood pressure/ hypertension
☐ Phlebitis
☐ Thrombophlebitis
☐ Varicose veins
☐ Aneurysm
☐ Claudication
☐ High lipid (cholesterol or triglycerides)
☐ Other _____

b. Which family member has been treated for this condition? *(pop up list)*

c. How long ago was the diagnosis? ☐ 0-6 months ☐ 7-12 months ☐ 13-24 months ☐ 2-5 years ago ☐ 6-10 years ago

d. When was your last treatment? ☐ Current ☐ 0-6 months ☐ 7-12 months ☐ 13-24 months ☐ 2-5 years ago ☐ 6-10 years ago

e. When did you have your blood pressure checked? *Date* _____ What was the reading? _____

f. When did you have your cholesterol checked? *Date* _____ What was the reading? _____

g. What Medical Professional treated the condition? _____

h. What treatment, tests, procedures or medications were prescribed or performed? _____

_____

i. What were the results of the treatment? _____

4. Blood/Lymph/Anemia ☐Yes ☐No

a. Which of the following conditions have any of you been treated for? *(check all that apply)*
☐ Anemia ☐ Thrombocytopenia ☐ Bleeding disorders ☐ Other _____
☐ Hemophillia ☐ Hyperglycemia (high blood sugar)

b. What type of anemia? ☐ Iron Deficiency ☐ Pernicious ☐ Hypoplastic ☐ Sickle Cell ☐ Other _____

c. Which family member has been treated for this condition? *(pop up list)*

d. How long ago was the diagnosis? ☐ 0-6 months ☐ 7-12 months ☐ 13-24 months ☐ 2-5 years ago ☐ 6-10 years ago

e. When was your last treatment? ☐ Current ☐ 0-6 months ☐ 7-12 months ☐ 13-24 months ☐ 2-5 years ago ☐ 6-10 years ago

f. What Medical Professional treated the condition? _____

g. What treatment, tests, procedures or medications were prescribed or performed? _____
_____

h. What were the results of the treatment? _____

5. Digestive ☐Yes ☐No

a. Which of the following conditions have any of you been treated for? *(check all that apply)*
☐ Esophagitis ☐ Ulcers ☐ Ulcerative colitis ☐ Chronic diarrhea
☐ Gastric reflux ☐ Gastritis ☐ Crohn's disease ☐ Rectal bleeding
☐ GERD ☐ Recurrent indigestion ☐ Hemorrhoids ☐ Other _____
☐ Hernia ☐ Irritable bowel ☐ Diverticulosis

b. Which family member has been treated for this condition? *(pop up list)*

c. How long ago was the diagnosis? ☐ 0-6 months ☐ 7-12 months ☐ 13-24 months ☐ 2-5 years ago ☐ 6-10 years ago

d. When was your last treatment? ☐ Current ☐ 0-6 months ☐ 7-12 months ☐ 13-24 months ☐ 2-5 years ago ☐ 6-10 years ago

e. What Medical Professional treated the condition? _____

f. What treatment, tests, procedures or medications were prescribed or performed? _____
_____

g. What were the results of the treatment? _____

6. Liver/Gallbladder/Pancreas ☐Yes ☐No

a. Which of the following conditions have any of you been treated for? *(check all that apply)*
☐ Cirrhosis ☐ Fatty liver ☐ Pancreatitis ☐ Other _____
☐ Hepatitis ☐ Gallstones ☐ Spleen/pancreas disease

b. Which family member has been treated for this condition? *(pop up list)*

c. How long ago was the diagnosis? ☐ 0-6 months ☐ 7-12 months ☐ 13-24 months ☐ 2-5 years ago ☐ 6-10 years ago

d. When was your last treatment? ☐ Current ☐ 0-6 months ☐ 7-12 months ☐ 13-24 months ☐ 2-5 years ago ☐ 6-10 years ago

e. Has your gallbladder been removed? ☐Yes ☐No

f. What Medical Professional treated the condition? _____

g. What treatment, tests, procedures or medications were prescribed or performed? _____
_____

h. What were the results of the treatment? _____

7. Urologic/Kidney/Bladder ☐Yes ☐No

a. Which of the following conditions have any of you been treated for? *(check all that apply)*
☐ Bladder infections ☐ Overactive bladder ☐ Interstitial cystitis ☐ Nephritis
☐ Incontinence ☐ Kidney stones ☐ Pyelonephritis ☐ Other _____

b. Which family member has been treated for this condition? *(pop up list)*

c. How long ago was the diagnosis? ☐ 0-6 months ☐ 7-12 months ☐ 13-24 months ☐ 2-5 years ago ☐ 6-10 years ago

d. When was your last treatment? ☐ Current ☐ 0-6 months ☐ 7-12 months ☐ 13-24 months ☐ 2-5 years ago ☐ 6-10 years ago

e. How often do you treat for bladder infections? ☐ 1-2 times per year ☐ 3 or more times per year

f. How many times have you had Kidney stones? ☐ 1 time ☐ 2 times ☐ 3 times ☐ more than 3 times

g. What Medical Professional treated the condition? _____

h. What treatment, tests, procedures or medications were prescribed or performed? _____
_____

i. What were the results of the treatment? _____

8. Reproductive/Breast ..... ☐Yes ☐No

a. Which of the following conditions have any of you been treated for? *(check all that apply)*

☐ Prostate disorder ☐ Ovarian disorders ☐ Cesarean section delivery ☐ Menstrual disorders (painful, excessive or irregular bleeding
☐ Impotence ☐ Infertility ☐ Breast cysts
☐ Abnormal PSA ☐ Sexually transmitted disease ☐ Abnormal mammogram
☐ Abnormal PAP smear ☐ Complications of pregnancy ☐ Gynecomastia ☐ Endometriosis
☐ Uterine fibroids ☐ HPV ☐ Mastitis ☐ Other _____

b. Which family member has been treated for this condition? *(pop up list)*

c. How long ago was the diagnosis? ☐ 0-6 months ☐ 7-12 months ☐ 13-24 months ☐ 2-5 years ago ☐ 6-10 years ago

d. When was your last treatment? ☐ Current ☐ 0-6 months ☐ 7-12 months ☐ 13-24 months ☐ 2-5 years ago ☐ 6-10 years ago

e. Have you had 2 normal PAPs since? ..... ☐Yes ☐No

f. What Medical Professional treated the condition? _____

g. What treatment, tests, procedures or medications were prescribed or performed? _____
_____

h. What were the results of the treatment? _____

9. Skin ..... ☐Yes ☐No

a. Which of the following conditions have any of you been treated for? *(check all that apply)*

☐ Acne/rosacea ☐ Eczema ☐ Shingles ☐ Keratosis
☐ Hemangioma ☐ Psoriasis ☐ Herpes ☐ Other _____

b. Which family member has been treated for this condition? *(pop up list)*

c. How long ago was the diagnosis? ☐ 0-6 months ☐ 7-12 months ☐ 13-24 months ☐ 2-5 years ago ☐ 6-10 years ago

d. When was your last treatment? ☐ Current ☐ 0-6 months ☐ 7-12 months ☐ 13-24 months ☐ 2-5 years ago ☐ 6-10 years ago

e. Do you treat this condition with a prescription medication? ..... ☐Yes ☐No

f. What Medical Professional treated the condition? _____

g. What treatment, tests, procedures or medications were prescribed or performed? _____
_____

h. What were the results of the treatment? _____

10. Bone/Muscular/Connective Tissue ..... ☐Yes ☐No

a. Which of the following conditions have any of you been treated for? *(check all that apply)*

☐ Arthritis ☐ Osteoarthritis ☐ Joint pain ☐ Sciatica
☐ Gout ☐ Joint replacement ☐ Curvature subluxation ☐ Fracture(s)
☐ Back/spine conditions ☐ Back pain ☐ Osteopenia/osteoporosis ☐ Fibromyalgia
☐ Herniated, bulging or degenerative discs ☐ Scoliosis ☐ Rheumatoid arthritis ☐ Other _____
☐ Degenerative joint disease ☐ Muscular pain

b. Which family member has been treated for this condition? *(pop up list)*

c. How long ago was the diagnosis? ☐ 0-6 months ☐ 7-12 months ☐ 13-24 months ☐ 2-5 years ago ☐ 6-10 years ago

d. When was your last treatment? ☐ Current ☐ 0-6 months ☐ 7-12 months ☐ 13-24 months ☐ 2-5 years ago ☐ 6-10 years ago

e. Where was the fracture located?

☐ Left arm ☐ Left leg ☐ Ribs ☐ Orbit
☐ Right arm ☐ Right leg ☐ Skull ☐ Nose
☐ Left wrist ☐ Left ankle ☐ Pelvis ☐ Spine
☐ Right wrist ☐ Right ankle ☐ Jaw ☐ Other _____

f. Do you have pins, plates or screws? ..... ☐Yes ☐No

g. What Medical Professional treated the condition? _____

h. What treatment, tests, procedures or medications were prescribed or performed? _____
_____

i. What were the results of the treatment? _____

11. Prosthetic Devices/Plates, Pins, Screws ..... ☐Yes ☐No

a. Which of the following conditions have any of you been treated for? *(check all that apply)*

☐ Plates, pins, screws ☐ Artificial limb ☐ Shunts ☐ Other _____
☐ Rods ☐ Pacemakers ☐ Valve/joint replacement

b. Which family member has been treated for this condition? *(pop up list)*

c. How long have you had the prosthetic device? ☐ 0-6 months ☐ 7-12 months ☐ 13-24 months ☐ 2-5 years ago ☐ 6-10 years ago

d. When was your last treatment? ☐ 0-6 months ☐ 7-12 months ☐ 13-24 months ☐ 2-5 years ago ☐ 6-10 years ago

e. What Medical Professional treated the condition? _____

f. What were the results of the treatment? _____

12. Nervous System ..... ☐Yes ☐No

a. Which of the following conditions have any of you been treated for? *(check all that apply)*

☐ Dizziness/syncope ☐ Restless leg syndrome ☐ Seizures ☐ Other _____
☐ Cerebral palsy ☐ Carpal tunnel syndrome ☐ Epilepsy
☐ Neuropathy ☐ Headaches/migraines ☐ Tourette's syndrome
☐ Muscular weakness ☐ Paralysis ☐ Convulsions

b. Which family member has been treated for this condition? *(pop up list)*

c. How long ago was the diagnosis? ☐ 0-6 months ☐ 7-12 months ☐ 13-24 months ☐ 2-5 years ago ☐ 6-10 years ago

d. When was your last treatment? ☐ Current ☐ 0-6 months ☐ 7-12 months ☐ 13-24 months ☐ 2-5 years ago ☐ 6-10 years ago

e. What type of headaches do you have?

☐ Migraine/cluster ☐ Tension/stress ☐ Sinus ☐ Other _____

f. How often do you treat your headaches? ☐ 1-3 times per year ☐ 3-6 times per year ☐ more than 6 times per year

g. When was your last headache? ☐ 0-1 year ago ☐ 1-2 years ago

h. Has your carpal tunnel been surgically treated? ..... ☐Yes ☐No

i. What Medical Professional treated the condition? _____

j. What treatment, tests, procedures or medications were prescribed or performed? _____
_____

k. What were the results of the treatment? _____

13. Endocrine/Thyroid ..... ☐Yes ☐No

a. Which of the following conditions have any of you been treated for? *(check all that apply)*

☐ Diabetes ☐ Hyperthyroid ☐ High blood sugar ☐ Impaired glucose tolerance
☐ Goiter ☐ Hypothyroid ☐ Insulin resistance ☐ Other _____

b. Which family member has been treated for this condition? *(pop up list)*

c. How long ago was the diagnosis? ☐ 0-6 months ☐ 7-12 months ☐ 13-24 months ☐ 2-5 years ago ☐ 6-10 years ago

d. When was your last treatment? ☐ Current ☐ 0-6 months ☐ 7-12 months ☐ 13-24 months ☐ 2-5 years ago ☐ 6-10 years ago

e. Is your thyroid controlled with medication? ..... ☐Yes ☐No

f. Is your goiter controlled with medication? ..... ☐Yes ☐No

g. What Medical Professional treated the condition? _____

h. What treatment, tests, procedures or medications were prescribed or performed? _____
_____

i. What were the results of the treatment? _____

14. Cancer/Tumors ..... ☐Yes ☐No

a. Which of the following conditions have any of you been treated for? *(check all that apply)*

☐ Any internal organ ☐ Hodgkin's disease ☐ Adenoma ☐ Breast cancer
☐ Leukemia ☐ Sarcoma ☐ Basal or squamous cell skin cancer ☐ Neoplasm
☐ Melanoma ☐ Other lymphoma ☐ Other _____

b. Which family member has been treated for this condition? *(pop up list)*

c. How long ago was the diagnosis? ☐ 0-6 months ☐ 7-12 months ☐ 13-24 months ☐ 2-5 years ago ☐ 6-10 years ago

d. When was your last treatment? ☐ Current ☐ 0-6 months ☐ 7-12 months ☐ 13-24 months ☐ 2-5 years ago ☐ 6-10 years ago

e. How many times have you been treated for basal or squamous cell carcinoma? ☐ 1 time ☐ 2 times ☐ 3 times ☐ more than 3 times

f. What Medical Professional treated the condition? _____

g. What treatment, tests, procedures or medications were prescribed or performed? _____
_____

h. What were the results of the treatment? _____

15. Psychological ..... ☐Yes ☐No

a. Which of the following conditions have any of you been treated for? *(check all that apply)*

☐ Emotional disorder ☐ Attention deficit disorder ☐ Bipolar (manic depression) ☐ Obsessive compulsive disorder
☐ Anxiety ☐ Eating disorder ☐ Psychiatric treatment or counseling
☐ Depression ☐ Chemical imbalance ☐ Other _____

b. Which family member has been treated for this condition? *(pop up list)*

c. How long ago was the diagnosis? ☐ 0-6 months ☐ 7-12 months ☐ 13-24 months ☐ 2-5 years ago ☐ 6-10 years ago

d. When was your last treatment? ☐ Current ☐ 0-6 months ☐ 7-12 months ☐ 13-24 months ☐ 2-5 years ago ☐ 6-10 years ago

e. Is ADD controlled with medication? ..... ☐Yes ☐No

f. What Medical Professional treated the condition? _____

g. What treatment, tests, procedures or medications were prescribed or performed? _____
_____

h. What were the results of the treatment? _____

16. Congenital Disorders/Birth Defects/Developmental Disorders ..... ☐Yes ☐No

a. Which of the following conditions have any of you been treated for? *(check all that apply)*

☐ Down's syndrome ☐ Autism ☐ Cleft lip/palate ☐ Speech impairment
☐ Mental retardation ☐ Club foot ☐ Delayed development ☐ Other _____

b. Which family member has been treated for this condition? *(pop up list)*

c. How long ago was the diagnosis? ☐ 0-6 months ☐ 7-12 months ☐ 13-24 months ☐ 2-5 years ago ☐ 6-10 years ago

d. When was your last treatment? ☐ Current ☐ 0-6 months ☐ 7-12 months ☐ 13-24 months ☐ 2-5 years ago ☐ 6-10 years ago

e. Has the condition been repaired or successfully treated? ..... ☐Yes ☐No

f. What Medical Professional treated the condition? _____

g. What treatment, tests, procedures or medications were prescribed or performed? _____
_____

h. What were the results of the treatment? _____

17. Other Conditions

a. Any other conditions for which any of you required an emergency room visit, hospital stay, surgery, or treatment, or were any of you suggested to have surgery or to receive treatment from a physician, chiropractor or other practitioner in the past 10 years? ..... ☐Yes ☐No

b. Do any of you have any medical condition for which you have not seen a health care provider? ____ ☐Yes ☐No

c. Have any of you had any tests or procedures recommended that have not yet been performed? ___ ☐Yes ☐No

18. Medication Use

a. Have you taken or been recommended to take any prescription medication in the last 2 years? ..... ☐Yes ☐No

Please check all medication types that apply:

☐ Birth control pills for contraception ☐ Medication for adult hypothyroidism
☐ Antibiotics taken no more than 2 episodes ☐ Allergy meds already discussed previously
☐ Headache meds already discussed previously ☐ GERD meds already discussed previously
☐ Other medications *(please list all other medications)* _____
_____

b. In the last 2 years, have you taken any herbal or over-the-counter medication more often than once a week? ..... ☐Yes ☐No

Please check all types that apply:

☐ Daily vitamins ☐ Other *(please list)* _____

19. Substance Abuse/Advice to Reduce or Eliminate Use

a. Within the past 5 years, have you or any applicant ever been advised to either stop drinking alcohol or reduce the use of alcohol, received treatment because of alcohol use, or been a member of a self-help group, including but not limited to, Alcoholics Anonymous? ..... ☐Yes ☐No

b. In the past 5 years, have you or any applicant ever used controlled substances including, but not limited to, marijuana, heroin, cocaine, methamphetamines, other drugs not prescribed by a physician, or received or had treatment recommended for a drug habit? ..... ☐Yes ☐No

20. Tobacco Use

In the past year, has anyone used cigarettes, cigars, pipes, oral tobacco or nicotine replacements? ..... ☐Yes ☐No

If "YES", list name(s): _____

21. Hazardous Activities

In the past 2 years, has anyone participated in hazardous activities, including activities like hang-gliding, scuba diving, rodeoing or racing (including automobile, motorcycle, etc.)? ..... ☐Yes ☐No

If "YES", list name(s): _____

Activity: _____ Frequency: _____

22. Driving Violations

In the past 2 years, has anyone been convicted of any driving violation, including DUI, DWI, license suspension or revocation, or recurrent speeding?..... ☐Yes ☐No

Name: _____ Date: _____ Violation _____

Name: _____ Date: _____ Violation _____

23. Insurance Declination

In the past 5 years, has anyone been declined for health insurance or had coverage rated or issued with waivers? ..... ☐Yes ☐No

Name(s) _____

Insurance Company(ies)_____ Date(s) _____

Reason(s) _____ Details _____

Explanation of Health

Provide details for all questions 1 through 19 with "YES" answers. If you need additional space, please include a separate sheet and sign, date and attach to this application.

a. Name _____ Medical Condition _____

Date of Onset_____ Dates of Treatment _____

Treatment *(prescription drugs, herbal or over-the-counter medications, office visits, therapy, or surgery)* _____

_____

Physician's Name _____ Physician's Location (City/State)_____ Phone Number _____

b. Name _____ Medical Condition _____

Date of Onset_____ Dates of Treatment _____

Treatment *(prescription drugs, herbal or over-the-counter medications, office visits, therapy, or surgery)* _____

_____

Physician's Name _____ Physician's Location (City/State)_____ Phone Number _____

c. Name _____ Medical Condition _____

Date of Onset_____ Dates of Treatment _____

Treatment *(prescription drugs, herbal or over-the-counter medications, office visits, therapy, or surgery)* _____

_____

Physician's Name _____ Physician's Location (City/State)_____ Phone Number _____

Physician Information

Primary

Physician's Name _____ Physician's Location (City/State)_____ Phone Number _____

Date Last Seen _____ Reason for Visit _____ Results _____

Spouse

Physician's Name _____ Physician's Location (City/State)_____ Phone Number _____

Date Last Seen _____ Reason for Visit _____ Results _____

Dependent

Physician's Name _____ Physician's Location (City/State)_____ Phone Number _____

Date Last Seen _____ Reason for Visit _____ Results _____

Dependent

Physician's Name _____ Physician's Location (City/State)_____ Phone Number _____

Date Last Seen _____ Reason for Visit _____ Results _____

Dependent

Physician's Name _____ Physician's Location (City/State)_____ Phone Number _____

Date Last Seen _____ Reason for Visit _____ Results _____

Dependent

Physician's Name _____ Physician's Location (City/State)_____ Phone Number _____

Date Last Seen _____ Reason for Visit _____ Results _____

a. When did each of you last see the physician? ☐ 0-3 months ☐ 4-6 months ☐ 7-12 months ☐ 13-24 months
☐ 2-5 years ago ☐ more than 5 years ago

b. What was the reason for the visit? ☐ Annual exam ☐ cold or flu ☐ other illnesses _____

c. What were the results of the visit? ☐ follow-up recommended ☐ everything okay ☐ abnormal test result ☐ medical condition diagnosed
☐ other _____

Note: If last visit is more than 7 months and less than 24 months for annual exam or cold or flu, and everything okay, then STP; otherwise stop STP.

Other Coverage

1. Is any person applying for coverage covered by another plan? ..... ☐Yes ☐No
   If "Yes", list name(s): _____
   If "Yes", check all that apply: ☐ COBRA ☐ Individual ☐ Medicare/Medicaid ☐ Other Coverage _____
2. Will the plan applied for replace the existing coverage(s)? ..... ☐Yes ☐No
   Effective date of other coverage(s):_____
   Paid-to-date(s) or expected termination date(s) of their coverage(s): _____
   _____
   Name(s), policy number(s) and telephone number(s) of other carrier(s): _____
   _____

Please add any additional information you feel will be helpful in evaluating your application on a separate sheet and sign, date and attach to this application.

WORLD INSURANCE
P.O. Box 3160, Omaha, NE 68103-0160

Preferred Rating Guidelines/Questionnaire

Guidelines

To be eligible to apply for Preferred Rates, the proposed insured and/or proposed insured spouse*:

(a) must be between the ages of 18 and 60;

(b) must not have a health exclusion rider or health rate-up; and

(c) must answer "No" to questions 1-5 listed below.

Note: Information that is compiled during the application process concerning medical conditions, occupations, or medications you are taking may keep you from becoming eligible for Preferred Rates.

**Dependents are not eligible for Preferred Rates.*

Questionnaire

To be eligible for Preferred Rates, each proposed insured must answer the questions below and be within the Build Chart for Preferred Risks.

	Proposed Insured		Proposed Insured's Spouse	
1. Within the past 12 months, have you had a blood pressure reading that exceeded 140/90 (greater than 140 systolic and/or greater than 90 diastolic) or been treated for high blood pressure?	☐ Yes	☐ No	☐ Yes	☐ No
2. Within the past 12 months, have you had total cholesterol readings that exceeded 220 or been treated for elevated cholesterol or triglycerides?	☐ Yes	☐ No	☐ Yes	☐ No
3. Within the past 2 years, have you had any DUI or DWI convictions or more than 2 moving violations?	☐ Yes	☐ No	☐ Yes	☐ No
4. Has it been more than 90 days since you had health coverage (group or individual) in force?	☐ Yes	☐ No	☐ Yes	☐ No
5. If you are over age 50, has it been more than 2 years since your last physical exam?	☐ Yes	☐ No	☐ Yes	☐ No

To be eligible for Super Preferred Rates, each proposed insured must answer the questions below and be within the Build Chart for Super Preferred Risks.

6. Have you had a complete physical in the last 2 years?	☐ Yes	☐ No	☐ Yes	☐ No
7. Do you exercise at least 3 times a week?	☐ Yes	☐ No	☐ Yes	☐ No
8. Have you smoked in the last 10 years?	☐ Yes	☐ No	☐ Yes	☐ No

I understand and agree that this questionnaire, if completed, is part of the application for health insurance coverage with World Insurance Company.

X _____ _____
Signature of the Proposed Insured *Date*

X _____ _____
Signature of Spouse *Date*

X _____ _____
Signature of Licensed Agent *Date*

_____
Agent Number

Build Chart for Preferred Risks

Male		Female	
Height	Weight (lbs.)	Height	Weight (lbs.)
4' 6"	80-131	4' 6"	79-126
4' 7"	83-134	4' 7"	82-129
4' 8"	86-138	4' 8"	83-132
4' 9"	89-142	4' 9"	87-135
4' 10"	92-145	4' 10"	90-138
4' 11"	95-149	4' 11"	92-140
5' 0"	98-152	5' 0"	94-143
5' 1"	101-155	5' 1"	96-146
5' 2"	103-159	5' 2"	98-150
5' 3"	105-162	5' 3"	101-153
5' 4"	107-166	5' 4"	104-158
5' 5"	110-171	5' 5"	107-163
5' 6"	112-175	5' 6"	109-168
5' 7"	115-181	5' 7"	112-173
5' 8"	118-186	5' 8"	115-178
5' 9"	121-191	5' 9"	117-185
5' 10"	124-197	5' 10"	119-192
5' 11"	126-203	5' 11"	122-197
6' 0"	129-208	6' 0"	123-202
6' 1"	132-215	6' 1"	126-207
6' 2"	135-220	6' 2"	130-212
6' 3"	139-226	6' 3"	134-217
6' 4"	143-232	6' 4"	138-222
6' 5"	146-240	6' 5"	142-227
6' 6"	149-246	6' 6"	146-232
6' 7"	153-252	6' 7"	150-237
6' 8"	156-258	6' 8"	154-242
6' 9"	160-264	6' 9"	158-247
6' 10"	163-270	6' 10"	162-252
6' 11"	167-276	6' 11"	166-257

Build Chart for Super Preferred Risks

Male		Female	
Height	Weight (lbs.)	Height	Weight (lbs.)
4' 6"	80-84	4' 6"	79-82
4' 7"	83-89	4' 7"	82-88
4' 8"	86-95	4' 8"	83-93
4' 9"	89-102	4' 9"	87-99
4' 10"	92-108	4' 10"	90-104
4' 11"	95-115	4' 11"	92-110
5' 0"	98-122	5' 0"	94-115
5' 1"	101-128	5' 1"	96-121
5' 2"	103-135	5' 2"	98-126
5' 3"	105-141	5' 3"	101-132
5' 4"	107-148	5' 4"	104-137
5' 5"	110-155	5' 5"	107-143
5' 6"	112-161	5' 6"	109-148
5' 7"	115-168	5' 7"	112-154
5' 8"	118-179	5' 8"	115-159
5' 9"	121-181	5' 9"	117-165
5' 10"	124-188	5' 10"	119-170
5' 11"	126-194	5' 11"	122-176
6' 0"	129-201	6' 0"	123-181
6' 1"	132-207	6' 1"	126-187
6' 2"	135-214	6' 2"	130-192
6' 3"	139-221	6' 3"	134-198
6' 4"	143-227	6' 4"	138-203
6' 5"	146-234	6' 5"	142-209
6' 6"	149-240	6' 6"	146-214
6' 7"	153-249	6' 7"	150-220
6' 8"	156-254	6' 8"	154-225
6' 9"	160-262	6' 9"	158-231
6' 10"	163-269	6' 10"	162-236
6' 11"	167-273	6' 11"	166-242

WORLD INSURANCE
Omaha, Nebraska

Application to World Insurance Company
(herein called the Company) for Health Coverage
P.O. Box 3160 • Omaha, NE 68103-0160

Application for Internal Substitution

Instructions: The information in this application will be used to determine eligibility for Internal Substitution. Please include the following completed forms with the application.

- ❑ **Software Proposal – Please attach an accurate proposal.** This will identify which plan/PPO network/options are being applied for.
- ❑ **Application for Internal Substitution –** Questions must be answered for all applicants.

Fax or Mail: **Please submit the signed application and the proposal to:**

Fax: 402.496.8377
Mail: World Insurance Company, P.O. Box 3160, Omaha, Nebraska 68103-0160

A. Qualifications

Please answer the following questions completely and accurately.

1. Have any persons seeking Substitution (except a dependent added at birth or adoption) been insured under the current policy/certificate for less than 24 consecutive months? ..... ☐Yes ☐No
2. Is the total premium for the proposed Substitution policy/certificate greater than the total premium (renewal premium if within 60 days of renewal) for the current policy/certificate? ..... ☐Yes ☐No
3. Is the current plan a guarantee-issued HIPAA plan? ..... ☐Yes ☐No
4. Has any applicant been hospitalized in the last 12 months? ..... ☐Yes ☐No
5. Has any applicant been recommended or scheduled for surgery, consultation, diagnostic testing, treatment or follow up for which final results have not been received or which has not be completed? ..... ☐Yes ☐No
6. Has any applicant had any testing with abnormal results within the past 12 months? ..... ☐Yes ☐No
7. Is any applicant now pregnant, or an expectant parent, or in the process of adopting a child? ..... ☐Yes ☐No
8. Has any applicant been treated for, been diagnosed as having, or had any symptoms of a serious medical condition, including, but not limited to: cancer, stroke, heart disease, liver disease, internal organ failure, diabetes, HIV, AIDS, or any other disabling or progressive condition? ..... ☐Yes ☐No

Please note that applicant(s) who answered "Yes" to any question in this section will be required to complete a full application.

Applicant(s) who answered "No" to all questions in this section, may be eligible for Internal Substitution. We will review the application, claims history and the current policy/certificate, and then contact you if additional information is required. A new policy/certificate number will be issued if an Internal Substitution is approved. We will coordinate coverage to ensure no lapse in coverage and credit for all premiums received.

B. General Information *(please print)*

1. Your Information

Current Policy/Certificate Number	Primary Insured's Name *(First, Middle, Last)*	Birth Date

Address *(Street, City, State, ZIP)*

Home Phone Number	Cell Phone Number	Work Phone Number	Best to Call: ☐AM ☐PM ☐Home ☐Work ☐Cell

Email Address *(It may be used to send you important notices.)*

2. Please list all persons on the current policy/certificate **not** to be insured under the Substitution policy/certificate. **All persons listed below will remain on the current policy/certificate.**

Name *(First, Middle, Last)*	Birth Date Mo./Day/Yr.	Social Security Number

Please Read, Sign and Date

I have read and agree:

- **No change in coverage will occur unless coverage is approved by the Company, the first premium is paid and a policy/certificate is delivered.**
- The information furnished is complete, true and correctly recorded to the best of my knowledge.
- Any false statement or misrepresentation may result in loss or reduction of coverage or an increase in premium.
- *(Where applicable)* Association membership and dues may be required to purchase and continue this insurance.
- If requested, I will complete a recorded telephone call with a company representative as part of the underwriting process.
- I must tell the Company if the health of any applicant changes prior to delivery of the contract.
- I will be informed of the status of coverage within 90 days.

Warning: Any person who knowingly files a claim containing false, incomplete, or misleading information with intent to injure, defraud or deceive, may be guilty of a crime and may be subject to civil and criminal penalties. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Signed at _____ this _____ day of _____ , _____.
(City/State) *(Date)* *(Month)* *(Year)*

X _____
Your Signature

X _____
Your Spouse's Signature, if applying

X _____
Dependent's Signature, if 18 or older

X _____
Dependent's Signature, if 18 or older

X _____
Dependent's Signature, if 18 or older

For Agent Use Only

I certify that the answers given to the foregoing questions in this application were provided by the applicant and accurately recorded. I have no information to add to the application that could affect the acceptance or rejection of the risk. I have provided the applicant with the Special Notice Federal Fair Credit Report Act and an outline of coverage where required.

Are you aware of any information, not recorded on the application, which might have a bearing on insurability of any person proposed for insurance. (If Yes, please list details below.) ..... ☐Yes ☐No

_____

X _____ _____ X _____ _____
Agent Name *Agent Number* *Agent Signature* *Date*

_____ _____ _____ _____
Agent Phone Number *Agent Cell Phone Number* *Agent Fax Number* *Agent Email Address*

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WORLD INSURANCE

P. O. Box 3160 • Omaha, NE 68103-0160 • (402) 496-8000 • FAX: (402) 496-8040

February 26, 2008

The Honorable Julie Benafield Bowman
Commissioner of Insurance
Arkansas Department of Insurance
Compliance - Life and Health
1200 West Third
Little Rock, Arkansas 72201-1904

Attention: Joe Musgrove

Re: NAIC #70609
Association Group Certificate AC4800W, et al
Attachment A

Dear Mr. Musgrove:

Please find enclosed the above-captioned certificate form which is being submitted on an informational basis for your review. These forms (as shown on Attachment A) will be used with association groups in located in Missouri and in accordance with code section 376.421(5) of the Missouri Insurance Code.

The certificate of coverage (AC4800W) as well as the optional riders, will be marketed only to members of associations. Membership in the Association provides the member with the opportunity to apply for the insurance coverage.

The Schedule of Benefits provides the variable material and is bracketed to indicate that such material is subject to change.

The forms are in final print subject only to minor modifications in paper size, stock, color, border, font, company logo and adaptation to computer printing. Depending on printer capabilities, the application will be printed as either simplex or duplex.

Your earliest acknowledgement of this filing will be greatly appreciated.

Sincerely,

Norman Von Seggern, FLMI, HIA
Product Analyst 4
World Insurance Company
Phone: (402) 496-8289
Fax: (402) 496-8040
e-mail: norm.von.seggern@americanenterprise.com

LISTING OF VARIABLE PAGES – Attachment A

Certificate Page (Title)	Description
AC4800W	Certificate of Coverage
Validation of Coverage	Insured Information
Schedule of Benefits	Schedule of Benefits --- variable information is bracketed.
Certificate of Coverage – AC4800W	Sections
	Definitions Benefit Provisions (Comp) Benefit Provisions (Cat) General Exclusions (Comp) General Exclusions (Cat) Certificate Provisions Claims Provisions Continuation and Conversion
R4800W-AR	Mandated Benefits Rider
Available Optional Benefits	**Description**
R4801W	Accident Expense Benefit Rider
R4802W	Accidental Death Benefit Rider
R4803W	Critical Illness Benefit Rider
R4804W	Decreasing Deductible Rider
R4805W	Premium Discount for Good Health (Rider)
R4806W	Refund of Premium for Good Health (Rider)
R4808W	Office Visit Benefit Rider
R4808W-1	Office Visit Benefit Rider with DXL
R4809W	Short Term Convalescent Care Rider
R4810W-AR	Outpatient Prescription Benefit Rider (Deductible/Coinsurance)
R4811W-AR	Outpatient Prescription Benefit Rider (Generic only)
R4812W-AR	Outpatient Prescription Benefit Rider (Generic with Specialty)
R4813W-AR	Outpatient Prescription Benefit Rider (3-Tier with Specialty, Copay)
R4814W	Wellness Benefit Rider
R4816W	Life Benefits
R4815W-AR	Maternity Expense Benefits Rider
R4817W-AR	Alcoholism/Substance Abuse Treatment Benefit Rider
Application	

G4800W	Application For Coverage
G4800W-Eapp	E-application insert to be used with the G4800W
M1184W	Preferred Rating Guidelines/Questionnaire
G4820W	Application for Internal Substitution

Certification

Carrier: WORLD INSURANCE COMPANY

Submission: Form AC4800W, et al

I hereby certify, to the best of my knowledge and belief, that the benefits payable a Participating Provider (PPO) and a Non-Participating Provider (Non-PPO) comply with the requirements outlined in Bulletin 9-85 (no more than a 25% differential in payment between a PPO and Non-PPO).

Signature of Company Officer: _____

Name (typed or printed): _____

Title or business affiliation: _____

Date: March 25, 2008

Small Business Association of America

1015 15th Street, NW STE 1000, Washington, DC 20005

Incorporated in Washington DC

1. Is there a current office in Arkansas? NO
2. Does the Arkansas part of the organization have any officers, committees, or chapters? If so, give details. DNA
3. Are annual dues charged? If so, specify amount. $24.00 per month
4. What benefits are provided to the members in addition to insurance? Can you provide a set of the benefit brochures for this association?

   Member's guide attached.

5. What qualifies an individual for membership? An individual or family that has the desire to benefit from the common purpose of receiving information, education, services and products of a greater value to a member than would be available on an independent basis must apply for membership by completing the association membership application.
6. Members are recruited by enrollers and by referrals from existing members
7. Also, enclose a list of dues paying members residing in Arkansas with full addresses. If the organization considers this privileged information, we will treat it as such and once it has served our purpose, it will be destroyed.
8. Please attach a copy of the organization's most recent financial statement.
9. Does the organization receive any compensation of any kind from the insurer issuing contracts to its members? NO

Responses to Arkansas:

1. USBenefit Plan RX America, 16476 Wild Horse Creek Rd., Chesterfield, MO 63017.
2. Incorporated in the state of Missouri February 1, 1996
3. No current office in AR
4. NA.
5. Yes, amount of dues: $12.50 on basic level.
6. Purpose: To enhance the quality of life for members by offering or providing educational information; to provide access to goods, services and discount benefits by using the buying power of all members. To exercise all the powers conferred upon corporations formed under the Missouri Not-For-Profit Corporation Act.
7. See attached member's guides.
8. An individual or family that has the desire to benefit from the common purpose of receiving information, education, services and products of a greater value to a member than would be available on an independent basis must apply for membership by completing the association membership application.
9. Members are recruited by enrollers and by referrals from existing members.
10. Bylaws attached.
11. List of members residing in AR
12. Financial statement attached
13. No.

Responses to Arkansas:

1. National Consumer Alliance Association, 208 S. LaSalle, Chicago, IL 60604
2. Incorporated in the state of Illinois.
3. No current office in AR
4. NA.
5. Dues are $7.50 per month
6. To provide the association membership awareness and education on improved health practices, medically related information and other benefits as appropriate.
7. See attached member's guide
8. An individual interested in the benefits and services must apply for membership and be approved by the Board of Directors.
9. Members are recruited by enrollers and by referrals from existing members.
10. Bylaws attached.
11. List of members residing in AR - NONE
12. Financial statement attached.
13. No

Responses to Arkansas:

1. Advisory Care Association, 208 S. LaSalle, Chicago, IL 60604
2. Incorporated in the state of Illinois.
3. No current office in AR
4. NA.
5. Dues are $7.50 per month
6. To engage in the promotion and contribution of charitable organizations and to provide the association membership awareness and education on improved health practices, medically related information and other benefits as appropriate.

7. See attached member's guide
8. An individual interested in the benefits and services must apply for membership and be approved by the Board of Directors.
9. Members are recruited by enrollers and by referrals from existing members.
10. Bylaws attached.
11. List of members residing in AR - NONE
12. Financial statement attached.
13. No

Responses to Arkansas:

1. Consumer Health Savings Association, 208 S. LaSalle, Chicago, IL 60604
2. Incorporated in the state of Illinois.
3. No current office in AR
4. NA.
5. Dues are
6. To enhance the quality of life for members by offering or providing educational information; to provide access to goods, services and discount benefits by using the buying power of all members.

7. See attached member's guide
8. An individual interested in the benefits and services must apply for membership and be approved by the Board of Directors.
9. Members are recruited by enrollers and by referrals from existing members.
10. Bylaws attached.
11. List of members residing in AR - NONE
12. Financial statement attached.
13. No

Responses to Arkansas:

1. Americas Business Benefit Association, 16476 Wild Horse Creek Rd., Chesterfield, MO 63017
2. Incorporated in the state of Missouri.
3. No current office in AR
4. NA.
5. Dues are
6. To enhance the quality of life for members by offering or providing educational information; to provide access to goods, services and discount benefits by using the buying power of all members.

7. See attached member's guide
8. An individual interested in the benefits and services must apply for membership and be approved by the Board of Directors.
9. Members are recruited by enrollers and by referrals from existing members.
10. Bylaws attached.
11. List of members residing in AR - NONE
12. Financial statement attached.
13. No

BY-LAWS OF
"AMERICAN ENTREPRENEUR ASSOCIATION"

ARTICLE I
PURPOSES

The purpose of "AMERICAN ENTREPRENEUR ASSOCIATION" ("association") shall be: To engage in the promotion of the development, establishment or expansion of industries and engage in any related lawful activity as permitted by the Illinois Not-For-Profit Corporation Act.

ARTICLE II
OFFICES

The Association shall have and continuously maintain in this state a registered office and a registered agent, and the registered office of the association shall be identical with that of its registered agent. The Association may have other offices within or without the State of Illinois as the Board of Directors may from time to time determine.

