

SERFF Tracking Number: MGCC-125610406 State: Arkansas
Filing Company: The Mega Life and Health Insurance Company - State Tracking Number: 38722
IC
Company Tracking Number: 26026 PPO-IP AR
TOI: H15I Individual Health - Sub-TOI: H15I.001 Health - Hospital/Surgical/Medical
Hospital/Surgical/Medical Expense Expense
Product Name: 2008 MEGA CareChoice Individual
Project Name/Number: /

Filing at a Glance

Company: The Mega Life and Health Insurance Company - IC

Product Name: 2008 MEGA CareChoice Individual SERFF Tr Num: MGCC-125610406 State: ArkansasLH

Individual

TOI: H15I Individual Health -

SERFF Status: Closed

State Tr Num: 38722

Hospital/Surgical/Medical Expense

Sub-TOI: H15I.001 Health -

Co Tr Num: 26026 PPO-IP AR

State Status: Approved-Closed

Hospital/Surgical/Medical Expense

Filing Type: Form/Rate

Co Status:

Reviewer(s): Rosalind Minor

Authors: Courtney Andre, Kathleen Allen

Disposition Date: 04/21/2008

Allen

Date Submitted: 04/15/2008

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name:

Status of Filing in Domicile:

Project Number:

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 04/21/2008

State Status Changed: 04/21/2008

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

The above referenced forms are submitted for your review and approval. These forms are identical to the SERFF filing MGCC-125375768 which was approved by your Department on December 18, 2007. The forms are new and are not

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intended to replace any forms currently approved by your department.

For marketing purposes, the Company has prepared an additional Policy Schedule of Benefits structure ("Option B"). Schedule pages enclosed include the following new marketing components:

1. Deductible structure: the Deductible will be applied per "Calendar Year".
2. PPO & Non-PPO Coinsurance structure: traditional PPO and Non-PPO Coinsurance level variances have been added in lieu of the 25% out-of-network reduction.
3. Physician's Visits While Hospital Confined Benefit: the one visit limitation has been deleted.
4. Assistant Surgeon Benefit: the 20% of primary surgeon expenses limit has been deleted.
5. Anesthesiologist Benefit: the 50% of primary surgeon expenses limit has been deleted.
6. Outpatient Diagnostic Services Benefit: the maximum benefit has been increased to \$10,000 per Calendar Year.
7. Availability of "Physician's Office Visit Rider" (once approved)

Coupled with the marketing changes explained above, Amendatory Endorsement form AE 26026 PPO-IP AR has been created to amend the policy definitions and benefits to correspond with the marketing enhancements shown in the Policy Schedules.

Please be advised the purpose of bracketed items contained within the enclosed Policy Schedule pages and Amendatory Endorsement is to allow for the Policyholder to customize benefits or to give the Company flexibility to provide less administrative restrictions. Please be assured that at no time will the enclosed bracketed information be arranged in such a way as to violate the laws of your state.

To the best of our knowledge, information and belief, the forms submitted herewith are in compliance in all respects with the provisions of the insurance laws, rules, and regulations of your state. Additionally, Actuarial Memoranda and Rates reflecting these marketing options have been enclosed herewith, as well as all required Certifications and/or Transmittal Forms.

Thank you for your assistance with this filing; we appreciate the opportunity. Should you have any questions regarding this submission, or if anything further is needed to expedite your review and approval, please do not hesitate to call me

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 Hospital/Surgical/Medical Expense Expense
 Product Name: 2008 MEGA CareChoice Individual
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 collect at (817) 255-3590.

Company and Contact

Filing Contact Information

Kathleen Allen, Compliance Analyst III kathleen.allen@healthmarkets.com
 9151 Boulevard 26 (817) 255-3590 [Phone]
 North Richland Hills, TX 76180 (817) 255-8153[FAX]

Filing Company Information

The Mega Life and Health Insurance Company CoCode: 97055 State of Domicile: Oklahoma
 - IC
 9151 Boulevard 26 Group Code: 264 Company Type: Health
 North Richland Hills, TX 76180 Group Name: State ID Number:
 (817) 255-3100 ext. [Phone] FEIN Number: 59-2213662

Filing Fees

Fee Required? Yes
 Fee Amount: \$100.00
 Retaliatory? No
 Fee Explanation: 1 rate filing=\$50.00
 1 policy form filing=\$50.00
 \$50.00 rate filing+\$50.00 policy form filing=\$100.00
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Mega Life and Health Insurance Company - IC	\$100.00	04/15/2008	19580753

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Hospital/Surgical/Medical Expense
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	04/21/2008	04/21/2008

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Hospital/Surgical/Medical Expense *Expense*
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Disposition

Disposition Date: 04/21/2008

Implementation Date:

Status: Approved-Closed

Comment: This submission is being approved effective on the date under the condition that benefit payable a PPO and Non-PPO provider will comply with our Bulletin 9-85.

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form	CATASTROPHIC EXPENSE PREFERRED PROVIDER ORGANIZATION (PPO) POLICY	Approved-Closed	Yes
Form	Outline of coverage	Approved-Closed	Yes
Form	Outline of coverage	Approved-Closed	Yes
Form	Amendatory Endorsement	Approved-Closed	Yes
Form	PHYSICIAN OFFICE VISIT BENEFIT RIDER	Approved-Closed	Yes

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Form Schedule

Lead Form Number:

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	26026 PPO-IP AR	Policy/Contract/Fraternal Certificate	CATASTROPHIC EXPENSE PREFERRED PROVIDER ORGANIZATION (PPO) POLICY	Initial			26026 PPO-IP AR.pdf
Approved-Closed	26026 PPO-IP AR	Outline of Coverage	Outline of coverage	Initial			26026 IP OC AR.pdf
Approved-Closed	26026 PPO-IP AR	Outline of Coverage	Outline of coverage	Initial			26026 IP OC AR NOTICE.pdf
Approved-Closed	AE 26026 PPO-IP AR	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Amendatory Endorsement	Initial			AE 26026 PPO-IP AR.pdf
Approved-Closed	25886-IP	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement	PHYSICIAN OFFICE VISIT BENEFIT RIDER	Initial			25886-IP.pdf

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nt or Rider

THE MEGA LIFE AND HEALTH INSURANCE COMPANY

A Stock Company
(Hereinafter called: the Company, We, Our or Us)
Home Office: Oklahoma City, Oklahoma
Administrative Office: P.O. Box 982010
North Richland Hills, Texas 76182-8010
Customer Service: 1-800-527-5504

CATASTROPHIC EXPENSE PREFERRED PROVIDER ORGANIZATION (PPO) POLICY

IMPORTANT NOTICE ABOUT STATEMENTS IN THE APPLICATION

The attached application is a part of this Policy. Please read it and check it carefully. This Policy is issued on the basis that Your answers are correct and complete. If it is not complete or has an error, please let Us know within 10 days. An incorrect application may cause Your coverage to be voided, or a claim to be reduced or denied.

10 DAY RIGHT TO EXAMINE THE POLICY

It is important to Us that You understand and are satisfied with the coverage being provided to You. If You are not satisfied that this coverage will meet Your insurance needs, You may return this Policy to Us at Our administrative office in North Richland Hills, Texas, within 10 days after You receive it. Upon receipt, We will cancel Your coverage as of the Policy Date, refund all premiums paid and treat the Policy as if it were never issued.

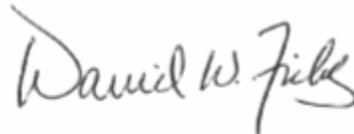
RENEWABILITY

This Policy is guaranteed renewable, subject to the Company's right to discontinue or terminate the coverage as provided in the TERMINATION OF COVERAGE section of this Policy. The Company reserves the right to change the applicable table of premium rates on a Class Basis. The premium for the Policy may change in amount by reason of an increase in the age of an Insured Person.

This Policy is a legal contract between You and Us. **PLEASE READ YOUR POLICY CAREFULLY!**



SECRETARY



PRESIDENT

IMPORTANT MESSAGE TO OUR POLICYHOLDERS

Canceling health insurance coverage and purchasing new coverage, on account of encouragement by any agent, is called replacement. Some states have laws which forbid any misrepresentation by any agent that may occur at the time of replacement. Beware of anyone who encourages You to replace this coverage without allowing You time to carefully investigate the replacement proposal, or discourages You from talking with a representative of the Company whose coverage is being recommended for replacement. For Your protection, if You are encouraged to replace this coverage, We urge You to seek advice and to take the time to investigate any recommendation.

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POLICY SCHEDULE

PRIMARY INSURED: [John Doe, Sr.]	EFFECTIVE DATE OF COVERAGE: [01/02/08]
COVERED DEPENDENTS: [Johnette Doe] [John Doe, Jr.] [Johnita Doe]	EFFECTIVE DATE OF COVERAGE: [01/02/08] [03/12/09] [01/22/10]
POLICY NUMBER: [ABC1234567]	POLICY DATE: [01/02/08]
INITIAL PREMIUM: \$[0.00]	MODE OF PAYMENT: [Monthly]
POLICY FEE: [\$50.00]	

SCHEDULE OF BENEFITS

Insured Persons have the right to obtain medical care from the Physicians, Hospitals and other health care providers of their choice; however, if Covered Expenses are incurred from services provided by a non-PPO Provider, Benefits may be less than the amount that would have otherwise been payable for Covered Expenses incurred from services provided by a PPO Provider.

LIFETIME MAXIMUM AMOUNT:	[\$5,000,000]				
[AGGREGATE MAXIMUM AMOUNT:	[\$1,000,000]]				
DEDUCTIBLE: (Applies per Insured Person, per Calendar Year)	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 33%;">PPO Provider</td> <td style="width: 33%;">Non-PPO Provider</td> </tr> <tr> <td>[\$1,500 / \$2,000 / \$2,500 / \$3,000 / \$3,500 / \$5,000 / \$7,500 / \$10,000]</td> <td>[\$3,000 / \$4000 / \$5,000 / \$6,000 / \$7,000 / \$10,000 / \$15,000 / \$20,000]</td> </tr> </table>	PPO Provider	Non-PPO Provider	[\$1,500 / \$2,000 / \$2,500 / \$3,000 / \$3,500 / \$5,000 / \$7,500 / \$10,000]	[\$3,000 / \$4000 / \$5,000 / \$6,000 / \$7,000 / \$10,000 / \$15,000 / \$20,000]
PPO Provider	Non-PPO Provider				
[\$1,500 / \$2,000 / \$2,500 / \$3,000 / \$3,500 / \$5,000 / \$7,500 / \$10,000]	[\$3,000 / \$4000 / \$5,000 / \$6,000 / \$7,000 / \$10,000 / \$15,000 / \$20,000]				
COINSURANCE MAXIMUM:	[\$4,000 / \$6,000 / \$8,000] [\$8,000 / \$12,000 / \$16,000]				

BENEFITS

PPO COINSURANCE

NON-PPO COINSURANCE

Inpatient Hospital Services	[70%][80%][90%] of Covered Expenses	[50%][60%][70%] of Covered Expenses
Physician Visits while Hospital Confined [Not to exceed a [\$100] Maximum benefit per Insured Person, per day]	[100%] of Covered Expenses	[100%] of Covered Expenses
Surgeon Benefit	[70%][80%][90%] of Covered Expenses	[50%][60%][70%] of Covered Expenses
Assistant Surgeon Benefit	[70%][80%][90%] of Covered Expenses	[50%][60%][70%] of Covered Expenses
Anesthesiologist Benefit	[70%][80%][90%] of Covered Expenses	[50%][60%][70%] of Covered Expenses
Outpatient Surgery Facility Charges	[70%][80%][90%] of Covered Expenses	[50%][60%][70%] of Covered Expenses

**POLICY SCHEDULE (Continued)
SCHEDULE OF BENEFITS (Continued)**

<u>BENEFITS</u>	<u>PPO COINSURANCE</u>	<u>NON-PPO COINSURANCE</u>
<p>Durable Medical Equipment and Prosthetic Devices [Not to exceed a [\$5,000] Maximum Benefit per Insured Person, per Calendar Year]</p>	[70%][80%][90%] of Covered Expenses	[50%][60%][70%] of Covered Expenses
<p>Second Surgical Opinion</p>	[70%][80%][90%] of Covered Expenses	[50%][60%][70%] of Covered Expenses
<p>Outpatient Diagnostic Services [(incurred within [21] days of a Surgery or Hospital Confinement and related to and necessary for the diagnosis and treatment of the Sickness or Injury that results in Surgery or Hospital Confinement)]</p> <p>[Not to exceed a [\$10,000] Maximum Benefit, per Insured Person, per Calendar Year]</p> <p>[Copayment, per Insured Person, per [24] hour period [\$50][\$100][\$150]]</p>	[70%][80%][90%] of Covered Expenses	[50%][60%][70%] of Covered Expenses
<p>Ambulance Transport [(payable only when Hospital Confined)]</p> <p>[Not to exceed a [\$500] Maximum Benefit per Insured Person, per trip]</p>	[70%][80%][90%] of Covered Expenses	[70%][80%][90%] of Covered Expenses
<p>Chemotherapy [With approved Chemotherapy or Radiation Therapy Course of Treatment Plan]</p> <p>[Without approved Chemotherapy or Radiation Therapy Course of Treatment Plan, not to exceed a [\$1,500] Maximum Benefit, per day]</p>	[70%][80%][90%] of Covered Expenses	[50%][60%][70%] of Covered Expenses
<p>Radiation Therapy [With approved Chemotherapy or Radiation Therapy Course of Treatment Plan]</p> <p>[Without approved Chemotherapy or Radiation Therapy Course of Treatment Plan, not to exceed a [\$1,250] Maximum Benefit, per day]</p>	[70%][80%][90%] of Covered Expenses	[50%][60%][70%] of Covered Expenses

POLICY SCHEDULE (Continued)
SCHEDULE OF BENEFITS (Continued)

<u>BENEFITS</u>	<u>PPO COINSURANCE</u>	<u>NON-PPO COINSURANCE</u>
<p>Transplant Procedures In Designated Transplant Facility</p> <p>Travel and Accommodation Expenses provided the transplant facility is more than [300] miles from the Insured Person's home:</p> <p>Maximum Benefit payable per day [\$150]</p> <p>Maximum Benefit payable per Transplant Benefit Period [\$3,000]</p>	[100%] of Covered Expenses	[100%] of Covered Expenses
<p>Transplant Procedures In Non-Designated Transplant Facility</p> <p>Not to exceed [\$100,000] per Insured Person, per Transplant Procedure</p>	[70%] [80%] [90%] of Covered Expenses	[70%] [80%] [90%] of Covered Expenses
<p>Child Health Supervision Services</p> <p>Immunizations only</p>	[100%] of Covered Expenses	[100%] of Covered Expenses
<p>All Other Covered Expenses shown in the BENEFITS section of this Policy but not specifically listed in this Policy Schedule and not specifically excluded</p>	[70%][80%][90%] of Covered Expenses	[50%][60%][70%] of Covered Expenses

<u>OPTIONAL RIDER BENEFITS</u>	<u>PPO COINSURANCE</u>	<u>NON-PPO COINSURANCE</u>
<p>OUTPATIENT SPEECH THERAPY, PHYSICAL THERAPY AND OCCUPATIONAL THERAPY BENEFIT RIDER</p> <p>(Commencing within [14 days] of a covered Hospital Confinement or Surgery and completed within [90 days])</p> <p>[Limited to [3] visits per Insured Person, per week]</p> <p>[Not to exceed a [\$150] Maximum Benefit per Insured Person, per day]</p> <p>[Copayment: [\$50] per Insured Person, per visit]</p>	[70%][80%][90%] of Covered Expenses	[50%][60%][70%] of Covered Expenses

POLICY SCHEDULE (Continued)
SCHEDULE OF BENEFITS (Continued)

OPTIONAL RIDER BENEFITS

PPO COINSURANCE

NON-PPO COINSURANCE

PHYSICIAN'S OFFICE VISIT BENEFIT RIDER

[100%] of Covered Expenses not to exceed a [\$125] Maximum Benefit, per Insured Person per visit

[100%] of Covered Expenses not to exceed a [\$100] Maximum Benefit, per Insured Person per visit

Copayment, per Insured Person, per visit [\$30]

[Maximum Number of visits per calendar quarter For You and Your Covered Dependent Spouse [1] [2] visits each]

[Maximum Number of visits per calendar quarter For Your Covered Dependent Child(ren) [2][4] visits each]

[*The **Sickness Exclusion**, as shown in the EXCLUSIONS AND LIMITATIONS section of this Policy, does not apply to this Rider.]

CONTINUED CARE BENEFIT RIDER

Skilled Nursing Care

Limited to [30 days] per Insured Person, per Calendar Year

[70%][80%][90%] of Covered Expenses

[50%][60%][70%] of Covered Expenses

Not to exceed a [\$250] Maximum Benefit per Insured Person, per day

Home Health Care

Limited to [80 visits] per Insured Person, per Calendar Year

[70%][80%][90%] of Covered Expenses

[50%][60%][70%] of Covered Expenses

Not to exceed a [\$50] Maximum Benefit per Insured Person, per day

Private Duty Nursing

Limited to [40 eight-hour shifts] per Insured Person, per Calendar Year

[70%][80%][90%] of Covered Expenses

[50%][60%][70%] of Covered Expenses

Not to exceed a [\$50] Maximum Benefit per Insured Person, per shift

Hospice Care

Not to exceed a [\$5,000] Maximum Benefit per Insured Person, per lifetime

[70%][80%][90%] of Covered Expenses

[50%][60%][70%] of Covered Expenses

**POLICY SCHEDULE (Continued)
SCHEDULE OF BENEFITS (Continued)**

OPTIONAL RIDER BENEFITS

PPO COINSURANCE

NON-PPO COINSURANCE

EMERGENCY SERVICES BENEFIT RIDER

[Not to exceed a [\$1,000] [\$2,000] Maximum Benefit per Insured, per visit]

[Physician's Office or Urgent Care Center Copayment, per visit]
[\$100][\$250][\$500][\$1,000]

[Hospital Emergency Room Copayment, per visit] [\$100][\$250][\$500][\$1,000]

[70%][80%][90%] of Covered Expenses

[70%][80%][90%] of Covered Expenses

PREGNANCY/CHILDBIRTH BENEFIT RIDER

Coinsurance

[0-10] months in force

[11-24] months in force

[25] months in force and over

Lifetime Maximum for In Vitro Fertilization Benefits:

PPO/NON-PPO COINSURANCE

[0%]

[50%] of Covered Expenses not to exceed a [\$1,000] Maximum Benefit per in vitro fertilization procedure and/or pregnancy/childbirth for You or Your Covered Dependent Spouse

[100%] of Covered Expenses not to exceed a [\$2,000] Maximum Benefit per in vitro fertilization procedure and/or pregnancy/childbirth for You or Your Covered Dependent Spouse

[\$15,000]

OUTPATIENT ACCIDENT EXPENSE BENEFIT RIDER

[Deductible, per Injury]

[100%] of Covered Expenses not to exceed a [\$1,000][\$1,500][\$2,000] Maximum Benefit per Insured Person, per Injury

[\$100][\$150][\$200]

AIR AMBULANCE RIDER

Maximum Benefit, per Insured Person, per Calendar Year [\$5,000]

[70%][80%] [90%] not to exceed a base rate of [\$2,500], plus an additional [\$50] per mile

LEGEND PRESCRIPTION DRUG EXPENSE RIDER

[YES]

[PREVENTIVE PLUS] BENEFIT RIDER

[YES]

DEFINITIONS

Aggregate Maximum Amount means the maximum amount payable under this Policy and its Riders, if any, for any one covered Injury or Sickness for each Insured Person, occurring while coverage is in effect under this Policy for such person. Multiple Sickness or Injury Periods of Treatment for the same Sickness or Injury will accumulate toward the Aggregate Maximum Amount. The Aggregate Maximum Amount is shown in the POLICY SCHEDULE. This amount is included in and part of the Lifetime Maximum Amount for each Insured Person.

Ambulance means a ground vehicle which is licensed as required by law, as an Ambulance, and is equipped to transport Sick or Injured people.

Attained Age means the Insured Person's age on the most recent annual anniversary of the Policy.

Benefit means the actual amount paid under this Policy and any attached riders after the application of the Deductible, Coinsurance or Copayments, if any.

Calendar Year means a twelve month period which begins at 12:01 a.m. on January 1 of any year and ends at 12:00 midnight on December 31 of that year.

Chemotherapy or Radiation Therapy Course of Treatment Plan means a written plan by the Insured Person's Physician which indicates but is not limited to:

1. The condition requiring treatment, along with the recommended individual protocol; and
2. The anticipated duration of treatment and schedule of services and supplies; and
3. The facility to be used, if any and the name of any other Provider that performs the services.

Class Basis means the classification by which each Insured Person's rates are determined. We will not and cannot change the rates on this Policy unless rates are changed on all Policies issued on the same Class Basis.

Coinsurance means the shared percentage of Covered Expenses after satisfying the Deductible and any Copayments. The Coinsurance percentage We pay is shown in the POLICY SCHEDULE.

Coinsurance Maximum means the total amount of Covered Expenses each Insured Person must pay after application of the Coinsurance per each [Sickness or Injury Period of Treatment]. Once this maximum is met, Covered Expenses remaining thereafter for the same [Sickness or Injury Period of Treatment] will be paid at 100% after any Copayment, up to the Maximum Benefit shown in the POLICY SCHEDULE, if any. **Deductibles, Copayments and any charges exceeding any Maximum Benefit shown in the POLICY SCHEDULE do not count toward meeting the Coinsurance Maximum.** The Coinsurance Maximum is shown in the POLICY SCHEDULE.

Complications of Pregnancy means:

1. Hospital Confinement or treatment in an Outpatient Surgery Facility (when the pregnancy is not terminated) required to treat conditions, such as the following, in a pregnant female Insured Person: (a) acute nephritis; (b) nephrosis; (c) cardiac decompensation; (d) HELLP syndrome; (e) uterine rupture; (f) amniotic fluid embolism; (g) chorioamnionitis; (h) fatty liver in pregnancy; (i) septic abortion; (j) placenta accreta; (k) gestational hypertension; (l) puerperal sepsis; (m) peripartum cardiomyopathy; (n) cholestasis in pregnancy; (o) thrombocytopenia in pregnancy; (p) placenta previa; (q) placental abruption; (r) acute cholecystitis and pancreatitis in pregnancy; (s) postpartum hemorrhage; (t) septic pelvic thrombophlebitis; (u) retained placenta; (v) venous air embolus associated with pregnancy; (w) miscarriage; or (x) an emergency c-section required because of (i) fetal or maternal distress during labor, or (ii) severe pre-eclampsia, or (iii) arrest of descent or dilatation, or (iv) obstruction of the birth canal by fibroids or ovarian tumors, or (v) necessary because of the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that, in the absence of immediate medical attention, will result in placing the life of the mother or fetus in jeopardy. For purposes of this paragraph, a c-section delivery is not considered to be an emergency c-section if it is merely for the convenience of the Insured Person and/or Physician or solely due to a previous c-section.

2. Treatment, diagnosis or care for conditions, including the following, in a pregnant female Insured Person when the condition was caused by, necessary because of, or aggravated by the pregnancy: (a) hyperthyroidism; (b) hepatitis B or C; (c) HIV; (d) Human papilloma virus; (e) abnormal PAP; (f) syphilis; (g) chlamydia; (h) herpes; (i) urinary tract infections; (j) thromboembolism; (k) appendicitis; (l) hypothyroidism; (m) pulmonary embolism; (n) sickle cell disease; (o) tuberculosis; (p) migraine headaches; (q) depression; (r) acute myocarditis; (s) asthma; (t) maternal cytomegalovirus; (u) urolithiasis; (v) DVT prophylaxis; (w) ovarian dermoid tumors; (x) biliary atresia and/or cirrhosis; (y) first trimester adnexal mass; (z) hydatidiform mole; or (aa) ectopic pregnancy.

Complications of Pregnancy do not include false labor; occasional spotting; Physician prescribed rest during the period of pregnancy; morning sickness; hyperemesis gravidarum; and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication.

Confined/Confinement means an Insured Person's Medically Necessary admission to and subsequent continued stay in a Hospital or Skilled Nursing Facility as an overnight bed patient and a charge for room and board is made.

Consultation means evaluation, diagnosis, or medical advice given without the necessity of a personal examination or visit.

Copayment means the amount the Insured Person is required to pay for specifically listed Covered Expenses. The Copayment, if any, is shown in the POLICY SCHEDULE. Copayments do not count toward [Deductibles or]Coinsurance Maximums.

Cosmetic Surgery means the surgical procedures for the sole purpose of improvement of appearance, which does not effect a substantial improvement or restoration of bodily function, except:

1. Reconstructive Surgery incidental to or following Surgery resulting from trauma, infection or other disease of the involved part; or
2. Reconstructive Surgery due to a congenital disease or anomaly of a newborn child which has resulted in a functional defect.

The condition which necessitates the Surgery must first occur while coverage is in force and coverage remains in force through the date of Surgery.

Covered Dependent means an Eligible Dependent whose coverage has become effective under this Policy and has not terminated.

Covered Expenses means [Usual and Customary] Charges for the services, supplies, care or treatment covered under this Policy which are incurred by an Insured Person as a result of Injury or Sickness and for which the Insured Person is legally obligated to pay and are not otherwise excluded or limited herein. They are incurred on the date that the service is performed or the supply is furnished. Only that portion of a [Usual and Customary] Charge or fee which is Medically Necessary is a Covered Expense. Covered Expenses must be incurred while this coverage is in force.

Non-Medical Emergency Covered Expenses incurred for services provided by a non-PPO provider will be reduced by 25% before application of any Deductibles, Copayments or Coinsurance amounts. [Any charges in excess of the Maximum Benefit shown in the Policy Schedule, if any, will not be considered a Covered Expense.]

Covered Expenses under the Riders, if any, may or may not be considered Covered Expenses under this Policy.

Deductible means the amount of Covered Expenses that an Insured Person must pay for each [Sickness or Injury Period of Treatment] before Benefits will be paid. Deductible does **not** include non-Covered Expenses [or Copayments]. **The Deductible will be applied separately for each [Sickness or Injury Period of Treatment] for each Insured Person.**

Once this Deductible has been met [3] times in a [Calendar Year] by any or all Insured Persons under Your Policy, no further Deductibles must be met for the remainder of that [Calendar Year] for any or all Insured Persons under Your Policy. [The Deductibles for PPO and Non-PPO services are shown in the POLICY SCHEDULE.]

If more than one Insured Person in Your family is injured in the same accident, only one Deductible must be satisfied for Covered Expenses associated with that accident.

Dental Care means services, supplies or other care for dental services and procedures involving tooth structures, extractions, gingival tissues, alveolar processes, dental x-rays (for other than an accidental Injury), procedures of dental origin, odontogenic cysts/tumors, or any orthodontic, periodontic, orthognathic treatment regardless of Medical Necessity. Dental care includes services and supplies for maxillary and/or mandibular augmentation/implant procedures to facilitate the use of full or partial dentures, prosthesis, fixed or removable.

Designated Transplant Facility means a facility affiliated with the national organ transplant network which has entered into an agreement to render transplant services to Insured Persons. Selection of the Designated Transplant Facility to be used for a particular transplant will be determined by the Insured Person's attending Physician in Consultation with the transplant network's staff and Us. The Designated Transplant Facility chosen may or may not be located within the Insured Person's geographic area.

Effective Date of Coverage means the date coverage becomes effective under this Policy with respect to a particular Insured Person.

Eligible Dependent means Your lawful spouse and Your unmarried natural and adopted children and step-children who reside in Your home for more than 6 months in a year, who are under 19 years of age (the Limiting Age). The Limiting Age is extended from the child's 19th birthday to the child's [24th] birthday if the child is enrolled as a full-time student and attends classes regularly at an accredited college or university.

Experimental or Investigational Medicine means a drug, device or medical treatment or procedure:

1. If the drug, or device cannot lawfully be marketed without approval of the United States Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
2. If reliable evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or
3. If reliable evidence shows that the consensus of opinion among experts regarding the drug, device or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence means only published reports and articles in authoritative medical and scientific literature; the written protocol or protocols by the treating facility or the protocols of another facility studying substantially the same drug, device, or medical treatment or procedures; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure.

Hospital means an institution operated pursuant to its license for the care and treatment of sick and injured persons for which a charge is made that the Insured Person is legally obligated to pay. The institution must:

1. Maintain on its premises organized facilities for medical, diagnostic and surgical care for sick and injured persons on an inpatient basis;
2. Maintain a staff of one or more duly licensed Physicians;
3. Provide 24 hour nursing care by or under the supervision of a registered graduate professional nurse (R.N.); and
4. Is accredited as a Hospital by the Joint Commission on Accreditation of Hospitals.

The term "Hospital" does not include:

1. A convalescent, nursing, rest or rehabilitative facility; a home for the aged; a facility for the care and treatment of drug addicts and alcoholics; or a special ward, floor or other accommodation for convalescent, nursing, rehabilitation, ambulatory or extended care purposes; or hotel units, residential annexes or nurse administered units in or associated with a Hospital; or

2. Any military or veteran's hospital, soldier's home or any Hospital contracted for or operated by the Federal Government or any agencies thereof for the treatment of members or former members of the Armed Forces, unless the Insured Person is legally required to pay for services in the absence of this insurance coverage.

