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|---------------------------------|--|-------------------------------|---------------------------------------|
| <i>SERFF Tracking Number:</i> | <i>MADS-125643562</i> | <i>State:</i> | <i>Arkansas</i> |
| <i>Filing Company:</i> | <i>Independence American Insurance Company</i> | <i>State Tracking Number:</i> | <i>39791</i> |
| <i>Company Tracking Number:</i> | <i>IAIC-AR</i> | | |
| <i>TOI:</i> | <i>H16G Group Health - Major Medical</i> | <i>Sub-TOI:</i> | <i>H16G.001A Any Size Group - PPO</i> |
| <i>Product Name:</i> | <i>IAIC-AR</i> | | |
| <i>Project Name/Number:</i> | <i>IAIC-AR/</i> | | |

Filing at a Glance

Company: Independence American Insurance Company

Product Name: IAIC-AR

SERFF Tr Num: MADS-125643562 State: ArkansasLH

TOI: H16G Group Health - Major Medical

SERFF Status: Closed

State Tr Num: 39791

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

Co Tr Num: IAIC-AR

State Status: Approved-Closed

Filing Type: Form

Co Status: Initial Submission

Reviewer(s): Rosalind Minor

Authors: Anna Clevidencea,
Marianne Cinquini

Disposition Date: 08/26/2008

Date Submitted: 07/30/2008

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: IAIC-AR

Status of Filing in Domicile: Not Filed

Project Number:

Date Approved in Domicile:

Requested Filing Mode:

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: 08/26/2008

State Status Changed: 08/26/2008

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

We are submitting for your approval the above referenced out-of-state Group Policy forms on behalf of Independence American Insurance Company (IAIC). These forms are new and will not replace any existing forms on file with the Department.

The content of the policy forms is substantially similar to the SSL policy documents approved by the State of Arkansas on June 6, 2008 (SERFF Tracking No. MADS-125619508). We have changed the carrier information and form numbers

SERFF Tracking Number: MADS-125643562 State: Arkansas
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 Product Name: IAIC-AR
 Project Name/Number: IAIC-AR/

on the policy forms in this submission to reflect IAIC as the carrier.

Company and Contact

Filing Contact Information

Anna Clevidence, clevidencea@iacusa.com
 2101 W. Peoria Ave, Suite 100 (602) 417-2156 [Phone]
 Phoenix, AZ 85029

Filing Company Information

Independence American Insurance Company CoCode: 26581 State of Domicile: Delaware
 485 Madison Avenue Group Code: 450 Company Type:
 New York, NY 10022 Group Name: State ID Number:
 (212) 355-4141 ext. [Phone] FEIN Number: 74-1746542

Filing Fees

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

| COMPANY | AMOUNT | DATE PROCESSED | TRANSACTION # |
|---|--------|----------------|---------------|
| Independence American Insurance Company | \$0.00 | 07/30/2008 | |

SERFF Tracking Number: MADS-125643562 State: Arkansas
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 Product Name: IAIC-AR
 Project Name/Number: IAIC-AR/

Correspondence Summary

Dispositions

| Status | Created By | Created On | Date Submitted |
|-----------------|----------------|------------|----------------|
| Approved-Closed | Rosalind Minor | 08/26/2008 | 08/26/2008 |

Filing Notes

| Subject | Note Type | Created By | Created On | Date Submitted |
|----------------------------|------------------|-------------------|------------|----------------|
| Check Mailing Notification | Note To Reviewer | Marianne Cinquini | 08/15/2008 | 08/15/2008 |

SERFF Tracking Number: *MADS-125643562* *State:* *Arkansas*
Filing Company: *Independence American Insurance Company* *State Tracking Number:* *39791*
Company Tracking Number: *IAIC-AR*
TOI: *H16G Group Health - Major Medical* *Sub-TOI:* *H16G.001A Any Size Group - PPO*
Product Name: *IAIC-AR*
Project Name/Number: *IAIC-AR/*

Disposition

Disposition Date: 08/26/2008

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: MADS-125643562 State: Arkansas
 Filing Company: Independence American Insurance Company State Tracking Number: 39791
 Company Tracking Number: IAIC-AR
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
 Product Name: IAIC-AR
 Project Name/Number: IAIC-AR/

| Item Type | Item Name | Item Status | Public Access |
|---------------------|--|-----------------|---------------|
| Supporting Document | Certification/Notice | Approved-Closed | Yes |
| Supporting Document | Application | Approved-Closed | Yes |
| Supporting Document | Cover Letter | Approved-Closed | Yes |
| Supporting Document | AR Association Approval | Approved-Closed | Yes |
| Supporting Document | IAIC Authorization Letter | Approved-Closed | Yes |
| Supporting Document | Actuarial Memo Certification | Approved-Closed | No |
| Form | Policyholder Application | Approved-Closed | Yes |
| Form | Master Group Major Medical Insurance Policy | Approved-Closed | Yes |
| Form | Group Health Insurance Certificate of Coverage | Approved-Closed | Yes |
| Form | Member Application for Insurance | Approved-Closed | Yes |
| Form | Benefit Plan Selection Form | Approved-Closed | Yes |
| Form | Health History Supplemental to Application | Approved-Closed | Yes |
| Form | Application for Preferred Underwriting Classification | Approved-Closed | Yes |
| Form | Amendatory Endorsement | Approved-Closed | Yes |
| Form | [Optional]Dental Rider | Approved-Closed | Yes |
| Form | Exclusion Endorsement | Approved-Closed | Yes |
| Form | [Optional] Supplemental Accident Benefit Rider | Approved-Closed | Yes |
| Form | [Optional] Preventative Care Benefit Rider | Approved-Closed | Yes |
| Form | [Optional] 24-Hour Occupational Coverage Benefit Rider | Approved-Closed | Yes |
| Form | Application Amendment | Approved-Closed | Yes |
| Form | Application Amendment | Approved-Closed | Yes |
| Form | [Optional] Graduated Dental Benefit Rider | Approved-Closed | Yes |
| Form | Rescission Endorsement | Approved-Closed | Yes |
| Form | AR Amendatory Endorsement | Approved-Closed | Yes |
| Form | AR Policyholder Election Form | Approved-Closed | Yes |
| Form | Amendatory Endorsement | Approved-Closed | Yes |
| Form | Amendatory Endorsement | Approved-Closed | Yes |

SERFF Tracking Number: MADS-125643562 State: Arkansas
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 Company Tracking Number: IAIC-AR
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
 Product Name: IAIC-AR
 Project Name/Number: IAIC-AR/

| | | | |
|-------------|--|-----------------|-----|
| Form | Amendatory Endorsement | Approved-Closed | Yes |
| Form | [Optional] Maternity Benefit Rider | Approved-Closed | Yes |
| Form | [Optional] Schedule Plan Maternity Benefit Rider | Approved-Closed | Yes |
| Form | [Optional] Rx Rider | Approved-Closed | Yes |
| Form | Schedule of Benefits (PPO) | Approved-Closed | Yes |
| Form | Schedule of Benefits | Approved-Closed | Yes |

SERFF Tracking Number: MADS-125643562 *State:* Arkansas
Filing Company: Independence American Insurance Company *State Tracking Number:* 39791
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TOI: H16G Group Health - Major Medical *Sub-TOI:* H16G.001A Any Size Group - PPO
Product Name: IAIC-AR
Project Name/Number: IAIC-AR/

Note To Reviewer

Created By:

Marianne Cinquini on 08/15/2008 11:22 AM

Subject:

Check Mailing Notification

Comments:

Good morning Rosalind, I just checked with our accounting department and check #55735 for \$50 was mailed to the department on August 6, 2008 to pay for this filing.

Thank you,

Shellie Howard

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 Product Name: IAIC-AR
 Project Name/Number: IAIC-AR/

Form Schedule

Lead Form Number: IAIC GP 107

| Review Status | Form Number | Form Type | Form Name | Action | Action Specific Data | Readability | Attachment |
|-----------------|--------------------|--|--|---------|----------------------|-------------|---|
| Approved-Closed | IAIC GA 107 | Application/ Enrollment Form | Policyholder Application Form | Initial | | | IAIC GA 107 (Policyholder Application for Group Ins)- For Filing (1-07).pdf |
| Approved-Closed | IAIC GP 107 | Policy/Cont ract/Fraternal Certificate | Master Group Major Medical Insurance Policy | Initial | | | IAIC GP 107 (Policy) For Filing (1-07).pdf |
| Approved-Closed | IAIC GC 107 | Certificate of Coverage | Group Health Insurance Certificate of Coverage | Initial | | | IAIC GC 107 (Certificate)- For Filing (1-07).pdf |
| Approved-Closed | IAIC MED APP 0307 | Application/ Enrollment Form | Member Application for Insurance | Initial | | | IAIC MED APP 0307 (General Application) Rev For Filing (3-12-07).pdf |
| Approved-Closed | IAIC MED BSF 0107 | Application/ Enrollment Form | Benefit Plan Selection Form | Initial | | | IAIC MED BSF 0107 (Plan Selection) For Filing (1-07).pdf |
| Approved-Closed | IAIC MED HHSF 0107 | Application/ Enrollment Form | Health History Supplemental to Application | Initial | | | IAIC MED HHSF 0107 (Health History Supplement) For Filing (1- |

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 Filing Company: Independence American Insurance Company State Tracking Number: 39791
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 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
 Product Name: IAIC-AR
 Project Name/Number: IAIC-AR/

| | | | | | |
|---------------------|-----------------------|---|--|---------|---|
| Approved- Closed | IAIC MED AFPU 0307 | Application/ Enrollment Form | Application for Preferred Underwriting Classification | Initial | 07).pdf IAIC MED AFPU 0307 (Preferred UW Class App Supplement)F or Filing (03- 07-07).pdf |
| Approved- Closed | IAIC AE 107 | Certificate Amendmen t, Insert Page, Endorseme nt or Rider | Amendatory Endorsement | Initial | IAIC AE 107 {Amend Endorsement (Effectuate chgs)} For Filing (1- 07).pdf |
| Approved- Closed | IAIC DBR 107 | Certificate Amendmen t, Insert Page, Endorseme nt or Rider | [Optional]Dental Rider | Initial | IAIC DBR 107 (DENTAL RIDER)- For Filing (1- 07).pdf |
| Approved- Closed | IAIC EXCL AE 107 | Certificate Amendmen t, Insert Page, Endorseme nt or Rider | Exclusion Endorsement | Initial | IAIC EXCL AE 107 (Exclusion Endorsement) -For Filing(1- 07).pdf |
| Approved- Closed | IAIC SABR 107 | Certificate Amendmen t, Insert Page, Endorseme nt or Rider | [Optional] Supplemental Accident Benefit Rider | Initial | IAIC SABR 107 (SUPP ACC RIDER)- For Filing (1- 07).pdf |
| Approved- Closed | IAIC PCBR 107 | Certificate Amendmen t, Insert Page, | [Optional] Preventative Care Benefit Rider | Initial | IAIC PCBR 107 (Preventive Care Benefit |

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| <i>Product Name:</i> | <i>IAIC-AR</i> | | |
| <i>Project Name/Number:</i> | <i>IAIC-AR/</i> | | |
| Closed | 107 | Amendmen t, Insert Page, Endorseme nt or Rider | 107 (AR Amendatory Endorsement) For Filing 072808.pdf |
| Approved- Closed | IAIC AEAR OPT ELC AR 107 | Other AR Policyholder Election Form | Initial IAIC AEAR OPT ELC AR 107 For Filing 072808.pdf |
| Approved- Closed | IAIC AECD AR 107 | Certificate Amendatory Amendmen t, Insert Page, Endorseme nt or Rider | Initial IAIC AECD AR 107 (Chemical Dep) For Filing 072808.pdf |
| Approved- Closed | IAIC AEHEAR AR 107 | Certificate Amendatory Amendmen t, Insert Page, Endorseme nt or Rider | Initial IAIC AEHEAR AR 107 (Hearing Exams) For Filing 072808.pdf |
| Approved- Closed | IAIC AEMI AR 107 | Certificate Amendatory Amendmen t, Insert Page, Endorseme nt or Rider | Initial IAIC AEMI AR 107 (Mental Disorder) For Filing 072808.pdf |
| Approved- Closed | IAIC MBR AR 107 | Certificate [Optional] Maternity Amendmen t, Insert Page, Endorseme nt or Rider | Initial IAIC MBR AR107 (Maternity Rider) For Filing 072808.pdf |
| Approved- Closed | IAIC MSBR AR 107 | Certificate [Optional] Schedule Amendmen t, Insert Page, Endorseme | Initial IAIC MSBR AR 107 (Maternity Rider- Schedule |

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|---------------------------------|--|---|--|
| <i>SERFF Tracking Number:</i> | <i>MADS-125643562</i> | <i>State:</i> | <i>Arkansas</i> |
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| <i>Product Name:</i> | <i>IAIC-AR</i> | | |
| <i>Project Name/Number:</i> | <i>IAIC-AR/ nt or Rider</i> | | <i>Plan) For Filing 072808.pdf</i> |
| | | | |
| <i>Approved-Closed</i> | <i>IAIC PMBR Certificate [Optional] Rx Rider AR 107 Amendmen t, Insert Page, Endorseme nt or Rider</i> | <i>Initial</i> | <i>IAIC PMBR AR 107 (Rx Rider) For Filing 072808.pdf</i> |
| | | | |
| <i>Approved-Closed</i> | <i>IAIC SOB Schedule AR 107 Pages</i> | <i>Schedule of Benefits (PPO)</i> | <i>Initial IAIC SOB AR 107 (SOB PPO) For Filing 072808.pdf</i> |
| | | | |
| <i>Approved-Closed</i> | <i>IAIC SOB Schedule IND AR Pages 107</i> | <i>Schedule of Benefits Initial</i> | <i>IAIC SOB IND AR 107 (SOB Indemnity) For Filing 072808.pdf</i> |

INDEPENDENCE AMERICAN INSURANCE COMPANY
a Delaware Insurance Company
Administrative Office: [485 Madison Avenue, New York, NY 10022]

APPLICATION FOR GROUP INSURANCE

GROUP POLICY NUMBER [XX-XXXX]

Application is hereby made to Independence American Insurance Company for Group Insurance Benefits in the Policy form attached to and made a part hereof; and if this application is accepted by Independence American Insurance Company, the Policy shall be issued to:

Name of Applicant: [ABC Association]

State of Delivery: District of Columbia

To be effective 12:01 A.M. on the 1st day of [January, 2007].

Applicant's Signature: _____ [*Jane Doe*]

Title: _____ [President]

Date: _____ [December 1, 2006]

INDEPENDENCE AMERICAN INSURANCE COMPANY
a Delaware Insurance Company
Administrative Office: [485 Madison Avenue, New York, NY 10022]

(Herein called We, Our, Us or the Company)

POLICYHOLDER: [ABC Association]
POLICY NUMBER: [XX-XXXXX]
EFFECTIVE DATE: [January 1, 2007]
STATE OF DELIVERY: District of Columbia

In consideration of the Master Group Policy Application made by the Policyholder, and in consideration of the payment of any applicable premium due, We agree to pay the group insurance benefits herein with respect to each Covered Person, in accordance with and subject to the terms, conditions and limitations of the Policy. Benefits are payable in United States dollars only.

The Policy becomes effective at 12:01 a.m. Standard Time at the Policyholder's address on the Effective Date shown above, and will remain in force until it is terminated by [sixty (60)] days written notice to the Policyholder or Us. The Policy renews monthly following the Effective Date shown above.

This Policy is governed by the laws of the jurisdiction of the State of delivery.

This face page and all endorsements, Riders, Schedule of Benefits, Certificates, applications and any addendums, form the Master Policy. These pages are all part of this Policy as if fully recited over the signature shown below.

Executed for Independence American Insurance Company as of the Effective Date.

GROUP POLICY PROVIDING MAJOR MEDICAL EXPENSE BENEFITS

INDEPENDENCE AMERICAN INSURANCE COMPANY



David Kettig
President



Adam C. Vandervoort
Secretary

INDEPENDENCE AMERICAN INSURANCE COMPANY

a Delaware Insurance Company

Administrative Office: [485 Madison Avenue, New York, NY 10022]

Group Health Insurance Certificate Of Coverage

VALIDATION OF COVERAGE

Your Certificate is validated by the attachment of this Validation of Coverage showing Your name and plan information.

Policyholder [ABC Association]
[Term Life Insurance Beneficiary] [Not Applicable] [As specified on Your most recent Application or Change Beneficiary form on file at the office where the Beneficiary Records are kept : designated by Us.]]
Insured Person: [INSURED NAME]
Dependent Coverage: [SPOUSE][CHILD][CHILDREN]
[Case Number:] [CASE NO.] **[Part Number:]** [PART NO.]
Insured Person's Effective Date: [INSURED EFFECTIVE DATE]
Dependent Effective Date: [DEPENDENT EFFECTIVE DATE]

The insurance coverage, benefits and the principal provisions that apply to the Insured Person named above are summarized in this Validation of Coverage, the Schedule of Benefits and this Certificate of Coverage and are merely evidence of insurance under the Policy. Insurance coverages are subject to the terms of the Policy, which alone constitutes the contract under which payment is made. The Policy is a contract between the Policyholder and Us. It may be changed or terminated only by those parties. Coverage is provided under group policy number [POLICY NO.].

[10]-DAY RIGHT TO RETURN THIS CERTIFICATE OF COVERAGE

If for any reason You are not satisfied with this Certificate, You may return it to Us at Our Plan Administrator's office within [10] days after You receive it. We will refund any premium paid and Your coverage issued under the Policy will be deemed void, just as though coverage had not been issued.

IMPORTANT NOTICE

The application attached to this Certificate must be carefully reviewed. If any information shown on the application for You or Your Dependents is not correct or is incomplete, or if any medical history has not been included, You must detail the inaccurate or omitted information, and send it to Us at Our Plan Administrator's office within [10] days of receipt of this Certificate. The coverage under the Policy is issued on the basis that the answers to all questions and any other information requested in the application is correct and complete. **Omissions or misstatements in the application may cause Rescission or Reformation of coverage. Please see Section 10 – GENERAL PROVISIONS, subparagraph D. Correcting Omissions or Misstatements.**

**THIS FACE PAGE SUPERCEDES AND REPLACES ANY AND ALL
PREVIOUSLY ISSUED TO THE INSURED PERSON NAMED ABOVE**

INDEPENDENCE AMERICAN INSURANCE COMPANY



David Kettig
President



Adam C. Vandervoort
Secretary

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SECTION 1 – INTRODUCTION

This Certificate of Coverage is composed of 5 parts:

1. The Validation of Coverage;
2. The Schedule of Benefits;
3. This Certificate;
4. The application; and
5. The Optional Benefit Riders as selected by You and reflected on the Schedule of Benefits.

This Certificate of Coverage describes the Covered Person's eligibility and enrollment requirements, benefits, exclusions and limitations applicable to the insurance benefit plan You selected. If You are covered under a PPO Plan, as specified on the Schedule of Benefits, the highest level of benefits are available when In-Network Providers are used for covered services. If You are covered under an Indemnity Plan, as specified on the Schedule of Benefits, the Covered Person has the freedom to use any Provider.

Specific definitions apply to many terms used in this Certificate of Coverage. When used herein, these words are capitalized. Please see SECTION [11] – DEFINITIONS for the definitions of specific terms. Headings, as used in this Certificate, are for convenience and ease of reference only and shall not be considered in interpreting the terms and conditions of this Certificate.

SECTION 2 – ELIGIBILITY FOR INSURANCE (INSURABILITY REQUIREMENTS)

INSURED PERSON

You will become eligible for coverage under the Policy upon meeting all the following requirements:

1. You are under age [64] years [and [6] months];
2. You are a dues paying member of the Policyholder named on the Validation of Coverage;
3. You have submitted a written request, upon a form approved by Us, seeking to apply for coverage as an Insured Person;
4. You are insurable pursuant to Our then current underwriting guidelines; and
5. You are a permanent resident of the United States.

DEPENDENT INSURANCE

A Dependent, as defined in SECTION 11 – DEFINITIONS, is eligible for coverage under the Policy upon meeting all of the following requirements:

1. The Dependent is the Insured Person's spouse and/or Child;
2. The Insured Person has submitted a written request, upon a form approved by Us, naming the individual as a Dependent;
3. The Dependent is insurable pursuant to Our then current underwriting guidelines (unless waived under other provisions of the Policy); and
4. The Dependent is a permanent resident of the United States.

Under this SECTION 2 – ELIGIBILITY FOR INSURANCE, all evidence that the Insured Person and Dependents are insurable pursuant to Our current underwriting guidelines shall be provided without expense to Us.

SECTION 3 – EFFECTIVE DATE OF INSURANCE

Insured Person Insurance: Your insurance coverage under the Policy shall become effective on the monthly premium due date coincident with or next following the date on which We approve Your written request for coverage and You pay the applicable premium. If You are Confined in a Hospital or other treatment Facility or Totally Disabled on the Effective Date, the approval of coverage is void and coverage will not take effect. A new application will be required to consider coverage in the future.

Dependent Insurance: An eligible Dependent's coverage under the Policy shall become effective on the premium due date coincident with or next following the date on which We approve Your written request for coverage and the applicable premium is paid. If the Dependent is Confined in a Hospital or other treatment Facility or Totally Disabled on the Effective Date, the approval of coverage is void and coverage will not take effect. A new application will be required to consider coverage in the future. This requirement is not applicable to a newborn or adopted child who would be otherwise be covered for Sickness or Injury from the moment of birth or date of placement.

Dependents Acquired After Effective Date

Newborn Children: Coverage will be effective for a newborn Child of the Insured Person for 31 days following the moment of birth. Coverage shall continue beyond the 31-day period provided that the Insured Person meets the following requirements:

1. makes a written request for coverage, on forms approved by Us, within 31 days from the birth; and
2. makes the required premium payment, if applicable.

If the above requirements are not met and the Insured Person desires to provide future coverage under the Policy to the newborn, evidence of the newborn's insurability must be provided at no expense to Us and the newborn must meet Our then current underwriting guidelines. Coverage shall then take effect on the premium due date coincident with or next following the date on which We approve coverage.

Adopted Children: Coverage will be effective for adopted children of the Insured Person for 31 days following placement in the custody of the Insured Person. Placement means the assumption by the Insured Person of the physical custody of the adopted Child. Coverage shall continue beyond the 31-day period provided that the Insured Person meets the following requirements:

1. makes written request for coverage, on forms approved by Us, within 31 days from placement; and
2. makes the required premium payment, if applicable.

If the above requirements are not met and the Insured Person desires to provide coverage under the Policy to an adopted Child, evidence of the adopted Child's insurability must be provided at no expense to Us and the adopted Child must meet Our then current underwriting guidelines. Coverage shall then take effect on the premium due date coincident with or next following the date on which We approve coverage and any applicable premium is paid.

Additional Dependents: An Insured Person may acquire additional Dependents while covered under the Policy. The insurance coverage with respect to such additional Dependents shall become effective on the premium due date coincident with or next following the date on which We approve coverage provided such Dependent satisfies the Eligibility Requirements as set forth in SECTION 2 – ELIGIBILITY FOR INSURANCE and any applicable premium is paid.

SECTION 4 – BENEFITS

[Coinsurance Family Maximum

[When [three] Covered Persons under the Policy have each satisfied their Coinsurance requirements in any Calendar Year.] [When the sum of all Covered Person's Covered Charges used toward the individual Coinsurance equals [three] times the Coinsurance requirements for the Calendar Year,] [When the amount as specified on the Schedule of Benefits is satisfied,] no further Coinsurance payments will be required for the remainder of that Calendar Year. [This does not apply to the Coinsurance for Mental, Nervous and Chemical Dependency Outpatient Care.] [If the Covered Person is covered under a PPO Plan, as specified on the Schedule of Benefits, the Coinsurance Family Maximum [does not] [will] apply to the Coinsurance requirements for Out-of-Network Providers.]]

[Calendar Year Deductible Carryover

Covered Charges incurred during the last [[three] months of a Calendar Year] [[three] months of the first Calendar Year [following Your Effective Date]] and used to meet that Calendar Year Deductible, will also apply toward meeting the Covered Person's Calendar Year Deductible for the next Calendar Year. [If the Covered Person is covered under a PPO Plan, as specified on the Schedule of Benefits, the Calendar Year Deductible Carryover will [not] apply to any Covered Charges used to meet the Calendar Year Deductible for Out-of-Network providers.] [The Calendar Year Deductible Carryover [does not apply] [applies] to any separate Deductibles required under any Rider providing additional benefits that may be attached to this Certificate.] [The Calendar Year Deductible Carryover applies to the separate Deductible required under the [Prescription Medication Benefit Rider] as specified as applicable on the Schedule of Benefits.]]

[Calendar Year Deductible Family Maximum

[When [3] Covered Persons under the Policy have each satisfied their Calendar Year Deductible in any given Calendar Year.] [When the sum of all Covered Person's Covered Charges used toward the individual Calendar Year Deductible equals [3] times the Calendar Year Deductible,] [When the amount as specified on the Schedule of Benefits is satisfied,] no further Calendar Year Deductible will apply for the remainder of that Calendar Year. [If the Covered Person is covered under a PPO Plan, as specified on the Schedule of Benefits, the Calendar Year Deductible Family Maximum [does not] [will] apply to the Calendar Year Deductible for Out-Of-Network Providers.] [The Calendar Year Deductible Family Maximum does not apply to any separate Deductibles required under any Rider providing additional benefits that may be attached to this Certificate.]]