ARTICLE III
MEMBERS

Section 1. Classes of Members. The Association shall have two (2) classes of members. The designation of such classes and qualifications of the members of such classes shall be as follows:

1. Individual membership: The individual is entitled to participate in all benefit programs offered by the Association.

2. Family membership: The member and his spouse are entitled to participate in all benefit programs offered by the Association.

Section 2. Voting Rights. Each member of classes 1 and 2 shall be entitled to one vote on each matter submitted to a vote of the members by the Board of Directors. Voting may be in person or by proxy; provided that no proxy may be used for voting purposes unless the original of the proxy is filed with the Secretary of the Association at least seven (7) days before the meeting at which it is to be used.

Section 3. Termination of Membership. Any member who shall be in default in the payment of dues for the period fixed in Article XI of the By-Laws is automatically ineligible for membership and loses all privileges and rights of the Association, subject to the discretion of the Board of Directors to extend such time period for the payment of dues.

Section 4. Resignation. Any member may resign by filing a written resignation with the Secretary, but such resignation shall not entitle such member to any refund of dues and the member shall immediately lose all privileges and rights of the Association.

Section 5. Reinstatement. Upon written reapplication a former member may be reinstated to membership in the Association.

Section 6. Transfer of Membership. Membership in the Association is not transferable or assignable.

ARTICLE IV
MEETINGS OF MEMBERS

Section 1. Annual Meeting. An annual meeting of the members of the Association shall be held for the purpose of electing Directors and the transaction of any other business as may come before the meeting. The date of the annual meeting shall be determined by the Board of Directors.

Section 2. Special Meeting. Special meetings of the members, for any purpose or purposes, unless otherwise prescribed by law, may be called by the President and shall be called by the Secretary at the direction of a majority of the Board of Directors, or at the request in writing of members representing at least one hundred (100) votes entitled to be cast at such meeting.

Section 3. Place of Meeting. The Board of Directors may designate any place, within or without the State of Missouri as the place of meeting for any annual meeting. The President or the Board of Directors may designate any place within or without the State of Missouri as the place of the meeting for any special meeting. If no designation is made, the place of meeting shall be the registered office of the Association.

Section 4. Notice Notice of any special meeting of the Board of Directors and the business to be transacted shall be given at least five (5) days previously thereto by written notice delivered either personally, by mail or through the internet, to each director at his address shown on the records of the Association. If notice be given by mail, such notice shall be deemed to be delivered when deposited in the United States mail addressed to the director. Any director may waive notice of any meeting. The attendance of a director at any meeting shall constitute a waiver of notice of such meeting, except where a director attends a meeting for the express purpose of objecting to the transaction of any business because the meeting is not lawfully called or convened. The purpose of any special meeting of the Board of Directors shall be specified in the notice of such meeting.

Section 5. Quorum. There shall be no minimum number of members necessary to be present at any regular meeting or special meeting, in order to constitute a quorum. Those members present shall therefore constitute a quorum.

Section 6. Manner of Acting. The act of a majority of the members present at any regular or special meeting shall constitute the act of the members.

Section 7. Informal Action by Members. Upon approval by the directors, any action required to be taken at a meeting of the members of the Association or any other action which may be taken at a meeting, may be taken without a meeting if consents in writing, setting forth the action so taken, shall be signed by a majority of the members with respect to the subject matter thereof.

Section 8. Parliamentary Procedures. Parliamentary Procedure for all meetings of members, directors, and committees shall be conducted in accordance with the latest revised edition of Robert's Rules of Order, unless otherwise inconsistent with these By-Laws.

Section 9. Voting. At all meetings of the members, each member of records shall be entitled to one (1) vote. A vote may be cast either orally or in writing in person or by proxy. A

"member of record" is a person who is a member in good standing of the Association as of the close of business on a date, selected by the Board of Directors, not less than forty (40) days nor more than fifty (50) days before the date of the meeting (the "record date"). When a quorum is present at any meeting, the vote of the holders of a majority of members present shall decide any questions brought before such meeting, unless the questions are ones upon which, by express provision of law or of the Association's Articles of Incorporation, a different vote is required, in which case such express provision shall govern and control the decision of such question.

Section 10. Matters Reserved to Membership Vote. The following matters shall be authorized only upon a vote "thereon" by the members at a meeting called to consider such matter:

1. An amendment to the Association's Articles of Incorporation;

2. The election of the Board of Directors; and

3. Any other matter which the Board of Directors, in their sole discretion, by resolution shall commit to a vote of the members.

ARTICLE V
BOARD OF DIRECTORS

Section 1. General Powers. The affairs of the Association shall be managed by its Board of Directors.

Section 2. Number, Tenure and Qualifications. The number of directors shall be no fewer than three (3) and no more than twenty-five (25) and may be changed from time to time by resolution of the Board of Directors. The Board of Directors shall appoint a committee to nominate successor directors. The directors shall be elected at an annual meeting of the members, except as provided in Section 8 of this Article, and each director elected shall hold office until his successor is

elected and qualified or until his earlier death, resignation or removal. Directors shall be residents of the United States of America and be members of the Association.

Section 3. Regular Meetings. A regular annual meeting of the Board of Directors shall be held each year immediately after the annual meeting of the members of the Association for the purpose of electing officers and for the transaction of such other business as may come before the meeting. The regular annual meeting of directors shall be held without other notice than these By-Laws. The Board of Directors may provide by resolution the time and place, within or without the State of Missouri for the holding of additional regular meetings of the Board of Directors.

Section 4. Special Meetings. Special meetings of the Board of Directors may be called by or at the request of the President or any two (2) directors. All special meetings shall be held at the registered office of the Association unless otherwise agreed upon by a majority of the Board of Directors in attendance at the meeting.

Section 5. Notice. Notice of any special meeting of the Board of Directors and the business to be transacted shall be given at least five (5) days previously thereto by written notice delivered personally or sent by mail to each director at his address shown on the records of the Association. If notice be given by mail, such notice shall be deemed to be delivered when deposited in the United States mail addressed to the director. Any director may waive notice of any meeting. The attendance of a director at any meeting shall constitute a waiver of notice of such meeting, except where a director attends a meeting for the express purpose of objecting to the transaction of any business because the meeting is not lawfully called or convened. The purpose of any special meeting of the Board of Directors shall be specified in the notice of such meeting.

Section 6. Quorum. A majority of the Board of Directors shall constitute a quorum for the transaction of business at any meeting of the Board of Directors provided that if less than a majority of the directors are present at said meeting, a majority of the directors present may adjourn the meeting from time to time without further notice.

Section 7. Manner of Acting. The act of a majority of the directors present at a meeting at which a quorum is present shall be the act of the Board of Directors, except where otherwise provided by law or these By-Laws.

Section 8. Vacancies. Vacancies created by the death, resignation, or removal of a director may be filled by a majority vote of the directors then in office though less than a quorum, and each director so chosen shall hold office until his successor is elected and qualified or until his earlier death, resignation or removal. A director may be removed at any time, with or without cause, by a vote of a majority of the remaining directors. If there are not directors in office, then an election of directors may be held in the manner provided by law. Newly created directorships shall be filled by election at an annual meeting or special meeting called for that purpose.

Section 9. Compensation. Directors as such shall not receive any stated salaries for their services, but by resolution of the Board of Directors, a fixed sum and expenses of attendance, if any, may be allowed for attendance at each meeting of the Board of Directors. Nothing herein contained shall be construed to preclude any director from serving the Association in any other capacity and receiving compensation therefor upon approval by the Board.

Section 10. Telephonic Participation in Meeting. The members of the Board of Directors, or of any committee designated by the Board of Directors, may participate in a meeting of the Board of Directors or committee by means of conference telephone or similar communications equipment whereby all persons participating in the meeting can hear each other, and participation in a meeting in this manner shall constitute presence in person at the meeting.

Section 11. Action by Written Consent. Any action which is required to be or may be taken at a meeting of the directors, or of any committee of the directors, may be taken without a meeting if consents in writing, setting forth the action so taken are signed by all of the members of the Board of Directors or of the committee as the case may be. The consents shall have the same force and effect as a unanimous vote at a meeting duly held. The Secretary shall file the consents with the minutes of the meetings of the Board of Directors or of the committee as the case may be.

ARTICLE VI
OFFICERS

Section 1. Officers. The Officers of the Association shall be a President, one or more Vice Presidents (the number thereof to be determined by the Board of Directors), a Treasurer, a Secretary or combination thereof, and such other officers as may be elected in accordance with the provisions of this article. The Board of Directors may elect or appoint other officers, including one or more Assistant Secretaries and one or more Assistant Treasurers, as it shall deem desirable, such officers to have the authority and perform the duties prescribed, from time to time, by the Board of

Directors. Any two or more offices may be held by the same person, except the offices of President and Secretary.

Section 2. Election and Term of Office. The Officers of the Association shall be elected annually by the Board of Directors at the regular annual meeting of the Board of Directors. If the election of Officers shall not be held at such meeting, such election shall be held as soon thereafter as convenient. Vacancies may be filled or new officers created and filled at any meeting of the Board of Directors. Each Officer shall hold office until his successor shall have been duly elected and shall have qualified.

Section 3. Removal. Any Officer or Agent elected or appointed by the Board of Directors may be removed by the Board of Directors whenever in its judgment the best interests of the Association would be served thereby.

Section 4. Vacancies. A vacancy in any office because of death, resignation, removal, disqualification or otherwise, may be filled by the Board of Directors for the unexpired portion of the term.

Section 5. President. The President of the Association shall be the principal executive officer of the Association. He shall supervise and conduct the affairs of the Association in such manner as will best accomplish the purposes set forth in the Articles of Incorporation of the Association. He shall preside at all meetings of the Association members and the Board of Directors. He shall countersign all checks together with the Treasurer.

Section 6. Vice President. In the absence of the President, or in the event of his inability or refusal to act, the Vice President shall perform the duties of the President, and when so acting, shall have all the powers of and be subject to all the restrictions upon the President. The Vice President shall perform such other duties as from time to time may be assigned to him by the President or by the Board of Directors.

Section 7. Treasurer. The Treasurer or Assistant Treasurer shall have charge and custody of and be responsible for all funds and securities of the Association; receive and give receipts for monies received by the Association from any source whatsoever, and deposit all such monies in the name of the Association in such banks, trust companies or other depositories as shall be selected in accordance with the provisions of Article VIII of these By-Laws.

Section 8. Secretary. The Secretary or Assistant Secretary of the Association shall keep the minutes of the meetings of the members and of the Board of Directors in one or more books provided for that purpose; see that all notices are duly given in accordance with the provisions of these By-Laws or as required by law; be custodian of the corporate records of the Association; see that the seal of the Association, if any, is affixed to all documents, the execution of which on behalf of the Association under its seal, if any, is duly authorized in accordance with the provisions of these By-Laws; keep a register of the post office address of each member which shall be furnished to the Secretary or Assistant Secretary by such member; and in general perform all duties incident to the office of Secretary and such other duties as from time to time may be assigned to the Secretary or Assistant Secretary by the President or by the Board of Directors.

ARTICLE VII
COMMITTEES

Section 1. Committees of Directors. The Board of Directors, by resolution adopted by the majority of the directors in office, may designate one or more committees, each of which shall consist of two (2) or more directors, which committees, to the extent provided in said resolution, shall have and exercise the authority of the Board of Directors in the management of the Association; but the designation of such committees and the delegation thereto of authority shall not operate to relieve the Board of Directors, or any individual director, of any responsibility imposed upon it or him by law. The President shall be an ex-officio member of all committees of directors.

Section 2. Other Committees. Other committees not having and exercising the authority of the Board of Directors in the management of the Association may be designated by a resolution adopted by a majority of the directors present at a meeting at which a quorum is present. Except as otherwise provided in such resolution, members of each such committee shall be members of the Association, and the President of the Association shall appoint the members thereof. Any member thereof may be removed by the person or persons authorized to appoint such member whenever in their judgment the best interests of the Association will be served by such removal. One member of each committee shall be a director.

Section 3 Vacancies. Vacancies in the membership of any committee may be filled by appointments made in the same manner as provided in the case of original appointments.

Section 4. Quorum. Unless provided in the resolution of the Board of Directors designating a committee, a majority of the whole committee shall constitute a quorum and the act of a majority of the members present at a meeting at which a quorum is present shall be the act of the committee.

Section 5. Rules. Each committee may adopt rules for its own government not inconsistent with these By-Laws or with rules adopted by the Board of Directors.

ARTICLE VIII
CONTRACTS, CHECKS, DEPOSITS, AND FUNDS

Section 1. Contracts. The Board of Directors may authorize the officers or agents of the Association to enter into contracts or to execute and deliver documents in the name of and on behalf of the Association. Such authority shall be confined to specific instances. Such contracts may be for any purpose deemed by the Board of Directors to be appropriate, including the contracting with a third party for any or all administrative and other services and functions necessary for the Association to achieve its purpose.

Section 2. Checks, Drafts, Etc. All checks, drafts, or other orders for payment of money, notes or other evidences of indebtedness issued in the name of the Association shall be signed by such officer or officers, agent or agents of the Association and in such manner as shall from time to time be determined by the resolution of the Board of Directors. In the absence of such determination by the Board of Directors, such instruments shall be signed by the Treasurer or an Assistant Treasurer and countersigned by the President or Vice President of the Association.

Section 3. Deposits. All funds coming into possession of the Association shall be deposited from time to time to the credit of the Association in such banks, trust companies, or other depositories as the Board of Directors may select.

Section 4. Gifts. The Board of Directors may accept on behalf of the Association any contributions, gifts, bequests, or device for the general purpose or for any special purpose of the Association.

Section 5. Loans. The Association may, upon authorization of the Board of Directors, from time to time accept or negotiate loans of financial assistance to be repaid at such time as the Association is reasonably able to repay.

ARTICLE IX
CERTIFICATES OF MEMBERSHIP

Section 1. Certificates of Membership. The Board of Directors may provide for the issuance of certificates evidencing membership in the Association which shall be in such form as may be determined by the Board. Such certificates shall be signed by the President or Vice President and shall be sealed with the seal of the Association, if any. The name and address of each member and the date of issuance of the certificate shall be entered on the records of the Association. If any certificate shall become lost, mutilated or destroyed, a new certificate may be issued therefor upon such terms and conditions as the Board of Directors may determine.

Section 2. Issuance of Certificates. When a member has applied for and is eligible for membership and has paid any initiation fee and dues that may then be required, a certificate of membership shall be issued and delivered to him by the Secretary, if the Board of Directors shall have provided for the issuance of certificates of membership under the provisions of Section 1 of this article.

ARTICLE X
BOOKS AND RECORDS

The Association shall keep correct and complete books and records of accounts and shall also keep minutes of the proceedings of its members, Board of Directors and committees having any of the authority of the Board of Directors, and shall keep at the registered or principal office a record giving the names and addresses of the members entitled to vote. All books and records of the Association may be inspected by any member, or his agent or attorney for any purpose at any reasonable time.

ARTICLE XI
DUES AND INITIATION FEE

Section 1. Annual Dues. The Board of Directors may determine from time to time the amount of annual dues payable to the Association by members of each class.

Section 2. Payment of Dues. Dues shall be payable in advance.

Section 3. Default and Termination of Membership. When any member of any class shall be in default in the payment of dues for a period of one month from the beginning of the period from which such dues became payable, such member shall be automatically dropped from membership unless the Board of Directors, in its discretion, extends the time for payment of dues.

Section 4. Initiation Fee. Each member may be required to pay, in addition to applicable dues, the amount of any initiation fee designated by the Board of Directors as a prerequisite to membership. The Board of Directors may provide that the initiation fee is waived for members who are part of a group where the sponsor pays a stated initiation fee on behalf of all group members.

ARTICLE XII
FISCAL YEAR

The fiscal year of the Association shall begin the first day of January and end on the last day of December in each year.

ARTICLE XIII
SEAL

The Board of Directors may provide a corporate seal which shall be in the form of a circle and shall have inscribed thereon the name of the corporation and the words "Corporate Seal".

ARTICLE XIV
WAIVER OF NOTICE

Whenever any notice is required to be given under the provisions of the General Not-For-Profit Corporation Law of Missouri under the provisions of the Articles of Incorporation or the By-Laws of the Association, a waiver thereof in writing signed by the person or persons entitled to such notice, whether before or after the time stated therein, shall be deemed equivalent to the giving of such notice.

ARTICLE XV
AMENDMENT OF BY-LAWS

These By-Laws may be altered, amended or repealed and new By-Laws may be adopted by a two-thirds (2/3) majority of the directors present at any regular meeting or any special meeting, provided that at least seven (7) days' written notice is given of intention to alter, amend or repeal or to adopt new By-Laws at such meeting.

ARTICLE XVI
INDEMNIFICATION

The Association shall provide for indemnification by the Association of any and all of its directors of officers or former directors or officers against expenses actually and necessarily incurred by them in connection with the defense of any action, suit, or proceeding, in which they or any of them are made parties, or a party, by reason of having been directors or officers of the Association, except in relation to matters as to which such director or officer or former director or officer shall be adjudged in such action, suit, or proceeding to be liable for gross negligence or misconduct in the performance of duty and to such matters as shall be settled by agreement predicated on the existence of such liability for gross negligence or misconduct.

ARTICLE XVII
DISSOLUTION

The Association shall use its funds only to accomplish the objectives and purposes specified in these By-Laws, and no part of said funds shall inure, or be distributed, to the members of the Association. On dissolution of the Association any funds remaining shall be distributed to one or more regularly organized and qualified charitable, educational, scientific, or philanthropic organizations to be selected by the Board of Directors.

BY-LAWS OF
"ADVISORY CARE ASSOCIATION"
as amended May 14, 2001

ARTICLE I
PURPOSES

The purpose of "Advisory Care Association" ("association") shall be as follows:

To engage in the promotion and contribution of charitable orgranizations and other permitted purposes under the Illinois General Not For Profit Corporation Act of 1986 (Ill. Rev. Stats., Ch. 32, sec. 103.05).

ARTICLE II
OFFICES

The Association shall have and continuously maintain in this state a registered office and a registered agent, and the registered office of the association shall be identical with that of its registered agent. The Association may have other offices within or without the State of Illinois as the Board of Directors may from time to time determine.

ARTICLE III
MEMBERS

Section 1. Classes of Members. The Association shall have two (2) classes of members. The designation of such classes and qualifications of the members of such classes shall be as follows:

1. Individual membership: The individual is entitled to participate in all benefit programs offered by the Association.

2. Family membership: The member and his spouse are entitled to participate in all benefit programs offered by the Association.

Section 2. Voting Rights. Each member of classes 1 and 2 shall be entitled to one vote on each matter submitted to a vote of the members by the Board of Directors. Voting may be in person or

by proxy; provided that no proxy may be used for voting purposes unless the original of the proxy is filed with the Secretary of the Association at least seven (7) days before the meeting at which it is to be used.

Section 3. Termination of Membership. Any member who shall be in default in the payment of dues for the period fixed in Article XI of the By-Laws is automatically ineligible for membership and loses all privileges and rights of the Association, subject to the discretion of the Board of Directors to extend such time period for the payment of dues.

Section 4. Resignation. Any member may resign by filing a written resignation with the Secretary, but such resignation shall not entitle such member to any refund of dues and the member shall immediately lose all privileges and rights of the Association.

Section 5. Reinstatement. Upon written reapplication a former member may be reinstated to membership in the Association.

Section 6. Transfer of Membership. Membership in the Association is not transferable or assignable.

ARTICLE IV
MEETINGS OF MEMBERS

Section 1. Annual Meeting. An annual meeting of the members of the Association shall be held for the purpose of electing Directors and the transaction of any other business as may come before the meeting. The date of the annual meeting shall be determined by the Board of Directors.

Section 2. Special Meeting. Special meetings of the members, for any purpose or purposes, unless otherwise prescribed by law, may be called by the President and shall be called by the Secretary at the direction of a majority of the Board of Directors, or at the request in writing of members representing at least one hundred (100) votes entitled to be cast at such meeting.

Section 3. Place of Meeting. The Board of Directors may designate any place, within or without the State of Illinois as the place of meeting for any annual meeting. The President or the Board of Directors may designate any place within or without the State of Illinois as the place of the meeting

for any special meeting. If no designation is made, the place of meeting shall be the registered office of the Association.

Section 4. Notice of Meetings. Written or printed notice stating the place, day and hour of any regular or special meeting of the Association members shall be delivered, either personally or by mail, to each member, not less than seven (7) or more than forty (40) days before the date of such meeting, by or at the direction of the President, or Secretary, or the Board of Directors or person calling the meeting. In the case of special meetings, the purpose for which the meeting is called shall be stated in the notice. If mailed, the notice of meeting shall be deemed delivered when deposited in the United States mail addressed to the member at this address as it appears on the records of the Association, with postage thereon paid. Notice of meetings may be included in any publication that is distributed to the member.

Section 5. Quorum. There shall be no minimum number of members necessary to be present at any regular meeting or special meeting, in order to constitute a quorum. Those members present shall therefore constitute a quorum.

Section 6. Manner of Acting. The act of a majority of the members present at any regular or special meeting shall constitute the act of the members.

Section 7. Informal Action by Members. Upon approval by the directors, any action required to be taken at a meeting of the members of the Association or any other action which may be taken at a meeting, may be taken without a meeting if consents in writing, setting forth the action so taken, shall be signed by a majority of the members with respect to the subject matter thereof.

Section 8. Parliamentary Procedures. Parliamentary Procedure for all meetings of members, directors, and committees shall be conducted in accordance with the latest revised edition of Robert's Rules of Order, unless otherwise inconsistent with these By-Laws.

Section 9. Voting. At all meetings of the members, each member of records shall be entitled to one (1) vote. A vote may be cast either orally or in writing in person or by proxy. A "member of record" is a person who is a member in good standing of the Association as of the close of business on a date, selected by the Board of Directors, not less than forty (40) days nor more than fifty (50) days before the date of the meeting (the "record date"). When a quorum is present at any meeting, the vote of the holders of a majority of members present shall decide any questions brought before such meeting, unless the questions are ones upon which, by express provision of law or of the

Association's Articles of Incorporation, a different vote is required, in which case such express provision shall govern and control the decision of such question.

Section 10. Matters Reserved to Membership Vote. The following matters shall be authorized only upon a vote "thereon" by the members at a meeting called to consider such matter:

1. An amendment to the Association's Articles of Incorporation;

2. The election of the Board of Directors; and

3. Any other matter which the Board of Directors, in their sole discretion, by resolution shall commit to a vote of the members.

ARTICLE V
BOARD OF DIRECTORS

Section 1. General Powers. The affairs of the Association shall be managed by its Board of Directors.

Section 2. Number, Tenure and Qualifications. The number of directors shall be no fewer than three (3) and no more than twenty-five (25) and may be changed from time to time by resolution of the Board of Directors. The Board of Directors shall appoint a committee to nominate successor directors. The directors shall be elected at an annual meeting of the members, except as provided in Section 8 of this Article, and each director elected shall hold office until his successor is elected and qualified or until his earlier death, resignation or removal. Directors shall be residents of the United States of America and be members of the Association.

Section 3. Regular Meetings. A regular annual meeting of the Board of Directors shall be held each year immediately after the annual meeting of the members of the Association for the purpose of electing officers and for the transaction of such other business as may come before the meeting. The regular annual meeting of directors shall be held without other notice than these By-Laws. The Board of Directors may provide by resolution the time and place, within or without the State of Illinois for the holding of additional regular meetings of the Board of Directors.

Section 4. Special Meetings. Special meetings of the Board of Directors may be called by or at the request of the President or any two (2) directors. All special meetings shall be held at the registered office of the Association unless otherwise agreed upon by a majority of the Board of Directors in attendance at the meeting.

Section 5. Notice. Notice of any special meeting of the Board of Directors and the business to be transacted shall be given at least five (5) days previously thereto by written notice delivered personally or sent by mail to each director at his address shown on the records of the Association. If notice be given by mail, such notice shall be deemed to be delivered when deposited in the United States mail addressed to the director. Any director may waive notice of any meeting. The attendance of a director at any meeting shall constitute a waiver of notice of such meeting, except where a director attends a meeting for the express purpose of objecting to the transaction of any business because the meeting is not lawfully called or convened. The purpose of any special meeting of the Board of Directors shall be specified in the notice of such meeting.

Section 6. Quorum. A majority of the Board of Directors shall constitute a quorum for the transaction of business at any meeting of the Board of Directors provided that if less than a majority of the directors are present at said meeting, a majority of the directors present may adjourn the meeting from time to time without further notice.

Section 7. Manner of Acting. The act of a majority of the directors present at a meeting at which a quorum is present shall be the act of the Board of Directors, except where otherwise provided by law or these By-Laws.

Section 8. Vacancies. Vacancies created by the death, resignation, or removal of a director may be filled by a majority vote of the directors then in office though less than a quorum, and each director so chosen shall hold office until his successor is elected and qualified or until his earlier death, resignation or removal. A director may be removed at any time, with or without cause, by a vote of a majority of the remaining directors. If there are not directors in office, then an election of directors may be held in the manner provided by law. Newly created directorships shall be filled by election at an annual meeting or special meeting called for that purpose.

Section 9. Compensation. Directors as such shall not receive any stated salaries for their services, but by resolution of the Board of Directors, a fixed sum and expenses of attendance, if any, may be allowed for attendance at each meeting of the Board of Directors. Nothing herein contained shall be construed to preclude any director from serving the Association in any other capacity and receiving compensation therefor upon approval by the Board.

Section 10. Telephonic Participation in Meeting. The members of the Board of Directors, or of any committee designated by the Board of Directors, may participate in a meeting of the Board of Directors or committee by means of conference telephone or similar communications equipment whereby all persons participating in the meeting can hear each other, and participation in a meeting in this manner shall constitute presence in person at the meeting.

Section 11. Action by Written Consent. Any action which is required to be or may be taken at a meeting of the directors, or of any committee of the directors, may be taken without a meeting if consents in writing, setting forth the action so taken are signed by all of the members of the Board of Directors or of the committee as the case may be. The consents shall have the same force and effect as a unanimous vote at a meeting duly held. The Secretary shall file the consents with the minutes of the meetings of the Board of Directors or of the committee as the case may be.

ARTICLE VI
OFFICERS

Section 1. Officers. The Officers of the Association shall be a President, one or more Vice Presidents (the number thereof to be determined by the Board of Directors), a Treasurer, a Secretary or combination thereof, and such other officers as may be elected in accordance with the provisions of this article. The Board of Directors may elect or appoint other officers, including one or more Assistant Secretaries and one or more Assistant Treasurers, as it shall deem desirable, such officers to have the authority and perform the duties prescribed, from time to time, by the Board of Directors. Any two or more offices may be held by the same person, except the offices of President and Secretary.

Section 2. Election and Term of Office. The Officers of the Association shall be elected annually by the Board of Directors at the regular annual meeting of the Board of Directors. If the election of Officers shall not be held at such meeting, such election shall be held as soon thereafter as convenient. Vacancies may be filled or new officers created and filled at any meeting of the Board of Directors. Each Officer shall hold office until his successor shall have been duly elected and shall have qualified.

Section 3. Removal. Any Officer or Agent elected or appointed by the Board of Directors may be removed by the Board of Directors whenever in its judgment the best interests of the Association would be served thereby.

Section 4. Vacancies. A vacancy in any office because of death, resignation, removal, disqualification or otherwise, may be filled by the Board of Directors for the unexpired portion of the term.

Section 5. President. The President of the Association shall be the principal executive officer of the Association. He shall supervise and conduct the affairs of the Association in such manner as will best accomplish the purposes set forth in the Articles of Incorporation of the Association. He shall preside at all meetings of the Association members and the Board of Directors. He shall countersign all checks together with the Treasurer.

Section 6. Vice President. In the absence of the President, or in the event of his inability or refusal to act, the Vice President shall perform the duties of the President, and when so acting, shall have all the powers of and be subject to all the restrictions upon the President. The Vice President shall perform such other duties as from time to time may be assigned to him by the President or by the Board of Directors.

Section 7. Treasurer. The Treasurer or Assistant Treasurer shall have charge and custody of and be responsible for all funds and securities of the Association; receive and give receipts for monies received by the Association from any source whatsoever, and deposit all such monies in the name of the Association in such banks, trust companies or other depositories as shall be selected in accordance with the provisions of Article VIII of these By-Laws.

Section 8. Secretary. The Secretary or Assistant Secretary of the Association shall keep the minutes of the meetings of the members and of the Board of Directors in one or more books provided for that purpose; see that all notices are duly given in accordance with the provisions of these By-Laws or as required by law; be custodian of the corporate records of the Association; see that the seal of the Association, if any, is affixed to all documents, the execution of which on behalf of the Association under its seal, if any, is duly authorized in accordance with the provisions of these By-Laws; keep a register of the post office address of each member which shall be furnished to the Secretary or Assistant Secretary by such member; and in general perform all duties incident to the office of Secretary and such other duties as from time to time may be assigned to the Secretary or Assistant Secretary by the President or by the Board of Directors.

ARTICLE VII
COMMITTEES

Section 1. Committees of Directors. The Board of Directors, by resolution adopted by the majority of the directors in office, may designate one or more committees, each of which shall consist of two (2) or more directors, which committees, to the extent provided in said resolution, shall have and exercise the authority of the Board of Directors in the management of the Association; but the designation of such committees and the delegation thereto of authority shall not operate to relieve the Board of Directors, or any individual director, of any responsibility imposed upon it or him by law. The President shall be an ex-officio member of all committees of directors.

Section 2. Other Committees. Other committees not having and exercising the authority of the Board of Directors in the management of the Association may be designated by a resolution adopted by a majority of the directors present at a meeting at which a quorum is present. Except as otherwise provided in such resolution, members of each such committee shall be members of the Association, and the President of the Association shall appoint the members thereof. Any member thereof may be removed by the person or persons authorized to appoint such member whenever in their judgment the best interests of the Association will be served by such removal. One member of each committee shall be a director.

Section 3 Vacancies. Vacancies in the membership of any committee may be filled by appointments made in the same manner as provided in the case of original appointments.

Section 4. Quorum. Unless provided in the resolution of the Board of Directors designating a committee, a majority of the whole committee shall constitute a quorum and the act of a majority of the members present at a meeting at which a quorum is present shall be the act of the committee.

Section 5. Rules. Each committee may adopt rules for its own government not inconsistent with these By-Laws or with rules adopted by the Board of Directors.

ARTICLE VIII
CONTRACTS, CHECKS, DEPOSITS, AND FUNDS

Section 1. Contracts. The Board of Directors may authorize the officers or agents of the Association to enter into contracts or to execute and deliver documents in the name of and on behalf of the Association. Such authority shall be confined to specific instances. Such contracts may be for any purpose deemed by the Board of Directors to be appropriate, including the contracting with a third party for any or all administrative and other services and functions necessary for the Association to achieve its purpose.

Section 2. Checks, Drafts, Etc. All checks, drafts, or other orders for payment of money, notes or other evidences of indebtedness issued in the name of the Association shall be signed by such officer or officers, agent or agents of the Association and in such manner as shall from time to time be determined by the resolution of the Board of Directors. In the absence of such determination by the Board of Directors, such instruments shall be signed by the Treasurer or an Assistant Treasurer and countersigned by the President or Vice President of the Association.

Section 3. Deposits. All funds coming into possession of the Association shall be deposited from time to time to the credit of the Association in such banks, trust companies, or other depositories as the Board of Directors may select.

Section 4. Gifts. The Board of Directors may accept on behalf of the Association any contributions, gifts, bequests, or device for the general purpose or for any special purpose of the Association.

Section 5. Loans. The Association may, upon authorization of the Board of Directors, from time to time accept or negotiate loans of financial assistance to be repaid at such time as the Association is reasonably able to repay.

ARTICLE IX
CERTIFICATES OF MEMBERSHIP

Section 1. Certificates of Membership. The Board of Directors may provide for the issuance of certificates evidencing membership in the Association which shall be in such form as may be determined by the Board. Such certificates shall be signed by the President or Vice President and shall be sealed with the seal of the Association, if any. The name and address of each member and the date of issuance of the certificate shall be entered on the records of the Association. If any certificate shall

become lost, mutilated or destroyed, a new certificate may be issued therefor upon such terms and conditions as the Board of Directors may determine.

Section 2. Issuance of Certificates. When a member has applied for and is eligible for membership and has paid any initiation fee and dues that may then be required, a certificate of membership shall be issued and delivered to him by the Secretary, if the Board of Directors shall have provided for the issuance of certificates of membership under the provisions of Section 1 of this article.

ARTICLE X
BOOKS AND RECORDS

The Association shall keep correct and complete books and records of accounts and shall also keep minutes of the proceedings of its members, Board of Directors and committees having any of the authority of the Board of Directors, and shall keep at the registered or principal office a record giving the names and addresses of the members entitled to vote. All books and records of the Association may be inspected by any member, or his agent or attorney for any purpose at any reasonable time.

ARTICLE XI
DUES AND INITIATION FEE

Section 1. Annual Dues. The Board of Directors may determine from time to time the amount of annual dues payable to the Association by members of each class.

Section 2. Payment of Dues. Dues shall be payable in advance.

Section 3. Default and Termination of Membership. When any member of any class shall be in default in the payment of dues for a period of one month from the beginning of the period from

which such dues became payable, such member shall be automatically dropped from membership unless the Board of Directors, in its discretion, extends the time for payment of dues.

Section 4. Initiation Fee. Each member may be required to pay, in addition to applicable dues, the amount of any initiation fee designated by the Board of Directors as a prerequisite to membership. The Board of Directors may provide that the initiation fee is waived for members who are part of a group where the sponsor pays a stated initiation fee on behalf of all group members.

ARTICLE XII
FISCAL YEAR

The fiscal year of the Association shall begin the first day of January and end on the last day of December in each year.

ARTICLE XIII
SEAL

The Board of Directors may provide a corporate seal which shall be in the form of a circle and shall have inscribed thereon the name of the corporation and the words "Corporate Seal".

ARTICLE XIV
WAIVER OF NOTICE

Whenever any notice is required to be given under the provisions of the General Not-For-Profit Corporation Law of Illinois under the provisions of the Articles of Incorporation or the By-Laws of the Association, a waiver thereof in writing signed by the person or persons entitled to such notice, whether before or after the time stated therein, shall be deemed equivalent to the giving of such notice.

ARTICLE XV
AMENDMENT OF BY-LAWS

These By-Laws may be altered, amended or repealed and new By-Laws may be adopted by a two-thirds (2/3) majority of the directors present at any regular meeting or any special meeting, provided that at least seven (7) days' written notice is given of intention to alter, amend or repeal or to adopt new By-Laws at such meeting.

ARTICLE XVI
INDEMNIFICATION

The Association shall provide for indemnification by the Association of any and all of its directors of officers or former directors or officers against expenses actually and necessarily incurred by them in connection with the defense of any action, suit, or proceeding, in which they or any of them are made parties, or a party, by reason of having been directors or officers of the Association, except in relation to matters as to which such director or officer or former director or officer shall be adjudged in such action, suit, or proceeding to be liable for gross negligence or misconduct in the performance of duty and to such matters as shall be settled by agreement predicated on the existence of such liability for gross negligence or misconduct.

ARTICLE XVII
DISSOLUTION

The Association shall use its funds only to accomplish the objectives and purposes specified in these By-Laws, and no part of said funds shall inure, or be distributed, to the members of the Association. On dissolution of the Association any funds remaining shall be distributed to one or more regularly organized and qualified charitable, educational, scientific, or philanthropic organizations to be selected by the Board of Directors.

Bylaws approved this 14th day of May, 2001 by

Karen Boeker

Karen Boeker, Vice President/Director

BY-LAWS
OF
"NATIONAL CONSUMER ALLIANCE ASSOCIATION"

ARTICLE I
PURPOSES

The purpose of "NATIONAL CONSUMER ALLIANCE ASSOCIATION" ("association") shall be as that stated in the Certificate of Incorporation, as well as any powers as are now or may hereafter be granted by the General Not-For-Profit Law of the State of Illinois.

ARTICLE II
OFFICES

The Association shall have and continuously maintain in this state a registered office and a registered agent, and the registered office of the association shall be identical with that of its registered agent. The Association may have other offices within or without the State of Missouri as the Board of Directors may from time to time determine.

ARTICLE III
MEMBERS

Section 1. Classes of Members. The Association shall have three (3) classes of members. The designation of such classes and qualifications of the members of such classes shall be as follows:

1. Individual membership: The individual is entitled to participate in all benefit programs offered by the Association.

2. Family membership: The member and his spouse are entitled to participate in all benefit programs offered by the Association.

3. Limited membership: The member who is interested in only certain designated benefit programs offered by the Association.

Section 2. Voting Rights. Each member of classes 1, 2 and 3 shall be entitled to one vote on each matter submitted to a vote of the members by the Board of Directors. Voting may be in person or by proxy; provided that no proxy may be used for voting purposes unless the original of the proxy is filed with the Secretary of the Association at least seven (7) days before the meeting at which it is to be used.

Section 3. Termination of Membership. Any member who shall be in default in the payment of dues for the period fixed in Article XI of the By-Laws is automatically ineligible for membership and loses all privileges and rights of the Association, subject to the discretion of the Board of Directors to extend such time period for the payment of dues.

Section 4. Resignation. Any member may resign by filing a written resignation with the Secretary, but such resignation shall not entitle such member to any refund of dues and the member shall immediately lose all privileges and rights of the Association.

Section 5. Reinstatement. Upon written reapplication a former member may be reinstated to membership in the Association.

Section 6. Transfer of Membership. Membership in the Association is not transferable or assignable.

ARTICLE IV
MEETINGS OF MEMBERS

Section 1. Annual Meeting. An annual meeting of the members of the Association shall be held for the purpose of electing Directors and the transaction of any other business as may come before the meeting. The date of the annual meeting shall be determined by the Board of Directors.

Section 2. Special Meeting. Special meetings of the members, for any purpose or purposes, unless otherwise prescribed by law, may be called by the President and shall be called by the Secretary at the direction of a majority of the Board of Directors, or at the request in writing of members representing at least one hundred (100) votes entitled to be cast at such meeting.

Section 3. Place of Meeting. The Board of Directors may designate any place, within or without the State of Missouri as the place of meeting for any annual meeting. The President or the Board of Directors may designate any place within or without the State of Missouri as the place of the meeting for any special meeting. If no designation is made, the place of meeting shall be the registered office of the Association.

Section 4. Notice of Meetings. Written or printed notice stating the place, day and hour of any regular or special meeting of the Association members shall be delivered, either personally, by mail or through the internet, to each member, not less than seven (7) or more than forty (40) days before the date of such meeting, by or at the direction of the President, or Secretary, or the Board of Directors or person calling the meeting. In the case of special meetings, the purpose for which the meeting is called shall be stated in the notice. If mailed, the notice of meeting shall be deemed delivered when deposited in the United States mail addressed to the member at this address as it appears on the records of the Association, with postage thereon paid. Notice of meetings may be included in any publication that is distributed to the member.

Section 5. Quorum. There shall be no minimum number of members necessary to be present at any regular meeting or special meeting, in order to constitute a quorum. Those members present shall therefore constitute a quorum.

Section 6. Manner of Acting. The act of a majority of the members present at any regular or special meeting shall constitute the act of the members.