Immediate Family means the spouse, parent, son, daughter, brother or sister of the Insured Person.

Injury means bodily harm caused by an accident resulting in unforeseen trauma requiring immediate medical attention and is not contributed to, directly or indirectly, by a Sickness. The Injury must occur after the Insured Person's coverage has become effective and while the coverage is in force.

Insured Person means You or a Covered Dependent under this Policy.

Intensive Care/Cardiac Care Unit means that part of a Hospital which:

1. Is segregated from the rest of the Hospital facilities;
2. Is exclusively reserved for critically ill patients who require audio-visual observation and/or cardiac monitoring as prescribed by the attending Physician; and
3. Provides room and board, specialized registered graduate professional nurses (R.N.), and special life saving equipment and supplies.

Lifetime Maximum Amount means the maximum amount payable under this Policy and its Riders, if any, for all Covered Expenses combined, for each Insured Person. Any and all Benefit amounts paid by Us will accumulate toward the Lifetime Maximum Amount from the Policy Date. The Lifetime Maximum Amount is shown in the POLICY SCHEDULE.

Maximum Benefit means the maximum amount payable for a Covered Expense(s) under this Policy for each Insured Person, after the application of any Deductibles, Copayments and/or Coinsurance. The Maximum Benefit is shown in the POLICY SCHEDULE.

Medical Emergency means the sudden onset of a medical condition for which the Insured Person seeks immediate medical treatment at the nearest available facility. The condition must be one which manifests itself by acute symptoms which are sufficiently severe that without immediate medical attention could reasonably be expected to result in:

1. Placing the Insured Person's health in serious jeopardy;
2. Serious impairment of bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Medically Necessary or Medical Necessity means that a service or supply is necessary and appropriate for the diagnosis or treatment of an Injury or Sickness based on generally accepted current medical practice. A service or supply will not be considered Medically Necessary if:

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

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

Medicare means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, as amended.

Mental or Nervous Disorder means any condition or disease, regardless of its cause, listed in the most recent edition of the International Classification of Diseases as a Mental Disorder, including but not limited to neurosis, psychoneurosis, psychopathy, psychosis, bipolar affective disorder or autism.

Outpatient Surgery Facility means a licensed or certified public or private medical facility:

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

The term "Outpatient Surgery Facility" will include surgical suites, and facilities operated by a Hospital, which provide scheduled, non-emergency outpatient surgical care.

The term "Outpatient Surgery Facility" does not include:

1. Hospital emergency room;
2. Trauma center;
3. Physician's office (except as shown above);
4. Clinic; or
5. Any facility that an Insured Person is admitted to as an overnight bed-patient and charged for room and board.

Physical Therapy means physical or corrective rehabilitation or physical or corrective treatment of any bodily or mental condition of any person by the use of physical, chemical, and other properties of heat, light, water, electricity, sound, and active, passive, and resistive exercise, and shall include evaluation, treatment planning, instruction and consultative services. Physical Therapy does not include spinal manipulations or manipulative therapy.

Physician means a legally qualified licensed practitioner of the healing arts who provides care within the scope of his or her license. (A member of the Insured Person's Immediate Family will not be considered a Physician.)

Policy means the written description of coverage provided to You.

Pre-Existing Condition means a medical condition, Sickness or Injury not excluded by name or specific description for which:

1. Medical advice, Consultation, or treatment was recommended by or received from a Physician within the two year period before the Effective Date of Coverage; or
2. Symptoms existed which would cause an ordinarily prudent person to seek diagnosis, care or treatment within the two year period before the Effective Date of Coverage.

Preferred Provider Organization (PPO) means a managed health care arrangement in which the Insured Person has access to a network of Physicians, Hospitals, or other licensed or certified entities or persons who have entered into a contract to provide health care services to Insured Persons under this Policy. Non-Medical Emergency Covered Expenses incurred for services provided by a non-PPO provider will be reduced by [25%] before the application of any Deductibles, Copayments or Coinsurance amounts. This reduction is limited to [\$5,000] in Covered Expenses, per Insured Person, per [Sickness or Injury Period of Treatment]. Please refer to the POLICY SCHEDULE for additional information. The providers contract must be in effect at the time services are rendered.

Sickness or Injury Period of Treatment means a period which begins on the date an Insured Person first incurs Covered Expenses for a Sickness or Injury under this Policy and ends after 365 days. If the same or related Sickness or Injury continues beyond 365 days, a new Deductible and Sickness or Injury Period of Treatment will apply and will continue to accumulate toward the Aggregate Maximum Amount and Lifetime Maximum Amount. A separate Sickness or Injury Period of Treatment and Deductible will apply to each Injury or Sickness.

Sickness means an illness or disease which first manifests itself after the Insured Person's coverage becomes effective and while the coverage is in force. Sickness includes Complications of Pregnancy.

Surgery means:

1. The performance of generally accepted operative and cutting procedures, including surgical diagnostic procedures, specialized instrumentation's, endoscopic examinations, and other invasive procedures while an Insured Person is under local or general anesthesia;
2. The correction of fractures and dislocations; and
3. Any of the procedures designated by Current Procedural Terminology codes as Surgery.

Total Disability or Totally Disabled means:

1. With respect to You, You are unable to engage in any employment or occupation for which You are qualified by reason of education, training or experience and are not in fact engaged in any employment or occupation for wage or profit; and
2. With respect to any other person under the Policy, Confinement as a bed patient in a Hospital.

Transplant Benefit Period means the period of time:

1. Beginning on the date the Insured Person first receives services directly related to evaluation as a candidate for a Transplant Procedure; and
2. Ending on the earlier of:
 - a) the date [18 months] after the Transplant Procedure is performed; or
 - b) the date this Policy terminates.

Transplant Procedure means the following Medically Necessary human organ and tissue transplants:

1. Heart transplant;
2. Combined heart and lung transplant;
3. Lung transplant;
4. Kidney transplant;
5. Kidney and pancreas transplant;
6. Liver transplant;
7. Bone marrow transplant, either allogenic or autologous, including High Dose Chemotherapy[.]; or
8. Peripheral stem cell transplant.]

Transplant Treatment Plan means a written plan by the Insured Person's Physician which indicates but is not limited to:

1. The condition requiring treatment, along with recommended procedures; and
2. The anticipated date of Confinement and schedule of services and supplies; and
3. The transplant facility recommended by the surgeon.

Travel and Accommodation Expenses mean expenses incurred, with respect to Transplant Procedures:

1. For transportation for the Insured Person and one companion to accompany him/her to and from a Designated Transplant Facility; and
2. By the companion who accompanies the Insured Person while the Insured Person is receiving Medically Necessary outpatient treatment at the Designated Transplant Facility as part of the transplant plan, for meals and lodging at or near the Designated Transplant Facility.

Treatment Plan means a written plan by the Insured Person's Physician which indicates but is not limited to:

1. The condition requiring treatment, along with recommended procedures and a certification that without such care the Insured Person would require Surgery; and
2. The anticipated duration of treatment and schedule of services and supplies; and
3. The facility to be used, if any and the name of any other Provider that performs the services.

Usual and Customary Charges means charge which is the smallest of:

1. The actual charge;
2. The charge usually made for the Covered Expense by the provider who furnishes it;
3. The prevailing charge made for a Covered Expense in a geographical area by those of similar professional standing; and
4. The negotiated rate in effect with a PPO on the date it provides a Covered Expense.

We, Us and Our means The MEGA Life and Health Insurance Company.

You, Your, Yours means the primary insured named in the Policy Schedule whose coverage has become effective and has not terminated.

EFFECTIVE DATE OF COVERAGE

Beginning of Coverage

We require evidence of insurability before coverage is provided. Once We have approved Your application based upon the information You provided therein, the Effective Date of Coverage for You and those Eligible Dependents listed in the application and accepted by Us will be the Policy Date shown in the POLICY SCHEDULE.

Newborn Children

Your or Your Covered Dependent Spouse's newborn child(ren) will be provided coverage after the Policy Date from the moment of birth for 90 days, or the next premium due date, whichever is later. Coverage will include but not be limited to: illness, injury, congenital defects, premature birth, tests for hypothyroidism, phenylketonuria, galactosemia, sickle-cell anemia, and all other disorders of metabolism for which screening is performed by or for the State of Arkansas. Coverage will also include routine nursery care and pediatric charges for a well newborn for up to five (5) full days in a Hospital nursery or until the mother is discharged from the Hospital following the birth of the newborn, whichever is the lesser period of time. To continue coverage beyond the 90 days, You must send written notice directing Us to add the newborn child(ren). This notice must be received by Us within 90 days of the newborn child's date of birth and must be accompanied by any required additional premium. A claim form or Hospital bill does not constitute written notice.

Adopted Children

Any minor under Your or Your Covered Dependent Spouse's charge, care and control for whom You or Your Covered Dependent Spouse have filed a petition to adopt, will be provided coverage on the same basis as coverage for other Covered Dependents under the Policy. This coverage will begin on the date of the filing of a petition; or from the moment of birth, if the petition for adoption and application for coverage is filed within sixty (60) days after the date of birth.

Additional Dependents

You may add Eligible Dependents by providing evidence of insurability satisfactory to Us and upon payment of any additional premium, if required.

The acceptance of a new Eligible Dependent and the Effective Date of Coverage for such Eligible Dependent will be shown by endorsement and the date of the endorsement.

PREMIUMS

Premium Due Date

Premiums are payable to Us at Our administrative office in North Richland Hills, Texas. The premium is payable monthly, quarterly, semi-annually or annually, as indicated in the POLICY SCHEDULE. Payment of any premium will not maintain coverage in force beyond the next premium due date, except as provided by the Grace Period.

Upon the payment of a claim under this Policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

Grace Period

There is a grace period of 31 days for the payment of any premiums due, except the first. At the end of the 31 day grace period, We may cancel the Policy without further notice. During the grace period, the contract will remain in force; however, the Company is not obligated to pay any claims incurred by Insured Persons during the grace period unless and until the premium due is received during the grace period.

Premium Changes

We reserve the right to change the table of premiums, on a Class Basis, becoming due under the Policy at any time and from time to time; provided, We have given the Policyholder written notice of at least 31 days prior to the effective date of the new rates. Such change will be on a Class Basis. The premium for the Policy may change in amount by reason of an increase in the Attained Age of the Insured Person.

Unearned Premiums Refund

Upon the death of an Insured Person, the proceeds payable to the Insured Person or his/her estate shall include premiums paid for insurance coverage for the period beyond the end of the month in which the death occurred. Unearned Premiums shall be paid in a lump sum payment no later than thirty (30) days after the proof of the Insured Person's death has been furnished to Us.

TERMINATION OF COVERAGE

You

Your coverage will terminate and no Benefits will be payable under this Policy and any attached Riders:

1. At the end of the period for which premium has been paid;
2. If Your mode of premium is monthly, at the end of the period through which premium has been paid following Our receipt of Your request of termination;
3. If Your mode of premium is other than monthly, upon the next monthly anniversary day following Our receipt of Your request of termination. Premium will be refunded for any amounts paid beyond the termination date;
4. On the date of fraud or misrepresentation by You;
5. On the date We elect to discontinue this plan or type of coverage. We will give You at least 90 days notice before the date coverage will be discontinued. You will be offered an option to purchase any other coverage that We offer without regard to health status;
6. On the date We elect to discontinue all coverage in Your state. We will give You and the proper state authority at least 180 days notice before the date coverage will be discontinued; or
7. On the date an Insured Person is no longer a permanent resident of the United States.

Covered Dependents

Your Covered Dependent's coverage will terminate under this Policy on:

1. The date Your coverage terminates;
2. The date such dependent ceases to be an Eligible Dependent; or
3. The date We receive Your written request to terminate a dependent's coverage.

The attainment of the Limiting Age for an Eligible Dependent will not cause coverage to terminate while that person is and continues to be both:

1. Incapable of self-sustaining employment by reason of mental retardation or physical handicap; and
2. Chiefly dependent on You for support and maintenance. For the purpose of this provision "Chiefly Dependent" means the Eligible Dependent receives the majority of his or her financial support from You.

We will require that You provide proof that the dependent is in fact a disabled and dependent person. In the absence of such proof We may terminate the coverage of such person after the attainment of the Limiting Age.

Family Security Benefit

Beginning with the next premium due date following Our receipt of due proof of Your death, We will waive premiums for a period of 12 months for Your Covered Dependents. During this premium waiver period no increase in Benefits or addition of Eligible Dependents, except newborns, will be considered. Provisions for termination of coverage for Covered Dependents will apply. Upon expiration of the waiver period, Your Covered Dependent spouse may continue coverage, as stated in the SPECIAL CONTINUATION PROVISION FOR DEPENDENTS by making required premium payments.

Special Continuation Provision For Dependents

Your Covered Dependents may continue their same (or substantially similar) coverage under a new Policy without evidence of insurability if their coverage under this Policy would otherwise terminate because they cease to be an Eligible Dependent for any of the following reasons:

1. Divorce, legal separation, Your death; or
2. A dependent child reaches the Limiting Age.

To continue coverage, You or Your Covered Dependent must request continuation of coverage by application or written notification within 31 days of the date coverage would otherwise terminate, pay any required premium.

Reinstatement

If coverage under this Policy terminates due to non-payment of premium, We require an application for reinstatement. The reinstatement will not become effective unless We approved such application. We will advise You of the effective date of reinstatement by giving You written notice of the date, by issuing You an amended Policy or by issuing You a new Policy. In any case, the reinstated coverage provides Benefits only for:

1. Injury occurring after the effective date of reinstatement; and
2. Sickness first manifesting itself more than 10 days after the effective date of reinstatement.

Replacement of the Policy by Another Insurer

If a Covered Person is Hospital Confined when the Policy is terminated and replaced by a health insurance policy issued by another insurer, extension of benefits beyond the period the Policy was in force may be predicated upon the continuous total disability of the Insured Person, limited to the duration of the Policy benefit period, or payment of the maximum benefits.

CASE MANAGEMENT

Pre-notification Requests of Medical Non-Emergency Admissions

Your Physician or Hospital should call the toll-free telephone number shown on Your I.D. card at least 5 working days prior to the planned admission or Surgery. Pre-notification of a Hospital admission or Surgery will enable Us to process claims more expeditiously. The lack of pre-notification will require verification of admission or Surgery through the receipt of actual claims.

For emergency admissions, the patient, patient's representative, Physician or Hospital should call the toll-free telephone number shown on Your I.D. card within 2 working days of the admission, or as soon as reasonably possible, to provide notification of any admission due to a Medical Emergency.

IMPORTANT: Pre-notification is not a guarantee that Benefits will be paid.

Case Management

Case Management authorized by Us or Our designated representative can provide reimbursement for alternative methods of care, even if the Insured Person is not covered for the alternate care or setting. Case Management is a method where We or Our designated representative will review an Insured Person's health problem and

develop a plan of care that provides the most cost effective care for the Insured Person's specialized needs. The intent of Case Management is to ensure appropriate, cost effective care by extending extra-contractual Benefits for alternative methods of care to Insured Persons who require the acute level of care setting. It is not designed to extend extra-contractual Benefits for alternative methods of care to Insured Persons who do not meet Our standards or for services not authorized by Us or Our designated representative.

Benefits will be provided for the approved alternative methods of care only when and for so long as is determined that the alternative services are Medically Necessary and cost effective. These Benefits will count toward the Insured Person's [Aggregate Maximum Amount and] Lifetime Maximum Amount.

Treatment Plans will be used to review and maximize the Benefits available under this Policy.

Our decision to implement Case Management will be made following Consultation with the affected Insured Person, or his or her legal representative, and the Insured Person's Physician.

If alternative Benefits are provided for an Insured Person in one instance, it will not obligate Us to provide the same or similar Benefits for any person in any other instance; nor will it be construed as a waiver of Our right to administer the Policy in strict accordance with its express terms.

Second Physician's Opinion

We or Our designated representative may require an Insured Person to obtain a second opinion with respect to the procedures in question from a Physician selected by Us. The Insured Person must cooperate in obtaining a second opinion including any examination, testing, x-ray, or diagnostic procedures as are reasonable. There is no Coinsurance for the Physician's evaluation for the second opinion, nor for any tests needed to form the second opinion.

Pre-Admission Testing

We or Our designated representative may require that certain testing be done before admission to a Hospital.

BENEFITS

Benefits are the actual amount payable under this Policy for the following Covered Expenses after application of the following, unless otherwise stated herein:

1. The Maximum Benefit[, Aggregate] and Lifetime Maximum Amounts shown in the POLICY SCHEDULE;
2. The Deductibles shown in the POLICY SCHEDULE;
3. The Copayments shown in the POLICY SCHEDULE, if any;
4. The Coinsurance shown in the POLICY SCHEDULE;
5. The non-PPO reduction shown in the POLICY SCHEDULE, if any,
6. The EXCLUSIONS AND LIMITATIONS; and
7. All other provisions of the Policy.

COVERED EXPENSES

Covered Expenses means the Medically Necessary [Usual and Customary] Charges for the services, supplies, care or treatment covered under this Policy which are incurred by an Insured Person as a result of Injury or Sickness and for which the Insured Person is legally obligated to pay. They are incurred on the date that the service is performed or the supply is furnished. Only that portion of a [Usual and Customary] Charge which is Medically Necessary is a Covered Expense. Covered Expenses must be incurred while this coverage is in force.

[Any charges in excess of the Maximum Benefit shown in the Policy Schedule, if any, will not be considered a Covered Expense.]

Inpatient Hospital Services

Covered Expenses incurred for services and supplies provided by the Hospital for semi-private accommodations and general nursing care furnished by the Hospital including Confinement in the Hospital's intensive care or cardiac care unit (in lieu of Benefit amount payable for Hospital room and board) and miscellaneous medical services and supplies necessary for the treatment of the Insured Person during that [Sickness or Injury Period of Treatment].

Covered Expenses will also include x-ray, laboratory, diagnostic tests and services of a radiologist, radiology group, and the services of a pathologist or pathology group for interpretation of diagnostic tests or studies, performed while the Insured Person is Hospital Confined.

The fees charged for take home drugs, personal convenience items, or items not intended primarily for use of the Insured Person while Hospital Confined are not Covered Expenses.

Physician Visits while Hospital Confined

Covered Expenses incurred for visits by a Physician, other than the surgeon, while Hospital Confined, limited to a single Physician visit per day.

Surgeon Benefit

Covered Expenses incurred for services by the Physician performing Surgery.

If two or more Surgeries are performed at the same time through separate incisions, We will consider the one providing the largest Benefit. We will also consider [50%] of the Benefits otherwise payable for the other Surgeries performed at the same time.

We will not consider more than one Surgery performed through the same incision during the same operation; however, We will consider the Surgery providing the largest Benefit.

If it is recommended that you have Physical Therapy in lieu of Surgery, We may consider Physical Therapy as an alternative to Surgery. Such Physical Therapy must be in accordance with a Treatment Plan approved by Us. Covered Expenses incurred under this Surgeon Benefit for Physical Therapy will be counted toward the applicable Surgeon Benefit shown in the POLICY SCHEDULE.

Assistant Surgeon Benefit

Covered Expenses incurred for services by the Physician assisting the Physician performing Surgery.

Anesthesiologist Benefit

Covered Expenses incurred for services by the Physician providing anesthesia during Surgery.

Outpatient Surgery Facility Charges

Covered Expenses incurred for services furnished by and supplies received for use in an Outpatient Surgery Facility, including but not limited to:

1. Use of operating room and recovery room;
2. Administration of drugs and medicines during Surgery;
3. Dressings, casts, splints; and
4. Diagnostic services including radiology, laboratory or pathology performed at the time of the Surgery.

Second Surgical Opinion

Covered Expenses incurred for services by a Physician for a second opinion. The Physician providing the second opinion cannot be financially associated with the referring Physician or perform or assist in the Surgery in order for services to be considered a Covered Expense under this Policy.

If the second opinion disagrees with the first, a third opinion will also be considered a Covered Expense.

Durable Medical Equipment and Prosthetic Devices

Covered Expenses incurred for the rental of durable medical equipment not to exceed the actual purchase price of such equipment, and the purchase, fitting, repair and replacement of fitted prosthetic devices which replace a natural limb or eye, when ordered or prescribed by a Physician for use by the Insured Person.

The durable medical equipment or prosthetic device must be for use solely by the Insured Person for the treatment of a Sickness or Injury which occurred while such Insured Person's coverage is in force.

Routine maintenance and repairs of rental equipment are not Covered Expenses.

Outpatient Diagnostic Services

Covered Expenses incurred for diagnostic x-rays and interpretation charges, and laboratory and pathological examinations received while not Confined to a Hospital and that are related to and necessary for the diagnosis and treatment of the Sickness or Injury. Covered Expenses include but are not limited to CAT Scans, Magnetic Resonance Imaging (MRI), Mammogram, Upper/Lower G.I. Series, Electrocardiogram (EKG), Blood or serum analysis, Angiogram and Stress Tests.

Covered Expenses do not include routine physical examinations or checkups.

Ambulance Transport

Covered Expenses incurred for Ambulance transportation to a Hospital, provided the Insured Person is Confined to the Hospital.

Chemotherapy

Covered Expenses incurred for chemotherapy received while Hospital Confined or on an outpatient basis. The condition for which chemotherapy is provided must be first diagnosed and the treatment must be received while coverage is in force.

Radiation Therapy

Covered Expenses incurred for radiation therapy received while Hospital Confined or on an outpatient basis. The condition for which radiation therapy is provided must be first diagnosed and the treatment must be received while coverage is in force.

Transplants

Covered Expenses include Transplant Procedures incurred during a Transplant Benefit Period. Covered Expenses for Transplant Procedures include:

1. Inpatient and outpatient Hospital services;
2. Services of a Physician for diagnosis, treatment and Surgery for a Transplant Procedure;
3. Procurement of an organ or tissue, including services provided to a living donor of an organ or tissue for procurement of an organ or tissue, provided the donor and transplant recipient are both insured under this Policy. Covered Expenses are limited to the actual procurement expenses, and will not be more than any maximums under the Policy applicable to the recipient;

4. [Usual and Customary] Charges for Travel and Accommodation Expenses related to a Transplant Procedure for the transplant recipient and one companion during a Transplant Benefit Period, provided the transplant facility is more than [300] miles from the Insured Person's home. If the recipient is a minor, Travel and Accommodation Expenses for [two] companions may be covered. Benefits for Travel and Accommodation Expenses are subject to the Travel and Accommodation Expense maximum shown in the POLICY SCHEDULE[.];
5. Rental of durable medical equipment for use outside the Hospital. Covered Expenses are limited to the purchase price of the same equipment;
6. Prescription Drugs, including immunosuppressive drugs;
7. Oxygen;
8. Speech therapy, occupational therapy, Physical Therapy and chemotherapy;
9. Services and supplies for and related to high dose chemotherapy and bone marrow tissue transplantation when provided as part of a treatment plan which includes bone marrow transplantation and high dose chemotherapy;
10. Surgical dressings and supplies.]

When the Insured Person's Physician advises the Insured Person that a Transplant Procedure is being considered, the Insured Person or the Insured Person's Physician should notify Us or Our designee in order for Us to direct the Insured Person to an appropriate Designated Transplant Facility.

Covered Expenses for a live donor shall be paid to the extent that benefits remain and are available under this Policy for the Insured Person receiving the transplant, and after all Covered Expenses for the Insured Person has been paid.

Benefits are not payable for animal organ or artificial organ transplants or for personal hygiene and convenience items, such as air conditioners, humidifiers, hot tubs, whirlpools, or physical exercise equipment, even if such items are prescribed by a Physician.

Benefits are not payable for Covered Expenses incurred beyond the Transplant Benefit Period.

Medically Necessary transplants not specifically defined as a Transplant Procedure under the Policy , which are not determined to be Experimental or Investigational Medicine will be payable the same as any other Transplant Procedure under this Policy in accordance with the provisions of the Policy.

Musculoskeletal Disorders

Covered Expenses incurred for the medical treatment of musculoskeletal disorders affecting any bone or joint in the face, neck, or head, including temporomandibular joint disorder and craniomandibular disorder, on the same basis as that provided for any other musculoskeletal disorder in the body, whether prescribed or administered by a Physician or dentist. Treatment shall include both surgical and nonsurgical procedures, and shall be provided for the diagnosis and treatment of these conditions whether they are the result of accident, trauma, congenital defect, developmental defect, or pathology.

Child Health Supervision Services

Covered Expenses incurred for each Covered Dependent from the moment of birth to age eighteen (18) years. In keeping with prevailing medical standards, such services shall include:

1. anticipatory guidance;
2. developmental assessment;
3. laboratory tests;
4. appropriate immunizations
5. a medical history; and
6. physical examination.

Benefits will be payable for 20 visits provided by or under the supervision of a single Physician during the course of one visit, at approximately the following intervals: birth; two weeks; two, four, six, nine, twelve, fifteen and eighteen months and two, three, four, five, six, eight, ten, twelve, fourteen, sixteen and eighteen years.

Benefits payable will not exceed current reimbursement levels for the same services under the Medicaid Early Periodic Screening Diagnosis and Treatment program in the State of Arkansas.

Benefits for recommended immunization services shall be exempt from any Coinsurance, Deductible or dollar limit provisions.

Maternity Stay Requirements For Covered Maternity Care

This provision applies to an Insured Person's coverage only when the Insured Person incurs Covered Expenses for a normal childbirth or cesarean section delivery that is covered by an optional Maternity Benefit Rider or for Complications of Pregnancy as defined in the Policy. A minimum of 48 hours of inpatient care will be provided to the mother and newborn child following a vaginal delivery and 96 hours following a cesarean section. Any normal delivery is subject to the Maximum Benefit for Pregnancy/Childbirth as stated in the optional Maternity Benefit Rider.

Medical Foods and Low Protein Modified Food Products

Covered Expenses incurred for the treatment of a Covered Dependent inflicted with phenylketonuria if:

1. The medical food or low protein modified food products are prescribed as Medically Necessary for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemia and disorders of amino acid metabolism;
2. The products are administered under the direction of a licensed Physician; and
3. The cost of the medical food or low protein modified food products for an individual or a family with a dependent person or persons exceeds the [two thousand four hundred dollars (\$2,400)] per year per person income tax credit allowed.

Diabetes

Covered Expenses incurred for diabetes self-management training, supplies and related services for the treatment of Type I, Type II and gestational diabetes when determined Medically Necessary by Your Physician or other licensed health care provider.

Diabetes Self-Management Training means instructions in an inpatient or outpatient setting including medical nutrition therapy relating to diet, caloric intake and diabetes management, excluding any programs in which the only purpose is weight reduction, which enables diabetic patients to understand the diabetic management process and daily management of diabetic therapy as a method of avoiding frequent hospitalizations and complications when the instruction is provided in accordance with a program in compliance with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association.

Impairment or Loss of Speech or Hearing

Covered Expenses incurred for the communicative disorders generally treated by speech pathologist or audiologist licensed by the Board of Examiners in Speech-Language Pathology and Audiology and which fall within the scope of his/her area of certification. Coverage does not apply to hearing instruments or devices.

Colorectal Cancer Screening

Covered expenses incurred for colorectal cancer examinations and laboratory tests for Insured Persons who are 50 years of age or older; who are less than 50 years of age and at high risk for colorectal cancer according to American Cancer Society colorectal cancer screening guidelines as they existed on [January 1, 2005]; and 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 as determined by a licensed Physician.

For the purpose of this benefit "high risk for colorectal cancer" means: Individuals over 50 years of age or who face a high risk for colorectal cancer because of the presence of polyps on a previous colonoscopy, barium enema, or flexible sigmoidoscopy; family history of colorectal cancer in close relatives of parents, brothers, sisters, or children; genetic alterations of hereditary nonpolyposis colon cancer or familial adenomatous polyposis;

personal history of colorectal cancer, ulcerative colitis, or Crohn's disease; or the presence of any appropriate recognized gene markers for colorectal cancer or other predisposing factors; and any definition recognized by medical science and determined by the Director of the Department of Health in consultation with the University of Arkansas for Medical Sciences.

Outpatient Contraceptive Services and Devices

Covered Expenses incurred for Outpatient Contraceptive Services and Devices including closed formularies; however, formularies must include implant and injectable contraceptive drugs, and intrauterine devices.

Covered Expenses do not include charges for abortion, an abortifacient or any U.S. Food and Drug Administration approved emergency contraception.

Outpatient Contraceptive benefits are subject to the same Deductibles and Coinsurances as prescription drugs.