Covered Charges

We will pay for Covered Charges under this Section for a Covered Person in connection with the treatment of an Injury or Sickness if the Charges are: (a) Medically Necessary; (b) Usual and Reasonable; (c) authorized by a Physician; (d) incurred while coverage under the Policy is in force; and (e) not excluded or limited by Section 5 – Exclusions and Limitations From Coverage. Covered Charges are subject to the Calendar Year Deductible(s) or Daily Deductible(s); Copay(s), Coinsurance Percentage(s), and the limitations and maximums specified in the Schedule of Benefits. **THE FOLLOWING COVERED CHARGES MAY BE SUBJECT TO SPECIFIC BENEFIT MAXIMUMS OR LIMITATIONS, AS SPECIFIED IN THE SCHEDULE OF BENEFITS. IT IS IMPORTANT THAT THE COVERED PERSON REVIEWS THE SCHEDULE OF BENEFITS FOR THE BENEFITS MAXIMUMS OR LIMITATIONS.**

1. Hospital room and board at the most common daily rate including:
 - a. Hospital Intensive Care Unit;
 - b. Intermediate Care Unit;
 - c. Hospital Observation Room;
 - d. Emergency Room Covered Charges for services rendered at any Hospital or licensed or accredited Emergency Care Facility, including the contracted Emergency Room Physicians for Emergency Care; and
 - e. Those services, drugs and supplies necessary for the treatment of the Covered Person while Confined to the Hospital.
2. Skilled Nursing Facility room and board, in lieu of a hospitalization, provided Confinement must begin within 14 days after a Hospital stay of at least 2 consecutive days.
3. Ambulatory Surgical Center services for the performance of a surgical procedure.
4. Urgent Care Facility service and professional fees.
5. Physician services, including home, office and Hospital visits, surgery, and other medical care and treatment, including surgical procedure Charges for performing the operation, subject to the following:
 - a. Charges for an assistant surgeon, shall be a maximum of:
 - 1) [25]% of the contracted fee payable to the primary surgeon if the primary surgeon is an In-Network Provider; or
 - 2) [25]% of the Covered Charge of the primary surgeon for the surgical procedure if the primary surgeon is an Out-of-Network Provider.
 - b. Benefits payable for multiple surgical procedures shall be determined based on the following guidelines:
 - 1) When multiple or bilateral surgical procedures through different incisions are performed that increase the time and amount of patient care, the Covered Charge for the major procedure is either the contracted fee for an In-Network Provider or the Usual and Reasonable fee for an Out-of-Network Provider. The Covered Charge for each of the other procedures is the lesser of either: (i) [50]% the contracted fee for an In-Network Provider or [50]% of the Usual and Reasonable fee for an Out-of-Network Provider; or (ii) the actual fee charged;

- 2) When an incidental procedure is performed through the same incision, the Covered Charge is the Charge for the major surgical procedure only. Examples of incidental procedures include, but are not limited to, excision of a scar, appendectomy, or lysis of adhesions.
6. Outpatient services by a Registered Nurse if We determine that such services are not for Custodial Care or convalescent care and could not be provided by a person other than a Registered Nurse. Such Covered Charges exclude services provided by a private duty Nurse.
7. Professional licensed ambulance service as follows:
 - a. Emergency ground transportation when Medically Necessary and used locally to or from the nearest Facility qualified to render treatment;
 - b. Emergency [air or] water ambulance when Medically Necessary to transport a Covered Person to the nearest Facility qualified to render treatment in a life-threatening situation;
 - c. Ambulance transportation necessary for the provision of Emergency medical care for a newborn Child when such Child is transported to the nearest Hospital capable of providing the Medically Necessary treatment on a timely basis, and the mode of transportation is the most economically consistent with the well-being of such Child; or
 - d. [When Pre-Determined in accordance with SECTION 6 – ACCESSING AND ADMINISTERING YOUR BENEFITS herein.]
8. Medical services and supplies necessary for the treatment of the Covered Person, including:
 - a. Imaging, laboratory and diagnostic tests.
 - b. Radiation therapy and chemotherapy for the treatment of cancer.
 - c. Casts and splints.
 - d. Antibiotic therapy administered intravenously in a home-health setting, total parenteral nutrition and total parenteral administration.
 - e. Blood and its administration; but not for the cost of blood or blood components if replaced.
 - f. The initial purchase of a functional prosthetic device.
 - g. The repair or replacement of a functional prosthetic device in the event of: (i) a pathologic change to the affected post surgical appendage or site; or (ii) if the Covered Person's functional prosthetic device no longer functions properly due to circumstances other than abuse, misuse, or use in a fashion other than as intended by the manufacturer.
 - h. The initial purchase of an artificial larynx or a prosthetic eye.
 - i. The rental of Durable Medical Equipment, including, but not limited to, a wheelchair, hospital bed, crutches, braces (excluding dental braces and orthodontics), canes, walkers, crutches, trusses, oxygen equipment, Glucometer, T.E.N.S unit, continuous peripheral motor unit (CPM), Apnea monitor or other Durable Medical Equipment required for the therapeutic use of a Covered Person. At Our option, We may pay for the lease or purchase of such equipment. If approved by Us, reimbursement for authorized purchases may be paid by Us on a prorated basis, over a 12-month period, subject to the Calendar Year Deductible or Daily Deductible and Coinsurance so long as the Covered Person remains insured under the Policy during this time. [Pre-Determination is required for Durable Medical Equipment that exceeds \$[1000].]
 - j. Anesthetics, oxygen and their administration.
9. Mastectomy as a result of diagnosis of breast cancer including the following:
 - a. Inpatient care following a mastectomy for the length of time determined to be Medically Necessary by the attending Physician upon evaluation of the Covered Person;
 - b. Reconstructive surgery performed to reconstruct the breast on which the mastectomy has been performed;
 - c. Surgery or reconstruction of the non-diseased breast for which mastectomy was not required in order to restore or achieve breast symmetry; and

- d. Prosthetic devices and treatment of physical complications, including lymphedemas at all stages of mastectomy.

10. Screening Services as follows:

- a. Preventive care services for covered Dependent Children from birth until [18] years of age as follows:

- 1) Unlimited preventive screening visits for children up to the age of [12] years;
- 2) [3] preventive screening visits per Calendar Year for minor children ages [12] years up to [18] years of age;

Preventive screenings may include, as recommended by a Physician, physical examinations, measurements, sensory screening, neuropsychiatric evaluation, development screening, hereditary and metabolic screening at birth, immunizations, urinalysis, tuberculin tests, and hematocrit, hemoglobin, sickle hemoglobinopathy and other appropriate blood tests.

- b. Low-dose screening mammography as follows:

- 1) Age 35 – 39 – a single baseline mammography;
- 2) Age 40 and older – yearly; and
- 3) A mammogram at the age and intervals considered Medically Necessary, as recommended by a Physician, for any woman who is at risk for breast cancer. A woman is considered at risk for breast cancer if any one or more of the following is true:
 - (i) The woman has a personal history of breast cancer.
 - (ii) The woman has a personal history of biopsy-proven benign breast disease;
 - (iii) The woman's mother, sister, or daughter has or has had breast cancer; or
 - (iv) The woman has not given birth prior to the age of 30.

This benefit is not subject to the [In-Network] Calendar Year Deductible or Daily Deductible, Outpatient Diagnostic Testing Copay, [Physician Office Visit Copay] and Coinsurance. [If the Covered Person uses an Out-of-Network Provider, the Out-of-Network [Calendar Year Deductible or Daily Deductible] [Copay] and Coinsurance requirements apply.] Additional mammograms needed for the Medically Necessary treatment of a covered Sickness will be considered under the Policy as a Covered Charge and benefits are payable on the same basis as other covered radiologic diagnostic tests.

- c. One cervical smear or pap smear for the early detection of cervical cancer and endometrial cancer per Calendar Year, and as needed upon certification by an attending Physician that the test is Medically Necessary [and the Physician's office visit in connection with the cervical or pap smear]. Examination and laboratory tests, which means conventional pap smear screening, liquid-based cytology, and human papilloma virus (HPV) detection methods for women with equivocal findings on cervical cytologic analysis that are subject to the approval of and have been approved by the United States Food and Drug Administration.

This benefit is not subject to the [In-Network] Calendar Year Deductible or Daily Deductible, Outpatient Diagnostic Testing Copay, [Physician Office Visit Copay] and Coinsurance. [The office visit is subject to the [Calendar Year Deductible or Daily Deductible,] Physician's Office Visit Copay and Coinsurance.] [If the Covered Person uses an Out-of-Network Provider, the Out-of-Network [Calendar Year Deductible or Daily Deductible] [Copay] and Coinsurance requirements apply.]

- d. One digital rectal examination and a prostate cancer screening known as Prostate Specific Antigen (PSA) test [and the Physician's office visit in connection with the examination] per Calendar Year for male insureds age 50 and over; and for male insureds age 40 and over who are in high-risk categories according to the most current American Cancer Society prostate cancer screening guidelines. A person may be at high risk for prostate cancer if they are an African-American male and men with a strong family history of one or more first-degree relatives {father, brothers} diagnosed with prostate cancer before age 65.

Additional screenings needed during the Calendar Year for the Medically Necessary treatment of a covered Sickness will be considered under the Policy as a Covered Charge and benefits are payable on the same basis as other covered diagnostic tests.

- e. Colorectal cancer examinations and laboratory tests for colorectal cancer [and the Physician's office visit in connection with this cancer screening] for Covered Persons who are 50 years of age or older, or less than fifty (50) years of age and at high risk for colorectal cancer according to the most current American Cancer Society colorectal cancer screening guidelines.

A person may be at high risk for colorectal cancer if they have any of the following colorectal cancer risk factors:

- a personal history of colorectal cancer or adenomatous polyps;
- a strong family history of colorectal cancer or polyps (cancer or polyps in a first-degree relative {parent, sibling, or child} younger than 60 or in 2 first-degree relatives of any age);
- a personal history of chronic inflammatory bowel disease;
- a family history of an hereditary colorectal cancer syndrome (familial adenomatous polyposis or hereditary non-polyposis colon cancer).

The colorectal cancer screening and examination, includes the following:

- (i) An annual fecal occult blood test utilizing the take-home multiple sample method, or an annual fecal immunochemical test; and
- (ii) Flexible sigmoidoscopy every five years; or
- (iii) Double contrast barium enema every five years; or
- (iv) Colonoscopy every ten years.

Additional screening services needed for the Medically Necessary treatment of a covered Sickness will be considered under the Policy as a Covered Charge and benefits are payable on the same basis as other covered diagnostic tests.

- [f. Routine physical examinations [when provided by an In-Network Provider] [after the Covered Person has been covered under the Policy as specified in the Schedule of Benefits] as follows:
 - a. one routine physical examination of the heart, lungs and abdomen by a Physician per Calendar Year;
 - b. such diagnostic tests as may be required, and that are performed during the routine physical examination or in conjunction with the exam;
 - c. an evaluation of the Covered Person's general health status by his or her primary Physician; [and]
 - d. an annual flu shot; [and]
 - e. [Human Papillomavirus Vaccines, approved by the U.S. Food and Drug Administration and administered in accordance with the recommendations by the Advisory Committee on Immunizations Practices.]]

- 11. Outpatient diabetes self-management training and education, equipment and supplies for the treatment of type 1 diabetes, type 2 diabetes, and gestational diabetes mellitus including:

- a. the purchase of the following equipment and supplies when Medically Necessary and prescribed by a Physician. [Covered Charges which are payable under the Prescription Medication Benefit Rider, if Rider has been issued as specified in the Schedule of Benefits, will be paid in accordance with the terms and provisions of that Rider rather than under this benefit];
 - 1) visual reading and urine testing strips;
 - 2) insulin pumps and appurtenances thereto;
 - 3) insulin infusion devices;
 - 4) podiatric appliances for prevention of complications associated with diabetes;
 - 5) blood glucose monitors;
 - 6) blood glucose monitors for the legally blind;
 - 7) test strips for glucose monitors;
 - 8) insulin;
 - 9) injection aids;
 - 10) cartridges for the legally blind;
 - 11) syringes;
 - 12) lancets and lancing devices; and
 - 13) oral agents for controlling blood sugar.

- b. regular foot care exams by a Physician.
 - c. self-management training, including medical nutrition education limited to:
 - 1) Up to [3] visits to a qualified provider upon initial diagnosis of diabetes by a Covered Person's Physician; and
 - 2) Up to [2] visits to a qualified provider upon a determination by a Covered Person's Physician that a significant change in the Covered Person's symptoms or medical condition has occurred.
 - d. For the purposes of this benefit, the following definitions apply:
 - 1) "Diabetes self-management training" means instruction in an Outpatient setting which enables a diabetic patient to understand the diabetic management process and daily management of diabetic therapy as a means of avoiding frequent hospitalization and complications. Diabetes self-management training shall include the content areas listed in the National Standards for Diabetes Self-Management Education Programs as published by the American Diabetes Association, including medical nutrition therapy.
 - 2) A "qualified provider" is a certified, registered, or licensed health care professional with expertise in diabetes management to whom the Covered Person has been referred by a Physician.
 - 3) A "significant change" in condition means symptomatic hyperglycemia (greater than 250 mg/dl on repeated occasions), severe hypoglycemia (requiring the assistance of another person), onset or progression of diabetes, or a significant change in medical condition that would require a significantly different treatment regimen.
12. Oral surgery including cutting procedures for the treatment of tumors, abscesses or cysts or injuries to the jaw.
13. Physical, Speech or Occupational Therapy as follows:
- a. Services of a licensed professional physiotherapist or physical therapist for physiotherapeutic Rehabilitative Treatment, when such services are prescribed by a Physician;
 - b. Services of a licensed professional occupational therapist for Rehabilitative Treatment to increase function, enhance development and prevent disability, including adaptive tasks to achieve maximum independence and optimum quality of life, when prescribed by a Physician; and
 - c. Services of a licensed professional speech therapist as part of Rehabilitative Treatment in a Home Health or appropriate Outpatient setting, except that Charges for voice training or a lisp are not covered.
14. Transplant services as follows:
- a. The following Human Organ and Tissue Transplant Services are Covered Charges if incurred during a Transplant Benefit Period:
 - 1) Allogenic bone marrow transplant or peripheral stem cell support;
 - 2) Autologus bone marrow transplants;
 - 3) Cornea transplants;
 - 4) Heart transplants;
 - 5) Heart-lung transplants;
 - 6) Kidney transplants;
 - 7) Living related segmental simultaneous pancreas kidney transplant;
 - 8) Lung transplants;
 - 9) Pancreas transplants;
 - 10) Liver transplants;
 - 11) Pancreas-kidney transplants; and
 - 12) Small bowel transplants.

- b. This benefit is payable only if the Covered Person receives two opinions on the need for transplant surgery. These opinions must be given: (1) by a board certified specialist in the involved field of surgery; and (2) in writing. The specialist must certify that alternative procedures, services or courses of treatment would not be effective in the treatment of the Covered Person's condition.
- c. The following are Covered Charges if incurred during a Transplant Benefit Period in connection with a transplant specifically listed in paragraph a. above:
 - (a) Hospital room and board and medical supplies for the Covered Person transplant recipient;
 - (b) Diagnosis, treatment and surgery by a Physician;
 - (c) Outpatient nursing care by a Registered Nurse (RN);
 - (d) The rental of wheelchairs, hospital-type beds and other mechanical equipment required to treat respiratory impairment;
 - (e) Local ambulance service, medication, x-rays, imaging and other diagnostic services, laboratory tests or oxygen;
 - (f) Rehabilitative Therapy consisting of speech therapy (not for voice training or a lisp); audio therapy, visual therapy, occupational therapy and physiotherapy; and
 - (g) Surgical dressings and supplies.
- d. If a Center of Excellence is used, the following are Covered Charges in connection with a transplant specifically listed in paragraph a. above. If a Center of Excellence is not used, Charges incurred for the following are not covered:
 - (a) Transportation of the recipient and a companion to and from the site of the transplant. If the Covered Person is a minor, transportation of two persons who travel with the minor is included;
 - (b) Room and board for the Covered Person transplant recipient's companion(s);
 - (c) Ventricular assist devices are only covered when provided as a bridge to the transplantation of a human heart. Ventricular assist devices are not covered as an artificial heart.
- e. No benefits are payable for the following Charges for Human Organ and Tissue Transplant Services:
 - 1) Not ordered by a Physician; or
 - 2) Not performed in the United States; or
 - 3) For which a Covered Person would not legally have to pay if there were no insurance; or
 - 4) For an Injury or Sickness due to employment with any employer or self-employment; or
 - 5) For Custodial Care; or
 - 6) For a Pre-Existing Condition; or
 - 7) That are animal to human transplants; or
 - 8) That use artificial and/or mechanical organs; or
 - 9) That are not generally accepted by the general medical community as an effective treatment for a covered Injury or Sickness; or
 - 10) That are specifically excluded under the Policy; or
 - 11) Not provided in connection with a transplant specifically listed in paragraph a. above.
- f. If a covered Human Organ and Tissue Transplant is not done as scheduled due to the Covered Person's medical condition or death, the Covered Person's Charges incurred for organ and tissue procurement and transportation will be considered Covered Charges.
- g. Covered Charges related to a covered Human Organ and Tissue Transplant will be applied toward the Lifetime Maximum Benefit for Human Organ and Tissue Transplants and the Lifetime Maximum Benefit for all Benefits While Covered Under the Policy as specified in the Schedule of Benefits, as follows:

- 1) When both the recipient and the donor are Covered Persons, Covered Charges incurred by each person will be applied toward their separate Lifetime Maximum Benefit for Human Organ and Tissue Transplants; and
- 2) When only the recipient is a Covered Person, Covered Charges incurred by the donor, in excess of the benefits provided by other coverage, will be eligible for payment under the Policy after payment of the Covered Person's Covered Charges. The donor's Covered Charges will be applied and limited to the Covered Person's Lifetime Maximum Benefit for Human Organ and Tissue Transplants; and
- 3) When only the donor is a Covered Person, Covered Charges related to the covered transplants will be provided only in excess of the amounts paid by the recipient's coverage. The Covered Charges will be applied towards the donor's Lifetime Maximum Benefit for Human Organ and Tissue Transplants. If the recipient does not have insurance coverage, the Charges incurred by the Covered Person as the donor, are not Covered Charges.

h. For purposes of this transplant benefit, the following definitions apply:

- 1) For a Covered Person transplant recipient, Human Organ and Tissue Transplant service means:

Organ and tissue procurement which consists of removing, preserving and transporting the donated part.

- 2) Transplant Benefit Period means:

The period beginning [5] days before the date of the human organ or tissue transplant and ending [6] months after the organ or tissue transplant is performed. Two or more transplant benefit periods are treated as follows:

- (a) If they are due to unrelated causes, they are treated as separate periods.
- (b) If they are due to related causes, they are treated as separate periods if:
 - 1) For the Insured Person they are separated by his or her return to active work; or
 - 2) For the Insured Person's covered Dependent, they are separated by at least three consecutive months.
- (c) If they are due to related causes, they are treated as one period when not separated as specified in Section (b), above.

15. Outpatient treatment of Chemical Dependency Disorders [if specified on the Schedule of Benefits as a Covered Charge].

16. [Inpatient] [and] [Outpatient] treatment of Mental or Nervous Disorders by a Physician, Psychologist, or a mental health professional [if specified on the Schedule of Benefits as a Covered Charge]. [If specified as a Covered Charge on the Schedule of Benefits,] Covered Charges include: (a) diagnostic evaluation; (b) individual Outpatient mental health care; and (c) Inpatient mental health care in a licensed Facility. [[Group Outpatient mental health care visits may be substituted on a two-for-one basis for individual Outpatient mental health care visits as deemed appropriate by the attending Physician.] [Care in a Day Treatment Program may be substituted on a two-for-one basis for Inpatient Hospital care as deemed appropriate by the attending Physician.]]

17. Hospice Care Services provided under active management through a Hospice which is responsible for coordinating all Hospice care services and which are provided for a Covered Person who is terminally ill and is expected to die within [6] months. [Hospice Care services must be approved through Pre-certification. if required and specified on the Schedule of Benefits.]

a. Covered Charges under the Hospice benefit include:

- 1) Room and board Charges by the Hospice and continuous home care provided that prior approval has been received from the interdisciplinary team of the Hospice;
- 2) Professional nursing services provided by or under the supervision of a Registered Nurse;
- 3) Home health aide services under the supervision of a Registered Nurse or specialized Rehabilitative therapist;
- 4) Physical therapy;
- 5) Respiratory and inhalation therapy;
- 6) Nutrition counseling by a nutritionist or dietitian;
- 7) Medical social services;
- 8) Family counseling related to the Covered Person's terminal condition;
- 9) Respite care; and
- 10) Bereavement support services for the Covered Person's family during the [3]-month period after death, but not to exceed \$[250].

b. The following are not Covered Charges:

- 1) Services or supplies for personal comfort or convenience; or
- 2) Meals or food services other than dietary counseling; or
- 3) Services provided by volunteers.

18. Home Health Care Services when provided in the Covered Person's home by a Home Health Care Agency.

a. Home Health Care services must be:

- 1) Provided upon the recommendation and under the care and direction of a Physician; and
- 2) In lieu of Hospital services; [and]

[3. approved through Pre-certification, if required and specified on the Schedule of Benefits. Review of Medical Necessity may be periodically required.]

b. Home Health Care Services are Covered Charges only if provided by:

- 1) A Registered Nurse or a licensed practical nurse; or
- 2) A therapist to provide physical, occupational or speech therapy; or
- 3) A home health aide, while under the supervision of a Registered Nurse.

c. Each visit up to 4 hours in any 24-hour period will be considered one visit.

d. The following are not Covered Charges:

- 1) Homemaker services or domestic maid services; or
- 2) Sitter or companion services; or
- 3) Services or supplies rendered by an employee of an adult congregate living center; an adult foster home; an adult day care center; or a nursing home facility; or
- 4) Charges incurred after a period of 7 consecutive days in which a Covered Person: (i) receives no Home Health Care Services; and (ii) is not Confined to a Hospital or Skilled Nursing Facility.

19. Non-Surgical Back Treatment [if specified on the Schedule of Benefits as a Covered Charge and] provided that the services must be performed by a Physician to meet the functional needs of the Covered Person and the treatment must be designed to accomplish a specific diagnosis-related goal which enables the Covered Person to achieve measurable improvement in a reasonable and predictable length of time.

- a. The following Non-Surgical Back Treatment Services are Covered Charges:
 - 1) Initial medical history and physical examination of patient assessment and objective evaluation;
 - 2) Spinal adjustment and manipulation; and
 - 3) Physiological therapeutics used as an adjunct therapy prior to or in conjunction with spinal treatment.
- b. The following are not Covered Charges:
 - 1) Any service not specifically covered in the list of Covered Non-Surgical Back Treatment Services in paragraph a. above; or
 - 2) Thermography;
 - 3) Orthomolecular therapy; or
 - 4) Contact reflex analysis; or
 - 5) Bioenergetical synchronization techniques (BEST); or
 - 6) Iridology (study of the iris); or
 - 7) Stress management; or
 - 8) Dietary supplements; or
 - 9) Nutritional counseling; or
 - 10) Long term chronic care and maintenance/preventative/palliative care; or
 - 11) Experimental or investigative procedures as defined; or
 - 12) Three dimensional contour studies; or
 - 13) Lifestyle education.

20. Reconstructive procedures, or complications of such procedures, when such procedure is:

- a. incidental to or follows a covered Injury or Sickness occurring while coverage under the Policy is inforce, except reconstruction for post-mastectomy patients; or,
- b. performed on a covered Dependent Child who is 18 years of age or less because of congenital disease or anomaly that resulted in a functional defect as determined by the attending Physician as long as the covered Dependent Child was covered continuously under the Policy from birth.

[21.] [Medical treatment, services and supplies received in a Retail Health Clinic for the treatment of a covered Sickness or Injury. [Covered Charges are [not] subject to the [Calendar Year Deductible or Daily Deductible,] [Co-payments] [and] [or] [Coinsurance] requirements.] [If the Covered Person is covered under the PPO Plan, as specified on the Schedule of Benefits, Covered Charges will be paid at the In-Network Provider benefit level [subject to the Usual and Reasonable Charge].]]

[22.] [Electronic Consultations for non-urgent medical care, provided such Electronic Consultations are provided for the Medically Necessary treatment of a covered Sickness or Injury and in accordance with generally accepted health care practices and standards prevailing in the applicable professional community at the time the Electronic Consultation is rendered. [[If the Covered Person is covered under the PPO Plan, as specified on the Schedule of Benefits,] Covered Charges are subject to the [[In-Network] Physician Office Visit Co-pay] [and] [In-Network] Physician Office Visit Coinsurance] as specified in the Schedule Benefits.] [[Covered Charges will be paid [at the In-Network Provider benefit level [subject to the Usual and Reasonable Charge]] [up to a maximum benefit of [\$35] per Electronic Consultation [and a maximum of [3] Electronic Consultations per [calendar week] [day]] per Covered Person].]

To be considered a Covered Charge, Electronic Consultations must meet all of the following conditions:

- 1. The Covered Person is currently a patient of and under the care of the Physician rendering the Electronic Consultation;
- 2. The Physician provides online medical evaluation and management service in response to the Covered Person's request; and
- 3. The Physician maintains all documentation related to the Electronic Consultation in the Covered Person's medical file, including:
 - a. written documentation of the Covered Person's condition and symptoms;
 - b. the Physician's diagnosis and plan of treatment; and
 - c. the name and dosage of any medications prescribed.

The following are not Covered Charges under this benefit:

1. Urgent medical needs or urgent message responses; or
2. Appointment scheduling, cancellations or rescheduling, or reminders of scheduled office visit appointments; or
3. Refilling, renewing or transferring existing prescriptions; or
4. Scheduling of diagnostic tests or the reporting of normal test results; or
5. Providing counseling, instructional or educational training or materials.]