Section 7. Informal Action by Members. Upon approval by the directors, any action required to be taken at a meeting of the members of the Association or any other action which may be taken at a meeting, may be taken without a meeting if consents in writing, setting forth the action so taken, shall be signed by a majority of the members with respect to the subject matter thereof.

Section 8. Parliamentary Procedures. Parliamentary Procedure for all meetings of members, directors, and committees shall be conducted in accordance with the latest revised edition of Robert's Rules of Order, unless otherwise inconsistent with these By-Laws.

Section 9. Voting. At all meetings of the members, each member of records shall be entitled to one (1) vote. A vote may be cast either orally or in writing in person or by proxy. A "member of record" is a person who is a member in good standing of the Association as of the close of business on a date, selected by the Board of Directors, not less than forty (40) days nor more than fifty (50) days before the date of the meeting (the "record date"). When a quorum is present at any meeting, the vote of the holders of a majority of members present shall decide any questions brought before such meeting, unless the questions are ones upon which, by express provision of law or of the Association's Articles of Incorporation, a different vote is required, in which case such express provision shall govern and control the decision of such question.

Section 10. Matters Reserved to Membership Vote. The following matters shall be authorized only upon a vote "thereon" by the members at a meeting called to consider such matter:

1. An amendment to the Association's Articles of Incorporation;

2. The election of the Board of Directors; and

3. Any other matter which the Board of Directors, in their sole discretion, by resolution shall commit to a vote of the members.

ARTICLE V
BOARD OF DIRECTORS

Section 1. General Powers. The affairs of the Association shall be managed by its Board of Directors.

Section 2. Number, Tenure and Qualifications. The number of directors shall be no fewer than three (3) and no more than twenty-five (25) and may be changed from time to time by resolution of the Board of Directors. The Board of Directors shall appoint a committee to nominate successor directors. The directors shall be elected at an annual meeting of the members, except as provided in Section 8 of this Article, and each director elected shall hold office until his successor is elected and qualified or until his earlier death, resignation or removal. Directors shall be residents of the United States of America and members of the Association.

Section 3. Regular Meetings. A regular annual meeting of the Board of Directors shall be held each year immediately after the annual meeting of the members of the Association for the purpose of electing officers and for the transaction of such other business as may come before the meeting. The regular annual meeting of directors shall be held without other notice than these By-Laws. The Board of Directors may provide by resolution the time and place, within or without the State of Missouri for the holding of additional regular meetings of the Board of Directors.

Section 4. Special Meetings. Special meetings of the Board of Directors may be called by or at the request of the President or any two (2) directors. All special meetings shall be held at the registered office of the Association unless otherwise agreed upon by a majority of the Board of Directors in attendance at the meeting.

Section 5. Notice. Notice of any special meeting of the Board of Directors and the business to be transacted shall be given at least five (5) days previously thereto by written notice delivered personally, by mail or through the internet to each director at his address shown on the records of the Association. If notice be given by mail, such notice shall be deemed to be delivered when deposited in the United States mail addressed to the director. Any director may waive notice of any meeting. The attendance of a director at any meeting shall constitute a waiver of notice of such meeting, except where a director attends a meeting for the express purpose of objecting to the transaction of any business because the meeting is not lawfully called or convened. The purpose of any special meeting of the Board of Directors shall be specified in the notice of such meeting.

Section 6. Quorum. A majority of the Board of Directors shall constitute a quorum for the transaction of business at any meeting of the Board of Directors provided that if less than a majority of the directors are present at said meeting, a majority of the directors present may adjourn the meeting from time to time without further notice.

Section 7. Manner of Acting. The act of a majority of the directors present at a meeting at which a quorum is present shall be the act of the Board of Directors, except where otherwise provided by law or these By-Laws.

Section 8. Vacancies. Vacancies created by the death, resignation, or removal of a director may be filled by a majority vote of the directors then in office though less than a quorum, and each director so chosen shall hold office until his successor is elected and qualified or until his earlier death, resignation or removal. A director may be removed at any time, with or without cause, by a vote of a majority of the remaining directors. If there are not directors in office, then an election of directors may be held in the manner provided by law. Newly created directorships shall be filled by election at an annual meeting or special meeting called for that purpose.

Section 9. Compensation. Directors as such shall not receive any stated salaries for their services, but by resolution of the Board of Directors, a fixed sum and expenses of attendance, if any, may be allowed for attendance at each meeting of the Board of Directors. Nothing herein contained shall be construed to preclude any director from serving the Association in any other capacity and receiving compensation therefor upon approval by the Board.

Section 10. Telephonic Participation in Meeting. The members of the Board of Directors, or of any committee designated by the Board of Directors, may participate in a meeting of the Board of Directors or committee by means of conference telephone or similar communications equipment whereby all persons participating in the meeting can hear each other, and participation in a meeting in this manner shall constitute presence in person at the meeting.

Section 11. Action by Written Consent. Any action which is required to be or may be taken at a meeting of the directors, or of any committee of the directors, may be taken without a meeting if consents in writing, setting forth the action so taken are signed by all of the members of the Board of Directors or of the committee as the case may be. The consents shall have the same force and effect as a unanimous vote at a meeting duly held. The Secretary shall file the consents with the minutes of the meetings of the Board of Directors or of the committee as the case may be.

ARTICLE VI
OFFICERS

Section 1. Officers. The Officers of the Association shall be a President, one or more Vice Presidents (the number thereof to be determined by the Board of Directors), a Treasurer, a Secretary or combination thereof, and such other officers as may be elected in accordance with the provisions of this article. The Board of Directors may elect or appoint other officers, including one or more Assistant Secretaries and one or more Assistant Treasurers, as it shall deem desirable, such officers to have the authority and perform the duties prescribed, from time to time, by the Board of Directors. Any two or more offices may be held by the same person, except the offices of President and Secretary.

Section 2. Election and Term of Office. The Officers of the Association shall be elected annually by the Board of Directors at the regular annual meeting of the Board of Directors. If the election of Officers shall not be held at such meeting, such election shall be held as soon thereafter as convenient. Vacancies may be filled or new officers created and filled at any meeting of the Board of Directors. Each Officer shall hold office until his successor shall have been duly elected and shall have qualified.

Section 3. Removal. Any Officer or Agent elected or appointed by the Board of Directors may be removed by the Board of Directors whenever in its judgment the best interests of the Association would be served thereby.

Section 4. Vacancies. A vacancy in any office because of death, resignation, removal, disqualification or otherwise, may be filled by the Board of Directors for the unexpired portion of the term.

Section 5. President. The President of the Association shall be the principal executive officer of the Association. He shall supervise and conduct the affairs of the Association in such manner as will best accomplish the purposes set forth in the Articles of Incorporation of the Association. He shall preside at all meetings of the Association members and the Board of Directors. He shall countersign all checks together with the Treasurer.

Section 6. Vice President. In the absence of the President, or in the event of his inability or refusal to act, the Vice President shall perform the duties of the President, and when so acting, shall have all the powers of and be subject to all the restrictions upon the President. The Vice President shall perform such other duties as from time to time may be assigned to him by the President or by the Board of Directors.

Section 7. Treasurer. The Treasurer or Assistant Treasurer shall have charge and custody of and be responsible for all funds and securities of the Association; receive and give receipts for monies received by the Association from any source whatsoever, and deposit all such monies in the name of the Association in such banks, trust companies or other depositories as shall be selected in accordance with the provisions of Article VIII of these By-Laws.

Section 8. Secretary. The Secretary or Assistant Secretary of the Association shall keep the minutes of the meetings of the members and of the Board of Directors in one or more books provided for that purpose; see that all notices are duly given in accordance with the provisions of these By-Laws or as required by law; be custodian of the corporate records of the Association; see that the seal of the Association, if any, is affixed to all documents, the execution of which on behalf of the Association under its seal, if any, is duly authorized in accordance with the provisions of these By-Laws; keep a register of the post office address of each member which shall be furnished to the Secretary or Assistant Secretary by such member; and in general perform all duties incident to the office of Secretary and such other duties as from time to time may be assigned to the Secretary or Assistant Secretary by the President or by the Board of Directors.

ARTICLE VII
COMMITTEES

Section 1. Committees of Directors. The Board of Directors, by resolution adopted by the majority of the directors in office, may designate one or more committees, each of which shall consist of two (2) or more directors, which committees, to the extent provided in said resolution, shall have and exercise the authority of the Board of Directors in the management of the Association; but the designation of such committees and the delegation thereto of authority shall not operate to relieve the Board of Directors, or any individual director, of any responsibility imposed upon it or him by law. The President shall be an ex-officio member of all committees of directors.

Section 2. Other Committees. Other committees not having and exercising the authority of the Board of Directors in the management of the Association may be designated by a resolution adopted by a majority of the directors present at a meeting at which a quorum is present. Except as otherwise provided in such resolution, members of each such committee shall be members of the Association, and the President of the Association shall appoint the members thereof. Any member thereof may be removed by the person or persons authorized to appoint such member whenever in their judgment the best interests of the Association will be served by such removal. One member of each committee shall be a director.

Section 3. Vancancies. Vacancies in the membership of any committee may be filled by appointments made in the same manner as provided in the case of original appointments.

Section 4. Quorum. Unless provided in the resolution of the Board of Directors designating a committee, a majority of the whole committee shall constitute a quorum and the act of a majority of the members present at a meeting at which a quorum is present shall be the act of the committee.

Section 5. Rules. Each committee may adopt rules for its own government not inconsistent with these By-Laws or with rules adopted by the Board of Directors.

ARTICLE VIII
CONTRACTS, CHECKS, DEPOSITS, AND FUNDS

Section 1. Contracts. The Board of Directors may authorize the officers or agents of the Association to enter into contracts or to execute and deliver documents in the name of and on behalf of the Association. Such authority shall be confined to specific instances. Such contracts may be for any purpose deemed by the Board of Directors to be appropriate, including the contracting with a third party for any or all administrative and other services and functions necessary for the Association to achieve its purpose.

Section 2. Checks, Drafts, Etc. All checks, drafts, or other orders for payment of money, notes or other evidences of indebtedness issued in the name of the Association shall be signed by such officer or officers, agent or agents of the Association and in such manner as shall from time to time be determined by the resolution of the Board of Directors. In the absence of such determination by the Board of Directors, such instruments shall be signed by the Treasurer or an Assistant Treasurer and countersigned by the President or Vice President of the Association.

Section 3. Deposits. All funds coming into possession of the Association shall be deposited from time to time to the credit of the Association in such banks, trust companies, or other depositories as the Board of Directors may select.

Section 4. Gifts. The Board of Directors may accept on behalf of the Association any contributions, gifts, bequests, or device for the general purpose or for any special purpose of the Association.

Section 5. Loans. The Association may, upon authorization of the Board of Directors, from time to time accept or negotiate loans of financial assistance to be repaid at such time as the Association is reasonably able to repay.

ARTICLE IX
CERTIFICATES OF MEMBERSHIP

Section 1. Certificates of Membership. The Board of Directors may provide for the issuance of certificates evidencing membership in the Association which shall be in such form as may be determined by the Board. Such certificates shall be signed by the President or Vice President and shall be sealed with the seal of the Association, if any. The name and address of each member and the date of issuance of the certificate shall be entered on the records of the Association. If any certificate shall become lost, mutilated or destroyed, a new certificate may be issued therefor upon such terms and conditions as the Board of Directors may determine.

Section 2. Issuance of Certificates. When a member has applied for and is eligible for membership and has paid any initiation fee and dues that may then be required, a certificate of membership shall be issued and delivered to him by the Secretary, if the Board of Directors shall have provided for the issuance of certificates of membership under the provisions of Section 1 of this article.

ARTICLE X
BOOKS AND RECORDS

The Association shall keep correct and complete books and records of accounts and shall also keep minutes of the proceedings of its members, Board of Directors and committees having any of the authority of the Board of Directors, and shall keep at the registered or principal office a record giving the names and addresses of the members entitled to vote. All books and records of the Association may be inspected by any member, or his agent or attorney for any purpose at any reasonable time.

ARTICLE XI
DUES AND INITIATION FEE

Section 1. Annual Dues. The Board of Directors may determine from time to time the amount of annual dues payable to the Association by members of each class.

Section 2. Payment of Dues. Dues shall be payable in advance.

Section 3. Default and Termination of Membership. When any member of any class shall be in default in the payment of dues for a period of one month from the beginning of the period from which such dues became payable, such member shall be automatically dropped from membership unless the Board of Directors, in its discretion, extends the time for payment of dues.

Section 4. Initiation Fee. Each member may be required to pay, in addition to applicable dues, the amount of any initiation fee designated by the Board of Directors as a prerequisite to membership. The Board of Directors may provide that the initiation fee is waived for members who are part of a group where the sponsor pays a stated initiation fee on behalf of all group members.

ARTICLE XII
FISCAL YEAR

The fiscal year of the Association shall begin the first day of January and end on the last day of December in each year.

ARTICLE XIII
SEAL

The Board of Directors may provide a corporate seal which shall be in the form of a circle and shall have inscribed thereon the name of the corporation and the words "Corporate Seal".

ARTICLE XIV
WAIVER OF NOTICE

Whenever any notice is required to be given under the provisions of the General Not-For-Profit Corporation Law of Missouri under the provisions of the Articles of Incorporation or the By-Laws of the Association, a waiver thereof in writing signed by the person or persons entitled to such notice, whether before or after the time stated therein, shall be deemed equivalent to the giving of such notice.

ARTICLE XV
AMENDMENT OF BY-LAWS

These By-Laws may be altered, amended or repealed and new By-Laws may be adopted by a two-thirds (2/3) majority of the directors present at any regular meeting or any special meeting, provided that at least seven (7) days' written notice is given of intention to alter, amend or repeal or to adopt new By-Laws at such meeting.

ARTICLE XVI
INDEMNIFICATION

The Association shall provide for indemnification by the Association of any and all of its directors of officers or former directors or officers against expenses actually and necessarily incurred by them in connection with the defense of any action, suit, or proceeding, in which they or any of them are made parties, or a party, by reason of having been directors or officers of the Association, except in relation to matters as to which such director or officer or former director or officer shall be adjudged in such action, suit, or proceeding to be liable for gross negligence or misconduct in the performance of duty and to such matters as shall be settled by agreement predicated on the existence of such liability for gross negligence or misconduct.

ARTICLE XVII
DISSOLUTION

The Association shall use its funds only to accomplish the objectives and purposes specified in these By-Laws, and no part of said funds shall inure, or be distributed, to the members of the Association. On dissolution of the Association any funds remaining shall be distributed to one or more regularly organized and qualified charitable, educational, scientific, or philanthropic organizations to be selected by the Board of Directors.

ACCEPTED THIS MAY 1, 2001.
Date

BY: Karen Boeker
Karen Boeker, Secretary

BY-LAWS
OF
"SMALL BUSINESS ASSOCIATION OF AMERICA"

ARTICLE I
PURPOSES

The purpose of "SMALL BUSINESS ASSOCIATION OF AMERICA" ("association") is: To promote the common interests of small businesses; to consider & deal by all lawful means with common problems of small businesses; and help them take advantage of the mass purchasing power and other benefit enhancements of other organizations; and to do and perform everything necessary, proper, advisable or convenient for the accomplishment of the purposes and objectives set forth hereinabove, and to perform every act and do everything incidental thereto or connected therewith, which is not forbidden by the laws of the District of Columbia or the Articles of Incorporation.

ARTICLE II
OFFICES

The Association shall have and continuously maintain in this state a registered office and a registered agent, and the registered office of the association shall be identical with that of its registered agent. The Association may have other offices within or without the District of Columbia as the Board of Directors may from time to time determine.

ARTICLE III
MEMBERS

Section 1. Classes of Members. The Association shall have two (2) classes of members. The designation of such classes and qualifications of the members of such classes shall be as follows:

1. Individual membership: The individual is entitled to participate in all benefit programs offered by the Association.

2. Family membership: The member and his spouse are entitled to participate in all benefit programs offered by the Association.

Section 2. Voting Rights. Each member of classes 1 and 2 shall be entitled to one vote on each matter submitted to a vote of the members by the Board of Directors. Voting may be in person or by proxy; provided that no proxy may be used for voting purposes unless the original of the proxy is filed with the Secretary of the Association at least seven (7) days before the meeting at which it is to be used.

Section 3. Termination of Membership. Any member who shall be in default in the payment of dues for the period fixed in Article XI of the By-Laws is automatically ineligible for membership and loses all privileges and rights of the Association, subject to the discretion of the Board of Directors to extend such time period for the payment of dues.

Section 4. Resignation. Any member may resign by filing a written resignation with the Secretary, but such resignation shall not entitle such member to any refund of dues and the member shall immediately lose all privileges and rights of the Association.

Section 5. Reinstatement. Upon written reapplication a former member may be reinstated to membership in the Association.

Section 6. Transfer of Membership. Membership in the Association is not transferable or assignable.

ARTICLE IV
MEETINGS OF MEMBERS

Section 1. Annual Meeting. An annual meeting of the members of the Association shall be held for the purpose of electing Directors and the transaction of any other business as may come

before the meeting. The date of the annual meeting shall be determined by the Board of Directors.

Section 2. Special Meeting. Special meetings of the members, for any purpose or purposes, unless otherwise prescribed by law, may be called by the President and shall be called by the Secretary at the direction of a majority of the Board of Directors, or at the request in writing of members representing at least one hundred (100) votes entitled to be cast at such meeting.

Section 3. Place of Meeting. The Board of Directors may designate any place, within or without the District of Columbia as the place of meeting for any annual meeting. The President or the Board of Directors may designate any place within or without the District of Columbia as the place of the meeting for any special meeting. If no designation is made, the place of meeting shall be the registered office of the Association.

Section 4. Notice of Meetings. Written or printed notice stating the place, day and hour of any regular or special meeting of the Association members shall be delivered, either personally, by mail or through the internet, to each member, not less than seven (7) or more than forty (40) days before the date of such meeting, by or at the direction of the President, or Secretary, or the Board of Directors or person calling the meeting. In the case of special meetings, the purpose for which the meeting is called shall be stated in the notice. If mailed, the notice of meeting shall be deemed delivered when deposited in the United States mail addressed to the member at this address as it appears on the records of the Association, with postage thereon paid. Notice of meetings may be included in any publication that is distributed to the member.

Section 5. Quorum. There shall be no minimum number of members necessary to be present at any regular meeting or special meeting, in order to constitute a quorum. Those members present shall therefore constitute a quorum.

Section 6. Manner of Acting. The act of a majority of the members present at any regular or special meeting shall constitute the act of the members.

Section 7. Informal Action by Members. Upon approval by the directors, any action required to be taken at a meeting of the members of the Association or any other action which may be taken at a meeting, may be taken without a meeting if consents in writing, setting forth the action so taken, shall be signed by a majority of the members with respect to the subject matter thereof.

Section 8. Parliamentary Procedures. Parliamentary Procedure for all meetings of members, directors, and committees shall be conducted in accordance with the latest revised edition of Robert's Rules of Order, unless otherwise inconsistent with these By-Laws.

Section 9. Voting. At all meetings of the members, each member of records shall be entitled to one (1) vote. A vote may be cast either orally or in writing in person or by proxy. A "member of record" is a person who is a member in good standing of the Association as of the close of business on a date, selected by the Board of Directors, not less than forty (40) days nor more than fifty (50) days before the date of the meeting (the "record date"). When a quorum is present at any meeting, the vote of the holders of a majority of members present shall decide any questions brought before such meeting, unless the questions are ones upon which, by express provision of law or of the Association's Articles of Incorporation, a different vote is required, in which case such express provision shall govern and control the decision of such question.

Section 10. Matters Reserved to Membership Vote. The following matters shall be authorized only upon a vote "thereon" by the members at a meeting called to consider such matter:

1. An amendment to the Association's Articles of Incorporation;

2. The election of the Board of Directors; and

3. Any other matter which the Board of Directors, in their sole discretion, by resolution shall commit to a vote of the members.

ARTICLE V
BOARD OF DIRECTORS

Section 1. General Powers. The affairs of the Association shall be managed by its Board of Directors.

Section 2. Number, Tenure and Qualifications. The number of directors shall be no fewer than three (3) and no more than twenty-five (25) and may be changed from time to time by resolution of the Board of Directors. The Board of Directors shall appoint a committee to nominate successor directors. The directors shall be elected at an annual meeting of the members, except as provided in Section 8 of this Article, and each director elected shall hold office until his successor is elected and qualified or until his earlier death, resignation or removal. Directors shall be residents of the United States of America and members of the Association.

Section 3. Regular Meetings. A regular annual meeting of the Board of Directors shall be held each year immediately after the annual meeting of the members of the Association for the purpose of electing officers and for the transaction of such other business as may come before the meeting. The regular annual meeting of directors shall be held without other notice than these By-Laws. The Board of Directors may provide by resolution the time and place, within or without the State of Missouri for the holding of additional regular meetings of the Board of Directors.

Section 4. Special Meetings. Special meetings of the Board of Directors may be called by or at the request of the President or any two (2) directors. All special meetings shall be held at the registered office of the Association unless otherwise agreed upon by a majority of the Board of Directors in attendance at the meeting.

Section 5. Notice. Notice of any special meeting of the Board of Directors and the business to be transacted shall be given at least five (5) days previously thereto by written notice delivered personally or sent by mail to each director at his address shown on the records of the Association. If notice be given by mail, such notice shall be deemed to be delivered when deposited in the United States mail addressed to the director. Any director may waive notice of any meeting. The attendance of a director at any meeting shall constitute a waiver of notice of such meeting, except where a director attends a meeting for the express purpose of objecting to the transaction of any business because the meeting is not lawfully called or convened. The purpose of any special meeting of the Board of Directors shall be specified in the notice of such meeting.

Section 6. Quorum. A majority of the Board of Directors shall constitute a quorum for the transaction of business at any meeting of the Board of Directors provided that if less than a majority of the directors are present at said meeting, a majority of the directors present may adjourn the meeting from time to time without further notice.

Section 7. Manner of Acting. The act of a majority of the directors present at a meeting at which a quorum is present shall be the act of the Board of Directors, except where otherwise provided by law or these By-Laws.

Section 8. Vacancies. Vacancies created by the death, resignation, or removal of a director may be filled by a majority vote of the directors then in office though less than a quorum, and each director so chosen shall hold office until his successor is elected and qualified or until his earlier death, resignation or removal. A director may be removed at any time, with or without cause, by a vote of a majority of the remaining directors. If there are not directors in office, then an election of directors may be held in the manner provided by law. Newly created directorships shall be filled by election at an annual meeting or special meeting called for that purpose.

Section 9. Compensation. Directors as such shall not receive any stated salaries for their services, but by resolution of the

Board of Directors, a fixed sum and expenses of attendance, if any, may be allowed for attendance at each meeting of the Board of Directors. Nothing herein contained shall be construed to preclude any director from serving the Association in any other capacity and receiving compensation therefor upon approval by the Board.

Section 10. Telephonic Participation in Meeting. The members of the Board of Directors, or of any committee designated by the Board of Directors, may participate in a meeting of the Board of Directors or committee by means of conference telephone or similar communications equipment whereby all persons participating in the meeting can hear each other, and participation in a meeting in this manner shall constitute presence in person at the meeting.

Section 11. Action by Written Consent. Any action which is required to be or may be taken at a meeting of the directors, or of any committee of the directors, may be taken without a meeting if consents in writing, setting forth the action so taken are signed by all of the members of the Board of Directors or of the committee as the case may be. The consents shall have the same force and effect as a unanimous vote at a meeting duly held. The Secretary shall file the consents with the minutes of the meetings of the Board of Directors or of the committee as the case may be.

ARTICLE VI
OFFICERS

Section 1. Officers. The Officers of the Association shall be a President, one or more Vice Presidents (the number thereof to be determined by the Board of Directors), a Treasurer, a Secretary or combination thereof, and such other officers as may be elected in accordance with the provisions of this article. The Board of Directors may elect or appoint other officers, including one or more Assistant Secretaries and one or more Assistant Treasurers, as it shall deem desirable, such officers to have the authority and perform the duties prescribed, from time to time, by the Board of Directors. Any two or more offices may be held by the same person, except the offices of President and Secretary.

Section 2. Election and Term of Office. The Officers of the Association shall be elected annually by the Board of Directors at the regular annual meeting of the Board of Directors. If the election of Officers shall not be held at such meeting, such election shall be held as soon thereafter as convenient. Vacancies may be filled or new officers created and filled at any meeting of the Board of Directors. Each Officer shall hold office until his successor shall have been duly elected and shall have qualified.

Section 3. Removal. Any Officer or Agent elected or appointed by the Board of Directors may be removed by the Board of Directors whenever in its judgment the best interests of the Association would be served thereby.

Section 4. Vacancies. A vacancy in any office because of death, resignation, removal, disqualification or otherwise, may be filled by the Board of Directors for the unexpired portion of the term.

Section 5. President. The President of the Association shall be the principal executive officer of the Association. He shall supervise and conduct the affairs of the Association in such manner as will best accomplish the purposes set forth in the Articles of Incorporation of the Association. He shall preside at all meetings of the Association members and the Board of Directors. He shall countersign all checks together with the Treasurer.

Section 6. Vice President. In the absence of the President, or in the event of his inability or refusal to act, the Vice President shall perform the duties of the President, and when so acting, shall have all the powers of and be subject to all the restrictions upon the President. The Vice President shall perform such other duties as from time to time may be assigned to him by the President or by the Board of Directors.

Section 7. Treasurer. The Treasurer or Assistant Treasurer shall have charge and custody of and be responsible for all funds and securities of the Association; receive and give receipts for monies received by the Association from any source whatsoever, and

deposit all such monies in the name of the Association in such banks, trust companies or other depositories as shall be selected in accordance with the provisions of Article VIII of these By-Laws.

Section 8. Secretary. The Secretary or Assistant Secretary of the Association shall keep the minutes of the meetings of the members and of the Board of Directors in one or more books provided for that purpose; see that all notices are duly given in accordance with the provisions of these By-Laws or as required by law; be custodian of the corporate records of the Association; see that the seal of the Association, if any, is affixed to all documents, the execution of which on behalf of the Association under its seal, if any, is duly authorized in accordance with the provisions of these By-Laws; keep a register of the post office address of each member which shall be furnished to the Secretary or Assistant Secretary by such member; and in general perform all duties incident to the office of Secretary and such other duties as from time to time may be assigned to the Secretary or Assistant Secretary by the President or by the Board of Directors.

ARTICLE VII
COMMITTEES

Section 1. Committees of Directors. The Board of Directors, by resolution adopted by the majority of the directors in office, may designate one or more committees, each of which shall consist of two (2) or more directors, which committees, to the extent provided in said resolution, shall have and exercise the authority of the Board of Directors in the management of the Association; but the designation of such committees and the delegation thereto of authority shall not operate to relieve the Board of Directors, or any individual director, of any responsibility imposed upon it or him by law. The President shall be an ex-officio member of all committees of directors.

Section 2. Other Committees. Other committees not having and exercising the authority of the Board of Directors in the management of the Association may be designated by a resolution adopted by a majority of the directors present at a meeting at which a quorum is present. Except as otherwise provided in such

resolution, members of each such committee shall be members of the Association, and the President of the Association shall appoint the members thereof. Any member thereof may be removed by the person or persons authorized to appoint such member whenever in their judgment the best interests of the Association will be served by such removal. One member of each committee shall be a director.

Section 3 Vacancies. Vacancies in the membership of any committee may be filled by appointments made in the same manner as provided in the case of original appointments.

Section 4. Quorum. Unless provided in the resolution of the Board of Directors designating a committee, a majority of the whole committee shall constitute a quorum and the act of a majority of the members present at a meeting at which a quorum is present shall be the act of the committee.

Section 5. Rules. Each committee may adopt rules for its own government not inconsistent with these By-Laws or with rules adopted by the Board of Directors.

ARTICLE VIII
CONTRACTS, CHECKS, DEPOSITS, AND FUNDS

Section 1. Contracts. The Board of Directors may authorize the officers or agents of the Association to enter into contracts or to execute and deliver documents in the name of and on behalf of the Association. Such authority shall be confined to specific instances. Such contracts may be for any purpose deemed by the Board of Directors to be appropriate, including the contracting with a third party for any or all administrative and other services and functions necessary for the Association to achieve its purpose.

Section 2. Checks, Drafts, Etc. All checks, drafts, or other orders for payment of money, notes or other evidences of

indebtedness issued in the name of the Association shall be signed by such officer or officers, agent or agents of the Association and in such manner as shall from time to time be determined by the resolution of the Board of Directors. In the absence of such determination by the Board of Directors, such instruments shall be signed by the Treasurer or an Assistant Treasurer and countersigned by the President or Vice President of the Association.

Section 3. Deposits. All funds coming into possession of the Association shall be deposited from time to time to the credit of the Association in such banks, trust companies, or other depositories as the Board of Directors may select.

Section 4. Gifts. The Board of Directors may accept on behalf of the Association any contributions, gifts, bequests, or device for the general purpose or for any special purpose of the Association.

Section 5. Loans. The Association may, upon authorization of the Board of Directors, from time to time accept or negotiate loans of financial assistance to be repaid at such time as the Association is reasonably able to repay.

ARTICLE IX
CERTIFICATES OF MEMBERSHIP

Section 1. Certificates of Membership. The Board of Directors may provide for the issuance of certificates evidencing membership in the Association which shall be in such form as may be determined by the Board. Such certificates shall be signed by the President or Vice President and shall be sealed with the seal of the Association, if any. The name and address of each member and the date of issuance of the certificate shall be entered on the records of the Association. If any certificate shall become lost, mutilated or destroyed, a new certificate may be issued therefor upon such terms and conditions as the Board of Directors may determine.

Section 2. Issuance of Certificates. When a member has applied for and is eligible for membership and has paid any initiation fee and dues that may then be required, a certificate of membership shall be issued and delivered to him by the Secretary, if the Board of Directors shall have provided for the issuance of certificates of membership under the provisions of Section 1 of this article.

ARTICLE X
BOOKS AND RECORDS

The Association shall keep correct and complete books and records of accounts and shall also keep minutes of the proceedings of its members, Board of Directors and committees having any of the authority of the Board of Directors, and shall keep at the registered or principal office a record giving the names and addresses of the members entitled to vote. All books and records of the Association may be inspected by any member, or his agent or attorney for any purpose at any reasonable time.

ARTICLE XI
DUES AND INITIATION FEE

Section 1. Annual Dues. The Board of Directors may determine from time to time the amount of annual dues payable to the Association by members of each class.

Section 2. Payment of Dues. Dues shall be payable in advance.

Section 3. Default and Termination of Membership. When any member of any class shall be in default in the payment of dues for a period of one month from the beginning of the period from which such dues became payable, such member shall be automatically dropped from membership unless the Board of Directors, in its discretion, extends the time for payment of dues.

Section 4. Initiation Fee. Each member may be required to pay, in addition to applicable dues, the amount of any initiation fee designated by the Board of Directors as a prerequisite to membership. The Board of Directors may provide that the initiation fee is waived for members who are part of a group where the sponsor pays a stated initiation fee on behalf of all group members.

ARTICLE XII
FISCAL YEAR

The fiscal year of the Association shall begin the first day of January and end on the last day of December in each year.

ARTICLE XIII
SEAL

The Board of Directors may provide a corporate seal which shall be in the form of a circle and shall have inscribed thereon the name of the corporation and the words "Corporate Seal".

ARTICLE XIV
WAIVER OF NOTICE

Whenever any notice is required to be given under the provisions of the General Not-For-Profit Corporation Law of

District of Columbia under the provisions of the Articles of Incorporation or the By-Laws of the Association, a waiver thereof in writing signed by the person or persons entitled to such notice, whether before or after the time stated therein, shall be deemed equivalent to the giving of such notice.

ARTICLE XV
AMENDMENT OF BY-LAWS

These By-Laws may be altered, amended or repealed and new By-Laws may be adopted by a two-thirds (2/3) majority of the directors present at any regular meeting or any special meeting, provided that at least seven (7) days' written notice is given of intention to alter, amend or repeal or to adopt new By-Laws at such meeting.

ARTICLE XVI
INDEMNIFICATION

The Association shall provide for indemnification by the Association of any and all of its directors of officers or former directors or officers against expenses actually and necessarily incurred by them in connection with the defense of any action, suit, or proceeding, in which they or any of them are made parties, or a party, by reason of having been directors or officers of the Association, except in relation to matters as to which such director or officer or former director or officer shall be adjudged in such action, suit, or proceeding to be liable for gross negligence or misconduct in the performance of duty and to such matters as shall be settled by agreement predicated on the existence of such liability for gross negligence or misconduct.

ARTICLE XVII
DISSOLUTION

The Association shall use its funds only to accomplish the objectives and purposes specified in these By-Laws, and no part of said funds shall inure, or be distributed, to the members of the Association. On dissolution of the Association any funds remaining shall be distributed to one or more regularly organized and qualified charitable, educational, scientific, or philanthropic organizations to be selected by the Board of Directors.

BY-LAWS
OF
"CONSUMER HEALTH SAVINGS ASSOCIATION"

ARTICLE I
PURPOSES

The purpose or purposes of "Consumer Health Savings Association" ("association") shall be:

To enhance the quality of life for members by offering or providing educational information; to provide access to goods, services and discount benefits by using the buying power of all members. To exercise all the powers conferred upon corporations formed under the Missouri Not-For-Profit Corporation Act.

ARTICLE II
OFFICES

The Association shall have and continuously maintain in this state a registered office and a registered agent, and the registered office of the association shall be identical with that of its registered agent. The Association may have other offices within or without the State of Missouri as the Board of Directors may from time to time determine.

ARTICLE III
MEMBERS

Section 1. Classes of Members. The Association shall have two (2) classes of members. The designation of such classes and qualifications of the members of such classes shall be as follows:

1. Individual membership: The individual is entitled to participate in all benefit programs offered by the Association.

2. Family membership: The member and his spouse are entitled to participate in all benefit programs offered by the Association.

Section 2. Voting Rights. Each member of classes 1 and 2 shall be entitled to one vote on each matter submitted to a vote of the members by the Board of Directors. Voting may be in person or by proxy; provided that no proxy may be used for voting purposes unless the original of the proxy is filed with the Secretary of the Association at least seven (7) days before the meeting at which it is to be used.

Section 3. Termination of Membership. Any member who shall be in default in the payment of dues for the period fixed in Article XI of the By-Laws is automatically ineligible for

membership and loses all privileges and rights of the Association, subject to the discretion of the Board of Directors to extend such time period for the payment of dues.

Section 4. Resignation. Any member may resign by filing a written resignation with the Secretary, but such resignation shall not entitle such member to any refund of dues and the member shall immediately lose all privileges and rights of the Association.

Section 5. Reinstatement. Upon written reapplication a former member may be reinstated to membership in the Association.

Section 6. Transfer of Membership. Membership in the Association is not transferable or assignable.

ARTICLE IV
MEETINGS OF MEMBERS

Section 1. Annual Meeting. An annual meeting of the members of the Association shall be held for the purpose of electing Directors and the transaction of any other business as may come before the meeting. The date of the annual meeting shall be determined by the Board of Directors.

Section 2. Special Meeting. Special meetings of the members, for any purpose or purposes, unless otherwise prescribed by law, may be called by the President and shall be called by the Secretary at the direction of a majority of the Board of Directors, or at the request in writing of members representing at least one hundred (100) votes entitled to be cast at such meeting.

Section 3. Place of Meeting. The Board of Directors may designate any place, within or without the State of Missouri as the place of meeting for any annual meeting. The President or the Board of Directors may designate any place within or without the State of Missouri as the place of the meeting for any special meeting. If no designation is made, the place of meeting shall be the registered office of the Association.

Section 4. Notice of Meetings. Written or printed notice stating the place, day and hour of any regular or special meeting of the Association members shall be delivered, either personally, by mail or through the internet, to each member, not less than seven (7) or more than forty (40) days before the date of such meeting, by or at the direction of the President, or Secretary, or the Board of Directors or person calling the meeting. In the case of special meetings, the purpose for which the

meeting is called shall be stated in the notice. If mailed, the notice of meeting shall be deemed delivered when deposited in the United States mail addressed to the member at this address as it appears on the records of the Association, with postage thereon paid. Notice of meetings may be included in any publication that is distributed to the member.

Section 5. Quorum. There shall be no minimum number of members necessary to be present at any regular meeting or special meeting, in order to constitute a quorum. Those members present shall therefore constitute a quorum.

Section 6. Manner of Acting. The act of a majority of the members present at any regular or special meeting shall constitute the act of the members.

Section 7. Informal Action by Members. Upon approval by the directors, any action required to be taken at a meeting of the members of the Association or any other action which may be taken at a meeting, may be taken without a meeting if consents in writing, setting forth the action so taken, shall be signed by a majority of the members with respect to the subject matter thereof.

Section 8. Parliamentary Procedures. Parliamentary Procedure for all meetings of members, directors, and committees shall be conducted in accordance with the latest revised edition of Robert's Rules of Order, unless otherwise inconsistent with these By-Laws.

Section 9. Voting. At all meetings of the members, each member of records shall be entitled to one (1) vote. A vote may be cast either orally or in writing in person or by proxy. A "member of record" is a person who is a member in good standing of the Association as of the close of business on a date, selected by the Board of Directors, not less than forty (40) days nor more than fifty (50) days before the date of the meeting (the "record date"). When a quorum is present at any meeting, the vote of the holders of a majority of members present shall decide any questions brought before such meeting, unless the questions are ones upon which, by express provision of law or of the Association's Articles of Incorporation, a different vote is required, in which case such express provision shall govern and control the decision of such question.

Section 10. Matters Reserved to Membership Vote. The following matters shall be authorized only upon a vote "thereon" by the members at a meeting called to consider such matter:

1. An amendment to the Association's Articles of Incorporation;

2. The election of the Board of Directors; and

3. Any other matter which the Board of Directors, in their sole discretion, by resolution shall commit to a vote of the members.

ARTICLE V
BOARD OF DIRECTORS

Section 1. General Powers. The affairs of the Association shall be managed by its Board of Directors.

Section 2. Number, Tenure and Qualifications. The number of directors shall be no fewer than three (3) and no more than twenty-five (25) and may be changed from time to time by resolution of the Board of Directors. The Board of Directors shall appoint a committee to nominate successor directors. The directors shall be elected at an annual meeting of the members, except as provided in Section 8 of this Article, and each director elected shall hold office until his successor is elected and qualified or until his earlier death, resignation or removal. Directors shall be residents of the United States of America.

Section 3. Regular Meetings. A regular annual meeting of the Board of Directors shall be held each year immediately after the annual meeting of the members of the Association for the purpose of electing officers and for the transaction of such other business as may come before the meeting. The regular annual meeting of directors shall be held without other notice than these By-Laws. The Board of Directors may provide by resolution the time and place, within or without the State of Missouri for the holding of additional regular meetings of the Board of Directors.

Section 4. Special Meetings. Special meetings of the Board of Directors may be called by or at the request of the President or any two (2) directors. All special meetings shall be held at the registered office of the Association unless otherwise agreed upon by a majority of the Board of Directors in attendance at the meeting.

Section 5. Notice. Notice of any special meeting of the Board of Directors and the business to be transacted shall be given at least five (5) days previously thereto by written notice delivered personally, by mail or through the internet to each director at his address shown on the records of the Association. If notice be given by mail, such notice shall be deemed to be delivered when deposited in the United States mail addressed to the director. Any director may waive notice

of any meeting. The attendance of a director at any meeting shall constitute a waiver of notice of such meeting, except where a director attends a meeting for the express purpose of objecting to the transaction of any business because the meeting is not lawfully called or convened. The purpose of any special meeting of the Board of Directors shall be specified in the notice of such meeting.