EXCLUSIONS AND LIMITATIONS

We will not provide any Benefits for charges resulting from or in connection with:

- 1.
2. Any care not Medically Necessary or charges for which Benefits are not specifically provided for in this Policy;
3. Any act of war, declared or undeclared;
4. Suicide, attempted suicide, or any intentionally self-inflicted injury, while sane or insane;
5. Any routine physical examination, unless otherwise stated herein;
6. Any Injury or Sickness arising out of, or in the course of, employment for wage or profit, provided the Insured Person is covered under any Worker's Compensation Act, Occupational Disease Act, or similar act or law, unless the Insured Person is self-employed;
7. Mental or Nervous Disorders, unless otherwise stated herein;
8. Drug abuse or addiction including alcoholism, or overdose of drugs, narcotics, or hallucinogens, directly or indirectly, unless taken as prescribed by a Physician;
9. An overdose of drugs, being intoxicated or under the influence of intoxicants, hallucinogens, narcotics or other drugs, directly or indirectly, unless taken as prescribed by a Physician;
10. Any treatment including prescription drugs or non-prescription drugs, or procedure that promotes conception or prevents childbirth, including but not limited to: (a) artificial insemination; (b) in-vitro fertilization or other treatment for infertility; (c) treatment for impotency; (d) sterilization or reversal of sterilization; or (e) abortion (unless the life of the mother would be endangered if the fetus were carried to term), unless otherwise stated herein;
11. Laser vision correction, radial keratotomy or any eye Surgery when the primary purpose is to correct nearsightedness, farsightedness, astigmatism, or any other refractive error;
12. Spinal manipulations and manual manipulative treatment or therapy;
13. Weight loss or modification, or complications arising therefrom, or procedures resulting therefrom or for surgical treatment of obesity including but not limited to gastric by-pass, wiring of the teeth and all forms of Surgery performed for the purpose of weight loss or modification or the reversal/modification of such procedure;
14. Breast reduction or augmentation unless necessary in connection with breast reconstructive Surgery following a mastectomy;
15. Modification of the physical body in order to improve the psychological, mental or emotional well-being of the Insured Person, such as but not limited to sex-change Surgery;
16. Marriage, family, or child counseling for the treatment of premarital, marriage, family or child relationship dysfunctions;
17. Routine newborn care, unless otherwise stated herein;
18. Directly or indirectly engaging in an illegal occupation or illegal activity;
19. Care in a nursing home, custodial institution or domiciliary care or rest cures;
20. Preparation and presentation of medical reports for appearance at trials or hearings;
21. Physical examinations required for school events, camp, employment, licensing and insurance are expressly excluded;
22. Immunizations required for the sole purpose of travel outside of the U.S.A.;
23. Payment for care for military service connected disabilities for which the Insured Person is legally entitled to services and for which facilities are reasonably available to the Insured Person and payment for care for conditions that state or local law requires be treated in a public facility;

24. Experimental medical, surgical or other health care procedures, treatments, products or services, unless otherwise stated herein;
25. Personal comfort items, such as television, telephone, lotions, shampoos, etc.;
26. Cosmetic Surgery;
27. Dental Care, treatment or Surgery unless necessitated by Injury to sound natural teeth which occurs while insured under this Policy. (The expense must be incurred within one year from the date of Injury, and while Hospital Confined or in an Outpatient Surgery Facility);
28. Corrective vision or hearing supplies or for the examination for prescribing or fitting such supplies;
29. The removal of warts, corns, calluses, the cutting and trimming of toenails, care for flat feet, fallen arches or chronic foot strain;
30. Hernia, hemorrhoids, tonsils, adenoids, middle ear disorders, myringotomy; or any disease or disorder of the reproductive organs unless the loss is incurred 6 months after the Insured Person becomes covered under this Policy;
31. Expenses incurred for prescription drugs, except if added by Rider;
32. Normal pregnancy, except for Complications of Pregnancy, except Benefits added by Rider, if any; and
33. Treatment, services or supplies received outside the U.S. or Canada. However, Benefits will be payable for Covered Expenses incurred as a result of an acute Sickness or Injury sustained during the first 30 days of travel outside of the U.S. or Canada. In no event will Benefits be payable beyond the first 30 days of travel outside of the U.S. or Canada.

Sickness Exclusion

We will not provide Benefits for any loss resulting from a Sickness, as defined, which first manifests itself within the 30 days after the Insured Person's Effective Date of Coverage, until such coverage has been in force for a period of 12 months. However, if an Insured Person had Prior Coverage in force prior to their Effective Date of Coverage under this Policy, without a break in coverage of more than 30 days, this Sickness Exclusion will be waived.

For the purpose of this provision, 'Prior Coverage' means accident and sickness insurance that would have otherwise covered the Sickness.

Pre-Existing Condition

We will not provide Benefits for any loss resulting from a Pre-Existing Condition, as defined, unless the loss is incurred at least one year after the Effective Date of Coverage for an Insured Person.

Coverage After Age 65 or Earlier Medicare Eligibility

When an Insured Person attains age 65 or becomes eligible for Medicare, whichever happens first, the Benefits of this Policy and its attachments, if any, are payable only to the extent that Covered Expenses are not paid by Medicare and they would otherwise be payable under this Policy. The Benefits will also be subject to any other EXCLUSIONS AND LIMITATIONS set forth in this Policy.

COORDINATION OF BENEFITS

All of the benefits provided under this Policy are subject to this section. However, Coordination of Benefits (COB) may not be applied to claims less than fifty dollars (\$50.00). If additional liability is incurred to raise the claim above fifty dollars (\$50.00), the entire liability may be included in the COB computation.

Plan means any plan providing benefits or services for or by a reason of expenses incurred for hospital, medical, or dental care or treatment.

The term "Plan" shall be construed separately with respect to each policy, contract or other arrangement for benefits or services and separately with respect to that portion of such policy, contract or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

This Plan refers to provisions of the Policy which are subject to this section.

Allowable Expense will be any necessary, Usual and Customary Charge, all or part of which is covered by at least one of the Plans covering the Insured Person. Allowable Expenses to a "secondary" plan will include the value or amount of any deductible amount or co-insurance percentage or amount of otherwise Allowable Expenses which is not paid by the "primary" or first paying plan.

Some plans provide benefits in the form of services rather than cash payments. For those plans, the reasonable cash value of each service rendered will be deemed to be both an Allowable Expense and a benefit paid.

Claim Determination Period is a Calendar Year or portion thereof during which the Insured Person has been covered under This Plan.

Determination of benefits payable under This Plan and all other applicable Plans will be controlled by this section, if without this section the sum of the benefits payable under:

1. This Plan; and
2. All other applicable plans,

would exceed the Allowable Expense.

If the sum of 1. and 2. above does exceed the total Allowable Expense, benefits payable under This Plan will be reduced by the amount of benefits payable under all other Plans.

Benefits of any other Plans which contain a COB provision will be ignored when computing the benefits of This Plan if:

1. The other plan's COB provision states that the benefits will be determined after This Plan computes its benefits; and
2. The rules set forth below would require This Plan to compute its benefits first.

The rules that set the order of benefit determination are:

1. The benefits of a Plan which covers the Insured Person on whose expenses claim is based other than as a dependent shall be determined before the benefits of a Plan which covers such person as a dependent, and benefits of a Plan which covers such person as an employee shall be determined before the benefits of a Plan which covers such person as a member;
2. The benefits of a Plan which covers the Insured Person on whose expenses claim is based as a dependent of the parent whose birthday falls earlier in the year shall be determined before those of the parent whose birthday falls later in that year;
3. If both parents have the same birthday, the benefits of the plan which covered the parent longest are determined before those of the Plan which covered the other parent for a shorter period of time;

However, if the other Plan does not have the birthday rule as described above, but instead has a rule based upon the gender of the parents, and as a result the Plans do not agree on the order of benefits, the rule in the other Plan utilizing the gender rule will determine the order of benefits;

4. In the case of divorced or separated parents, the benefits for a child will be determined as follows:
 - a) First the Plan of the parent with custody of the child;
 - b) Then the Plan of the spouse of the parent with the custody of the child;
 - c) Finally, the plan of the parent not having custody of the child;
 - d) If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply with respect to any Claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge;

5. When Rules 1. and 2. do not establish an order of benefit determination, the benefits of a Plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a Plan which has covered such person for the shorter period of time.

We reserve the right to release or obtain information that We deem necessary, about any person to or from:

1. Any other insurance company; or
2. Any organization or person.

At Our request, the Insured Person shall furnish us with any information needed to determine payment of benefits under this COB provision.

Facility of Payment

Whenever benefits which should have been paid under This Plan are paid under any other Plan, We shall have the right to pay to the organization that made the payments any amount that We feel will satisfy this provision. Amounts so paid will be deemed benefits paid under This Plan and We will be fully discharged from liability under This Plan.

Right of Recovery

If We, at any time, pay the total Allowable Expense and that amount exceeds the payment required to satisfy the intent of this section, We will have the right to recover such payments, to the extent of such excess, from among one or more of the following, as We shall determine: any persons to or for or with respect to whom such payments were made; any other insurance companies; any other organization.

Time Limit for Payment

Payment of benefits must be made within thirty (30) calendar days after submittal of a proof of loss, unless We provide the claimant a clear and concise statement of a valid reason for further delay which is in no way connected with or caused by the existence of this COB section nor otherwise attributable to Us.

GENERAL PROVISIONS

Entire Contract

The Entire Contract consists of:

1. The Policy ;
2. Any applications for the proposed insured individuals; and
3. Any endorsements, amendments or riders attached.

All statements made or by You will, in the absence of fraud, be deemed representations and not warranties.

Only Our President, a Vice President or Secretary has the power on Our behalf to execute or amend the Policy. No other person will have the authority to bind Us in any manner. No agent may accept risks, alter or amend coverage or waive any provisions of the Policy. Any change in the Policy will be made by an amendment signed by Us. Such amendment will not require the consent of any Insured Person.

Notice of Claim

Written notice of claim must be given to Us within 20 days, or as soon as reasonably possible. Written notice of claim given by or on behalf of the Insured Person to Us with information sufficient to identify such person will be considered notice to Us.

Claim Forms

When We receive the notice of claim, We will send the Insured Person forms for filing proof of loss. If these forms are not furnished within 15 days, the Insured Person will meet the proof of loss requirements by giving Us a written statement of the nature and extent of the loss within the time limit stated in the next provision.

Proof of Loss

Written proof of loss must be furnished to Us at Our administrative office in North Richland Hills, Texas, within 90 days after the date of the loss for which claim is made. Failure to furnish written proof of loss within that time will neither invalidate nor reduce any claim if it is shown that it was not reasonably possible to furnish written proof of loss within that time; provided such proof is furnished as soon as reasonably possible and in no event, in the absence of legal incapacity, later than one year from the time proof is otherwise required.

Claim Payments

We will pay all Benefits due under the Policy promptly upon receipt of due proof of loss.

All Benefits are payable to You, however, at Our option, We may pay the provider of service instead, unless You have requested otherwise in writing prior to providing proof of loss. If any such Benefits remain unpaid at Your death, or if You are, in Our opinion, incapable of giving a legally binding receipt for payment of any Benefit, We may, at Our option, pay such Benefit to Your estate or any one or more of the following relatives: Your spouse; mother, father, child or children; brother or brothers; sister or sisters. Any payment so made will constitute a complete discharge of Our obligations to the extent of such payment.

Assignment of Claim Payments

Payment for services provided by the PPO provider is automatically assigned to the provider. The PPO provider is responsible for filing the claim and We will make payments directly to the PPO provider for any Benefits that are payable.

Physical Examination

We will, at Our own expense, have the right and opportunity to examine the Insured Person whose Injury or Sickness is the basis of a claim when and as often as We may reasonably require during the pendency of a claim and to make an autopsy in case of death, unless prohibited by law.

Legal Action

No action at law or in equity will be brought to recover on the Policy prior to the expiration of 60 days after proof of loss has been filed as required by the Policy; nor may any action be brought after the expiration of 3 years after the time written proof of loss is required to be furnished.

Age Misstatement

If the age of any Insured Person has been misstated, Our records will be changed to show the correct age. The Benefits provided will not be affected if the Insured Person continues to be eligible for coverage at the correct age. However, premium adjustments, including collection of any premium due Us because of past underpayments, will be made so that We receive the premiums due at the correct age payable on the premium due date following Our notification of an age correction.

Incontestability

After 2 years from the Insured Person's Effective Date of Coverage, no misstatements, except fraudulent misstatements, made in the application will be used to void the coverage, or deny a claim unless the loss was incurred during the first 2 years following such Insured Person's Effective Date of Coverage.

No claim for a loss incurred one year after an Insured Person's Effective Date of Coverage will be reduced or denied as a Pre-Existing Condition.

Conformity

Any provision of this Policy which, on the Effective Date of Coverage, is in conflict with the extraterritorial statutes of the state in which You reside on such date, is hereby amended to conform to the minimum requirements of such statutes.

Change of Residence

If You move, You must notify the Company.

Subrogation

You agree that We shall be subrogated to Your right to damages, to the extent of the Benefits provided by the Policy, for Injury or Sickness that a third party is liable for or causes. You agree to repay Us first out of any monies You obtain regardless of the amount that You recover. In the event that We retain Our own attorney to represent Our subrogation interest, We will not be responsible for paying a portion of Your attorney fees or costs.

You assign to Us Your claim against a liable party to the extent of Our payments, and shall not prejudice Our subrogation rights. Entering into a settlement or compromise arrangement with a third party without Our prior written consent shall be deemed to prejudice Our rights. You shall promptly advise Us in writing whenever a claim against another party is made and shall further provide to Us such additional information as is reasonably requested by Us. You agree to fully cooperate in protecting Our rights against a third party.

Right of Reimbursement

You may receive Benefits under the Policy, and may also recover losses from another source, including Workers' Compensation, uninsured, underinsured, no-fault or personal injury protection coverages. The recovery may be in the form of a settlement, judgment, or other payment.

You must reimburse Us from these recoveries in an amount up to the Benefits paid by Us under the Policy. You agree to repay Us first out of any monies You obtain regardless of the amount that You recover. We have an automatic lien on any recovery.

THE MEGA LIFE AND HEALTH INSURANCE COMPANY

A Stock Company
(Hereinafter called: the Company, We, Our or Us)
Home Office: Oklahoma City, Oklahoma
Administrative Office: P.O. Box 982010
North Richland Hills, Texas 76182-8010
Customer Service: 1-800-527-5504

CATASTROPHIC EXPENSE PREFERRED PROVIDER ORGANIZATION (PPO) POLICY OUTLINE OF COVERAGE FOR FORM 26026 PPO-IP AR

- 1. READ YOUR POLICY CAREFULLY!** This Outline of Coverage provides a very brief description of some of the important features of Your Policy. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth, in detail, the rights and obligations of both You and Us. It is, therefore, important that You **READ YOUR POLICY CAREFULLY**.
- 2. CATASTROPHIC EXPENSE PREFERRED PROVIDER ORGANIZATION (PPO) COVERAGE** - The plan provides coverage for catastrophic expenses with the option of obtaining services through a Preferred Provider Organization, payable at a higher coinsurance level. The plan has a [\$5,000,000] Lifetime Maximum Amount and a [\$1,000,000] Aggregate Maximum Amount for all covered Injuries and Sicknesses. Covered Expenses are subject to a Deductible, unless otherwise stated.
- 3. BENEFITS** - For the purpose of this Outline of Coverage, Insured Person means You and Your Covered Dependents who are covered under the Policy.

The plan pays for Covered Expenses incurred under the Policy, subject to a [\$5,000,000] Lifetime Maximum Amount for all Injuries and Sicknesses per Insured Person. The plan pays for Covered Expenses incurred under the Policy, subject to a [\$1,000,000 Aggregate Maximum Amount] for any one covered Injury or Sickness for each Insured Person. Unless otherwise stated, all Covered Expenses are subject to the Maximum Benefits as shown in the Policy, Deductibles, Copayments, [Coinsurance Maximum] and Coinsurance shown below:

Insured Persons have the right to obtain medical care from the Physicians, Hospitals and other health care providers of their choice; however, if Covered Expenses are incurred from services provided by a non-PPO provider, Benefits will be less than the amount that would have otherwise been payable for Covered Expenses incurred from services provided by a PPO provider as shown below.

Deductible:

The Deductible applies to each Insured Person and for each [Calendar Year.]

<u>PPO Provider</u>	<u>Non-PPO Provider</u>
<input type="checkbox"/> \$1,500	\$3,000
<input type="checkbox"/> \$2,000	\$4,000
<input type="checkbox"/> \$2,500	\$5,000
<input type="checkbox"/> \$3,000	\$6,000
<input type="checkbox"/> \$3,500	\$7,000
<input type="checkbox"/> \$5,000	\$10,000
<input type="checkbox"/> \$7,500	\$15,000
<input type="checkbox"/> \$10,000]	\$20,000]

<u>PPO Provider</u>	<u>Non-PPO Provider</u>
---------------------	-------------------------

Coinsurance Maximum: [\$4,000] [\$6,000] [\$8,000] [\$8,000] [\$12,000] [\$16,000]

Coinsurance: 70%] 80%] 90%] 50%] 60%] 70%]
of Covered Expenses of Covered Expenses

COVERED EXPENSES

Covered Expenses means [Usual and Customary] Charges for the services, supplies, care or treatment covered under this Policy which are incurred by an Insured Person as a result of Injury or Sickness and for which the Insured Person is legally obligated to pay and are not otherwise excluded or limited herein. They are incurred on the date that the service is performed or the supply is furnished. Only that portion of a [Usual and Customary] Charge or fee which is Medically Necessary is a Covered Expense. Covered Expenses must be incurred while this coverage is in force.

[Any charges in excess of the Maximum Benefit, if any, will not be considered a Covered Expense.]

Covered Expenses under the Riders, if any, may or may not be considered Covered Expenses under the Policy.

Inpatient Hospital Services - Covered Expenses incurred for services and supplies provided by the Hospital for semi-private accommodations and general nursing care furnished by the Hospital including Confinement in the Hospital's intensive care or cardiac care unit (in lieu of Benefit amount payable for Hospital room and board) and miscellaneous medical services and supplies necessary for the treatment of the Insured Person during that [Calendar Year].

Covered Expenses will also include x-ray, laboratory, diagnostic tests and services of a radiologist, radiology group, and the services of a pathologist or pathology group for interpretation of diagnostic tests or studies, performed while the Insured Person is Hospital Confined.

The fees charged for take home drugs, personal convenience items, or items not intended primarily for use of the Insured Person while Hospital Confined are not Covered Expenses.

Physician Visits while Hospital Confined - Covered Expenses incurred for visits by a Physician, other than the surgeon, while Hospital Confined, not exceed a [\$100] Maximum Benefit, per Insured Person, per day.

Surgeon Benefit - Covered Expenses incurred [while Hospital Confined or in an Outpatient Surgery Facility] for services by the Physician performing Surgery.

If two or more Surgeries are performed at the same time through separate incisions, We will consider the one providing the largest Benefit. We will also consider [50%] of the Benefits otherwise payable for the other Surgeries performed at the same time.

We will not consider more than one Surgery performed through the same incision during the same operation; however, We will consider the Surgery providing the largest Benefit.

If it is recommended that You have Physical Therapy in lieu of Surgery, We may consider Physical Therapy as an alternative to Surgery. Such Physical Therapy must be in accordance with a Treatment Plan approved by Us. Covered Expenses incurred under this Surgeon Benefit for Physical Therapy will be counted toward the applicable Surgeon Benefit.

Assistant Surgeon Benefit - Covered Expenses incurred for services by the Physician assisting the Physician performing Surgery.

Anesthesiologist Benefit - Covered Expenses incurred for services by the Physician providing anesthesia during Surgery.

Outpatient Surgery Facility Charges - Covered Expenses incurred for services furnished by and supplies received for use in an Outpatient Surgery Facility, including but not limited to:

1. Use of operating room and recovery room;
2. Administration of drugs and medicines during Surgery;
3. Dressings, casts, splints; and
4. Diagnostic services including radiology, laboratory or pathology performed at the time of the Surgery.

Second Surgical Opinion - Covered Expenses incurred for services by a Physician for a second opinion. The Physician providing the second opinion cannot be financially associated with the referring Physician or perform or assist in the Surgery in order for services to be considered a Covered Expense under the Policy.

If the second opinion disagrees with the first, a third opinion will also be considered a Covered Expense.

Durable Medical Equipment and Prosthetic Devices - Covered Expenses incurred for the rental of durable medical equipment not to exceed the actual purchase price of such equipment, and the purchase, fitting, repair and replacement of fitted prosthetic devices which replace a natural limb or eye, when ordered or prescribed by a Physician for use by the Insured Person.

The durable medical equipment or prosthetic device must be for use solely by the Insured Person for the treatment of a Sickness or Injury which occurred while such Insured Person's coverage is in force.

Routine maintenance and repairs of rental equipment are not Covered Expenses.

Covered Expenses will not exceed a Maximum Benefit of [\$5,000] per Insured Person, per [Calendar Year].

Outpatient Diagnostic Services - Covered Expenses incurred [within [21] days of a Surgery or Hospital Confinement] for diagnostic x-rays and interpretation charges, and laboratory and pathological examinations received while not Confined to a Hospital and that are related to and necessary for the diagnosis and treatment of the Sickness or Injury [that results in Surgery or Hospital Confinement]. [Covered Expenses include but are not limited to CAT Scans, Magnetic Resonance Imaging (MRI), Mammogram, Upper/Lower G.I. Series, Electrocardiogram (EKG), Blood or serum analysis, Angiogram and Stress Tests. [Please refer to the CASE MANAGEMENT provision shown in the Policy for Pre-Notification Requests of Non-Emergency Admissions.]]

Covered Expenses do not include routine physical examinations or checkups.

[Covered Expenses will not exceed a Maximum Benefit of [\$10,000] per Insured Person, per Calendar Year and must be related to and necessary for the diagnosis and treatment of the Sickness or Injury that results in Surgery or Hospital Confinement.] A [\$50] [\$100] [\$150] Copayment, per Insured Person, per 24 hour period, will apply.

Ambulance Transport - Covered Expenses incurred for Ambulance transportation to a Hospital, provided the Insured Person is Confined to the Hospital. Covered Expenses will not exceed a Maximum Benefit of [\$500] per Insured Person, per trip.

Chemotherapy - Covered Expenses incurred for chemotherapy received while Hospital Confined or on an outpatient basis. The condition for which chemotherapy is provided must be first diagnosed and the treatment must be received while coverage is in force.

Covered Expenses incurred with an approved Chemotherapy or Radiation Therapy Course of Treatment Plan will be considered at the Coinsurance amount selected.

Covered Expenses incurred without an approved Chemotherapy or Radiation Therapy Course of Treatment Plan will be considered at the Coinsurance amount selected, up to a Maximum Benefit of [\$1,500] per Insured Person, per day.

Radiation Therapy - Covered Expenses incurred for radiation therapy received while Hospital Confined or on an outpatient basis. The condition for which radiation therapy is provided must be first diagnosed and the treatment must be received while coverage is in force.

Covered Expenses incurred with an approved Chemotherapy or Radiation Therapy Course of Treatment Plan will be considered at the Coinsurance amount selected.

Covered Expenses incurred without an approved Chemotherapy or Radiation Therapy Course of Treatment Plan will be considered at the Coinsurance amount selected, up to a Maximum Benefit of [\$1,250] per Insured Person, per day.

Transplants - Covered Expenses include Transplant Procedures incurred during a Transplant Benefit Period.

Covered Expenses for Transplant Procedures include:

1. Inpatient and outpatient Hospital services;
2. Services of a Physician for diagnosis, treatment and Surgery for a Transplant Procedure;
3. Procurement of an organ or tissue, including services provided to a living donor of an organ or tissue for procurement of an organ or tissue, provided the donor and transplant recipient are both insured under the Policy. Covered Expenses are limited to the actual procurement expenses, and will not be more than any maximums under the Policy applicable to the recipient;
4. [Usual and Customary] Charges for Travel and Accommodation Expenses related to a Transplant Procedure for the transplant recipient and one companion during a Transplant Benefit Period, provided the transplant facility is more than [300] miles from the Insured Person's home. If the recipient is a minor, Travel and Accommodation Expenses for two companions may be covered. Benefits for Travel and Accommodation Expenses are subject to the Travel and Accommodation Expense maximum[.];
5. Rental of durable medical equipment for use outside the Hospital. Covered Expenses are limited to the purchase price of the same equipment;
6. Prescription Drugs, including immunosuppressive drugs;
7. Oxygen;
8. Speech therapy, occupational therapy, Physical Therapy and chemotherapy;
9. Services and supplies for and related to high dose chemotherapy and bone marrow tissue transplantation when provided as part of a Transplant Treatment Plan which includes bone marrow transplantation and high dose chemotherapy; and
10. Surgical dressings and supplies.]

When the Insured Person's Physician advises the Insured Person that a Transplant Procedure is being considered, the Insured Person or the Insured Person's Physician should notify Us or Our designee in order for Us to direct the Insured Person to an appropriate Designated Transplant Facility. Covered Expenses for a live donor shall be paid to the extent that benefits remain and are available under this Policy for the Insured Person receiving the transplant, and after all Covered Expenses for the Insured Person has been paid. Benefits are not payable for animal organ or artificial organ transplants or for personal hygiene and convenience items, such as air conditioners, humidifiers, hot tubs, whirlpools, or physical exercise equipment, even if such items are prescribed by a Physician. Benefits are not payable for Covered Expenses incurred beyond the Transplant Benefit Period. Medically Necessary transplants not specifically defined as a Transplant Procedure under the Policy, which are not determined to be Experimental or Investigational Medicine will be payable the same as any other Transplant Procedure under the Policy in accordance with the provisions of the Policy.

Covered Expenses incurred for Transplant Procedures in a Designated Transplant Facility will be considered at [100%], with a Maximum Benefit payable for incurred Travel and Accommodation Expenses of [\$150] per day and [\$3,000] per Transplant Benefit Period.

Covered Expenses incurred for Transplant Procedures outside a Designated Transplant Facility will be considered at the Coinsurance amount selected with a Maximum Benefit payable of [\$100,000] per Transplant Procedure. [Travel and Accommodation Expenses incurred will not be considered as Covered Expenses.]

Musculoskeletal Disorders - Covered Expenses incurred for the medical treatment of musculoskeletal disorders affecting any bone or joint in the face, neck, or head, including temporomandibular joint disorder and craniomandibular disorder, on the same basis as that provided for any other musculoskeletal disorder in the body, whether prescribed or administered by a Physician or dentist. Treatment shall include both surgical and nonsurgical procedures, and shall be provided for the diagnosis and treatment of these conditions whether they are the result of accident, trauma, congenital defect, developmental defect, or pathology.

Child Health Supervision Services - Covered Expenses incurred for each Covered Dependent from the moment of birth to age eighteen (18) years. In keeping with prevailing medical standards, such services shall include:

1. anticipatory guidance;
2. developmental assessment;
3. laboratory tests;
4. appropriate immunizations
5. a medical history; and
6. physical examination.

Benefits will be payable for 20 visits provided by or under the supervision of a single Physician during the course of one visit, at approximately the following intervals: birth; two weeks; two, four, six, nine, twelve, fifteen and eighteen months and two, three, four, five, six, eight, ten, twelve, fourteen, sixteen and eighteen years.

Benefits payable will not exceed current reimbursement levels for the same services under the Medicaid Early Periodic Screening Diagnosis and Treatment program in the State of Arkansas.

Benefits for recommended immunization services shall be exempt from any Coinsurance, Deductible or dollar limit provisions.

Maternity Stay Requirements For Covered Maternity Care - This provision applies to an Insured Person's coverage only when the Insured Person incurs Covered Expenses for a normal childbirth or cesarean section delivery that is covered by an optional Maternity Benefit Rider or for Complications of Pregnancy as defined in the Policy. A minimum of 48 hours of inpatient care will be provided to the mother and newborn child following a vaginal delivery and 96 hours following a cesarean section. Any normal delivery is subject to the Maximum Benefit for Pregnancy/Childbirth as stated in the optional Maternity Benefit Rider.

Medical Foods and Low Protein Modified Food Products - Covered Expenses incurred for the treatment of a Covered Dependent inflicted with phenylketonuria if:

1. The medical food or low protein modified food products are prescribed as Medically Necessary for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemia and disorders of amino acid metabolism;
2. The products are administered under the direction of a licensed Physician; and
3. The cost of the medical food or low protein modified food products for an individual or a family with a dependent person or persons exceeds the [two thousand four hundred dollars (\$2,400)] per year per person income tax credit allowed.

Diabetes - Covered Expenses incurred for diabetes self-management training, supplies and related services for the treatment of Type I, Type II and gestational diabetes when determined Medically Necessary by Your Physician or other licensed health care provider.

Diabetes Self-Management Training means instructions in an inpatient or outpatient setting including medical nutrition therapy relating to diet, caloric intake and diabetes management, excluding any programs in which the only purpose is weight reduction, which enables diabetic patients to understand the diabetic management process and daily management of diabetic therapy as a method of avoiding frequent hospitalizations and complications when the instruction is provided in accordance with a program in compliance with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association.

Impairment or Loss of Speech or Hearing - Covered Expenses incurred for the communicative disorders generally treated by speech pathologist or audiologist licensed by the Board of Examiners in Speech-Language Pathology and Audiology and which fall within the scope of his/her area of certification. Coverage does not apply to hearing instruments or devices.

Colorectal Cancer Screening - Covered expenses incurred for colorectal cancer examinations and laboratory tests for Insured Persons who are 50 years of age or older; who are less than 50 years of age and at high risk for colorectal cancer according to American Cancer Society colorectal cancer screening guidelines as they existed on [January 1, 2005]; and 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 as determined by a licensed Physician.