[23.] [Telephone medical consultation with a [In-Network] Physician for non-emergency health care, provided such consultation is provided for the Medically Necessary treatment of a covered Sickness or Injury. [Benefits are subject to a [\$35] telephone consultation fee per consultation.] [[If the Covered Person is covered under the PPO Plan, as specified on the Schedule of Benefits,] Benefits are subject to the [[In-Network] Physician Office Visit Co-pay] [and] [In-Network] Physician Office Visit Coinsurance] as specified on the Schedule of Benefits.] [Benefits are payable up to a maximum benefit of [\$35] per consultation [and a maximum of [3] consultations per [calendar week] [day] per Covered Person].]

[To be considered a Covered Charge, telephone medical consultations must meet all of the following conditions:

1. The Covered Person is currently a patient of and under the care of the Physician rendering the telephone medical consultation; and
2. The Physician maintains all documentation related to the telephone consultation in the Covered Person's medical file, including:
 - a. written documentation of the Covered Person's condition and symptoms;
 - b. the Physician's diagnosis and plan of treatment; and
 - c. the name and dosage of any medications prescribed.]

[The following are not Covered Charges under this benefit:

1. Urgent medical needs or urgent message responses; or
2. Appointment scheduling, cancellations or rescheduling, or reminders of scheduled office visit appointments; or
3. Refilling, renewing or transferring existing prescriptions; or
4. Scheduling of diagnostic tests or the reporting of normal test results; or
5. Providing counseling, instructional or educational training or materials.]

SECTION 5 – EXCLUSIONS AND LIMITATIONS FROM COVERAGE

The Policy contains certain exclusions and limitations as described. **EXCEPT AS SPECIFICALLY PROVIDED FOR IN THE POLICY AS SPECIFIED IN SECTION 4 – BENEFITS**, Charges for any services, supplies, and treatment as described below will not be considered as Covered Charges under the Policy and no benefits will be payable for such Charges. The Policy does not provide any benefits for the following Charges, treatment, services or supplies for or related to:

1. A Pre-Existing Condition until a continuous period of [24 months] has elapsed from the Covered Person's Effective Date. [A Pre-existing condition will be considered a Covered Charge at the end of a continuous [12-month] period following the Covered Person's Effective Date of coverage if it is duly disclosed in the Application for coverage of the Covered Person and otherwise covered by the Policy, unless the condition is specifically excluded by Endorsement or Rider attached to this Certificate.]; or
2. Equipment including, but not limited to, modifications to motor vehicles or motor homes such, as wheelchair lifts or ramps; water therapy devices, such as Jacuzzi's or hot tubs; and exercise equipment; or
3. Physical examinations, immunizations and check-ups which are not Medically Necessary for the treatment of Injury or Sickness, [unless the [Optional] Preventive Care Benefit Rider is specified as applicable on the Schedule of Benefits]; or
4. Prophylactic Treatment, surgery or diagnostic testing; or

5. Outpatient Prescription Medications, including, but not limited to, Specialty Medications [unless the [Optional] Prescription Medication Benefit Rider is specified as applicable on the Schedule of Benefits]; or
6. Any service or supply in connection with the implant of an artificial organ; or
7. Any treatment, service, supply, or Prescription Medication which: (a) is not due to a Sickness or Injury; (b) is not recommended by a Physician; or (c) is not Medically Necessary; or
8. Treatment, services or supplies for which no Charge is made or for which the Covered Person is not required to pay; or
9. Any treatment, service or supply provided by a government owned or operated facility or by government employed health care providers, unless the Insured Person is legally required to pay the Charges incurred or We are required to provide reimbursement by local, state or federal law; or
10. Hospital and Physician Charges for weekend Hospital admissions occurring between noon on any Friday and noon the following Sunday for non-emergency procedures, unless Medically Necessary or unless surgery is scheduled for the next day; or
11. An Injury or Sickness which arises out of or in the course of any employment for wage or profit [This exclusion does not apply to employment related Injuries or Sicknesses if the Covered Person is a sole proprietor, partner, owner [or other person] eligible under state law to legally elect to not be covered under Workers' Compensation and who are not insured under, or who has or had a right to recovery under, any Workers' Compensation Law or Occupational Disease Law]; or
12. Physical or psychological examinations required by any third party, such as by a court or for employment, licensing, insurance, school, sports or recreational purposes, and the completion of any forms for such examinations; or
13. An Injury or Sickness incurred while on active duty with the military of any country or international organization; or
14. An Injury or Sickness resulting from war or any act of war (declared or undeclared) or the participation in a riot or insurrection; or
15. An Injury or Sickness incurred: (a) during the commission or attempted commission of a crime or felony or while engaged in an illegal act; or (b) while imprisoned; or
16. Treatment, services or supplies for any loss sustained, incurred due to, or contracted as a consequence of a Covered Person: (a) being intoxicated; or (b) being under the influence of any narcotic, barbiturate, hallucinatory or other drug, unless administered by a Physician and taken in accordance with the prescribed dosage; or (c) being under the influence of any illegal drug as defined by state or Federal law. A Covered Person is conclusively determined to be intoxicated by drug or alcohol if a test, including but not limited to a chemical or breath test, administered in the jurisdiction where the loss or cause of loss occurred is at or above the legal limit set by that jurisdiction; or
17. Treatment, services or supplies related to: (a) the teeth; gums and any other associated structures except for tumors, cuts, and injuries; (b) the prevention or correction of teeth irregularities and malocclusion of jaws by wire appliances, braces or other mechanical aids; (c) dental implants, regardless of the cause; and (d) extraction of impacted, unerupted teeth; or
18. Treatment, services or supplies as the result of prognathism, retrognathism, micrognathism, or any treatment, services or supplies to reposition the maxilla (upper jaw), mandible (lower jaw), or both maxilla and mandible, unless due to an Injury, which occurs while covered under the Policy, to Sound Natural Teeth, provided that such treatment is received within [12] months following the date of Injury; or
19. Treatment, services or supplies provided for temporomandibular joint (TMJ) dysfunction; or
20. Treatment, services or supplies to improve the appearance or self-perception of a Covered Person, which does not restore a bodily function including, but not limited to, cosmetic or plastic surgery, hair loss or skin wrinkling, or the complications of any such treatment; or
21. Treatment, services or supplies for: (a) breast augmentation; (b) the removal of breast implants unless Medically Necessary and related to surgery performed as reconstructive surgery due to a Sickness; and (c) breast reduction surgery unless Medically Necessary due to a Sickness; or
22. Surgery to correct refractive errors, such as radial keratotomy or radial keratectomy; or

23. Routine eye exams, glasses, visual therapy, or contact lenses, except for the first pair of glasses or lenses for use after cataract surgery; or
24. Routine hearing exams to assess the need for, or change to, hearing aids; and the purchase, fittings or adjustments of hearing aids; and the surgical or non-surgical treatment for the improvement of hearing including, but not limited to, the insertion of hearing aids or implants, [except if such treatment was incidental to or follows a covered Injury or Sickness occurring while coverage under the Policy is in force]; or
25. Contraceptive [drugs and.] devices, including, but not limited to, injectable, implantable or intradermal patch contraceptives, and any professional service fees related to the insertion or removal of such contraceptives, [unless prescribed by a Physician as Medically Necessary treatment of a Sickness]; or
26. Pregnancy and related services of a Covered Person [unless the [Optional] Maternity Benefit Rider is specified as applicable on the Schedule of Benefits]; or
27. A newborn's well baby Charges including, but not limited to, Hospital expenses, nursery Charges and Charges incurred for circumcision [unless the [Optional] Maternity Benefit Rider is specified as applicable on the Schedule of Benefits]; or.
28. Penile implants and fertility and sterility studies; or
29. Treatment, services or supplies: (a) to restore or enhance fertility; or (b) to reverse sterilization; or
30. Vasectomy or tubal ligation for the purpose of voluntary sterilization; or
31. Impregnation techniques such as: (a) artificial insemination; or (b) in vitro fertilization; including but not limited to: artificial insemination, in vitro zygote and intra-fallopian transfers, gamete intra-fallopian transfer, genetic counseling, and all Charges related to such in vitro fertilization; or
32. Voluntary abortion; except if the life of the mother would be in danger if the fetus were carried to term, or except for complications of a voluntary abortion; or
33. The non-therapeutic release of nuclear energy; or
34. Hypnosis; or
35. Attempted suicide or intentionally self-inflicted Injury or Sickness, while sane or insane; or
36. Treatment, services or supplies for [Inpatient] Chemical Dependency Disorders; or
37. The voluntary taking of poison; or
38. The voluntary inhaling of gas; or
39. Treatment, services or supplies to eliminate or reduce a dependency on or an addiction to tobacco, including but not limited to: nicotine withdrawal programs; nicotine products, such as transdermal patches and gums; hypnotism; and goal oriented behavioral modification; or
40. Marriage or family counseling, or
41. Any therapy not listed as a Covered Charge including, but not limited to massage therapy, recreational therapy, equine therapy, hippotherapy, educational therapy, social therapy, art therapy, music therapy, sex therapy; or any speech or occupational therapy if the therapy is in connection with or related in any way to the treatment of a learning disability, speech impediment, or developmental delay even if therapy is recommended due to organic dysfunction, including, but not limited to, congenital deformity or birth trauma; or
42. Sexual reassignments or sexual dysfunctions or inadequacies; or
43. Meridian therapy (acupuncture), except when used in lieu of an anesthetic; or
44. Treatment, services or supplies related to paring or removal of corns, calluses, bunions or toenails (other than partial or complete removal of nail roots), except when prescribed by an attending Physician who is treating the Covered Person for a metabolic disease, such as diabetes mellitus or a peripheral-vascular disease such as arteriosclerosis; or
45. Treatment, services or supplies related to the feet by means of posting or strapping, or range of motion studies; or
46. Orthotics; or

47. Treatment, services, supplies for obesity, extreme obesity, Morbid Obesity or weight reduction, including, but not limited to, wiring of the teeth and all forms of surgery including, but not limited to, bariatric surgery, intestinal bypass surgery and complications resulting from any such surgery; or
48. Treatment, services or supplies received from a Physician, Nurse or other provider if such provider: (a) is a Close Relative of the Insured Person; or (b) lives in the same household as the Covered Person, except for Charges rendered while a Hospital Inpatient; or
49. Treatment, services or supplies received from a Physician, Nurse or other provider if such provider is an owner, partner, officer, director or employee of the same employer as the Covered Person; except for Charges rendered while a Hospital Inpatient; or
50. Treatment, services or supplies that are Experimental Medical Treatment, Procedure or Medication; or
51. Any surgical removal of an organ or tissue unless Medically Necessary; or
52. Private duty nursing; or
53. Any over-the-counter medication or medication that may be obtained without a prescription; or
54. Custodial Care, regardless of who prescribes or renders such Care; or
55. Treatment, services or supplies received or purchased outside the United States unless the Charges are incurred while traveling on business or for pleasure, for a period not to exceed [90] days, and the Charges are incurred for Urgent Care, provided the treatment, services or supplies used in connection with the Urgent Care are approved for use in the United States; or
56. Any education or training materials including, but not limited to, programs or materials for pre-natal education and management of pain, asthma and heart disorders; or
57. Inpatient personal convenience items including, but not limited to, beauty or barber services, radio and television, massages, telephone Charges, take home supplies, guest meals, and motel accommodations; or
58. [[Telephone] [and email] consultations], missed appointment fees, fees for completing Claim forms, fees related to obtaining Hospital Pre-Certification, and fees related to the provision of medical records; or
59. Treatment, services or supplies for complications of conditions that are not covered under the Policy except for complications of a voluntary abortion; or
60. [[Non-Emergency Care ambulance services,] [Durable Medical Equipment that exceeds \$[1000]] [and] [Prescription Medications listed in Section 6, Paragraph B,] unless Pre-Determined]; or
62. Any conditions specifically excluded by Riders, Endorsements, or exclusions attached to this Certificate.
63. Charges incurred after coverage under the Policy terminates, regardless of when the condition originated; or
64. Charges in excess of the Usual and Reasonable charges; or
65. Charges incurred to treat complications resulting from treatment, drugs, supplies, devices, procedures or conditions which are not covered under the Policy; or
66. Charges determined by Us to be Unbundled Charges; or
- [67. Treatment, services or supplies for Outpatient treatment of Chemical Dependency Disorders, if specified as not covered on the Schedule of Benefits; or]
- [68. Treatment, services or supplies for [Inpatient] [and] [Outpatient] treatment of Mental or Nervous Disorders by a Physician, Psychologist, or a mental health professional, if specified as not covered on the Schedule of Benefits; or]
- [69. Non-Surgical Back Treatment, if specified as not covered on the Schedule of Benefits] [or]
- [70. [Charges incurred, prior to the date the Covered Person has been covered under the Policy for [6] consecutive calendar months for the care or treatment of:
 - hernia;
 - removal of adenoids;
 - varicose veins;
 - hemorrhoids;
 - middle ear disorders;
 - any disease or disorder of the reproductive organs;

- the knees or hips, including, but not limited to, any surgical treatments; or
- laminectomy, discectomy or spinal fusion.

Any such condition may also be excluded as a Preexisting Condition. This limitation shall not apply to services provided for an Emergency where such condition is not excluded as a Preexisting Condition.

This exclusion will not apply to a Covered Person receiving treatment due to a malignancy, provided such treatment is not being rendered to a Preexisting Condition.]

SECTION 6 – ACCESSING AND ADMINISTERING YOUR BENEFITS

A. Managed Care

Health Care Coordination

Health Care Coordination is a program conducted by the case coordinator designated by Us which:

1. Identifies cases in which a Covered Person has a Sickness or Injury which is complicated, complex or which has the potential for catastrophic claims;
2. Assesses the appropriateness of the Covered Person's level of patient care and the setting in which it is received;
3. Develops, introduces and implements viable alternate treatment plans for such cases that maintain or enhance the quality of patient care; and
4. Maximizes benefits through implementation of the agreed upon alternate treatment plan.

The alternate treatment plan is a specific written plan developed by the case coordinator through discussion and agreement with the Covered Person or the Covered Person's legal guardian (if necessary), the Physician and Us. It includes:

1. Treatment plan objectives;
2. Course of treatment planned to accomplish such objectives;
3. Responsibility of each party (case coordinator, attending Physician and Covered Person and his family, if any) in implementing the plan; and
4. Estimated cost and savings.

If We agree with the case coordinator, the attending Physician and Covered Person on an alternate treatment plan, We may pay incurred Covered Charges at a higher percentage for treatment, services or supplies as specified in the alternate treatment plan. In the event the approved alternate treatment plan specifies services or supplies not considered as Covered Charges under the terms and provisions of the Policy, payment of benefits under the Policy for such treatment, services or supplies shall be contingent upon written approval by Us or Our authorized Plan Administrator. If such written approval is granted, payment of benefits under the Policy for such treatment, services or supplies shall be on the same basis as if such treatment, services or supplies were Covered Charges under the terms and provisions of the Policy.

No Covered Person is required, in any way whatsoever, to accept an alternate treatment plan recommended by the case coordinator.

Pre-Certification Program

The Pre-Certification Program is applicable to all Inpatient Confinements for Injury or Sickness, including Complications of Pregnancy and medical treatment and services as specified on the Schedule of Benefits.

The Pre-Certification penalty amount is specified in the Schedule of Benefits applicable to Covered Charges incurred in connection with an Inpatient Confinement or specific medical treatment and services when the Covered Person does **NOT** comply with Pre-Certification. The Pre-Certification penalty amount is in addition to the applicable Calendar Year Deductible or Daily Deductible, Copayments and Coinsurance. If the Covered Person complies with Pre-Certification, the Pre-Certification penalty amount will not apply.

Pre-Certification is a screening process using established medical criteria to determine whether the proposed length of stay and date of an Inpatient Confinement, the proposed treatment plan, or the proposed services or supplies are Medically Necessary and being provided in an appropriate setting. It may also include proposing alternative treatment plans and continued stay review.

The Policy requires Pre-Certification of all proposed Inpatient Confinements as defined by the Policy for more than 23 hours. Pre-Certification is also required of proposed medical treatment and services, as specified on the Schedule of Benefits.

Pre-Certification of Non-Emergency Care

To request Pre-Certification, the Insured Person or the Covered Person's attending Physician must contact the designated Pre-Certification service at least [7] days prior to each Inpatient Confinement or obtaining the treatment or, service as specified on the Schedule of Benefits. The Pre-Certification service may be reached by writing, or by telephone during normal business hours each business day. The name of the Pre-Certification service and instructions are provided to each Insured Person. The Insured Person or Physician will be requested to provide:

1. name, address and the telephone number of the attending Physician;
2. the proposed treatment plan;
3. the Covered Person's authorization (or, if a minor, authorization on his behalf) to release medical information.

The Pre-Certification service will then consult with the Covered Person's attending Physician. If the Pre-Certification service concurs with the Covered Person's attending Physician with the appropriateness of the setting and Medical Necessity of the proposed treatment plan, the Pre-Certification service will notify the Insured Person in writing and the Insured Person will be deemed to have complied with the Pre-Certification requirement described herein.

The Pre-Certification service may also conduct a continued stay review for any ongoing Inpatient Confinement. The continued stay review is a process of monitoring a Covered Person's progress on a daily basis to determine if the Covered Person will be discharged within the Pre-certified number of days and to determine the appropriate number of additional days of Inpatient Confinement that may be required according to the Covered Person's condition and plan of treatment. Inpatient Confinements will be monitored to assure that the Covered Person will be discharged timely. The attending Physician and the Facility's utilization review nurses will be contacted to determine the progress of the Covered Person and the need, if any, for an extension of the length of stay of the Inpatient Confinement. If an extension of the Inpatient Confinement is not Pre-certified for all or part of the requested day(s), the Insured Person and the attending Physician will be notified.

If the Covered Person does not comply with Pre-Certification, Covered Charges are subject to the Pre-Certification penalty amount, as specified in the Schedule of Benefits.

Charges incurred for any Inpatient Confinement or treatment plan which extends beyond the number of days deemed by the Pre-Certification service to be Medically Necessary are not Covered Charges.

If the Pre-Certification service does not concur with the Covered Person's Physician, the Pre-Certification service will so notify the Insured Person in writing and the Insured Person will not be deemed to be in compliance with the Pre-Certification requirement described herein and the Pre-Certification penalty amount, as specified in the Schedule of Benefits, will apply to Covered Charges.

PRE-CERTIFICATION IS NOT A GUARANTEE OF PAYMENT. PAYMENT OF BENEFITS WILL BE DETERMINED BY US IN ACCORDANCE WITH AND SUBJECT TO ALL THE TERMS, CONDITIONS, LIMITATIONS AND EXCLUSIONS OF THE POLICY.

Pre-Certification of Emergency Care

Inpatient Confinements for Emergency Care must be Pre-certified in the same manner as a non-Emergency Inpatient Confinement; however, the Insured Person or the Covered Person's Physician may notify the Pre-Certification service of the Emergency Inpatient Confinement within [48] hours of the Inpatient admission or as soon as reasonably possible and be in compliance with the Pre-Certification requirement. The attending Physician must verify that an Emergency condition existed.

If the Covered Person does not comply with Pre-Certification for Emergency Care, Covered Charges are subject to the Pre-Certification penalty amount specified in the Schedule of Benefits.

[Pre-certification of Pregnancy

Please refer to the [optional] Maternity Benefit Rider, if specified as applicable on the Schedule of Benefits, for the Pre-certification of Pregnancy requirements.]

B. Pre-Determination of Non Emergency Care Ambulance Transportation Services, Durable Medical Equipment that exceeds \$[1000] and Certain Prescription Medications

Pre-Determination is required in order to receive any benefits for the Charges listed below. The Insured Person is responsible for assuring that the required Pre-Determination is received before the Charges are incurred by calling the designated Pre-Determination service. Failure to comply with the Pre-Determination requirement will result in no benefits being paid and no coverage for such Charges.

The Insured Person must obtain Pre-Determination for the following Charges. If the Insured Person does not obtain Pre-Determination, Charges incurred for the following are not Covered Charges:

1. Non-Emergency Care licensed professional Ambulance transportation services to transport a Covered Person to a Facility or from a Facility to another Facility. [and]
2. Durable Medical Equipment as provided in SECTION 4 – BENEFITS, Covered Charges, subsection 8 that exceeds \$[1000] [and]
- [3. The following Prescription Medications:
 - a. Specialty Medications including, but not limited to, growth hormones, insulin, chemotherapy immunosuppressants; *provided however*, injectible antibiotics, vitamins, allergen desensitizing agents, vaccines and local anesthetics do not require Pre-Determination.
 - b. Immunosuppressants;
 - c. AZT, Retrovir, Zidovudine or any HIV antiretroviral medication;
 - d. “Off Label” use, Orphan Drugs and Investigative New Drugs (IND);
 - e. Group “C” Cancer Drugs (drugs for specific types of tumors that have specified to have beneficial effect, but are awaiting FDA approval);

Pre-Determination of the above described Prescription Medications is required [only if the [Optional] Prescription Medication Benefit Rider is specified as applicable on the Schedule of Benefits.] [The Prescription Medications listed in sub-paragraph 3 above are covered only if the [Optional] Prescription Medication Benefit Rider is specified as applicable in the Schedule of Benefits and the Pre-Determination requirement has been met.]]

C. Provider Networks [– applicable if the Covered Person is covered under a PPO Plan, as specified on the Schedule of Benefits]:

Reimbursement for Covered Charges varies depending on the provider that the Covered Person selects to provide treatment, services or supplies. An In-Network Provider has affiliated with an organization, association or entity, such as a preferred provider organization or managed care organization that has established a network of providers in a specific geographic area to provide medical treatment, services and supplies at predetermined rates. An Out-of-Network Provider is a provider who is not participating in Your selected Network Provider Organization. There is a limited number of Network Provider Organizations We designate who contract with In-Network Providers. When You select a Network Provider Organization, it becomes the only Network Provider Organization under which In-Network Providers and benefits are accessible. Accessing Network Provider Organizations other than the Network Provider Organization that You select will not allow the Covered Person to receive In-Network benefits unless authorized by Us in advance. If treatment, services or supplies are obtained or received from an Out-Of-Network Provider, unless otherwise stated herein, the following applies: (i) Covered Charges will be reimbursed at the Out-Of-Network Benefit Level; (ii) Charges will be reduced to the Usual and Reasonable Charge, as determined by Us, for such treatment, service or supply before being considered a Covered Charge; and (iii) the Covered Person will be responsible for any portion of the Charges that exceed the Usual and Reasonable Charge for such treatment, service or supply.

We do not arrange or provide treatment, services or supplies. It is always the Covered Person’s responsibility to select a health care provider of their choice. We have no control over, and are not responsible for, the actions or lack of actions of any provider or provider organization pertaining to any treatment, services or supplies rendered to a Covered Person.

The In-Network service area is the geographical area in which In-Network Providers are located. Please call the toll-free telephone number on Your insurance identification card to obtain information about the service area and the participating providers within Your selected Network Provider Organization.

When a Covered Person receives treatment, services or supplies at an In-Network facility from an Out-of-Network anesthesiologist, assistant surgeon, pathologist or radiologist, Covered Charges will be paid at the In-Network Provider benefit level [subject to the Usual and Reasonable Charge].

APPLICABLE WHEN THE COVERED PERSON IS COVERED UNDER A PPO PLAN AND THE SCHEDULE OF BENEFITS PROVIDES IN-NETWORK PROVIDER BENEFITS: If a Covered Person is taken to an Out-Of-Network Physician or Facility for Emergency Care, benefits will be paid by Us at the In-Network level of benefit as specified in the Schedule of Benefits [subject to the Usual and Reasonable Charge]. However, the Insured Person must arrange transfer to an In-Network Hospital within [48] hours, or as soon as the transfer may take place without detriment to the Covered Person's health. Otherwise, benefits will be reduced to the Out-Of-Network Provider benefit level [subject to the Usual and Reasonable Charge].

When a Covered Person receives treatment, services or supplies outside the In-Network service area for a Sickness or Injury with symptoms which arise suddenly and require immediate care and treatment while traveling out of the In-Network service area for business or vacation, Covered Charges received from Out-of-Network Providers will be paid at the In-Network Provider benefit level [subject to the Usual and Reasonable Charge] provided such treatment, services or supplies were not pre-arranged or pre-scheduled prior to the Covered Person's trip and were received or purchased within the United States.

[When an Insured Dependent Child is a full-time student actively attending an accredited college, vocational or high school outside the In-Network service area [for more than [ninety (90)] days], Covered Charges received from Out-of-Network Providers will be paid at the In Network Provider benefit level [subject to the Usual, Reasonable and Customary Charge] provided such Charges were received or purchased within the United States.]

[When an Insured Dependent Child lives apart from You and resides outside the In-Network service area [for more than [ninety (90)] days], Covered Charges received from Out-of-Network Providers will be paid at the In Network Provider benefit level [subject to the Usual, Reasonable and Customary Charge] provided such Charges were received or purchased within the United States.]]

D. Subrogation/Right of Reimbursement

As a condition to receiving benefits under the Policy, Covered Person(s) agree to transfer to Us their right to recover damages to the extent of benefits paid by Us when an Injury or Sickness occurs through the act or omission of another person. If a Covered Person received payment from another person or entity on account of, due to, or arising out of an Injury or Sickness, the Covered Person agrees to reimburse Us to the full extent of Covered Charges paid. If a repayment agreement is required to be signed, all rights of recovery are transferred to Us regardless of whether it is actually signed. It is only necessary that the Injury or Sickness occur through the act or omission of another person or entity. Our rights of full recovery may be from any other person or entity, any liability or other insurance covering such other person or entity party, the Covered Person's own uninsured motorist insurance, underinsured motorist insurance, any medical payments, no-fault, workers compensation or school insurance coverages which are paid or payable. We may enforce Our reimbursement rights by requiring the Covered Person to assert a claim to any of the foregoing coverages to which the Covered Person may be entitled. Covered Person(s) shall provide all requested accident and insurance information to Us. We shall not be required to pay any portion of Covered Person's attorneys' fees or other costs associated with a claim/lawsuit.