Section 6. Quorum. A majority of the Board of Directors shall constitute a quorum for the transaction of business at any meeting of the Board of Directors provided that if less than a majority of the directors are present at said meeting, a majority of the directors present may adjourn the meeting from time to time without further notice.

Section 7. Manner of Acting. The act of a majority of the directors present at a meeting at which a quorum is present shall be the act of the Board of Directors, except where otherwise provided by law or these By-Laws.

Section 8. Vacancies. Vacancies created by the death, resignation, or removal of a director may be filled by a majority vote of the directors then in office though less than a quorum, and each director so chosen shall hold office until his successor is elected and qualified or until his earlier death, resignation or removal. A director may be removed at any time, with or without cause, by a vote of a majority of the remaining directors. If there are not directors in office, then an election of directors may be held in the manner provided by law. Newly created directorships shall be filled by election at an annual meeting or special meeting called for that purpose.

Section 9. Compensation. Directors as such shall not receive any stated salaries for their services, but by resolution of the Board of Directors, a fixed sum and expenses of attendance, if any, may be allowed for attendance at each meeting of the Board of Directors. Nothing herein contained shall be construed to preclude any director from serving the Association in any other capacity and receiving compensation therefor upon approval by the Board.

Section 10. Telephonic Participation in Meeting. The members of the Board of Directors, or of any committee designated by the Board of Directors, may participate in a meeting of the Board of Directors or committee by means of conference telephone or similar communications equipment whereby all persons participating in the meeting can hear each other, and participation in a meeting in this manner shall constitute presence in person at the meeting.

Section 11. Action by Written Consent. Any action which is required to be or may be taken at a meeting of the directors, or of any committee of the directors, may be taken without a meeting if consents in writing, setting forth the action so taken are signed by all of the members of

the Board of Directors or of the committee as the case may be. The consents shall have the same force and effect as a unanimous vote at a meeting duly held. The Secretary shall file the consents with the minutes of the meetings of the Board of Directors or of the committee as the case may be.

ARTICLE VI
OFFICERS

Section 1. Officers. The Officers of the Association shall be a President, one or more Vice Presidents (the number thereof to be determined by the Board of Directors), a Treasurer, a Secretary or combination thereof, and such other officers as may be elected in accordance with the provisions of this article. The Board of Directors may elect or appoint other officers, including one or more Assistant Secretaries and one or more Assistant Treasurers, as it shall deem desirable, such officers to have the authority and perform the duties prescribed, from time to time, by the Board of Directors. Any two or more offices may be held by the same person, except the offices of President and Secretary.

Section 2. Election and Term of Office. The Officers of the Association shall be elected annually by the Board of Directors at the regular annual meeting of the Board of Directors. If the election of Officers shall not be held at such meeting, such election shall be held as soon thereafter as convenient. Vacancies may be filled or new officers created and filled at any meeting of the Board of Directors. Each Officer shall hold office until his successor shall have been duly elected and shall have qualified.

Section 3. Removal. Any Officer or Agent elected or appointed by the Board of Directors may be removed by the Board of Directors whenever in its judgment the best interests of the Association would be served thereby.

Section 4. Vacancies. A vacancy in any office because of death, resignation, removal, disqualification or otherwise, may be filled by the Board of Directors for the unexpired portion of the term.

Section 5. President. The President of the Association shall be the principal executive officer of the Association. He shall supervise and conduct the affairs of the Association in such manner as will best accomplish the purposes set forth in the Articles of Incorporation of the Association. He shall preside at all meetings of the Association members and the Board of Directors. He shall countersign all checks together with the Treasurer.

Section 6. Vice President. In the absence of the President, or in the event of his inability or refusal to act, the Vice President shall perform the duties of the President, and when so acting, shall have all the powers of and be subject to all the restrictions upon the President. The Vice President shall perform such other duties as from time to time may be assigned to him by the President or by the Board of Directors.

Section 7. Treasurer. The Treasurer or Assistant Treasurer shall have charge and custody of and be responsible for all funds and securities of the Association; receive and give receipts for monies received by the Association from any source whatsoever, and deposit all such monies in the name of the Association in such banks, trust companies or other depositories as shall be selected in accordance with the provisions of Article VIII of these By-Laws.

Section 8. Secretary. The Secretary or Assistant Secretary of the Association shall keep the minutes of the meetings of the members and of the Board of Directors in one or more books provided for that purpose; see that all notices are duly given in accordance with the provisions of these By-Laws or as required by law; be custodian of the corporate records of the Association; see that the seal of the Association, if any, is affixed to all documents, the execution of which on behalf of the Association under its seal, if any, is duly authorized in accordance with the provisions of these By-Laws; keep a register of the post office address of each member which shall be furnished to the Secretary or Assistant Secretary by such member; and in general perform all duties incident to the office of Secretary and such other duties as from time to time may be assigned to the Secretary or Assistant Secretary by the President or by the Board of Directors.

ARTICLE VII
COMMITTEES

Section 1. Committees of Directors. The Board of Directors, by resolution adopted by the majority of the directors in office, may designate one or more committees, each of which shall consist of two (2) or more directors, which committees, to the extent provided in said resolution, shall have and exercise the authority of the Board of Directors in the management of the Association; but the designation of such committees and the delegation thereto of authority shall not operate to relieve the Board of Directors, or any individual director, of any responsibility imposed upon it or him by law. The President shall be an ex-officio member of all committees of directors.

Section 2. Other Committees. Other committees not having and exercising the authority of the Board of Directors in the management of the Association may be designated by a resolution adopted by a majority of the directors present at a meeting at which a quorum is present.

Except as otherwise provided in such resolution, members of each such committee shall be members of the Association, and the President of the Association shall appoint the members thereof. Any member thereof may be removed by the person or persons authorized to appoint such member whenever in their judgment the best interests of the Association will be served by such removal. One member of each committee shall be a director.

Section 3 Vacancies. Vacancies in the membership of any committee may be filled by appointments made in the same manner as provided in the case of original appointments.

Section 4. Quorum. Unless provided in the resolution of the Board of Directors designating a committee, a majority of the whole committee shall constitute a quorum and the act of a majority of the members present at a meeting at which a quorum is present shall be the act of the committee.

Section 5. Rules. Each committee may adopt rules for its own government not inconsistent with these By-Laws or with rules adopted by the Board of Directors.

ARTICLE VIII
CONTRACTS, CHECKS, DEPOSITS, AND FUNDS

Section 1. Contracts. The Board of Directors may authorize the officers or agents of the Association to enter into contracts or to execute and deliver documents in the name of and on behalf of the Association. Such authority shall be confined to specific instances. Such contracts may be for any purpose deemed by the Board of Directors to be appropriate, including the contracting with a third party for any or all administrative and other services and functions necessary for the Association to achieve its purpose.

Section 2. Checks, Drafts, Etc. All checks, drafts, or other orders for payment of money, notes or other evidences of indebtedness issued in the name of the Association shall be signed by such officer or officers, agent or agents of the Association and in such manner as shall from time to time be determined by the resolution of the Board of Directors. In the absence of such determination by the Board of Directors, such instruments shall be signed by the Treasurer or an Assistant Treasurer and countersigned by the President or Vice President of the Association.

Section 3. Deposits. All funds coming into possession of the Association shall be deposited from time to time to the credit of the Association in such banks, trust companies, or other depositories as the Board of Directors may select.

Section 4. Gifts. The Board of Directors may accept on behalf of the Association any contributions, gifts, bequests, or device for the general purpose or for any special purpose of the Association.

Section 5. Loans. The Association may, upon authorization of the Board of Directors, from time to time accept or negotiate loans of financial assistance to be repaid at such time as the Association is reasonably able to repay.

ARTICLE IX
CERTIFICATES OF MEMBERSHIP

Section 1. Certificates of Membership. The Board of Directors may provide for the issuance of certificates evidencing membership in the Association which shall be in such form as may be determined by the Board. Such certificates shall be signed by the President or Vice President and shall be sealed with the seal of the Association, if any. The name and address of each member and the date of issuance of the certificate shall be entered on the records of the Association. If any certificate shall become lost, mutilated or destroyed, a new certificate may be issued therefor upon such terms and conditions as the Board of Directors may determine.

Section 2. Issuance of Certificates. When a member has applied for and is eligible for membership and has paid any initiation fee and dues that may then be required, a certificate of membership shall be issued and delivered to him by the Secretary, if the Board of Directors shall have provided for the issuance of certificates of membership under the provisions of Section 1 of this article.

ARTICLE X
BOOKS AND RECORDS

The Association shall keep correct and complete books and records of accounts and shall also keep minutes of the proceedings of its members, Board of Directors and committees having any of the authority of the Board of Directors, and shall keep at the registered or principal office a record giving the names and addresses of the members entitled to vote. All books and records of the Association may be inspected by any member, or his agent or attorney for any purpose at any reasonable time.

ARTICLE XI

DUES AND INITIATION FEE

Section 1. Annual Dues. The Board of Directors may determine from time to time the amount of annual dues payable to the Association by members of each class.

Section 2. Payment of Dues. Dues shall be payable in advance.

Section 3. Default and Termination of Membership. When any member of any class shall be in default in the payment of dues for a period of one month from the beginning of the period from which such dues became payable, such member shall be automatically dropped from membership unless the Board of Directors, in its discretion, extends the time for payment of dues.

Section 4. Initiation Fee. Each member may be required to pay, in addition to applicable dues, the amount of any initiation fee designated by the Board of Directors as a prerequisite to membership. The Board of Directors may provide that the initiation fee is waived for members who are part of a group where the sponsor pays a stated initiation fee on behalf of all group members.

ARTICLE XII
FISCAL YEAR

The fiscal year of the Association shall begin the first day of January and end on the last day of December in each year.

ARTICLE XIII
SEAL

The Board of Directors may provide a corporate seal which shall be in the form of a circle and shall have inscribed thereon the name of the corporation and the words "Corporate Seal".

ARTICLE XIV
WAIVER OF NOTICE

Whenever any notice is required to be given under the provisions of the General Not-For-Profit Corporation Law of Missouri under the provisions of the Articles of Incorporation or the By-Laws of the Association, a waiver thereof in writing signed by the person or persons entitled to such notice, whether before or after the time stated therein, shall be deemed equivalent to the giving of such notice.

ARTICLE XV
AMENDMENT OF BY-LAWS

These By-Laws may be altered, amended or repealed and new By-Laws may be adopted by a two-thirds (2/3) majority of the directors present at any regular meeting or any special meeting, provided that at least seven (7) days' written notice is given of intention to alter, amend or repeal or to adopt new By-Laws at such meeting.

ARTICLE XVI
INDEMNIFICATION

The Association shall provide for indemnification by the Association of any and all of its directors of officers or former directors or officers against expenses actually and necessarily incurred by them in connection with the defense of any action, suit, or proceeding, in which they or any of them are made parties, or a party, by reason of having been directors or officers of the Association, except in relation to matters as to which such director or officer or former director or officer shall be adjudged in such action, suit, or proceeding to be liable for gross negligence or misconduct in the performance of duty and to such matters as shall be settled by agreement predicated on the existence of such liability for gross negligence or misconduct.

ARTICLE XVII
DISSOLUTION

The Association shall use its funds only to accomplish the objectives and purposes specified in these By-Laws, and no part of said funds shall inure, or be distributed, to the members of the Association. On dissolution of the Association any funds remaining shall be distributed to one or more regularly organized and qualified charitable, educational, scientific, or philanthropic organizations to be selected by the Board of Directors.

BY-LAWS OF
"AMERICA'S BUSINESS BENEFIT ASSOCIATION"

ARTICLE I
PURPOSES

The purpose or purposes of "America's Business Benefit Association" ("association") shall be:

To enhance the quality of life for members by offering or providing educational information; to provide access to goods, services, benefits or group discounts by using the buying power of all members. To exercise all the powers conferred upon corporations formed under the Missouri Not-For-Profit Corporation Act.

ARTICLE II
OFFICES

The Association shall have and continuously maintain in this state a registered office and a registered agent, and the registered office of the association shall be identical with that of its registered agent. The Association may have other offices within or without the State of Missouri as the Board of Directors may from time to time determine.

ARTICLE III
MEMBERS

Section 1. Classes of Members. The Association shall have two (2) classes of members. The designation of such classes and qualifications of the members of such classes shall be as follows:

1. Individual membership: The individual is entitled to participate in all benefit programs offered by the Association.

2. Family membership: The member and his spouse are entitled to participate in all benefit programs offered by the Association.

Section 2. Voting Rights. Each member of classes 1 and 2 shall be entitled to one vote on each matter submitted to a vote of the members by the Board of Directors. Voting may be in person or by proxy; provided that no proxy may be used for voting purposes unless the original of the proxy is filed with the Secretary of the Association at least seven (7) days before the meeting at which it is to be used.

Section 3. Termination of Membership. Any member who shall be in default in the payment of dues for the period fixed in Article XI of the By-Laws is automatically ineligible for membership and loses all privileges and rights of the Association, subject to the discretion of the Board of Directors to extend such time period for the payment of dues.

Section 4. Resignation. Any member may resign by filing a written resignation with the Secretary, but such resignation shall not entitle such member to any refund of dues and the member shall immediately lose all privileges and rights of the Association.

Section 5. Reinstatement. Upon written reapplication a former member may be reinstated to membership in the Association.

Section 6. Transfer of Membership. Membership in the Association is not transferable or assignable.

ARTICLE IV
MEETINGS OF MEMBERS

Section 1. Annual Meeting. An annual meeting of the members of the Association shall be held for the purpose of electing Directors and the transaction of any other business as may come before the meeting. The date of the annual meeting shall be determined by the Board of Directors.

Section 2. Special Meeting. Special meetings of the members, for any purpose or purposes, unless otherwise prescribed by law, may be called by the President and shall be called by the Secretary at the direction of a majority of the Board of Directors, or at the request in writing of members representing at least one hundred (100) votes entitled to be cast at such meeting.

Section 3. Place of Meeting. The Board of Directors may designate any place, within or without the State of Missouri as the place of meeting for any annual meeting. The President or the Board of Directors may designate any place within or without the State of Missouri as the place of the meeting for any special meeting. If no designation is made, the place of meeting shall be the registered office of the Association.

Section 4. Notice of Meetings. Written or printed notice stating the place, day and hour of any regular or special meeting of the Association members shall be delivered, either personally, by mail or through the internet, to each member, not less than seven (7) or more than forty (40) days before the date of such meeting, by or at the direction of the President, or Secretary, or the Board of Directors or person calling the meeting. In the case of special meetings, the purpose for which the meeting is called shall be stated in the notice. If mailed, the notice of meeting shall be deemed delivered when deposited in the United States mail addressed to the member at this address as it appears on the

records of the Association, with postage thereon paid. Notice of meetings may be included in any publication that is distributed to the member.

Section 5. Quorum. There shall be no minimum number of members necessary to be present at any regular meeting or special meeting, in order to constitute a quorum. Those members present shall therefore constitute a quorum.

Section 6. Manner of Acting. The act of a majority of the members present at any regular or special meeting shall constitute the act of the members.

Section 7. Informal Action by Members. Upon approval by the directors, any action required to be taken at a meeting of the members of the Association or any other action which may be taken at a meeting, may be taken without a meeting if consents in writing, setting forth the action so taken, shall be signed by a majority of the members with respect to the subject matter thereof.

Section 8. Parliamentary Procedures. Parliamentary Procedure for all meetings of members, directors, and committees shall be conducted in accordance with the latest revised edition of Robert's Rules of Order, unless otherwise inconsistent with these By-Laws.

Section 9. Voting. At all meetings of the members, each member of records shall be entitled to one (1) vote. A vote may be cast either orally or in writing in person or by proxy. A "member of record" is a person who is a member in good standing of the Association as of the close of business on a date, selected by the Board of Directors, not less than forty (40) days nor more than fifty (50) days before the date of the meeting (the "record date"). When a quorum is present at any meeting, the vote of the holders of a majority of members present shall decide any questions brought before such meeting, unless the questions are ones upon which, by express provision of law or of the Association's Articles of Incorporation, a different vote is required, in which case such express provision shall govern and control the decision of such question.

Section 10. Matters Reserved to Membership Vote. The following matters shall be authorized only upon a vote "thereon" by the members at a meeting called to consider such matter:

1. An amendment to the Association's Articles of Incorporation;

2. The election of the Board of Directors; and

3. Any other matter which the Board of Directors, in their sole discretion, by resolution shall commit to a vote of the members.

ARTICLE V
BOARD OF DIRECTORS

Section 1. General Powers. The affairs of the Association shall be managed by its Board of Directors.

Section 2. Number, Tenure and Qualifications. The number of directors shall be no fewer than three (3) and no more than twenty-five (25) and may be changed from time to time by resolution of the Board of Directors. The Board of Directors shall appoint a committee to nominate successor directors. The directors shall be elected at an annual meeting of the members, except as provided in Section 8 of this Article, and each director elected shall hold office until his successor is elected and qualified or until his earlier death, resignation or removal. Directors shall be residents of the United States of America and members of the Association.

Section 3. Regular Meetings. A regular annual meeting of the Board of Directors shall be held each year immediately after the annual meeting of the members of the Association for the purpose of electing officers and for the transaction of such other business as may come before the meeting. The regular annual meeting of directors shall be held without other notice than these By-Laws. The Board of Directors may provide by resolution the time and place, within or without the State of Missouri for the holding of additional regular meetings of the Board of Directors.

Section 4. Special Meetings. Special meetings of the Board of Directors may be called by or at the request of the President or any two (2) directors. All special meetings shall be held at the registered office of the Association unless otherwise agreed upon by a majority of the Board of Directors in attendance at the meeting.

Section 5. Notice. Notice of any special meeting of the Board of Directors and the business to be transacted shall be given at least five (5) days previously thereto by written notice delivered personally, by mail or through the internet to each director at his address shown on the records of the Association. If notice be given by mail, such notice shall be deemed to be delivered when deposited in the United States mail addressed to the director. Any director may waive notice of any meeting. The attendance of a director at any meeting shall constitute a waiver of notice of such

meeting, except where a director attends a meeting for the express purpose of objecting to the transaction of any business because the meeting is not lawfully called or convened. The purpose of any special meeting of the Board of Directors shall be specified in the notice of such meeting.

Section 6. Quorum. A majority of the Board of Directors shall constitute a quorum for the transaction of business at any meeting of the Board of Directors provided that if less than a majority of the directors are present at said meeting, a majority of the directors present may adjourn the meeting from time to time without further notice.

Section 7. Manner of Acting. The act of a majority of the directors present at a meeting at which a quorum is present shall be the act of the Board of Directors, except where otherwise provided by law or these By-Laws.

Section 8. Vacancies. Vacancies created by the death, resignation, or removal of a director may be filled by a majority vote of the directors then in office though less than a quorum, and each director so chosen shall hold office until his successor is elected and qualified or until his earlier death, resignation or removal. A director may be removed at any time, with or without cause, by a vote of a majority of the remaining directors. If there are not directors in office, then an election of directors may be held in the manner provided by law. Newly created directorships shall be filled by election at an annual meeting or special meeting called for that purpose.

Section 9. Compensation. Directors as such shall not receive any stated salaries for their services, but by resolution of the Board of Directors, a fixed sum and expenses of attendance, if any, may be allowed for attendance at each meeting of the Board of Directors. Nothing herein contained shall be construed to preclude any director from serving the Association in any other capacity and receiving compensation therefor upon approval by the Board.

Section 10. Telephonic Participation in Meeting. The members of the Board of Directors, or of any committee designated by the Board of Directors, may participate in a meeting of the Board of Directors or committee by means of conference telephone or similar communications equipment whereby all persons participating in the meeting can hear each other, and participation in a meeting in this manner shall constitute presence in person at the meeting.

Section 11. Action by Written Consent. Any action which is required to be or may be taken at a meeting of the directors, or of any committee of the directors, may be taken without a meeting if consents in writing, setting forth the action so taken are signed by all of the members of the Board of Directors or of the committee as the case may be. The consents shall have the same force

and effect as a unanimous vote at a meeting duly held. The Secretary shall file the consents with the minutes of the meetings of the Board of Directors or of the committee as the case may be.

ARTICLE VI
OFFICERS

Section 1. Officers. The Officers of the Association shall be a President, one or more Vice Presidents (the number thereof to be determined by the Board of Directors), a Treasurer, a Secretary or combination thereof, and such other officers as may be elected in accordance with the provisions of this article. The Board of Directors may elect or appoint other officers, including one or more Assistant Secretaries and one or more Assistant Treasurers, as it shall deem desirable, such officers to have the authority and perform the duties prescribed, from time to time, by the Board of Directors. Any two or more offices may be held by the same person, except the offices of President and Secretary.

Section 2. Election and Term of Office. The Officers of the Association shall be elected annually by the Board of Directors at the regular annual meeting of the Board of Directors. If the election of Officers shall not be held at such meeting, such election shall be held as soon thereafter as convenient. Vacancies may be filled or new officers created and filled at any meeting of the Board of Directors. Each Officer shall hold office until his successor shall have been duly elected and shall have qualified.

Section 3. Removal. Any Officer or Agent elected or appointed by the Board of Directors may be removed by the Board of Directors whenever in its judgment the best interests of the Association would be served thereby.

Section 4. Vacancies. A vacancy in any office because of death, resignation, removal, disqualification or otherwise, may be filled by the Board of Directors for the unexpired portion of the term.

Section 5. President. The President of the Association shall be the principal executive officer of the Association. He shall supervise and conduct the affairs of the Association in such manner as will best accomplish the purposes set forth in the Articles of Incorporation of the Association. He shall preside at all meetings of the Association members and the Board of Directors. He shall countersign all checks together with the Treasurer.

Section 6. Vice President. In the absence of the President, or in the event of his inability or refusal to act, the Vice President shall perform the duties of the President, and when so acting, shall

have all the powers of and be subject to all the restrictions upon the President. The Vice President shall perform such other duties as from time to time may be assigned to him by the President or by the Board of Directors.

Section 7. Treasurer. The Treasurer or Assistant Treasurer shall have charge and custody of and be responsible for all funds and securities of the Association; receive and give receipts for monies received by the Association from any source whatsoever, and deposit all such monies in the name of the Association in such banks, trust companies or other depositories as shall be selected in accordance with the provisions of Article VIII of these By-Laws.

Section 8. Secretary. The Secretary or Assistant Secretary of the Association shall keep the minutes of the meetings of the members and of the Board of Directors in one or more books provided for that purpose; see that all notices are duly given in accordance with the provisions of these By-Laws or as required by law; be custodian of the corporate records of the Association; see that the seal of the Association, if any, is affixed to all documents, the execution of which on behalf of the Association under its seal, if any, is duly authorized in accordance with the provisions of these By-Laws; keep a register of the post office address of each member which shall be furnished to the Secretary or Assistant Secretary by such member; and in general perform all duties incident to the office of Secretary and such other duties as from time to time may be assigned to the Secretary or Assistant Secretary by the President or by the Board of Directors.

ARTICLE VII
COMMITTEES

Section 1. Committees of Directors. The Board of Directors, by resolution adopted by the majority of the directors in office, may designate one or more committees, each of which shall consist of two (2) or more directors, which committees, to the extent provided in said resolution, shall have and exercise the authority of the Board of Directors in the management of the Association; but the designation of such committees and the delegation thereto of authority shall not operate to relieve the Board of Directors, or any individual director, of any responsibility imposed upon it or him by law. The President shall be an ex-officio member of all committees of directors.

Section 2. Other Committees. Other committees not having and exercising the authority of the Board of Directors in the management of the Association may be designated by a resolution adopted by a majority of the directors present at a meeting at which a quorum is present. Except as otherwise provided in such resolution, members of each such committee shall be members of the Association, and the President of the Association shall appoint the members thereof. Any member thereof may be removed by the person or persons authorized to appoint such member whenever in

their judgment the best interests of the Association will be served by such removal. One member of each committee shall be a director.

Section 3 Vacancies. Vacancies in the membership of any committee may be filled by appointments made in the same manner as provided in the case of original appointments.

Section 4. Quorum. Unless provided in the resolution of the Board of Directors designating a committee, a majority of the whole committee shall constitute a quorum and the act of a majority of the members present at a meeting at which a quorum is present shall be the act of the committee.

Section 5. Rules. Each committee may adopt rules for its own government not inconsistent with these By-Laws or with rules adopted by the Board of Directors.

ARTICLE VIII
CONTRACTS, CHECKS, DEPOSITS, AND FUNDS

Section 1. Contracts. The Board of Directors may authorize the officers or agents of the Association to enter into contracts or to execute and deliver documents in the name of and on behalf of the Association. Such authority shall be confined to specific instances. Such contracts may be for any purpose deemed by the Board of Directors to be appropriate, including the contracting with a third party for any or all administrative and other services and functions necessary for the Association to achieve its purpose.

Section 2. Checks, Drafts, Etc. All checks, drafts, or other orders for payment of money, notes or other evidences of indebtedness issued in the name of the Association shall be signed by such officer or officers, agent or agents of the Association and in such manner as shall from time to time be determined by the resolution of the Board of Directors. In the absence of such determination by the Board of Directors, such instruments shall be signed by the Treasurer or an Assistant Treasurer and countersigned by the President or Vice President of the Association.

Section 3. Deposits. All funds coming into possession of the Association shall be deposited from time to time to the credit of the Association in such banks, trust companies, or other depositories as the Board of Directors may select.

Section 4. Gifts. The Board of Directors may accept on behalf of the Association any contributions, gifts, bequests, or device for the general purpose or for any special purpose of the Association.

Section 5. Loans. The Association may, upon authorization of the Board of Directors, from time to time accept or negotiate loans of financial assistance to be repaid at such time as the Association is reasonably able to repay.

ARTICLE IX
CERTIFICATES OF MEMBERSHIP

Section 1. Certificates of Membership. The Board of Directors may provide for the issuance of certificates evidencing membership in the Association which shall be in such form as may be determined by the Board. Such certificates shall be signed by the President or Vice President and shall be sealed with the seal of the Association, if any. The name and address of each member and the date of issuance of the certificate shall be entered on the records of the Association. If any certificate shall become lost, mutilated or destroyed, a new certificate may be issued therefor upon such terms and conditions as the Board of Directors may determine.

Section 2. Issuance of Certificates. When a member has applied for and is eligible for membership and has paid any initiation fee and dues that may then be required, a certificate of membership shall be issued and delivered to him by the Secretary, if the Board of Directors shall have provided for the issuance of certificates of membership under the provisions of Section 1 of this article.

ARTICLE X
BOOKS AND RECORDS

The Association shall keep correct and complete books and records of accounts and shall also keep minutes of the proceedings of its members, Board of Directors and committees having any of the authority of the Board of Directors, and shall keep at the registered or principal office a record giving the names and addresses of the members entitled to vote. All books and records of the Association may be inspected by any member, or his agent or attorney for any purpose at any reasonable time.

ARTICLE XI
DUES AND INITIATION FEE

Section 1. Annual Dues. The Board of Directors may determine from time to time the amount of annual dues payable to the Association by members of each class.

Section 2. Payment of Dues. Dues shall be payable in advance.

Section 3. Default and Termination of Membership. When any member of any class shall be in default in the payment of dues for a period of one month from the beginning of the period from which such dues became payable, such member shall be automatically dropped from membership unless the Board of Directors, in its discretion, extends the time for payment of dues.

Section 4. Initiation Fee. Each member may be required to pay, in addition to applicable dues, the amount of any initiation fee designated by the Board of Directors as a prerequisite to membership. The Board of Directors may provide that the initiation fee is waived for members who are part of a group where the sponsor pays a stated initiation fee on behalf of all group members.

ARTICLE XII
FISCAL YEAR

The fiscal year of the Association shall begin the first day of January and end on the last day of December in each year.

ARTICLE XIII
SEAL

The Board of Directors may provide a corporate seal which shall be in the form of a circle and shall have inscribed thereon the name of the corporation and the words "Corporate Seal".

ARTICLE XIV
WAIVER OF NOTICE

Whenever any notice is required to be given under the provisions of the General Not-For-Profit Corporation Law of Missouri under the provisions of the Articles of Incorporation or the By-Laws of the Association, a waiver thereof in writing signed by the person or persons entitled to such notice, whether before or after the time stated therein, shall be deemed equivalent to the giving of such notice.

ARTICLE XV
AMENDMENT OF BY-LAWS

These By-Laws may be altered, amended or repealed and new By-Laws may be adopted by a two-thirds (2/3) majority of the directors present at any regular meeting or any special meeting, provided that at least seven (7) days' written notice is given of intention to alter, amend or repeal or to adopt new By-Laws at such meeting.

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INDEMNIFICATION

The Association shall provide for indemnification by the Association of any and all of its directors of officers or former directors or officers against expenses actually and necessarily incurred by them in connection with the defense of any action, suit, or proceeding, in which they or any of them are made parties, or a party, by reason of having been directors or officers of the Association, except in relation to matters as to which such director or officer or former director or officer shall be adjudged in such action, suit, or proceeding to be liable for gross negligence or misconduct in the performance of duty and to such matters as shall be settled by agreement predicated on the existence of such liability for gross negligence or misconduct.

ARTICLE XVII
DISSOLUTION

The Association shall use its funds only to accomplish the objectives and purposes specified in these By-Laws, and no part of said funds shall inure, or be distributed, to the members of the Association. On dissolution of the Association any funds remaining shall be distributed to one or more regularly organized and qualified charitable, educational, scientific, or philanthropic organizations to be selected by the Board of Directors.

STATE OF MISSOURI

Matt Blunt
Secretary of State

CERTIFICATE OF AMENDMENT
OF A
MISSOURI NONPROFIT CORPORATION

WHEREAS,

USBenefit Plan RX America
N00053753

Formerly,

INTERNET VALUE ASSOCIATION

a corporation organized under The Missouri Nonprofit Corporation Law has delivered to me duplicate originals of Articles of Amendment of its Articles of Incorporation and has in all respects complied with the requirements of law governing the Amendment of Articles of Incorporation under The Missouri Nonprofit Corporation Law, and that the Articles of Incorporation of said corporation are amended in accordance therewith.

IN TESTIMONY WHEREOF, I have set my hand and imprinted the GREAT SEAL of the State of Missouri, on this, the 5th day of August, 2003.

Matt Blunt
Secretary of State

SOS #30 (1-01)

State of Missouri
Amend/Restate - NonProfit 2 Page(s)

T0321807003

P.O. Box 778, Jefferson City, MO 65102

James C
600 W. Main St

File Number: 200321821105
Charter # N00053753
Date Filed: 08/05/2003 04:31 PM
Matt Blunt
Secretary of State

Articles of Amendment for a Nonprofit Corporation

(Submit in duplicate with filing fee of $10.00)

The undersigned corporation, for the purpose of amending its articles of incorporation, hereby executes the following articles of amendment:

(1) The name of corporation is: Internet Value Association

(2) The amendment was adopted on 7-31-03 (month/day/year) and changed article(s) 1, 6 and 8 to state as follows:

Article number One (1) is amended to read: The name of the corporation is: USBenefit Plan RX America
Article number Six (6) is amended to indicate that the corporation has members.
Article number Eight (8) is amended to read as follows: see attached.

(3) If approval of members was not required, and the amendment(s) was approved by a sufficient vote of the board of directors or incorporators, check here and skip to number (5): ✓

(4) If approval by members was required, check here and provide the following information: _____

A. Number of memberships outstanding: _____
B. Complete either i or ii:

i. Number of votes for and against the amendments(s) by class was:

Class:	Number entitled to vote:	Number voting for:	Number voting against:

ii. Number of undisputed votes cast for the amendment(s) was sufficient for approval, and was:

Class:	Number Voting undisputed:

The number of votes cast in favor of the amendment(s) by each class was sufficient for approval by that class.

(5) If approval of the amendment(s) by some person(s) other than the members, the board or the incorporators was required pursuant to section 355.606, check here to indicate that approval was obtained: _____

In affirmation of the facts stated above,

(Authorized signature of officer or chairman of the board)	(Printed Name)	(Title)	(Date)
	DONALD E. BRECKENRIDGE JR	PRESIDENT	7/31/03

Corp. #53A (11/00)

The purpose or purposes for which the Corporation is organized are:

To enhance the quality of life for members by offering or providing educational information; to provide access to goods, services and discount benefits by using the buying power of all members. To exercise all the powers conferred upon corporations formed under the Missouri Not-For-Profit Corporation Act.

No. N00053753

STATE OF MISSOURI

Rebecca McDowell Cook
Secretary of State

CORPORATION DIVISION

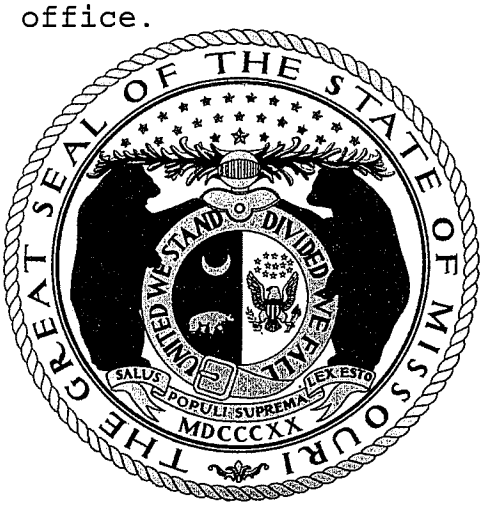
CERTIFICATE OF CORPORATE GOOD STANDING

I, REBECCA McDOWELL COOK, Secretary of State of the State of Missouri, do hereby certify that the records in my office and in my care and custody reveal that

INTERNET VALUE ASSOCIATION

was incorporated under the laws of this State on the 1st day of FEBRUARY, 1996, and is in good standing, having fully complied with all requirements of this office.

IN TESTIMONY WHEREOF, I have set my hand and imprinted the GREAT SEAL of the State of Missouri, on this, the 3rd day of MARCH, 2000.



Rebecca McDowell Cook
Secretary of State

S.O.S. #30

No. N00053753

STATE OF MISSOURI

Rebecca McDowell Cook
Secretary of State

CORPORATION DIVISION
CERTIFICATE OF AMENDMENT
OF A
MISSOURI NONPROFIT CORPORATION

WHEREAS,

INTERNET VALUE ASSOCIATION

Formerly,

AMERICAN AUTOMOTIVE TRADE ASSOCIATION

a corporation organized under The Missouri Nonprofit Corporation Law has delivered to me duplicate originals of Articles of Amendment of its Articles of Incorporation and has in all respects complied with requirements of law governing the amendment of Articles of Incorporation under The Missouri Nonprofit Corporation Law, and that the Articles of Incorporation of said corporation are amended in accordance therewith.

IN TESTIMONY WHEREOF, I have set my hand and imprinted the GREAT SEAL of the State of Missouri, on this, the 17th day of FEBRUARY, 2000.

Rebecca McDowell Cook
Secretary of State

$10.00

S.O.S. #30

State of Missouri

Rebecca McDowell Cook, Secretary of State
P. O. Box 778, Jefferson City, MO 65102
Corporation Division

FILED AND CERTIFIED
ISSUED
FEB 17 2000
Rebecca McDowell Cook
SECRETARY OF STATE

Articles of Amendment for a Nonprofit Corporation

(Submit in duplicate with filing fee of $10.00)

The undersigned corporation, for the purpose amending its articles of incorporation, hereby executes the following articles of amendment:

(1) The name of corporation is: American Automotive Trade Association

(2) The text of the amendment(s) and the date(s) of adoption are as follows:
Article number One is amended to read as follows:
The name of the corporation is:
Internet Value Association
Adopted 2-14-00
Article number Eight is amended to read as follows: See Attached

(3) If approval of members was not required, and the amendment(s) was approved by a sufficient vote of the board of directors or incorporators, check here and skip to number (5): ✓

(4) If approval by members was required, check here and provide the following information: _____

A. Number of memberships outstanding: _____

B. Complete either i or ii.

i. Number of votes for and against the amendment(s) by class was:

Class:	Number entitled to vote:	Number voting for:	Number voting against:

ii. Number of undisputed votes cast for the amendment(s) was sufficient for approval, and was:

Class:	Number voting undisputed:

The number of votes cast in favor of the amendment(s) by each class was sufficient for approval by that class.

(5) If approval of the amendment(s) by some person(s) other than the members, the board or the incorporators was required pursuant to section 355.606, check here to indicate that approval was obtained: _____

In affirmation of the facts stated above,

(Authorized signature of officer or chairman of the board)	President (Title)	2/14/00 (Date of signature)

Corp. #53A (6-95)

Article number Eight (8) is amended to read as follows:

The purpose or purposes for which the corporation is organized are:

> To promote the common interests of Internet Value members; to consider and deal by all lawful means with common problems and concerns of internet users. To provide information, education, products and services which would enhance the use of the internet to Internet Value members, as well as any other activity under the Missouri Not-For-Profit Corporation Act.

Adopted: 2/14/00

FILED AND CERTIFICATE
ISSUED

FEB 17 2000

Rebecca McDowell Cook
SECRETARY OF STATE

No. N00053753

STATE OF MISSOURI

Rebecca McDowell Cook
Secretary of State

CORPORATION DIVISION

CERTIFICATE OF INCORPORATION

MISSOURI NONPROFIT

WHEREAS, DUPLICATE ORIGINALS OF ARTICLES OF INCORPORATION OF

AMERICAN AUTOMOTIVE TRADE ASSOCIATION

HAVE BEEN RECEIVED AND FILED IN THE OFFICE OF THE SECRETARY OF STATE, WHICH ARTICLES, IN ALL RESPECTS, COMPLY WITH THE REQUIREMENTS OF MISSOURI NONPROFIT CORPORATION LAW;

NOW, THEREFORE, I, REBECCA McDOWELL COOK, SECRETARY OF STATE OF THE STATE OF MISSOURI, BY VIRTUE OF THE AUTHORITY VESTED IN ME BY LAW, DO HEREBY CERTIFY AND DECLARE THIS ENTITY A BODY CORPORATE, DULY ORGANIZED THIS DATE AND THAT IT IS ENTITLED TO ALL RIGHTS AND PRIVILEGES GRANTED CORPORATIONS ORGANIZED UNDER THE MISSOURI NONPROFIT CORPORATION LAW.

IN TESTIMONY WHEREOF, I HAVE SET MY HAND AND IMPRINTED THE GREAT SEAL OF THE STATE OF MISSOURI, ON THIS, THE 1ST DAY OF FEBRUARY, 1996.