For the purpose of this benefit "high risk for colorectal cancer" means: Individuals over 50 years of age or who face a high risk for colorectal cancer because of the presence of polyps on a previous colonoscopy, barium enema, or flexible sigmoidoscopy; family history of colorectal cancer in close relatives of parents, brothers, sisters, or children; genetic alterations of hereditary nonpolyposis colon cancer or familial adenomatous polyposis; personal history of colorectal cancer, ulcerative colitis, or Crohn's disease; or the presence of any appropriate recognized gene markers for colorectal cancer or other predisposing factors; and any definition recognized by medical science and determined by the Director of the Department of Health in consultation with the University of Arkansas for Medical Sciences.

Outpatient Contraceptive Services and Devices - Covered Expenses incurred for Outpatient Contraceptive Services and Devices including closed formularies; however, formularies must include implant and injectable contraceptive drugs, and intrauterine devices.

Covered Expenses do not include charges for abortion, an abortifacient or any U.S. Food and Drug Administration approved emergency contraception.

Outpatient Contraceptive benefits are subject to the same Deductibles and Coinsurances as prescription drugs.

4. EXCLUSIONS AND LIMITATIONS - We will not provide any Benefits for charges resulting from or in connection with:

1. Any care not Medically Necessary or charges for which Benefits are not specifically provided for in the Policy;
2. Any act of war, declared or undeclared;
3. Suicide, attempted suicide, or any intentionally self-inflicted injury, while sane or insane;
4. Any routine physical examination, unless otherwise stated in the Policy;
5. Any Injury or Sickness arising out of, or in the course of, employment for wage or profit, provided the Insured Person is covered under any Worker's Compensation Act, Occupational Disease Act, or similar act or law, unless the Insured Person is self-employed;
6. Mental or Nervous Disorders, unless otherwise stated in the Policy;
7. Drug abuse or addiction including alcoholism, or overdose of drugs, narcotics, or hallucinogens, directly or indirectly, unless taken as prescribed by a Physician;
8. An overdose of drugs, being intoxicated or under the influence of intoxicants, hallucinogens, narcotics or other drugs, directly or indirectly, unless taken as prescribed by a Physician;
9. Any treatment including prescription drugs or non-prescription drugs, or procedure that promotes conception or prevents childbirth, including but not limited to: (a) artificial insemination; (b) in-vitro fertilization or other treatment for infertility; (c) treatment for impotency; (d) sterilization or reversal of sterilization; or (e) abortion (unless the life of the mother would be endangered if the fetus were carried to term), unless otherwise stated in the Policy;
10. Laser vision correction, radial keratotomy or any eye Surgery when the primary purpose is to correct nearsightedness, farsightedness, astigmatism, or any other refractive error;
11. Spinal manipulations and manual manipulative treatment or therapy;
12. Weight loss or modification, or complications arising therefrom, or procedures resulting therefrom or for surgical treatment of obesity including but not limited to gastric by-pass, wiring of the teeth and all forms of Surgery performed for the purpose of weight loss or modification or the reversal/modification of such procedure;
13. Breast reduction or augmentation unless necessary in connection with breast reconstructive Surgery following a mastectomy;
14. Modification of the physical body in order to improve the psychological, mental or emotional well-being of the Insured Person, such as but not limited to sex-change Surgery;
15. Marriage, family, or child counseling for the treatment of premarital, marriage, family or child relationship dysfunctions;
16. Routine newborn care, unless otherwise stated in the Policy;
17. Directly or indirectly engaging in an illegal occupation or illegal activity;
18. Care in a nursing home, custodial institution or domiciliary care or rest cures;
19. Preparation and presentation of medical reports for appearance at trials or hearings;
20. Physical examinations required for school events, camp, employment, licensing and insurance are expressly excluded;
21. Immunizations required for the sole purpose of travel outside of the U.S.A.;

22. Payment for care for military service connected disabilities for which the Insured Person is legally entitled to services and for which facilities are reasonably available to the Insured Person and payment for care for conditions that state or local law requires be treated in a public facility;
23. Experimental medical, surgical or other health care procedures, treatments, products or services, unless otherwise stated in the Policy;
24. Personal comfort items, such as television, telephone, lotions, shampoos, etc.;
25. Cosmetic Surgery;
26. Dental Care, treatment or Surgery unless necessitated by Injury to sound natural teeth which occurs while insured under this Policy. (The expense must be incurred within one year from the date of Injury, and while Hospital Confined or in an Outpatient Surgery Facility);
27. Corrective vision or hearing supplies or for the examination for prescribing or fitting such supplies;
28. The removal of warts, corns, calluses, the cutting and trimming of toenails, care for flat feet, fallen arches or chronic foot strain;
29. Hernia, hemorrhoids, tonsils, adenoids, middle ear disorders, myringotomy; or any disease or disorder of the reproductive organs unless the loss is incurred 6 months after the Insured Person becomes covered under this Policy;
30. Expenses incurred for prescription drugs, except if added by Rider;
31. Normal pregnancy, except for Complications of Pregnancy, except Benefits added by Rider, if any; and
32. Treatment, services or supplies received outside the U.S. or Canada. However, Benefits will be payable for Covered Expenses incurred as a result of an acute Sickness or Injury sustained during the first 30 days of travel outside of the U.S. or Canada. In no event will Benefits be payable beyond the first 30 days of travel outside of the U.S. or Canada.

Pre-Existing Condition - We will not provide Benefits for any loss resulting from a Pre-Existing Condition, as defined, unless the loss is incurred at least one year after the Effective Date of Coverage for an Insured Person.

Coverage After Age 65 or Earlier Medicare Eligibility - When an Insured Person attains age 65 or becomes eligible for Medicare, whichever happens first, the Benefits of the Policy and its attachments, if any, are payable only to the extent that Covered Expenses are not paid by Medicare and they would otherwise be payable under the Policy. The Benefits will also be subject to any other EXCLUSIONS AND LIMITATIONS set forth in the Policy.

5. **RENEWABILITY** - The Policy is guaranteed renewable, subject to the Company's right to discontinue or terminate the coverage as provided in the TERMINATION OF COVERAGE section of the Policy. The Company reserves the right to change the applicable table of premium rates on a Class Basis. The premium for the Policy may change in amount by reason of an increase in the age of an Insured Person.

6. TERMINATION OF COVERAGE –

You

Your coverage will terminate and no Benefits will be payable under the Policy and any attached Riders:

1. At the end of the period for which premium has been paid;
2. If Your mode of premium is monthly, at the end of the period through which premium has been paid following Our receipt of Your request of termination;
3. If Your mode of premium is other than monthly, upon the next monthly anniversary day following Our receipt of Your request of termination. Premium will be refunded for any amounts paid beyond the termination date;
4. On the date of fraud or misrepresentation by You;
5. On the date We elect to discontinue this plan or type of coverage. We will give You at least 90 days notice before the date coverage will be discontinued. You will be offered an option to purchase any other coverage that We offer without regard to health status;
6. On the date We elect to discontinue all coverage in Your state. We will give You and the proper state authority at least 180 days notice before the date coverage will be discontinued; or
7. On the date an Insured Person is no longer a permanent resident of the United States.

Covered Dependents

Your Covered Dependent's coverage will terminate under the Policy on:

1. The date Your coverage terminates;
2. The date such Dependent ceases to be an Eligible Dependent; or

- The date We receive Your written request to terminate a dependent's coverage.

The attainment of the Limiting Age for an Eligible Dependent will not cause coverage to terminate while that person is and continues to be both:

- Incapable of self-sustaining employment by reason of mental retardation or physical handicap; and
- Chiefly dependent on You for support and maintenance. For the purpose of this provision "Chiefly Dependent" means the Eligible Dependent receives the majority of his or her financial support from You.

We will require that You provide proof that the dependent is in fact a disabled and dependent person. In the absence of such proof We may terminate the coverage of such person after the attainment of the Limiting Age.

Special Continuation Provision For Dependents

Your Covered Dependents may continue their same (or substantially similar) coverage under a new Policy without evidence of insurability if their coverage under this Policy would otherwise terminate because they cease to be an Eligible Dependent for any of the following reasons:

- Divorce, legal separation, Your death; or
- A dependent child reaches the Limiting Age.

To continue coverage, You or Your Covered Dependent must request continuation of coverage by application or written notification within 31 days of the date coverage would otherwise terminate and pay any required premium.

7. RIDER BENEFITS –

Outpatient Speech Therapy, Physical Therapy and Occupational Therapy Rider (Form Number 26029 (10/05)-IR) – Covered Expenses incurred for Speech Therapy, Physical Therapy and Occupational Therapy that is related to and necessary for the treatment of a Sickness or Injury. The Benefits provided by this Rider will not duplicate benefits provided under the Policy and any other rider and are subject to the [Maximum Benefit Amount,] [Copayment,] [Coinsurance] and any other limitation shown for this Rider in the Policy Schedule. [Covered Expenses incurred under this Rider will not be considered a Covered Expense under the Policy and are not subject to and will not be used to satisfy the Policy Deductible.] In order to be considered a Covered Expense, therapy services must commence within 14 days of a covered Hospital Confinement or Surgery and be rendered in the 90 days immediately following the related covered Hospital Confinement or Surgery. Therapy provided beyond 90 days following a Hospital Confinement or Surgery will not be considered a Covered Expense.

	<u>PPO Provider</u>	<u>Non-PPO Provider</u>
Coinsurance	<input type="checkbox"/> 70%] <input type="checkbox"/> 80%] <input type="checkbox"/> 90%]	<input type="checkbox"/> 50%] <input type="checkbox"/> 60%] <input type="checkbox"/> 70%]
Maximum Benefit, per Insured Person, per week: [3] visits		
Not to exceed a [\$150] Maximum Benefit, per Insured Person, per day:		
Copayment, per visit: <input type="checkbox"/> \$25] <input type="checkbox"/> \$35] <input type="checkbox"/> \$50]		

Outpatient Accident Expense Benefit Rider (Form Number 25987(10/05)-IR) - Covered Expenses incurred by an Insured Person while the Rider is in force, for the Medically Necessary treatment of an Injury while not Hospital Confined. Benefit is subject to the following conditions: 1) Initial treatment by a Physician must begin within [72] hours of the Injury; and 2) Any treatment of the Injury, beyond the initial treatment, must be received within [45 days] of the Injury. The Benefits provided by this Rider will not duplicate Benefits provided under the Policy and any other rider and are subject to the [Rider Deductible, Coinsurance and the Maximum Benefit] shown for this Rider in the Policy Schedule. [Benefit paid under this Rider and amounts used to satisfy the Rider Deductible will not be considered a Covered Expense under the Policy and are not subject to and will not be used to satisfy the Policy Deductible.]

Coinsurance	[100%]
Maximum Benefit, per Insured Person, per Injury	<input type="checkbox"/> \$500] <input type="checkbox"/> \$1,000] <input type="checkbox"/> \$1,500][<input type="checkbox"/> \$2,000]
Deductible, per Injury	<input type="checkbox"/> \$50] <input type="checkbox"/> \$100] <input type="checkbox"/> \$150] <input type="checkbox"/> \$200]

Pregnancy/Childbirth Benefit Rider – (Form Number 25984 (10/05)-IR) AR – Covered Expenses incurred for normal pregnancy and childbirth at a Coinsurance amount in accordance with the length of time the Rider is in force. Covered Expenses will not exceed the Maximum Benefit selected. The Benefits provided by this Rider will not duplicate benefits provided under the Policy and any other rider and are subject to the Maximum Benefit Amount [Copayment,] [and Coinsurance] shown for this Rider in the Policy Schedule. [Covered Expenses incurred under this Rider will not be considered a Covered Expense under the Policy and are not subject to and will not be used to satisfy the Policy Deductible.]

[0-10] months in force	[0%] of Maximum Benefit selected
[11-24] months in force	[50%] of Maximum Benefit selected
[25] months in force and over	[100%] of Maximum Benefit selected

Maximum Benefit, per in vitro fertilization procedure and/or pregnancy/childbirth, for You or Your Covered Dependent Spouse \$2,000

Lifetime Maximum for In Vitro Fertilization Benefits: \$15,000

Air Ambulance Rider - (Form Number 25983 (10/05)-IR)- Covered Expenses incurred while the Rider is in force for Air Ambulance transportation to the nearest available medical facility that can provide adequate care in the event of a Medical Emergency, as defined in the Policy, at the Coinsurance amount selected. The Benefits provided by this Rider will not duplicate benefits provided under the Policy and any other rider and are subject to the [Maximum Benefit Amount,] [Copayment] [and Coinsurance] and any other limitation shown for this Rider in the Policy Schedule. [Covered Expenses incurred under this Rider will not be considered a Covered Expense under the Policy and are not subject to and will not be used to satisfy the Policy Deductible.] Covered Expenses will not exceed the base rate or the Maximum Benefit.

Coinsurance	<input type="checkbox"/> 70% <input type="checkbox"/> 80% <input type="checkbox"/> 90%
Base rate	[\$2,500]
Plus an additional	[\$50] per mile
Maximum Benefit, per Insured Person, per Calendar Year	[\$5,000]

Continued Care Benefit Rider – Form Number 25883 (10/05)-IR) AR – Covered Expenses incurred for Skilled Nursing Care, Home Health Care, Private Duty Nurse, or Hospice Care, following a covered Hospital Confinement for Medically Necessary continued care in accordance with a Treatment Plan, and as described in the rider. The Benefits provided by this Rider will not duplicate benefits provided under the Policy and any other rider and are subject to the Maximum Benefits, Coinsurance and other limitations shown for this Rider [and the Policy Deductible shown] in the Policy Schedule. [Covered Expenses incurred under this Rider will not be considered a Covered Expense under the Policy and are not subject to and will not be used to satisfy the Policy Deductible.]

PPO Provider

Non-PPO Provider

Skilled Nursing Care

Coinsurance Limited to [30 days] per Insured Person, per [Calendar Year]	<input type="checkbox"/> 70% <input type="checkbox"/> 80% <input type="checkbox"/> 90%	<input type="checkbox"/> 50% <input type="checkbox"/> 60% <input type="checkbox"/> 70%
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Maximum Benefit per Insured Person, per day [\$250]

Home Health Care

Coinsurance 70% 80% 90% 50% 60% 70%

Limited to [80 visits] per Insured Person, per [Calendar Year]

Not to exceed a [\$50] Maximum Benefit per Insured Person, per day

Private Duty Nursing

Coinsurance 70% 80% 90% 50% 60% 70%

Limited to [40 eight-hour shifts] per Insured Person, per [Calendar Year]

Not to exceed a [\$50] Maximum Benefit per Insured Person, per shift

Hospice Care

Coinsurance 70% 80% 90% 50% 60% 70%

Not to exceed a [\$5,000] Maximum Benefit per Insured Person, per lifetime

Legend Prescription Drug Expense Rider (Form Number 25985 (10/05)-IR) AR - We will pay a benefit if an Insured Person incurs Covered Expenses for Sickness or Injury. This benefit is the amount equal to the actual charge based on Participating Pharmacy prices for a Covered Expense, subject to the applicable Benefit Payment Rate/Deductible/Copayment shown below. Expenses are considered incurred on the date of Pharmacy service.

Deductible, per Calendar Year, per Insured Person \$50 \$100

Participating Pharmacy

(Not to exceed a 30 day supply)

Generic Drugs We pay [100%] less the [\$15] Copayment
Formulary Drugs We pay [50%], You pay the remainder
Non-Formulary Drugs We pay [25%], You pay the remainder

Non-Participating Pharmacy

(Not to exceed a 30 day supply)

Generic Drugs We pay [75%] less the [\$15] Copayment
Formulary Drugs We pay [25%], You pay the remainder
Non-Formulary Drugs We pay [0%], You pay the remainder

Mail Service Legend Prescription Drugs

(Not to exceed a 90 day supply through Our designated mail service program)

Generic Drugs We pay [100%] less the [\$30] Copayment
Formulary Drugs We pay [50%], You pay the remainder
Non-Formulary Drugs We pay [25%], You pay the remainder

Benefit Maximum

Per Insured Person [\$1,500] per Calendar Year

[PREVENTIVE PLUS] Benefit Rider (Form Number 26028 (10/05)-IR) – Benefits under the Rider are provided for [Medically Necessary] [non-Covered Expenses] for [Physician office visits, except for visits related to Mental or Nervous Disorders or fertility treatment;] [Allergy injections;] [Outpatient Diagnostic expenses not otherwise considered a Covered Expense under the Policy or any attached Riders;] [Emergency Room services not otherwise considered a Covered Expense under the Policy or any attached Riders; and] [Spinal manipulations]. [Routine preventive health care services, including but not limited to routine physical exams and related laboratory and x-rays services and immunizations, not otherwise paid under the Policy; and] [Acupuncture] will also be considered under the Rider.

All Benefits under the Rider are subject to subject to [Usual and Customary Charges][the Maximum Allowable Charge (MAC)], based on the Annual [PREVENTIVE PLUS] Benefit Amount selected, subject to a Quarterly Benefit Accumulation Amount.

ANNUAL [PREVENTIVE PLUS] BENEFIT AMOUNT:	QUARTERLY BENEFIT ACCUMULATION AMOUNT: (per quarterly Rider anniversary for You and Your Covered Dependents, if any)
<input type="checkbox"/> \$250	[\$62.50]
<input type="checkbox"/> \$500	[\$125.00]
<input type="checkbox"/> \$1,000	[\$250.00]
<input type="checkbox"/> \$2,000	[\$500.00]

Benefits under the Rider can accumulate if unused; however, there are limits to the amount that can accumulate. If there is more than one Insured Person covered under the Rider, there are limits to the maximum amount available to each Insured Person. Any Pre-Existing Condition limitations, conditions excluded by Waiver or Benefits paid under the Policy or any attached Riders, will not be considered under this Rider.

Benefits will be paid from the [PREVENTIVE PLUS] Benefit Amount on the date the services are rendered. Benefits accumulated subsequent to the date the services are rendered will not be used to pay benefits on services rendered before the accumulation date. In order for benefits to be considered under the Rider, services must be rendered during the time period for which premium has been paid for the Rider.

Emergency Services Benefit Rider (Form Number 26032 (10/05)-IR or 26032 PPO (10/05)-IR)- Covered Expenses incurred while the Rider is in force for Emergency Treatment of a Sickness or Injury not resulting in Hospital Confinement. The Benefits provided by this Rider will not duplicate the Benefits provided under the Policy and any other rider and are subject to the [[Policy Deductible] shown in the POLICY SCHEDULE] [and the [Copayment,][and Coinsurance][and Maximum Benefit] shown for this Rider in the POLICY SCHEDULE.

	<u>PPO Provider</u>	<u>Non-PPO Provider</u>
Coinsurance [Not to exceed a [\$1,000][\$2,000] Maximum Benefit per Insured Person, per visit]	<input type="checkbox"/> 70%][<input type="checkbox"/> 80%][<input type="checkbox"/> 90%]	<input type="checkbox"/> 50%][<input type="checkbox"/> 60%][<input type="checkbox"/> 70%]
[Physician's Office or Urgent Care Center Copayment, per visit <input type="checkbox"/> \$100] <input type="checkbox"/> \$250] <input type="checkbox"/> \$500] <input type="checkbox"/> \$1,000]]		
[Hospital Emergency Room Copayment, per visit <input type="checkbox"/> \$100] <input type="checkbox"/> \$250] <input type="checkbox"/> \$500] <input type="checkbox"/> \$1,000]]		

Physician's Office Visit Benefit Rider[*] (Form Number 25886-IP) - We will pay Covered Expenses incurred by an Insured Person, while this Rider is in force, for Medically Necessary visits to the Physician's office or clinic and for related care services provided by the Physician as a part of such visit. Benefits payable under this Rider are not subject to the Policy Deductible.

	<u>PPO Provider</u>	<u>Non-PPO Provider</u>
Copayment, per Insured Person, per visit	[\$30]	[\$30]
Daily Maximum Benefit, per Insured, Person per visit	[\$125]	[\$100]

Maximum Number of visits per calendar quarter
For You and Your Covered Dependent Spouse

1] 2] visits each

Maximum Number of visits per calendar quarter
For Your Covered Dependent Child(ren)

2] 4] visits each

[*The **Sickness Exclusion**, as shown in the EXCLUSIONS AND LIMITATIONS section of this Policy, does not apply to this Rider.]

- 8. **RIGHT TO RETURN POLICY** - It is important to Us that You understand and are satisfied with the coverage being provided to You. If You are not satisfied that this coverage will meet Your insurance needs, You may return the Policy to Us at Our administrative office in North Richland Hills, Texas, within 10 days after You receive it. Upon receipt, We will cancel Your coverage as of the Policy Date, refund all premiums paid and treat the Policy as if it were never issued.
- 9. **PREMIUMS** - We reserve the right to change the table of premiums, on a Class Basis, becoming due under the Policy at any time and from time to time; provided, We have given the Policyholder written notice of at least 31 days prior to the effective date of the new rates. Such change will be on a Class Basis. The premium for the Policy may change in amount by reason of an increase in the Attained Age of the Insured Person.

Initial Premium for Policy _____
 [Policy Fee _____]
 Rider Premium _____
 Total Initial Premium due with Application _____

THE MEGA LIFE AND HEALTH INSURANCE COMPANY

A Stock Company
(Hereinafter called: the Company, We, Our or Us)
Home Office: Oklahoma City, Oklahoma
Administrative Office: P.O. Box 982010
North Richland Hills, Texas 76182-8010
Customer Service: 1-800-527-5504

CATASTROPHIC EXPENSE PREFERRED PROVIDER ORGANIZATION (PPO) POLICY OUTLINE OF COVERAGE FOR FORM 26026 PPO-IP AR

NOTICE: Read this Outline of Coverage carefully. It is not identical to the Outline of Coverage provided upon application and the coverage originally applied for has not been issued.

- 1. READ YOUR POLICY CAREFULLY!** This Outline of Coverage provides a very brief description of some of the important features of Your Policy. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth, in detail, the rights and obligations of both You and Us. It is, therefore, important that You **READ YOUR POLICY CAREFULLY.**
- 2. CATASTROPHIC EXPENSE PREFERRED PROVIDER ORGANIZATION (PPO) COVERAGE** - The plan provides coverage for catastrophic expenses with the option of obtaining services through a Preferred Provider Organization, payable at a higher coinsurance level. The plan has a [\$5,000,000] Lifetime Maximum Amount and a [\$1,000,000] Aggregate Maximum Amount for all covered Injuries and Sicknesses. Covered Expenses are subject to a Deductible, unless otherwise stated.
- 3. BENEFITS** - For the purpose of this Outline of Coverage, Insured Person means You and Your Covered Dependents who are covered under the Policy.

The plan pays for Covered Expenses incurred under the Policy, subject to a [\$5,000,000] Lifetime Maximum Amount for all Injuries and Sicknesses per Insured Person. The plan pays for Covered Expenses incurred under the Policy, subject to a [\$1,000,000 Aggregate Maximum Amount] for any one covered Injury or Sickness for each Insured Person. Unless otherwise stated, all Covered Expenses are subject to the Maximum Benefits as shown in the Policy, Deductibles, Copayments, [Coinsurance Maximum] and Coinsurance shown below:

Insured Persons have the right to obtain medical care from the Physicians, Hospitals and other health care providers of their choice; however, if Covered Expenses are incurred from services provided by a non-PPO provider, Benefits will be less than the amount that would have otherwise been payable for Covered Expenses incurred from services provided by a PPO provider as shown below.

Deductible:

The Deductible applies to each Insured Person and for each [Calendar Year.]

<u>PPO Provider</u>	<u>Non-PPO Provider</u>
<input type="checkbox"/> \$1,500	\$3,000
<input type="checkbox"/> \$2,000	\$4,000
<input type="checkbox"/> \$2,500	\$5,000
<input type="checkbox"/> \$3,000	\$6,000
<input type="checkbox"/> \$3,500	\$7,000
<input type="checkbox"/> \$5,000	\$10,000
<input type="checkbox"/> \$7,500	\$15,000
<input type="checkbox"/> \$10,000]	\$20,000]

	<u>PPO Provider</u>	<u>Non-PPO Provider</u>
Coinsurance Maximum:	[\$4,000] [\$6,000] [\$8,000]	[\$8,000] [\$12,000] [\$16,000]
Coinsurance:	<input type="checkbox"/> 70% <input type="checkbox"/> 80% <input type="checkbox"/> 90% of Covered Expenses	<input type="checkbox"/> 50% <input type="checkbox"/> 60% <input type="checkbox"/> 70% of Covered Expenses

COVERED EXPENSES

Covered Expenses means [Usual and Customary] Charges for the services, supplies, care or treatment covered under this Policy which are incurred by an Insured Person as a result of Injury or Sickness and for which the Insured Person is legally obligated to pay and are not otherwise excluded or limited herein. They are incurred on the date that the service is performed or the supply is furnished. Only that portion of a [Usual and Customary] Charge or fee which is Medically Necessary is a Covered Expense. Covered Expenses must be incurred while this coverage is in force.

[Any charges in excess of the Maximum Benefit, if any, will not be considered a Covered Expense.]

Covered Expenses under the Riders, if any, may or may not be considered Covered Expenses under the Policy.

Inpatient Hospital Services - Covered Expenses incurred for services and supplies provided by the Hospital for semi-private accommodations and general nursing care furnished by the Hospital including Confinement in the Hospital's intensive care or cardiac care unit (in lieu of Benefit amount payable for Hospital room and board) and miscellaneous medical services and supplies necessary for the treatment of the Insured Person during that [Calendar Year].

Covered Expenses will also include x-ray, laboratory, diagnostic tests and services of a radiologist, radiology group, and the services of a pathologist or pathology group for interpretation of diagnostic tests or studies, performed while the Insured Person is Hospital Confined.

The fees charged for take home drugs, personal convenience items, or items not intended primarily for use of the Insured Person while Hospital Confined are not Covered Expenses.

Physician Visits while Hospital Confined - Covered Expenses incurred for visits by a Physician, other than the surgeon, while Hospital Confined, not exceed a [\$100] Maximum Benefit, per Insured Person, per day.

Surgeon Benefit - Covered Expenses incurred [while Hospital Confined or in an Outpatient Surgery Facility] for services by the Physician performing Surgery.

If two or more Surgeries are performed at the same time through separate incisions, We will consider the one providing the largest Benefit. We will also consider [50%] of the Benefits otherwise payable for the other Surgeries performed at the same time.

We will not consider more than one Surgery performed through the same incision during the same operation; however, We will consider the Surgery providing the largest Benefit.

If it is recommended that You have Physical Therapy in lieu of Surgery, We may consider Physical Therapy as an alternative to Surgery. Such Physical Therapy must be in accordance with a Treatment Plan approved by Us. Covered Expenses incurred under this Surgeon Benefit for Physical Therapy will be counted toward the applicable Surgeon Benefit.

Assistant Surgeon Benefit - Covered Expenses incurred for services by the Physician assisting the Physician performing Surgery.

Anesthesiologist Benefit - Covered Expenses incurred for services by the Physician providing anesthesia during Surgery.

Outpatient Surgery Facility Charges - Covered Expenses incurred for services furnished by and supplies received for use in an Outpatient Surgery Facility, including but not limited to:

1. Use of operating room and recovery room;
2. Administration of drugs and medicines during Surgery;
3. Dressings, casts, splints; and
4. Diagnostic services including radiology, laboratory or pathology performed at the time of the Surgery.

Second Surgical Opinion - Covered Expenses incurred for services by a Physician for a second opinion. The Physician providing the second opinion cannot be financially associated with the referring Physician or perform or assist in the Surgery in order for services to be considered a Covered Expense under the Policy.

If the second opinion disagrees with the first, a third opinion will also be considered a Covered Expense.

Durable Medical Equipment and Prosthetic Devices - Covered Expenses incurred for the rental of durable medical equipment not to exceed the actual purchase price of such equipment, and the purchase, fitting, repair and replacement of fitted prosthetic devices which replace a natural limb or eye, when ordered or prescribed by a Physician for use by the Insured Person.

The durable medical equipment or prosthetic device must be for use solely by the Insured Person for the treatment of a Sickness or Injury which occurred while such Insured Person's coverage is in force.

Routine maintenance and repairs of rental equipment are not Covered Expenses.

Covered Expenses will not exceed a Maximum Benefit of [\$5,000] per Insured Person, per [Calendar Year].

Outpatient Diagnostic Services - Covered Expenses incurred [within [21] days of a Surgery or Hospital Confinement] for diagnostic x-rays and interpretation charges, and laboratory and pathological examinations received while not Confined to a Hospital and that are related to and necessary for the diagnosis and treatment of the Sickness or Injury [that results in Surgery or Hospital Confinement]. [Covered Expenses include but are not limited to CAT Scans, Magnetic Resonance Imaging (MRI), Mammogram, Upper/Lower G.I. Series, Electrocardiogram (EKG), Blood or serum analysis, Angiogram and Stress Tests. [Please refer to the CASE MANAGEMENT provision shown in the Policy for Pre-Notification Requests of Non-Emergency Admissions.]]

Covered Expenses do not include routine physical examinations or checkups.

[Covered Expenses will not exceed a Maximum Benefit of [\$10,000] per Insured Person, per Calendar Year and must be related to and necessary for the diagnosis and treatment of the Sickness or Injury that results in Surgery or Hospital Confinement.] A [\$50] [\$100] [\$150] Copayment, per Insured Person, per 24 hour period, will apply.