E. Audit Expense Benefits

If a Covered Person discovers an error on any Claim submitted by a Provider or Facility for Covered Charges, We will pay the Insured Person a reward for those errors brought to Our attention in the amount of [50]% of the reduction in Covered Charges, up to \$[1000] per Calendar Year, that results from the Covered Person's discovery. Proof of errors made by the Provider or Facility will be satisfied by comparing the final billing with the errors and subsequent itemized billing giving credit for such errors. The Provider or Facility must acknowledge such errors on a form acceptable to Us. **We reserve the right to determine the amount of the reduction in Covered Charges and the right to hold payment of the reward until the Provider or Facility acknowledges the accuracy of the Covered Person's discovery of the error.**

SECTION 7 – COORDINATION OF BENEFITS

Applicability

1. This Coordination of Benefit ("COB") provision applies to the Policy ("This Plan") when a Covered Person has health care coverage under more than one Plan. "Plan" and "This Plan" are defined below.
2. If this COB provision applies, the order of benefit determination rules ("Rules") should be looked at first. Those Rules determine whether the benefits of This Plan are determined before or after those of another Plan. The benefits of This Plan:
 - a. shall not be reduced when, under the Rules, This Plan determines its benefits before another Plan; but
 - b. may be reduced when, under the Rules, another Plan determines its benefits first.

Definitions

1. "Plan" is any of these which provides benefits or services for, or because of, medical or dental care or treatment:
 - a. Group insurance or group-type coverage, whether insured or self-insured. This includes: (1) prepayment; (2) group or individual practice; (3) individual and group type automobile and homeowners coverage. This does not include: (1) student accident; (2) blanket; or (3) franchise individual;
 - b. Coverage under a governmental plan (including Medicare) where required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act as amended from time to time.) It also does not include any plan when, by law, its benefits are in excess to those of any private insurance program or other non-governmental program.

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

2. "This Plan" is the part of the Policy that provides benefits for health care expenses.
3. "PRIMARY PLAN"/"SECONDARY PLAN." The Rules state whether This Plan is a Primary Plan or Secondary Plan as to another Plan covering the person.

When this Plan is a Primary Plan, its benefits are determined before those of the other Plan and without considering the other Plan's benefits.

When This Plan is a Secondary Plan, its benefits are determined after those of the other Plan and may be reduced because of the other Plan's benefits.

When there are more than two Plans covering the person, This Plan: (a) may be a Primary Plan as to one or more other Plans; and (b) may be a Secondary Plan as to a different Plan or Plans.

4. "Allowable Expense." This means a Usual and Reasonable, item of expense for health care, when the item of expense is covered at least in part by one or more Plans covering the person for whom the Claim is made.

The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room is not considered an Allowable Expense under the above definition. That is unless the patient's stay in a private Hospital room is Medically Necessary either: (a) in terms of generally accepted Medical practice; or (b) as precisely defined in the Plan.

A Plan might provide benefits in the form of services. In this case the reasonable cash value of each service rendered will be considered both an Allowable Expense and a benefit paid.

5. "Claim Determination Period." This means a Calendar Year. But, it does not include any part of a year: (a) during which a person has no coverage under This Plan; or (b) before the date this COB provision or a similar provision takes effect.

Effect on the Benefits of this Plan

1. When This Section Applies. This Section applies when This Plan is a Secondary Plan as to one or more Plans. In that case the benefits of This Plan may be reduced under this section. Such other Plan or Plans are referred to as "the other Plans" in 2. below.
2. Reduction in This Plan's Benefits. The benefits of This Plan will be reduced when the sum of:
 - a. the benefits that would be payable for the Allowable Expenses under This Plan in the absence of this COB provision; and
 - b. the benefits that would be payable for the Allowable Expenses under the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not Claim is made;exceed those Allowable Expenses in a Claim Determination Period. In that case, the benefits of This Plan will be reduced so that they and the benefits payable under the other Plans do not total more than those Allowable Expenses.

When the benefits of This Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of This Plan.

Order of Benefit Determination Rules

1. General. When there is a basis for a Claim under This Plan and another Plan, This Plan is a Secondary Plan which has its benefits determined after those of the other Plan, unless:
 - a. the other Plan has Rules coordinating its benefits with those of This Plan;
 - b. both those Rules and This Plan's Rules, in item 2 below, require that This Plan's benefits be determined before those of the other Plan.
2. Rules. This Plan decides its order of benefits using the first of the following rules which applies:
 - a. Non-Dependent/Dependent. The benefits of the Plan that covers the person, other than as a dependent, are determined before those of the Plan that covers the person as a dependent.
 - b. Dependent Child/Parents Not Separated or Divorced. Except as stated in subparagraph 2. c. below, when this Plan and another Plan cover the same Child as a dependent of different persons, called "parents":
 - 1) the benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in that year; but
 - 2) if both parents have the same birthday, the benefits of the Plan that covered the parent longer are determined before those of the Plan that covered the other parent for a shorter period of time.

However, the other Plan may not have the rule described above. Instead it may have a rule based upon the gender of the parent. If so, and if, as a result, the Plans do not agree on the order of benefits, then the rule in the other Plan will decide the order of benefits.

- c. Dependent Child/Separated or Divorced Parents. Two or more Plans may cover a person as a dependent Child of divorced or separated parents. In this case benefits for the Child are determined in this order:
 - 1) first, the Plan of the parent with custody of the Child;
 - 2) the Plan of the spouse of the parent with the custody of the Child; and finally
 - 3) the Plan of the parent not having custody of the Child.

However, the specific terms of a court decree might state that one of the parents is responsible for the health care expenses of the Child. In this case if 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 item 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.

- d. Dependent Child/Joint Custody. If the court decree awards joint custody, then benefits are paid as in 2.b. above.

- e. Active/Inactive Employee. The benefits of a Plan that covers a person as an Employee who is neither laid off nor retired (nor as that employee's dependent) are determined before those of a Plan that covers that person as a laid off or retired employee (or as that employee's dependent.) The other Plan might not have this rule. If so, and as a result, the Plans do not agree on the order of benefits, this rule is ignored.
- f. Longer/Shorter Length of Coverage. If none of the above rules decides the order of benefits, the benefits of the Plan that covered the person longer are determined before those of the Plan that covered that person for the shorter time.

Right to Receive and Release Needed Information

Certain facts are needed to apply these COB rules. We have the right to decide which facts We need and to obtain them from or give them to any other organization or person. We need not tell, or get the consent of, any person to do this. Each person claiming benefits under This Plan must give Us any facts We need to pay the Claim.

Facility of Payment

A payment made under another Plan may include an amount that should have been paid under This Plan. If it does, We may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. We will not have to pay that amount again. The term "payment made" includes providing benefits in the forms of services. In such a case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

The amount of the payments made by Us might be more than We should have paid under this COB provision. In such a case, We may recover the excess from one or more of these:

1. Any persons to, or for whom, such payments are made; or
2. Any insurance companies; or
3. Any other organizations.

The "amount of the payment made" includes the reasonable cash value of any benefits provided in the form of services. The right of recovery does not include liability settlements. However, the right will not apply unless the Insured Person, whose loss is the basis for applying such provision, is made whole. Any such right of reimbursement provided to Us under the Policy shall not apply or shall be limited to the extent that states or the state courts eliminate or restrict such rights.

Medicare Coordination

With respect to Covered Persons who are eligible for coverage under Medicare, a benefit otherwise payable under the Policy shall be reduced by the amount of any similar Medicare benefit so that the total reimbursements hereunder with respect to a Covered Person shall not exceed one hundred percent (100%) of such person's actual expenses otherwise reimbursable under the Policy. It will be conclusively presumed that each Covered Person eligible for coverage under Medicare became covered for all parts of Medicare to which he or she is entitled on the earliest possible date and thereafter maintained such coverage in force.

SECTION 8 - TERMINATION OF INSURANCE

Insured Person's Insurance

The Insured Person's insurance shall terminate on the earliest of the following dates:

1. The next premium due date after We receive Your written request to terminate Your coverage under the Policy;
2. The premium due date, if the premium then due is not paid by the end of the grace period;
3. The date the Insured Person has been determined by Us to have committed an act of fraud or made an intentional misrepresentation of material fact under the terms of the Policy;
4. The date the Insured Person reaches the Maximum Benefit while covered under the Policy as specified in the Schedule of Benefits;
5. The first date following 90 days advance written notice by Us to the Insured Person when We may lawfully discontinue offering coverage under the Policy in the state where this Certificate was issued;
6. The first date following 180 days advance written notice by Us to the Insured Person when We may lawfully discontinue offering all health insurance coverage in the individual market in the state where this Certificate was issued;
7. The date of Your death; or
8. The premium due date coinciding with or following the date of the termination of the Policy.

Dependent Insurance

The insurance coverage of a Dependent shall terminate on the earliest of the following dates:

1. The next premium due date after We receive Your written request to terminate coverage of the Dependent under the Policy;
2. With respect to the Insured Person's covered Dependent spouse, the premium due coinciding with or next following the date on which the Insured Person is divorced or legally separated from such spouse or such marriage was annulled.
3. The premium due date coinciding with or next following the date on which a Dependent Child marries or ceases to meet the definition of Dependent;
4. The date the Dependent has been determined by Us to have committed an act of fraud or made an intentional misrepresentation of material fact under the terms of the Policy;
5. The date the Dependent reaches the Maximum Benefit while covered under the Policy as specified in the Schedule of Benefits;
6. The first date following 90 days advance written notice by Us to the Insured Person when We may lawfully discontinue offering coverage under the Policy in the state where this Certificate was issued; or
7. The first date following 180 days advance written notice by Us to the Insured Person when We may lawfully discontinue offering all health insurance coverage in the individual market in the state where this Certificate was issued;
8. The date of the Dependent's death; or
9. The date of termination of the Insured Person's coverage under the Policy, unless the Dependent continues coverage pursuant to the Continuation of Coverage provision.

The attainment of the limiting age by a covered 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 or physical incapacity and Chiefly Dependent on You for support and maintenance.

"Chiefly Dependent" means the covered Dependent receives the majority of his/her financial support from You. If a covered Dependent is handicapped beyond the limiting age and You desire continued coverage for Your covered Dependent, You must provide written proof that the covered Dependent is Chiefly Dependent, at least 31 days prior to the date upon which the covered Dependent would otherwise reach the limiting age. Thereafter, We may request such proof no more frequently than annually. In the absence of such proof, We may terminate the coverage of such person after the attainment of the limiting age.

Continuation of Coverage

If coverage under the Policy terminates as the result of the death of the Insured Person, or the severance of the family relationship because of annulment or valid decree of divorce, a Dependent may continue coverage without providing evidence of insurability by making the required premium payments for issuance of his or her own Certificate. The eligible Dependent must submit a written request for this continuation of coverage within 31 days of the date on which coverage would otherwise terminate.

SECTION 9 - PREMIUM PAYMENT

A. Payment Of Premium

Premiums are payable to Us. No insurance agent, insurance broker or insurance consultant is authorized to accept any premium payment on Our behalf. The Insured Person must timely pay the monthly premium in order to maintain coverage under the Policy. The payment of any premium will not keep coverage under the Policy in force beyond the due date of the next premium, except as provided under B. the Grace Period below. If any premium is not received by Us before or at the end of the Grace Period, coverage for the Insured Person and Dependents will automatically end at the end of the period for which the last premium payment has been paid.

B. Grace Period

After payment of the first premium, We will allow a Grace Period of 31 days following a premium due date to pay subsequent monthly premiums. During this Grace Period, the Insured Person's coverage under the Policy will remain in force. No benefits are payable for expenses incurred during the Grace Period if the premium has not been received by the end of the Grace Period. If the Insured Person fails to pay the premium during the Grace Period, coverage under the Policy for the Insured Person and Dependents will automatically end at the end of the period for which the last premium payment has been paid. The Grace Period does not apply if coverage under the Policy terminates for reasons other than nonpayment of premium.

C. Premium Changes

We reserve the right to change premiums under the Policy on any premium due date by giving the Insured Person at least 31 days prior written notice.

If the Insured Person has selected an initial rate guarantee period when applying for coverage under the Policy, the premium will not change during the initial rate guarantee period except for the following reasons:

1. The addition or deletion of Dependents to or from the coverage under the Policy; or
2. An Covered Person enters into a new age rate-band; or
3. The Insured Person changes the Network Provider Organization to a Network Provider Organization that is different than the Network Provider Organization he or she selected when applying for coverage; or
4. The Insured Person moves to a different location from where the Insured Person was located at the time they applied for coverage; or
5. The Insured Person requests that coverage under the Policy be modified to increase or decrease benefits from those selected when applying for coverage; or
6. Change in benefits as mandated by new state or federal statutes, rules or regulations which become effective after the Effective Date of coverage and affect Our liability under the Policy.

SECTION 10 - GENERAL PROVISIONS

A. Entire Contract

The entire contract is made up of: (a) the Policy; (b) the Policyholder's application; and (c) the applications of the Insured Persons. No agent or other individual, except Our President, Vice President, Secretary or Assistant Secretary can: (a) approve a change to the Policy; or (b) extend the time for payment of any premium. No change will be valid unless it is made: (a) by an Endorsement or Rider to the Policy; or (b) by an Amendment signed by Our President, Vice President, Secretary or Assistant Secretary. Any change made will be binding on each Covered Person and on any other individual(s) referred to in the Policy.

B. Modification of the Plan

The Policy may be modified on any renewal date by written agreement between the Policyholder and Us, without the consent of any Covered Person. Any such modification shall be consistent with state law and shall be effective on a uniform basis among all individuals with coverage under the Policy in the state in which the Insured Person originally obtained coverage.

Any modification to the Policy shall be effective for all Covered Persons on the first day of the month immediately following the date on which such modification becomes effective.

C. Contestability

In the absence of fraud, statements made by an Insured Person are representations and not warranties. After the Insured Person or a Dependent has been covered under the Policy for two consecutive years, only fraudulent misstatements in the application may be used to void Your coverage or a Dependent's coverage under the Policy or deny any Claim for loss incurred or disability starting after the 2-year period.

D. Correcting Omissions or Misstatements

If We determine that there was a misrepresentation or omission in the application for coverage, the true facts will be used to determine whether insurance is in force or whether an adjustment of premiums and/or other benefits is required. If the age of any Covered Person has been misstated, an adjustment in premium or benefits, or both, will be made based on the true facts. No misstatement of age will continue insurance otherwise terminated or terminate insurance otherwise in force.

Reformation. If We determine that there was a misrepresentation or omission in the application for coverage that caused Us to issue coverage without a specific condition Exclusion Endorsement, Rider or premium rate adjustment that would have been included had there been no misrepresentation or omission, We may reform Your insurance coverage by (1) issuing such Exclusion Endorsement or Rider and requiring that You execute it in order to maintain the Covered Person's coverage; or (2) adding a premium adjustment to Your coverage and requiring that You pay the additional premium retroactively to the Effective Date of the Covered Person's coverage. Once executed, the Exclusion Endorsement or Rider will apply to Your coverage beginning on the Effective Date of the Covered Person's coverage. Once the Exclusion Endorsement or Rider is applicable to

Your coverage We may request a refund for Claims paid which would not have been eligible under the Exclusion Endorsement or Rider. If You do not accept the proposed Exclusion Endorsement Rider or remit the adjusted additional premium, We may rescind the Covered Person's coverage.

Rescission. If We determine that there was a misrepresentation or omission in the application for coverage that caused Us to issue coverage when coverage would not have been issued had there been no misrepresentation or omission, We may rescind coverage. If the misrepresentation or omission pertained to the Insured Person, coverage may be rescinded for the Insured Person and all Covered Dependents. If the misrepresentation or omission pertained to a Covered Dependent, coverage may be rescinded for that Dependent. Rescission causes coverage to be terminated back to the Effective Date as if the coverage was never issued.

Rescission will result in denial of all claims submitted. If rescission occurs, We will refund premiums received for any coverage We rescind within a reasonable time of the rescission; however, We will subtract total Claim payments for the person whose coverage We rescinded from this premium refund. If we have paid Claims in excess of the amount of premium We received for the person whose coverage We rescinded, We have the right to obtain a refund from the Insured Person.

E. Notice of Claim

Written notice of Claim must be given to Us: (a) within 20 days after the date on which the Claim was incurred; or (b) as soon as reasonably possible thereafter. Notice can be sent to Our authorized Plan Administrator or Our home office. The notice should include the Insured Person's name and group Policy number.

F. Proof of Loss

Proof of loss is information and supporting documentation We need to determine the benefits payable under the Policy. It includes, but it is not limited to, medical history, medical records, accident reports and other information We request to make the determination. Written proof of loss must be given to Us or Our authorized Plan Administrator within 90 days of the date on which the Charges are incurred. If it was not possible for proof to be given within the 90 days, We will not deny the Charges provided proof is given as soon as reasonably possible. The date on which the Charges are incurred is the date on which the services or supplies were provided. If the Charges are for an Inpatient Confinement in a Facility, the Charges are incurred on the date of discharge. Notwithstanding the foregoing, proof must be sent no later than one year from the date on which the Charges are incurred unless the Covered Person is legally incapacitated.

Insured Persons are required to submit complete billings from providers using the standard HCFA-1500 form, UB-82, UB-92, standard superbill or similar billing format. Such billing must be completed in the entirety including, without limitation, the name of the Insured Person, name of patient, the CPT-4 procedures codes, the ICD-9 diagnosis codes, the date of service, the Charges and the name and address of Physician, Facility or other health care provider providing service. If the Covered Person is covered under a PPO Plan, and uses an In-Network Provider, the In-Network Provider may submit the Claim to Us.

Originals of all bills must be submitted to Us or Our authorized Plan Administrator unless they were previously submitted to another primary carrier under a Coordination of Benefits provision.

Claims for Covered Charges incurred for the purchase of Prescription Medications must show the following information:

1. Name of person for whom the drug was prescribed;
2. Prescription number;
3. Name of the drug;
4. Cost of the drug;
5. Date of purchase;
6. Name of the doctor who prescribed the medication; and
7. Attending Physician statement indicating diagnosis at least once each year for continuing prescriptions.

NOTE: Cash register receipts and canceled checks cannot be accepted as proof of the cost of the drug for reimbursement.

Claims for all other Covered Charges must show the following:

1. Name of the Insured Person;
2. Name of the patient;
3. Date of the Charge or period of time covered by Charge;
4. Type of treatment or medical services; and
5. Name of the Physician prescribing treatment.

G. Time of Payment of Claims

Payments for Covered Charges will be paid subject to written proof of loss. Any balance unpaid at the end of liability will be paid on receipt of written proof of loss. Covered Charges paid by the Policy will be paid within 45 days following the date on which We or Our authorized Plan Administrator receives written proof of loss. Covered Charges for Claims payable under the Policy are overdue if not paid within 45 days after We, or Our Plan Administrator, receives proof of loss and necessary medical information or other information required by Us as essential to administer the provisions of the Policy including, but not limited to, the Coordination of Benefits and Subrogation Provisions. If such information is not supplied as to the entire Claim, the amount supported by reasonable proof is overdue if not paid within 45 days. Any part or all of the remainder of the Claim that is later supported by such proof is over due if not paid within 45 days.

H. Payment of Claims

Covered Charges will be payable to the Insured Person unless they are assigned to a Physician, Facility or other health care provider. Any notice of assignment of benefits must be in writing and mailed to Us or Our authorized Plan Administrator. Notice of the assignment of benefits received from a Physician, Facility or other health care provider will be sufficient to cause Covered Charges to be paid to such Physician, Facility or other health care provider. You may revoke an assignment of benefits at any time by providing written notice of such revocation to Us or Our authorized Plan Administrator. Any such written revocation of an assignment of benefits shall be valid as to both You and the Physician, Facility or other health care provider.

I. Allocation of Covered Charges

We reserve the right to allocate the Calendar Year Deductible or Daily Deductible to any Covered Charge and to apportion the benefits to the Covered Person and any assignees. Such allocation and apportionment by Us shall be conclusive. The Covered Person or any assignee cannot change this, nor can they direct which claims can be used to satisfy the Calendar Year Deductible or Daily Deductible requirements.

J. Administrative Appeals of a Claim Decision

If the Covered Person or the Covered Person's provider would like additional information or have any complaints concerning the basis upon which payment was made, they may contact Our Customer Service Department at [1-800-XXX-XXXX]. We will address the Covered Person's concerns and will attempt to resolve them satisfactorily. If We are unable to resolve a concern over the phone, We will request submission of the concern in writing to pursue a formal grievance.

K. Recovery of Overpayments

We reserve the right to deduct from any future benefits payable under the Policy the amount of any payment that has been made:

1. In error; or
2. pursuant to a misstatement contained in a proof of loss; or
3. pursuant to fraud or misrepresentation made to obtain coverage under the Policy within 2 years after the Effective Date; or
4. with respect to an ineligible person; or
5. pursuant to a Claim for which benefits are recoverable under any Policy or act of law providing coverage for occupational Injury or disease to the extent that such benefits are recovered.

Such deduction may be against any future Claim for benefits under the Policy made by a Covered Person if Claim payments previously were made with respect to such Covered Person.

L. Fraud or Misrepresentation

No payments will be made for Claims involving fraud or misrepresentation. If benefits are paid for a Claim involving fraud or misrepresentation We will be entitled to a refund from the Insured Person or the Covered Person's provider.

M. Other Insurance With This Insurer

If a Covered Person is covered under more than one major medical policy with Us comparable to the Policy, only one policy chosen by the Covered Person, his beneficiary or his estate, as the case may be, will be effective. We will refund all premiums paid, less the amount of Claims paid, for the coverage under all the other major medical policies for the term during which duplicate coverage was provided.

N. Arbitration Action

No arbitration action may be brought to recover benefits under the Policy prior to the expiration of: (1) 60 days after written proof of loss has been furnished, (2) the Covered Person has completed all administrative appeals required by the Policy, and (3) the Covered Person has notified Us of their intent to demand arbitration 60 days prior to the filing of such demand for arbitration. No such action will be brought after the expiration of 2 years following the date written proof of loss was required to be furnished.

O. Arbitration

Disputes, disagreements or controversies arising out of, in connection with, or relating to the terms, conditions, limitations, exclusions or provisions of the coverage under the policy or breach thereof (including any issue related to arbitrability) which cannot be resolved to the satisfaction of all parties shall be resolved by arbitration. Arbitration shall be conducted in accordance with the rules of the American Arbitration Association ("AAA"), before a panel of 3 neutral arbitrators who are knowledgeable in the field of insurance and appointed from a panel list provided by the AAA.

Each party waives the right to a jury trial with respect to any dispute, disagreement or controversy between them. The arbitration panel shall have no power to ignore or vary the terms of the policy.

The factual basis and legal conclusions of the award, including the law relied upon, must be identified. The decision in arbitration is confidential, final, binding and conclusive upon all parties and may not be disclosed by any party. The decision in arbitration cannot be reviewed in court by a judge and jury. Judgment upon the award rendered by the arbitration panel may be entered in any court have jurisdiction.

If any provision of this subsection is found to be unenforceable, such provision shall be considered severed from the remaining provisions of this subsection, which shall remain in full force and effect.

P. Conformity with Federal and State Laws

Any provision of the Policy which is in conflict with Federal laws or any applicable state law, is hereby amended to meet the minimum requirements of the law.

Q. Ambiguities

Any terms or conditions specified in the Policy that are determined as a result of arbitration to be ambiguous or in conflict with applicable State or Federal laws shall be considered separately and shall not void or affect the legality of the remaining terms and conditions that are included in the Policy.

R. Physical Examination

We have the right, at Our own expense, to have a Covered Person examined as often as is reasonable while a Claim is pending.

S. Workers' Compensation

The Policy is not in lieu of and does not affect any requirements for coverage by Workers' Compensation insurance.

T. Certificates of Coverage

We will issue to the Insured Person a Certificate which shall state the essential features of the insurance to which each Covered Person is entitled, to whom benefits are payable, and the requirements for payment of benefits.

U. Waiver Of Rights

If We fail to enforce any provision of the Policy, such failure will not affect Our right to do so at a later date; nor will it affect Our right to enforce any other provision of the Policy. Any waiver of rights must be in writing and signed by Our President, Vice President Secretary or Assistant Secretary or an individual authorized by them to agree to such waiver.

V. Required Information

The Insured Person agrees to provide to Us any information or data that we reasonably request for the proper administration of the Policy including; but not limited to, information pertaining to medical history, medical records, the names of all health care providers from whom the Covered Person has received treatment or services, marriage license, documentation of adoption or placement for adoption, documentation of legal custody of a Dependent, student status information, and treating provider statements.

W. Effective Date

No insurance under the Policy shall become effective until notice in writing is given to the Insured Person by Us. Issuance of a Certificate with a Validation of Coverage will be deemed proper notification, provided premium due has been paid in accordance with the terms of the Policy.

SECTION 11 - DEFINITIONS

The capitalized terms used herein shall be defined as follows:

Ambulatory Surgical Center. A free-standing surgical facility that:

1. meets licensing standards;
2. is equipped and operates for general surgery;
3. bills for Charges on its behalf;
4. is directed by a staff of Physicians, with a Physician present when surgery is performed and during the recovery period;
5. has at least one certified anesthesiologist present when surgery, which requires general or spinal anesthesia, is performed and during the recovery period;
6. extends surgical staff privileges to Physicians who practice surgery in a local area hospital and to dentists who perform oral surgery;
7. has at least two operating rooms and one recovery room;
8. provides or arranges with a medical facility in the local area for diagnostic X-ray and lab services necessary for surgery;
9. is equipped and has a staff trained for medical emergencies, which requires:
 - a. a Physician trained in cardiopulmonary resuscitation;
 - b. a defibrillator;
 - c. a tracheotomy set; and
 - d. a blood volume expander;
10. has written agreement with a Hospital in the local area for immediate emergency transfer of patients;
11. provides an ongoing quality assurance program by review Physicians who do not own or direct the facility;
12. maintains medical records on each patient;
13. is not a part of a Hospital; and
14. admits and discharges patients within the same working day.