Rebecca McDowell Cook

Secretary of State

$25.00

S.O.S. #30

State of Missouri

Rebecca McDowell Cook, Secretary of State
P. O. Box 778, Jefferson City, MO 65102
Corporation Division

Articles of Incorporation of a Nonprofit Corporation

(To be submitted in duplicate with a filing fee of $25)

The undersigned natural person(s) of the age of eighteen years or more for the purpose of forming a corporation under the Nonprofit Corporation Law of Missouri adopt the following Articles of Incorporation:

(1) The name of the corporation is AMERICAN AUTOMOTIVE TRADE ASSOCIATION

(2) This corporation is a Mutual Benefit Corporation.
(Public or Mutual)

(3) The period of duration of the corporation is "Perpetual"
("Perpetual" unless stated otherwise)

(4) The name and street address of the Registered Agent and Registered Office in Missouri is:
Karen Boeker 1819 Clarkson Rd, Ste 301, Chesterfield, MO 63017
Name Address City/State/Zip

(5) The name(s) and address(es) of each incorporator:

Dale Turvey 16601 Kehrsgrove Dr, Chesterfield, MO 63005

Gary Johnston 4506 Meadowford Dr, St. Louis, MO 63129

William A. Warmann, Jr. 32 Green #4 Dr, St. Charles, MO 63303

(6) Does the corporation have members? YES____ NO XX

(7) Provisions not inconsistent with law regarding the distribution of assets on dissolution
In accordance with sections 355.662 through 355.746

(8) The corporation is formed for the following purpose(s): To provide education, informati
Benefits and discounts to individuals in the automotive industry.

(9) The effective date of this document is the date it is filed by the Secretary of State of Missouri, unless you indicate a future date, as follows: _____
(Date may not be more than 90 days after the filing date in this office.)

In affirmation of the facts stated above,

Signed by Incorporator(s):

FILED AND CERTIFICATE OF INCORPORATION ISSUED

FEB 1 1996

Rebecca McDowell Cook
SECRETARY OF STATE

Corp. #52 (6-95)

STATE OF NEBRASKA ♦ SECRETARY OF STATE'S OFFICE
1445 "K" ST. • STATE CAPITOL SUITE 1301 • LINCOLN, NE • 68509
BUSINESS SERVICES DIVISION

CORPORATIONS	UNIFORM COMMERCIAL CODE	NOTARY
P.O. BOX 94608	P.O. BOX 95104	P.O. BOX 95104
(402) 471-4079	(402) 471-4080	(402) 471-2558

JOHN A. GALE
Secretary of State

DEBBIE PESTER
Director

August 27, 2003

NATIONAL ADMINISTRATION COMPANY, INC.
1819 CLARKSON ROAD
SUITE 301
CHESTERFIELD, MO 63017

ACKNOWLEDGEMENT OF FILING

The attached documents were filed with the Nebraska Secretary of State's Office, Corporation Division. A label has been affixed to each filing signifying the filing stamp for the Nebraska Secretary of State's Office, Corporation Division. This filing label indicates the date and time of the filing and also references a document number that can be used to reference this filing in the future.

ACKNOWLEDGEMENT OF FILING FEES RECEIVED

Action/Service	Company/Entity Name	Fee Received
Foreign Authority	USBENEFIT PLAN RX AMERICA	10.00
Per Page Charge	USBENEFIT PLAN RX AMERICA	15.00
	Total Fees Received	$25.00

BRANDON
Filing Officer

LINCOLN JOURNAL STAR
journalstar.com Connect.

926 P Street
P. O. Box 80528
Lincoln, NE 68501-0528

BEATRICE DAILY SUN
200 N. 7th St.
Beatrice, NE 68310

09/25/03	N	A

TOTAL AMOUNT DUE	TERMS OF PAYMENT
39.21	PLEASE PAY BY 10-09-03

CURRENT NET AMOUNT DUE	30 DAYS	60 DAYS	OVER 90 DAYS

PAGE #/ BILLING DATE	BILLED ACCOUNT NAME AND ADDRESS	REMITTANCE ADDRESS
1 09/25/03	N A 1819 CLARKSON ROAD SUITE 301 CHESTERFIELD MO 63017	**CR00 LINCOLN JOURNAL STAR P.O. BOX 80499 LINCOLN, NE 68501-0499

BILLED ACCOUNT NUMBER: 2452431-2

ADVERTISER/CLIENT NUMBER: 2452431-2

BILLING INQUIRIES 402-473-7448 INVOICE #24524312 TL CREDIT CARD

AFFIDAVIT OF PUBLICATION

State of Nebraska
LANCASTER COUNTY, } ss.

cert of authority [redacted]

The undersigned, being first duly sworn, deposes and says that she/he is a Clerk of the Lincoln Journal Star, legal newspaper printed, published and having a general circulation in the County of Lancaster and State of Nebraska, and that the attached printed notice was published in said newspaper three successive time(s) the first insertion having been on the 5 day of September A.D., 20 03 and thereafter on September 12 and 19, 20 03 and that said newspaper is the legal newspaper under the statutes of the State of Nebraska. The above facts are within my personal knowledge and are further verified by my personal inspection of each notice in each of said issues.

Janice Krueger

Subscribed in my presence and sworn to before me this 22 day of Sept, 20 03

Jennifer Anne Melton
Notary Public

Printer's Fee, $ 39.21

GENERAL NOTARY-State of Nebraska
JENNIFER ANNE MELTON
My Comm. Exp. May 5, 2004

NOTICE OF CERTIFICATE OF AUTHORITY TO TRANSACT BUSINESS FOR USBENEFIT PLAN RX AMERICA

Notice is hereby given that a Certificate of Authority to transact business has been issued to USBenefit Plan RX America, a non-profit corporation.

1. The name of the Corporation is USBenefit Plan RX America, a not-for-profit corporation domiciled in the state of Missouri.
2. It is a mutual benefit corporation.
3. The corporation does have members.
4. The street address of the initial office of the corporation is: 11305 Chicago Circle, Omaha, NE 68154. The name of its initial registered agent at that address is: Warren Foss.

#2452431-3t-Sept. 5, 12, 19

2452431

ACCOUNT NUMBER	BILLING PERIOD	ADVERTISER INFORMATION BILLED ACCOUNT NUMBER	ADVERTISER CLIENT NUMBER	ADVERTISER CLIENT NAME
24524312	09/25/03	2452431-2	2452431-2	N A

Questions regarding your charges?

LINCOLN JOURNAL STAR
journalstar.com Connect.
926 'P' Street
P. O. Box 80528
Lincoln, NE 68501-0528
(402) 473-7276
(800) 742-7315 ext. 7276

BEATRICE DAILY SUN
200 North 7th
Beatrice, NE 68310
(800) 666-5233

Retain This Portion For Your Records
FED. I.D. NO. 47-0787330

APPLICATION FOR CERTIFICATE OF AUTHORITY TO TRANSACT BUSINESS
(Non-Profit Corporations)

NE Sec of State - CORP FA
1000417361 Pgs: 3
USBENEFIT PLAN RX AMERICA
Filed: 08/27/2003 11:59 AM

John A. Gale, Secretary of State
Room 1305 State Capitol, P.O. Box 94608
Lincoln, NE 68509
http://www.nol.org/home/SOS/

Submit in Duplicate

Attach a certificate of good standing duly authenticated by the official having custody of the corporate records in the state or country under whose law the corporation is incorporated. Such certificate shall not be more than 60 days old. A certified copy of the articles of incorporation should not be submitted and is not acceptable in lieu of such certificate.

Name of Corporation USBenefit Plan RX America

Fictitious Name of Corporation _____
(to be used only if actual corporate name is unavailable for use or does not comply with Nebraska law)

Incorporated under the laws of MISSOURI

Date Incorporation February 1, 1996 (Year) Period of Duration PERPETUAL

Corporate Type (check one) ☐ Public Benefit ☑ Mutual Benefit ☐ Religious

Does the Corporation Have Members? ☑ Yes ☐ No

Address of Principal Office 1819 Clarkson #301 Chesterfield MO 63017
(Street Address, City, State, Zip)

Registered Agent Warren Foss

Registered Office 11305 Chicago Circle Omaha NE 68154
(Street Address, City, Zip)

DATED 8/22/03

Signature

Don Breckenridge, Jr. President
Printed Name/Title

NOTE: Every filing must be signed by the chairperson of the board of directors, the president, or one of the officers of the corporation. If the corporation has not yet been formed or directors have not yet been selected, the filing shall be signed by an incorporator. If the corporation is in the hands of a receiver, trustee, or other court appointed fiduciary, the filing shall be signed by that fiduciary.

NOTE: To complete this form, you must list officers and directors on back

FILING FEE: $25.00 (if you have more than one page listing officers and directors please add $5.00 a page for each additional page)

Revised 12/20/2000

Neb. Rev. Stat. 21-19,148

OFFICERS:

Don Breckenridge, Jr. President
Name/Title

18500 Edison Chesterfield MO 63005
Address

Heather Tegethoff - V.P.
Name/Title

34 Oakland Hills Chesterfield MO 63017
Address

Rick Hall - Secretary/Treasurer
Name/Title

1659 Forestview St Louis, MO 63122
Address

Name/Title

Address

Name/Title

Address

Name/Title

Address

Name/Title

Address

Name/Title

Address

Name/Title

Address

DIRECTORS:

Don Breckenridge, Jr.
Name

same
Address

Heather Tegethoff
Name

same
Address

Rick Hall
Name

same
Address

Name

Address

Name

Address

Name

Address

Name

Address

Name

Address

Name

Address

Please Copy this page and submit additional pages if needed.

N A C, INC.
1819 CLARKSON ROAD, SUITE 301
CHESTERFIELD, MO 63017
PHONE # 636-530-7700
FAX # 636-530-7777

FACSIMILE TRANSMISSION

DATE: 8/1/03

OF PAGES: 1

TO: Name Availabity

FROM: Barbara

RE:

COMMENTS: I have one more name to check for a non-profit corporation. It is:
USBenefit Plan Rx America

Thank you for your time.

THE NAME(S) ARE AVAILABLE AS OF 8/4/2003. PLEASE RETURN A COPY OF THIS LETTER WITH YOUR FILING.

FAXED TO: 402 471 3666

Barb McCann

From: Mike Owens [mowens@insurance-capital.com]
Sent: Saturday, August 09, 2003 3:46 PM
To: Barb McCann
Cc: 'Scott Smith'; 'Marianne Cinquini'
Subject: NEBRASKA ADDRESS

Here is the information for our Nebraska office

USBenefit Plan Rx America
Attn: Warren Foss
warren@jetter.com
11305 Chicago Circle
Omaha, NE 68154
402-330-2900
402-330-5078 fax

Mike Owens

-----Original Message-----
From: Barb McCann [mailto:bmccann@egroupmanager.com]
Sent: Thursday, July 31, 2003 10:47 AM
To: Mike Owens
Subject: ne address
Importance: High

Mike,

We also need the name and address for the person in NE who will serve as registered agent and office.

Barb

CC: PETER NAUERT VIA FAX

OFFICE OF THE SECRETARY OF STATE

JESSE WHITE • Secretary of State

JANUARY 13, 2005 6399-172-4

NATIONAL ADMINISTRATION COMPANY INC.
1819 CLARKSON RD, STE 301
CHESTERFIELD, MO 63017

RE USBENEFIT PLAN RX AMERICA, (INC.)

DEAR SIR OR MADAM:

ENCLOSED YOU WILL FIND THE AUTHORITY OF THE ABOVE NAMED CORPORATION TO CONDUCT AFFAIRS IN THIS STATE.

THIS DOCUMENT MUST BE RECORDED IN THE OFFICE OF THE RECORDER OF THE COUNTY IN WHICH THE REGISTERED OFFICE OF THE CORPORATION IS LOCATED.

CERTAIN NOT FOR PROFIT CORPORATIONS ORGANIZED AS A CHARITABLE CORPORATION ARE REQUIRED TO REGISTER WITH THE OFFICE OF THE ATTORNEY GENERAL. UPON RECEIPT OF THE ENCLOSED AUTHORITY, YOU MUST CONTACT THE CHARITABLE TRUST DIVISION, OFFICE OF THE ATTORNEY GENERAL, 100 W. RANDOLPH, 3RD FLOOR, CHICAGO, ILLINOIS 60601, TELEPHONE (312) 814-2595.

SINCERELY,

JESSE WHITE
SECRETARY OF STATE

DEPARTMENT OF BUSINESS SERVICES
CORPORATION DIVISION

TELEPHONE (217) 782-6961

JW:CD

2005R05062

STATE OF ILLINOIS
MADISON COUNTY
FILED FOR RECORD IN
THE RECORDERS OFFICE

01/28/2005 09:10AM

DANIEL R. DONOHOO
RECORDER

DOC FEE: $18.00
PAGES: 2

FILED
JAN 13 2005
JESSE WHITE
SECRETARY OF STATE

FORM **NFP 113.15** (rev. Dec. 2003)
APPLICATION FOR AUTHORITY TO CONDUCT AFFAIRS IN ILLINOIS (Foreign Corporations)
General Not For Profit Corporation Act

Jesse White, Secretary of State
Department of Business Services
Springfield, IL 62756
Telephone (217) 782-1834
www.cyberdriveillinois.com

Remit payment in the form of a cashier's check, certified check, money order or an Illinois attorney's or CPA's check payable to the Secretary of State.

File # 6399-172-4 Filing Fee: $ 50.00 Approved:

Submit in duplicate — Type or Print clearly in black ink — Do not write above this line

1. (a) CORPORATE NAME: USBenefit Plan RX America, Inc.

18.00 CK # 253

(Complete item 1(b) only if the corporate name is not available in this state.)

(b) ASSUMED CORPORATE NAME: _____

(By electing this assumed name, the corporation hereby agrees NOT to use its corporate name in the conducting of affairs in Illinois. Form NFP 104.15 is attached.)

2. State or Country of Incorporation Missouri ; Date of Incorporation 2/1/96 ; Period of Duration perpetual

3. (a) The address of its principal office, wherever located, is 1819 Clarkson Rd., Suite 301 Chesterfield, MO 63017

(b) The address of its principal office in Illinois is 707 Vivian Collinsville, IL 62234

4. The name and address of its registered agent and its registered office in Illinois are:

Registered Agent: Tim Trunnell
First Name *Middle Name* *Last Name*

Registered Office: 707 Vivian
Number *Street* *Suite # (A P.O. box alone is not acceptable)*

Collinsville, IL 62234 Madison County
City *ZIP Code* *County*

5. The states and countries in which it is admitted or qualified to conduct affairs are: MO, NE

6. The names and respective addresses of its officers and directors are:

	No. & Street	City State ZIP
President Chuck Emmeneger	2220 Stonebriar Ridge Drive	Chesterfield, MO 63017
Secretary Alan Harshbarger	3715 Bradford Terrace	Manhattan, KS 66503
Director Ted Mintert	196 Cherry Hills Meadow Dr	Wilwood, MO 63040
Director Alan Harshbarger	same as above	
Director Chuck Emmeneger	same as above	

If there are additional officers or more than 3 directors, attach list.

7. The purpose or purposes for which it is organized and which it proposes to pursue in the conduct of affairs in this State are:

If not sufficient space to cover this point, add one or more sheets of this size.

Educational

8. This application must be accompanied by an originally certified copy of the Articles of Incorporation and any amendments or mergers, duly authenticated within the last ninety days, by the proper officer of the state or country wherein the corporation is incorporated.

9. The undersigned corporation has caused this application to be signed by a duly authorized officer, who affirms, under penalties of perjury, that the facts stated herein are true. (All signatures must be in **BLACK INK**.)

Dated November 24 (Month & Day), 2004 (Year)

USBenefit Plan RX America, Inc.
(Exact Name of Corporation)

Chuck Emmeneger / President / Director
(Any authorized officer's signature)

Chuck Emmeneger, President/Director
(Type or Print Name and Title)

A corporation which is to function as a club, as defined in Section 1-3.24 of the "Liquor Control Act of 1934," must insert in its purpose clause a statement that **it will comply with the State and local laws and ordinances relating to alcoholic liquors**.

ent
Ret: NAP, Inc
1819 Clarkson #301
Chesterfield, MO 63017

END OF DOCUMENT

C-160.13

Superseded Attachments

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Original Date:	Schedule	Document Name	Replaced Date	Attach Document
No original date	Form	Certificate of Coverage	02/26/2008	AC4800W (certbook for ARkansas).pdf

P.O. Box 3160
Omaha, NE 68103-0160
(402) 496-8000

Certificate of Coverage

World Insurance certifies that the Member is insured as of the Issue Date shown on the Validation of Coverage page, subject to the terms and conditions of the Group Insurance Policy issued to the Policyholder, shown on the Validation of Coverage.

When we use “we,” “us,” or “our,” we mean World Insurance Company; and when we use “you” or “your,” we mean the person named as Member on the Validation of Coverage page.

This Certificate explains, in general, the terms of your coverage. However, when reading this Certificate, remember that decisions regarding a Covered Person’s medical Treatment are between the Covered Person and his or her Physician.

This Certificate is not being sold as an employment benefit plan and the Member’s employer is not responsible, either directly or indirectly, for paying the premium or benefits.

This Certificate describes, in general terms, the principal features of the insurance. Nothing in this Certificate will waive or alter any of the terms or conditions of the Group Insurance Policy, and if any discrepancies, misprint of certificates, or change in benefits occur, the Group Insurance Policy will govern.

No statement made by any of our representatives if in conflict with this Certificate or the provisions of the Group Insurance Policy shall be binding on us.

Eligibility for the benefits provided by this Certificate is based on: a) your being a member of the Policyholder; and b) the information you provided on the Application.

Important Notice: This Certificate was issued on the basis of the information provided on your Application, a copy of which is attached. Please read the Application carefully. If there is any misstatement on the Application, or if any past medical history has been omitted, you must write to us within 10 days regarding the incorrect or omitted information; otherwise, this Certificate may not be valid.

Signed for World Insurance Company on the Policy Date

Michael E. Abbott
President

Mary K. Durand
Secretary

Table of Contents

Validation of Coverage

Schedule of Benefits

Section I. Definitions

Section II. Benefit Provisions

Section III. General Exclusions and Limitations

Section IV. Certificate Provisions

Section V. Claim Provisions

Section VI. Continuation and Conversion

[VALIDATION OF COVERAGE

POLICYHOLDER:	Association Name
MEMBER:	John Doe
CERTIFICATE NUMBER:	0001234567
ISSUE DATE:	02/01/2008
COVERED PERSONS	
COVERED MEMBER:	John Doe
COVERED DEPENDENTS:	Dependent 1 Name
	Dependent 2 Name
BENEFIT INFORMATION	See Schedule of Benefits
PREMIUM INFORMATION	
FIRST PREMIUM:	$500.00
PREMIUM FREQUENCY:	Monthly]

SCHEDULE OF BENEFITS

This Schedule of Benefits (Schedule) provides important information about the benefits you have selected and out-of-pocket expenses for which you are responsible when you Incur Covered Expenses under your Certificate.

SECTION 1. Maximum Benefits

Maximum Lifetime Benefit

Maximum cumulative amount we will ever pay in benefits for your Covered Expenses: ..... [$250,000-$25,000,000]

[Calendar Year Maximum Benefit

Maximum amount we will pay in benefits during a Calendar Year for your Covered Expenses: ..... [$None/$100,000/$250,000, $500,000/$1,000,000/$5,000,000]]

SECTION 2. Your Out-of-Pocket Expenses

Your out-of-pocket expenses are the amounts you must pay each Calendar Year before Covered Expenses are payable at 100% for the remainder of the Calendar Year. Depending on the benefit for which you are making a claim under this Certificate, you are responsible for paying one of (or a combination of) the following amounts before we have an obligation to pay benefits related to the claim.

Deductibles

Individual Deductible (per Calendar Year per Covered Person)

Participating Provider: ..... [0,$500, $1,000, $1,500, $2,000, $2,500, $3,000, $3,500, $4,000, $5,000, $6,000, $7,500, $10,000, $12,500, $15,000, $20,000, $25,000]

Nonparticipating Provider: ..... [0, $1,000, $2,000, $3,000, $4,000, $5,000, $6,000, $7,000, $8,000, $10,000, $12,000, $15,000, $20,000, $25,000, $30,000, $40,000, $50,000]

Family Deductible (per Calendar Year)

Participating Provider: ..... [$ *(Two/Three times the above Individual Deductible for Participating Provider)*]

Nonparticipating Provider: [$ *(Two/Three times the above Individual Deductible for Nonparticipating Provider)*]

When [two/three] family members have each satisfied a Calendar Year Deductible in a Calendar Year for a particular type of Provider (Participating or Nonparticipating), no further Deductible(s) will apply for the remainder of that Calendar Year for that type of Provider.

Coinsurance Percentage

Calendar Year Coinsurance Percentage

For Covered Expenses that are subject to the Certificate's Deductible and Coinsurance, after you have satisfied the appropriate Deductible, you are responsible for paying Coinsurance as follows. After you satisfy your Coinsurance obligation, we will pay 100% of the remainder of Covered Expenses through the end of the Calendar Year.

Participating Provider: ..... [30%/20%/10%/0%] of the next [$10,000/$20,000]

Nonparticipating Provider: ..... [50%/40%/30%/20%] of the next [$20,000/$40,000]

Copayment Amounts

(Copayment amounts do not apply toward satisfying the Deductible, Coinsurance Percentage amount or Out-of-Pocket Limit.)

Office Visit Copayment

Participating Provider: ..... [$30/$40/$50/N/A - Covered Expenses are subject to the Certificate's Participating Provider Deductible and Coinsurance Percentage [and number of waived Copayments]

Nonparticipating Provider: ..... N/A - Covered Expenses are subject to the Certificate's Nonparticipating Provider Deductible and Coinsurance Percentage

Access Fees

(Access Fees do not apply toward satisfying the Deductible, Coinsurance Percentage amount or Out-of-Pocket Limit.)

Emergency Room Access Fee

Participating and Nonparticipating Providers: ..... [$75]

(This Access Fee will be waived if the Covered Person is admitted directly from the emergency room into the Hospital as an Inpatient.)

Or

Emergency Benefit

Participating Provider

Emergency Room Access Fee per visit:..... [$150]*

Maximum amount we pay for an emergency room visit:..... [$1,000]

Covered Expense in excess of the Calendar Year Maximum is subject to the Certificate's Participating Provider Calendar Year Deductible and Coinsurance Percentage.

Nonparticipating Provider

Emergency Room Access Fee per visit: ..... [$150]*
Maximum amount we pay for an emergency room visit: ..... [$1,000]
Covered Expense in excess of the Emergency Room Access Fee is subject to the Certificate's Nonparticipating Provider Calendar Year Deductible and Coinsurance Percentage.

* The Emergency Benefit Access Fee amount will not be applied to the Certificate's Participating or Nonparticipating Provider Calendar Year Deductibles or to any Out-of-Pocket Limit.

[**Covered Diagnostic X-ray and Laboratory Access Fee**
(This Access Fee does not apply to Covered Expenses under any other benefit provision or limitation such as Treatment for Allergies; Spinal Manipulation; Occupational, Speech or Physical Therapy; and Mental or Nervous Disorders, if applicable. Any other services, such as office surgeries, processing, or reading charges are subject to the Certificate's Calendar Year Deductible and Coinsurance Percentage amount.)

Participating Provider: ..... [100% of the first $150 of Covered Expenses per Covered Person per Calendar Year; remainder subject to the Certificate's Participating Provider Calendar Year Deductible and Coinsurance Percentage.]

Nonparticipating Provider: ..... Covered Expenses are subject to the Certificate's Non-participating Provider Calendar Year Deductible and Coinsurance Percentage]

Your Out-of-Pocket Limit
Subject to the certificate's provisions, exclusions and limitations, the maximum amount a Covered Person will have to pay during a Calendar Year for Covered Expenses:

Participating Providers: ..... [$000000]

Nonparticipating Providers: ..... [$000000]

[(If product is an HSA, this statement must be included on Schedule)

PLEASE NOTE: ON EACH JANUARY 1ST, THE DEDUCTIBLE AND THE OUT-OF-POCKET LIMIT ARE INDEXED FOR INFLATION IN $50 INCREMENTS, BASED ON THE NATIONAL CONSUMER PRICE INDEX. A CHANGE IN THE DEDUCTIBLE AND THE OUT-OF-POCKET COVERED EXPENSE LIMIT MAY AFFECT THE DOLLAR AMOUNTS SHOWN UNDER THE SECTION TITLED "YOUR OUT-OF-POCKET LIMIT."]

SECTION 3. Our Maximum Obligation for Each Type of Benefit

Subject to the Certificate's provisions, exclusions and limitations, after you have satisfied your out-of-pocket obligation(s) in Section 2 above, our responsibility to pay for a particular benefit is described below.

INPATIENT TREATMENT

This benefit is subject to the certificate's Deductible and Coinsurance. Subject to other provisions, exclusions, and limitations in your certificate, once you have satisfied the applicable Deductible and Coinsurance Percentage, we will pay benefits for Inpatient Covered Expenses.

OTHER BENEFITS

Transplants
(This benefit subject to Certificate Deductible and Coinsurance.)

Transplants performed at a Center of Excellence (COE)

Maximum lifetime amount we pay for this benefit per Covered Person at a COE..... [$1,000,000 / N/A]

Maximum amount we pay per Covered Person per Transplant at a COE:..... [$500,000 / N/A]

[Maximum transportation and living expenses we pay per covered transplant:..... $5,000]

Transplants not performed at a COE

Maximum lifetime amount we pay for this benefit per transplant per Covered Person:..... [$100,000]

Maximum amount we pay per Covered Person per transplant at a Non-COE: ..... [$100,000]

Acute Rehabilitation..... This benefit subject to Certificate Deductible and Coinsurance.

Ambulance Service

[Local Ground Ambulance..... Included/Not Included]

[Air Ambulance..... $5,000]

(and – if applies) [per covered Illness or Injury]

(or – if applies) [per Covered Person per Calendar Year]

(and – if applies) [due to a life-threatening Illness or Injury]

(or) [Not Included]

(and – if applies) [Subject to Certificate's Deductible and Coinsurance]

[**Emergency Foreign Travel Benefit**
(This benefit subject to Certificate Deductible and Coinsurance)
[Maximum lifetime amount we pay for all
covered Illnesses and/or Injuries under this benefit: ..... $100,000]

Home Health Care
(This benefit subject to Certificate Deductible and Coinsurance)
Maximum number of Home Health Care Visits per Calendar Year: ... [40]

Hospice Treatment and Services
(This benefit subject to Certificate Deductible and Coinsurance)
Maximum we pay for Outpatient Hospice benefits, per day: ..... [$100]
Maximum we pay for Treatment and Room and Board Expenses
while an Inpatient in a Hospice Facility, per day: ..... [$200]
Maximum lifetime benefit we pay for Inpatient and Outpatient
Hospice Treatment (combined): ..... [$5,000]

Outpatient Occupational, Physical and Speech Therapy
(This benefit subject to Certificate Deductible and Coinsurance)
Maximum we pay per visit: ..... [$50]
Maximum we pay for all three types of therapy (combined),
per Covered Person per Calendar Year: ..... [$2,000]

Skilled Care Facility Benefit
(This benefit subject to Certificate Deductible and Coinsurance)
Maximum number of days we pay per Calendar Year: ..... [60]

Spinal Manipulation
(This benefit subject to Certificate Deductible and Coinsurance)
Maximum we pay per day of Treatment (does not include x-rays): ..... [$25]
Maximum for all Treatments and x-rays under this benefit,
per Covered Person, per Calendar Year: ..... [$500]

[Sterilization
(This benefit subject to Certificate Deductible and Coinsurance)
Maximum lifetime amount we pay for this benefit,
per Covered Person: ..... [$500]]

[Treatment of Allergies
(This benefit subject to Certificate Deductible and Coinsurance)
Maximum amount we pay for this benefit, per Covered Person,
per Calendar Year: ..... [$500]]

[**Treatment for Sleep Apnea**
(This benefit subject to Certificate Deductible and Coinsurance)
Maximum lifetime benefit we will pay, per Covered Person: ..... [$15,000]]

[**Treatment for Growth Disorders**
(This benefit subject to Certificate Deductible and Coinsurance)
Maximum lifetime benefit we will pay,
per Covered Dependent child ..... [$15,000]

OPTIONAL RIDERS

[Accident Expense Benefit
Maximum amount we pay for this benefit, per Covered Person,
per Calendar Year:..... [$500/$1,000/$1,500/$2,000/
$2,500/$3,000/$5,000]]

[Accidental Death Benefit
Maximum amount we pay for this benefit..... [$00000]]

[Convalescent Care Benefit (Short Term)
(This benefit subject to Certificate Deductible and Coinsurance)
Maximum Benefit Period
(number of days per Calendar Year for which we pay benefit): ..... [XX days]
Elimination Period:..... [XX days]
Daily Benefit Amount
(maximum amount per day we pay for this benefit): ..... [$00]]

[Critical Illness Benefit
Critical Illness Maximum Lifetime Benefit..... [$25,000]

Specified Critical Illness and Specified Surgeries	Percentage of Critical Illness Maximum Benefit Payable
Angioplasty	[10%]
Blindness	[100%]
Coronary Artery Bypass Surgery	[25%]
End Stage Renal Failure	[100%]
Heart Attack	[100%]
Life-Threatening Cancer	[100%]
Loss of Limbs	[100%]
Major Organ Transplant Surgery	[100%]
Multiple Sclerosis	[100%]
Permanent Paralysis	[100%]
Stroke	[100%]]

[Decreasing Deductible
First Certificate Year Decrease ..... [$000]
Second Certificate Year Decrease ..... [$000]]

[Maternity Expense Benefit
Maternity Waiting Period..... [00 days]
Maternity Benefit Deductible Amount..... [$000]
Maternity Benefit Percentage..... [00%]]

[**Office Visit Benefit**
Maximum benefit amount we pay,
per Covered Person, per visit (after Copayment) ..... [$25/$50/$75/$100/$125]
[Maximum number of visits for which we will pay,
per Covered Person, per Calendar Year: ..... [XX]]
Office Visit Waiting Period:..... [XX months]]

[Premium Discount for Good Health..... Included]

[Refund of Premium for Good Health]

Consecutive Calendar Years	Specified Percentage
First	[5%]
Second	[10%]
Third and thereafter	[15%]]

[Wellness Benefit

Wellness Services Annual Maximum
Maximum we pay per Covered Person per Calendar Year: ..... [$0000]

[Waiting Period before this benefit is available ..... [None, 6 months, 12 months]]

or

[Wellness Benefit

[Participating Provider
Covered Expenses are subject to the Participating Provider
Calendar Year Deductible and Coinsurance Percentage to: ..... [$500]]

[Nonparticipating Provider
Covered Expenses are subject to the Nonparticipating Provider
Calendar Year Deductible and Coinsurance Percentage]

[Preventive Dental Services ..... [$50/$75/$100 applied against Wellness Benefit Maximum

[Waiting Period before this benefit is available ..... [None, 6 months, 12 months]]

[Term Life Insurance Rider]

Life Insurance Benefit Amount

Insured	[$15,000/$25,000…]
Covered Dependent	[$7,500/$12,500
Covered Dependent Child - 14 days to 6 months old	[$250/$500]
Covered Dependent Child – 6 months to 18 years old	[$1,000/$2,000]

Persons named here are covered under the rider:

[Insured	Name]
[Covered Dependent]	Name]
[Covered Dependent Child/Children]	Child Name 1]
	[Child Name 2]
	[Child Name 3, etc.]

[

SCHEDULE OF BENEFITS
FOR
OUTPATIENT PRESCRIPTION DRUG BENEFIT

SECTION 1. Maximum Benefits

[Amounts we pay for Outpatient Prescription Drugs and Specialty Medications apply toward the Certificate's Calendar Year Maximum.]

or

[Amounts we pay for Outpatient Prescription Drugs and Specialty Medications apply toward the Certificate's Maximum Lifetime Benefit.]

SECTION 2. Your Out-of-Pocket Expenses

Prescription Drugs and Specialty Medications are subject to the Certificate's applicable Deductible and Coinsurance Percentage.

SECTION 3. Our Maximum Obligation for Prescription Drugs

For this benefit, once you have satisfied your certificate's Calendar Year Deductible and Coinsurance percentage, if any, charges for Prescription Drugs and Specialty Medications will be covered, during the same Calendar Year, according to the provisions of your certificate.]

[

SCHEDULE OF BENEFITS
FOR
OUTPATIENT PRESCRIPTION DRUG BENEFIT
(Generic Drugs Only)

SECTION 1. Maximum Benefits

Prescription Drug Maximum
[Maximum amount we will pay for Outpatient Prescription Drugs, per Covered Person, per Calendar Year: ..... [$0000]

or [Amounts we pay for Outpatient Prescription Drugs apply toward the Certificate's Calendar Year Maximum.]

or [Amounts we pay for Outpatient Prescription Drugs apply toward the Certificate's Maximum Lifetime Benefit.]

SECTION 2. Your Out-of-Pocket Expenses

For Outpatient Prescription Drugs, you are responsible for one of (or a combination of) the following amounts before we have any obligation to pay benefits.

Prescription Drug Deductible
[Amount of Covered Expenses each Covered Person must pay for Outpatient Prescription Drugs in a Calendar Year: ..... $100/$200/$300/$400/$500]
or
..... [This deductible does not apply to your certificate.]

Then

[Prescription Drug Copayment (and/or Prescription Drug Percentage)
Amount of Covered Expenses each Covered Person must pay to the pharmacy each time a Generic Drug prescription is filled or refilled before we pay benefits.
You pay the higher of: ..... [$10] Prescription Drug Copayment or [20%] Prescription Drug Percentage]

SECTION 3. Our Maximum Obligation for Prescription Drugs

For this benefit, we will pay 100% of Covered Prescription Expenses after applying the Prescription Drug Deductible, if any, and Prescription Drug Copayment [and/or Prescription Drug Percentage], if any, up to the Prescription Drug Maximum.]

[

SCHEDULE OF BENEFITS
FOR
OUTPATIENT PRESCRIPTION DRUG BENEFIT
(Generic Drugs and Specialty Medications)

SECTION 1. Maximum Benefits

Prescription Drug Maximum
[Maximum amount we will pay for Outpatient Prescription Drugs, per Covered Person, per Calendar Year: ..... [$0000]

or [Amounts we pay for Outpatient Prescription Drugs apply toward the Certificate's Calendar Year Maximum.]

or [Amounts we pay for Outpatient Prescription Drugs apply toward the Certificate's Maximum Lifetime Benefit.]

Section 2. Your Out-of-Pocket Expenses

For Outpatient Prescription Drugs, you are responsible for one of (or a combination of) the following amounts before we have any obligation to pay benefits.

Prescription Drug Deductible

Generic Prescription Drugs
[Amount of Covered Expenses each Covered Person must pay for Outpatient Prescription Drugs in a Calendar Year: ..... $100/$200/$300/$400/$500]
or
..... [This deductible does not apply to your certificate.]

Specialty Medications
Specialty Medications are subject to the **Certificate's** Deductible and Coinsurance Percentage.

[Prescription Drug Copayment (and/or Prescription Drug Percentage)

Generic Prescription Drugs
Amount of Covered Expenses each Covered Person must pay to the pharmacy each time a Generic Drug prescription is filled or refilled before we pay benefits.
You pay the higher of: ..... [$10] Prescription Drug Copayment or [20%] Prescription Drug Percentage]
or ..... [This copayment and/or percentage does not apply to your certificate.]

Specialty Medications
Specialty Medications are subject to the **Certificate's** Deductible and Coinsurance Percentage.

SECTION 3. Our Maximum Obligation for Prescription Drugs

Generic Prescription Drugs
For this benefit, we will pay 100% of Covered Prescription Expenses after applying the Prescription Drug Deductible, if any, and Prescription Drug Copayment [and/or Prescription Drug Percentage], if any, up to the Prescription Drug Maximum.

Specialty Medications
For this benefit, once you have satisfied your Certificate's Calendar Year Deductible and Coinsurance Percentage, charges for Specialty Medications will be covered, during the same Calendar Year, according to the provisions of your Certificate. Amounts we pay for this benefit are applied toward the Certificate's Maximum Lifetime Benefit.]

[

SCHEDULE OF BENEFITS
FOR
OUTPATIENT PRESCRIPTION DRUG BENEFIT
(3-Tier and Specialty Medications)

SECTION 1. Maximum Benefits

Prescription Drug Maximum

[Maximum amount we will pay for
Generic Prescription Drugs per Covered Person,
per Calendar Year: .....[None]

Brand Name Formulary/Brand Name Nonformulary
Prescription Drugs, per Covered Person,
per Calendar Year: .....[NA/$500, NA/$1,000, NA/$2000]]

or [Amounts we pay for Outpatient Prescription Drugs apply toward the Certificate's Calendar Year Maximum.]

or [Amounts we pay for Outpatient Prescription Drugs apply toward the Certificate's Maximum Lifetime Benefit.]

SECTION 2. Your Out-of-Pocket Expenses

For Outpatient Prescription Drugs, you are responsible for one of (or a combination of) the following amounts before we have any obligation to pay benefits.

Prescription Drug Deductible

[Amount of Covered Expenses each Covered Person must pay
in a Calendar Year:

Generic Prescription Drugs.....[$0]
Brand Name Formulary/Nonformulary Prescription Drugs .....[$0/$200, $0/$500, $250, $500, $1000]

or
.....[This deductible does not apply to your Certificate.]

Deductible for Specialty Medications

Specialty Medications are subject to the **Certificate's** Deductible and Coinsurance Percentage.

Then

[**Prescription Drug Copayment (and/or Prescription Drug Percentage)**

Amount of covered Expenses each Covered Person must pay
to the pharmacy each time a Prescription Drug is filled or refilled
before we pay benefits.

Tier 1

For Generic Prescription Drugs you pay the higher of:.....[$10] Prescription Drug Copayment or [20% Prescription Drug Percentage]

Tier 2

For Brand Name Formulary Prescription Drugs you pay the higher of: .....[$20] Prescription Drug Copayment or [50% Prescription Drug percentage]

Tier 3

For Brand Name Nonformulary Prescription Drugs you pay the higher of: .....[$30] Prescription Drug Copayment or [50% Prescription Drug Percentage]]

Section I. Definitions

Terms and provisions used at various points in your Certificate are defined in this section. The presence of a particular definition below does not necessarily mean that the term applies to your coverage. Certain definitions below may not apply to you because of the benefit selections you made when applying for this coverage. "You" and "your" as used in this Certificate refers to each person shown on the Validation of Coverage page as a "Covered Person". "We" and "Our" refers to the insurance company issuing this Certificate.

Access Fee: An Access Fee is the dollar amount that you must pay each time you receive certain Treatments, services and supplies. The Access Fee is subtracted from Covered Expenses before applying any Deductible or Coinsurance Percentage. An Access Fee will not be reimbursed by us nor does it count toward satisfying any Deductible, Coinsurance Percentage or other out-of-pocket limit. The Access Fee may be waived in certain situations. The primary difference between a Copayment (Copay) and an Access Fee is that: (a) when a Copay applies, Covered Expenses are not subject to Deductible and Coinsurance after you have paid the Copay; (b) when an Access Fee applies, Covered Expenses are subject to Deductible and Coinsurance Percentage after you have paid the Access Fee. Please refer to your Schedule of Benefits to determine if Access Fees apply to your coverage and, if so, the amount(s) of the Access Fees.

Acute Rehabilitation: A coordinated multidisciplinary physical restorative Treatment provided to Inpatients under the direction of a Physician.

Acute Rehabilitation Facility: A specialized Hospital or unit of a Hospital providing Acute Rehabilitation Treatment. Beds must be set up and staffed in a unit specifically designed for rehabilitation.

Age: Your age as of your most recent birthday.

Application: The form(s) used to apply for this Certificate that provides us with the relevant information upon which we rely in making our determination of whether to issue or amend a Certificate. The Application becomes part of your Certificate.

Benefit Maximums: The maximum amount of benefits allowable for a Covered Expense. The Benefit Maximums, if any, are shown on the Schedule of Benefits.