Ambulance Transport - Covered Expenses incurred for Ambulance transportation to a Hospital, provided the Insured Person is Confined to the Hospital. Covered Expenses will not exceed a Maximum Benefit of [\$500] per Insured Person, per trip.

Chemotherapy - Covered Expenses incurred for chemotherapy received while Hospital Confined or on an outpatient basis. The condition for which chemotherapy is provided must be first diagnosed and the treatment must be received while coverage is in force.

Covered Expenses incurred with an approved Chemotherapy or Radiation Therapy Course of Treatment Plan will be considered at the Coinsurance amount selected.

Covered Expenses incurred without an approved Chemotherapy or Radiation Therapy Course of Treatment Plan will be considered at the Coinsurance amount selected, up to a Maximum Benefit of [\$1,500] per Insured Person, per day.

Radiation Therapy - Covered Expenses incurred for radiation therapy received while Hospital Confined or on an outpatient basis. The condition for which radiation therapy is provided must be first diagnosed and the treatment must be received while coverage is in force.

Covered Expenses incurred with an approved Chemotherapy or Radiation Therapy Course of Treatment Plan will be considered at the Coinsurance amount selected.

Covered Expenses incurred without an approved Chemotherapy or Radiation Therapy Course of Treatment Plan will be considered at the Coinsurance amount selected, up to a Maximum Benefit of [\$1,250] per Insured Person, per day.

Transplants - Covered Expenses include Transplant Procedures incurred during a Transplant Benefit Period. Covered Expenses for Transplant Procedures include:

1. Inpatient and outpatient Hospital services;
2. Services of a Physician for diagnosis, treatment and Surgery for a Transplant Procedure;
3. Procurement of an organ or tissue, including services provided to a living donor of an organ or tissue for procurement of an organ or tissue, provided the donor and transplant recipient are both insured under the Policy. Covered Expenses are limited to the actual procurement expenses, and will not be more than any maximums under the Policy applicable to the recipient;
4. [Usual and Customary] Charges for Travel and Accommodation Expenses related to a Transplant Procedure for the transplant recipient and one companion during a Transplant Benefit Period, provided the transplant facility is more than [300] miles from the Insured Person's home. If the recipient is a minor, Travel and Accommodation Expenses for two companions may be covered. Benefits for Travel and Accommodation Expenses are subject to the Travel and Accommodation Expense maximum[.];
5. Rental of durable medical equipment for use outside the Hospital. Covered Expenses are limited to the purchase price of the same equipment;
6. Prescription Drugs, including immunosuppressive drugs;
7. Oxygen;
8. Speech therapy, occupational therapy, Physical Therapy and chemotherapy;
9. Services and supplies for and related to high dose chemotherapy and bone marrow tissue transplantation when provided as part of a Transplant Treatment Plan which includes bone marrow transplantation and high dose chemotherapy; and
10. Surgical dressings and supplies.]

When the Insured Person's Physician advises the Insured Person that a Transplant Procedure is being considered, the Insured Person or the Insured Person's Physician should notify Us or Our designee in order for Us to direct the Insured Person to an appropriate Designated Transplant Facility. Covered Expenses for a live donor shall be paid to the extent that benefits remain and are available under this Policy for the Insured Person receiving the transplant, and after all Covered Expenses for the Insured Person has been paid. Benefits are not payable for animal organ or artificial organ transplants or for personal hygiene and convenience items, such as air conditioners, humidifiers, hot tubs, whirlpools, or physical exercise equipment, even if such items are prescribed by a Physician. Benefits are not payable for Covered Expenses incurred beyond the Transplant Benefit Period. Medically Necessary transplants not specifically defined as a Transplant Procedure under the Policy, which are not determined to be Experimental or Investigational Medicine will be payable the same as any other Transplant Procedure under the Policy in accordance with the provisions of the Policy.

Covered Expenses incurred for Transplant Procedures in a Designated Transplant Facility will be considered at [100%], with a Maximum Benefit payable for incurred Travel and Accommodation Expenses of [\$150] per day and [\$3,000] per Transplant Benefit Period.

Covered Expenses incurred for Transplant Procedures outside a Designated Transplant Facility will be considered at the Coinsurance amount selected with a Maximum Benefit payable of [\$100,000] per Transplant Procedure. [Travel and Accommodation Expenses incurred will not be considered as Covered Expenses.]

Musculoskeletal Disorders - Covered Expenses incurred for the medical treatment of musculoskeletal disorders affecting any bone or joint in the face, neck, or head, including temporomandibular joint disorder and craniomandibular disorder, on the same basis as that provided for any other musculoskeletal disorder in the body, whether prescribed or administered by a Physician or dentist. Treatment shall include both surgical and

nonsurgical procedures, and shall be provided for the diagnosis and treatment of these conditions whether they are the result of accident, trauma, congenital defect, developmental defect, or pathology.

Child Health Supervision Services - Covered Expenses incurred for each Covered Dependent from the moment of birth to age eighteen (18) years. In keeping with prevailing medical standards, such services shall include:

1. anticipatory guidance;
2. developmental assessment;
3. laboratory tests;
4. appropriate immunizations
5. a medical history; and
6. physical examination.

Benefits will be payable for 20 visits provided by or under the supervision of a single Physician during the course of one visit, at approximately the following intervals: birth; two weeks; two, four, six, nine, twelve, fifteen and eighteen months and two, three, four, five, six, eight, ten, twelve, fourteen, sixteen and eighteen years.

Benefits payable will not exceed current reimbursement levels for the same services under the Medicaid Early Periodic Screening Diagnosis and Treatment program in the State of Arkansas.

Benefits for recommended immunization services shall be exempt from any Coinsurance, Deductible or dollar limit provisions.

Maternity Stay Requirements For Covered Maternity Care - This provision applies to an Insured Person's coverage only when the Insured Person incurs Covered Expenses for a normal childbirth or cesarean section delivery that is covered by an optional Maternity Benefit Rider or for Complications of Pregnancy as defined in the Policy. A minimum of 48 hours of inpatient care will be provided to the mother and newborn child following a vaginal delivery and 96 hours following a cesarean section. Any normal delivery is subject to the Maximum Benefit for Pregnancy/Childbirth as stated in the optional Maternity Benefit Rider.

Medical Foods and Low Protein Modified Food Products - Covered Expenses incurred for the treatment of a Covered Dependent inflicted with phenylketonuria if:

1. The medical food or low protein modified food products are prescribed as Medically Necessary for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemia and disorders of amino acid metabolism;
2. The products are administered under the direction of a licensed Physician; and
3. The cost of the medical food or low protein modified food products for an individual or a family with a dependent person or persons exceeds the [two thousand four hundred dollars (\$2,400)] per year per person income tax credit allowed.

Diabetes - Covered Expenses incurred for diabetes self-management training, supplies and related services for the treatment of Type I, Type II and gestational diabetes when determined Medically Necessary by Your Physician or other licensed health care provider.

Diabetes Self-Management Training means instructions in an inpatient or outpatient setting including medical nutrition therapy relating to diet, caloric intake and diabetes management, excluding any programs in which the only purpose is weight reduction, which enables diabetic patients to understand the diabetic management process and daily management of diabetic therapy as a method of avoiding frequent hospitalizations and complications when the instruction is provided in accordance with a program in compliance with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association.

Impairment or Loss of Speech or Hearing - Covered Expenses incurred for the communicative disorders generally treated by speech pathologist or audiologist licensed by the Board of Examiners in Speech-Language Pathology and Audiology and which fall within the scope of his/her area of certification. Coverage does not apply to hearing instruments or devices.

Colorectal Cancer Screening - Covered expenses incurred for colorectal cancer examinations and laboratory tests for Insured Persons who are 50 years of age or older; who are less than 50 years of age and at high risk for colorectal cancer according to American Cancer Society colorectal cancer screening guidelines as they existed on [January 1, 2005]; and 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 as determined by a licensed Physician.

For the purpose of this benefit "high risk for colorectal cancer" means: Individuals over 50 years of age or who face a high risk for colorectal cancer because of the presence of polyps on a previous colonoscopy, barium enema, or flexible sigmoidoscopy; family history of colorectal cancer in close relatives of parents, brothers, sisters, or children; genetic alterations of hereditary nonpolyposis colon cancer or familial adenomatous polyposis; personal history of colorectal cancer, ulcerative colitis, or Crohn's disease; or the presence of any appropriate recognized gene markers for colorectal cancer or other predisposing factors; and any definition recognized by medical science and determined by the Director of the Department of Health in consultation with the University of Arkansas for Medical Sciences.

Outpatient Contraceptive Services and Devices - Covered Expenses incurred for Outpatient Contraceptive Services and Devices including closed formularies; however, formularies must include implant and injectable contraceptive drugs, and intrauterine devices.

Covered Expenses do not include charges for abortion, an abortifacient or any U.S. Food and Drug Administration approved emergency contraception.

Outpatient Contraceptive benefits are subject to the same Deductibles and Coinsurances as prescription drugs.

4. EXCLUSIONS AND LIMITATIONS - We will not provide any Benefits for charges resulting from or in connection with:

1. Any care not Medically Necessary or charges for which Benefits are not specifically provided for in the Policy;
2. Any act of war, declared or undeclared;
3. Suicide, attempted suicide, or any intentionally self-inflicted injury, while sane or insane;
4. Any routine physical examination, unless otherwise stated in the Policy;
5. Any Injury or Sickness arising out of, or in the course of, employment for wage or profit, provided the Insured Person is covered under any Worker's Compensation Act, Occupational Disease Act, or similar act or law, unless the Insured Person is self-employed;
6. Mental or Nervous Disorders, unless otherwise stated in the Policy;
7. Drug abuse or addiction including alcoholism, or overdose of drugs, narcotics, or hallucinogens, directly or indirectly, unless taken as prescribed by a Physician;
8. An overdose of drugs, being intoxicated or under the influence of intoxicants, hallucinogens, narcotics or other drugs, directly or indirectly, unless taken as prescribed by a Physician;
9. Any treatment including prescription drugs or non-prescription drugs, or procedure that promotes conception or prevents childbirth, including but not limited to: (a) artificial insemination; (b) in-vitro fertilization or other treatment for infertility; (c) treatment for impotency; (d) sterilization or reversal of sterilization; or (e) abortion (unless the life of the mother would be endangered if the fetus were carried to term), unless otherwise stated in the Policy;
10. Laser vision correction, radial keratotomy or any eye Surgery when the primary purpose is to correct nearsightedness, farsightedness, astigmatism, or any other refractive error;
11. Spinal manipulations and manual manipulative treatment or therapy;
12. Weight loss or modification, or complications arising therefrom, or procedures resulting therefrom or for surgical treatment of obesity including but not limited to gastric by-pass, wiring of the teeth and all forms of Surgery performed for the purpose of weight loss or modification or the reversal/modification of such procedure;
13. Breast reduction or augmentation unless necessary in connection with breast reconstructive Surgery following a mastectomy;
14. Modification of the physical body in order to improve the psychological, mental or emotional well-being of the Insured Person, such as but not limited to sex-change Surgery;
15. Marriage, family, or child counseling for the treatment of premarital, marriage, family or child relationship dysfunctions;
16. Routine newborn care, unless otherwise stated in the Policy;
17. Directly or indirectly engaging in an illegal occupation or illegal activity;
18. Care in a nursing home, custodial institution or domiciliary care or rest cures;
19. Preparation and presentation of medical reports for appearance at trials or hearings;

20. Physical examinations required for school events, camp, employment, licensing and insurance are expressly excluded;
21. Immunizations required for the sole purpose of travel outside of the U.S.A.;
22. Payment for care for military service connected disabilities for which the Insured Person is legally entitled to services and for which facilities are reasonably available to the Insured Person and payment for care for conditions that state or local law requires be treated in a public facility;
23. Experimental medical, surgical or other health care procedures, treatments, products or services, unless otherwise stated in the Policy;
24. Personal comfort items, such as television, telephone, lotions, shampoos, etc.;
25. Cosmetic Surgery;
26. Dental Care, treatment or Surgery unless necessitated by Injury to sound natural teeth which occurs while insured under this Policy. (The expense must be incurred within one year from the date of Injury, and while Hospital Confined or in an Outpatient Surgery Facility);
27. Corrective vision or hearing supplies or for the examination for prescribing or fitting such supplies;
28. The removal of warts, corns, calluses, the cutting and trimming of toenails, care for flat feet, fallen arches or chronic foot strain;
29. Hernia, hemorrhoids, tonsils, adenoids, middle ear disorders, myringotomy; or any disease or disorder of the reproductive organs unless the loss is incurred 6 months after the Insured Person becomes covered under this Policy;
30. Expenses incurred for prescription drugs, except if added by Rider;
31. Normal pregnancy, except for Complications of Pregnancy, except Benefits added by Rider, if any; and
32. Treatment, services or supplies received outside the U.S. or Canada. However, Benefits will be payable for Covered Expenses incurred as a result of an acute Sickness or Injury sustained during the first 30 days of travel outside of the U.S. or Canada. In no event will Benefits be payable beyond the first 30 days of travel outside of the U.S. or Canada.

Pre-Existing Condition - We will not provide Benefits for any loss resulting from a Pre-Existing Condition, as defined, unless the loss is incurred at least one year after the Effective Date of Coverage for an Insured Person.

Coverage After Age 65 or Earlier Medicare Eligibility - When an Insured Person attains age 65 or becomes eligible for Medicare, whichever happens first, the Benefits of the Policy and its attachments, if any, are payable only to the extent that Covered Expenses are not paid by Medicare and they would otherwise be payable under the Policy. The Benefits will also be subject to any other EXCLUSIONS AND LIMITATIONS set forth in the Policy.

5. **RENEWABILITY** - The Policy is guaranteed renewable, subject to the Company's right to discontinue or terminate the coverage as provided in the TERMINATION OF COVERAGE section of the Policy. The Company reserves the right to change the applicable table of premium rates on a Class Basis. The premium for the Policy may change in amount by reason of an increase in the age of an Insured Person.

6. TERMINATION OF COVERAGE –

You

Your coverage will terminate and no Benefits will be payable under the Policy and any attached Riders:

1. At the end of the period for which premium has been paid;
2. If Your mode of premium is monthly, at the end of the period through which premium has been paid following Our receipt of Your request of termination;
3. If Your mode of premium is other than monthly, upon the next monthly anniversary day following Our receipt of Your request of termination. Premium will be refunded for any amounts paid beyond the termination date;
4. On the date of fraud or misrepresentation by You;
5. On the date We elect to discontinue this plan or type of coverage. We will give You at least 90 days notice before the date coverage will be discontinued. You will be offered an option to purchase any other coverage that We offer without regard to health status;
6. On the date We elect to discontinue all coverage in Your state. We will give You and the proper state authority at least 180 days notice before the date coverage will be discontinued; or
7. On the date an Insured Person is no longer a permanent resident of the United States.

Covered Dependents

Your Covered Dependent’s coverage will terminate under the Policy on:

- 1. The date Your coverage terminates;
- 2. The date such Dependent ceases to be an Eligible Dependent; or
- 3. The date We receive Your written request to terminate a dependent’s coverage.

The attainment of the Limiting Age for an Eligible Dependent will not cause coverage to terminate while that person is and continues to be both:

- 1. Incapable of self-sustaining employment by reason of mental retardation or physical handicap; and
- 2. Chiefly dependent on You for support and maintenance. For the purpose of this provision “Chiefly Dependent” means the Eligible Dependent receives the majority of his or her financial support from You.

We will require that You provide proof that the dependent is in fact a disabled and dependent person. In the absence of such proof We may terminate the coverage of such person after the attainment of the Limiting Age.

Special Continuation Provision For Dependents

Your Covered Dependents may continue their same (or substantially similar) coverage under a new Policy without evidence of insurability if their coverage under this Policy would otherwise terminate because they cease to be an Eligible Dependent for any of the following reasons:

- 1. Divorce, legal separation, Your death; or
- 2. A dependent child reaches the Limiting Age.

To continue coverage, You or Your Covered Dependent must request continuation of coverage by application or written notification within 31 days of the date coverage would otherwise terminate and pay any required premium.

7. RIDER BENEFITS –

Outpatient Speech Therapy, Physical Therapy and Occupational Therapy Rider (Form Number 26029 (10/05)-IR) – Covered Expenses incurred for Speech Therapy, Physical Therapy and Occupational Therapy that is related to and necessary for the treatment of a Sickness or Injury. The Benefits provided by this Rider will not duplicate benefits provided under the Policy and any other rider and are subject to the [Maximum Benefit Amount,] [Copayment,] [Coinsurance] and any other limitation shown for this Rider in the Policy Schedule. [Covered Expenses incurred under this Rider will not be considered a Covered Expense under the Policy and are not subject to and will not be used to satisfy the Policy Deductible.] In order to be considered a Covered Expense, therapy services must commence within 14 days of a covered Hospital Confinement or Surgery and be rendered in the 90 days immediately following the related covered Hospital Confinement or Surgery. Therapy provided beyond 90 days following a Hospital Confinement or Surgery will not be considered a Covered Expense.

	<u>PPO Provider</u>	<u>Non-PPO Provider</u>
Coinsurance	<input type="checkbox"/> 70%] <input type="checkbox"/> 80%] <input type="checkbox"/> 90%]	<input type="checkbox"/> 50%] <input type="checkbox"/> 60%] <input type="checkbox"/> 70%]
Maximum Benefit, per Insured Person, per week: [3] visits		
Not to exceed a [\$150] Maximum Benefit, per Insured Person, per day:		
Copayment, per visit: <input type="checkbox"/> \$25] <input type="checkbox"/> \$35] <input type="checkbox"/> \$50]		

Outpatient Accident Expense Benefit Rider (Form Number 25987(10/05)-IR) - Covered Expenses incurred by an Insured Person while the Rider is in force, for the Medically Necessary treatment of an Injury while not Hospital Confined. Benefit is subject to the following conditions: 1) Initial treatment by a Physician must begin within [72] hours of the Injury; and 2) Any treatment of the Injury, beyond the initial treatment, must be received within [45] days of the Injury. The Benefits provided by this Rider will not duplicate Benefits provided under the Policy and any other rider and are subject to the [Rider Deductible, Coinsurance and the Maximum Benefit] shown for this Rider in the Policy Schedule. [Benefit paid under this Rider and amounts used to satisfy the Rider Deductible will not be considered a Covered Expense under the Policy and are not subject to and will not be used to satisfy the Policy Deductible.]

Coinsurance	[100%]
Maximum Benefit, per Insured Person, per Injury	<input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000
Deductible, per Injury	<input type="checkbox"/> \$50 <input type="checkbox"/> \$100 <input type="checkbox"/> \$150 <input type="checkbox"/> \$200

Pregnancy/Childbirth Benefit Rider – (Form Number 25984 (10/05)-IR) AR – Covered Expenses incurred for normal pregnancy and childbirth at a Coinsurance amount in accordance with the length of time the Rider is in force. Covered Expenses will not exceed the Maximum Benefit selected. The Benefits provided by this Rider will not duplicate benefits provided under the Policy and any other rider and are subject to the Maximum Benefit Amount [,Copayment,] [and Coinsurance] shown for this Rider in the Policy Schedule. [Covered Expenses incurred under this Rider will not be considered a Covered Expense under the Policy and are not subject to and will not be used to satisfy the Policy Deductible.]

[0-10] months in force	[0%] of Maximum Benefit selected
[11-24] months in force	[50%] of Maximum Benefit selected
[25] months in force and over	[100%] of Maximum Benefit selected
Maximum Benefit, per in vitro fertilization procedure and/or pregnancychildbirth, for You or Your Covered Dependent Spouse	<input type="checkbox"/> \$2,000
Lifetime Maximum for In Vitro Fertilization Benefits:	[\$15,000]

Air Ambulance Rider - (Form Number 25983 (10/05)-IR)- Covered Expenses incurred while the Rider is in force for Air Ambulance transportation to the nearest available medical facility that can provide adequate care in the event of a Medical Emergency, as defined in the Policy, at the Coinsurance amount selected. The Benefits provided by this Rider will not duplicate benefits provided under the Policy and any other rider and are subject to the [Maximum Benefit Amount,] [Copayment] [and Coinsurance] and any other limitation shown for this Rider in the Policy Schedule. [Covered Expenses incurred under this Rider will not be considered a Covered Expense under the Policy and are not subject to and will not be used to satisfy the Policy Deductible.] Covered Expenses will not exceed the base rate or the Maximum Benefit.

Coinsurance	<input type="checkbox"/> 70% <input type="checkbox"/> 80% <input type="checkbox"/> 90%
Base rate	[\$2,500]
Plus an additional	[\$50] per mile
Maximum Benefit, per Insured Person, per Calendar Year	[\$5,000]

Continued Care Benefit Rider – Form Number 25883 (10/05)-IR) AR – Covered Expenses incurred for Skilled Nursing Care, Home Health Care, Private Duty Nurse, or Hospice Care, following a covered Hospital Confinement for Medically Necessary continued care in accordance with a Treatment Plan, and as described in the rider. The Benefits provided by this Rider will not duplicate benefits provided under the Policy and any other rider and are subject to the Maximum Benefits, Coinsurance and other limitations shown for this Rider [and the Policy Deductible shown] in the Policy Schedule. [Covered Expenses incurred under this Rider will not be considered a Covered Expense under the Policy and are not subject to and will not be used to satisfy the Policy Deductible.]

	<u>PPO Provider</u>	<u>Non-PPO Provider</u>
Skilled Nursing Care		
Coinsurance Limited to [30 days] per Insured Person, per [Calendar Year]	<input type="checkbox"/> 70% <input type="checkbox"/> 80% <input type="checkbox"/> 90%	<input type="checkbox"/> 50% <input type="checkbox"/> 60% <input type="checkbox"/> 70%
Maximum Benefit per Insured Person, per day [\$250]		
Home Health Care		
Coinsurance Limited to [80 visits] per Insured Person, per [Calendar Year]	<input type="checkbox"/> 70% <input type="checkbox"/> 80% <input type="checkbox"/> 90%	<input type="checkbox"/> 50% <input type="checkbox"/> 60% <input type="checkbox"/> 70%
Not to exceed a [\$50] Maximum Benefit per Insured Person, per day		
Private Duty Nursing		
Coinsurance Limited to [40 eight-hour shifts] per Insured Person, per [Calendar Year]	<input type="checkbox"/> 70% <input type="checkbox"/> 80% <input type="checkbox"/> 90%	<input type="checkbox"/> 50% <input type="checkbox"/> 60% <input type="checkbox"/> 70%
Not to exceed a [\$50] Maximum Benefit per Insured Person, per shift		
Hospice Care		
Coinsurance Not to exceed a [\$5,000] Maximum Benefit per Insured Person, per lifetime	<input type="checkbox"/> 70% <input type="checkbox"/> 80% <input type="checkbox"/> 90%	<input type="checkbox"/> 50% <input type="checkbox"/> 60% <input type="checkbox"/> 70%

Legend Prescription Drug Expense Rider (Form Number 25985 (10/05)-IR) AR - We will pay a benefit if an Insured Person incurs Covered Expenses for Sickness or Injury. This benefit is the amount equal to the actual charge based on Participating Pharmacy prices for a Covered Expense, subject to the applicable Benefit Payment Rate/Deductible/Copayment shown below. Expenses are considered incurred on the date of Pharmacy service.

Deductible, per Calendar Year, per Insured Person \$50 \$100

Participating Pharmacy

(Not to exceed a 30 day supply)

Generic Drugs	We pay [100%] less the [\$15] Copayment
Formulary Drugs	We pay [50%], You pay the remainder
Non-Formulary Drugs	We pay [25%], You pay the remainder

Non-Participating Pharmacy

(Not to exceed a 30 day supply)

Generic Drugs	We pay [75%] less the [\$15] Copayment
Formulary Drugs	We pay [25%], You pay the remainder
Non-Formulary Drugs	We pay [0%], You pay the remainder

Mail Service Legend Prescription Drugs

(Not to exceed a 90 day supply through Our designated mail service program)

Generic Drugs	We pay [100%] less the [\$30] Copayment
Formulary Drugs	We pay [50%], You pay the remainder
Non-Formulary Drugs	We pay [25%], You pay the remainder

Benefit Maximum

Per Insured Person \$1,500 per Calendar Year

[PREVENTIVE PLUS] Benefit Rider (Form Number 26028 (10/05)-IR) – Benefits under the Rider are provided for [Medically Necessary] [non-Covered Expenses] for [Physician office visits, except for visits related to Mental or Nervous Disorders or fertility treatment;] [Allergy injections;] [Outpatient Diagnostic expenses not otherwise considered a Covered Expense under the Policy or any attached Riders;] [Emergency Room services not otherwise considered a Covered Expense under the Policy or any attached Riders; and] [Spinal manipulations]. [Routine preventive health care services, including but not limited to routine physical exams and related laboratory and x-rays services and immunizations, not otherwise paid under the Policy; and] [Acupuncture] will also be considered under the Rider.

All Benefits under the Rider are subject to subject to [Usual and Customary Charges][the Maximum Allowable Charge (MAC)], based on the Annual [PREVENTIVE PLUS] Benefit Amount selected, subject to a Quarterly Benefit Accumulation Amount.

ANNUAL [PREVENTIVE PLUS] BENEFIT AMOUNT:	QUARTERLY BENEFIT ACCUMULATION AMOUNT: (per quarterly Rider anniversary for You and Your Covered Dependents, if any)
<input type="checkbox"/> \$250	[\$62.50]
<input type="checkbox"/> \$500	[\$125.00]
<input type="checkbox"/> \$1,000	[\$250.00]
<input type="checkbox"/> \$2,000	[\$500.00]

Benefits under the Rider can accumulate if unused; however, there are limits to the amount that can accumulate. If there is more than one Insured Person covered under the Rider, there are limits to the maximum amount

available to each Insured Person. Any Pre-Existing Condition limitations, conditions excluded by Waiver or Benefits paid under the Policy or any attached Riders, will not be considered under this Rider.

Benefits will be paid from the [PREVENTIVE PLUS] Benefit Amount on the date the services are rendered. Benefits accumulated subsequent to the date the services are rendered will not be used to pay benefits on services rendered before the accumulation date. In order for benefits to be considered under the Rider, services must be rendered during the time period for which premium has been paid for the Rider.

Emergency Services Benefit Rider - (Form Number 26032 (10/05)-IR or 26032 PPO (10/05)-IR)- Covered Expenses incurred while the Rider is in force for Emergency Treatment of a Sickness or Injury not resulting in Hospital Confinement. The Benefits provided by this Rider will not duplicate the Benefits provided under the Policy and any other rider and are subject to the [[Policy Deductible] shown in the POLICY SCHEDULE] [and the [Copayment,][and Coinsurance][and Maximum Benefit] shown for this Rider in the POLICY SCHEDULE.

	<u>PPO Provider</u>	<u>Non-PPO Provider</u>
Coinsurance [Not to exceed a [\$1,000][\$2,000] Maximum Benefit per Insured Person, per visit]	<input type="checkbox"/> 70%][<input type="checkbox"/> 80%][<input type="checkbox"/> 90%]	<input type="checkbox"/> 50%][<input type="checkbox"/> 60%][<input type="checkbox"/> 70%]
[Physician's Office or Urgent Care Center Copayment, per visit [<input type="checkbox"/> \$100] [<input type="checkbox"/> \$250] [<input type="checkbox"/> \$500] [<input type="checkbox"/> \$1,000]]		
[Hospital Emergency Room Copayment, per visit [<input type="checkbox"/> \$100] [<input type="checkbox"/> \$250] [<input type="checkbox"/> \$500] [<input type="checkbox"/> \$1,000]]		

Physician's Office Visit Benefit Rider[*] (Form Number 25886-IP) - We will pay Covered Expenses incurred by an Insured Person, while this Rider is in force, for Medically Necessary visits to the Physician's office or clinic and for related care services provided by the Physician as a part of such visit. Benefits payable under this Rider are not subject to the Policy Deductible.

	<u>PPO Provider</u>	<u>Non-PPO Provider</u>
Copayment, per Insured Person, per visit	[\$30]	[\$30]
Daily Maximum Benefit, per Insured, Person per visit	[\$125]	[\$100]

Maximum Number of visits per calendar quarter
For You and Your Covered Dependent Spouse
 1] [2] visits each

Maximum Number of visits per calendar quarter
For Your Covered Dependent Child(ren)
 2] [4] visits each

[*The **Sickness Exclusion**, as shown in the EXCLUSIONS AND LIMITATIONS section of this Policy, does not apply to this Rider.]

8. RIGHT TO RETURN POLICY - It is important to Us that You understand and are satisfied with the coverage being provided to You. If You are not satisfied that this coverage will meet Your insurance needs, You may return the Policy to Us at Our administrative office in North Richland Hills, Texas, within 10 days after You receive it. Upon receipt, We will cancel Your coverage as of the Policy Date, refund all premiums paid and treat the Policy as if it were never issued.

9. PREMIUMS - We reserve the right to change the table of premiums, on a Class Basis, becoming due under the Policy at any time and from time to time; provided, We have given the Policyholder written notice of at least 31 days prior to the effective date of the new rates. Such change will be on a Class Basis. The premium for the Policy may change in amount by reason of an increase in the Attained Age of the Insured Person.