Calendar Year. A period of one year that starts on January 1 and ends on December 31.

Calendar Year Deductible. The amount(s) of Covered Charges as specified in the Schedule of Benefits which each Covered Person must first incur each Calendar Year before the Policy will begin payment for Covered Charges. [If the Covered Person is covered under the PPO Plan, as specified on the Schedule of Benefits, the In-Network and Out-of-Network Calendar Year Deductibles are accumulated separately [and must be met for each category of provider]. [However, if the Covered Person satisfies the Out-of-Network Calendar Year Deductible for the Calendar Year, the Covered Person's In-Network Calendar Year Deductible will be deemed satisfied for the remainder of that Calendar Year.]] [The applicable Individual Calendar Year Deductible or Family Calendar Year Deductible is specified on the Schedule of Benefits. The Family Calendar Year Deductible is deemed satisfied for the balance of that Calendar Year once one Covered Person or any combination of Covered Persons has/have met the Family Calendar Year Deductible amount as specified on the Schedule of Benefits.]

Calendar Year Deductible Family Maximum: The total amount of Calendar Year Deductibles that must be met by all Covered Persons during the Calendar Year before no further Calendar Year Deductibles are applied, as specified on the Schedule of Benefits.

Center of Excellence. A Facility designated by Us that represents itself to be highly qualified to provide Medically Necessary care for a Sickness or Injury that may or may not be affiliated with the Insured Person's designated Network Provider Organization and for which specially designated benefits may be available under the Policy.

Certificate/Certificate of Coverage. This summary of the Master Group Policy which constitutes evidence of Your coverage under the Policy.

Charge. The billed amount for a treatment, service or supply rendered to a Covered Person. Such Charge shall be considered to have been incurred on the date the treatment, service or supply was provided.

Chemical Dependency Disorders. The pathological use or abuse of alcohol or other drugs in a manner and to a degree that produces impairment in personal, social or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal.

[Chemical Dependency Treatment Center. A facility that provides a program for the treatment of Chemical Dependency pursuant to a written treatment plan approved and monitored by a Physician. The term shall include Chemical Dependency and psychiatric units of a licensed Hospital or a Facility that is:

1. affiliated with a Hospital under a contractual agreement with an established system for Inpatient referral; or
2. licensed, certified or approved as a Chemical Dependency Treatment Center or program by a state agency having legal authority to so license, certify or approve.]

Child.

1. An Insured Person's natural child;
2. An Insured Person's lawfully adopted child;
3. A child placed for adoption with an Insured Person;
4. A child for whom the Insured Person has been appointed legal guardian by a court of competent jurisdiction and who resides with and who is dependent upon the Insured Person in a conventional parent-child relationship; or
5. A child of the Insured Person for whom the Insured Person is obligated to provide medical child support pursuant to a Qualified Medical Support Order, provided that the requirement for qualifications of the order as outlined in the Policy are met.

Claim. A HCFA 1500 or UB92, or any replacement form published by the U.S. Department of Health and Human Services or Centers for Medicare and Medicaid Services, that establishes a demand by or on behalf of a Covered Person for the payment of benefits under the Policy and contains all the required data elements as required by state law. In the absence of state law as are required to process the Claim.

Close Relative. The Insured Person's spouse or the parent, brother, sister, Child or grandparent of the Insured Person or of the Insured Person's spouse.

Coinsurance/Coinsurance Percentage. The sharing of health care expenses between Us and the Covered Person. The Coinsurance percentage, as specified in the Schedule of Benefits, is the percentage of Covered Charges for which We are responsible after payment by the Covered Person of any applicable Co-payments and Calendar Year Deductibles or Daily Deductibles, as specified in the Schedule of Benefits.

Complications of Pregnancy. Conditions which are caused by Pregnancy or are distinct from Pregnancy but are adversely affected by Pregnancy, including but not limited to severe dehydration requiring intravenous (IV) therapy; acute nephritis or nephrosis; cardiac decompensation; premature labor or threatened abortion requiring intravenous (IV) therapy; eclampsia; pre-eclampsia; abrupt previa; non-elective Cesarean section; or spontaneous termination of pregnancy that occurs during period of gestation in which a viable birth is not possible. The term does not include: false labor, occasional spotting, Physician prescribed rest during a Pregnancy, morning sickness, elective Cesarean section, or similar conditions that are associated with a difficult pregnancy but do not constitute a classifiably distinct Complication of Pregnancy. Normal deliveries and associated services, even if following a Complication of Pregnancy, are not considered a Complication of Pregnancy.

Confined/Confinement. Registered as an Inpatient in a Facility, on the order of a Physician, for Medically Necessary treatment.

Copay/Copayment. If the Covered Person has a Copay, it is specified in the Schedule of Benefits and it is the amount the Covered Person must pay to each provider for each service or each supply, as specified in the Schedule of Benefits. After the Covered Person pays the applicable Copay, We will reimburse the Insured Person for the remainder of the Covered Charges at the Coinsurance Percentage for each service or supply as specified in the Schedule of Benefits. [Copayments do not apply toward the Calendar Year Deductible or Daily Deductible, Coinsurance or Out-of-Pocket Maximum.]

Covered Charges: Covered Charges are the Charges for services and supplies that are eligible for reimbursement under the Policy. In order for a Charge to be a Covered Charge, it must be all of the following:

1. Listed as Covered Charges under SECTION 4 – BENEFITS; and
2. Be Medically Necessary; and
3. Be the Usual and Reasonable Charge for such service or supply; and
4. Be authorized or ordered by a Physician; and
5. Be incurred while coverage under the Policy is in force; and
6. Not be excluded by the Policy.

Covered Person. The Insured Person and/or his or her Dependent who: (a) has applied for coverage; (b) meets the eligibility rules set forth in the Policy; (c) is approved for coverage by Us; and (d) for whom all applicable premiums are paid, and is therefore insured.

Custodial Care. Any care, regardless of whether it is prescribed by a Physician, that is provided to a Covered Person who is disabled to support the essential activities of daily living.

[Daily Deductible. If shown on the Schedule of Benefits, the amount of Covered Charges a Covered Person must first incur each calendar day before the Policy will begin payment for Covered Charges incurred on that calendar day. The Daily Deductible amount applies per calendar day regardless of the number of providers rendering services on that day. [If the Covered Person is covered under the PPO Plan, as specified on the Schedule of Benefits, the In-Network and Out-of-Network Daily Deductibles are accumulated separately [and must be met for each category of provider].] [The applicable Individual Daily Deductible or Family Daily Deductible is specified on the Schedule of Benefits.]

[Daily Deductible Family Maximum: The total amount of Daily Deductibles that must be met by all Covered Persons during the Calendar Year before no further Daily Deductibles are applied, as specified on the Schedule of Benefits].

[Day Treatment Program. A program or Facility providing medical treatment for Mental or Nervous Disorder or Chemical Dependency Disorders within or on the immediate campus of a licensed and accredited Hospital and under the supervision of a Registered Nurse during the hours of treatment or therapy.]

Dependent. An Insured Person's:

1. Lawful spouse [of the opposite gender] [under age [64] years [and [6] months]];
2. Unmarried Child who is primarily dependent upon the Insured Person for support and maintenance and is:
 - a. Less than [19] years of age; or
 - b. Between [19] and [25] years of age; provided however, that the Child is dependent upon the Insured Person for support and maintenance and a full-time student actively attending an accredited college, vocational or high school. Full-time, as used in this definition, means actively attending at least 12 hours of classes a week or, if less, attending the minimum hours of class the school considers as full-time status;

[Designated Clinical Laboratory. A vendor under contract with Us or Our authorized Plan Administrator to provide Outpatient laboratory and diagnostic testing at negotiated discounted rates. [The vendor, if applicable, is named on the Schedule of Benefits.]

Doctor. See definition for Physician.

[Durable Medical Equipment. Equipment that is:

1. able to withstand repeated use;
2. primarily and customarily used to serve a medical purpose; and
3. not generally useful to a person in the absence of Sickness or Injury.]

Effective Date. The date, as assigned by Us and shown on Your Validation of Coverage, on which coverage becomes effective under the Policy.

[Electronic Consultations: The practice, by a Physician of health care delivery, diagnosis, consultation, treatment, by means of the Internet or similar electronic communications, that does not require a face-to-face encounter with the patient for all or any part of the Electronic Consultation.

The term includes online medical evaluations, online visits and terms with similar web-based nomenclature.]

Emergency Care. Bona fide emergency services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in: (a) placing the patient's health in serious jeopardy; (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part.

Experimental Medical Treatment, Procedure or Medication. As determined by Us, a treatment, medication, drug, device, procedure, supply or service and related services (or any portion thereof, including the form, administration or dosage) for a particular diagnosis or condition when any one of the following exists: (1) It cannot be legally marketed without the approval of the United States Food and Drug Administration (FDA) and such approval has not been granted at the time of its proposed use; (2) It is not yet recognized as acceptable medical practice throughout the United States to treat that Sickness or Injury; (3) It is the subject of either: (a) a written investigational or research protocol; or (b) a written informed consent or protocol used by the treating facility in which reference is made to it being experimental, investigative, educational, for a research study, or posing an uncertain outcome, or having an unusual risk; or (c) an ongoing phase I, or phase II clinical trial or as the experimental or research arm of a phase III clinical trial, as the phases are defined in regulations and other official actions and publications issued by the FDA and the Department of Health and Human Services (HHS); or (d) an ongoing review by an Institutional Review Board (IRB); (4) It does not have the positive endorsement of national medical bodies or panels, such as the American Cancer Society; or (5) It is regarded within a physician's profession as appropriate only when provided in a clinical research setting.

We may also determine whether a treatment, drug, device, procedure, supply or service is experimental or investigational by using the following evaluations: (1) Reports in peer review medical literature published in the English language as of the date of service; (2) Scientific evaluations published by organizations that conduct health care research such as the Agency for Health Care Policy and Research, the National Institutes of Health, the American Medical Association, and the American College of Physicians; (3) Opinions of independent medical consultants; (4) Listings in drug correspondence, including the American Medical Association's Drug Evaluations, the American Hospital Formulary Service Drug Information, and the United States Pharmacopoeia Drug Information; (5) Use of a written informed consent addressing the experimental or investigational nature of the service or supply. This applies whether consent is used by the Insured Person's Physician or by any other Physician studying the same or similar service or supply; (6) Any requirement that the use of the service or supply be subject to Institutional Review Board ("IRB") approval; or (7) Written protocols used by the health care provider.

Facility. A Hospital, Hospice, Rehabilitation Facility, Residential Treatment Program, Ambulatory Surgical Center or Skilled Nursing Facility.

Home Health Care Agency. A public or private agency or organization that specializes in providing medical care and treatment in the home under the supervision of a Physician or Nurse. Such provider must meet all of these requirements:

1. it operates pursuant to law;
2. it mainly provides skilled Nursing and other therapeutic services in the Covered Person's home;
3. it maintains a complete medical record on each person served; and
4. it has a full-time administrator.

Hospice. An agency which:

1. is licensed and operates pursuant to law;
2. provides a hospice care program of palliative, supportive and interdisciplinary team services;
3. provides a continuum of Inpatient care, home care and follow-up bereavement services on a 24-hour, 7-day-a-week basis, for Covered Persons who:
 - a. are in the terminal stage of Sickness; and
 - b. are expected to die within 6 months.

Hospice Care Program. A plan for palliative and supportive medical, nursing and other health services to terminally ill persons and members of their families in a Hospice or in the home. The Insured Person's Physician must certify that proper care and treatment would otherwise require Confinement in a Hospital or Skilled Nursing Facility.

Hospital. An institution that meets fully every one of the following tests:

1. it provides medical and surgical facilities for the treatment and care of injuries or sick persons on an Inpatient basis;
2. it is under supervision of a staff of Physicians;
3. it provides 24-hour a day nursing service by Registered Nurses (R.N.s);
4. it is duly licensed as a Hospital, except that this requirement will not apply in the case of a state tax-supported or charitable institution;
5. is approved as a Hospital by the Joint Commission on the Accreditation of Health Care Organizations or the American Osteopathic Association;
6. is not, other than incidentally, a place for rest, a place for the aged, a nursing home or custodial or training type institution, or an institution that is supported in whole or in part by a federal government fund.

The requirement of surgical facilities shall not apply to a Hospital specializing in the care and treatment of mentally ill patients. Hospital shall also mean, where appropriate:

1. for the purpose of Chemical Dependency treatment, a facility or institution which provides a program for the treatment of Chemical Dependency pursuant to a written treatment plan approved and monitored by a Physician, which facility is also:
 - a. accredited as such a facility by the Joint Commission on the Accreditation of Health Care Organizations;
 - b. affiliated with a Hospital, as defined above, under contractual agreement with an established system for patient referral; or
 - c. a state agency; or
 - d. licensed, certified or approved as a Chemical Dependency treatment program or center by any state agency having legal authority to so license, certify or approve.

Injury. Bodily injury resulting directly from an accident and independently of all other causes occurring while a Covered Person's coverage is in force under the Policy. It does not include an intentional, self-inflicted Injury.

In-Network/In-Network Provider. A Hospital, Physician, Pharmacy, or any other health services provider which has signed an agreement affiliating with an organization, association or other such entity to provide services and supplies at a predetermined rate. We or Our subcontractor vendor selects In-Network Providers to make their services and supplies available in specific geographic areas at benefit levels as specified in the Schedule of Benefits, applicable to Covered Persons covered under the PPO Plan.

Inpatient and Outpatient. The terms "Inpatient" and "Outpatient" refer either to the setting in which medical care is given or to a Covered Person who is receiving care in that setting.

When the terms describe the setting in which medical care is given:

1. "Inpatient" means therapeutic services which are available on a 24-hour basis to a Covered Person while Confined in a Hospital or other treatment Facility, as a registered bed patient;
2. "Outpatient" means therapeutic services are furnished to Covered Persons while not Confined.

When the terms refers to a Covered Person who is receiving medical care:

1. "Inpatient" means a Covered Person who is Confined in a Hospital as a registered bed patient for a period of 23 consecutive hours or longer upon the advice of a Physician for the purpose of other than Custodial or Convalescence Care;
2. "Outpatient" means a Covered Person who is not so Confined.

Insured/Insured Person. The member of the Policyholder. The Insured Person is named on the Validation of Coverage.

Intensive Care Unit. A separate part of a Hospital that provides each of the following:

1. treatment to patients in critical condition;
2. continuous special nursing care or observation by trained and qualified personnel; and
3. life-saving equipment.

Intermediate Care Unit. A separate part of a Hospital designated to provide a greater degree of care or observation than the Hospital's standard Semi-Private room, but less than that provided in an Intensive Care Unit.

Lifetime Maximum Benefit For All Benefits While Covered Under the Policy. The Maximum Benefit, as specified in the Schedule of Benefits, payable for all Covered Charges combined for each Covered Person while covered under the Policy under any and all plans selected by the Insured Person. No benefits will be paid for Charges incurred by a Covered Person after the Covered Person's coverage under the Policy terminates, except as may be provided under any extended benefits provision, if applicable.

Lifetime Maximum Benefit While Covered under the Policy: The Maximum Benefit payable for Covered Charges for certain treatment and services, as specified in the Schedule of Benefits, for each Covered Person while covered under the Policy under any and all plans selected by the Insured Person. When a Covered Person reaches the Maximum Benefit While Covered under the Policy, no further Charges incurred after such date for the specific treatment and services in which the Maximum Benefit is reached will be considered Covered Charges for that Covered Person.

Maximum Calendar Year Benefit: The Calendar Year Maximum Benefit payable under the Policy for each Covered Person for Covered Charges incurred for certain treatment and services is specified on the Schedule of Benefits. When a Covered Person reaches the Maximum Calendar Year Benefit while covered under the Policy, no further Charges incurred after such date for the specific treatment and services in which the Maximum Benefit is reached will be considered Covered Charges for the remainder of that Calendar Year for that Covered Person.

[Maximum Calendar Year Benefit for all Covered Charges Combined. The Calendar Year Maximum Benefit, as specified in the Schedule of Benefits, payable for all Covered Charges combined, for each Covered Person while covered under the Policy under any and all plans selected by the Insured Person. When a Covered Person reaches the Maximum Calendar Year Benefit for all Covered Charges Combined, no further Charges incurred after such date will be considered Covered Charges for the remainder of that Calendar Year for that Covered Person.]

Medically Necessary. Treatment, services or supplies provided for a Sickness or Injury which:

1. have been established as safe and effective;
2. are furnished in accordance with generally accepted professional standards to treat a Sickness or Injury;
3. are determined by Us to be:
 - a. rendered for the treatment or diagnosis of an Injury or Sickness, including premature birth, congenital defects and birth defects;
 - b. appropriate for the symptoms, consistent with the diagnosis;
 - c. are otherwise in accordance with generally accepted medical practice and professionally recognized standards;
 - d. not mainly for the convenience of the Covered Person, his or her Physician or other providers;
 - e. not in excess (in scope, duration or intensity) of that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment.
 - f. services and supplies that are necessary for the therapeutic treatment of an Injury or Sickness; and

4. when applied to Confinement in a Hospital, the Covered Person:
 - a. must be Confined as an Inpatient due to the nature of treatment, services or supplies rendered or due to his or her condition;
 - b. cannot receive safe and adequate care through Outpatient treatment.

Treatment, services or supplies are not automatically deemed Medically Necessary based solely on the fact that they were prescribed, ordered or recommended by a Physician or any other health care practitioner.

Medicare. Title XVIII – Health Insurance for the Aged and Disabled, of the United States Social Security Act of 1965, as then constituted or as later amended.

Mental or Nervous Disorder. Any nervous, emotional and mental disease, illness, syndrome, or dysfunction, other than a behavior or conduct disorders, classified in the most recent edition of the *American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders* including, but not limited to neurosis, psychoneurosis, psychopathy, psychosis, and eating or panic disorder except for mental retardation. It also includes any nervous, emotional or nervous disorder that may be a manifestation of an organic condition, disease, illness, or syndrome, including organic mental syndrome associated with psychoactive substances (e.g., alcohol, cocaine, opiate, and others).

Morbid Obesity. Obesity of such degree as to interfere with normal activities, including but not limited to respiration.

Network Provider Organization. A vendor under contract with Us or Our authorized Plan Administrator to provide certain services within a service area. The vendor will enter into separate and distinct contracts with In-Network Providers to provide services covered by the Policy at a reduced reimbursement rate, applicable to Covered Persons covered under the PPO Plan.

Observation Room. A room in a Hospital or Outpatient Facility in which a Covered Person receives observation of less than 23 hours for the purpose of monitoring the Covered Person prior to or following an Emergency treatment, Outpatient surgery, or major diagnostic test(s).

Out-of-Network Providers. A Hospital, Physician, Pharmacy, or any other health services provider who has not signed an agreement affiliating with an organization, association or other such entity, and has not agreed to provide services and supplies at a predetermined rate, applicable to Covered Persons covered under the PPO Plan.

[Out-of-Pocket Maximum. [The amount of Covered Charges that the Covered Person must pay each Calendar Year, as specified in the Schedule of Benefits [excluding] [including] Calendar Year Deductible or Daily Deductible and Coinsurance. [If the Covered Person is covered under the PPO Plan, as specified on the Schedule of Benefits, the In-Network and Out-of-Network Calendar Year Out-of-Pocket Maximums are accumulated separately, except when the Out-of-Network Calendar Year Out-of-Pocket Maximum is satisfied, then In-Network Out-of-Pocket Maximum will be deemed satisfied for the remainder of that Calendar Year.]] [The maximum amount an Individual or Family pays each Calendar Year for Covered Charges. The applicable Individual Calendar Year Out-of-Pocket Maximum or Family Calendar Year Out-of-Pocket Maximum amount is specified on the Schedule of Benefits. The Family Calendar Year Out-of-Pocket Maximum is deemed satisfied for the balance of that Calendar Year once one Covered Person or any combination of Covered Persons has/have met the Family Calendar Year Out-of-Pocket Maximum amount as specified on the Schedule of Benefits.]

The amounts paid by the Covered Person for Charges that do not count towards the Out-of-Pocket Maximum are:

1. Pre-Certification penalty amounts, as specified on the Schedule of Benefits [for failure to comply with the Pre-Certification requirements];
2. Charges incurred for specified Prescription Medications, services and supplies for failure to comply with the Pre-Determination requirements;
3. [Charges incurred for Outpatient Mental or Nervous Disorder and Chemical Dependency Disorders;]
4. [Separate Calendar Year Deductibles, [Co-payments] [and Coinsurance] as required under any separate Benefit Rider providing additional benefits that may be attached to this Certificate, if any as specified on the Schedule of Benefits]]

5. Co-payments, if any, as specified on the Schedule of Benefits;
6. Charges excluded under the Policy or under any Rider attached to this Certificate;
7. Charges incurred during the balance of the Calendar Year after the Maximum Calendar Year Benefit has been paid; and
8. Charges incurred after the Lifetime Maximum Benefit While Covered under the Policy has been paid.]]

Outpatient. See definition for Inpatient and Outpatient.

Physician or Doctor. A person who is licensed by the proper authorities of the state in which he or she practices and is operating within the scope of his or her license in rendering or prescribing treatment which gives rise to Covered Charge for which Claim is made; who is not the Insured Person or a Close Relative of the Insured Person by blood or marriage or who ordinarily does not reside in the household of such Insured Person.

Such duly licensed health care provider must act within the scope of his or her license and includes: (a) a Doctor of Medicine (M.D.); (b) a Doctor of Osteopathy (D.O.); (c) a Doctor of Podiatric Medicine (D.P.M.); (d) a Doctor of Dental Surgery (D.D.S); (e) a Doctor of Chiropractic (D.C.); (f) a Doctor of Optometry (O.D.); (g) a Psychiatrist (M.D.), (h) a Psychologist (PHD.) or (i) such other medical health care practitioners We recognize pursuant to applicable state law.

[Plan Administrator. A third party administrator contracted by Us to perform the administration required under the Policy.]

Policy. The contract providing the benefits described herein issued to the Policyholder.

Policyholder. The entity, in whose name the Policy is issued, as specified on the Validation of Coverage.

Pregnancy. Being pregnant as confirmed by the results on an over-the-counter or Physician administered urine test, blood test, ultrasound, detection of fetal heartbeat, or an X-ray.

Pre-Certification/Pre-Certify. A screening process to determine if the proposed Inpatient Hospital Confinement and treatment plan are Medically Necessary. Pre-Certification is not pre-authorization or pre-approval of coverage and does not guarantee payment of benefits.

Pre- Determination/Pre-Determine. A screening process to determine if the proposed services, drugs or supplies are Medically Necessary. Pre-Determination is not pre-authorization or pre-approval of coverage and does not guarantee payment of benefits.

Pre-Existing Condition. Any condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was received within the [2] year period ending on the Effective Date of the Covered Person's coverage.

Prescription Medication. Any medical substance, remedy, vaccine, biological product, drug, pharmaceutical or chemical compound, other than an Specialty Medications, which can only be dispensed pursuant to a prescription and which is required to bear the following statement on the label: "Caution: Federal law prohibits dispensing without a prescription."

Prophylactic Treatment. Treatment, service or supplies to prevent the occurrence of a Sickness or Injury of a Covered Person who does not manifest the symptoms of that Sickness or Injury.

Rehabilitation Facility. A legally operating institute or distinct part of an institution which is primarily engaged in providing comprehensive, multidisciplinary physical restorative services, post-acute Hospital and Rehabilitative Inpatient care, is duly licensed by the appropriate government agency to provide such services and is accredited as such a facility by the Joint Commission on the Accreditation of Health Care Organizations or the Commission for the Accreditation on Rehabilitation Facilities. It does not include institutions that provide only minimal care, Custodial Care, ambulatory or part-time care services, or an institution which primarily provides treatment of Mental or Nervous Disorder or Chemical Dependency Disorders.

Rehabilitative Treatment. Treatment for the purpose of restoring bodily function, which has been lost due to a covered Sickness or Injury. Care ceases to be Rehabilitative Treatment when either: (i) the Covered Person can perform the activities which are normal for someone of the same age and gender; or (ii) the Covered Person has reached the maximum therapeutic benefit and further Rehabilitative Treatment cannot restore further bodily function beyond the level the Covered Person currently possesses.

[Retail Health Clinics. A medical clinic located in a retail operation that offers medical services a non-Emergency or Urgent Care basis and meets all of the following conditions:

- a. It has a well-defined and limited scope of clinical services;
- b. Clinical services and treatment plans must be evidenced-based and quality improvement-oriented;
- c. It must have a formal connection with physician practices in the local community, preferably with family physicians, to provide continuity of care;
- d. It must be duly licensed by the state or regulatory agency responsible for such licensing in the state in which the Clinic is located;
- e. Other health professionals, such as nurse practitioners, can only operate in accordance with state and local regulations, as part of a "team-based" approach to health care and under responsible supervision of a practicing, licensed physician;
- f. It must have a referral system to physician practices or to other appropriate entities when the patient's symptoms exceed the clinic's scope of services; and
- g. It uses an electronic health record systems compatible with the continuity of care record supported by the American Academy of Family Physicians that can communicate the patient's information with the family physician's offices.