Benefit Percentage: The percentage of Covered Expenses we will pay:

1. after you have paid the Copayment and/or Access Fee, if any; and
2. after the Deductible has been satisfied.

The Benefit Percentage is shown on the Schedule of Benefits.

Calendar Year: A Calendar Year begins on January 1st and ends on December 31st of the same year.

Center of Excellence (COE): A COE is a Hospital that specializes in a specific type or types of transplants. The COE also has agreed, through a transplant network as designated by us, to provide quality care on a cost efficient basis.

Coinsurance Percentage: The percentage of Covered Expenses you must pay:

1. after you have paid the Copayment and/or Access Fee, if any; and
2. after the Deductible has been satisfied.

The Coinsurance Percentage is shown on the Schedule of Benefits.

Complications of Pregnancy:

1. Complications of Pregnancy include any of the following:
    a. Conditions (when the pregnancy is not terminated) that are caused by pregnancy, or are distinct from pregnancy but adversely affected by pregnancy, including, but not limited to:

(1) Severe dehydration requiring intravenous (IV) therapy;

(2) Acute nephritis or nephrosis;

(3) Cardiac decompensation;

(4) Premature labor or threatened abortion;

(5) Preeclampsia and eclampsia; and

(6) Abruptio placentae or placenta previa.

b. Emergency cesarean section;

c. Termination of ectopic pregnancy; and

d. Spontaneous termination of pregnancy occurring during a period of gestation in which a live birth is not possible.

2. The term Complications of Pregnancy does not include any of the following:

a. Nonemergency cesarean sections including, but not limited to, either or both of the following:

(1) Cesarean sections that don't satisfy the definition of "Emergency Care" under this Certificate; and/or

(2) Cesarean sections that are merely for the convenience of the patient or solely due to a previous cesarean section.

b. Conditions associated with the management of a difficult pregnancy including, but not limited to, any one or more of the following:

(1) Postpartum bleeding unless it requires Confinement in a Hospital beyond the normal period of Confinement for a normal childbirth;

(2) Morning sickness;

(3) Occasional spotting; and/or

(4) False labor.

c. Normal deliveries and associated services, even if the deliveries and associated services follow Complications of Pregnancy.

Confined or Confinement: A Hospital stay as a registered Inpatient because of Illness or Injury. The stay must last for a period of at least 12 consecutive hours. A Physician must recommend and supervise the stay.

Copayment (or Copay): A dollar amount that you must pay to the health care Provider each time certain visits take place or certain services are provided. Copayment amounts are shown on the Schedule of Benefits. A Copayment does not count toward satisfying the Deductible, Coinsurance Percentage, or the out-of-pocket limit.

Covered Dependent: A person:

1. Who meets the definition of a Dependent; and
2. For whom premiums are paid under this Certificate; and
3. Who is eligible to receive benefits under this Certificate.

Covered Expenses: Medical expenses you Incur for services that are all of the following:

1. The result of an Illness or Injury;
2. Ordered by a Provider;
3. Usual and Customary for the Treatment;

4. Medically Necessary;
5. Not Preexisting as defined by this Certificate; and
6. Not excluded elsewhere in this Certificate.

Covered Member: A person who is all of the following:

1. A Member with the Policyholder;
2. At least 16 years of age;
3. Approved by us for coverage under the terms of this Certificate and for whom premiums are paid; and
4. Named as a "Covered Member" on the Validation of Coverage page.

Covered Person: A Covered Member and/or Covered Dependent, as approved by us or as added to coverage by endorsement. If coverage is terminated, the person is no longer a Covered Person.

Custodial Care: Custodial Care means nonhealth-related services. Custodial Care includes assistance in activities of daily living or health-related services that: (a) do not seek to cure; or (b) are provided during periods when the medical condition of the patient is not changing; or (c) do not require continued administration by trained medical personnel. Examples of activities of daily living include, but are not limited to:

1. Bathing;
2. Getting dressed;
3. Eating;
4. Getting in and out of bed or a chair;
5. Getting to and back from the restroom; and
6. Administering oral medications or eye drops.

Deductible: Deductibles are amounts that you and/or a Covered Person must pay during a Calendar Year for Covered Expenses before benefits will be payable under this Certificate. [Separate Deductibles may be charged for Participating and Nonparticipating Providers.] All applicable Deductibles will be shown on your Schedule of Benefits.

One or more of the following Deductibles may apply to your Certificate:

1. **Individual Deductible:** An Individual Deductible is the dollar amount of Covered Expenses that each Covered Person must satisfy before benefits will be payable by us. When Covered Expenses equal to the Individual Deductible have been Incurred and processed by us, the Individual Deductible for that Covered Person will be satisfied for the remainder of the Calendar Year.
2. **Family Deductible:** Your Family Deductible will be one of the following:
   a. **Standard Family Deductible:** When the designated number of Covered Persons (as shown on the Schedule of Benefits) have each satisfied the Individual Deductible (per Covered Person) in any given Calendar Year, no further Deductibles will apply for the remainder of that Calendar Year.
   b. **Family Aggregate Deductible for Qualified High Deductible Health Plan**: If you have a Qualified High Deductible Health Plan certificate, you will have only one aggregate Deductible. Covered Expenses Incurred by all Covered Persons count toward satisfying the one aggregate Deductible. When Covered Expenses equal to the Family Aggregate Deductible have been Incurred and processed by us, the Family Aggregate Deductible for all Covered Persons will be satisfied for the remainder of the Calendar Year.

3. **Common Accident Deductible:** If two or more Covered Persons insured under the same Certificate Incur Covered Expenses due to injuries in the same accident, only one Deductible will be applied to all eligible charges Incurred as a result of such accident during the Calendar Year the accident occurs.

Other information about your Deductible(s) is shown in your Schedule of Benefits.

Dependent: A Dependent can be any of the following:

1. Your spouse under the age of 65 if said spouse is not legally separated from you;
2. Your domestic partner who is under the age of 65;
3. Someone with whom you have a civil union who is under the age of 65;
4. Your unmarried child under age 19, including:
   a. Your biological child; or
   b. Your legally adopted child or a child Placed for Adoption; or
   c. A stepchild who permanently resides with you; or
   d. A grandchild for whom you are legal guardian.
5. The term Dependent also will include your unmarried child age 19 or older who is:
   a. Incapable of self-sustaining employment because of the child's disability (including mental retardation, mental illness or disorder, or physical handicap). In order to be considered in this category, you must furnish proof of the child's incapacity within 31 days of the date insurance would have otherwise terminated due to age. We may require proof of continued incapacity each year after the first two-year period that insurance has been extended;
   b. Fully dependent on you or other care providers for lifetime care and supervision. "Other care providers" means a community-integrated living arrangement, group home, supervised apartment, or other residential service licensed or certified by the Department of Human Services, the Department of Health, or the Department of Public Aide; and
   c. Insured on the date immediately preceding the day the insurance would have terminated due to age.
6. Your unmarried child who is:
   a. Age 19 or older but under the age of 27; and
   b. Enrolled as a full-time student in an accredited school; and
   c. Financially dependent on you.

Durable Medical Equipment and Personal Medical Equipment: Durable Medical Equipment and Personal Medical Equipment are the Medically Necessary apparatus needed for therapeutic use. Such apparatus must satisfy all of the following:

1. Be for the Medically Necessary care and Treatment of a covered Illness or Injury;
2. Be able to withstand repeated use;
3. Be primarily designated for medical purposes (not personal comfort or convenience);
4. Not be useful in the absence of Illness or Injury;
5. Be ordered by a Physician; and
6. Be Basic equipment. "Basic" means the most cost effective equipment that will meet the particular medical need.

Emergency Care: Treatment required immediately for a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson could reasonably expect the absence of immediate medical attention to result in:

1. Placing his or her health in serious jeopardy;
2. Serious impairment to bodily function; or
3. Serious dysfunction of any bodily organ or part.

Without limiting the foregoing, Treatment that is scheduled with a Physician more than 24 hours before the Treatment is to be provided is not considered Emergency Care for the purposes of this Certificate.

Evidence of Insurability: Satisfactory proof, as determined by us, that a person is acceptable for this insurance coverage.

Experimental/Investigational: A drug, device, procedure or Treatment will be considered Experimental or Investigational if any of the following exist:

1. Approval required by the FDA or another appropriate government agency has not been granted for marketing;
2. Recognized national medical specialty societies or governmental agencies have determined, in writing, that it is experimental, investigational or for research purposes;
3. It is a drug, device or Treatment that is the subject of a Phase I or Phase II clinical trial or the experimental or research arm of a Phase III clinical trial. The "phases" are those identified in regulations and other official actions and publications of the FDA and Department of Health and Human Services;
4. The written protocol or protocols that the treating facility uses, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or Treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or Treatment states that it is experimental, investigational or for research purposes;
5. Completed randomized Phase III Clinical Trials have not proven the relative effectiveness of the Treatment to be as good as or better than standard therapy or no therapy; and/or
6. There is insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the Illness or Injury involved.

Home Health Care Agency: An agency that has been:

1. Certified under Medicare as a Home Health Care Agency; or
2. Licensed by the proper state authority as a Home Health Care Agency.

Home Health Care Services: Medically Necessary services that a Home Health Care Agency provides to you. Such noncustodial services must be all of the following:

1. Part of a written home health care plan that a Physician orders for you;
2. Received while not Confined in a Hospital or Skilled Care Facility; and
3. Provided in lieu of Hospital or skilled care Confinement.

Home Health Care Services are limited to:

1. Nursing care provided by a registered nurse (RN); or Licensed practical nurse (LPN); and
2. Physical or speech therapy provided by a licensed therapist.

Home Health Care Services also can include services provided by a home health aide in conjunction with the services of an RN, LPN, physical therapist or speech therapist.

Home Health Care Visit: A Home Health Care Visit is up to four consecutive hours of Home Health Care Services in a 24-hour period. If a Home Health Care Visit extends beyond four hours, each additional four-hour increment into which that Home Health Care Visit extends will be considered an additional Home Health Care Visit.

Hospice: An organization that provides medical services in an Inpatient, Outpatient or home setting to support and care for persons who are terminally ill with a life expectancy of 6 months or less as certified by a Physician. A Hospice must meet all of the following requirements:

1. Comply with all state licensing requirements;
2. Be Medicare certified and/or accredited by the Joint Commission on Accreditation of Healthcare Organizations; and
3. Provide a Treatment plan and services under the direction of a Physician.

Hospice Facility: An organization that meets the definition of Hospice and, in addition, satisfies all of the following additional requirements:

1. Be a dedicated unit within a Skilled Care Facility or a separate facility that provides Hospice services on an Inpatient basis;
2. Be licensed to provide Inpatient Hospice services by the state in which the services are rendered;
3. Be staffed by an on-call Physician 24 hours per day;
4. Provide nursing services supervised by an on duty registered nurse 24 hours per day;
5. Maintain daily clinical records;
6. Admit patients who have a terminal illness; and
7. Not provide patients with services that involve active intervention for the terminal illness although ongoing care for comorbid conditions and palliative care for the terminal illness may be provided.

Hospice Treatment Program: A formal program to care for a terminally ill person. The program primarily will provide home care services. The program also may be provided through Confinement in a Hospice Facility.

Hospital: An institution that satisfies all of the following:

1. It provides Inpatient Treatment;
2. It is licensed as a Hospital by the proper state authority;
3. At a minimum, the services it provides must include services for emergencies, clinical laboratory, diagnostic x-ray and surgery;
4. It provides 24-hour nursing services under the supervision of a registered nurse (RN);
5. It is supervised by a staff of one or more Physicians; and
6. It maintains access to patient medical records on its premises.

The following are not considered Hospitals:

1. Skilled Care Facilities;
2. Assisted living facilities;
3. A facility that is primarily for the Treatment of substance abuse, although such services may be provided in a distinct section of a Hospital; and
4. Extended care or convalescent sections of a Hospital.

Illness: A sickness or disease, including all related conditions, symptoms, and occurrences, requiring medical Treatment. Illness does not include:

1. The presence or absence of a family history of a particular Illness; or
2. A genetic predisposition for the development of a future disease or Illness.

Immediate Family: The term Immediate Family includes all of the following:

1. You;
2. Your spouse;
3. The children, brothers, sisters, and parents of either you or your spouse; and
4. The spouses of children, brothers, and sisters of either you or your spouse.

Incur or Incurred: The date Treatment, services and/or supplies are provided or received.

In Force: The period of time we insure you. This Certificate is "In Force" as long as all premiums are paid when due and this Certificate has not been terminated (either voluntarily or involuntarily).

Injury: Accidental bodily damage, independent of disease or bodily infirmity, occurring unexpectedly and unintentionally. This Certificate must be In Force at the time of the Injury.

Inpatient: A person who is Confined and receives services and Treatment in a Hospital, Skilled Care Facility or Hospice Facility on an Inpatient basis as opposed to services and Treatment provided on an Outpatient basis.

Intoxication: Intoxication means the level of concentration of alcohol in your body that is considered illegal for the purpose of operating a motor vehicle in the state in which the Illness or Injury occurs.

Issue Date: The date coverage under this Certificate begins.

Maximum Lifetime Benefit: The cumulative amount of payments we will make for all Covered Expenses under this Certificate or any extension thereof, for all of your Illnesses and Injuries. Such expenses will never be more than the Maximum Lifetime Benefit that is set forth in the Schedule of Benefits. Regardless of the number of our certificates under which you may be covered over time, there is only one Maximum Lifetime Benefit.

Medical Transportation: Professional air and ground ambulance transportation to a Hospital or Skilled Care Facility in the surrounding area where your Medical Transportation originates. All of the following are required in order to qualify for this benefit:

1. No other method of transportation is appropriate;
2. The services required to treat your Illness or Injury are not available in the facility where you are currently receiving care if you are an Inpatient at a facility; and
3. You are transported to the nearest Hospital or Skilled Care Facility that has facilities that are adequate to treat your medical condition.

Medically Necessary Treatment (Medical Necessity): Medically Necessary Treatment means services or supplies that a Provider, exercising prudent clinical judgment, would provide to a person for the purpose of preventing, evaluating, diagnosing or treating an Illness and/or Injury, and that are all of the following:

1. Commonly accepted as proper care or Treatment of the condition consistent with generally accepted standards of good medical practice or published guidelines in the United States;
2. Not primarily for the personal comfort, social well-being or convenience of you, your family or the Provider, or part of or associated with your scholastic education or vocational training;
3. Clinically appropriate in terms of type, frequency, extent, site and duration and considered safe, adequate, and effective for the patient's Illness and/or Injury;

4. Reasonably expected to result in or contribute substantially to the improvement of a condition resulting from an Illness or Injury;
5. Not Experimental or Investigational in nature or otherwise limited by exclusions and limitations found elsewhere in this Certificate.

The fact that a Provider may prescribe, order, recommend or approve a Treatment, service or supply does not, of itself, make the Treatment, service or supply Medically Necessary for the purpose of determining eligibility for coverage under this Certificate.

Medicare: The provisions of Title XVIII of the Federal Social Security Act, as amended, or any federal law that replaces the foregoing Act.

Member: A person who has a membership with the Policyholder and is at least 16 years of age.

Mental or Nervous Disorders: Conditions listed in the Diagnostic and Statistical Manual of Mental Disorders, DSM IV, or current edition.

Never Event: Means a significant error that occurs in a Provider's delivery or failure to deliver medical services. The event must be identifiable and preventable. In determining whether an event is a "Never Event," we will take into consideration the complexity of the particular service and the fact that certain medical events are not always avoidable.

Other Insurance: A plan that provides insurance, reimbursement, or service benefits for hospital, surgical or medical expenses. The term "Other Insurance" includes coverage under any one of, or combination of, the following:

1. Individual or group insurance policies;
2. Group insurance certificates;
3. Nonprofit health service plans;
4. Health Maintenance Organization (HMO) subscriber contracts;
5. Preferred Provider Organization (PPO) subscriber contracts;
6. Self-insured group plans;
7. First-party medical expense coverage under automobile insurance;
8. Prepayment plans;
9. Medicare; and/or
10. Any state or federal mandated health insurance plan.

Outpatient: Services and Treatment provided to you on an Outpatient basis by a Hospital, Skilled Care Facility, Hospice, or other Outpatient Facility as opposed to Confinement as an Inpatient.

Outpatient Facility: An Outpatient department of a Hospital, an ambulatory surgical facility, or an Urgent Care center that is operated in accordance with the laws of the state in which it is located. In order to be considered an Outpatient Facility in this Certificate, the facility also must be licensed for the primary purpose of diagnosing and treating Illness or Injury on an Outpatient basis.

Physician: A person who:

1. Is a qualified doctor and/or surgeon licensed to practice, so long as the service provided or to be provided is within the scope of the license as a Medical Doctor (MD) or Doctor of Osteopathic Medicine (DO); and
2. Is not a member of your Immediate Family.

Placed for Adoption: For the purposes of this Certificate, the moment a child is "Placed for Adoption" with a person is the moment at which the person adopting the child assumes and retains a legal obligation to totally or partially support such child in anticipation of the adoption of such child. The child's "placement" with the person terminates upon the termination of such legal obligation.

Policyholder: The entity to which the Master Policy has been issued.

Preexisting Condition: A condition:

1. For which medical advice was given or Treatment was recommended by a Physician within a 12-month period prior to the Issue Date of coverage for that Covered Person; or
2. For which prescription medication was taken within a 12-month period prior to the Issue date of coverage for that Covered Person.

A pregnancy that exists on the day before the Covered Person's Issue Date of coverage will be considered a Preexisting Condition.

Provider: A person or facility licensed by the state to treat or provide supplies for the kind of Illness or Injury for which a claim is made. A Provider must be practicing within the scope of their license and in the geographic area in which they are licensed. A Provider cannot be a member of your Immediate Family.

Rehabilitative Treatment: Treatment for purposes of restoring bodily function and independence that has been lost due to Illness or Injury. Care ceases to be considered "rehabilitative" when either:

1. You can perform the activities of daily living of someone of the same age and gender; or
2. You have reached maximum therapeutic benefit and further Treatment cannot reasonably be expected to restore bodily function beyond the current level of bodily function.

Room and Board Expenses: Charges from a Hospital or Skilled Care Facility for the room, meals, and nursing services it has provided to an Inpatient.

Skilled Care Facility: A facility that provides continuous skilled nursing services on an Inpatient basis for persons recovering from an Illness or an Injury. The facility must meet all of the following requirements:

1. Be licensed by the state to provide skilled nursing services;
2. Be staffed by an on-call Physician 24 hours per day;
3. Provide skilled nursing services supervised by an on duty registered nurse 24 hours per day;
4. Maintain daily clinical records; and
5. Not primarily be a place for rest, Custodial Care, or the Treatment of substance abuse, although any of the foregoing services may be provided in a distinct section of the same physical facility.

Total Disability or Totally Disabled: For the purposes of this Certificate, you have a Total Disability when, as a direct result of Illness or Injury:

1. You are unable to perform the essential and material activities of a person of like age and gender who is in good health; and
2. The Social Security Administration has made a formal determination that you are disabled.

Treatment: Any and all forms of care including, but not limited to, medical or surgical care, advice, consultation, diagnosis, cure, mitigation or prevention of disease, drugs (prescribed or nonprescribed), examination, observation, services, or testing. Treatment also includes equipment, devices and supplies that are Medically Necessary.

Urgent Care: Treatment or services provided for an Illness or an Injury that:

1. Develops suddenly and unexpectedly outside of a Physician's normal business hours; and
2. Requires immediate Treatment, but is not of sufficient severity to require Emergency Care.

Usual and Customary Allowance: The Usual and Customary Allowance is the amount determined to be eligible for any service, supply or Treatment in a geographic region. We will consider the lesser of the Provider's billed charge, the negotiated contractual amount agreed upon with the Participating Provider organization, or the Usual and Customary Allowance. We determine the Usual and Customary Allowance using payment methodologies that may include, but are not limited to, one or more of the following:

1. Negotiated Payment Arrangements made directly or indirectly between health care Providers and insurers;
2. The reimbursement made by Medicare for similar services, supplies or Treatment;
3. Charging protocols and billing practices generally accepted by the medical community;
4. The amount we would have paid to a Participating Provider in the same geographic region for the same or similar services;
5. Proprietary or commercially available fee or reimbursement data;
6. The expected or estimated charges of facilities of a similar type and/or in the same geographic area, when providing the same or similar goods and services defined by Current Procedural Terminology (CPT) codes or Healthcare Common Procedure Coding System (HCPCS) codes, or grouping of services as determined through standard Diagnosis-Related Group (DRG), refined DRG or other standard industry methodologies;
7. The amount derived by applying comparable markups from facilities of a similar type and/or in the same geographic area, to the estimated costs of the facility providing the goods and services reported on the claim, established utilizing the facility's most recently available cost reports submitted to The Centers for Medicare and Medicaid Services (CMS); and/or
8. In addition to the above methodologies, if you have a Prescription Rider that covers specialty medications, we may consider the Average Wholesale Price, Average Sales Price and/or other nationally recognized drug cost basis used by nationally contracted vendors.

We reserve the right to change our payment methodologies, update pricing profiles, and modify factors we use to calculate the Usual and Customary Allowance. Amounts billed in excess of the Usual and Customary Allowance by or on behalf of a Provider are not considered eligible expenses under this Certificate.

Negotiated Payment Arrangement: The dollar amount agreed to either directly or indirectly by a Provider as the total allowed amount for medical procedures, services and supplies.

Nonparticipating Provider: A Provider of health care services or supplies who has not agreed to participate in our Preferred Provider Network.

Participating Provider: A Provider of health care services or supplies who has agreed to participate in the network shown on your insurance identification card.

Preferred Provider Network: A selected network of Physicians, Hospitals, and other Providers. These Providers have an agreement with us to deliver health care services at negotiated prices.

Section II. Benefit Provisions

A. General Benefit Provisions

Payment of Benefits

Benefits will be paid if you Incur Covered Expenses during the Calendar Year that exceed any Deductible, Coinsurance Percentage, Copayment amounts and Access Fees (if any) that may apply as set forth on the Schedule of Benefits.

Determination of Benefits

Benefits will be determined by multiplying the Benefit Percentage times the amount of Covered Expenses that exceed:

1. The Deductible (and Copayments and Access Fees, if any); and
2. Any amount payable under any other benefit provision of this Certificate. If a service or Treatment is payable under more than one provision of this Certificate, the expenses will be considered under the provision that provides the higher benefit.

Out-of-Pocket Limit

The amount each Covered Person can be obligated to pay for Covered Expenses per Calendar Year. Expenses in excess of a specific dollar limit for any of the following cannot be used to satisfy any Benefit Percentage amount requirement or to meet the out-of-pocket limit:

1. Specific Benefit Provisions;
2. Covered Expenses Subject to Limitations provision;
3. Copayment amounts, if any, as shown in the Schedule of Benefits;
4. Penalties under the Utilization Review provision; or
5. Access Fees.

Your Benefits under this Certificate are not available to pay for Covered Expenses that are applied toward satisfying a Deductible, your Coinsurance Percentage, Copayment amount or Access Fee, if applicable. Such expenses are your responsibility.

Covered Expenses

The following are Covered Expenses under this Certificate:

1. Inpatient Hospital Confinement:
   a. Hospital daily Room and Board Expenses not to exceed the usual and customary semiprivate room charge of the Hospital.
   b. Other Medically Necessary Hospital services and supplies.
2. Anesthetics and their administration (includes the services of a certified nurse anesthetist).
3. Medical services and supplies furnished by an Outpatient department of a Hospital or an ambulatory surgical facility.
4. Medically Necessary services provided by a Provider.
5. Treatment in an Urgent Care facility licensed to provide Urgent Care.
6. Other Covered Expenses:
   a. Laboratory tests;

b. Radiologic exams and other diagnostic services (including but not limited to: x-rays; Positron Emission Tomography (PET); computerized transverse tomography (CAT scans); and magnetic resonance imaging (MRI)).

c. Radiation therapy and chemotherapy Treatment.

d. Medical Transportation within the 48 contiguous states. Air ambulance service must be:

   i. Required to transport the Covered Person to the nearest Hospital that provides the special medical Treatment not available in the immediate area; and

   ii. Ordered by a Physician; and

   iii. An aircraft used primarily for transporting ill and injured persons to the nearest Hospital providing the Medically Necessary Treatment.

   Air ambulance benefits are limited to the amount and terms set forth on the Schedule of Benefits.

e. Breast Reconstruction. Prosthetic devices or reconstructive surgery following the surgical procedure mastectomy. Coverage for prosthetic devices and reconstructive surgery is subject to the same Deductible and coinsurance applicable to the mastectomy and all other terms and conditions of this Certificate. Breast reconstruction following a Medically Necessary mastectomy will be provided in a manner determined in consultation with the attending Physician and the Covered Person, and will include:

   (1) Reconstruction of the breast on which the mastectomy has been performed;

   (2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

   (3) Expenses for physical complications from all stages of a mastectomy, including lymphedema. For the purposes of this provision, “mastectomy” means the removal of all or part of the breast for Medically Necessary reasons as determined by a Physician.

B. Covered Expenses Subject to Limitations

All Covered Expenses referenced in this provision are subject to the applicable Deductibles, Benefit Percentages (amounts), Benefit Maximums and Calendar Year or Lifetime Maximums, as set forth on the Schedule of Benefits. However, the Covered Expenses referenced in this provision are not subject to the office visit Copayments (if any) or any Access Fees. Expenses that exceed the Benefit Maximums shown on the Schedule of Benefits:

1. Will not be considered Covered Expenses under this Certificate; and
2. Will not apply to the out-of-pocket Covered Expense limit.

The following expenses are also subject to any applicable limitations set forth in the General Exclusions and Limitations Section.

Emergency Foreign Travel Benefit

We will pay the Benefit Percentage of the Covered Expenses Incurred for emergency Hospital, Physician, and medical care that you receive outside the United States. This benefit is subject to all of the following limitations and requirements:

1. Benefits are payable only for care that would be covered as Emergency Care under this Certificate had the care been provided in the United States;
2. Benefits are limited to care beginning during the first 60 consecutive days of each trip outside the United States;

3. An English language translation of the claims, medical records and proof of loss must be received by us. You are responsible for obtaining this information at your expense;
4. Benefits are not payable under this provision in a foreign country where travel warnings, issued by a state in the United States and/or by a United States federal governmental agency, exist for visitors from the United States at the time the services are received; and
5. Benefits are not payable under this provision if one of the purposes for traveling outside of the United States is to obtain medical care.

Home Health Care

Home Health Care must be provided by a Home Health Care Agency. Benefits under this provision are limited to the number of Home Health Care Visits per Calendar Year that are shown on the Schedule of Benefits. Such care must be provided pursuant to a written plan of Treatment ordered by a Physician and be in lieu of Hospital Confinement.

Hospice Treatment and Services

Hospice Treatment and Services, whether on an Inpatient or Outpatient basis, that are provided pursuant to a Hospice Treatment Program approved by us. Such Treatment and services must be provided within six months from the date you entered or reentered the Hospice Treatment Program or a Hospice Facility, as defined in this Certificate.

Benefits under this provision are subject to all of the following requirements and limitations:

1. The attending Physician must certify that you have a terminal illness and life expectancy of six months or less;
2. We will determine your eligibility for the Hospice Treatment and Services benefits and we also will administer your benefits; and
3. All Covered Expenses for this benefit must be billed by the Hospice Treatment Program or the approved Hospice Care Provider, and the Covered Expenses will be subject to all the terms of this Certificate. This benefit will be paid for Covered Expenses actually Incurred, not to exceed the Benefit Maximums set forth on the Schedule of Benefits.

Outpatient Occupational, Physical and Speech Therapy

Benefits will be paid for Covered Expenses per Covered Person per Calendar Year for each type of therapy combined, not to exceed the Benefit Maximums shown on the Schedule of Benefits. This benefit is subject to the following requirements and limitations:

1. Occupational, Physical or Speech Therapy must be ordered by a Physician, and such therapy must be directly related to and begin within six months following Illness, Injury or surgery;
2. We must determine that the occupational, physical or speech therapy is Medically Necessary prior to the beginning of any Treatment;
3. Therapy under this benefit must be performed by a licensed occupational, physical or speech therapist and be under the supervision of a Physician; and
4. Benefits under this provision will cease when measurable and significant progress toward expected and reasonable outcomes has been achieved or the results have plateaued.

Covered Expenses under this provision do not include Treatment of a learning disability or developmental delay even though therapy is recommended due to organic dysfunction (including, but not limited to, congenital deformity or birth trauma).

Acute Rehabilitation

Benefits under this provision will be paid for Covered Expenses when you receive Acute Rehabilitation services as an Inpatient at an Acute Rehabilitation Facility. This benefit is subject to all of the following requirements and limitations:

1. You must be Confined in an Acute Rehabilitation Facility;
2. Prior to your Confinement in the Acute Rehabilitation Facility, you must have been Confined in a Hospital or Skilled Care Facility; and
3. Your admission to the Acute Rehabilitation Facility must begin within seven days of discharge from the Hospital or Skilled Care Facility.

Skilled Care Facility Benefit

Benefits under this provision will be paid for Covered Expenses you Incur while you are an Inpatient at a Skilled Care Facility. These benefits are subject to all of the following requirements and limitations:

1. You must be an Inpatient at a Skilled Care Facility;
2. Admission to the Skilled Care Facility must begin within fourteen days of discharge from a Hospital;
3. The attending Physician must certify the Confinement as being Medically Necessary for your care and Treatment if you are Totally Disabled and if you otherwise would have been Confined to a bed in a Hospital; and
4. Confinement must be under the direct care of a Physician.

Durable Medical Equipment and Personal Medical Equipment Benefit

Rental or purchase, whichever is most cost effective, of the following items when prescribed by a Physician:

1. A Basic wheelchair;
2. A Basic Hospital bed; and
3. Basic crutches.

In addition, Durable Medical Equipment and Personal Medical Equipment include the following:

1. Orthopedic braces, excluding foot orthotics;
2. The temporary interim and initial permanent basic artificial limb or eye;
3. External breast prostheses needed because of surgical removal of all or part of the breast;
4. Oxygen and the equipment needed for the administration of oxygen; and
5. Other Durable Medical Equipment and supplies that are approved in advance by us.

Observation Room Expense

When you seek Treatment at a Hospital and are placed under observation for more than 24 hours, but are not admitted to the Hospital, we will pay benefits as if you had been admitted as an Inpatient, not to exceed the Hospital's standard semiprivate Room and Board rate.

Spinal Manipulation

Benefits will be paid for spinal manipulation including, but not limited to, manipulation for spinal subluxation and associated Treatment or services within the scope of the Provider’s license, not to exceed the Benefit Maximums shown on the Schedule of Benefits. Benefits under this provision will cease when measurable and significant progress toward an expected and reasonable outcome has been achieved, or the results have reached a plateau.

Sterilization

After you have been insured under this Certificate for a period of 12 consecutive months, benefits will be paid for sterilization. The benefits under this provision will not exceed the Benefit Maximum shown on the Schedule of Benefits.

Treatment of Allergies

Benefits will be paid for allergy testing and allergy injections including, but not limited to, injectable antigens and extracts, not to exceed the Benefit Maximum shown on the Schedule of Benefits.

Treatment of Sleep Apnea

Benefits will be paid for the Treatment of sleep apnea including, but not limited to, sleep study, Durable Medical Equipment (CPAP or BiPAP), and surgery. Benefits under this provision will not exceed the Benefit Maximum shown on the Schedule of Benefits.

Treatment of Growth Disorders

Benefits will be paid for Treatment of a growth disorder or abnormally short stature, including, but not limited to, growth hormone deficiency therapy (GHDT), not to exceed the Benefit Maximum shown on the Schedule of Benefits for each Covered Dependent child.

C. Center of Excellence (COE) Benefit

This section includes information about the non-Experimental and non-Investigational organ/tissue transplants that will be considered Covered Expenses.

Center of Excellence (COE) Transplants

The following are considered COE Transplants under this Certificate:

1. Heart transplant;
2. Heart/lung transplant;
3. Kidney transplant;
4. Liver transplant;
5. Bone marrow and/or stem cell transplant;
6. Kidney-pancreas transplant;
7. Lung transplant (unilateral or bilateral);
8. Pancreas; and
9. Small bowel transplant.

COE Enrollment

Your enrollment at a COE must satisfy all of the following:

1. The Covered Person must contact and work with one of our trained registered nurses to coordinate benefits for transplant services.
2. For us to consider you as a possible candidate for acceptance into the COE for any organ/tissue transplant services or procedure, you or your Physician (or a Physician's staff member) must contact the COE Coordinator to request a transplant evaluation. The decision as to whether or not you will be a transplant candidate in a COE is made by the COE medical staff and will be communicated by the COE Coordinator.

3. If you are denied a transplant procedure by the COE, you will be offered the opportunity to have a second COE evaluate you. If the second COE determines that you are not an acceptable candidate for the proposed organ/tissue transplant procedure, no further coverage under the COE Benefit will be provided for services or supplies that are related to the proposed organ/tissue transplant procedure.

COE Organ/Tissue Transplants

1. If you need an organ/tissue transplant that is a Covered Expense under this Certificate, you may request participation in the COE program. To be considered for a COE transplant, you must agree to use COE Providers for all Treatments related to an organ/tissue transplant in order for the Treatments to be Covered Expenses. The exception to this rule is that you are not required to use COE Providers for routine blood work or Emergency Care needs.
2. If you elect to participate in transplantation at a COE approved by us for the transplant services, Covered Expenses are subject to the limitations set forth in this Certificate. The Maximum Lifetime Benefit payable under the COE Benefit is set forth on the Schedule of Benefits.
3. Any Covered Expenses paid for organ/tissue transplant related expenses shall be cumulative for purposes of determining any maximum benefits under this Certificate.

Covered Expenses

The following Treatments are eligible for the COE Organ/Tissue Transplants benefits under this section:

1. Pretransplant services;
2. Pretransplant harvesting;
3. Pretransplant stabilization. “Pretransplant stabilization” means an Outpatient Treatment or Inpatient stay to medically stabilize the Covered Person for the purpose of, or preparation for, a later transplant, whether or not the transplant occurs;
4. The transplant itself; and
5. Post-transplant care and Treatment for a period of 180 days after the date of the transplant procedure. Such care or Treatment must be provided within 180 days of the date of the transplant.

Covered Expenses under this section also include the following, which will be included in determining the maximum transplant benefits:

1. The costs involved in the procurement of the donor organ;
2. The costs involved in the donor search; and
3. The Hospital expenses of the donor.

In order to be Covered Expenses under this section, the Treatments also must satisfy the definition of “Covered Expenses” set forth in the Definitions Section of this Certificate.

Transplants Not Performed at a COE

1. If you elect not to participate in the COE program or are denied a transplant procedure by the COE, benefits for any Covered Expenses under this section will be paid subject to the following: Covered Expenses for organ/tissue transplants that are neither Experimental nor Investigational Treatment are payable, but not to exceed the Maximum Lifetime Benefit shown on the Schedule of Benefits, per transplant per Covered Person (includes the immediate 180-day post-transplant follow-up).
2. Included within the maximum lifetime allowance for organ/tissue transplant are Covered Expenses for or related to:
   a. Initial testing and diagnostic work-up;
   b. Complications resulting from a transplant surgery or procedure;

c. Complications resulting from organ/tissue rejection or failure;

d. Expenses related to anticipated organ/tissue rejection or failure;

e. Any repeat transplants of the same type of organ/tissue within 180 days of the first transplant;

f. All other Covered Expenses for or related to organ/tissue transplant; and

g. High dose chemotherapy, and/or radiation therapy, done in conjunction with a transplant.

3. Expenses for or related to the transplant of an artificial or animal organ are excluded from coverage.

Transportation and Living Expenses

1. If a COE transplant is performed at a designated COE, we will provide the following as Covered Expenses subject to the Maximum Lifetime Benefit.

   a. The reasonable travel and living expenses Incurred by:

      (1) A live donor, if applicable; and

      (2) You and one companion or, if the Covered Person is a dependent child, two parents.

   b. Round trip transportation to the COE (including round trip coach airfare, train, or other commercial carrier). Reimbursement for transportation in a private auto shall be based on the IRS allowance per mile for medical travel.

   c. The cost of meals and hotel accommodations for you and/or the donor if Treatment is required in an Outpatient setting.

   d. The cost of meals and hotel accommodations for one companion (or two parents if the Covered Person is a dependent child) while accompanying you during hospitalization and Outpatient Treatment.

2. Any benefit payable under this travel and living expense provision shall be subject to our approval for reimbursement.

3. Transportation and living benefits will be limited to the amount shown on the Schedule of Benefits, per covered transplant at a COE

Section II. Benefit Provisions

A. General Benefit Provisions

Payment of Benefits

Benefits will be paid if you Incur Covered Expenses during the Calendar Year that exceed any Deductible, Coinsurance Percentage, Copayment amounts and Access Fees (if any) that may apply as set forth on the Schedule of Benefits.

Determination of Benefits

Benefits will be determined by multiplying the Benefit Percentage times the amount of Covered Expenses that exceed:

1. The Deductible (and Copayments and Access Fees, if any); and
2. Any amount payable under any other benefit provision of this Certificate. If a service or Treatment is payable under more than one provision of this Certificate, the expenses will be considered under the provision that provides the higher benefit.

Out-of-Pocket Limit

The amount each Covered Person can be obligated to pay for Covered Expenses per Calendar Year. Expenses in excess of a specific dollar limit for any of the following cannot be used to satisfy any Benefit Percentage amount requirement or to meet the out-of-pocket limit:

1. Specific Benefit Provisions;
2. Covered Expenses Subject to Limitations provision;
3. Copayment amounts, if any, as shown in the Schedule of Benefits;
4. Penalties under the Utilization Review provision; or
5. Access Fees.

Your Benefits under this Certificate are not available to pay for Covered Expenses that are applied toward satisfying a Deductible, your Coinsurance Percentage, Copayment amount or Access Fee, if applicable. Such expenses are your responsibility.

Covered Expenses

The following are Covered Expenses under this Certificate:

1. Inpatient Hospital Confinement:
   a. Hospital daily Room and Board Expenses not to exceed the usual and customary semiprivate room charge of the Hospital.
   b. Other Medically Necessary Hospital services and supplies.
   c. Medically Necessary services provided by a Provider.
   d. Anesthetics and their administration (includes the services of a certified nurse anesthetist).
2. Other Covered Expenses:
   a. Outpatient Surgical Expenses, as follows:
      (1) Surgery by a Physician in an Outpatient facility;

(2) Charges for services (including laboratory tests and x-rays), supplies, prescription drugs, oxygen and Durable Medical Equipment for which an Outpatient facility charges when related to and provided on the same day as the Outpatient surgery; and

(3) Anesthesiologist's service for a covered surgery in an Outpatient facility.

b. Radiation therapy and chemotherapy Treatment.

c. Medical Transportation within the 48 contiguous states. Air ambulance service must be:

(1) Required to transport the Covered Person to the nearest Hospital that provides the special medical Treatment not available in the immediate area; and

(2) Ordered by a Physician; and

(3) An aircraft used primarily for transporting ill and injured persons to the nearest Hospital providing the Medically Necessary Treatment.