Initial Premium for Policy	_____
[Policy Fee	_____]
Rider Premium	_____
Total Initial Premium due with Application	_____

THE MEGA LIFE AND HEALTH INSURANCE COMPANY

A Stock Company
(Hereinafter called: the Company, We, Our or Us)
Home Office: Oklahoma City, Oklahoma
Administrative Office: P.O. Box 982010
North Richland Hills, Texas 76182-8010
Customer Service: 1-800-527-5504

AMENDATORY ENDORSEMENT

This Amendatory Endorsement is made a part of the Policy which it is attached. It is subject to all the provisions of the Policy which are not inconsistent with this endorsement.

1. The **POLICY SCHEDULE** section of the POLICY is hereby deleted and replaced with the attached POLICY SCHEDULE. It is effective as of _____ or the Insured Person's Effective Date of Coverage, whichever is later.

[2.] The following definitions under the **DEFINITIONS** section are hereby deleted in their entirety and replaced with the following:

- **Aggregate Maximum Amount** means the maximum amount payable under this Policy and its Riders, if any, for any one covered Injury or Sickness for each Insured Person, occurring while coverage is in effect under this Policy for such person. The Aggregate Maximum Amount is shown in the POLICY SCHEDULE. This amount is included in and part of the Lifetime Maximum Amount for each Insured Person.
- **Coinsurance Maximum** means the total amount of Covered Expenses each Insured Person must pay after application of the Coinsurance per each Calendar Year. Once this maximum is met, Covered Expenses remaining thereafter for the same Calendar Year will be paid at 100% after any Copayment, up to the Maximum Benefit shown in the POLICY SCHEDULE, if any. **Deductibles, Copayments and any charges exceeding any Maximum Benefit shown in the POLICY SCHEDULE do not count toward meeting the Coinsurance Maximum.** Covered Expenses incurred within the PPO are subject to the "PPO Provider" Coinsurance Maximum and Covered Expenses incurred outside of the PPO are subject to the "Non-PPO Provider" Coinsurance Maximum, as shown in the POLICY SCHEDULE.
- **Covered Expenses** means [Usual and Customary] Charges for the services, supplies, care or treatment covered under this Policy which are incurred by an Insured Person as a result of Injury or Sickness and for which the Insured Person is legally obligated to pay and are not otherwise excluded or limited herein. They are incurred on the date that the service is performed or the supply is furnished. Only that portion of a [Usual and Customary] Charge or fee which is Medically Necessary is a Covered Expense. Covered Expenses must be incurred while this coverage is in force. Any charges in excess of the Maximum Benefit shown in the Policy Schedule, if any, will not be considered a Covered Expense. Covered Expenses under the Riders, if any, may or may not be considered Covered Expenses under this Policy.
- **Deductible** means the amount of Covered Expenses that an Insured Person must pay for each Calendar Year before Benefits will be paid. Deductible does **not** include non-Covered Expenses [or Copayments]. Covered Expenses incurred within the PPO are subject to the "PPO Provider" Deductible and Covered Expenses incurred outside of the PPO are subject to the "Non-PPO Provider" Deductible, as shown in the POLICY SCHEDULE. **The Deductible will be applied separately for each Insured Person per Calendar Year.**

Once this Deductible has been met [3] times in a Calendar Year by any or all Insured Persons under Your Policy, no further Deductibles must be met for the remainder of that Calendar Year for any or all Insured Persons under Your Policy. The Deductibles for PPO and Non-PPO benefits are shown in the POLICY SCHEDULE. If more than one Insured Person in Your family is injured in the same accident, only one Deductible must be satisfied for Covered Expenses associated with that accident.

- **Preferred Provider Organization (PPO)** means a managed health care arrangement in which the Insured Person has access to a network of Physicians, Hospitals, or other licensed or certified entities or persons who have entered into a contract to provide health care services to Insured Persons under this Policy. Covered Expenses incurred within the PPO will be paid at the "PPO Coinsurance" level shown in the POLICY SCHEDULE; otherwise, benefits will be paid at the "Non-PPO Coinsurance" level shown in the POLICY SCHEDULE. Please refer to the POLICY SCHEDULE for additional information. The providers contract must be in effect at the time services are rendered.

[3.] The following definition under the **DEFINITIONS** section is hereby added:

- **Preferred Provider or PPO Provider** means a provider of health care services that holds a valid contract with the PPO network to provide health care services in the network Service Area. A Preferred Provider may be a Hospital, Physician, or other facility or provider of health care services. We will maintain a current list of the Preferred Providers in the network Service Area.

[4.] The following definition under the **DEFINITIONS** section is hereby deleted in its entirety:

- **Sickness or Injury Period of Treatment** means a period which begins on the date an Insured Person first incurs Covered Expenses for a Sickness or Injury under this Policy and ends after 365 days. If the same or related Sickness or Injury continues beyond 365 days, a new Deductible and Sickness or Injury Period of Treatment will apply and will continue to accumulate toward the Aggregate Maximum Amount and Lifetime Maximum Amount. A separate Sickness or Injury Period of Treatment and Deductible will apply to each Injury or Sickness.

[5.] The following introductory provision within the **BENEFITS** section is hereby deleted in its entirety and replaced with the following:

- Benefits are the actual amount payable under this Policy for the following Covered Expenses after application of the following, unless otherwise stated herein:
 1. The EXCLUSIONS AND LIMITATIONS;
 2. The Deductibles shown in the POLICY SCHEDULE;
 3. The Copayments shown in the POLICY SCHEDULE, if any;
 4. The PPO Coinsurance level or Non-PPO Coinsurance level shown in the POLICY SCHEDULE;
 5. The Maximum Benefit[, Aggregate], Calendar Year and Lifetime Maximum Amounts shown in the POLICY SCHEDULE; and
 6. All other provisions of the Policy.

[6.] Under the **BENEFITS** section, the following Covered Expenses are hereby deleted in their entirety and replaced with the following. Unless otherwise stated, all Covered Expenses are subject to the EXCLUSIONS AND LIMITATIONS, Deductibles, Copayments (if any), PPO Coinsurance level or Non-PPO Coinsurance level, Maximum Benefit[, Aggregate], Calendar Year, and Lifetime Maximum Amounts as shown in the POLICY SCHEDULE. Unless otherwise stated, these Covered Expenses are also subject to all other provisions of the Policy.

- **Inpatient Hospital Services**

Covered Expenses incurred for services and supplies provided by the Hospital for semi-private accommodations and general nursing care furnished by the Hospital including Confinement in the Hospital's intensive care or cardiac care unit (in lieu of Benefit amount payable for Hospital room and board) and miscellaneous medical services and supplies necessary for the treatment of the Insured Person.

Covered Expenses will also include x-ray, laboratory, diagnostic tests and services of a radiologist, radiology group, and the services of a pathologist or pathology group for interpretation of diagnostic tests or studies, performed while the Insured Person is Hospital Confined.

The fees charged for take home drugs, personal convenience items, or items not intended primarily for use by the Insured Person while Hospital Confined are not Covered Expenses.

- **Physician Visits while Hospital Confined**

Covered Expenses incurred for visits by a Physician, other than the surgeon, while Hospital Confined.

- **Surgeon Benefit**

Covered Expenses incurred [while Hospital Confined or in an Outpatient Surgery Facility] for services by the Physician performing Surgery.

If two or more Surgeries are performed at the same time through separate incisions, We will consider the one providing the largest Benefit. We will also consider 50% of the Benefits otherwise payable for the other surgeries performed at the same time.

We will not consider more than one Surgery performed through the same incision during the same operation; however, We will consider the Surgery providing the largest Benefit.

If it is recommended that You have Physical Therapy in lieu of Surgery, We may consider Physical Therapy as an alternative to Surgery. Such Physical Therapy must be in accordance with a Treatment Plan approved by Us. Covered Expenses incurred under this Surgeon Benefit for Physical Therapy will be counted toward the applicable Surgeon Benefit shown in the POLICY SCHEDULE.

Any Benefits payable pursuant to this Amendatory Endorsement will not be duplicated under any optional benefit rider that may be attached to the Insured Person's Policy.

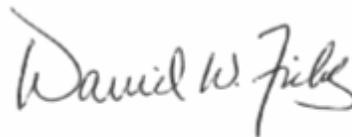
The provisions of this Amendatory Endorsement are effective on the Policy Date, the Insured Person's Effective Date of Coverage, or the date stated herein, whichever is later.

In Witness whereof, the Insurance Company has caused this Amendatory Endorsement to be signed by its President and Secretary.

Signed for The MEGA Life and Health Insurance Company at North Richland Hills, Texas.



SECRETARY



PRESIDENT

THE MEGA LIFE AND HEALTH INSURANCE COMPANY

A Stock Company
(Hereinafter called: the Company, We, Our or Us)
Home Office: Oklahoma City, Oklahoma
Administrative Office: P.O. Box 982010
North Richland Hills, Texas 76182-8010
Customer Service: 1-800-527-5504

PHYSICIAN OFFICE VISIT BENEFIT RIDER

This Rider is made a part of the Policy to which it is attached. The Rider is subject to all provisions, terms, DEFINITIONS and EXCLUSIONS AND LIMITATIONS of the Policy which are not inconsistent with the provisions of this Rider.

The benefits provided by this Rider will not duplicate the benefits provided under the Policy and any other rider and are subject to the maximum benefits and Copayments shown for this Rider in the POLICY SCHEDULE.

[Benefits payable under this Rider are not subject to the Policy Deductible.]

COVERED EXPENSES

We will pay Covered Expenses incurred by an Insured Person, while this Rider is in force, for Medically Necessary visits to the Physician's office or clinic and for related care services provided by the Physician as a part of such visit, up to the Daily Maximum Benefit subject to the Copayment shown in the POLICY SCHEDULE. No benefits are payable for services such as routine examinations, immunizations, and preventive care.

Copayment means the amount the Insured Person is required to pay for specifically listed Covered Expenses. The Copayment for this Rider is shown in the POLICY SCHEDULE. Copayments do not count toward Deductibles or Coinsurance Maximums.

Benefits payable under this Rider will not be used to satisfy the Policy Deductible.

We will provide this benefit in consideration of the payment of the required premium for this Rider.

Rider effective date, if different from Policy Date: _____

THE MEGA LIFE AND HEALTH INSURANCE COMPANY



SECRETARY



PRESIDENT

SERFF Tracking Number: MGCC-125610406 State: Arkansas
 Filing Company: The Mega Life and Health Insurance Company - State Tracking Number: 38722
 IC
 Company Tracking Number: 26026 PPO-IP AR
 TOI: H151 Individual Health - Sub-TOI: H151.001 Health - Hospital/Surgical/Medical
 Hospital/Surgical/Medical Expense Expense
 Product Name: 2008 MEGA CareChoice Individual
 Project Name/Number: /

Supporting Document Schedules

<p>Satisfied -Name: Certification/Notice Comments: Please refer to attached. Attachments: ARGA 0104.pdf Cert Compl Rule-Reg19 -AR.pdf Cert Compliance AR-Readability.pdf</p>	<p>Review Status: Approved-Closed 04/21/2008</p>
<p>Satisfied -Name: Application Comments: Form number: 25098-APP (2/08) Approval date: 12/18/07</p>	<p>Review Status: Approved-Closed 04/21/2008</p>
<p>Satisfied -Name: Health - Actuarial Justification Comments: Please refer to attached. Attachment: 26026-IP AR with AE 26026-IP AR (20080408).pdf</p>	<p>Review Status: Approved-Closed 04/21/2008</p>
<p>Satisfied -Name: Outline of Coverage Comments: The outline of coverages were also attached under the Form Schedule Tab. Attachments: 26026 IP OC AR.pdf 26026 IP OC AR NOTICE.pdf</p>	<p>Review Status: Approved-Closed 04/21/2008</p>

LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract..

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice.

**The Arkansas Life and Health Insurance Guaranty Association
C/O The Liquidation Division
1023 West Capitol, Suite 2
Little Rock, Arkansas 72201**

**Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904**

The state law that provides for this safety-net coverage is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and they hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies or contracts are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose Guaranty Association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;

- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to suture assessments, or by an insurance exchange.

The Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans, to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals);
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC") (whether the FPBC is yet liable or not);
- Portions of any unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliated benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of \$300,000 – no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall \$300,000 limit, the Association will not pay more than \$300,000 in health insurance benefits, \$300,000 in present value of annuity benefits, or \$300,000 in life insurance death benefits for net cash surrender values – again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a \$1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.]

**Certificate of Compliance with
Arkansas Rule and Regulation 19**

Insurer: The MEGA Life and Health Insurance Company

Form Number(s):

26026 PPO-IP AR; AE 26026 PPO-IP AR

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.



Signature of Company Officer

Kay Phillips

Name

Vice President and Chief Compliance Officer

Title

April 15, 2008

Date

Certificate of Compliance for Arkansas

This is to certify the attached form has achieved the Flesch Reading Ease Score given below and complies with the requirements of Arkansas Stat. Ann, 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language simplification Act.

Form Name: CATASTROPHIC EXPENSE PREFERRED PROVIDER
ORGANIZATION (PPO) POLICY

Form Number: 26026 PPO-IP AR; AE 26026 PPO-IP AR

Flesch Reading Ease Score: 46.0



Kay Phillips, Vice President and Chief Compliance Officer

April 15, 2008

Date

THE MEGA LIFE AND HEALTH INSURANCE COMPANY

A Stock Company
(Hereinafter called: the Company, We, Our or Us)
Home Office: Oklahoma City, Oklahoma
Administrative Office: P.O. Box 982010
North Richland Hills, Texas 76182-8010
Customer Service: 1-800-527-5504

CATASTROPHIC EXPENSE PREFERRED PROVIDER ORGANIZATION (PPO) POLICY OUTLINE OF COVERAGE FOR FORM 26026 PPO-IP AR

- 1. READ YOUR POLICY CAREFULLY!** This Outline of Coverage provides a very brief description of some of the important features of Your Policy. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth, in detail, the rights and obligations of both You and Us. It is, therefore, important that You **READ YOUR POLICY CAREFULLY.**
- 2. CATASTROPHIC EXPENSE PREFERRED PROVIDER ORGANIZATION (PPO) COVERAGE** - The plan provides coverage for catastrophic expenses with the option of obtaining services through a Preferred Provider Organization, payable at a higher coinsurance level. The plan has a [\$5,000,000] Lifetime Maximum Amount and a [\$1,000,000] Aggregate Maximum Amount for all covered Injuries and Sicknesses. Covered Expenses are subject to a Deductible, unless otherwise stated.
- 3. BENEFITS** - For the purpose of this Outline of Coverage, Insured Person means You and Your Covered Dependents who are covered under the Policy.

The plan pays for Covered Expenses incurred under the Policy, subject to a [\$5,000,000] Lifetime Maximum Amount for all Injuries and Sicknesses per Insured Person. The plan pays for Covered Expenses incurred under the Policy, subject to a [\$1,000,000 Aggregate Maximum Amount] for any one covered Injury or Sickness for each Insured Person. Unless otherwise stated, all Covered Expenses are subject to the Maximum Benefits as shown in the Policy, Deductibles, Copayments, [Coinsurance Maximum] and Coinsurance shown below:

Insured Persons have the right to obtain medical care from the Physicians, Hospitals and other health care providers of their choice; however, if Covered Expenses are incurred from services provided by a non-PPO provider, Benefits will be less than the amount that would have otherwise been payable for Covered Expenses incurred from services provided by a PPO provider as shown below.

Deductible:

The Deductible applies to each Insured Person and for each [Calendar Year.]

<u>PPO Provider</u>	<u>Non-PPO Provider</u>
<input type="checkbox"/> \$1,500	\$3,000
<input type="checkbox"/> \$2,000	\$4,000
<input type="checkbox"/> \$2,500	\$5,000
<input type="checkbox"/> \$3,000	\$6,000
<input type="checkbox"/> \$3,500	\$7,000
<input type="checkbox"/> \$5,000	\$10,000
<input type="checkbox"/> \$7,500	\$15,000
<input type="checkbox"/> \$10,000]	\$20,000]

<u>PPO Provider</u>	<u>Non-PPO Provider</u>
---------------------	-------------------------

Coinsurance Maximum: [\$4,000] [\$6,000] [\$8,000] [\$8,000] [\$12,000] [\$16,000]

Coinsurance: 70%] 80%] 90%] 50%] 60%] 70%]
of Covered Expenses of Covered Expenses

COVERED EXPENSES

Covered Expenses means [Usual and Customary] Charges for the services, supplies, care or treatment covered under this Policy which are incurred by an Insured Person as a result of Injury or Sickness and for which the Insured Person is legally obligated to pay and are not otherwise excluded or limited herein. They are incurred on the date that the service is performed or the supply is furnished. Only that portion of a [Usual and Customary] Charge or fee which is Medically Necessary is a Covered Expense. Covered Expenses must be incurred while this coverage is in force.

[Any charges in excess of the Maximum Benefit, if any, will not be considered a Covered Expense.]

Covered Expenses under the Riders, if any, may or may not be considered Covered Expenses under the Policy.

Inpatient Hospital Services - Covered Expenses incurred for services and supplies provided by the Hospital for semi-private accommodations and general nursing care furnished by the Hospital including Confinement in the Hospital's intensive care or cardiac care unit (in lieu of Benefit amount payable for Hospital room and board) and miscellaneous medical services and supplies necessary for the treatment of the Insured Person during that [Calendar Year].

Covered Expenses will also include x-ray, laboratory, diagnostic tests and services of a radiologist, radiology group, and the services of a pathologist or pathology group for interpretation of diagnostic tests or studies, performed while the Insured Person is Hospital Confined.

The fees charged for take home drugs, personal convenience items, or items not intended primarily for use of the Insured Person while Hospital Confined are not Covered Expenses.

Physician Visits while Hospital Confined - Covered Expenses incurred for visits by a Physician, other than the surgeon, while Hospital Confined, not exceed a [\$100] Maximum Benefit, per Insured Person, per day.

Surgeon Benefit - Covered Expenses incurred [while Hospital Confined or in an Outpatient Surgery Facility] for services by the Physician performing Surgery.

If two or more Surgeries are performed at the same time through separate incisions, We will consider the one providing the largest Benefit. We will also consider [50%] of the Benefits otherwise payable for the other Surgeries performed at the same time.

We will not consider more than one Surgery performed through the same incision during the same operation; however, We will consider the Surgery providing the largest Benefit.

If it is recommended that You have Physical Therapy in lieu of Surgery, We may consider Physical Therapy as an alternative to Surgery. Such Physical Therapy must be in accordance with a Treatment Plan approved by Us. Covered Expenses incurred under this Surgeon Benefit for Physical Therapy will be counted toward the applicable Surgeon Benefit.

Assistant Surgeon Benefit - Covered Expenses incurred for services by the Physician assisting the Physician performing Surgery.

Anesthesiologist Benefit - Covered Expenses incurred for services by the Physician providing anesthesia during Surgery.

Outpatient Surgery Facility Charges - Covered Expenses incurred for services furnished by and supplies received for use in an Outpatient Surgery Facility, including but not limited to:

1. Use of operating room and recovery room;
2. Administration of drugs and medicines during Surgery;
3. Dressings, casts, splints; and
4. Diagnostic services including radiology, laboratory or pathology performed at the time of the Surgery.

Second Surgical Opinion - Covered Expenses incurred for services by a Physician for a second opinion. The Physician providing the second opinion cannot be financially associated with the referring Physician or perform or assist in the Surgery in order for services to be considered a Covered Expense under the Policy.

If the second opinion disagrees with the first, a third opinion will also be considered a Covered Expense.

Durable Medical Equipment and Prosthetic Devices - Covered Expenses incurred for the rental of durable medical equipment not to exceed the actual purchase price of such equipment, and the purchase, fitting, repair and replacement of fitted prosthetic devices which replace a natural limb or eye, when ordered or prescribed by a Physician for use by the Insured Person.

The durable medical equipment or prosthetic device must be for use solely by the Insured Person for the treatment of a Sickness or Injury which occurred while such Insured Person's coverage is in force.

Routine maintenance and repairs of rental equipment are not Covered Expenses.

Covered Expenses will not exceed a Maximum Benefit of [\$5,000] per Insured Person, per [Calendar Year].

Outpatient Diagnostic Services - Covered Expenses incurred [within [21] days of a Surgery or Hospital Confinement] for diagnostic x-rays and interpretation charges, and laboratory and pathological examinations received while not Confined to a Hospital and that are related to and necessary for the diagnosis and treatment of the Sickness or Injury [that results in Surgery or Hospital Confinement]. [Covered Expenses include but are not limited to CAT Scans, Magnetic Resonance Imaging (MRI), Mammogram, Upper/Lower G.I. Series, Electrocardiogram (EKG), Blood or serum analysis, Angiogram and Stress Tests. [Please refer to the CASE MANAGEMENT provision shown in the Policy for Pre-Notification Requests of Non-Emergency Admissions.]]

Covered Expenses do not include routine physical examinations or checkups.

[Covered Expenses will not exceed a Maximum Benefit of [\$10,000] per Insured Person, per Calendar Year and must be related to and necessary for the diagnosis and treatment of the Sickness or Injury that results in Surgery or Hospital Confinement.] A [\$50] [\$100] [\$150] Copayment, per Insured Person, per 24 hour period, will apply.

Ambulance Transport - Covered Expenses incurred for Ambulance transportation to a Hospital, provided the Insured Person is Confined to the Hospital. Covered Expenses will not exceed a Maximum Benefit of [\$500] per Insured Person, per trip.

Chemotherapy - Covered Expenses incurred for chemotherapy received while Hospital Confined or on an outpatient basis. The condition for which chemotherapy is provided must be first diagnosed and the treatment must be received while coverage is in force.

Covered Expenses incurred with an approved Chemotherapy or Radiation Therapy Course of Treatment Plan will be considered at the Coinsurance amount selected.

Covered Expenses incurred without an approved Chemotherapy or Radiation Therapy Course of Treatment Plan will be considered at the Coinsurance amount selected, up to a Maximum Benefit of [\$1,500] per Insured Person, per day.

Radiation Therapy - Covered Expenses incurred for radiation therapy received while Hospital Confined or on an outpatient basis. The condition for which radiation therapy is provided must be first diagnosed and the treatment must be received while coverage is in force.

Covered Expenses incurred with an approved Chemotherapy or Radiation Therapy Course of Treatment Plan will be considered at the Coinsurance amount selected.

Covered Expenses incurred without an approved Chemotherapy or Radiation Therapy Course of Treatment Plan will be considered at the Coinsurance amount selected, up to a Maximum Benefit of [\$1,250] per Insured Person, per day.

Transplants - Covered Expenses include Transplant Procedures incurred during a Transplant Benefit Period.

Covered Expenses for Transplant Procedures include:

1. Inpatient and outpatient Hospital services;
2. Services of a Physician for diagnosis, treatment and Surgery for a Transplant Procedure;
3. Procurement of an organ or tissue, including services provided to a living donor of an organ or tissue for procurement of an organ or tissue, provided the donor and transplant recipient are both insured under the Policy. Covered Expenses are limited to the actual procurement expenses, and will not be more than any maximums under the Policy applicable to the recipient;
4. [Usual and Customary] Charges for Travel and Accommodation Expenses related to a Transplant Procedure for the transplant recipient and one companion during a Transplant Benefit Period, provided the transplant facility is more than [300] miles from the Insured Person's home. If the recipient is a minor, Travel and Accommodation Expenses for two companions may be covered. Benefits for Travel and Accommodation Expenses are subject to the Travel and Accommodation Expense maximum[.];
5. Rental of durable medical equipment for use outside the Hospital. Covered Expenses are limited to the purchase price of the same equipment;
6. Prescription Drugs, including immunosuppressive drugs;
7. Oxygen;
8. Speech therapy, occupational therapy, Physical Therapy and chemotherapy;
9. Services and supplies for and related to high dose chemotherapy and bone marrow tissue transplantation when provided as part of a Transplant Treatment Plan which includes bone marrow transplantation and high dose chemotherapy; and
10. Surgical dressings and supplies.]

When the Insured Person's Physician advises the Insured Person that a Transplant Procedure is being considered, the Insured Person or the Insured Person's Physician should notify Us or Our designee in order for Us to direct the Insured Person to an appropriate Designated Transplant Facility. Covered Expenses for a live donor shall be paid to the extent that benefits remain and are available under this Policy for the Insured Person receiving the transplant, and after all Covered Expenses for the Insured Person has been paid. Benefits are not payable for animal organ or artificial organ transplants or for personal hygiene and convenience items, such as air conditioners, humidifiers, hot tubs, whirlpools, or physical exercise equipment, even if such items are prescribed by a Physician. Benefits are not payable for Covered Expenses incurred beyond the Transplant Benefit Period. Medically Necessary transplants not specifically defined as a Transplant Procedure under the Policy, which are not determined to be Experimental or Investigational Medicine will be payable the same as any other Transplant Procedure under the Policy in accordance with the provisions of the Policy.

Covered Expenses incurred for Transplant Procedures in a Designated Transplant Facility will be considered at [100%], with a Maximum Benefit payable for incurred Travel and Accommodation Expenses of [\$150] per day and [\$3,000] per Transplant Benefit Period.

Covered Expenses incurred for Transplant Procedures outside a Designated Transplant Facility will be considered at the Coinsurance amount selected with a Maximum Benefit payable of [\$100,000] per Transplant Procedure. [Travel and Accommodation Expenses incurred will not be considered as Covered Expenses.]

Musculoskeletal Disorders - Covered Expenses incurred for the medical treatment of musculoskeletal disorders affecting any bone or joint in the face, neck, or head, including temporomandibular joint disorder and craniomandibular disorder, on the same basis as that provided for any other musculoskeletal disorder in the body, whether prescribed or administered by a Physician or dentist. Treatment shall include both surgical and nonsurgical procedures, and shall be provided for the diagnosis and treatment of these conditions whether they are the result of accident, trauma, congenital defect, developmental defect, or pathology.

Child Health Supervision Services - Covered Expenses incurred for each Covered Dependent from the moment of birth to age eighteen (18) years. In keeping with prevailing medical standards, such services shall include:

1. anticipatory guidance;
2. developmental assessment;
3. laboratory tests;
4. appropriate immunizations
5. a medical history; and
6. physical examination.

Benefits will be payable for 20 visits provided by or under the supervision of a single Physician during the course of one visit, at approximately the following intervals: birth; two weeks; two, four, six, nine, twelve, fifteen and eighteen months and two, three, four, five, six, eight, ten, twelve, fourteen, sixteen and eighteen years.

Benefits payable will not exceed current reimbursement levels for the same services under the Medicaid Early Periodic Screening Diagnosis and Treatment program in the State of Arkansas.

Benefits for recommended immunization services shall be exempt from any Coinsurance, Deductible or dollar limit provisions.

Maternity Stay Requirements For Covered Maternity Care - This provision applies to an Insured Person's coverage only when the Insured Person incurs Covered Expenses for a normal childbirth or cesarean section delivery that is covered by an optional Maternity Benefit Rider or for Complications of Pregnancy as defined in the Policy. A minimum of 48 hours of inpatient care will be provided to the mother and newborn child following a vaginal delivery and 96 hours following a cesarean section. Any normal delivery is subject to the Maximum Benefit for Pregnancy/Childbirth as stated in the optional Maternity Benefit Rider.

Medical Foods and Low Protein Modified Food Products - Covered Expenses incurred for the treatment of a Covered Dependent inflicted with phenylketonuria if:

1. The medical food or low protein modified food products are prescribed as Medically Necessary for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemia and disorders of amino acid metabolism;
2. The products are administered under the direction of a licensed Physician; and
3. The cost of the medical food or low protein modified food products for an individual or a family with a dependent person or persons exceeds the [two thousand four hundred dollars (\$2,400)] per year per person income tax credit allowed.

Diabetes - Covered Expenses incurred for diabetes self-management training, supplies and related services for the treatment of Type I, Type II and gestational diabetes when determined Medically Necessary by Your Physician or other licensed health care provider.

Diabetes Self-Management Training means instructions in an inpatient or outpatient setting including medical nutrition therapy relating to diet, caloric intake and diabetes management, excluding any programs in which the only purpose is weight reduction, which enables diabetic patients to understand the diabetic management process and daily management of diabetic therapy as a method of avoiding frequent hospitalizations and complications when the instruction is provided in accordance with a program in compliance with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association.

Impairment or Loss of Speech or Hearing - Covered Expenses incurred for the communicative disorders generally treated by speech pathologist or audiologist licensed by the Board of Examiners in Speech-Language Pathology and Audiology and which fall within the scope of his/her area of certification. Coverage does not apply to hearing instruments or devices.

Colorectal Cancer Screening - Covered expenses incurred for colorectal cancer examinations and laboratory tests for Insured Persons who are 50 years of age or older; who are less than 50 years of age and at high risk for colorectal cancer according to American Cancer Society colorectal cancer screening guidelines as they existed on [January 1, 2005]; and 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 as determined by a licensed Physician.