The term shall also apply to an institution which otherwise meets the required conditions, referring to itself as a Minute Clinic, or any such other term. A Retail Health Clinic does not include: Ambulatory Surgical Centers, Urgent Care Facility, or any such Facility.]

Rider. An amendment or endorsement, modifying the terms of the Policy, which is attached to this Certificate.

Semi-Private Rate. The Hospital's most common charge for a two-bed room.

Sickness. An illness, disease, or Complications of Pregnancy that causes loss while a Covered Person's coverage is in force under the Policy.

Skilled Nursing Facility. An institution meeting all of these requirements:

1. It operates pursuant to law and primarily provides room and board for people convalescing from Sickness or Injury;
2. It provides 24-hour nursing services for the full-time supervision of a Physician or Registered Nurse (RN);
3. It maintains adequate medical records;
4. It has the services of a Physician under an established agreement, if a Physician does not supervise the institution;
5. It is not: a rest home; or a nursing home; or a home for the aged; or a Free-standing Birthing Center; or a place primarily for the treatment of mental disease, drug addiction or alcoholism.

This term shall also apply to an institution which otherwise meets the required conditions, referring to itself as: a Skilled Nursing Facility; or a Convalescent Nursing Home; or any such other similar term.

Sound Natural Teeth. Teeth which are intact with a root, pulp, and have a maximum of two surfaces restored and/or decayed, and no missing tooth structure due to fracture.

Specialty Medications. Prescription Medications that may be administered by a Physician as an Outpatient or self-administered in a home setting and are listed on the Specialty Drug List maintained by Us or Our designee as revised from time to time at Our discretion.

Total Disability/Totally Disabled. The inability of the Covered Person to perform the normal substantial activities of his/her occupation if employed immediately prior to the onset of the disability, or of a person of like age and sex in good health if not so employed.

Unbundling/Unbundled Charge. The separation of related Charges for room, supplies and other Charges for goods, services and medications that are otherwise recognized by industry standards including, but not limited to National Correct Coding Initiative, Packaging and Bundling Rules, Current Procedure Terminology, Outpatient Prospective Payment System, Complete Global Service Data for Orthopedic Surgery, Relative Value for Physicians, and Diagnosis Related Grouping as being included in the Charge for the primary medical procedure or room Charge.

Urgent Care. Medical services and supplies necessary for conditions that are not life threatening but which require treatment which cannot wait for a regularly scheduled clinical appointment because of the prospect of the conditions worsening without timely medical intervention.

Urgent Care Facility. A free-standing Facility, by whatever actual name it may be called, which is engaged primarily in providing minor emergency and episodic, medical care. A physician, a Registered Nurse and a registered X-Ray technician must be in attendance at all times that the facility is open. The Facility must include X-ray and laboratory equipment and a life support system. It must be licensed as an Urgent Care Facility, if required by law. However, a Facility located on the premises of, or physically a part of, a Hospital shall be excluded from this definition.

Usual and Reasonable. Charges for services and supplies, which are the lesser of: (a) the Charge usually made for the service or supply by the Physician or Facility who furnished it; (b) the negotiated rate; and; (c) the reasonable Charge as determined by Us made for the same service or supply in the same geographic area.

We shall determine to what extent the Charge is reasonable, taking into account: (a) The complexity involved; (b) The degree of professional skill involved; (c) Data compiled and regularly updated from Our records or those of Our agents. We use and subscribe to a standard industry reference source that collects data for determining excessive fees and makes it available to its member companies. The data base used reflects the amounts Charged by providers for health care services based on the smallest geographic zip code areas generating a statistically credible charge distribution. This data is updated and published twice annually. The data is reflective of reported provider Charges from the lowest to the highest for each service or supply. The data is also adjusted periodically to reflect negotiated fee schedules with providers not included in the data base. We then use a specific representative percentile of that range of Charges; (d) The condition being treated; (e) Any medical complications or unusual circumstances; (f) The amounts the Physician or Facility routinely accepts as full payment from all payers after good faith collection efforts; and (g) other pertinent factors.

The Physician's or Facility's usual Charge must not exceed the usual Charge made by most providers of like service in the same geographic area. Area means the geographical area as determined by Us which is significant enough to establish a representative base of Charges for the treatment.

The following are examples of Charges that will not be considered Usual and Reasonable: (1) Pharmaceutical charges which exceed 200% of Average Wholesale Price or cost, whichever is less; (2) Unbundled Charges; and (3) Charges which industry standards recognize as included in the primary charge. When it is determined by this specific payment methodology that a Charge by a Physician or Facility is above the Usual and Reasonable amount, the Charge is not a Covered Charge.

Utilization Review. A set of formal techniques designed to monitor the use of or evaluate Medical Necessity of treatment, services, supplies, and to monitor the use of or evaluate Physicians, providers, and Facilities.

These techniques may include:

1. Ambulatory review - Utilization review of services performed or provided in an Outpatient setting.
2. Case management - A coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or other health conditions.
3. Pre-Certification - A determination by Us or Our designated Utilization Review Organization that an admission, availability of care, continued stay, or other service has been reviewed and, based on the information provided, satisfies Our requirements for Medically Necessary services and supplies, appropriateness, health care setting, level of care, and effectiveness.
4. Concurrent review - Utilization review conducted during an Covered Person's Hospital stay or course of treatment.
5. Discharge planning - The formal process for determining, before discharge from a provider Facility, the coordination and management of the care that a Covered Person receives after discharge from a provider Facility.

6. Prospective review - Utilization review conducted before an admission or a course of treatment including any required Pre-Certification.
7. Retrospective review - Utilization review of Medically Necessary services and supplies that is conducted after services have been provided to a Covered Person, but not the review of a Claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment.
8. Second opinion - An opportunity or requirement to obtain a clinical evaluation by a provider other than the provider originally making a recommendation for a proposed service to assess the clinical necessity and appropriateness of the proposed service.

We, Our, Us, The Company. Independence American Insurance Company, New York, New York.

You, Your. The person named on the Validation of Coverage as the Insured Person.

[Medical Qualifying Questions:

1. Is any applicant currently applying for coverage pregnant or undergoing infertility treatment? Yes No
2. In the past [5] years has any applicant for this health plan been aware of, had symptoms, been diagnosed or treated for any of the following conditions:
- | | | | |
|--|--|---|--|
| • AIDS, AIDS related complex or tested HIV positive? | <input type="checkbox"/> Yes <input type="checkbox"/> No | • Mental or nervous disorder requiring hospitalization? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Hepatitis C or Cirrhosis of the liver? | <input type="checkbox"/> Yes <input type="checkbox"/> No | • COPD or Emphysema? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Alcoholism or abuse, Drug addiction or abuse? | <input type="checkbox"/> Yes <input type="checkbox"/> No | • Bipolar Disorder, Schizophrenia or other psychotic disorder? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Internal Cancer, leukemia or melanoma? | <input type="checkbox"/> Yes <input type="checkbox"/> No | • Heart attack, or coronary disease? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Congestive heart failure of valvular disease? | <input type="checkbox"/> Yes <input type="checkbox"/> No | • Organ Transplant? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Kidney failure, polycystic kidney or dialysis? | <input type="checkbox"/> Yes <input type="checkbox"/> No | • Stroke or transient ischemic attack (TIA)? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Diabetes? | <input type="checkbox"/> Yes <input type="checkbox"/> No | • Brain disease, Multiple Sclerosis, Muscular dystrophy or ALS? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
3. In the past [5] years have you been convicted of a felony, or been cited on [two] or more occasions for driving while intoxicated (DUI)?

If you answered "Yes" to questions 1, 2, or 3, you are ineligible for coverage under this plan.

4. Have you been diagnosed or treated for the following conditions in the past [5] years: Please document details of "yes" answers on page [4].
Hypertension? Yes No High Cholesterol or triglycerides? Yes No

If the applicant answered yes to both of these conditions in question 4 above, please add an additional [25]% load to the standard premium for the individual(s) with these conditions. If both questions are answered yes and the applicant is a tobacco user, please add [40]% to the standard premium. Tobacco users who have one of these conditions will require a [25]% load in addition to the standard premium.]

Requested Effective Date (check one):

- I request the Company assign my effective date to be the 1st of the month following approval.
 I request an effective date of _____ (must be the [1st] or [15th] of the month).

If the Company is unable to approve the application within [60] days of the application date, the requested effective date will not be honored and a new, currently dated application may be required.

[Mode of Payment: Direct Bill: Select Monthly Quarterly or Semi-annually. Submit check for first premium payment with this application.
 Credit Card* Bank Draft*

*Drawn monthly only. Complete the IAC Monthly Automatic Payment Plan page.]

[24-hour Occupational Coverage [(complete only if applying for optional 24-hour Occupational Coverage):]

1. Is any person to be insured currently covered under Workers' Compensation? Applicant: Yes No Spouse: Yes No
2. [Are you eligible to opt out of Workers' Compensation and are you a Sole proprietor, Partner, or Owner?
Applicant: Yes No Spouse: Yes No]

Other Health Insurance In force or Pending (must be completed for primary and dependent applicants)

Yes No If yes, please provide the following information:
Carrier Name: _____ Policy No. _____ Effec. Date: _____ Termination Date: _____
Is this an employer-sponsored group health plan? Yes No
Is it your intent to be considered under HIPAA provisions? Yes No If yes, you must complete the HIPAA eligibility section of this application.

EVIDENCE OF INSURABILITY

| | |
|---|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 1. Excluding MO residents: Has any person to be insured ever been declined, postponed, rideder, or rated up for medical, disability, or life insurance with another insurance carrier? If yes, please indicate the action and explain: 1. MO residents: Has any person to be insured ever been postponed, rideder, or rated up for medical, disability, or life insurance with another insurance carrier? If yes, please indicate the action and explain: |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 2. Is any person to be insured receiving treatment, taking medication, or been advised of a condition that will require medical attention or to have medical test(s)? If yes, list names and provide details in the Health History section on the following page. |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 3. Has any person to be insured received or are currently receiving disability benefits? If yes, list names and type of coverage: |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 4. Has any person to be insured ever been diagnosed or tested positive for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex by a Physician or member of the medical profession? If yes, list names: |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 5. Has anyone to be insured had breast implants, pin, plate, or other implants? If yes, list names and provide details on the following page. |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 6. Has any person to be insured had any convictions for reckless driving or driving under the influence of alcohol or drugs? If yes, list name, violation(s) and date(s) of occurrence in the Health History section on the following page. |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 7. In the past [5] years, has any person to be insured engaged in, or plan to engage in, any hazardous sport including, but not limited to: scuba diving, rodeo activities, skydiving or auto, motorcycle or motor boat racing? If yes, please explain on the following page. |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 8. Is any person to be insured now pregnant, an expectant parent, or in the process of adopting a child, whether applying for coverage or not? If yes, list names and provide details in the Health History section on the following page. |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 9. Is any person to be insured currently taking or been prescribed medications within the past [12] months? List details/medications on the following page. |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 10. Has any person to be insured previously applied for a policy administered by Insurers Administrative Corporation? If yes, list the policy number: _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 11. Has any person to be insured been hospitalized within the last [7] years? If yes, list names and provide details on the following page. |

12. Within the past [seven] years, has any person to be insured had any symptoms, diagnosis, consultation, treatment, or taken any medication or received counseling for (MARK ALL THAT APPLY):

| Condition | Yes | No | Condition | Yes | No | Condition | Yes | No |
|--|-----|----|---|-----|----|--|-----|----|
| Abnormal Test Results | | | Eye Disorders | | | Neurological Disease | | |
| Alcoholism/Alcohol Abuse | | | Fractures/Dislocations | | | Pap Smear, Abnormal | | |
| Allergies | | | Gallbladder Disorder | | | Paralysis | | |
| Arthritis or Rheumatism | | | Headaches/Migraine | | | Prostate/Rectal Disorder | | |
| Asthma/Respiratory Disorder | | | Heart Disorder/Murmur/Heart Attack/Coronary Artery Disease | | | Reproductive Organs Disorder/Endometriosis | | |
| Back/Muscle or Joint Disorder | | | Hepatitis: A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> | | | Sexually Transmitted Diseases | | |
| Bladder Disorder | | | Hernia | | | Sinus Disorder | | |
| Blood Disorder/Hemophilia | | | High Blood Pressure/Hypertension | | | Skin Disorder | | |
| Bone Disease/Deformity | | | High Cholesterol | | | Sleep Disorders | | |
| Breast Disorder/Fibrocystic Breast Disease | | | Infertility Testing/Treatment | | | Spinal Disorder/Back/Neck Strain | | |
| Cancer | | | Kidney Disorder | | | Stroke | | |
| Colitis, Spastic Colon, Polyps | | | Liver Disorder | | | Thyroid or Goiter | | |
| Congenital Disorder | | | Lupus/Systemic or Discoid | | | Transplants | | |
| Cystic Fibrosis | | | Lymphadenopathy/Immune Disorder | | | Tuberculosis | | |
| Diabetes/Pancreatic Disorders | | | Menstrual Disorder | | | Tumors/Cysts/Polyps/Growths | | |
| Digestive Disorder/Reflux | | | Mental, Nervous, Emotional Disorder / Anxiety/Depression/Attention Deficit Disorder | | | Ulcerative Colitis/Crohn's/ Regional Ileitis | | |
| Drug Addiction | | | Mental Retardation | | | Ulcers | | |
| Ear/Throat Disorders | | | Down's Syndrome | | | Urinary Tract Disorder | | |
| Eating Disorder/Anorexia/ Bulimia | | | Muscular Dystrophy | | | Vascular Disorder | | |
| Emphysema/Lung Disorder/COPD | | | Cerebral Palsy | | | Other conditions | | |
| Epilepsy and/or Seizure | | | Brain or Nerve Disorder | | | | | |

If you answered "Yes" to any of the above conditions, list the condition and provide details in the Health History section on the following page.

[I attest that the information provided above is true, complete and correct.

Name of Applicant or parent, if applicant is under age [18] (print) _____ Name of Spouse if applying for coverage (print) _____ Date _____

Signature of Applicant or parent, if applicant is under age [18] _____ Signature of Spouse if applying for coverage _____ Date] _____

HEALTH HISTORY

INSTRUCTIONS: Provide complete details to any question marked "Yes" in the Evidence of Insurability section in the space provided below. We may need to request additional information regarding your or any of your dependents' health history from you or your or your dependents' attending physician. If you need more space, please use the Health History Supplementary Form located at the end of this application.

| Question # | Applicant's Name | Condition(s) & Treatment | Date of Onset and Last Office Visit Mo./Yr. | Recovery Date Mo./Yr. | Complete Names and Addresses of Physicians & Hospitals |
|------------|------------------|--------------------------|---|-----------------------|--|
| | | | / | / | |
| | | | / | / | |
| | | | / | / | |
| | | | / | / | |
| | | | / | / | |
| | | | / | / | |
| | | | / | / | |

LAST PHYSICIAN SEEN

INSTRUCTIONS: List the name of the last medical care provider you visited and the condition that was treated.

| Physician's Name | Applicant's Name | Address | Condition(s) & Treatment | Phone | Dates visited |
|------------------|------------------|---------|--------------------------|-------|---------------|
| | | | | | / |
| | | | | | / |
| | | | | | / |
| | | | | | / |

MEDICATIONS CURRENTLY PRESCRIBED OR BEING USED

INSTRUCTIONS: List all medications prescribed or taken by you or your dependents currently and in the past [12] months.

| Applicant's Name | Medications | Frequency & Dosage | Length of time on medication | Date medication was last taken | Complete Names and Addresses of Physicians |
|------------------|-------------|--------------------|------------------------------|--------------------------------|--|
| | | | | / | |
| | | | | / | |
| | | | | / | |
| | | | | / | |
| | | | | / | |

[I attest that the information provided above is true, complete and correct.

Name of Applicant or parent, if applicant is under age [18] (print)

Name of Spouse if applying for coverage (print)

Date

Signature of Applicant or parent, if applicant is under age [18]

Signature of Spouse if applying for coverage

Date]

FRAUD WARNING

The following states require that insurance applicants acknowledge a fraud warning statement.

Please refer to the fraud warning statement for your state as indicated below.

[For Proposed Insureds in ARKANSAS and WEST VIRGINIA

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Proposed Insureds in COLORADO

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

For Proposed Insureds in DISTRICT OF COLUMBIA

It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

For Proposed Insureds in FLORIDA

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony in the third degree.

For Proposed Insureds in NEW MEXICO

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and criminal penalties.

For Proposed Insureds in OHIO

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

For Proposed Insureds in OKLAHOMA

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

For Proposed Insureds in PENNSYLVANIA

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For Proposed Insureds in TENNESSEE

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

For Proposed Insureds in VIRGINIA

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.]

HIPAA ELIGIBILITY-If applying for HIPAA coverage, complete this section and provide a copy of your Certificate of Creditable Coverage.

| | | | | |
|---|---|--|--|--|
| INSTRUCTIONS: This section must be completed if anyone applying for coverage is electing coverage under HIPAA provisions. If you reside in a state that offers coverage under a risk pool arrangement, please ask your producer about your risk pool coverage options. | | | | |
| Who is applying for HIPAA eligibility? What will the effective date of coverage be? / / | | <input type="checkbox"/> Applicant | <input type="checkbox"/> Spouse | <input type="checkbox"/> Child(ren) |
| Has anyone applying for HIPAA coverage been continuously covered by health insurance (the last of which is a group health plan) for a minimum of eighteen months? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| What was the reason the coverage terminated under the most recent health insurance plan? | Was it for non-payment of premium? Was it for fraud? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Was there a break in health insurance coverage in excess of 62 days during the past 18 months? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Is any HIPAA applicant eligible for or currently have group health insurance through an employer, spouse's employer or is a dependent on any person's plan? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Is any HIPAA applicant eligible for coverage under any of the following: COBRA, State Continuation, Federal Employee's Continuation, MEDICARE or MEDICAID? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Was the most recent coverage under COBRA or any State or Federal Continuation plan? a. If "yes," when did coverage begin _____ and when will coverage be exhausted under such plan _____? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Was the current coverage a conversion plan elected through a previous carrier? | | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

AGREEMENT & SIGNATURE

INSTRUCTIONS: Read the following information and signify your agreement with the terms of this agreement for insurance by signing and dating the application as indicated below.

Premium Payment: I agree that (1) I am responsible for making the proper monthly premium payments; (2) a grace period of 31 days is allowed for any premium due after the first premium and if such premium is not paid before the expiration of the 31 days grace period, coverage for all insured persons shall lapse as of the premium due date; (3) any negotiable premium checks received in an envelope postmarked after the thirty-one day grace period will be refunded less any amounts due (if any) from previous months; (4) negotiation of any check from or on behalf of the insured shall not constitute acceptance of premium as premium is only accepted when acknowledged and applied by insurer. There is a one-time, non-refundable application fee.

Pre-certification and Signature: I agree that failure to pre-certify treatment results in reduced benefits pursuant to the terms of the master policy.

U.S. Resident: I understand that the coverage under this plan is available to United States residents only, benefits are not payable for medical expenses outside of the United States except when traveling, and if I stay outside the United States for more than 90 days I will be deemed to be residing outside of the United States and not traveling.

Application for group plan membership I understand that I am applying as an individual for membership to the [America's Business Benefit Association] and am simultaneously applying for insurance to which I am now or may become eligible for under the provisions of the Group Master Policy issued to [America's Business Benefit Association] by [Independence American Insurance Company] I understand that my application is subject to medical underwriting and approval by [Independence American Insurance Company] or its authorized administrator in accordance with the underwriting guidelines in effect. I understand that this coverage is not an employer health plan and I certify that (a) premiums are being paid by me as a personal expense and, neither my employer nor the employer of my dependents is now or in the future will be paying any part of the premium either directly or through wage adjustments or otherwise and (b) to the best of my knowledge and belief my employer has not and will not maintain, endorse or represent this health plan as an employer health insurance plan for any purpose, including a tax deduction, individuals not meeting this certification above are not eligible for this plan. I further understand that acceptance of the check submitted with this application does not constitute approval or guarantee of coverage.

Updated Information: I agree to immediately notify [Independence American Insurance Company] or its authorized administrator if there is any change in my health or the health of my dependents that would require a change in the answers provided in this application prior to being notified of the approval of this coverage.

My answers are true, complete and correct: I have personally reviewed all of my answers to the questions on this application and any attachments to it and certify that all of the information I have provided is true, complete and correct, I agree that it is my responsibility to provide truthful, complete and correct information. I certify I fully understand the questions asked. I agree that any misstatements or failure to report information may be used as the basis of rescission or reformation of coverage for me or my dependents, if any. I agree that under no circumstances is any agent allowed to: (a) waive, alter or modify any questions; (b) permit me to inaccurately answer any question; or (c) instruct me not to disclose any particular medical condition on the application. I agree that no agent is authorized or has the authority to alter the terms of the Group Master Policy.

Attachments: I understand that any attachments to this application become a part of it.

I have reviewed and understand the policy's benefits, limitations, and exclusions, including the pre-existing condition limitation provision. I understand that the major medical health insurance coverage for each applicant, if issued, will be subject to a pre-existing condition limitation for up to [2 years]. [If the medical condition is disclosed in the Evidence of Insurability and Health History sections of this application and not specifically excluded under the certificate of coverage, the pre-existing condition limitation [is 1 year][shall not apply].

DO NOT CANCEL ANY EXISTING HEALTH INSURANCE UNTIL RECEIVING WRITTEN NOTICE OF APPROVAL.

Dated at _____ on the _____ day of _____, 20____.

City State Month Year

Name of Applicant or parent, if applicant is under age 18 (print) _____ Name of Spouse if applying for coverage (print) _____

Signature of Applicant (or parent, if applicant is under age 18) Date _____ Signature of Spouse (if applying for coverage) Date _____

PRODUCER / GENERAL AGENT INFORMATION

Producer's Name _____ Company Name _____

Producer # _____ Are you licensed in the state where the application was completed? Yes No

Are you currently appointed with IAIC in the state where the application was completed?

Yes No (If not, please refer to the Producers Guide for contracting rules.)

Address _____
Street City State Zip

Business Phone (____) _____ Fax (____) _____ E-Mail Address _____

PRODUCER'S STATEMENT: I certify that I have truly and accurately recorded all the information given to me by the applicant and I know of no other medical information about those persons applying for coverage other than that contained on this application. I understand that commissions cannot be paid unless appointed with Independence American Insurance Company.

Producer's Signature _____ Date _____ Date Application Sent to General Agent _____

[General Agent's Name: _____ General Agent's # _____

General Agent's Phone () _____ General Agent's Fax () _____ General Agent's E-Mail: _____

Date Application Received by General Agent: / / _____ Date Application Sent to IAC: / / _____

PRODUCER'S FINAL CHECKLIST

- ✓ Are all the questions answered and boxes checked?
- ✓ Has the applicant (and spouse, if applying) signed *both* Medical and Agreement on the application?
- ✓ Have you obtained a personal check from the applicant payable to Insurers Administrative Corporation?
- ✓ Have you offered the applicant the option of the Monthly Automatic Payment Plan?
- ✓ Has the applicant enclosed a voided check for the Monthly Automatic Payment Plan, if applicable?

Submit to **Independence American Insurance Company**
P.O. Box 37457, Phoenix, AZ 85069-7457
Fax No. (602) 861-6068]

Authorization for Release of Health-Related Information.

I authorize the disclosure of health information regarding, or related to the following individuals for whom an application for insurance has been submitted:

| Print Name(s): (Last) | (First) | (MI) | Date of Birth (Month/Day/Year) |
|-----------------------|---------|------|--------------------------------|
| 1 | | | / / |
| 2 | | | / / |
| 3 | | | / / |
| 4 | | | / / |
| 5 | | | / / |
| 6 | | | / / |

I authorize the disclosure of any and all information that: (i) is created or received by a health care provider, health plan including health insurer or health insurance agent, public health authority, employer, life insurer, school or university, or health care clearinghouse; and (ii) relates to the past, present, or future physical or mental health or condition of an individual listed above; the provision of health care to an individual listed above; or the past, present, or future payment for the provision of health care to an individual listed above. This authorization permits the disclosure of all medical records including without limitation those containing information relating to diagnoses, treatments, consultation, care, advice, laboratory or diagnostic tests, physical examinations, recommendations for future care, and prescription drug information.

I specifically authorize the disclosure of information related to (i) communicable diseases, including HIV, AIDS or AIDS related complex (to the extent permitted by both state and federal law); (ii) drug and alcohol abuse and treatment; (iii) mental illness and treatment; and (iv) genetic conditions including genetic testing (to the extent permitted by both state and federal law). Notwithstanding the above, this authorization does not authorize the release of psychotherapy notes.

I authorize any and all health care providers including without limitation physicians, medical practitioners, hospitals, clinics, medical or medically-related facilities, pharmacy benefit managers, pharmacies or pharmacy-related facilities; and any and all health plans, insurance companies, insurance support organizations (such as MIB Group, Inc.), business associates of health plans or insurance companies and those persons or entities providing services to such business associates to disclose the information described above.

I authorize Independence American Insurance Company ("IAIC"), including its affiliated companies, subsidiaries and business associates, including those persons or entities providing services to its business associates, to receive the disclosure of information authorized herein and use the information disclosed pursuant to this authorization.

The purpose of the disclosure authorized herein is to permit IAIC, including its affiliated companies, subsidiaries and business associates, including those persons or entities providing services to its business associates, to obtain and use the information described above to make prospective and retrospective eligibility, underwriting and risk rating determinations, including whether the individual is subject to a pre-existing condition exclusion.

This authorization shall expire twenty-four (24) months after the date on which it is executed below.

I understand that eligibility for the health plan is conditioned on my execution of this authorization for the use or disclosure of the information described above for the purpose of making eligibility, underwriting and risk rating determinations. Except as otherwise stated herein, treatment, payment, enrollment in a health plan, or eligibility for benefits is not conditioned on an authorization for the use or disclosure of the information described above.