Air ambulance benefits are limited to the amount and terms set forth on the Schedule of Benefits.

d. Breast Reconstruction. Prosthetic devices or reconstructive surgery following the surgical procedure mastectomy. Coverage for prosthetic devices and reconstructive surgery is subject to the same Deductible and coinsurance applicable to the mastectomy and all other terms and conditions of this Certificate. Breast reconstruction following a Medically Necessary mastectomy will be provided in a manner determined in consultation with the attending Physician and the Covered Person, and will include:

(1) Reconstruction of the breast on which the mastectomy has been performed;

(2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(3) Expenses for physical complications from all stages of a mastectomy, including lymphedema. For the purposes of this provision, "mastectomy" means the removal of all or part of the breast for Medically Necessary reasons as determined by a Physician.

B. Covered Expenses Subject to Limitations

All Covered Expenses referenced in this provision are subject to the applicable Deductibles, Benefit Percentages (amounts), Benefit Maximums and Calendar Year or Lifetime Maximums, as set forth on the Schedule of Benefits. However, the Covered Expenses referenced in this provision are not subject to the office visit Copayments (if any) or any Access Fees. Expenses that exceed the Benefit Maximums shown on the Schedule of Benefits:

1. Will not be considered Covered Expenses under this Certificate; and
2. Will not apply to the out-of-pocket Covered Expense limit.

The following expenses are also subject to any applicable limitations set forth in the General Exclusions and Limitations Section.

Home Health Care

Home Health Care must be provided by a Home Health Care Agency. Benefits under this provision are limited to the number of Home Health Care Visits per Calendar Year that are shown on the Schedule of Benefits. Such care must be provided pursuant to a written plan of Treatment ordered by a Physician and be in lieu of Hospital Confinement.

Hospice Treatment and Services

Hospice Treatment and Services, whether on an Inpatient or Outpatient basis, that are provided pursuant to a Hospice Treatment Program approved by us. Such Treatment and services must be provided within six months

from the date you entered or reentered the Hospice Treatment Program or a Hospice Facility, as defined in this Certificate.

Benefits under this provision are subject to all of the following requirements and limitations:

1. The attending Physician must certify that you have a terminal illness and life expectancy of six months or less;
2. We will determine your eligibility for the Hospice Treatment and Services benefits and we also will administer your benefits; and
3. All Covered Expenses for this benefit must be billed by the Hospice Treatment Program or the approved Hospice Care Provider, and the Covered Expenses will be subject to all the terms of this Certificate. This benefit will be paid for Covered Expenses actually Incurred, not to exceed the Benefit Maximums set forth on the Schedule of Benefits.

Acute Rehabilitation

Benefits under this provision will be paid for Covered Expenses when you receive Acute Rehabilitation services as an Inpatient at an Acute Rehabilitation Facility. This benefit is subject to all of the following requirements and limitations:

1. You must be Confined in an Acute Rehabilitation Facility;
2. Prior to your Confinement in the Acute Rehabilitation Facility, you must have been Confined in a Hospital or Skilled Care Facility; and
3. Your admission to the Acute Rehabilitation Facility must begin within seven days of discharge from the Hospital or Skilled Care Facility.

Skilled Care Facility Benefit

Benefits under this provision will be paid for Covered Expenses you Incur while you are an Inpatient at a Skilled Care Facility. These benefits are subject to all of the following requirements and limitations:

1. You must be an Inpatient at a Skilled Care Facility;
2. Admission to the Skilled Care Facility must begin within fourteen days of discharge from a Hospital;
3. The attending Physician must certify the Confinement as being Medically Necessary for your care and Treatment if you are Totally Disabled and if you otherwise would have been Confined to a bed in a Hospital; and
4. Confinement must be under the direct care of a Physician.

Durable Medical Equipment and Personal Medical Equipment Benefit

Rental or purchase, whichever is most cost effective, of the following items when prescribed by a Physician:

1. A Basic wheelchair;
2. A Basic Hospital bed; and
3. Basic crutches.

In addition, Durable Medical Equipment and Personal Medical Equipment include the following:

1. Orthopedic braces, excluding foot orthotics;
2. The temporary interim and initial permanent basic artificial limb or eye;
3. External breast prostheses needed because of surgical removal of all or part of the breast;
4. Oxygen and the equipment needed for the administration of oxygen; and
5. Other Durable Medical Equipment and supplies that are approved in advance by us.

Observation Room Expense

When you seek Treatment at a Hospital and are placed under observation for more than 24 hours, but are not admitted to the Hospital, we will pay benefits as if you had been admitted as an Inpatient, not to exceed the Hospital's standard semiprivate Room and Board rate.

C. Center of Excellence (COE) Benefit

This section includes information about the non-Experimental and non-Investigational organ/tissue transplants that will be considered Covered Expenses.

Center of Excellence (COE) Transplants

The following are considered COE Transplants under this Certificate:

1. Heart transplant;
2. Heart/lung transplant;
3. Kidney transplant;
4. Liver transplant;
5. Bone marrow and/or stem cell transplant;
6. Kidney-pancreas transplant;
7. Lung transplant (unilateral or bilateral);
8. Pancreas; and
9. Small bowel transplant.

COE Enrollment

Your enrollment at a COE must satisfy all of the following:

1. The Covered Person must contact and work with one of our trained registered nurses to coordinate benefits for transplant services.
2. For us to consider you as a possible candidate for acceptance into the COE for any organ/tissue transplant services or procedure, you or your Physician (or a Physician's staff member) must contact the COE Coordinator to request a transplant evaluation. The decision as to whether or not you will be a transplant candidate in a COE is made by the COE medical staff and will be communicated by the COE Coordinator.
3. If you are denied a transplant procedure by the COE, you will be offered the opportunity to have a second COE evaluate you. If the second COE determines that you are not an acceptable candidate for the proposed organ/tissue transplant procedure, no further coverage under the COE Benefit will be provided for services or supplies that are related to the proposed organ/tissue transplant procedure.

COE Organ/Tissue Transplants

1. If you need an organ/tissue transplant that is a Covered Expense under this Certificate, you may request participation in the COE program. To be considered for a COE transplant, you must agree to use COE Providers for all Treatments related to an organ/tissue transplant in order for the Treatments to be Covered Expenses. The exception to this rule is that you are not required to use COE Providers for routine blood work or Emergency Care needs.
2. If you elect to participate in transplantation at a COE approved by us for the transplant services, Covered Expenses are subject to the limitations set forth in this Certificate. The Maximum Lifetime Benefit payable under the COE Benefit is set forth on the Schedule of Benefits.

3. Any Covered Expenses paid for organ/tissue transplant related expenses shall be cumulative for purposes of determining any maximum benefits under this Certificate.

Covered Expenses

The following Treatments are eligible for the COE Organ/Tissue Transplants benefits under this section:

1. Pretransplant services;
2. Pretransplant harvesting;
3. Pretransplant stabilization. "Pretransplant stabilization" means an Outpatient Treatment or Inpatient stay to medically stabilize the Covered Person for the purpose of, or preparation for, a later transplant, whether or not the transplant occurs;
4. The transplant itself; and
5. Post-transplant care and Treatment for a period of 180 days after the date of the transplant procedure. Such care or Treatment must be provided within 180 days of the date of the transplant.

Covered Expenses under this section also include the following, which will be included in determining the maximum transplant benefits:

1. The costs involved in the procurement of the donor organ;
2. The costs involved in the donor search; and
3. The Hospital expenses of the donor.

In order to be Covered Expenses under this section, the Treatments also must satisfy the definition of "Covered Expenses" set forth in the Definitions Section of this Certificate.

Transplants Not Performed at a COE

1. If you elect not to participate in the COE program or are denied a transplant procedure by the COE, benefits for any Covered Expenses under this section will be paid subject to the following: Covered Expenses for organ/tissue transplants that are neither Experimental nor Investigational Treatment are payable, but not to exceed the Maximum Lifetime Benefit shown on the Schedule of Benefits, per transplant per Covered Person (includes the immediate 180-day post-transplant follow-up).
2. Included within the maximum lifetime allowance for organ/tissue transplant are Covered Expenses for or related to:
   a. Initial testing and diagnostic work-up;
   b. Complications resulting from a transplant surgery or procedure;
   c. Complications resulting from organ/tissue rejection or failure;
   d. Expenses related to anticipated organ/tissue rejection or failure;
   e. Any repeat transplants of the same type of organ/tissue within 180 days of the first transplant;
   f. All other Covered Expenses for or related to organ/tissue transplant; and
   g. High dose chemotherapy, and/or radiation therapy, done in conjunction with a transplant.
3. Expenses for or related to the transplant of an artificial or animal organ are excluded from coverage.

Transportation and Living Expenses

1. If a COE transplant is performed at a designated COE, we will provide the following as Covered Expenses subject to the Maximum Lifetime Benefit.
   a. The reasonable travel and living expenses Incurred by:

(1) A live donor, if applicable; and

(2) You and one companion or, if the Covered Person is a dependent child, two parents.

b. Round trip transportation to the COE (including round trip coach airfare, train, or other commercial carrier). Reimbursement for transportation in a private auto shall be based on the IRS allowance per mile for medical travel.

c. The cost of meals and hotel accommodations for you and/or the donor if Treatment is required in an Outpatient setting.

d. The cost of meals and hotel accommodations for one companion (or two parents if the Covered Person is a dependent child) while accompanying you during hospitalization and Outpatient Treatment.

2. Any benefit payable under this travel and living expense provision shall be subject to our approval for reimbursement.

3. Transportation and living benefits will be limited to the amount shown on the Schedule of Benefits, per covered transplant at a COE

Section III. General Exclusions and Limitations

A. General Benefit Provisions

This Certificate does not cover any of the following expenses or charges:

1. For Treatment, services and/or supplies not covered under this Certificate.
2. Incurred before the Issue Date.
3. Incurred after this Certificate terminates, regardless of when the condition originated, except as provided in the Extension of Benefits provision.
4. Preexisting Conditions are not covered during the first 12 months. After 12 months, benefits are payable unless specifically excluded from coverage. Conditions fully disclosed on the Application and not excluded from coverage by name or specific description are covered, subject to the provisions of this Certificate. Any period of time that a Covered Person was covered under qualifying creditable coverage will be applied to this 12-month period.
5. In excess of the Usual and Customary Allowance for Treatment, services or supplies covered under this Certificate.
6. Applied to a Deductible, Coinsurance Percentage, Copayment or Access Fee amount for any benefit of this Certificate.
7. For office visits including evaluation and management services as defined in the most recent edition of Current Procedural Terminology, except as specifically provided elsewhere in this Certificate.
8. For any drug or other item used for Treatment of hair loss.
9. For Treatment of acne or rosacea and related conditions.
10. For any of the following:
    a. Routine vision care;
    b. Glasses;
    c. Contact lenses, except when used to aid in healing an eye or eyes due to an Illness or an Injury;
    d. Vision therapy, exercise or training; and
    e. Surgery including any complications arising therefrom to correct visual acuity including, but not limited to, lasik and other laser surgery, radial keratotomy services or surgery to correct astigmatism, nearsightedness (myopia) and/or farsightedness (presbyopia).
11. For surgical repair of the eyelids, including, but not limited to, blepharoplasty or “eyebrow lifts”, except when required as a result of the following events or conditions that occurred while this Certificate is In Force and for which expenses are otherwise eligible under the terms of this Certificate:
    a. Accidental bodily Injury;
    b. Surgery; or
    c. Congenital ptosis (drooping) of the eyelid that was first diagnosed while you were insured under this Certificate.
12. For any of the following:
    a. Hearing care that is routine;
    b. Any artificial hearing device;

c. Cochlear implant;

d. Auditory prostheses; or

e. Other electrical, digital, mechanical or surgical means of enhancing, creating or restoring auditory comprehension.

13. For any of the following types of dental care:

a. Routine dental care, except as specifically provided elsewhere;

b. Dental charges, except as specifically provided elsewhere;

c. Bridges, crowns, caps, dentures, dental implants or other dental prostheses;

d. Dental braces or dental appliances;

e. Extraction of teeth;

f. Orthodontic charges;

g. Odontogenic cysts;

h. Any other expenses for Treatment or complications of teeth and gum tissue;

i. Dental extraction that is a pre-Treatment for any Illness.

This exclusion is not applicable to dental care or Treatment required as a result of a covered Injury. Such Treatment must be provided within 90 days of the date of the Injury.

14 For any appliance, medical or surgical expenses for:

a. Malocclusion or protrusion or recession of the mandible;

b. Maxillary or mandibular hyperplasia;

c. Maxillary or mandibular hypoplasia.

15. For Treatment of Temporomandibular Joint Dysfunction and Craniomandibular Joint Dysfunction that includes, but is not limited to:

a. Any electronic diagnostic modalities;

b. Occlusal analysis;

c. Surgery;

d. Splints;

e. Imaging; and/or

f. Muscle testing.

16. For the first six months this Certificate is In Force, surgeries for any of the following conditions are not covered unless such conditions satisfy the definition of Emergency Care:

a. Hernia;

b. Removal of adenoids and/or tonsils;

c. Varicose veins;

d. Hemorrhoids;

e. Middle ear disorders; or

f. Disorders of the reproductive organs.

17. For any of the following:
    a. Bunions;
    b. Removal of one or more corns, calluses or toenails;
    c. Foot inserts;
    d. Orthopedic shoes or supportive devices for the feet; or
    e. Treatment of toenail fungus that is not associated with bacterial infection or diabetes.
18. For any of the following:
    a. Any diagnosis, supplies, Treatment or regimen, whether medical or surgical, for purposes of controlling the Covered Person's weight or related to obesity, including Morbid Obesity, whether or not weight reduction is Medically Necessary or appropriate and regardless of potential benefits for comorbid conditions;
    b. Weight reduction or weight control surgery, Treatment or programs;
    c. Any type of gastric bypass surgery;
    d. Suction lipectomy;
    e. Physical fitness programs, exercise equipment or exercise therapy, including health club membership fees or services; or
    f. Nutritional counseling.
19. For cosmetic services. This exclusion includes any surgery, procedure, injection, medication or Treatment primarily designed to improve appearance, self-esteem or body image and/or to relieve or prevent social, emotional, or psychological distress. Cosmetic services and services for complications from cosmetic services are not covered regardless of whether the initial surgery occurred while this Certificate is In Force or under any previous coverage.
20. For chemical peels, reconstructive or plastic surgery that does not alleviate a functional impairment.
21. For breast reduction or augmentation or complications arising from these procedures, except as specifically provided elsewhere in this Certificate.
22. For cranial orthotic devices that are used to redirect growth of the skull bones or reduce cranial asymmetry.
23. For growth hormone therapy, including growth hormone medication and its derivatives or other drugs used to stimulate, promote or delay growth or to delay puberty to allow for increased growth.
24. For home traction units;
25. For home defibrillators;
26. For programs, Treatment, or procedures to help you stop using tobacco products.
27. For any drug (including birth control pills), supply, Treatment, or procedure for males or females, used for prevention of conception and/or childbirth.
28. For any of the following:
    a. Genetic testing or counseling;
    b. Genetic services and related procedures for screening purposes including, but not limited to, amniocentesis and chorionic villi testing.

29. For any of the following:
    a. Infertility diagnosis and Treatment for males or females including, but not limited to, drugs and medications regardless of intended use, artificial insemination, in vitro fertilization, reversal of reproductive sterilization and related tests, services or procedures and any Treatment to promote conception;
    b. Family planning;
    c. Cryopreservation of sperm or eggs;
    d. Surrogate pregnancy; or
    e. Umbilical cord stem cell or other blood component harvest and storage.
30. For pregnancy, prenatal care, or normal childbirth, except for covered Complications of Pregnancy.
31. Incurred for termination of pregnancy, except to protect the health of the mother.
32. For services, supplies and/or Treatment related to any of the following conditions, regardless of underlying causes:
    a. Sex transformation;
    b. Gender dysphoric disorder;
    c. Gender reassignment;
    d. Sexual function, dysfunction or inadequacy; or
    e. To enhance, restore or improve sexual energy, performance or desire.
33. For Treatment of a developmental delay.
34. For Treatment of Mental or Nervous Disorders, except as provided elsewhere in this Certificate.
35. For expenses resulting from suicide, attempted suicide or self-inflicted Illness or Injury, while sane or insane.
36. For transportation, except as specifically provided in this Certificate.
37. For living expenses, except as specifically provided in this Certificate.
38. For any over-the-counter or prescription products, drugs or medications, including, but not limited to, the following categories, whether or not prescribed by a Physician:
    a. Herbal or homeopathic medicines or products.
    b. Minerals.
    c. Health and beauty aids.
    d. Batteries.
    e. Appetite suppressants.
    f. Dietary or nutritional substances or dietary supplements.
    g. Nutraceuticals.
    h. Infant formulas.
    i. Vitamins.

    This exclusion also excludes from coverage the intentional taking of over-the-counter medications not in accordance with recommended dosage and warning instructions.

39. For prophylactic Treatment, services or surgery including, but not limited to, prophylactic mastectomy or any other Treatment, services or surgery performed to prevent a disease process from becoming evident in the organ or tissue at a later date.
40. For any of the following:
    a. Behavior modification or behavioral (conduct) problems;
    b. Learning disabilities;
    c. Educational testing, training or materials;
    d. Cognitive enhancement or training;
    e. Vocational programs; or
    f. Transitional living.
41. For services or supplies for personal convenience, including Custodial Care or homemaker services, except as specifically provided in this Certificate.
42. For Custodial Care, except as specifically covered elsewhere in this Certificate.
43. For Illness or Injury caused by, contributed to, or resulting from your Intoxication or use of alcohol, illegal drugs, voluntary use of any controlled substance (as defined by statute), or use of legal prescription or over-the-counter drugs that are not taken in the dosage or for the purpose prescribed or recommended by your Physician. This exclusion shall apply even if no traffic or criminal charges are filed or proposed.
44. For voluntarily taking, absorbing, or inhaling any gas, poison or other hazardous items.
45. Incurred while participating in the military service of any country or international organization, including nonmilitary units supporting such forces. This exclusion also includes expenses resulting from your participation in war, whether war has been declared or not.
46. For Illness or Injury sustained during your voluntary participation in an assault, strike, civil disorder, or riot.
47. For Illness or Injury resulting, either directly or indirectly, from your participation in a high risk activity for pay, profit or other commercial purposes including, but not limited to:
    a. Skydiving;
    b. Hang gliding;
    c. Parachuting;
    d. Piloting experimental or ultralight aircraft;
    e. Riding in any aircraft not licensed to carry passengers or not operated by a duly licensed pilot;
    f. Riding in a hot air balloon;
    g. Bungee jumping;
    h. Professional mountain and/or rock climbing;
    i. Rodeo participation; and
    j. Organized contests including, but not limited to, organized contests of speed, go-cart racing, dirt bike racing, demolition derbies, and mountain bike racing. This exclusion also includes the practice, qualification and/or testing for such activities
48. Incurred for Illness or Injury that result from:
    a. Engaging in an illegal act or occupation, as defined by statute; or

b. Committing, attempting to commit, or participating in a felony, as defined by statute.

49. For Treatment of complications from a noncovered service.
50. For Treatment, services or supplies that are not Medically Necessary.
51. For private duty nursing.
52. For having a Provider on standby.
53. For services, supplies and/or Treatment not ordered by a Provider;
54. For Treatment, supplies or services that are Experimental or Investigational as defined in this Certificate;
55. For Treatment, services, supplies, or drugs designed or used to diagnose, treat, alter, impact, or differentiate your genetic make-up or genetic predisposition.
56. For free Treatment provided in a federal, veteran's, state or municipal medical facility or through a school system.
57. Payable or reimbursable by Medicare Part A, Part B, or Part D, or any other governmental law or program when permitted by law, except Medicaid. If a Covered Person at any time was eligible to enroll in the Medicare program (including Part B and Part D) but did not do so, any benefits otherwise allowed under this Certificate will be reduced by any amount that would have been reimbursed by Medicare.
58. For Treatment, services and/or supplies for which you have no legal obligation to pay or for which no charge would be made if you did not have a health plan or insurance coverage.
59. For free services provided in a student health center.
60. For work-related Illness or Injury eligible for benefits under worker's compensation, employers' liability or similar laws even when you do not file a claim for those benefits.
61. For work hardening programs;
62. For Treatment, services or supplies that are covered under an extension of group health benefits provision by a previous employer-related health plan, health insurance plan, or other coverage arrangement. Such services and supplies will not be covered by this Certificate until the extension of benefits under the prior plan ends.
63. That are payable under any motor vehicle no-fault law insurance policy or certificate.
64. For Treatment, services or supplies received outside the United States or for drugs obtained from pharmacy provider sources outside the United States, except as specifically provided in this Certificate.
65. For Treatment, services and/or supplies provided by any of the following:
    a. A person who ordinarily resides in your home;
    b. A member of your Immediate Family; or
    c. Your employer or business partner.
66. For Treatment of hyperhidrosis (excessive sweating).
67. For Never Events as defined in this Certificate.
68. For services that are not documented in the Provider's records.
69. That are related to the supervision of laboratory services that do not involve written consultation by a Provider including, but not limited to, laboratory interpretation.
70. For complications resulting from leaving a licensed medical facility against the advice of the Covered Person's Provider.

71. For routine physical exams, premarital examination, or other services or supplies not needed for medical Treatment, except as specifically provided elsewhere in this Certificate.
72. For routine newborn or well-child care, except as otherwise covered in this Certificate.
73. For prescription drugs or medicines, except as specifically provided elsewhere in this Certificate. This exclusion also excludes from coverage the intentional misuse of prescription drugs or medicines.

Section III. General Exclusions and Limitations

A. General Benefit Provisions

This Certificate does not cover any of the following expenses or charges:

1. For Treatment, services and/or supplies not covered under this Certificate.
2. Incurred before the Issue Date.
3. Incurred after this Certificate terminates, regardless of when the condition originated, except as provided in the Extension of Benefits provision.
4. Preexisting Conditions are not covered during the first 12 months. After 12 months, benefits are payable unless specifically excluded from coverage. Conditions fully disclosed on the Application and not excluded from coverage by name or specific description are covered, subject to the provisions of this Certificate. Any period of time that a Covered Person was covered under qualifying creditable coverage will be applied to this 12-month period.
5. In excess of the Usual and Customary Allowance for Treatment, services or supplies covered under this Certificate.
6. Applied to a Deductible, Coinsurance Percentage, Copayment or Access Fee amount for any benefit of this Certificate.
7. For office visits including evaluation and management services as defined in the most recent edition of Current Procedural Terminology, except as specifically provided elsewhere in this Certificate.
8. For any drug or other item used for Treatment of hair loss.
9. For Treatment of acne or rosacea and related conditions.
10. For any of the following:
    a. Routine vision care;
    b. Glasses;
    c. Contact lenses, except when used to aid in healing an eye or eyes due to an Illness or an Injury;
    d. Vision therapy, exercise or training; and
    e. Surgery including any complications arising therefrom to correct visual acuity including, but not limited to, lasik and other laser surgery, radial keratotomy services or surgery to correct astigmatism, nearsightedness (myopia) and/or farsightedness (presbyopia).
11. For surgical repair of the eyelids, including, but not limited to, blepharoplasty or “eyebrow lifts”, except when required as a result of the following events or conditions that occurred while this Certificate is In Force and for which expenses are otherwise eligible under the terms of this Certificate:
    a. Accidental bodily Injury;
    b. Surgery; or
    c. Congenital ptosis (drooping) of the eyelid that was first diagnosed while you were insured under this Certificate.
12. For any of the following:
    a. Hearing care that is routine;
    b. Any artificial hearing device;

c. Cochlear implant;

d. Auditory prostheses; or

e. Other electrical, digital, mechanical or surgical means of enhancing, creating or restoring auditory comprehension.

13. For any of the following types of dental care:

a. Routine dental care, except as specifically provided elsewhere;

b. Dental charges, except as specifically provided elsewhere;

c. Bridges, crowns, caps, dentures, dental implants or other dental prostheses;

d. Dental braces or dental appliances;

e. Extraction of teeth;

f. Orthodontic charges;

g. Odontogenic cysts;

h. Any other expenses for Treatment or complications of teeth and gum tissue;

i. Dental extraction that is a pre-Treatment for any Illness.

This exclusion is not applicable to dental care or Treatment required as a result of a covered Injury. Such Treatment must be provided within 90 days of the date of the Injury.

14 For any appliance, medical or surgical expenses for:

a. Malocclusion or protrusion or recession of the mandible;

b. Maxillary or mandibular hyperplasia;

c. Maxillary or mandibular hypoplasia.

15. For Treatment of Temporomandibular Joint Dysfunction and Craniomandibular Joint Dysfunction that includes, but is not limited to:

a. Any electronic diagnostic modalities;

b. Occlusal analysis;

c. Surgery;

d. Splints;

e. Imaging; and/or

f. Muscle testing.

16. For the first six months this Certificate is In Force, surgeries for any of the following conditions are not covered unless such conditions satisfy the definition of Emergency Care:

a. Hernia;

b. Removal of adenoids and/or tonsils;

c. Varicose veins;

d. Hemorrhoids;

e. Middle ear disorders; or

f. Disorders of the reproductive organs.

17. For any of the following:
    a. Bunions;
    b. Removal of one or more corns, calluses or toenails;
    c. Foot inserts;
    d. Orthopedic shoes or supportive devices for the feet; or
    e. Treatment of toenail fungus that is not associated with bacterial infection or diabetes.
18. For any of the following:
    a. Any diagnosis, supplies, Treatment or regimen, whether medical or surgical, for purposes of controlling the Covered Person's weight or related to obesity, including Morbid Obesity, whether or not weight reduction is Medically Necessary or appropriate and regardless of potential benefits for comorbid conditions;
    b. Weight reduction or weight control surgery, Treatment or programs;
    c. Any type of gastric bypass surgery;
    d. Suction lipectomy;
    e. Physical fitness programs, exercise equipment or exercise therapy, including health club membership fees or services; or
    f. Nutritional counseling.
19. For cosmetic services. This exclusion includes any surgery, procedure, injection, medication or Treatment primarily designed to improve appearance, self-esteem or body image and/or to relieve or prevent social, emotional, or psychological distress. Cosmetic services and services for complications from cosmetic services are not covered regardless of whether the initial surgery occurred while this Certificate is In Force or under any previous coverage.
20. For chemical peels, reconstructive or plastic surgery that does not alleviate a functional impairment.
21. For breast reduction or augmentation or complications arising from these procedures, except as specifically provided elsewhere in this Certificate.
22. For cranial orthotic devices that are used to redirect growth of the skull bones or reduce cranial asymmetry.
23. For growth hormone therapy, including growth hormone medication and its derivatives or other drugs used to stimulate, promote or delay growth or to delay puberty to allow for increased growth.
24. For home traction units;
25. For home defibrillators;
26. For programs, Treatment, or procedures to help you stop using tobacco products.
27. For any drug (including birth control pills), supply, Treatment, or procedure for males or females, used for prevention of conception and/or childbirth.
28. For any of the following:
    a. Genetic testing or counseling;
    b. Genetic services and related procedures for screening purposes including, but not limited to, amniocentesis and chorionic villi testing.

29. For any of the following:
    a. Infertility diagnosis and Treatment for males or females including, but not limited to, drugs and medications regardless of intended use, artificial insemination, in vitro fertilization, reversal of reproductive sterilization and related tests, services or procedures and any Treatment to promote conception;
    b. Family planning;
    c. Cryopreservation of sperm or eggs;
    d. Surrogate pregnancy; or
    e. Umbilical cord stem cell or other blood component harvest and storage.
30. For pregnancy, prenatal care, or normal childbirth, except for covered Complications of Pregnancy.
31. Incurred for termination of pregnancy, except to protect the health of the mother.
32. For services, supplies and/or Treatment related to any of the following conditions, regardless of underlying causes:
    a. Sex transformation;
    b. Gender dysphoric disorder;
    c. Gender reassignment;
    d. Sexual function, dysfunction or inadequacy; or
    e. To enhance, restore or improve sexual energy, performance or desire.
33. For Treatment of a developmental delay.
34. For Treatment of Mental or Nervous Disorders, except as provided elsewhere in this Certificate.
35. For expenses resulting from suicide, attempted suicide or self-inflicted Illness or Injury, while sane or insane.
36. For transportation, except as specifically provided in this Certificate.
37. For living expenses, except as specifically provided in this Certificate.
38. For any over-the-counter or prescription products, drugs or medications, including, but not limited to, the following categories, whether or not prescribed by a Physician:
    a. Herbal or homeopathic medicines or products.
    b. Minerals.
    c. Health and beauty aids.
    d. Batteries.
    e. Appetite suppressants.
    f. Dietary or nutritional substances or dietary supplements.
    g. Nutraceuticals.
    h. Infant formulas.
    i. Vitamins.

    This exclusion also excludes from coverage the intentional taking of over-the-counter medications not in accordance with recommended dosage and warning instructions.

39. For prophylactic Treatment, services or surgery including, but not limited to, prophylactic mastectomy or any other Treatment, services or surgery performed to prevent a disease process from becoming evident in the organ or tissue at a later date.
40. For any of the following:
    a. Behavior modification or behavioral (conduct) problems;
    b. Learning disabilities;
    c. Educational testing, training or materials;
    d. Cognitive enhancement or training;
    e. Vocational programs; or
    f. Transitional living.
41. For services or supplies for personal convenience, including Custodial Care or homemaker services, except as specifically provided in this Certificate.
42. For Custodial Care, except as specifically covered elsewhere in this Certificate.
43. For Illness or Injury caused by, contributed to, or resulting from your Intoxication or use of alcohol, illegal drugs, voluntary use of any controlled substance (as defined by statute), or use of legal prescription or over-the-counter drugs that are not taken in the dosage or for the purpose prescribed or recommended by your Physician. This exclusion shall apply even if no traffic or criminal charges are filed or proposed.
44. For voluntarily taking, absorbing, or inhaling any gas, poison or other hazardous items.
45. Incurred while participating in the military service of any country or international organization, including nonmilitary units supporting such forces. This exclusion also includes expenses resulting from your participation in war, whether war has been declared or not.
46. For Illness or Injury sustained during your voluntary participation in an assault, strike, civil disorder, or riot.
47. For Illness or Injury resulting, either directly or indirectly, from your participation in a high risk activity for pay, profit or other commercial purposes including, but not limited to:
    a. Skydiving;
    b. Hang gliding;
    c. Parachuting;
    d. Piloting experimental or ultralight aircraft;
    e. Riding in any aircraft not licensed to carry passengers or not operated by a duly licensed pilot;
    f. Riding in a hot air balloon;
    g. Bungee jumping;
    h. Professional mountain and/or rock climbing;
    i. Rodeo participation; and
    j. Organized contests including, but not limited to, organized contests of speed, go-cart racing, dirt bike racing, demolition derbies, and mountain bike racing. This exclusion also includes the practice, qualification and/or testing for such activities
48. Incurred for Illness or Injury that result from:
    a. Engaging in an illegal act or occupation, as defined by statute; or

b. Committing, attempting to commit, or participating in a felony, as defined by statute.

49. For Treatment of complications from a noncovered service.
50. For Treatment, services or supplies that are not Medically Necessary.
51. For private duty nursing.
52. For having a Provider on standby.
53. For services, supplies and/or Treatment not ordered by a Provider;
54. For Treatment, supplies or services that are Experimental or Investigational as defined in this Certificate;
55. For Treatment, services, supplies, or drugs designed or used to diagnose, treat, alter, impact, or differentiate your genetic make-up or genetic predisposition.
56. For free Treatment provided in a federal, veteran's, state or municipal medical facility or through a school system.
57. Payable or reimbursable by Medicare Part A, Part B, or Part D, or any other governmental law or program when permitted by law, except Medicaid. If a Covered Person at any time was eligible to enroll in the Medicare program (including Part B and Part D) but did not do so, any benefits otherwise allowed under this Certificate will be reduced by any amount that would have been reimbursed by Medicare.
58. For Treatment, services and/or supplies for which you have no legal obligation to pay or for which no charge would be made if you did not have a health plan or insurance coverage.
59. For free services provided in a student health center.
60. For work-related Illness or Injury eligible for benefits under worker's compensation, employers' liability or similar laws even when you do not file a claim for those benefits.
61. For work hardening programs;
62. For Treatment, services or supplies that are covered under an extension of group health benefits provision by a previous employer-related health plan, health insurance plan, or other coverage arrangement. Such services and supplies will not be covered by this Certificate until the extension of benefits under the prior plan ends.
63. That are payable under any motor vehicle no-fault law insurance policy or certificate.
64. For Treatment, services or supplies received outside the United States or for drugs obtained from pharmacy provider sources outside the United States, except as specifically provided in this Certificate.
65. For Treatment, services and/or supplies provided by any of the following:
    a. A person who ordinarily resides in your home;
    b. A member of your Immediate Family; or
    c. Your employer or business partner.
66. For Treatment of hyperhidrosis (excessive sweating).
67. For Never Events as defined in this Certificate.
68. For services that are not documented in the Provider's records.
69. That are related to the supervision of laboratory services that do not involve written consultation by a Provider including, but not limited to, laboratory interpretation.
70. For complications resulting from leaving a licensed medical facility against the advice of the Covered Person's Provider.

71. For routine physical exams, premarital examination, or other services or supplies not needed for medical Treatment, except as specifically provided elsewhere in this Certificate.
72. For routine newborn or well-child care, except as otherwise covered in this Certificate.
73. For prescription drugs or medicines, except as specifically provided elsewhere in this Certificate. This exclusion also excludes from coverage the intentional misuse of prescription drugs or medicines.
74. For care received outside the United States.
75. For sterilization or the reversal of sterilization.
76. For spinal manipulation, including, but not limited to, manipulation for spinal subluxation and any associated Treatment or services;
77. For Outpatient occupational, physical, and speech therapy.
78. For Treatment of allergies.
79. For Treatment of growth disorders.

Adding Dependent Coverage

1. For newborns:
   a. Coverage will be effective for a period of 90 days following the "eligibility date." In order for coverage to continue beyond this initial 90-day period, we must receive a written request from you to add the newborn child within 90 days following the eligibility date.
   b. The "eligibility date" for a newborn is the newborn's date of birth.
2. For newly adopted children:
   a. Coverage will be effective for a period of 60 days following the "eligibility date." In order for coverage to continue beyond this initial 60-day period, we must receive a written request from you to add the newborn or adopted child within 60 days following the eligibility date.
   b. The "eligibility date" for an adopted child is the earlier of the date Placed for Adoption, or the date of legal adoption.
3. Other Dependents (not a newborn or adopted child):

   When you request coverage for a new family member you must complete an Application. Each dependent will be considered independently and, if approved by us, we will determine the Issue Date of coverage for that person.
4. The additional premium charge for the new Dependent, if any, will be added to your next premium statement and must be paid with that premium when due.
5. No dependent coverage will become effective for a Dependent before the Member's coverage is effective. Insurance for a Dependent Confined in a Hospital or Skilled Care Facility on the date that his or her coverage would otherwise have become effective will become effective on the day after the final discharge from the Hospital or the Skilled Care Facility. This provision will not apply to a newborn Hospital-Confined on his or her Issue Date.
6. Following written approval by us to the Member's Application, we will determine the Issue Date of coverage for a Dependent who was previously rejected for coverage by us.

Certificate/Premium Changes

1. The Group Policyholder may request in writing a change in this Certificate at any time without your consent or the consent of any other interested party. Any such change is subject to our approval and requires the signature of the Group Policyholder and an officer of ours in order to be effective. We will provide any such change to your Certificate and the required notice to you according to the Certificate provisions.
2. We may increase or otherwise adjust the premium rates on any premium due date with 30 days advance written notice to the Member.
3. If a Preferred Provider Organization (PPO) is used in conjunction with this Certificate, the list of Participating Providers is subject to change without advance notice to you. If the agreement between us and the PPO is terminated for any reason, we will offer you a substitute plan of our choice.

Coverage Exclusion

We reserve the right to exclude from coverage by name or specific description any condition or any organ, system, part or area of the body, or high risk activity as we deem necessary. We may require you to sign an amendment to this Certificate that specifically excludes from coverage the condition or the organ, system, part or area of the body, or high risk activity, as applies to you, your spouse, or your other Dependents. We further reserve the right to decline to insure you, your spouse or your other Dependents if you do not sign the amendment to this Certificate.

Issue Date of Insurance if Totally Disabled

If you have been approved in writing by us and are Totally Disabled on the date your coverage would have otherwise taken effect, your coverage will not become effective until the second consecutive day you are no longer Totally Disabled.

Eligibility

The following provisions apply to a person's eligibility for coverage:

1. An association Member who is between the ages of 16 and 64½ is eligible to apply for coverage. However, any Member who has coverage under a similar, employer-sponsored major medical plan is not eligible for coverage under this Certificate.
2. No individual will be eligible as a Covered Dependent of more than one Member or be eligible as both a Member and a Covered Dependent. In addition, any Dependent who has coverage under a similar employer-sponsored major medical plan is not eligible for coverage under this Certificate.

Extension of Benefits

If the Covered Person is Totally Disabled on the date this coverage terminates (for reasons other than nonpayment of the required premium payment), we will extend benefits only for the Illness or Injury that caused the Total Disability. Benefits are subject to all the terms, limits and conditions in this Certificate. Premium payment will not be required during the Extension of Benefits period. These benefits will be extended under this Certificate until the earliest of:

1. 12 months after coverage terminates;
2. The date the Maximum Lifetime Benefit is reached; or
3. The end of the Total Disability.

Grace Period

A grace period of 31 days will be provided for the payment of each premium falling due after the first premium. This Certificate will stay In Force during the grace period unless you have given advance written notice to us that this Certificate will terminate prior to the end of the grace period. Benefits will be provided for any eligible claim Incurred during the 31-day grace period only if the required premium payment is received on or before the end of the 31-day grace period.

Individual Exclusion

We reserve the right to exclude you, your spouse, or another of your Dependents from coverage as we deem necessary, based on that person's health history. We may require you to sign an amendment to this Certificate that specifically excludes a spouse or another Dependent from coverage. Another offer of coverage may be made to Dependents.

Misstatement of Age

If the Age of any Covered Person has been misstated, the premiums may be adjusted. If the amount of insurance would be affected by such misstatement, it will be changed to the amount the Covered Person would have had at the correct age, and the premium will be adjusted based on the corrected age.

Modifications or Discontinuance of Coverage

1. Uniform Modification of Coverage. At the time of coverage renewal, we may modify this Certificate to a product offered to an individual in the individual market, provided such modification is consistent with state law and effective on a uniform basis among all individuals with that product.
2. Discontinuation of Coverage.
   a. Discontinuation of a Particular Type of Coverage. If we decide to discontinue offering a particular type of health insurance coverage offered in the individual market, all coverage of that type will be discontinued uniformly by us by providing:
      (1) Notice to each Covered Person at least 90 days prior to the date of the discontinuation of the particular type of coverage; and
      (2) An offer to each Covered Member of the option to purchase any other individual health insurance coverage currently being offered by us for individuals in such market.
   b. Discontinuance of All Coverage.
      (1) If we elect to discontinue offering all health insurance coverage in the individual market in a particular state, health insurance coverage may be discontinued by us if:
         (a) We provide notice to the applicable state authority and to each Covered Person covered under such coverage at least 180 days prior to the date of the discontinuation of such coverage; and
         (b) Such coverage is not renewed.
      (2) If we discontinue all coverage in the individual market in a particular state, we may not issue any health insurance coverage in the individual market and state involved during the five-year period beginning on the date of the discontinuation of the last health insurance coverage not so renewed.