For the purpose of this benefit "high risk for colorectal cancer" means: Individuals over 50 years of age or who face a high risk for colorectal cancer because of the presence of polyps on a previous colonoscopy, barium enema, or flexible sigmoidoscopy; family history of colorectal cancer in close relatives of parents, brothers, sisters, or children; genetic alterations of hereditary nonpolyposis colon cancer or familial adenomatous polyposis; personal history of colorectal cancer, ulcerative colitis, or Crohn's disease; or the presence of any appropriate recognized gene markers for colorectal cancer or other predisposing factors; and any definition recognized by medical science and determined by the Director of the Department of Health in consultation with the University of Arkansas for Medical Sciences.

Outpatient Contraceptive Services and Devices - Covered Expenses incurred for Outpatient Contraceptive Services and Devices including closed formularies; however, formularies must include implant and injectable contraceptive drugs, and intrauterine devices.

Covered Expenses do not include charges for abortion, an abortifacient or any U.S. Food and Drug Administration approved emergency contraception.

Outpatient Contraceptive benefits are subject to the same Deductibles and Coinsurances as prescription drugs.

4. EXCLUSIONS AND LIMITATIONS - We will not provide any Benefits for charges resulting from or in connection with:

1. Any care not Medically Necessary or charges for which Benefits are not specifically provided for in the Policy;
2. Any act of war, declared or undeclared;
3. Suicide, attempted suicide, or any intentionally self-inflicted injury, while sane or insane;
4. Any routine physical examination, unless otherwise stated in the Policy;
5. Any Injury or Sickness arising out of, or in the course of, employment for wage or profit, provided the Insured Person is covered under any Worker's Compensation Act, Occupational Disease Act, or similar act or law, unless the Insured Person is self-employed;
6. Mental or Nervous Disorders, unless otherwise stated in the Policy;
7. Drug abuse or addiction including alcoholism, or overdose of drugs, narcotics, or hallucinogens, directly or indirectly, unless taken as prescribed by a Physician;
8. An overdose of drugs, being intoxicated or under the influence of intoxicants, hallucinogens, narcotics or other drugs, directly or indirectly, unless taken as prescribed by a Physician;
9. Any treatment including prescription drugs or non-prescription drugs, or procedure that promotes conception or prevents childbirth, including but not limited to: (a) artificial insemination; (b) in-vitro fertilization or other treatment for infertility; (c) treatment for impotency; (d) sterilization or reversal of sterilization; or (e) abortion (unless the life of the mother would be endangered if the fetus were carried to term), unless otherwise stated in the Policy;
10. Laser vision correction, radial keratotomy or any eye Surgery when the primary purpose is to correct nearsightedness, farsightedness, astigmatism, or any other refractive error;
11. Spinal manipulations and manual manipulative treatment or therapy;
12. Weight loss or modification, or complications arising therefrom, or procedures resulting therefrom or for surgical treatment of obesity including but not limited to gastric by-pass, wiring of the teeth and all forms of Surgery performed for the purpose of weight loss or modification or the reversal/modification of such procedure;
13. Breast reduction or augmentation unless necessary in connection with breast reconstructive Surgery following a mastectomy;
14. Modification of the physical body in order to improve the psychological, mental or emotional well-being of the Insured Person, such as but not limited to sex-change Surgery;
15. Marriage, family, or child counseling for the treatment of premarital, marriage, family or child relationship dysfunctions;
16. Routine newborn care, unless otherwise stated in the Policy;
17. Directly or indirectly engaging in an illegal occupation or illegal activity;
18. Care in a nursing home, custodial institution or domiciliary care or rest cures;
19. Preparation and presentation of medical reports for appearance at trials or hearings;
20. Physical examinations required for school events, camp, employment, licensing and insurance are expressly excluded;
21. Immunizations required for the sole purpose of travel outside of the U.S.A.;

22. Payment for care for military service connected disabilities for which the Insured Person is legally entitled to services and for which facilities are reasonably available to the Insured Person and payment for care for conditions that state or local law requires be treated in a public facility;
23. Experimental medical, surgical or other health care procedures, treatments, products or services, unless otherwise stated in the Policy;
24. Personal comfort items, such as television, telephone, lotions, shampoos, etc.;
25. Cosmetic Surgery;
26. Dental Care, treatment or Surgery unless necessitated by Injury to sound natural teeth which occurs while insured under this Policy. (The expense must be incurred within one year from the date of Injury, and while Hospital Confined or in an Outpatient Surgery Facility);
27. Corrective vision or hearing supplies or for the examination for prescribing or fitting such supplies;
28. The removal of warts, corns, calluses, the cutting and trimming of toenails, care for flat feet, fallen arches or chronic foot strain;
29. Hernia, hemorrhoids, tonsils, adenoids, middle ear disorders, myringotomy; or any disease or disorder of the reproductive organs unless the loss is incurred 6 months after the Insured Person becomes covered under this Policy;
30. Expenses incurred for prescription drugs, except if added by Rider;
31. Normal pregnancy, except for Complications of Pregnancy, except Benefits added by Rider, if any; and
32. Treatment, services or supplies received outside the U.S. or Canada. However, Benefits will be payable for Covered Expenses incurred as a result of an acute Sickness or Injury sustained during the first 30 days of travel outside of the U.S. or Canada. In no event will Benefits be payable beyond the first 30 days of travel outside of the U.S. or Canada.

Pre-Existing Condition - We will not provide Benefits for any loss resulting from a Pre-Existing Condition, as defined, unless the loss is incurred at least one year after the Effective Date of Coverage for an Insured Person.

Coverage After Age 65 or Earlier Medicare Eligibility - When an Insured Person attains age 65 or becomes eligible for Medicare, whichever happens first, the Benefits of the Policy and its attachments, if any, are payable only to the extent that Covered Expenses are not paid by Medicare and they would otherwise be payable under the Policy. The Benefits will also be subject to any other EXCLUSIONS AND LIMITATIONS set forth in the Policy.

5. **RENEWABILITY** - The Policy is guaranteed renewable, subject to the Company's right to discontinue or terminate the coverage as provided in the TERMINATION OF COVERAGE section of the Policy. The Company reserves the right to change the applicable table of premium rates on a Class Basis. The premium for the Policy may change in amount by reason of an increase in the age of an Insured Person.

6. TERMINATION OF COVERAGE –

You

Your coverage will terminate and no Benefits will be payable under the Policy and any attached Riders:

1. At the end of the period for which premium has been paid;
2. If Your mode of premium is monthly, at the end of the period through which premium has been paid following Our receipt of Your request of termination;
3. If Your mode of premium is other than monthly, upon the next monthly anniversary day following Our receipt of Your request of termination. Premium will be refunded for any amounts paid beyond the termination date;
4. On the date of fraud or misrepresentation by You;
5. On the date We elect to discontinue this plan or type of coverage. We will give You at least 90 days notice before the date coverage will be discontinued. You will be offered an option to purchase any other coverage that We offer without regard to health status;
6. On the date We elect to discontinue all coverage in Your state. We will give You and the proper state authority at least 180 days notice before the date coverage will be discontinued; or
7. On the date an Insured Person is no longer a permanent resident of the United States.

Covered Dependents

Your Covered Dependent's coverage will terminate under the Policy on:

1. The date Your coverage terminates;
2. The date such Dependent ceases to be an Eligible Dependent; or

- The date We receive Your written request to terminate a dependent's coverage.

The attainment of the Limiting Age for an Eligible Dependent will not cause coverage to terminate while that person is and continues to be both:

- Incapable of self-sustaining employment by reason of mental retardation or physical handicap; and
- Chiefly dependent on You for support and maintenance. For the purpose of this provision "Chiefly Dependent" means the Eligible Dependent receives the majority of his or her financial support from You.

We will require that You provide proof that the dependent is in fact a disabled and dependent person. In the absence of such proof We may terminate the coverage of such person after the attainment of the Limiting Age.

Special Continuation Provision For Dependents

Your Covered Dependents may continue their same (or substantially similar) coverage under a new Policy without evidence of insurability if their coverage under this Policy would otherwise terminate because they cease to be an Eligible Dependent for any of the following reasons:

- Divorce, legal separation, Your death; or
- A dependent child reaches the Limiting Age.

To continue coverage, You or Your Covered Dependent must request continuation of coverage by application or written notification within 31 days of the date coverage would otherwise terminate and pay any required premium.

7. RIDER BENEFITS –

Outpatient Speech Therapy, Physical Therapy and Occupational Therapy Rider (Form Number 26029 (10/05)-IR) – Covered Expenses incurred for Speech Therapy, Physical Therapy and Occupational Therapy that is related to and necessary for the treatment of a Sickness or Injury. The Benefits provided by this Rider will not duplicate benefits provided under the Policy and any other rider and are subject to the [Maximum Benefit Amount,] [Copayment,] [Coinsurance] and any other limitation shown for this Rider in the Policy Schedule. [Covered Expenses incurred under this Rider will not be considered a Covered Expense under the Policy and are not subject to and will not be used to satisfy the Policy Deductible.] In order to be considered a Covered Expense, therapy services must commence within 14 days of a covered Hospital Confinement or Surgery and be rendered in the 90 days immediately following the related covered Hospital Confinement or Surgery. Therapy provided beyond 90 days following a Hospital Confinement or Surgery will not be considered a Covered Expense.

	<u>PPO Provider</u>	<u>Non-PPO Provider</u>
Coinsurance	<input type="checkbox"/> 70%] <input type="checkbox"/> 80%] <input type="checkbox"/> 90%]	<input type="checkbox"/> 50%] <input type="checkbox"/> 60%] <input type="checkbox"/> 70%]
Maximum Benefit, per Insured Person, per week: [3] visits		
Not to exceed a [\$150] Maximum Benefit, per Insured Person, per day:		
Copayment, per visit: <input type="checkbox"/> \$25] <input type="checkbox"/> \$35] <input type="checkbox"/> \$50]		

Outpatient Accident Expense Benefit Rider (Form Number 25987(10/05)-IR) - Covered Expenses incurred by an Insured Person while the Rider is in force, for the Medically Necessary treatment of an Injury while not Hospital Confined. Benefit is subject to the following conditions: 1) Initial treatment by a Physician must begin within [72] hours of the Injury; and 2) Any treatment of the Injury, beyond the initial treatment, must be received within [45 days] of the Injury. The Benefits provided by this Rider will not duplicate Benefits provided under the Policy and any other rider and are subject to the [Rider Deductible, Coinsurance and the Maximum Benefit] shown for this Rider in the Policy Schedule. [Benefit paid under this Rider and amounts used to satisfy the Rider Deductible will not be considered a Covered Expense under the Policy and are not subject to and will not be used to satisfy the Policy Deductible.]

Coinsurance	[100%]
Maximum Benefit, per Insured Person, per Injury	<input type="checkbox"/> \$500] <input type="checkbox"/> \$1,000] <input type="checkbox"/> \$1,500][<input type="checkbox"/> \$2,000]
Deductible, per Injury	<input type="checkbox"/> \$50] <input type="checkbox"/> \$100] <input type="checkbox"/> \$150] <input type="checkbox"/> \$200]

Pregnancy/Childbirth Benefit Rider – (Form Number 25984 (10/05)-IR) AR – Covered Expenses incurred for normal pregnancy and childbirth at a Coinsurance amount in accordance with the length of time the Rider is in force. Covered Expenses will not exceed the Maximum Benefit selected. The Benefits provided by this Rider will not duplicate benefits provided under the Policy and any other rider and are subject to the Maximum Benefit Amount [Copayment,] [and Coinsurance] shown for this Rider in the Policy Schedule. [Covered Expenses incurred under this Rider will not be considered a Covered Expense under the Policy and are not subject to and will not be used to satisfy the Policy Deductible.]

[0-10] months in force	[0%] of Maximum Benefit selected
[11-24] months in force	[50%] of Maximum Benefit selected
[25] months in force and over	[100%] of Maximum Benefit selected

Maximum Benefit, per in vitro fertilization procedure and/or pregnancy/childbirth, for You or Your Covered Dependent Spouse \$2,000

Lifetime Maximum for In Vitro Fertilization Benefits: \$15,000

Air Ambulance Rider - (Form Number 25983 (10/05)-IR)- Covered Expenses incurred while the Rider is in force for Air Ambulance transportation to the nearest available medical facility that can provide adequate care in the event of a Medical Emergency, as defined in the Policy, at the Coinsurance amount selected. The Benefits provided by this Rider will not duplicate benefits provided under the Policy and any other rider and are subject to the [Maximum Benefit Amount,] [Copayment] [and Coinsurance] and any other limitation shown for this Rider in the Policy Schedule. [Covered Expenses incurred under this Rider will not be considered a Covered Expense under the Policy and are not subject to and will not be used to satisfy the Policy Deductible.] Covered Expenses will not exceed the base rate or the Maximum Benefit.

Coinsurance	<input type="checkbox"/> 70% <input type="checkbox"/> 80% <input type="checkbox"/> 90%
Base rate	[\$2,500]
Plus an additional	[\$50] per mile
Maximum Benefit, per Insured Person, per Calendar Year	[\$5,000]

Continued Care Benefit Rider – Form Number 25883 (10/05)-IR) AR – Covered Expenses incurred for Skilled Nursing Care, Home Health Care, Private Duty Nurse, or Hospice Care, following a covered Hospital Confinement for Medically Necessary continued care in accordance with a Treatment Plan, and as described in the rider. The Benefits provided by this Rider will not duplicate benefits provided under the Policy and any other rider and are subject to the Maximum Benefits, Coinsurance and other limitations shown for this Rider [and the Policy Deductible shown] in the Policy Schedule. [Covered Expenses incurred under this Rider will not be considered a Covered Expense under the Policy and are not subject to and will not be used to satisfy the Policy Deductible.]

PPO Provider

Non-PPO Provider

Skilled Nursing Care

Coinsurance Limited to [30 days] per Insured Person, per [Calendar Year]	<input type="checkbox"/> 70% <input type="checkbox"/> 80% <input type="checkbox"/> 90%	<input type="checkbox"/> 50% <input type="checkbox"/> 60% <input type="checkbox"/> 70%
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Maximum Benefit per Insured Person, per day [\$250]

Home Health Care

Coinsurance 70% 80% 90% 50% 60% 70%

Limited to [80 visits] per Insured Person, per [Calendar Year]

Not to exceed a [\$50] Maximum Benefit per Insured Person, per day

Private Duty Nursing

Coinsurance 70% 80% 90% 50% 60% 70%

Limited to [40 eight-hour shifts] per Insured Person, per [Calendar Year]

Not to exceed a [\$50] Maximum Benefit per Insured Person, per shift

Hospice Care

Coinsurance 70% 80% 90% 50% 60% 70%

Not to exceed a [\$5,000] Maximum Benefit per Insured Person, per lifetime

Legend Prescription Drug Expense Rider (Form Number 25985 (10/05)-IR) AR - We will pay a benefit if an Insured Person incurs Covered Expenses for Sickness or Injury. This benefit is the amount equal to the actual charge based on Participating Pharmacy prices for a Covered Expense, subject to the applicable Benefit Payment Rate/Deductible/Copayment shown below. Expenses are considered incurred on the date of Pharmacy service.

Deductible, per Calendar Year, per Insured Person \$50 \$100

Participating Pharmacy

(Not to exceed a 30 day supply)

Generic Drugs We pay [100%] less the [\$15] Copayment
Formulary Drugs We pay [50%], You pay the remainder
Non-Formulary Drugs We pay [25%], You pay the remainder

Non-Participating Pharmacy

(Not to exceed a 30 day supply)

Generic Drugs We pay [75%] less the [\$15] Copayment
Formulary Drugs We pay [25%], You pay the remainder
Non-Formulary Drugs We pay [0%], You pay the remainder

Mail Service Legend Prescription Drugs

(Not to exceed a 90 day supply through Our designated mail service program)

Generic Drugs We pay [100%] less the [\$30] Copayment
Formulary Drugs We pay [50%], You pay the remainder
Non-Formulary Drugs We pay [25%], You pay the remainder

Benefit Maximum

Per Insured Person [\$1,500] per Calendar Year

[PREVENTIVE PLUS] Benefit Rider (Form Number 26028 (10/05)-IR) – Benefits under the Rider are provided for [Medically Necessary] [non-Covered Expenses] for [Physician office visits, except for visits related to Mental or Nervous Disorders or fertility treatment;] [Allergy injections;] [Outpatient Diagnostic expenses not otherwise considered a Covered Expense under the Policy or any attached Riders;] [Emergency Room services not otherwise considered a Covered Expense under the Policy or any attached Riders; and] [Spinal manipulations]. [Routine preventive health care services, including but not limited to routine physical exams and related laboratory and x-rays services and immunizations, not otherwise paid under the Policy; and] [Acupuncture] will also be considered under the Rider.

All Benefits under the Rider are subject to subject to [Usual and Customary Charges][the Maximum Allowable Charge (MAC)], based on the Annual [PREVENTIVE PLUS] Benefit Amount selected, subject to a Quarterly Benefit Accumulation Amount.

ANNUAL [PREVENTIVE PLUS] BENEFIT AMOUNT:	QUARTERLY BENEFIT ACCUMULATION AMOUNT: (per quarterly Rider anniversary for You and Your Covered Dependents, if any)
<input type="checkbox"/> \$250	[\$62.50]
<input type="checkbox"/> \$500	[\$125.00]
<input type="checkbox"/> \$1,000	[\$250.00]
<input type="checkbox"/> \$2,000	[\$500.00]

Benefits under the Rider can accumulate if unused; however, there are limits to the amount that can accumulate. If there is more than one Insured Person covered under the Rider, there are limits to the maximum amount available to each Insured Person. Any Pre-Existing Condition limitations, conditions excluded by Waiver or Benefits paid under the Policy or any attached Riders, will not be considered under this Rider.

Benefits will be paid from the [PREVENTIVE PLUS] Benefit Amount on the date the services are rendered. Benefits accumulated subsequent to the date the services are rendered will not be used to pay benefits on services rendered before the accumulation date. In order for benefits to be considered under the Rider, services must be rendered during the time period for which premium has been paid for the Rider.

Emergency Services Benefit Rider (Form Number 26032 (10/05)-IR or 26032 PPO (10/05)-IR)- Covered Expenses incurred while the Rider is in force for Emergency Treatment of a Sickness or Injury not resulting in Hospital Confinement. The Benefits provided by this Rider will not duplicate the Benefits provided under the Policy and any other rider and are subject to the [[Policy Deductible] shown in the POLICY SCHEDULE] [and the [Copayment,][and Coinsurance][and Maximum Benefit] shown for this Rider in the POLICY SCHEDULE.

	<u>PPO Provider</u>	<u>Non-PPO Provider</u>
Coinsurance [Not to exceed a [\$1,000][\$2,000] Maximum Benefit per Insured Person, per visit]	<input type="checkbox"/> 70%][<input type="checkbox"/> 80%][<input type="checkbox"/> 90%]	<input type="checkbox"/> 50%][<input type="checkbox"/> 60%][<input type="checkbox"/> 70%]
[Physician's Office or Urgent Care Center Copayment, per visit <input type="checkbox"/> \$100] <input type="checkbox"/> \$250] <input type="checkbox"/> \$500] <input type="checkbox"/> \$1,000]]		
[Hospital Emergency Room Copayment, per visit <input type="checkbox"/> \$100] <input type="checkbox"/> \$250] <input type="checkbox"/> \$500] <input type="checkbox"/> \$1,000]]		

Physician's Office Visit Benefit Rider[*] (Form Number 25886-IP) - We will pay Covered Expenses incurred by an Insured Person, while this Rider is in force, for Medically Necessary visits to the Physician's office or clinic and for related care services provided by the Physician as a part of such visit. Benefits payable under this Rider are not subject to the Policy Deductible.

	<u>PPO Provider</u>	<u>Non-PPO Provider</u>
Copayment, per Insured Person, per visit	[\$30]	[\$30]
Daily Maximum Benefit, per Insured, Person per visit	[\$125]	[\$100]

Maximum Number of visits per calendar quarter
For You and Your Covered Dependent Spouse
 1] 2] visits each

Maximum Number of visits per calendar quarter
For Your Covered Dependent Child(ren)
 2] 4] visits each

[*The **Sickness Exclusion**, as shown in the EXCLUSIONS AND LIMITATIONS section of this Policy, does not apply to this Rider.]

- 8. **RIGHT TO RETURN POLICY** - It is important to Us that You understand and are satisfied with the coverage being provided to You. If You are not satisfied that this coverage will meet Your insurance needs, You may return the Policy to Us at Our administrative office in North Richland Hills, Texas, within 10 days after You receive it. Upon receipt, We will cancel Your coverage as of the Policy Date, refund all premiums paid and treat the Policy as if it were never issued.
- 9. **PREMIUMS** - We reserve the right to change the table of premiums, on a Class Basis, becoming due under the Policy at any time and from time to time; provided, We have given the Policyholder written notice of at least 31 days prior to the effective date of the new rates. Such change will be on a Class Basis. The premium for the Policy may change in amount by reason of an increase in the Attained Age of the Insured Person.

Initial Premium for Policy _____
 [Policy Fee _____]
 Rider Premium _____
 Total Initial Premium due with Application _____

THE MEGA LIFE AND HEALTH INSURANCE COMPANY

A Stock Company
(Hereinafter called: the Company, We, Our or Us)
Home Office: Oklahoma City, Oklahoma
Administrative Office: P.O. Box 982010
North Richland Hills, Texas 76182-8010
Customer Service: 1-800-527-5504

CATASTROPHIC EXPENSE PREFERRED PROVIDER ORGANIZATION (PPO) POLICY OUTLINE OF COVERAGE FOR FORM 26026 PPO-IP AR

NOTICE: Read this Outline of Coverage carefully. It is not identical to the Outline of Coverage provided upon application and the coverage originally applied for has not been issued.

- 1. READ YOUR POLICY CAREFULLY!** This Outline of Coverage provides a very brief description of some of the important features of Your Policy. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth, in detail, the rights and obligations of both You and Us. It is, therefore, important that You **READ YOUR POLICY CAREFULLY.**
- 2. CATASTROPHIC EXPENSE PREFERRED PROVIDER ORGANIZATION (PPO) COVERAGE** - The plan provides coverage for catastrophic expenses with the option of obtaining services through a Preferred Provider Organization, payable at a higher coinsurance level. The plan has a [\$5,000,000] Lifetime Maximum Amount and a [\$1,000,000] Aggregate Maximum Amount for all covered Injuries and Sicknesses. Covered Expenses are subject to a Deductible, unless otherwise stated.
- 3. BENEFITS** - For the purpose of this Outline of Coverage, Insured Person means You and Your Covered Dependents who are covered under the Policy.

The plan pays for Covered Expenses incurred under the Policy, subject to a [\$5,000,000] Lifetime Maximum Amount for all Injuries and Sicknesses per Insured Person. The plan pays for Covered Expenses incurred under the Policy, subject to a [\$1,000,000 Aggregate Maximum Amount] for any one covered Injury or Sickness for each Insured Person. Unless otherwise stated, all Covered Expenses are subject to the Maximum Benefits as shown in the Policy, Deductibles, Copayments, [Coinsurance Maximum] and Coinsurance shown below:

Insured Persons have the right to obtain medical care from the Physicians, Hospitals and other health care providers of their choice; however, if Covered Expenses are incurred from services provided by a non-PPO provider, Benefits will be less than the amount that would have otherwise been payable for Covered Expenses incurred from services provided by a PPO provider as shown below.

Deductible:

The Deductible applies to each Insured Person and for each [Calendar Year.]

<u>PPO Provider</u>	<u>Non-PPO Provider</u>
<input type="checkbox"/> \$1,500	\$3,000
<input type="checkbox"/> \$2,000	\$4,000
<input type="checkbox"/> \$2,500	\$5,000
<input type="checkbox"/> \$3,000	\$6,000
<input type="checkbox"/> \$3,500	\$7,000
<input type="checkbox"/> \$5,000	\$10,000
<input type="checkbox"/> \$7,500	\$15,000
<input type="checkbox"/> \$10,000]	\$20,000]

	<u>PPO Provider</u>	<u>Non-PPO Provider</u>
Coinsurance Maximum:	[\$4,000] [\$6,000] [\$8,000]	[\$8,000] [\$12,000] [\$16,000]
Coinsurance:	<input type="checkbox"/> 70% <input type="checkbox"/> 80% <input type="checkbox"/> 90% of Covered Expenses	<input type="checkbox"/> 50% <input type="checkbox"/> 60% <input type="checkbox"/> 70% of Covered Expenses

COVERED EXPENSES

Covered Expenses means [Usual and Customary] Charges for the services, supplies, care or treatment covered under this Policy which are incurred by an Insured Person as a result of Injury or Sickness and for which the Insured Person is legally obligated to pay and are not otherwise excluded or limited herein. They are incurred on the date that the service is performed or the supply is furnished. Only that portion of a [Usual and Customary] Charge or fee which is Medically Necessary is a Covered Expense. Covered Expenses must be incurred while this coverage is in force.

[Any charges in excess of the Maximum Benefit, if any, will not be considered a Covered Expense.]

Covered Expenses under the Riders, if any, may or may not be considered Covered Expenses under the Policy.

Inpatient Hospital Services - Covered Expenses incurred for services and supplies provided by the Hospital for semi-private accommodations and general nursing care furnished by the Hospital including Confinement in the Hospital's intensive care or cardiac care unit (in lieu of Benefit amount payable for Hospital room and board) and miscellaneous medical services and supplies necessary for the treatment of the Insured Person during that [Calendar Year].

Covered Expenses will also include x-ray, laboratory, diagnostic tests and services of a radiologist, radiology group, and the services of a pathologist or pathology group for interpretation of diagnostic tests or studies, performed while the Insured Person is Hospital Confined.

The fees charged for take home drugs, personal convenience items, or items not intended primarily for use of the Insured Person while Hospital Confined are not Covered Expenses.

Physician Visits while Hospital Confined - Covered Expenses incurred for visits by a Physician, other than the surgeon, while Hospital Confined, not exceed a [\$100] Maximum Benefit, per Insured Person, per day.

Surgeon Benefit - Covered Expenses incurred [while Hospital Confined or in an Outpatient Surgery Facility] for services by the Physician performing Surgery.

If two or more Surgeries are performed at the same time through separate incisions, We will consider the one providing the largest Benefit. We will also consider [50%] of the Benefits otherwise payable for the other Surgeries performed at the same time.

We will not consider more than one Surgery performed through the same incision during the same operation; however, We will consider the Surgery providing the largest Benefit.

If it is recommended that You have Physical Therapy in lieu of Surgery, We may consider Physical Therapy as an alternative to Surgery. Such Physical Therapy must be in accordance with a Treatment Plan approved by Us. Covered Expenses incurred under this Surgeon Benefit for Physical Therapy will be counted toward the applicable Surgeon Benefit.

Assistant Surgeon Benefit - Covered Expenses incurred for services by the Physician assisting the Physician performing Surgery.

Anesthesiologist Benefit - Covered Expenses incurred for services by the Physician providing anesthesia during Surgery.

Outpatient Surgery Facility Charges - Covered Expenses incurred for services furnished by and supplies received for use in an Outpatient Surgery Facility, including but not limited to:

1. Use of operating room and recovery room;
2. Administration of drugs and medicines during Surgery;
3. Dressings, casts, splints; and
4. Diagnostic services including radiology, laboratory or pathology performed at the time of the Surgery.

Second Surgical Opinion - Covered Expenses incurred for services by a Physician for a second opinion. The Physician providing the second opinion cannot be financially associated with the referring Physician or perform or assist in the Surgery in order for services to be considered a Covered Expense under the Policy.

If the second opinion disagrees with the first, a third opinion will also be considered a Covered Expense.

Durable Medical Equipment and Prosthetic Devices - Covered Expenses incurred for the rental of durable medical equipment not to exceed the actual purchase price of such equipment, and the purchase, fitting, repair and replacement of fitted prosthetic devices which replace a natural limb or eye, when ordered or prescribed by a Physician for use by the Insured Person.

The durable medical equipment or prosthetic device must be for use solely by the Insured Person for the treatment of a Sickness or Injury which occurred while such Insured Person's coverage is in force.

Routine maintenance and repairs of rental equipment are not Covered Expenses.

Covered Expenses will not exceed a Maximum Benefit of [\$5,000] per Insured Person, per [Calendar Year].

Outpatient Diagnostic Services - Covered Expenses incurred [within [21] days of a Surgery or Hospital Confinement] for diagnostic x-rays and interpretation charges, and laboratory and pathological examinations received while not Confined to a Hospital and that are related to and necessary for the diagnosis and treatment of the Sickness or Injury [that results in Surgery or Hospital Confinement]. [Covered Expenses include but are not limited to CAT Scans, Magnetic Resonance Imaging (MRI), Mammogram, Upper/Lower G.I. Series, Electrocardiogram (EKG), Blood or serum analysis, Angiogram and Stress Tests. [Please refer to the CASE MANAGEMENT provision shown in the Policy for Pre-Notification Requests of Non-Emergency Admissions.]]

Covered Expenses do not include routine physical examinations or checkups.

[Covered Expenses will not exceed a Maximum Benefit of [\$10,000] per Insured Person, per Calendar Year and must be related to and necessary for the diagnosis and treatment of the Sickness or Injury that results in Surgery or Hospital Confinement.] A [\$50] [\$100] [\$150] Copayment, per Insured Person, per 24 hour period, will apply.