I understand that I may revoke this authorization by sending written notice of my intent to revoke this authorization to P.O. Box 37587, Phoenix, AZ 85069, Attention Privacy Officer.

I understand that there is a possibility of re-disclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.

A copy or facsimile of this authorization shall be as valid as the original.

Signature of each Individual over the age of 18 or the Individual's Legal Representative: _____ Date: _____
 X _____
 X _____
 X _____

If signed by the individual's legal representative (e.g. a parent on behalf of a child), please describe the representative's authority to sign on behalf of the individual:

Name: _____ Authority: _____

[PLAN NAME] BENEFIT SELECTION FORM

Underwritten by Independence American Insurance Company

CASE NUMBER _____

| | |
|--|-------------------------------------|
| APPLICANT'S NAME _____ (LAST) (FIRST) (INITIAL) | SOCIAL SECURITY NUMBER _____ |
|--|-------------------------------------|

PLAN SELECTION: Design your plan by selecting your In-Network plan options. Out-of-Network benefits differ from In-Network benefits and are based on your selections below. See the product brochure for details.

| [Plan 1] | [Plan 2] | [Plan 3] | [Plan 4] | [Plan 5] | [Plan 6] |
|--|--|--|--|--|--|
| <u>Copay</u> <input type="checkbox"/> \$0-\$100 |
| <u>Deductible</u> <input type="checkbox"/> \$0-\$20,000 |
| <u>Coinsurance</u> <input type="checkbox"/> 50%-100% |
| <u>Maximum out-of-pocket options:</u> <input type="checkbox"/> \$0 - \$50,000 |

Preferred Provider Organization (PPO) Network Selected:

Optional Benefits

| | |
|---|---|
| [Outpatient Prescription Drug Coverage] | <input type="checkbox"/> Deductible & Coinsurance <input type="checkbox"/> Drug Card Outpatient Rx covered the same as any other illness. |
| [18-Month Rate Guarantee] | <input type="checkbox"/> Yes <input type="checkbox"/> No (12-Month Rate Guarantee will apply if not elected) |
| [Preventive Coverage] | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| [Supplemental Accident] | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| [Maternity Coverage] | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| [Dental Coverage] | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| [Vision Coverage] | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| [24-hour Occupational Coverage] | [Sole proprietors, partners (ownership over 10%), or business owners not covered by Workers' Compensation are eligible. Do you or your spouse qualify for this benefit? (Verification may be necessary.) Applicant: <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse: <input type="checkbox"/> Yes <input type="checkbox"/> No |

Attach this form to your *Application for Insurance*

For Administrative Use Only

| Case Number | Enter | Date | Approved By | Date | Eff Date | PCEFD |
|-------------|-------|------|-------------|------|----------|-------|
| | | | | | | |

INDEPENDENCE AMERICAN INSURANCE COMPANY

HEALTH HISTORY SUPPLEMENTAL FORM

INSTRUCTIONS: Provide complete details to any question marked "Yes" in the Evidence of Insurability section in the space provided below. We may need to request additional information regarding your health history from you or your attending physician. Attach as many of these Health History Supplemental Forms as necessary to provide complete information.

| Question # | Applicant's Name | Condition(s) & Treatment | Date of Onset and Last Office Visit Mo./Yr. | Recovery Date Mo./Yr. | Complete Names and Addresses of Physicians & Hospitals |
|------------|------------------|--------------------------|---|-----------------------|--|
| | | | / | / | |
| | | | / | / | |
| | | | / | / | |
| | | | / | / | |
| | | | / | / | |
| | | | / | / | |
| | | | / | / | |

LAST PHYSICIAN SEEN

INSTRUCTIONS: List the name of the last medical care provider you visited and the condition that was treated.

| Physician's Name | Applicant's Name | Address | Condition(s) & Treatment | Phone | Dates visited |
|------------------|------------------|---------|--------------------------|-------|---------------|
| | | | | | / |
| | | | | | / |
| | | | | | / |
| | | | | | / |

MEDICATIONS CURRENTLY PRESCRIBED OR BEING USED

INSTRUCTIONS: List all medications prescribed or taken by you or your dependents currently and in the past [12] months.

| Applicant's Name | Medications | Frequency & Dosage | Length of time on medication | Date medication was last taken | Complete Names and Addresses of Physicians |
|------------------|-------------|--------------------|------------------------------|--------------------------------|--|
| | | | | / | |
| | | | | / | |
| | | | | / | |
| | | | | / | |
| | | | | / | |

Complete and submit this form with the Independence American Insurance Company Application for Insurance.

INDEPENDENCE AMERICAN INSURANCE COMPANY
a Delaware Insurance Company

AMENDATORY ENDORSEMENT

It is understood and agreed that the Policy/Certificate to which this Amendatory Endorsement is attached is amended as follows:

[The Calendar Year Deductible amount as specified on the Schedule of Benefits has been changed from [\$250] to [\$500]]

[The Coinsurance as specified on the Schedule of Benefits has been changed from [80%] to [50%]]

[This Amendatory Endorsement amends Policy No. [xxxxx] [effective [October 1, 2006].] This Amendatory Endorsement is endorsed and made part of the Policy/Certificate to which it is attached as of [its Effective Date] [[October 1, 2006] or] [Your coverage Effective Date] [whichever is later]. The provisions of this Amendatory Endorsement are effective on the Effective Date stated herein and will expire concurrently with the Group Policy and Certificate unless otherwise terminated.

This Amendatory Endorsement is subject to all provisions of the Policy which are not in conflict with the provisions of this Amendatory Endorsement. Nothing in this Amendatory Endorsement will be held to vary, alter, waive, or extend any of the terms, conditions, provisions, agreements, or limitations of the Policy other than stated above.

IN WITNESS WHEREOF, the Insurance Company has caused this Amendatory Endorsement to be signed by its President.

INDEPENDENCE AMERICAN INSURANCE COMPANY



David Kettig
President



Adam C. Vandervoort
Secretary

INDEPENDENCE AMERICAN INSURANCE COMPANY
a Delaware Insurance Company

[OPTIONAL] DENTAL BENEFIT RIDER

This Rider is made a part of the Policy/Certificate to which it is attached. [The consideration for this Rider is the application for the Rider and payment of any applicable premium.]

When You are covered under the [Optional] Dental Benefit Rider and if specified as applicable on the Schedule of Benefits, We will pay for Covered Dental Charges a Covered Person incurs in connection with dental treatment, services or supplies described in this [Optional] Dental Benefit Rider. Payment for Covered Dental Charges are subject to:

1. The Maximum Benefits specified in the Schedule of Benefits; and
2. The exclusions and limitations contained in this Dental Benefit Rider.

A. BENEFITS

We will reimburse You for the following dental treatment, services or supplies furnished to a Covered Person. Dental benefits payable under this Rider for Covered Dental Charges are subject to the following, as specified in the Schedule of Benefits:

1. the Dental Coinsurance Percentage;
2. the Calendar Year Dental Deductible;
3. the Dental Benefit Waiting Period; and
4. the Maximum Calendar Year Dental Benefit [and the Lifetime Maximum Benefit for Dental Benefits While Covered under the Policy].

If there is more than one way to properly treat a particular dental condition, We have the right to determine if a less expensive procedure, service or supply would be appropriate. We will determine this using the dental profession's accepted standards of practice. Benefits for Covered Dental Charges will then be payable for the least expensive customary, professionally adequate treatment.

Covered Dental Charges are always subject to the least expensive customary, professionally adequate treatment including Charges incurred for the following treatments, services, or supplies:

1. Gold or porcelain, if silver or some other material would be acceptable or appropriate;
2. For partial dentures, any material other than cast chrome or acrylic;
3. Personalized fillings, inlays, or onlays or other restorations;
4. The use of special techniques, if standard techniques would be acceptable or appropriate; or
5. Replacement of a denture or bridge that could have been repaired or modified.

B. COVERED PROCEDURES [For Plans [1] and [2]]

Preventive Care (Type I) includes the following:

1. Prophylaxis (the cleaning and scaling of teeth); limited to [one] treatment in any continuous period of [6] months;
2. Routine oral exams, initial or periodic; limited to [one] exam in any continuous period of [6] months ;
3. One topical application of sodium fluoride or stannous fluoride for covered Dependent children to age 16; limited to [one] application in any continuous period of [12] months;
4. Full mouth x-rays; limited to [one] set in any continuous period of [36] months;
5. Bitewing x-rays; limited to [one] set in any continuous period of [6] months
6. Periapicals;
7. Tests and laboratory exams related to dental procedures and second opinions;
8. Emergency treatment if no other service was rendered except x-rays;
9. Space maintainers: the initial appliance for covered Dependent children to age 19, including all adjustments within the [six] month period immediately following installation; and
10. Sealants for covered Dependent children under age 14; limited to [one] treatment per tooth (permanent posterior only) or quadrant during a [36] consecutive month period.

Basic Care (Type II) includes the following:

1. Simple extractions; Abscesses;
2. Oral surgery and anesthesia or I.V. sedation for same, except for pre-orthodontics;
3. Amalgam, silicate, acrylic and composite fillings;
4. Maintenance prosthodontics; limited to [one] denture relining or rebasing in a [24] consecutive month period;
5. Tissue conditioning; limited to [two] treatments per arch within a [24] consecutive month period; and
6. Other restoration.

Major Care (Type III) includes the following:

1. Endodontic treatment (pulp capping, pulpotomy, and root canal therapy);
2. Periodontal treatment and treatment of other diseases of the gums and tissues of the mouth, except splinting;
3. Inlays, onlays, crowns (single restorations); and
4. Prosthodontics; Installation of bridges or partial or full dentures, including adjustments made within [6] months after installation (Treatment must begin after the Covered Person's Effective Date of coverage under the Dental Benefit Rider).

C. [ADDITIONAL COVERED PROCEDURES [Plan [1] only] [Applicable if Orthodontia is specified as applicable on the Schedule of Benefits]

Orthodontia (Type IV) includes the following:

Orthodontia and Orthodontic Procedures, including oral surgery and anesthesia or I.V. sedation for same, are limited to covered Dependent Children to age [19].]

D. [PREDETERMINATION OF DENTAL TREATMENT

If a Covered Person requires dental services which will cost more than the Predetermination Amount specified on the Schedule of Benefits, before beginning the dental treatment the Covered Person's Dentist must submit an advance notice of dental treatment to Us that describes the treatment necessary and the anticipated Charges. We have the right to request any additional information We deem necessary to evaluate the proposed course of treatment and Charges. This includes, but is not limited to, dental records and X-rays. Predetermination of Dental Treatment is not required for Emergency treatment, or oral examinations and prophylaxis.

We will prepare and return to You and the Covered Person's Dentist an estimate of the Covered Dental Charges for the course of treatment. This estimate is not, and should not be considered, a guarantee of payment by Us.

If a description of the procedures to be performed and an estimate of the dental Charges are not submitted in advance, the amount of the Charges included as Covered Dental Charges will be determined by Us, taking into account alternate procedures, services or courses of treatment based upon professionally endorsed standards of dental care.

[A second Predetermination of Dental Treatment will be required if the proposed course of treatment does not commence within [ninety (90)] days of the date the decision was made concerning the initial Predetermination of Dental Treatment. [A Predetermination Review must be provided for Orthodontia, if Orthodontia coverage is specified as applicable on the Schedule of Benefits.]]

E. EXCLUSIONS AND LIMITATIONS

Charges for the following dental treatment, services or supplies will not be considered as Covered Dental Charges under this Dental Benefit Rider and no benefit payments will be made for such Charges which:

1. The Covered Person would not be required to pay, which are covered by other insurance, or which would not have been billed in no insurance existed; or
2. Are related to self-inflicted injuries (while sane in Colorado or Missouri); or
3. Are related to war or an act of war, whether or not declared; or
4. Are related to the Covered Person's commission of a felony or an assault on another person; or
5. Are related to a riot, nuclear accident, or a major disaster; or
6. Are caused by, related to, or as a condition of employment, including self-employment, or which arises out of or in the course of any employment. This exclusion applies even if Workers' Compensation or any Occupational Disease or similar law does not cover the charges [and regardless of whether the Covered Person is covered under the [optional] 24-Hour Occupational Coverage Benefit Rider]; or
7. Are in excess of the Usual and Reasonable Charges; or
8. Are incurred, or for which treatment began, before the Covered Person's Effective Date of coverage under the Dental Benefit Rider or after the Covered Person's coverage under the Dental Benefit Rider is terminated; or

9. Are not appropriate and customary for the necessary care or treatment of the condition, or are primarily for cosmetic reasons; or
10. Are an Experimental Medical Treatment, Procedure or Medication; or
11. Are related to surgical implants or transplants of any type (including prosthetic devices attached to them); or
12. Are related to temporomandibular joint syndrome; or
13. Are related to periodontal splinting; or
14. Are related to facings on crowns, or pontics posterior to the 2nd bicuspid; or
15. Are for the replacement of partial or full dentures, fixed bridge work, crowns, gold restorations and jackets more often than once in any [5] year period; or
16. Are related to relining of dentures more often than once in any [2] year period; or
17. Are related to lost, stolen, or missing dentures or bridges or for duplicates; or
18. Are related to fixed or removable bridgework involving replacement of a natural tooth or teeth which was lost prior to the Covered Person's Effective Date of coverage under the Dental Benefit Rider. Benefits may be payable for bridgework required for loss of teeth while insured under the Rider, if such bridgework is not an abutment for non-covered bridgework; or
19. Are related to Prescription Medications and analgesia pre-medication; or
20. Are related to charges for telephone consultations, failure to keep a scheduled appointment, to complete claim forms or attending physician statements, and any other services or supplies which are not part of the direct treatment of the Covered Person; or
21. Are not made by a Dentist; or
22. Are related to dental education or training programs (this includes oral hygiene or plaque control programs); or
23. Are related to counseling on diet and nutrition; or
24. Are received from a Dentist who: (i) is the Insured Person's Close Relative, (ii) resides with the Covered Person, or (iii) is acting outside the scope of his/her license; or
25. Are caused by or related to a Covered Person's military service, including service in a military reserve unit; or
26. Are for dental services and supplies not otherwise specifically listed as a Covered Dental Charge; or
27. Are related to orthodontia and orthodontic procedures, [unless the [optional] Orthodontia coverage is elected on the application;[and] the required premium is paid; [and the Orthodontia coverage is specified as applicable on the Schedule of Benefits]]; or
28. Are payable under any medical insurance; or
29. Are made by any government entity unless the Covered Person is required to pay; or
30. Are related to the use of materials, other than fluorides or sealants, to prevent tooth decay; or
31. Are for bite registrations; or
32. Are bacteriologic cultures in connection with a covered dental service; or
33. Are therapeutic injections administered by a Dentist.

F. DEFINITIONS

All capitalized terms used herein shall have the same meaning as in the Policy unless otherwise stated herein. The following definitions are applicable to this Dental Benefit Rider. When used in this Rider these terms are capitalized:

Benefit Waiting Period: The period between the Effective Date of the Covered Person's coverage under the Dental Benefit Rider and the date the Covered Person becomes eligible to receive covered dental benefits. The Benefit Waiting Periods are shown on the Schedule of Benefits and vary based on the type of dental treatment and care. Separate Benefit Waiting Periods may apply for Preventive Care, Basic Care, [and] Major Care [and Orthodontia, if the optional Orthodontia benefit is elected].

[Calendar Year Dental Deductible: The amount of Covered Dental Charges that each Covered Person must satisfy each Calendar Year before the Policy will begin payment for Covered Dental Charges. The Calendar Year Dental Deductible is shown on the Schedule of Benefits. The Calendar Year Dental Deductible is separate from the Policy's Calendar Year Deductible and any separate Deductibles required under any Rider providing additional benefits that may be attached to the Policy/Certificate.]

[Calendar Year Dental Deductible Carryover: Covered Dental Charges incurred during the last [[three] months of a Calendar Year] [[three] months of the first Calendar Year [following Your Effective Date]] and used to meet that Calendar Year Dental Deductible, will also apply toward meeting the Covered Person's Calendar Year Dental Deductible for the next Calendar Year.]

[Calendar Year Dental Deductible Family Maximum: [When [3] Covered Persons under the Policy have each satisfied their Calendar Year Dental Deductible] [When the sum of all Covered Person's Covered Dental Charges used toward the individual Calendar Year Dental Deductible equals [3] times the Calendar Year Dental Deductible], no further Calendar Year Dental Deductible will apply for the remainder of that Calendar Year. [The Calendar Year Dental Deductible Family Maximum does not apply to any separate deductibles required under any Rider providing additional benefits that may be attached to the Policy/Certificate.].]]

Covered Dental Charge: The dental charges of a Dentist or Physician for the dental services, treatment or supplies which are:

1. Recommended, approved or certified by a Dentist as necessary and reasonable treatment of the condition;
2. Commonly viewed by the American Dental Association as being proper treatment;
3. Performed or ordered by:
 - a. a licensed Dentist acting within the scope of his license; or
 - b. a licensed physician performing dental services within the scope of his license; or
 - c. a licensed dental hygienist acting under the supervision and direction of a Dentist;
4. Not in excess of the Usual and Reasonable Charge for the services, treatment or supplies furnished;
5. Incurred while coverage under the Dental Benefit Rider is in force; and
6. Not otherwise excluded by the Dental Benefit Rider or the Policy.

Dentist. A person duly licensed to practice dentistry in the state in which the dental services are rendered as a Doctor of Dental Surgery (DDS) or Doctor of Medical Dentistry (DMD).

G. Termination

Coverage under this Rider will end on [the earliest of:]

1. the date coverage under the Policy ends; or
2. the premium due date coinciding with or next following the date We receive a written request to terminate the Rider].

This Rider is endorsed and made part of the Policy/Certificate as of [its Effective Date[[[October 1, 2006] or] [Your coverage Effective Date] whichever is later] [the Effective Date as specified by an attached Endorsement].

This Rider is subject to all provisions of the Policy which are not in conflict with the provisions of this Rider. Nothing in this Rider will be held to vary, alter, waive, or extend any of the terms, conditions, provisions, agreements, or limitations of the Policy other than stated above.

IN WITNESS WHEREOF, the Insurance Company has caused this Rider to be signed by its President.

INDEPENDENCE AMERICAN INSURANCE COMPANY



David Kettig
President



Adam C. Vandervoort
Secretary

INDEPENDENCE AMERICAN INSURANCE COMPANY
a Delaware Insurance Company

EXCLUSION ENDORSEMENT

This Endorsement is part of the policy/certificate to which it is attached.

In consideration for the issuance of coverage under the Policy, it is hereby understood and agreed that there will not be coverage under the Policy, nor shall any benefit be payable for:

[Any treatment, operation, or diagnostic procedure for coarctation of the aorta or any complications thereof.]

[This applies to:

[Mary Smith]

[[9/5/47]

Name]

Date of Birth]

[Effective Date 2/1/05]

[Attached to and forming a part of Certificate No. [xxx-xxx-xxxx].]

Nothing in this Exclusion Endorsement will be held to vary, alter, waive, or extend any of the terms, conditions, provisions, agreements, or limitations of the Policy other than stated above.

[This Endorsement amends Policy No. [xxxxx] [effective [October 1, 2006].] This Exclusion Endorsement is endorsed and made part of the Policy/Certificate to which it is attached as of [its Effective Date] [[October 1, 2006] or] [Your coverage Effective Date] [whichever is later]. The provisions of this Amendatory Endorsement are effective on the Effective Date stated herein and will expire concurrently with the Group Policy and Certificate unless otherwise terminated.

[Accepted by:

[Eugene Smith]

Insured Person

[1/22/06]

Date]

IN WITNESS WHEREOF, the Insurance Company has caused this Amendatory Endorsement to be signed by its President.

INDEPENDENCE AMERICAN INSURANCE COMPANY



David Kettig
President



Adam C. Vandervoort
Secretary

INDEPENDENCE AMERICAN INSURANCE COMPANY
a Delaware Insurance Company

[OPTIONAL] SUPPLEMENTAL ACCIDENT BENEFIT RIDER

This Rider is made a part of the Policy/Certificate to which it is attached. [The consideration for this Rider is the application for the Rider and payment of any applicable premium.]

When You are covered under the [Optional] Supplemental Accident Benefit Rider, and if specified as applicable on the Schedule of Benefits, We will pay [100]% of Covered Charges incurred by a Covered Person as a result of a covered Injury which occurs while the Covered Person's coverage is inforce under this Supplemental Accident Benefit Rider. Charges for the covered Injury must be incurred within [three (3) months] after the date of the covered Injury and while the Covered Person's coverage is continuously inforce under this Rider. Charges must be Usual and Reasonable. Benefits will be payable up to the Maximum Benefit per Covered Injury amount specified in the Schedule of Benefits. Covered Charges incurred in excess of the Maximum Benefit per Covered Injury amount, and Covered Charges incurred after [three (3) months] following the date of the covered Injury, are payable as any other Covered Charge under the Policy, subject to the Calendar Year Deductible and Coinsurance, and any applicable Copay, as specified in the Schedule of Benefits.

TERMINATION

Coverage under this Rider will end on [the earliest of:]

1. the date coverage under the Policy ends[; or
2. the premium due date coinciding with or next following the date We receive a written request to terminate the Rider].

This Rider is endorsed and made part of the Policy/Certificate as of [its Effective Date] [[October 1, 2006] or] [Your coverage Effective Date] [whichever is later] [the Effective Date as specified by an attached Endorsement].

This Rider is subject to all provisions of the Policy which are not in conflict with the provisions of this Rider. Nothing in this Rider will be held to vary, alter, waive, or extend any of the terms, conditions, provisions, agreements, or limitations of the Policy other than stated above.

IN WITNESS WHEREOF, the Insurance Company has caused this Rider to be signed by its President.

INDEPENDENCE AMERICAN INSURANCE COMPANY



David Kettig
President



Adam C. Vandervoort
Secretary

INDEPENDENCE AMERICAN INSURANCE COMPANY
a Delaware Insurance Company

[OPTIONAL] PREVENTIVE CARE BENEFIT RIDER

This Rider is made a part of the Policy/Certificate to which it is attached. [The consideration for this Rider is the application for the Rider and payment of any applicable premium.]

When You are covered under the [optional] Preventive Care Benefit Rider and if specified as applicable in the Schedule of Benefits, the Charges incurred by a Covered Person for the following Preventive Care Benefits, as listed in the Policy [when provided by an In-Network Provider] are included as a Covered Charge [after the Covered Person has been covered under this Preventive Care Benefit Rider as specified on the Schedule of Benefits]. Covered Charges are [subject to [the] [any applicable [Physician's Office Visit] [Outpatient Diagnostic Testing] Copay as specified on the Schedule of Benefits then benefits are] payable [at [[100%] [the Coinsurance as specified on the Schedule of Benefits]] [up to the Maximum Calendar Year Benefit for Preventive Care Benefits as specified in the Schedule of Benefits]. Covered Charges, as listed in the Policy under Section [4] – Benefits, covered item [10] Screening services, incurred in excess of the Maximum Calendar Year Benefit for Preventive Care Benefits are payable under the Policy, subject to the Calendar Year Deductible or Daily Deductible, Coinsurance, and any applicable Copay, as specified in the Schedule of Benefits.]

A. BENEFITS

[1.] Covered Charges incurred for the following Screening Services – as described in and in accordance with the age intervals in the Policy under Section [4] – Benefits, covered item [10]:

- a. Preventive care services for covered Dependent Children from birth until [18] years of age;
- b. One digital rectal examination and a prostate cancer screening known as Prostate Specific Antigen (PSA); [and]
- c. Colorectal cancer examinations and laboratory tests for colorectal cancer; [and]
- d. Routine physical examinations.]

[2.] Covered Charges for routine physical examinations [when provided by an In-Network Provider] as follows:

- a. one routine physical examination of the heart, lungs and abdomen by a Physician per Calendar Year;
- b. such diagnostic tests as may be required, and that are performed during the routine physical examination or in conjunction with the exam;
- c. an evaluation of the Covered Person's general health status by his or her primary Physician; [and]
- d. an annual flu shot; [and]
- e. Human Papillomavirus Vaccines, approved by the U.S. Food and Drug Administration and administered in accordance with the recommendations by the Advisory Committee on Immunizations Practices.]]

B. DEFINITIONS

All capitalized terms used herein shall have the same meaning as in the Policy unless otherwise stated herein.

C. TERMINATION

Coverage under this Rider will end on [the earliest of:]

1. the date coverage under the Policy ends; or
2. the premium due date coinciding with or next following the date We receive a written request to terminate the Rider].

This Rider is endorsed and made part of the Policy/Certificate as of [its Effective Date] [[October 1, 2006] or] [Your coverage Effective Date] whichever is later] [the Effective Date as specified by an attached Endorsement.]

This Rider is subject to all provisions of the Policy which are not in conflict with the provisions of this Rider. Nothing in this Rider will be held to vary, alter, waive, or extend any of the terms, conditions, provisions, agreements, or limitations of the Policy other than stated above.

IN WITNESS WHEREOF, the Insurance Company has caused this Rider to be signed by its President.

INDEPENDENCE AMERICAN INSURANCE COMPANY



David Kettig
President



Adam C. Vandervoort
Secretary

INDEPENDENCE AMERICAN INSURANCE COMPANY
a Delaware Insurance Company

[OPTIONAL] 24-HOUR OCCUPATIONAL COVERAGE BENEFIT RIDER

This Rider is made a part of the Policy/Certificate to which it is attached. [The consideration for this Rider is the application for the Rider and payment of any applicable premium.] [This Rider is applicable only to the individuals named on the Schedule of Benefits for 24-Hour Occupational coverage.]