Other Insurance With Us

You may only have one certificate with us that is comparable to this Certificate. If, through an error, we issue you more than one certificate, you may select which certificate will remain In Force. We will refund the money you paid on any other certificate, less claims paid.

Our Right to Cancel, Rescind or Reform

1. We reserve the right to cancel, rescind or reform your coverage under this Certificate in the event of fraud or misrepresentation by you or your representative including, but not limited to, fraud or misrepresentation related to any of the following:
   a. Applying for coverage, including the initial qualification for coverage or any subsequent requalification;
   b. Telephone verification of submitted information;
   c. The filing or processing of a claim; or
   d. Any other similar process or procedure.
2. In the absence of fraud, all statements made by you will be deemed representations and not warranties. No such statement will be used to deny a claim or reduce benefits unless it is stated in the Application for coverage.

Payment of Premium

1. All required premiums due are to be paid on or before the due date. Each premium payment must be received by us to be considered paid. The payment of any premium will not maintain this Certificate In Force beyond the date when the next premium is due.
2. Continued premium payments beyond the termination date will not have the effect of continuing any insurance coverage.

Renewal Agreement

We will renew this coverage or continue this coverage In Force at your option, unless any of the following occurs:

1. Nonpayment of premiums. You failed to pay premiums in accordance with the terms of this Certificate, or we have not received timely premium payments.
2. Fraud. You or your Dependents have performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact related to this Certificate or your coverage under this Certificate.
3. Loss of Eligibility. We may terminate this Certificate in any of the following situations:
   a. You are no longer a Member.
   b. The Covered Dependent, if applicable, ceases to meet the definition of a Covered Dependent.
   c. You moved to a state in which we do not hold a Certificate of Authority to issue insurance or you have moved to a state in which we do not actively market health insurance because we have discontinued all types of plans within that state.
4. Termination of Coverage. Based on the "Modifications or Discontinuance of Coverage" provision in this Certificate, we either: (a) cease to offer coverage; or (b) terminate this Certificate in its entirety.
5. Movement Outside of Service Area. If you elected Preferred Provider Organization (PPO) coverage and you no longer live, reside, or work in the service area, you may be switched to another PPO or you will be subject to Nonparticipating Provider benefits.
6. You may elect not to renew coverage by providing written notice to us. The earliest date that coverage will be terminated is on the last day of the month during which we receive written notice.

The Contract

The entire contract includes the Group Insurance Policy, this Certificate, the Application (a copy of which is attached to this Certificate), and any attached papers. We may use misstatements or omissions in your Application to contest the validity of your insurance coverage, reduce coverage, or deny a claim. Before we take any of the foregoing actions, we must first furnish you with a copy of the Application. All statements in an Application will, in the absence of fraud, be deemed representations and not warranties.

Section V. Claim Provisions

Most Providers will file claims directly with us. However, you are responsible for filing a claim with us if the Provider does not file it. The following provisions give you the information you need in order to properly file claims with us.

Notice of Loss/Claim

1. In order to properly file a claim, you must send us: a) a notice of the loss or notice of your claim; and at a later time b) a proof of loss. In the following paragraphs we describe these notices, what is required for each one, and the deadlines for submitting them.
2. We must receive your written notice of loss or claim within 20 days after the date of any covered loss. "Loss" as used in this context means the medical expenses you Incur resulting from a covered Illness or Injury. We do not require that the written notice be on a particular form; rather, you can simply send us a letter in which you inform us that you have Incurred medical expenses that you believe are Covered Expenses under this Certificate. If we have not received the written notice within 20 days of the date of loss, we will not deny or reduce a claim as long as you send us the notice as soon as is reasonably possible.
3. Within 15 days of our receipt of the notice of a claim, we will send you the forms you will need for filing a proof of loss. If we fail to provide the necessary forms within the stated time, you will be considered to have satisfied the proof of loss requirements if written proof of loss is submitted within the time requirements as stated in the Proof of Loss provision below.

Proof of Loss

1. Proof of loss as required in this Certificate means evidence of loss satisfactory to us. Our receipt, acknowledgment or investigation of a claim will not waive our rights to defend against any claim.
2. The proof of loss must include all of the following:
   a. Your name and Certificate number.
   b. The name of the Covered Person who Incurred the claim.
   c. The name and address of the Provider of the services.
   d. An itemized bill from the Provider of the services that includes all of the following (as applies):
      (1) International Classification of Diseases (ICD) diagnosis codes;
      (2) International Classification of Diseases (ICD) procedures;
      (3) Current Procedural Terminology (CPT) codes;
      (4) Healthcare Common Procedure Coding System (HCPCS) level II codes; and
      (5) National Drug Codes (NDC).
   e. A statement indicating whether the Covered Person has coverage for the services related to the Illness or Injury under any Other Insurance plan or program. If the Covered Person has other coverage, include the name and certificate or policy number of the other coverage.
3. We must receive written proof of loss no later than 90 days after the date of the loss ("Written Notice Period").
4. If we have not received written proof of loss within the Written Notice Period, we will not deny or reduce a claim as long as you send us the proof of loss as soon as is reasonably possible. Except in the case of documented legal incapacity, in no event will we accept proof of loss beyond one year after the end of the Written Notice Period.

5. After we receive written proof of loss, we may require additional information from you in order to evaluate your claim. You must furnish all such information pursuant to the Right to Collect Information provision below. We will not pay benefits if the required information, or an authorization for its release, is not furnished to us.

Right to Collect Information

To determine our liability, we may request additional information from a Covered Person, Provider, facility, or other individual or entity. A Covered Person must cooperate with us, and assist us by obtaining the following information within 30 days of our request. Charges will be denied if we are unable to determine our liability because a Covered Person, Provider, facility, or other individual or entity fails to do any of the following:

1. Authorize the release of all medical records to us and/or fails to authorize the release of other information we request;
2. Provide us with information we request about pending claims, Other Insurance coverage or proof of creditable coverage;
3. Provide us with information as required by any contract with us or a network including, but not limited to, repricing information;
4. Provide us with information that is accurate and complete;
5. Have any examination completed as requested by us; or
6. Reasonably cooperate with any requests made by us.

Such charges may be considered for Benefits upon receipt of the requested information, provided that we receive all necessary information before the expiration of the time allowed for submission of claim information as set forth in this Claims Provisions section.

Examination

We have the right to require that you be examined by a Physician of our choice, at our own expense, as often as we may require. In the event of your death, we have the right to require an autopsy, unless otherwise prohibited by law.

Payment of Claim

1. Benefits will be paid to you unless benefits have been assigned to the Provider. We are not responsible for verifying the validity of the assignment.
2. If we determine that you are not legally able to receive such payment, we may at our option pay the Benefits to:
   a. Providers; or
   b. Your estate; or
   c. Your closest living relative.
3. We reserve the right to allocate any Covered Expenses to any Deductible and to apportion the benefits to you and to any assignees. Such actions will be binding on you and the assignees.
4. Upon receipt of the required written proof of loss, we normally will pay claims within 30 days of our receipt of the written proof of loss.

Overpayment or Erroneous Payment

If a benefit is paid under this Certificate and it is later determined that a lesser amount or no amount should have been paid, we are entitled to recover the excess amount from you, the beneficiary or the Provider. We may offset the overpayment or erroneous payment against future benefit payments.

Utilization Review Process

You must call the toll-free number on your identification (ID) card to obtain our authorization for the services listed in the "When to Call" provision below. Benefits will be reduced as described in the "Reduction of Payment" provision below if a Covered Person does not comply with this Utilization Review Process and does not obtain authorization.

A review by the Utilization Review Manager does not guarantee that benefits will be paid. Payment of benefits will be subject to all other terms, limits and conditions in this Certificate.

1. **Utilization Review Procedures**.
   a. In order to obtain authorization for the services, the Covered Person must contact our Utilization Review Manager by calling the toll free number on the ID card. Please have all of the following information on hand before calling:
      (1) Your Certificate number for this Certificate;
      (2) The Provider's name and telephone number;
      (3) The service, procedure and diagnosis;
      (4) The proposed date of admission or date the service or procedure will be performed; and
      (5) The facility's name and phone number.
   b. The Utilization Review Manager may review a proposed service or procedure to determine any of the following:
      (1) Medical Necessity;
      (2) Whether it is a Cosmetic service or an Experimental or Investigational service;
      (3) Location of the Treatment; and
      (4) Length of stay for an Inpatient Confinement.
2. **When to Call.**
   a. **Contact the Utilization Review Manager for authorization of the following services:**
      (1) **Inpatient Confinements:** Call us to obtain authorization for an admission to an Inpatient facility, or transfer between Inpatient facilities, or any other Inpatient Confinement that will exceed 24 hours as follows:
         (a) ***Non-Emergency Confinements:*** Call at least 3 business days prior to an Inpatient admission for a nonemergency Confinement that will exceed 24 hours in length.
         (b) ***Emergency Care Confinements:*** Call within 24 hours, or as soon as reasonably possible, after admission for an Emergency Care Confinement that will exceed 24 hours in length. The Covered Person must provide or make available to the Utilization Review Manager the full details of the Emergency Care Confinement.
         (c) ***Extended Confinement for Complication of Pregnancy:*** In the event of a Complication of Pregnancy that results in an Inpatient Confinement exceeding 48 hours following a normal, vaginal delivery or 96 hours following a caesarean section delivery, the Covered Person must call prior to the end of the Confinement, or as soon as reasonably possible. Any other Inpatient Confinements because of Complications of Pregnancy that occur during a pregnancy must be authorized in accordance with the Non-Emergency Confinements and Emergency Confinements provisions above.

(d) ***Continued Stay Review:*** We may request additional clinical information during an Inpatient Confinement. Failure of the Physician or facility to provide the requested information will result in nonauthorization of benefits for continued Inpatient Confinement. No benefits will be considered until we receive the additional information. No benefits will be paid for the days of Inpatient Confinement beyond the originally scheduled discharge date if the continued stay would not have been authorized by the Utilization Review Manager based on review of the additional information provided.

(2) **Outpatient Procedures:** Call us to obtain authorization for the following procedures that are performed in an Outpatient setting. Call at least 3 business days before receiving any of the following nonemergency Outpatient services (if you have the particular benefit):

(a) Surgical procedures;

(b) Home Health Care;

(c) Home infusion;

(d) Hospice care;

(e) Physical medicine including physical therapy, occupational therapy or speech therapy.

(3) **Transplants:** Call at least 7 business days prior to any transplant evaluation, testing, preparative Treatment or donor search.

b. The review process must be repeated if Treatment is received more than 30 days after review by our Utilization Review Manager or if the type of Treatment, admitting Physician or facility differs from what the Utilization Review Manager authorized. A determination by the Utilization Review Manager does not alter, limit or restrict in any manner the attending Provider's ultimate patient care responsibility.

3. **Reduction of Payment**. If you do not obtain authorization from us for the course of Treatment for the services listed in the When to Call provision above, benefits will be reduced for otherwise Covered Expenses by 25% if any of the following occur:

a. The Covered Person does not contact the Utilization Review Manager within the required time frame;

b. The type of Treatment, admitting Physician or facility differs from what was authorized by the Utilization Review Manager; or

c. The Treatment is Incurred more than 30 days after review by the Utilization Review Manager.

The reduced amount, or any portion thereof, under this section will not count toward satisfying any Access Fee, Coinsurance, Copayment, Deductible or Out-of-Pocket Limit.

Case Management Program

1. You may be referred to our Case Management Program if you have a complex Illness or Injury requiring ongoing medical care. Our Case Management Program is a voluntary program. If you participate in the Case Management Program, one of our trained registered nurses ("a Care Manager") will coordinate with you and your Provider in the development of a health care treatment plan that is intended to:

a. Respond to your health care needs; and

b. Be cost-effective and promote efficient use of Certificate benefits.

2. The proposed health care treatment plan must be approved by us to ensure that any care provided pursuant to the treatment plan is Medically Necessary, cost-effective and involves efficient use of Certificate benefits. The health care treatment plan is also subject to approval by you and your Physician.

3. The Case Management Program may be initiated by:

a. You;

b. Your family members;

c. Your Physician or Provider; or

d. Us.

4. It is your decision whether or not to participate in our Case Management Program. Our Case Management Program does not replace the care received from your Physician. You and your Physician remain in charge of your health care treatment plan.

5. Through Case Management we may agree on a limited basis to modify certain terms or conditions of this Certificate. Providing benefits under the Case Management Program in a particular case does not commit us to do so in another case, nor does it waive or modify the terms and conditions of this Certificate, render them unenforceable or prevent us from strictly applying the benefits, limitations and exclusions of this Certificate at any other time or for any other insured person, whether or not the circumstances are similar or the same.

Coordination of Benefits

1. Coordination of Benefits (COB) may limit benefits when you are insured under more than one plan (certificate or policy). The Benefits payable under this Certificate may be reduced, under the rules shown below, so that you will receive no more than 100% of Covered Expenses from all plans combined.

2. The plans with which this Certificate coordinates benefits are:

   a. Group insurance;

   b. Individual insurance;

   c. Other arrangements, whether insured or uninsured, covering individuals in a group;

   d. Blue Cross and Blue Shield plans on an individual or group basis;

   e. Plans of Hospital or medical service organizations on a group basis;

   f. Group practice plans;

   g. Group prepayment plans;

   h. Federal government plans or programs;

   i. Medicare Parts A and B;

   j. Coverage required or provided by law;

   k. Student insurance, except that COB will not apply to accident-only coverage for elementary, middle, or high school students;

   l. Group auto insurance, including group no-fault auto insurance; and

   m. Individual no-fault auto insurance, by whatever name called.

3. We will pay the regular benefits if we are determined to be the primary plan. If we are determined to be the secondary plan, we will pay the excess of Covered Expenses after the primary plan pays its regular benefits. In any event, we will not pay more than the regular benefits of our Certificate.

4. The following rules determine which plan is primary and which is secondary:

   a. Any plan that does not have a COB provision will be the primary plan and pay first.

   b. For a plan having a COB provision, the following rules apply:

      (1) The plan that covers the Covered Person as an employee, member or nondependent will pay its benefits first.

(2) The plan that covers the Covered Person as a dependent (spouse or children) will be considered the secondary plan and pay after any other plan.

(3) For covered dependent children:

(a) The benefits of the plan of the parent whose birthday (month and day only) falls earlier in a year will apply for the covered dependent children before those of the plan of the parent whose birthday falls later in that year.

(b) If both parents have the same birthday (month and day only), the benefits of the plan that covered the parent longer will apply for the covered dependent children before those of the plan which covered the other parent for a shorter period of time.

(c) If the other plan does not have the birthday rule described above, but instead has a rule based upon the gender of the parent and if, as a result, the plans do not agree on the order of benefits, the rule based upon the gender of the parent will determine the order of benefits.

c. If the natural parents of the covered dependent child are divorced or otherwise separated, the following coordination of benefit rules apply:

(1) If the parent with custody of the child has not remarried, the plan which covers the child as a dependent of that parent will be considered before the plan that covers the child as the dependent of the parent without custody.

(2) If the parent with custody of the child has remarried, the plan which covers the child as a dependent of that parent will be considered before the plan that covers the child as a dependent of the current stepparent. The plan that covers the child as a dependent of the parent without custody will be considered last.

(3) If there is a court decree that establishes financial responsibility for the medical, dental or other health care expenses with respect to the child, (i) and (ii) above will not apply. The plan that covers the child as a dependent of the parent with such financial responsibility will be considered before any other plan that covers the child as a dependent.

d. When the rules above do not apply, the plan that has insured the person the longest will be primary, except that a plan insuring the individual as a retired or laid off employee will pay as secondary plan.

5. An allowable expense is a Medically Necessary expense under this Certificate and covered, at least in part, by one of the other plans. If a plan provides benefits in the form of services rather than cash payments, we will determine a reasonable cash value for each service that is provided and that cash value will be considered the allowable expense and the amount paid by the other plan.

6. Benefits will be coordinated on a Calendar Year basis or any portion of a Calendar Year in which the person was insured by us.

7. For purposes of this COB provision, any or all of the following may apply:

a. You are required to furnish us with complete information concerning all plans and benefits paid or payable from other plans.

b. As permitted by law, we may without your consent:

(1) Obtain information from all plans involved;

(2) Reimburse such other plans, if we determine that benefits have been paid by another plan that should have been paid by us. Such reimbursement will be a valid payment under the terms of this Certificate.

c. We may obtain reimbursement from any other plan, and/or from you, if we have paid benefits that should have been paid by any other plan. Such reimbursement is a valid payment under the other plan.

d. We may obtain a refund of any amount that exceeded 100% of Covered Expenses as a result of our payment as a secondary plan.

Cost Containment

We reserve the right to initiate, conduct and maintain, or to contract for, various programs and procedures directed at containing medical costs. Such programs and procedures include, but are not limited to:

1. Utilization Review;
2. Continued stay review;
3. Retrospective review;
4. Auditing of expenses including, but not limited to, the review of coding and payment. We will pay appropriate medical claims when coded according to the latest editions of the Current Procedural Terminology (CPT) manual or International Classification of Diseases (ICD) manual. We will not pay for any of the following:
   a. Charges that are billed separately as professional services when the procedure requires only a technical component;
   b. Charges that are billed incorrectly or billed separately but are an integral part of another billed service;
   c. Other claims that are improperly billed; or
   d. Duplicates of previously received or processed claims.
5. Our auditing process also includes adjustments when a Physician bills for a secondary or tertiary procedure. A secondary or tertiary procedure is a procedure that is separate and distinct from the primary procedure, but which is performed by the same Physician during the same operative session. A procedure is considered secondary or tertiary because the patient only requires anesthesia or analgesia one time, the procedure room is used only one time, and set up for the separate procedure is done at the same time. For secondary or tertiary procedures performed during the same operative session, the Covered Expenses for the Physician's bill will be:
   a. One hundred percent of the Usual and Customary Charge for the primary procedure;
   b. Fifty percent of the Usual and Customary Charge for the secondary procedure; and
   c. Twenty-five percent of the Usual and Customary Charge for each additional procedure.
6. Negotiated Payment Arrangements.

Workers' Compensation

This Certificate is not a workers' compensation policy. This Certificate does not satisfy any governmental requirements for coverage by workers' compensation insurance.

Time Limit on Certain Defenses

After 2 years from the Issue Date, no misstatements made by the applicant in the Application for this Certificate, except fraudulent misstatements, shall be used to void the Certificate or to deny a claim for loss Incurred or Total Disability commencing after the expiration of such 2 year period. No claim for loss Incurred or Total Disability commencing after 2 years from the Issue Date shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the Issue Date.

Appeal of (Claim) Decision

"Grievance" means a written complaint submitted by or on behalf of a Covered Person ("you" or "your") regarding the:

1. Availability, delivery or quality of health care services, including a complaint regarding an adverse determination made pursuant to utilization review:
2. Claims payment, handling or reimbursement for health care services; or
3. Matters pertaining to the contractual relationship between you and us.

The following grievance process is voluntary to you.

***Informal Reconsideration* —** If you have a problem or complaint concerning a claim, certificate provision, decision or action, you may attempt to resolve the problem immediately by contacting the Customer Service Department at this toll-free telephone number [1-800-786-7557]. An attempt will be made to solve the problem to your satisfaction during the initial telephone call.

If you are not satisfied, you may voluntarily submit a written grievance with us at:

[World Insurance Company
P.O. Box 2155
Omaha, Nebraska 68103-0155
ATTN: Grievance Coordinator]

Your state department of insurance is available to assist insurance consumers with insurance-related problems and questions.

You may inquire in writing to:

[Arkansas Insurance Department
Consumer Services Division
Third and Cross Streets
Little Rock, AR 72201
(501) 371-2640
Fax: (501) 371-2749
or call: 1-800-852-5494]

Internal Grievance Procedure

First-Level Grievance Review — The grievance may be submitted by you, your representative or your health care Provider ("Provider") acting on your behalf.

You must submit written material for consideration by the first-level reviewers.

Upon receipt of a request for the first-level grievance review, we will:

1. Within three business days after receiving a grievance, provide you with the name, address and telephone number of the grievance coordinator and information on how to submit written material;
2. Within 20 business days after receiving a grievance, issue a written decision to you or your representative. If we cannot make a decision within 20 business days due to circumstances beyond our control, we may take up to an additional 10 business days to issue a written decision. The person(s) reviewing the grievance shall not be the same person(s) who initially handled the matter that is the subject of the grievance; and if the issue is a clinical one, at least one of whom shall be a medical doctor with appropriate expertise to evaluate the matter. The written decision issued in a first-level grievance review will contain:
    a. The professional qualifications and licensure of the person or persons reviewing the grievance.
    b. A statement of the reviewers' understanding of the grievance.

c. The reviewers' decision in clear terms and the contractual basis or medical rationale in sufficient detail for you to respond further to our position.

d. A reference to the evidence or documentation used as the basis for the decision.

e. A statement advising you of your right to request a second-level grievance review and a description of the procedure for submitting a second-level grievance.

Second-Level Grievance Review — A second-level grievance review process is available for you if you are dissatisfied with the first-level grievance review decision or a Utilization Review (UR) appeal decision.

We will, within 10 business days after receiving a request for a second-level grievance review, provide the following information to you:

1. Name, address and telephone number of grievance review coordinator;
2. Statement of your rights, including the right to:
   a. Request and receive from us all information relevant to the case;
   b. Present your case to the review panel;
   c. Submit supporting material prior to and at the review meeting;
   d. Ask questions of any member of the panel; and
   e. Be assisted or represented by a person of your choosing; including a family member, authorized representative or attorney.

Second-Level Grievance Review Procedures — The second-level grievance review will include:

1. The review panel will schedule and hold a review meeting within 45 business days after receiving a request for a second-level review.
2. You will be notified in writing at least 15 working days before the review meeting date.
3. Your right to a full review will not be conditioned on your appearance at the review meeting.

Second-Level Grievance Review Decisions — We will issue a written decision to you and, if applicable, to your Provider within seven business days after completing the review meeting. The decision will include:

1. The professional qualifications and licensure of the members of the review panel;
2. A statement of the review panel's understanding of the nature of the grievance and all pertinent facts;
3. The review panel's recommendation to us and the rationale behind that recommendation;
4. A description of or reference to the evidence or documentation considered by the review panel in making the recommendation;
5. In the review of a noncertification or other clinical matter, a written statement of the clinical rationale, including the clinical review criteria, that was used by the review panel to make the recommendation;
6. The rationale for our decision if it differs from the review panel's recommendation;
7. A statement that the decision is our final determination in the matter; and
8. Notice of the availability of the Commissioner's office for assistance, including the telephone number and address of the Commissioner's office.

Expedited Second-Level Review Procedures

An expedited second-level review will be made available where medically justified, whether or not the initial review was expedited. We are not required to provide an expedited review for retrospective adverse determinations. The provisions of Second-Level Grievance Review, Second-Level Grievance Review

Procedures, and Second-Level Grievance Review Decisions apply to expedited review except for the following timetable:

1. Review proceeding must take place and the decision communicated to you within four business days of receiving all the necessary information.
2. Review meeting must take place by way of a telephone conference call or through the exchange of written information.

We will not discriminate against any Provider based on any action taken under this provision or under the UR provisions on your behalf.

Standard External Review

At the time we receive a request for an external review, we shall assign an independent review organization (IRO) from the list of approved IRO's compiled and maintained by the commissioner to conduct a preliminary review of the request to determine if:

1. Tthe report for external review meets the applicability standards for external review;
2. You have exhausted our internal grievance process unless you are not required to; and
3. You have provided all the information and forms required to process an external review, including the authorization form.

Within five (5) business days after receipt of the request for external review, the IRO assigned shall complete the preliminary review and notify us, you, and your treating health care professional in writing whether: a) the request is complete; and b) the request has been accepted for external review. The assigned IRO shall include in the notice a statement that we, you, and your treating health care professional may submit in writing to the IRO within seven (7) business days following the date of receipt of the notice, additional information and supporting documentation that the IRO shall consider when conducting the external review.

If the request: a) is not complete, the assigned IRO shall, within five (5) business days, inform us, you, and your treating health care professional what information or materials are needed to make the request complete; or b) is not accepted for external review, the assigned IRO shall inform you, your treating health care professional and us in writing within five (5) business days, of the reasons for its non-acceptance.

Upon receipt of any information submitted by you, the assigned IRO immediately shall forward copies of the information to us.

In reaching a decision to accept or reject a matter for external review, the assigned IRO is not bound by any decisions or conclusions reached during our internal grievance procedure or utilization review procedure.

Within seven (7) business days after the date of receipt of the notice, we shall provide to the assigned IRO, you, and your treating health care professional, the documents and any information considered in making the adverse determination or final adverse determination, together with any additional information we submit. Failure by us or our utilization review organization to provide the documents and information within the time specified shall not delay the conduct of the external review. If we or our utilization review organization fail to provide the documents and information within the time specified, the assigned IRO may terminate the external review and make a decision to reverse the adverse determination or final adverse determination. Immediately upon making the decision, IRO shall notify you, your treating health care professional, and us.

The assigned IRO shall review all of the information and documents submitted by you, your treating health care professional, and us. Upon receipt of the information, if any, required to be forwarded, we may reconsider its adverse determination or final adverse determination that is the subject of the external review. Reconsideration by us of our adverse determination or final adverse determination shall not delay or terminate the external review. The external review may only be terminated if we

decide, upon completion of our reconsideration, to reverse its adverse determination or final adverse determination and provide coverage or payment for the health care services that is the subject of the adverse determination or final adverse determination. Immediately upon making the decision to reverse its adverse determination or final adverse determination, we shall notify you, your treating health care professional, and the assigned IRO in writing of our decision. The assigned IRO shall terminate the external review upon receipt of the notice from us.

In exercising its independent medical judgment in reviewing an adverse determination, in additional to the documents and information provided, the assigned IRO, to the extent the information or documents are available, shall consider the following in reaching a decision:

1. Your medical records;
2. The treating health care professional's recommendation;
3. Consulting reports from appropriate health care professionals and other documents submitted by us, you, or your treating health care professional;
4. The applicable terms of coverage under your health benefit plan to ensure that the IRO's decision is not contrary to the terms of coverage;
5. The most appropriate practice guidelines, which may include generally accepted practice guidelines, evidence-based practice guidelines or any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;
6. Any applicable written screening procedures, decision abstracts, clinical protocols and practice guidelines used by us to determine the necessity and appropriateness of health care services;
7. If the adverse determination involves a denial of coverage based on a determination that the recommended or requested health care services is "Experimental" or "Investigational," the IRO shall also consider whether:
    a. The recommended or requested health care service or Treatment has been approved by the federal Food and Drug Administration for the condition, while realizing that Treatments or services are often legitimately used for purposes other than those listed in the FDA approval; or
    b. Medical or scientific evidence demonstrates that the expected benefits of the recommended or requested health care service or Treatment is more likely than not, to be more beneficial to you than any available standard health care service or Treatment, and the adverse risks of the recommended or requested health care service or Treatment would not be substantially increased over those of available standard health care services or Treatments.

Within 45 calendar days after the date of receipt of the request for an external review, the assigned IRO shall provide written notice of its decision to uphold, reverse, or partially uphold or reverse, the adverse determination or the final adverse determination to you, your treating health care professional, and us. The IRO shall include in the notice sent:

1. A general description of the reason for the request for external review;
2. The date the IRO received the assignment from us to conduct the preliminary review of the external review request;
3. The date the external review was conducted, if appropriate;
4. the date of its decision;
5. The principal reason or reasons for its decision;
6. The rationale for its decision; and

7. References to the evidence or documentation, including the practice guidelines, considered in reaching its decision.

If the adverse determination involves a denial of coverage based on a determination that the recommended or requested health care services is “experimental” or “investigational,” the IRO shall also consider whether:

1. Aa description of the indicators relevant to determining whether there is sufficient evidence to demonstrate that the recommended or requested health care service or Treatments is more likely than not, to be more beneficial to you than any available standard health care services or Treatments, and the adverse risks of the recommended or requested health care service or Treatment would not be substantially increased over those of available standard health care services or Treatments; and
2. A description and analysis of any medical or scientific evidence, considered in reaching the opinion.

Upon receipt of a notice of a decision reversing the adverse determination or final adverse determination, we immediately shall approve the coverage that was the subject of the adverse determination or final adverse determination.

Expedited External Review

You may make a request for an expedited external review with us at the time you receive an adverse determination if the criteria for an external review, as noted above, is met. At the time you make a request for an expedited external review, you or your treating health care professional shall submit additional information and supporting documentation that the IRO shall consider when conducting the expedited external review.

At the time we receive a request for an expedited external review, we immediately shall assign an IRO from the list compiled and maintained, to determine whether the request meets the reviewability requirements set forth in this provision, and conduct the external review if the request meets the reviewability requirements. In reaching a decision, the assigned IRO is not bound by any decisions or conclusions reached during our utilization review process or our internal grievance process.

At the time we assign an IRO to conduct the expedited external review, we shall immediately provide or transmit all documents and information considered in making the adverse determination or final adverse determination, as well as any additional information and supporting documentation, to the assigned IRO, you, and your person’s treating health care professional via electronically, facsimile or any other available expeditious method. We shall also submit to the IRO any information you submit, in addition to the documents and information provided or transmitted, to the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate.

As expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the date of receipt of the request for an expedited external review that meets the reviewability requirements, the assigned IRO shall:

1. Make a decision to uphold or reverse the adverse determination; and
2. Notify you, your treating health care professional, and us of the decision.

If the notice provided was not in writing within two (2) days after the date of providing that notice, the assigned IRO shall:

1. Provide a written or electronic media confirmation of the decision to you and us; and
2. Include the information set forth above under the standard external review requirements.

Upon receipt of notice of a decision reversing the adverse determination or final adverse determination, we immediately shall approve the coverage that was the subject of the adverse determination or final adverse determination.

An expedited external review may not be provided for adverse or final adverse determinations involving a retrospective review.

Binding Nature of External Review Decision

An external review decision is binding on us except to the extent we have other remedies available under applicable federal or state law. An external review decision is binding on you except to the extent you have other remedies available under applicable federal or state law. You may not file a subsequent request for external review involving the same adverse determination or final adverse determination for which you have already received an external review decision

Legal Actions

All of the following limitations apply to your ability to file an action at law or equity relating to this Certificate:

1. You cannot file such an action at law or equity before the expiration of 60 days after proof of loss has been furnished to us in accordance with the requirements of this Certificate;
2. You cannot file such an action at law or equity unless you have fully complied with this Certificate's appeal procedures; and
3. You cannot bring an action at law or equity unless you bring it within three years from the expiration of the time by which proof of loss is required under the terms of this Certificate.

Right of Reimbursement

1. If a Covered Person Incurs expenses for an Illness or Injury that occurred due to the negligence of a third party:
   a. We have the right to reimbursement for all Benefits we paid if damages are collected from the third party for those same expenses. This right of reimbursement exists regardless of whether such damages are recovered by action at law, settlement, or compromise, by you, your parents if you are a minor, or your legal representative; and
   b. We are assigned the right to recover from the third party or his or her insurer, to the extent of the benefits we paid for the Illness or Injury.
2. We shall have the right to first reimbursement out of all funds you, the Covered Person's parents (if the Covered Person is a minor) or the Covered Person's legal representative, are or were able to obtain for the same expenses we paid as a result of that Illness or Injury.
3. You are required to furnish any information or assistance or provide any documents that we may reasonably require in order to exercise our rights under this provision. This provision applies whether or not the third party admits liability.
4. You must provide us with timely written notification in the event that a Covered Person suffers an Illness or an Injury in which a third party might be responsible and the Covered Person seeks recourse against any person, entity or Other Insurance coverage by suit, settlement, judgment or otherwise. Such a notice must inform us of all of the following:
   a. The nature of the Illness or Injury;
   b. The names, addresses and phone numbers of any insurance companies or other third parties who may be responsible for payment of damages suffered by the Covered Person;
   c. A description of the accident or occurrence that the Covered Person reasonably believes was responsible for the Illness or Injury at issue and the approximate date(s) on which such accident or occurrence happened; and
   d. The name of any legal counsel retained by a Covered Person in connection with any such accident or occurrence.
5. If a Covered Person brings a lawsuit or other proceeding to recover damages in connection with any such accident or occurrence, you or your attorney must provide us with copies of all pleadings, notices and other documents and papers that are related to our right to reimbursement under this Certificate. We

reserve the right to intervene in any proceeding in which a Covered Person is a party to the extent that such intervention is reasonably necessary to protect our right to reimbursement under this Certificate.

6. Upon recovery of any portion of our reimbursement interest by way of settlement or judgment, we will not be required, under any circumstances, to pay a fee to the Covered Person's attorney or share in any costs Incurred by the Covered Person and/or the Covered Person's attorney in obtaining the settlement or judgment.
7. A Covered Person is not obligated by this provision to seek legal action against any person or entity for recovery of Benefits paid under this Certificate.

Section VI. Continuation and Conversion

Continuation of Coverage

You and Covered Dependents may be eligible to have the medical coverage continued under this Certificate after coverage otherwise would terminate if such termination is the result of your loss of membership. However, to have coverage continued under this provision, you and the Covered Dependents must continue to satisfy the other conditions of this Certificate. The following provisions apply to the continuation of coverage for you and Covered Dependents.

1. For you and your Covered Dependents.
   a. You may continue coverage under this Certificate for yourself and your Covered Dependents for as long as nine months when both of the following have occurred:
      (1) Your coverage ends because your membership in the association ends; and
      (2) You have been insured under this Certificate for at least three months before your coverage ends.
   b. If you elect to continue coverage under this Certificate, you must send to us:
      (1) Written notice that you want to continue coverage; and
      (2) The first monthly premium.
   c. If we provide you with written notice of your right to continue coverage, you must make your election to continue coverage on or before the later of the following dates:
      (1) Ten days after your membership in the association ends; or
      (2) Ten days after we have provided written notice of your right to continue coverage.
   d. If we do not provide you with the written notice, you must make your election to continue coverage no later than 60 days after your membership in the association ends (not when any applicable extension of benefits ends).
   e. You must continue to make premium payments to us throughout the period of continued coverage. During the period in which your coverage is continued, we are not required to send you any notification that your premium is due.
   f. Your continued coverage under this Certificate will end at 12:01 a.m. local time at your state of residence on the earliest of the following dates:
      (1) The day any premium is due but unpaid;
      (2) The date 9 months after the date you make your continuation election;
      (3) The day you become insured under similar group coverage that was not in effect on the day your membership in the association ended;
      (4) The date you become entitled to Medicare coverage;
      (5) The day you enter the armed forces;
      (6) The day you are no longer an eligible Dependent; or
      (7) The day continued coverage becomes conversion coverage.

2. For your Covered Dependents, covered spouse, former spouse, domestic partner, or person with whom you have a civil union ("civil union partner") if the forgoing were covered under this Certificate.

   a. Your current spouse, domestic partner or civil union partner (if covered under this Certificate), former covered spouse, domestic partner or civil union partner (in the event you die, your marriage is ended in divorce or annulment, or your domestic partnership or civil union ends) and any other Covered Dependents may continue this coverage until the earliest of:

      (1) The day any premium is due but unpaid, including any grace period provided by the Certificate;

      (2) The day coverage under the Certificate would end if you or your former spouse were still married;

      (3) The day coverage under the Certificate would end if you or your former domestic partner were still domestic partners;

      (4) The day coverage under the Certificate would end if you or your former civil union partner still were civil union partners;

      (5) The day a Dependent no longer meets the definition of a Covered Dependent under this Certificate;

      (6) The day your former spouse remarries;

      (7) The day your current or former spouse, current or former domestic partner, or current or former civil union partner becomes insured under any other group health plan;

      (8) The day continued coverage becomes Conversion Coverage.

   b. To elect to continue coverage under this Certificate, your current or former spouse, current or former domestic partner, current or former civil union partner, or another Covered Dependent must notify us of their desire to continue coverage within 30 days following your death, divorce, annulment, or the date that person no longer meets the definition of "Dependent" under this Certificate. Within 30 days after we receive such notice, we will send the following materials to your current or former spouse, current or former domestic partner, current or former civil union partner, or other Covered Dependent by certified mail, return receipt requested:

      (1) A form on which your current or former spouse, current or former domestic partner, current or former civil union partner, or other Covered Dependent can elect to continue coverage under this Certificate;

      (2) The dollar amount of the premiums that must be paid for coverage to continue and when such premium payments will be due;

      (3) The method and place of payment;

      (4) Instructions for returning the election form.

      If your former or current spouse, current or former domestic partner, or current or former civil union partner fails to return the election form and the required premium payment to us within the required time period, his or her rights of continuation and continued benefits will end. **We require that your current or former spouse, current or former domestic partner, current or former civil union partner or other Covered Dependent return the election form by certified mail, return receipt requested, within 30 days after the date on which we mail the election form to them.**

   c. If we fail to send the notification as described above, all premiums will be waived and benefits will continue under the terms of the Certificate. Such waiver of premiums and continuation of benefits will be limited to the period between the date such notice is required through the date such notice ultimately is sent. The foregoing waiver of premiums and continuation of benefits will not occur if the benefits that existed, at the time such notice was to be sent, end for all Covered Persons under the group policy.

Conversion Coverage

1. This Conversion Coverage provision sets forth the rules and processes for Covered Persons who want to obtain conversion coverage. In providing conversion coverage, please be advised that we may provide different benefit levels, covered services and premium rates.
2. Conversion coverage is available to you if your coverage under this Certificate ends unless your coverage ends for any one of the following reasons:
   a. You fail to make any required premium payment;
   b. The group policy is terminated;
   c. You have similar individual or group coverage;
   d. You are eligible for or have Medicare coverage; or
   e. You have been covered under this Certificate for less than three months immediately before your coverage ended.
3. Conversion coverage is available to your Covered Dependents if their coverage ends because:
   a. Your coverage ends;
   b. You die;
   c. Your marriage is ended by divorce or annulment;
   d. Your domestic partnership ends;
   e. Your civil union partnership ends; or
   c. A covered dependent child is no longer an eligible Dependent.
4. Conversion coverage is not available to a Covered Dependent when any one of the following occurs:
   a. You fail to make the required premium payment;
   b. The group policy is terminated;
   c. The Covered Dependent has similar individual or group coverage;
   d. The Covered Dependent is eligible for or has Medicare coverage; or
   e. You have been insured under this Certificate for less than three months immediately before your coverage ended.
5. Option to Obtain Conversion Coverage. If application and the first premium payment are made within the required time period, conversion coverage will be issued in accordance with our rules and the conversion law in effect when application is made.
6. If we provide you with written notice of the right to convert coverage, application and the first premium payment must be received by us by the later of:
   a. 31 days after coverage under this Certificate ends; or
   b. 15 days after we provide you with written notice of the right to convert coverage.

   If we do not provide you with written notice of the right to convert coverage, application and the first premium payment must be received by us no later than 60 days after coverage under this Certificate ends (not when any applicable extension of benefits ends).

7. Application to convert coverage may be made:
   a. By you:
      (1) For yourself;
      (2) For yourself and any Covered Dependent whose coverage under this Certificate ends because your coverage under this Certificate ends; or
      (3) For any Covered Dependent who does not have the legal capacity to apply.
   b. By any Covered Dependent to whom conversion coverage is available.
8. Conditions. Conversion coverage begins immediately after coverage under this Certificate ends. Covered Expenses for which Benefits are payable under this Certificate will not be paid under the conversion coverage. Coverage for conditions that are excluded under this Certificate may be excluded under the conversion coverage.