Ambulance Transport - Covered Expenses incurred for Ambulance transportation to a Hospital, provided the Insured Person is Confined to the Hospital. Covered Expenses will not exceed a Maximum Benefit of [\$500] per Insured Person, per trip.

Chemotherapy - Covered Expenses incurred for chemotherapy received while Hospital Confined or on an outpatient basis. The condition for which chemotherapy is provided must be first diagnosed and the treatment must be received while coverage is in force.

Covered Expenses incurred with an approved Chemotherapy or Radiation Therapy Course of Treatment Plan will be considered at the Coinsurance amount selected.

Covered Expenses incurred without an approved Chemotherapy or Radiation Therapy Course of Treatment Plan will be considered at the Coinsurance amount selected, up to a Maximum Benefit of [\$1,500] per Insured Person, per day.

Radiation Therapy - Covered Expenses incurred for radiation therapy received while Hospital Confined or on an outpatient basis. The condition for which radiation therapy is provided must be first diagnosed and the treatment must be received while coverage is in force.

Covered Expenses incurred with an approved Chemotherapy or Radiation Therapy Course of Treatment Plan will be considered at the Coinsurance amount selected.

Covered Expenses incurred without an approved Chemotherapy or Radiation Therapy Course of Treatment Plan will be considered at the Coinsurance amount selected, up to a Maximum Benefit of [\$1,250] per Insured Person, per day.

Transplants - Covered Expenses include Transplant Procedures incurred during a Transplant Benefit Period. Covered Expenses for Transplant Procedures include:

1. Inpatient and outpatient Hospital services;
2. Services of a Physician for diagnosis, treatment and Surgery for a Transplant Procedure;
3. Procurement of an organ or tissue, including services provided to a living donor of an organ or tissue for procurement of an organ or tissue, provided the donor and transplant recipient are both insured under the Policy. Covered Expenses are limited to the actual procurement expenses, and will not be more than any maximums under the Policy applicable to the recipient;
4. [Usual and Customary] Charges for Travel and Accommodation Expenses related to a Transplant Procedure for the transplant recipient and one companion during a Transplant Benefit Period, provided the transplant facility is more than [300] miles from the Insured Person's home. If the recipient is a minor, Travel and Accommodation Expenses for two companions may be covered. Benefits for Travel and Accommodation Expenses are subject to the Travel and Accommodation Expense maximum[.];
5. Rental of durable medical equipment for use outside the Hospital. Covered Expenses are limited to the purchase price of the same equipment;
6. Prescription Drugs, including immunosuppressive drugs;
7. Oxygen;
8. Speech therapy, occupational therapy, Physical Therapy and chemotherapy;
9. Services and supplies for and related to high dose chemotherapy and bone marrow tissue transplantation when provided as part of a Transplant Treatment Plan which includes bone marrow transplantation and high dose chemotherapy; and
10. Surgical dressings and supplies.]

When the Insured Person's Physician advises the Insured Person that a Transplant Procedure is being considered, the Insured Person or the Insured Person's Physician should notify Us or Our designee in order for Us to direct the Insured Person to an appropriate Designated Transplant Facility. Covered Expenses for a live donor shall be paid to the extent that benefits remain and are available under this Policy for the Insured Person receiving the transplant, and after all Covered Expenses for the Insured Person has been paid. Benefits are not payable for animal organ or artificial organ transplants or for personal hygiene and convenience items, such as air conditioners, humidifiers, hot tubs, whirlpools, or physical exercise equipment, even if such items are prescribed by a Physician. Benefits are not payable for Covered Expenses incurred beyond the Transplant Benefit Period. Medically Necessary transplants not specifically defined as a Transplant Procedure under the Policy, which are not determined to be Experimental or Investigational Medicine will be payable the same as any other Transplant Procedure under the Policy in accordance with the provisions of the Policy.

Covered Expenses incurred for Transplant Procedures in a Designated Transplant Facility will be considered at [100%], with a Maximum Benefit payable for incurred Travel and Accommodation Expenses of [\$150] per day and [\$3,000] per Transplant Benefit Period.

Covered Expenses incurred for Transplant Procedures outside a Designated Transplant Facility will be considered at the Coinsurance amount selected with a Maximum Benefit payable of [\$100,000] per Transplant Procedure. [Travel and Accommodation Expenses incurred will not be considered as Covered Expenses.]

Musculoskeletal Disorders - Covered Expenses incurred for the medical treatment of musculoskeletal disorders affecting any bone or joint in the face, neck, or head, including temporomandibular joint disorder and craniomandibular disorder, on the same basis as that provided for any other musculoskeletal disorder in the body, whether prescribed or administered by a Physician or dentist. Treatment shall include both surgical and

nonsurgical procedures, and shall be provided for the diagnosis and treatment of these conditions whether they are the result of accident, trauma, congenital defect, developmental defect, or pathology.

Child Health Supervision Services - Covered Expenses incurred for each Covered Dependent from the moment of birth to age eighteen (18) years. In keeping with prevailing medical standards, such services shall include:

1. anticipatory guidance;
2. developmental assessment;
3. laboratory tests;
4. appropriate immunizations
5. a medical history; and
6. physical examination.

Benefits will be payable for 20 visits provided by or under the supervision of a single Physician during the course of one visit, at approximately the following intervals: birth; two weeks; two, four, six, nine, twelve, fifteen and eighteen months and two, three, four, five, six, eight, ten, twelve, fourteen, sixteen and eighteen years.

Benefits payable will not exceed current reimbursement levels for the same services under the Medicaid Early Periodic Screening Diagnosis and Treatment program in the State of Arkansas.

Benefits for recommended immunization services shall be exempt from any Coinsurance, Deductible or dollar limit provisions.

Maternity Stay Requirements For Covered Maternity Care - This provision applies to an Insured Person's coverage only when the Insured Person incurs Covered Expenses for a normal childbirth or cesarean section delivery that is covered by an optional Maternity Benefit Rider or for Complications of Pregnancy as defined in the Policy. A minimum of 48 hours of inpatient care will be provided to the mother and newborn child following a vaginal delivery and 96 hours following a cesarean section. Any normal delivery is subject to the Maximum Benefit for Pregnancy/Childbirth as stated in the optional Maternity Benefit Rider.

Medical Foods and Low Protein Modified Food Products - Covered Expenses incurred for the treatment of a Covered Dependent inflicted with phenylketonuria if:

1. The medical food or low protein modified food products are prescribed as Medically Necessary for the therapeutic treatment of phenylketonuria, galactosemia, organic acidemia and disorders of amino acid metabolism;
2. The products are administered under the direction of a licensed Physician; and
3. The cost of the medical food or low protein modified food products for an individual or a family with a dependent person or persons exceeds the [two thousand four hundred dollars (\$2,400)] per year per person income tax credit allowed.

Diabetes - Covered Expenses incurred for diabetes self-management training, supplies and related services for the treatment of Type I, Type II and gestational diabetes when determined Medically Necessary by Your Physician or other licensed health care provider.

Diabetes Self-Management Training means instructions in an inpatient or outpatient setting including medical nutrition therapy relating to diet, caloric intake and diabetes management, excluding any programs in which the only purpose is weight reduction, which enables diabetic patients to understand the diabetic management process and daily management of diabetic therapy as a method of avoiding frequent hospitalizations and complications when the instruction is provided in accordance with a program in compliance with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association.

Impairment or Loss of Speech or Hearing - Covered Expenses incurred for the communicative disorders generally treated by speech pathologist or audiologist licensed by the Board of Examiners in Speech-Language Pathology and Audiology and which fall within the scope of his/her area of certification. Coverage does not apply to hearing instruments or devices.

Colorectal Cancer Screening - Covered expenses incurred for colorectal cancer examinations and laboratory tests for Insured Persons who are 50 years of age or older; who are less than 50 years of age and at high risk for colorectal cancer according to American Cancer Society colorectal cancer screening guidelines as they existed on [January 1, 2005]; and 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 as determined by a licensed Physician.

For the purpose of this benefit "high risk for colorectal cancer" means: Individuals over 50 years of age or who face a high risk for colorectal cancer because of the presence of polyps on a previous colonoscopy, barium enema, or flexible sigmoidoscopy; family history of colorectal cancer in close relatives of parents, brothers, sisters, or children; genetic alterations of hereditary nonpolyposis colon cancer or familial adenomatous polyposis; personal history of colorectal cancer, ulcerative colitis, or Crohn's disease; or the presence of any appropriate recognized gene markers for colorectal cancer or other predisposing factors; and any definition recognized by medical science and determined by the Director of the Department of Health in consultation with the University of Arkansas for Medical Sciences.

Outpatient Contraceptive Services and Devices - Covered Expenses incurred for Outpatient Contraceptive Services and Devices including closed formularies; however, formularies must include implant and injectable contraceptive drugs, and intrauterine devices.

Covered Expenses do not include charges for abortion, an abortifacient or any U.S. Food and Drug Administration approved emergency contraception.

Outpatient Contraceptive benefits are subject to the same Deductibles and Coinsurances as prescription drugs.

4. EXCLUSIONS AND LIMITATIONS - We will not provide any Benefits for charges resulting from or in connection with:

1. Any care not Medically Necessary or charges for which Benefits are not specifically provided for in the Policy;
2. Any act of war, declared or undeclared;
3. Suicide, attempted suicide, or any intentionally self-inflicted injury, while sane or insane;
4. Any routine physical examination, unless otherwise stated in the Policy;
5. Any Injury or Sickness arising out of, or in the course of, employment for wage or profit, provided the Insured Person is covered under any Worker's Compensation Act, Occupational Disease Act, or similar act or law, unless the Insured Person is self-employed;
6. Mental or Nervous Disorders, unless otherwise stated in the Policy;
7. Drug abuse or addiction including alcoholism, or overdose of drugs, narcotics, or hallucinogens, directly or indirectly, unless taken as prescribed by a Physician;
8. An overdose of drugs, being intoxicated or under the influence of intoxicants, hallucinogens, narcotics or other drugs, directly or indirectly, unless taken as prescribed by a Physician;
9. Any treatment including prescription drugs or non-prescription drugs, or procedure that promotes conception or prevents childbirth, including but not limited to: (a) artificial insemination; (b) in-vitro fertilization or other treatment for infertility; (c) treatment for impotency; (d) sterilization or reversal of sterilization; or (e) abortion (unless the life of the mother would be endangered if the fetus were carried to term), unless otherwise stated in the Policy;
10. Laser vision correction, radial keratotomy or any eye Surgery when the primary purpose is to correct nearsightedness, farsightedness, astigmatism, or any other refractive error;
11. Spinal manipulations and manual manipulative treatment or therapy;
12. Weight loss or modification, or complications arising therefrom, or procedures resulting therefrom or for surgical treatment of obesity including but not limited to gastric by-pass, wiring of the teeth and all forms of Surgery performed for the purpose of weight loss or modification or the reversal/modification of such procedure;
13. Breast reduction or augmentation unless necessary in connection with breast reconstructive Surgery following a mastectomy;
14. Modification of the physical body in order to improve the psychological, mental or emotional well-being of the Insured Person, such as but not limited to sex-change Surgery;
15. Marriage, family, or child counseling for the treatment of premarital, marriage, family or child relationship dysfunctions;
16. Routine newborn care, unless otherwise stated in the Policy;
17. Directly or indirectly engaging in an illegal occupation or illegal activity;
18. Care in a nursing home, custodial institution or domiciliary care or rest cures;
19. Preparation and presentation of medical reports for appearance at trials or hearings;

20. Physical examinations required for school events, camp, employment, licensing and insurance are expressly excluded;
21. Immunizations required for the sole purpose of travel outside of the U.S.A.;
22. Payment for care for military service connected disabilities for which the Insured Person is legally entitled to services and for which facilities are reasonably available to the Insured Person and payment for care for conditions that state or local law requires be treated in a public facility;
23. Experimental medical, surgical or other health care procedures, treatments, products or services, unless otherwise stated in the Policy;
24. Personal comfort items, such as television, telephone, lotions, shampoos, etc.;
25. Cosmetic Surgery;
26. Dental Care, treatment or Surgery unless necessitated by Injury to sound natural teeth which occurs while insured under this Policy. (The expense must be incurred within one year from the date of Injury, and while Hospital Confined or in an Outpatient Surgery Facility);
27. Corrective vision or hearing supplies or for the examination for prescribing or fitting such supplies;
28. The removal of warts, corns, calluses, the cutting and trimming of toenails, care for flat feet, fallen arches or chronic foot strain;
29. Hernia, hemorrhoids, tonsils, adenoids, middle ear disorders, myringotomy; or any disease or disorder of the reproductive organs unless the loss is incurred 6 months after the Insured Person becomes covered under this Policy;
30. Expenses incurred for prescription drugs, except if added by Rider;
31. Normal pregnancy, except for Complications of Pregnancy, except Benefits added by Rider, if any; and
32. Treatment, services or supplies received outside the U.S. or Canada. However, Benefits will be payable for Covered Expenses incurred as a result of an acute Sickness or Injury sustained during the first 30 days of travel outside of the U.S. or Canada. In no event will Benefits be payable beyond the first 30 days of travel outside of the U.S. or Canada.

Pre-Existing Condition - We will not provide Benefits for any loss resulting from a Pre-Existing Condition, as defined, unless the loss is incurred at least one year after the Effective Date of Coverage for an Insured Person.

Coverage After Age 65 or Earlier Medicare Eligibility - When an Insured Person attains age 65 or becomes eligible for Medicare, whichever happens first, the Benefits of the Policy and its attachments, if any, are payable only to the extent that Covered Expenses are not paid by Medicare and they would otherwise be payable under the Policy. The Benefits will also be subject to any other EXCLUSIONS AND LIMITATIONS set forth in the Policy.

5. **RENEWABILITY** - The Policy is guaranteed renewable, subject to the Company's right to discontinue or terminate the coverage as provided in the TERMINATION OF COVERAGE section of the Policy. The Company reserves the right to change the applicable table of premium rates on a Class Basis. The premium for the Policy may change in amount by reason of an increase in the age of an Insured Person.

6. TERMINATION OF COVERAGE –

You

Your coverage will terminate and no Benefits will be payable under the Policy and any attached Riders:

1. At the end of the period for which premium has been paid;
2. If Your mode of premium is monthly, at the end of the period through which premium has been paid following Our receipt of Your request of termination;
3. If Your mode of premium is other than monthly, upon the next monthly anniversary day following Our receipt of Your request of termination. Premium will be refunded for any amounts paid beyond the termination date;
4. On the date of fraud or misrepresentation by You;
5. On the date We elect to discontinue this plan or type of coverage. We will give You at least 90 days notice before the date coverage will be discontinued. You will be offered an option to purchase any other coverage that We offer without regard to health status;
6. On the date We elect to discontinue all coverage in Your state. We will give You and the proper state authority at least 180 days notice before the date coverage will be discontinued; or
7. On the date an Insured Person is no longer a permanent resident of the United States.

Covered Dependents

Your Covered Dependent’s coverage will terminate under the Policy on:

- 1. The date Your coverage terminates;
- 2. The date such Dependent ceases to be an Eligible Dependent; or
- 3. The date We receive Your written request to terminate a dependent’s coverage.

The attainment of the Limiting Age for an Eligible Dependent will not cause coverage to terminate while that person is and continues to be both:

- 1. Incapable of self-sustaining employment by reason of mental retardation or physical handicap; and
- 2. Chiefly dependent on You for support and maintenance. For the purpose of this provision “Chiefly Dependent” means the Eligible Dependent receives the majority of his or her financial support from You.

We will require that You provide proof that the dependent is in fact a disabled and dependent person. In the absence of such proof We may terminate the coverage of such person after the attainment of the Limiting Age.

Special Continuation Provision For Dependents

Your Covered Dependents may continue their same (or substantially similar) coverage under a new Policy without evidence of insurability if their coverage under this Policy would otherwise terminate because they cease to be an Eligible Dependent for any of the following reasons:

- 1. Divorce, legal separation, Your death; or
- 2. A dependent child reaches the Limiting Age.

To continue coverage, You or Your Covered Dependent must request continuation of coverage by application or written notification within 31 days of the date coverage would otherwise terminate and pay any required premium.

7. RIDER BENEFITS –

Outpatient Speech Therapy, Physical Therapy and Occupational Therapy Rider (Form Number 26029 (10/05)-IR) – Covered Expenses incurred for Speech Therapy, Physical Therapy and Occupational Therapy that is related to and necessary for the treatment of a Sickness or Injury. The Benefits provided by this Rider will not duplicate benefits provided under the Policy and any other rider and are subject to the [Maximum Benefit Amount,] [Copayment,] [Coinsurance] and any other limitation shown for this Rider in the Policy Schedule. [Covered Expenses incurred under this Rider will not be considered a Covered Expense under the Policy and are not subject to and will not be used to satisfy the Policy Deductible.] In order to be considered a Covered Expense, therapy services must commence within 14 days of a covered Hospital Confinement or Surgery and be rendered in the 90 days immediately following the related covered Hospital Confinement or Surgery. Therapy provided beyond 90 days following a Hospital Confinement or Surgery will not be considered a Covered Expense.

	<u>PPO Provider</u>	<u>Non-PPO Provider</u>
Coinsurance	<input type="checkbox"/> 70%] <input type="checkbox"/> 80%] <input type="checkbox"/> 90%]	<input type="checkbox"/> 50%] <input type="checkbox"/> 60%] <input type="checkbox"/> 70%]
Maximum Benefit, per Insured Person, per week: [3] visits		
Not to exceed a [\$150] Maximum Benefit, per Insured Person, per day:		
Copayment, per visit: <input type="checkbox"/> \$25] <input type="checkbox"/> \$35] <input type="checkbox"/> \$50]		

Outpatient Accident Expense Benefit Rider (Form Number 25987(10/05)-IR) - Covered Expenses incurred by an Insured Person while the Rider is in force, for the Medically Necessary treatment of an Injury while not Hospital Confined. Benefit is subject to the following conditions: 1) Initial treatment by a Physician must begin within [72] hours of the Injury; and 2) Any treatment of the Injury, beyond the initial treatment, must be received within [45] days of the Injury. The Benefits provided by this Rider will not duplicate Benefits provided under the Policy and any other rider and are subject to the [Rider Deductible, Coinsurance and the Maximum Benefit] shown for this Rider in the Policy Schedule. [Benefit paid under this Rider and amounts used to satisfy the Rider Deductible will not be considered a Covered Expense under the Policy and are not subject to and will not be used to satisfy the Policy Deductible.]

Coinsurance	[100%]
Maximum Benefit, per Insured Person, per Injury	<input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,000
Deductible, per Injury	<input type="checkbox"/> \$50 <input type="checkbox"/> \$100 <input type="checkbox"/> \$150 <input type="checkbox"/> \$200

Pregnancy/Childbirth Benefit Rider – (Form Number 25984 (10/05)-IR) AR – Covered Expenses incurred for normal pregnancy and childbirth at a Coinsurance amount in accordance with the length of time the Rider is in force. Covered Expenses will not exceed the Maximum Benefit selected. The Benefits provided by this Rider will not duplicate benefits provided under the Policy and any other rider and are subject to the Maximum Benefit Amount [,Copayment,] [and Coinsurance] shown for this Rider in the Policy Schedule. [Covered Expenses incurred under this Rider will not be considered a Covered Expense under the Policy and are not subject to and will not be used to satisfy the Policy Deductible.]

[0-10] months in force	[0%] of Maximum Benefit selected
[11-24] months in force	[50%] of Maximum Benefit selected
[25] months in force and over	[100%] of Maximum Benefit selected
Maximum Benefit, per in vitro fertilization procedure and/or pregnancychildbirth, for You or Your Covered Dependent Spouse	<input type="checkbox"/> \$2,000
Lifetime Maximum for In Vitro Fertilization Benefits:	[\$15,000]

Air Ambulance Rider - (Form Number 25983 (10/05)-IR)- Covered Expenses incurred while the Rider is in force for Air Ambulance transportation to the nearest available medical facility that can provide adequate care in the event of a Medical Emergency, as defined in the Policy, at the Coinsurance amount selected. The Benefits provided by this Rider will not duplicate benefits provided under the Policy and any other rider and are subject to the [Maximum Benefit Amount,] [Copayment] [and Coinsurance] and any other limitation shown for this Rider in the Policy Schedule. [Covered Expenses incurred under this Rider will not be considered a Covered Expense under the Policy and are not subject to and will not be used to satisfy the Policy Deductible.] Covered Expenses will not exceed the base rate or the Maximum Benefit.

Coinsurance	<input type="checkbox"/> 70% <input type="checkbox"/> 80% <input type="checkbox"/> 90%
Base rate	[\$2,500]
Plus an additional	[\$50] per mile
Maximum Benefit, per Insured Person, per Calendar Year	[\$5,000]

Continued Care Benefit Rider – Form Number 25883 (10/05)-IR) AR – Covered Expenses incurred for Skilled Nursing Care, Home Health Care, Private Duty Nurse, or Hospice Care, following a covered Hospital Confinement for Medically Necessary continued care in accordance with a Treatment Plan, and as described in the rider. The Benefits provided by this Rider will not duplicate benefits provided under the Policy and any other rider and are subject to the Maximum Benefits, Coinsurance and other limitations shown for this Rider [and the Policy Deductible shown] in the Policy Schedule. [Covered Expenses incurred under this Rider will not be considered a Covered Expense under the Policy and are not subject to and will not be used to satisfy the Policy Deductible.]

	<u>PPO Provider</u>	<u>Non-PPO Provider</u>
Skilled Nursing Care		
Coinsurance	<input type="checkbox"/> 70% <input type="checkbox"/> 80% <input type="checkbox"/> 90%	<input type="checkbox"/> 50% <input type="checkbox"/> 60% <input type="checkbox"/> 70%
Limited to [30 days] per Insured Person, per [Calendar Year]		
Maximum Benefit per Insured Person, per day [\$250]		
Home Health Care		
Coinsurance	<input type="checkbox"/> 70% <input type="checkbox"/> 80% <input type="checkbox"/> 90%	<input type="checkbox"/> 50% <input type="checkbox"/> 60% <input type="checkbox"/> 70%
Limited to [80 visits] per Insured Person, per [Calendar Year]		
Not to exceed a [\$50] Maximum Benefit per Insured Person, per day		
Private Duty Nursing		
Coinsurance	<input type="checkbox"/> 70% <input type="checkbox"/> 80% <input type="checkbox"/> 90%	<input type="checkbox"/> 50% <input type="checkbox"/> 60% <input type="checkbox"/> 70%
Limited to [40 eight-hour shifts] per Insured Person, per [Calendar Year]		
Not to exceed a [\$50] Maximum Benefit per Insured Person, per shift		
Hospice Care		
Coinsurance	<input type="checkbox"/> 70% <input type="checkbox"/> 80% <input type="checkbox"/> 90%	<input type="checkbox"/> 50% <input type="checkbox"/> 60% <input type="checkbox"/> 70%
Not to exceed a [\$5,000] Maximum Benefit per Insured Person, per lifetime		

Legend Prescription Drug Expense Rider (Form Number 25985 (10/05)-IR) AR - We will pay a benefit if an Insured Person incurs Covered Expenses for Sickness or Injury. This benefit is the amount equal to the actual charge based on Participating Pharmacy prices for a Covered Expense, subject to the applicable Benefit Payment Rate/Deductible/Copayment shown below. Expenses are considered incurred on the date of Pharmacy service.

Deductible, per Calendar Year, per Insured Person \$50 \$100

Participating Pharmacy

(Not to exceed a 30 day supply)

Generic Drugs	We pay [100%] less the [\$15] Copayment
Formulary Drugs	We pay [50%], You pay the remainder
Non-Formulary Drugs	We pay [25%], You pay the remainder

Non-Participating Pharmacy

(Not to exceed a 30 day supply)

Generic Drugs	We pay [75%] less the [\$15] Copayment
Formulary Drugs	We pay [25%], You pay the remainder
Non-Formulary Drugs	We pay [0%], You pay the remainder

Mail Service Legend Prescription Drugs

(Not to exceed a 90 day supply through Our designated mail service program)

Generic Drugs	We pay [100%] less the [\$30] Copayment
Formulary Drugs	We pay [50%], You pay the remainder
Non-Formulary Drugs	We pay [25%], You pay the remainder

Benefit Maximum

Per Insured Person \$1,500 per Calendar Year

[PREVENTIVE PLUS] Benefit Rider (Form Number 26028 (10/05)-IR) – Benefits under the Rider are provided for [Medically Necessary] [non-Covered Expenses] for [Physician office visits, except for visits related to Mental or Nervous Disorders or fertility treatment;] [Allergy injections;] [Outpatient Diagnostic expenses not otherwise considered a Covered Expense under the Policy or any attached Riders;] [Emergency Room services not otherwise considered a Covered Expense under the Policy or any attached Riders; and] [Spinal manipulations]. [Routine preventive health care services, including but not limited to routine physical exams and related laboratory and x-rays services and immunizations, not otherwise paid under the Policy; and] [Acupuncture] will also be considered under the Rider.

All Benefits under the Rider are subject to subject to [Usual and Customary Charges][the Maximum Allowable Charge (MAC)], based on the Annual [PREVENTIVE PLUS] Benefit Amount selected, subject to a Quarterly Benefit Accumulation Amount.

ANNUAL [PREVENTIVE PLUS] BENEFIT AMOUNT:	QUARTERLY BENEFIT ACCUMULATION AMOUNT: (per quarterly Rider anniversary for You and Your Covered Dependents, if any)
<input type="checkbox"/> \$250	[\$62.50]
<input type="checkbox"/> \$500	[\$125.00]
<input type="checkbox"/> \$1,000	[\$250.00]
<input type="checkbox"/> \$2,000	[\$500.00]

Benefits under the Rider can accumulate if unused; however, there are limits to the amount that can accumulate. If there is more than one Insured Person covered under the Rider, there are limits to the maximum amount

available to each Insured Person. Any Pre-Existing Condition limitations, conditions excluded by Waiver or Benefits paid under the Policy or any attached Riders, will not be considered under this Rider.

Benefits will be paid from the [PREVENTIVE PLUS] Benefit Amount on the date the services are rendered. Benefits accumulated subsequent to the date the services are rendered will not be used to pay benefits on services rendered before the accumulation date. In order for benefits to be considered under the Rider, services must be rendered during the time period for which premium has been paid for the Rider.

Emergency Services Benefit Rider - (Form Number 26032 (10/05)-IR or 26032 PPO (10/05)-IR)- Covered Expenses incurred while the Rider is in force for Emergency Treatment of a Sickness or Injury not resulting in Hospital Confinement. The Benefits provided by this Rider will not duplicate the Benefits provided under the Policy and any other rider and are subject to the [[Policy Deductible] shown in the POLICY SCHEDULE] [and the [Copayment,][and Coinsurance][and Maximum Benefit] shown for this Rider in the POLICY SCHEDULE.

	<u>PPO Provider</u>	<u>Non-PPO Provider</u>
Coinsurance [Not to exceed a [\$1,000][\$2,000] Maximum Benefit per Insured Person, per visit]	<input type="checkbox"/> 70% <input type="checkbox"/> 80% <input type="checkbox"/> 90%	<input type="checkbox"/> 50% <input type="checkbox"/> 60% <input type="checkbox"/> 70%
[Physician's Office or Urgent Care Center Copayment, per visit <input type="checkbox"/> \$100 <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000]]		
[Hospital Emergency Room Copayment, per visit <input type="checkbox"/> \$100 <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000]]		

Physician's Office Visit Benefit Rider[*] (Form Number 25886-IP) - We will pay Covered Expenses incurred by an Insured Person, while this Rider is in force, for Medically Necessary visits to the Physician's office or clinic and for related care services provided by the Physician as a part of such visit. Benefits payable under this Rider are not subject to the Policy Deductible.

	<u>PPO Provider</u>	<u>Non-PPO Provider</u>
Copayment, per Insured Person, per visit	[\$30]	[\$30]
Daily Maximum Benefit, per Insured, Person per visit	[\$125]	[\$100]

Maximum Number of visits per calendar quarter
For You and Your Covered Dependent Spouse
 1] 2] visits each

Maximum Number of visits per calendar quarter
For Your Covered Dependent Child(ren)
 2] 4] visits each

[*The **Sickness Exclusion**, as shown in the EXCLUSIONS AND LIMITATIONS section of this Policy, does not apply to this Rider.]

8. RIGHT TO RETURN POLICY - It is important to Us that You understand and are satisfied with the coverage being provided to You. If You are not satisfied that this coverage will meet Your insurance needs, You may return the Policy to Us at Our administrative office in North Richland Hills, Texas, within 10 days after You receive it. Upon receipt, We will cancel Your coverage as of the Policy Date, refund all premiums paid and treat the Policy as if it were never issued.

9. PREMIUMS - We reserve the right to change the table of premiums, on a Class Basis, becoming due under the Policy at any time and from time to time; provided, We have given the Policyholder written notice of at least 31 days prior to the effective date of the new rates. Such change will be on a Class Basis. The premium for the Policy may change in amount by reason of an increase in the Attained Age of the Insured Person.

Initial Premium for Policy	_____
[Policy Fee	_____]
Rider Premium	_____
Total Initial Premium due with Application	_____