If You are covered under the [optional] 24-hour Occupational Coverage Benefit Rider, and if specified as applicable on the Schedule of Benefits, the Certificate is amended by the addition of the following benefit:

A. BENEFITS

This benefit is not intended to take the place of Workers' Compensation insurance. If [an Insured Person] [a Covered Person] is covered by Workers' Compensation, no benefit will be paid in connection with this Rider.

With respect to [an Insured Person] [a Covered Person] who is not required to be covered and who has not elected to be covered under Workers' Compensation, any limitation or exclusion excluding benefits for Injury or Sickness which arises out of or in the course of any employment is hereby deleted.

Subject to all other provisions, terms, conditions, and limitations of the Policy, benefits may be payable for Covered Charges incurred for Injury or Sickness arising out of or in the course of any employment of [an Insured Person] [a Covered Person] who is eligible for Workers' Compensation and has legally elected not to be covered by Workers' Compensation.

B. LIMITATIONS

The benefits set out in this Rider will be paid only if:

1. The [Insured] [Covered] Person is not insured under any Workers' Compensation or similar law or required to be covered under any Workers' Compensation or similar law; [and]
2. The covered Injury or Sickness arising out of or in the course of any employment occurs while the [Insured] [Covered] Person's coverage is inforce under this Rider; [and]
3. The Charges are incurred while coverage under this Rider is inforce; [and]
4. [The [Insured] [Covered] Person's [occupation] [or] [employment status] as listed on the application for this benefit has not changed after the Effective Date of coverage under this Rider.]

The [occupation] [and] [employment] status of the [Insured] [Covered] Person at the time of claim will be the determining factor for eligibility for benefits according to this Rider.

[[Required Notice of Change in [Occupation] [or] [Change in Employment Status] [Our Right to Adjust Premium for Change in Occupational Risk]

[If the [Insured] [Covered] Person's occupation changes to an occupation different from the occupation listed on the application, the [Insured] [Covered] Person is required to notify Us [immediately] [within [thirty (30)] days of the date] of the change. [At Our option, We may adjust the premium for coverage under this Occupational Coverage Benefit Rider to reflect the change in occupation, based on Our classification of occupational risk in effect on the date of Our receipt of the [Insured] [Covered] Person's notice.]] [If the [Insured] [Covered] Person's [occupation] [or] [employment status] changes and the person is no longer a [sole proprietor], [partner], [corporate officer] [or] [owner] [or other eligible individual]] and is therefore no longer eligible for this benefit,] the [Insured] [Covered] Person is required to notify Us [immediately] [within [thirty (30)] days of the date] of the change.]]

C. TERMINATION

Coverage under this Rider will end on [the earliest of:]

1. the date coverage under the Policy ends; or
2. the premium due date coinciding with or next following the date We receive a written request to terminate the Rider].

This Rider is endorsed and made part of the Policy/Certificate as of [its Effective Date] [[October 1, 2006] or] [Your coverage Effective Date] [whichever is later] [the Effective Date as specified by an attached Endorsement].

This Rider is subject to all provisions of the Policy which are not in conflict with the provisions of this Rider. Nothing in this Rider will be held to vary, alter, waive, or extend any of the terms, conditions, provisions, agreements, or limitations of the Policy other than stated above.

IN WITNESS WHEREOF, the Insurance Company has caused this Rider to be signed by its President.

INDEPENDENCE AMERICAN INSURANCE COMPANY



David Kettig
President



Adam C. Vandervoort
Secretary

INDEPENDENCE AMERICAN INSURANCE COMPANY
a Delaware Insurance Company

APPLICATION AMENDMENT

The application for [Applicant Name], has been amended based on the answers provided in the [TAPED] underwriting telephone interview. The Application for this Major Medical insurance coverage has been amended as follows:

[The answer to medical question(s) 12. [Allergies] is YES for [Applicant Name]]

[The correct height and weight is 6'2", 200 lbs for [Applicant Name]]

[Tobacco use is YES for [Applicant Name]]

This Amendment becomes part of the Application.

Effective Date: [October 1, 2007]

[Case Number: 123456]

INDEPENDENCE AMERICAN INSURANCE COMPANY
a Delaware Insurance Company

AMENDMENT TO APPLICATION

I, [Applicant Name], hereby amend my Major Medical Insurance Application to Independence American Insurance Company under date of [10/01/07], as follows:

[[The EVIDENCE OF INSURABILITY section is clarified:]

[9.] Is any person to be insured currently taking or have you been prescribed medications within the past [12 months]? Yes No

Person's name: _____

Medications: _____

Frequency & Dosage: _____

Length of time on medication: _____

Date medication was last taken: _____

Complete Names and Addresses of Physicians _____

_____]

[The General Information section is amended by [correcting the following omission] [clarifying]:

The Date of Birth for the [Dependent] is [8/17/91].]

I hereby agree that this Amendment will be attached to and become part of my application for insurance coverage. I certify all statements contained herein are true, complete, and correct to the best of my knowledge and that no material information has been withheld or omitted.

Signature of Applicant (or parent if applicant is under age [18])

[Signature of Spouse (if applying)]

[Signature of Dependent over [18] (if applying)]

[Signature of Dependent over [18] (if applying)]

[10/01/07]

Date

[123456789]

[File Number]

INDEPENDENCE AMERICAN INSURANCE COMPANY
a Delaware Insurance Company

[OPTIONAL] GRADUATED DENTAL BENEFIT RIDER

This Rider is made a part of the Policy/Certificate to which it is attached. [The consideration for this Rider is the application for the Rider and payment of any applicable premium.]

[When You are covered under the [Optional] Graduated Dental Benefit Rider and if specified as applicable on the Schedule of Benefits,] We will pay for Covered Dental Charges a Covered Person incurs in connection with dental treatment, services or supplies described in this [Optional] Graduated Dental Benefit Rider. Payment for Covered Dental Charges are subject to:

1. The Maximum Benefits specified in [this Graduated Dental Benefit Rider] [the Schedule of Benefits]; and
2. The exclusions and limitations contained in this Graduated Dental Benefit Rider.

A. BENEFITS

We will reimburse You for the following dental treatment, services or supplies furnished to a Covered Person. Dental benefits payable under this Rider for Covered Dental Charges are subject to the Dental Coinsurance Percentage and Maximum Benefits as [shown in the following Dental Plan Schedule,] [as specified in the Schedule of Benefits]:

**[DENTAL PLAN SCHEDULE
Dental Benefit Maximums and Dental Coinsurance
Per Each Benefit Year Covered**

| | COINSURANCE | | MAXIMUM BENEFIT |
|--|--------------------|---------|--|
| Consecutive Period of Time the Covered Person is covered under this Rider: | | | Per Covered Person Per All Covered Persons |
| [12] months but less than [24] months: | [25%] | [\$125] | [\$ 250] |
| [24] months but less than [36] months | [50%] | [\$250] | [\$ 500] |
| [36] months but less than [48] months | [75%] | [\$375] | [\$ 750] |
| [48] months and longer | [100%] | [\$500] | [\$1,000] |

B. COVERED PROCEDURES

Preventive Care includes the following:

1. Prophylaxis (the cleaning and scaling of teeth); limited to [one] treatment in any continuous period of [6] months;
2. Routine oral exams, initial or periodic; limited to [one] exam in any continuous period of [6] months;
3. One topical application of sodium fluoride or stannous fluoride for covered Dependent children to age 16; limited to [one] application in any continuous period of [12] months;
4. Full mouth x-rays; limited to [one] set in any continuous period of [36] months;
5. Bitewing x-rays; limited to [one] set in any continuous period of [6] months;
6. Periapicals;
7. Tests and laboratory exams related to dental procedures and second opinions;
8. Emergency treatment if no other service was rendered except x-rays;
9. Space maintainers: the initial appliance for covered Dependent children to age 19, including all adjustments within the [six] month period immediately following installation; and
10. Sealants for covered Dependent children under age 14; limited to [one] treatment per tooth (permanent posterior only) or quadrant during a [36] consecutive month period.

Basic Care includes the following:

1. Surgical extractions of one or more teeth including impacted teeth; Abscesses;
2. Oral surgery and anesthesia or I.V. sedation as needed for the surgical extractions or abscesses covered under Basic Care procedure #1; and
3. Amalgam, silicate, acrylic and composite fillings.

C. EXCLUSIONS AND LIMITATIONS

Charges for the following dental treatment, services or supplies will not be considered as Covered Dental Charges under this Graduated Dental Benefit Rider and no benefit payments will be made for such Charges which:

1. The Covered Person would not be required to pay, which are covered by other insurance, or which would not have been billed in no insurance existed; or
2. Are related to self-inflicted injuries (while sane in Colorado or Missouri); or
3. Are related to war or an act of war, whether or not declared; or
4. Are related to the Covered Person's commission of a felony or an assault on another person; or
5. Are related to a riot, nuclear accident, or a major disaster; or
6. Are caused by, related to, or as a condition of employment, including self-employment, or which arises out of or in the course of any employment. This exclusion applies even if Workers' Compensation or any Occupational Disease or similar law does not cover the charges [and regardless of whether the Covered Person is covered under the [optional] 24-Hour Occupational Coverage Benefit Rider]; or
7. Are in excess of the Usual and Reasonable Charges; or
8. Are incurred, or for which treatment began, before the Covered Person has been continuously covered under this Graduated Dental Benefit Rider for at least [12] months, or after the Covered Person's coverage under this Rider is terminated; or
9. Are not appropriate and customary for the necessary care or treatment of the condition, or are primarily for cosmetic reasons; or
10. Are an Experimental Medical Treatment, Procedure or Medication; or
11. Are related to surgical implants or transplants of any type (including prosthetic devices attached to them); or
12. Are related to temporomandibular joint syndrome; or
13. Are related to periodontal splinting; or
14. Are related to facings on crowns, or pontics posterior to the 2nd bicuspid; or
15. Are for the replacement of partial or full dentures, fixed bridge work, crowns, gold restorations and jackets; or
16. Are related to relining of dentures; or
17. Are related to lost, stolen, or missing dentures or bridges or for duplicates; or
18. Are related to fixed or removable bridgework involving replacement of a natural tooth or teeth which was lost prior to the Covered Person's Effective Date of coverage under the Graduated Dental Benefit Rider. Benefits may be payable for bridgework required for loss of teeth while insured under the Rider, if such bridgework is not an abutment for non-covered bridgework; or
19. Are related to Prescription Medications and analgesia pre-medication; or
20. Are related to charges for telephone consultations, failure to keep a scheduled a appointment, to complete claim forms or attending physician statements, and any other services or supplies which are not part of the direct treatment of the Covered Person; or
21. Are not made by a Dentist; or
22. Are related to dental education or training programs (this includes oral hygiene or plaque control programs); or
23. Are related to counseling on diet and nutrition; or
24. Are received from a Dentist who: (i) is the Insured Person's Close Relative, (ii) resides with the Covered Person, or (iii) is acting outside the scope of his/her license; or
25. Are caused by or related to a Covered Person's military service, including service in a military reserve unit; or
26. Are for dental restorations, services and supplies not otherwise specifically listed as a Covered Dental Charge; or
27. Are related to orthodontia and orthodontic procedures, including oral surgery and anesthesia or I.V. sedation; or
28. Are payable under any medical insurance; or
29. Are made by any government entity unless the Covered Person is required to pay; or
30. Are related to the use of materials, other than fluorides or sealants, to prevent tooth decay; or
31. Are for bite registrations; or
32. Are bacteriologic cultures in connection with a covered dental service; or
33. Are therapeutic injections administered by a Dentist; or
34. Are related to endodontic treatment, including pulp capping, pulpotomy, and root canal therapy; or
35. Are related to periodontal treatment and treatment of other diseases of the gums and tissues of the mouth, including splinting; or
36. Are related to inlays, onlays, crowns (single restorations); or
37. Are related to prosthodontics, including maintenance prosthodontics; installation of bridges or partial or full dentures, including adjustments; or
38. Are related to tissue conditioning; or
39. Are incurred during the balance of the benefit year after the Maximum Benefits has been paid.

D. DEFINITIONS

All capitalized terms used herein shall have the same meaning as in the Policy unless otherwise stated herein. The following definitions are applicable to this Graduated Dental Benefit Rider. When used in this Rider these terms are capitalized:

Covered Dental Charge: The dental charges of a Dentist or Physician for the dental services, treatment or supplies which are:

1. Recommended, approved or certified by a Dentist as necessary and reasonable treatment of the condition;
2. Commonly viewed by the American Dental Association as being proper treatment;
3. Performed or ordered by:
 - a. a licensed Dentist acting within the scope of his license; or
 - b. a licensed physician performing dental services within the scope of his license; or
 - c. a licensed dental hygienist acting under the supervision and direction of a Dentist;
4. Not in excess of the Usual and Reasonable Charge for the services, treatment or supplies furnished;
5. Incurred while coverage under the Graduated Dental Benefit Rider is in force; and
6. Not otherwise excluded by the Graduated Dental Benefit Rider or the Policy.

Dentist. A person duly licensed to practice dentistry in the state in which the dental services are rendered as a Doctor of Dental Surgery (DDS) or Doctor of Medical Dentistry (DMD).

E. Termination

Coverage under this Rider will end on [the earliest of:]

1. the date coverage under the Policy ends; or
2. the premium due date coinciding with or next following the date We receive a written request to terminate the Rider].

This Rider is endorsed and made part of the Policy/Certificate as of [its Effective Date [[October 1, 2006] or] [Your coverage Effective Date] whichever is later] [the Effective Date as specified by an attached Endorsement].

This Rider is subject to all provisions of the Policy which are not in conflict with the provisions of this Rider. Nothing in this Rider will be held to vary, alter, waive, or extend any of the terms, conditions, provisions, agreements, or limitations of the Policy other than stated above.

IN WITNESS WHEREOF, the Insurance Company has caused this Rider to be signed by its President.

INDEPENDENCE AMERICAN INSURANCE COMPANY



David Kettig
President



Adam C. Vandervoort
Secretary

INDEPENDENCE AMERICAN INSURANCE COMPANY
a Delaware Insurance Company

RESCISSION ENDORSEMENT

This Endorsement is made a part of the Policy/Certificate to which it is attached.

There will not be coverage under the Policy, nor shall any benefit be payable for:

[Mary Smith]

[[9/5/47]

Name]

Date of Birth]

[Effective Date of this Exclusion Endorsement [2/1/05]]

[Attached to and forming a part of Certificate No. [xxx-xxx-xxxx].]

Nothing in this Dependent Exclusion Endorsement will be held to vary, alter, waive, or extend any of the terms, conditions, provisions, agreements, or limitations of the Policy other than stated above.

[This Endorsement amends Policy No. [xxx-xxx-xxx] effective [January 1, 2007].] Endorsed and made a part of the Certificate to which it is attached as of [its Effective Date] [[October 1, 2006] or] [Your coverage Effective Date] [whichever is later].

IN WITNESS WHEREOF, the Insurance Company has caused this Rescission Endorsement to be signed by its President.

INDEPENDENCE AMERICAN INSURANCE COMPANY



David Kettig
President



Adam C. Vandervoort
Secretary

INDEPENDENCE AMERICAN INSURANCE COMPANY
a Delaware Insurance Company

**AMENDATORY ENDORSEMENT
FOR ARKANSAS RESIDENTS ONLY**

Notwithstanding anything in the Policy and Certificate of Insurance to the contrary, it is hereby understood and agreed that the Policy and any Certificate of Insurance issued to Arkansas residents in connection therewith is amended as follows:

- A. SECTION 3 – EFFECTIVE DATE OF INSURANCE**, under the subsection **Dependents Acquired After Effective Date**, the provisions entitled “**Newborn Children**” and “**Adopted Children**” are deleted in their entirety and replaced with the following:

Newborn Children: Coverage will be effective for a newborn Child of the Insured Person for 90 days following the moment of birth. Coverage shall continue beyond the 90 day period provided that the Insured Person meets the following requirements:

1. makes a written request for coverage, on forms approved by Us, within 90 days from the birth; and
2. makes the required premium payment, if applicable.

If the above requirements are not met and the Insured Person desires to provide future coverage under the Policy in the newborn, evidence of the newborn’s insurability must be provided at no expense to Us and the newborn must meet Our then current underwriting guidelines. Coverage shall then take effect on the premium due date coincident with or next following the date on which We approve coverage and premium is paid, if applicable.

Adopted Children: Coverage will begin on the date of the filing of a petition for adoption if the Insured Person applies for coverage within 60 days after the filing of the petition for adoption. However, coverage will begin from the moment of birth if the petition for adoption and application for coverage is filed within 60 day after the birth of the minor. Coverage shall continue beyond the 60 day period provided that the Insured Person meets the following requirements:

1. makes written request for coverage, on forms approved by Us, within 60 days from placement; and
2. makes the required premium payment, if applicable.

If the above requirements are not met and the Insured Person desires to provide future coverage under the Policy for the adopted Child, evidence of the adopted Child’s insurability must be provided at no expense to Us and the adopted Child must meet Our then current underwriting guidelines. Coverage shall then take effect on the premium due date coincident with or next following the date on which We approve coverage and premium is paid, if applicable.

- B. SECTION 4 – BENEFITS** the following changes are hereby made:

1. Item 7 pertaining to ambulance services, the following has been added:

Ambulance benefits include transportation of a newborn adopted child or child Placed for Adoption from the place of birth to the nearest specialized treatment center.

We will reimburse directly any provider of covered ambulance service for Covered Charges as long as reimbursement is not received from any other source. The Covered Person or the provider of the service may submit the claim.

2. Item 9 pertaining to Mastectomy, subparagraph a., pertaining to Inpatient Hospital care, has been deleted and replaced with the following:
 - a. Inpatient care following a mastectomy for up to 48 hours unless the decision to discharge the Insured Person before the expiration of the minimum length of stay is made by an attending Physician in consultation with the Insured Person.
3. Item 10 pertaining to Screening services, subparagraph a. pertaining to preventive care services for covered Dependent Children is deleted and replaced with the following:

Preventive Care Services for covered Dependent Children from birth through [18] years of age as follows:

- 1) Newborn screening tests for hypothyroidism, PKU, galactosemia, sickle-cell anemia, and all other disorders of metabolism for which screening is performed by or for the state of Arkansas, as well as any testing of newborn infants as mandated by law;
- 2) Routine nursery care and pediatric charges for a well newborn child for up to 5 full days in a hospital nursery or until the mother is discharged from the hospital following the birth of the child, whichever is the lesser period of time;
- 3) Periodic preventive care visits from the moment of birth through 18 years of age. Coverage includes 20 visits under the supervision of a single Physician during the course of one visit, and at the following intervals: birth; 2 weeks; 2 months; 4 months; 6 months; 9 months; 12 months; 15 months; 18 months; 2 years; 3 years; 4 years; 5 years; 6 years; 8 years; 10 years; 12 years; 14 years; 16 years; and 18 years.

Preventive screenings may include, as recommended by a Physician, physical examinations, measurements, sensory screening, neuropsychiatric evaluation, development screening, hereditary and metabolic screening at birth, immunizations, urinalysis, tuberculin tests, and hematocrit, hemoglobin, sickle hemoglobinopathy and other appropriate blood tests.

Immunizations are not subject to the satisfaction of the Calendar Year Deductible or Daily Deductible or Coinsurance.

For the purposes of this benefit, the following definition applies:

“Periodic preventive care visits” means the routine tests and procedures for the purpose of detection of abnormalities or malfunctions of bodily systems and parts according to accepted medical practice.

4. Item 11 pertaining to Outpatient diabetes self-management training and education, subsection c. 3) has been added:
 - 3) One lifetime training program per Insured Person for diabetes self-management training when Medically Necessary as determined by a Physician and when provided by an appropriately licensed health care professional upon certification by the health care professional providing the training that the Insured Person has successfully completed the training is covered. In addition to the one lifetime training program provided, additional diabetes self-management training in the event that a Physician prescribes additional diabetes self-management training and it is Medically Necessary because of a significant change in the Insured Person’s symptoms or conditions.

5. The following benefits are hereby added:

[25.] Medical Foods and Low Protein Modified Food Products if:

1. The Medical Foods or Low Protein Modified Food Products are prescribed as Medically Necessary for the therapeutic treatment of phenylketonuria PKU, galactosemia, organic acidemias, and disorders of amino acid metabolism;
2. The products are administered under the direction of a Physician; and

3. The cost of the Medical Foods or Low Protein Modified Food Products for a Covered Person exceeds the income tax credit of two thousand four hundred dollars (\$2,400) per year per person allowed under Arkansas Code Section [23-79-702](#).

For the purposes of this benefit, the following definitions apply:

“Medical Foods” means a food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by recognized scientific principles and formulated to be consumed or administered enterally under the direction of a Physician.

“Low Protein Modified Food Product” means a food product that is specifically formulated to have less than one (1) gram of protein per serving and intended to be used under the direction of a Physician for the dietary treatment of an inherited metabolic disease.

- [26.] General anesthesia and Hospital or Ambulatory Surgical Center charges for services performed in connection with dental procedures in a Hospital or Ambulatory Surgical Center if: (a) the provider treating the Covered Person certifies that because of the Covered Person’s age, condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedures; and (b) the patient is: (i) a covered Dependent Child under 7 years of age who is determined by two dentists to have a significantly complex dental condition; (ii) a Covered Person diagnosed with a serious mental or physical condition; or (iii) a Covered Person with a significant behavioral problem as determined by his or her Physician. This benefit does not apply to TMJ. This benefit will not duplicate any benefit that may be payable under the [Optional Dental Benefit Rider][Optional Graded Dental Benefit Rider].

C. SECTION 5 – EXCLUSIONS AND LIMITATIONS FROM COVERAGE – the following change[s] [is] [are] hereby made:

Item #25 pertaining to Contraceptive [drugs] and devices is deleted in its entirety and replaced with:

25. Contraceptive [drugs and,] devices, including, but not limited to, injectable, implantable or intradermal patch contraceptives, and any professional service fees related to the insertion or removal of such contraceptives, [unless prescribed by a Physician as Medically Necessary treatment of a Sickness], [unless the Covered Person is covered under the under the Prescription Medication Benefit Rider, and such Rider is specified as applicable on the Schedule of Benefits]

D. SECTION 8- TERMINATION OF INSURANCE- the following change[s] [is] [are] hereby made:

1. The paragraph following Dependent Insurance is deleted and replaced with the following:

The attainment of the limiting age by a covered 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 or physical incapacity and Chiefly Dependent on You for support and maintenance.

“Chiefly Dependent” means the covered Dependent receives the majority of his/her financial support from You. If a covered Dependent is handicapped beyond the limiting age and You desire continued coverage for Your covered Dependent. You must provide written proof that the covered Dependent is Chiefly Dependent. Thereafter, We may request such proof no more frequently than annually. In the absence of such proof, We may terminate the coverage of such person after the attainment of the limiting age.

2. The following provision is added after **Continuation of Coverage**:

Entitled to Convert. A Covered Person is entitled to convert under this option if the covered person’s coverage under the policy terminates for any reason other than due to nonpayment of premium or fraud or material misrepresentation, or because the policy was replaced by a similar policy within 31 days after discontinuance.

We will not issue a converted policy to any covered person who is:

1. Covered or could be covered by Medicare; or
2. Covered for full coverage including pre-existing conditions by another hospital, surgical, or major medical expense insurance policy.

A covered person may convert and remain covered by that conversion policy until all pre-existing conditions are covered for such person under his or her coverage through another group policy.

E. SECTION 10 – GENERAL PROVISIONS the following change[s] [is] [are] hereby made:

1. Item **K. Recovery of Overpayments** the following is added:

Except in cases of fraud committed by a health care provider, We may exercise recoupment from a provider only during the 18 month period after the date We paid the claim submitted by the health care provider. If We exercise recoupment, We shall give the health care provider a written or electronic statement specifying the basis for the recoupment. The statement will provide the following information: (a) the amount of the recoupment; (b) the Insured Person's name to whom the recoupment applies; (c) the patient identification number; (d) date of date of service; (e) service or services on which the recoupment is based; (f) pending claims being recouped or future claims that will be recouped; and (g) specific reasons for the recoupment. As used in this section, recoupment means any action or attempt by a health care insurer to recover or collect payments already made to the health care provider with respect to a claim: (a) by reducing other payments currently owed to the health care provider; (b) by withholding or setting off the amount against current or future payments to the health care provider; (c) by demanding payment back from a health care provider for a claim already paid; or (d) by any other manner that reduces or affects the future claim payments to the health care provider.

2. Item **G. Time of Payment of Claims** is deleted in its entirety and replaced with the following:

Payments for Covered Charges will be paid subject to written proof of loss. Any balance unpaid at the end of liability will be paid on receipt of written proof of loss. Covered Charges paid by the Policy will be paid within 45 days following the date on which We or Our authorized Plan Administrator receives written proof of loss, and 30 days following the date of receipt of an electronic proof of loss in which no additional information is needed. Covered Charges for Claims payable under the Policy are overdue if not paid within 45 days for non-electronic claims and 30 days for electronic claims after We, or Our Plan Administrator, receives proof of loss and necessary medical information or other information required by Us as essential to administer the provisions of the Policy including, but not limited to, the Coordination of Benefits and Subrogation Provisions. If such information is not supplied as to the entire Claim, the amount supported by reasonable proof is overdue if not paid within 45 days. Any part or all of the remainder of the Claim that is later supported by such proof is over due if not paid within 45 days.

3. Item **N. Arbitration Action**, has been deleted in its entirety and replaced with the following:

N. Legal Action

No legal action may be brought to recover benefits under the Policy prior to the expiration of 60 days after written proof of loss has been furnished. No such action will be brought after the expiration of 3 years following the date written proof of loss was required to be furnished.

4. Item **O. Arbitration**, has been deleted in its entirety.

This Amendatory Endorsement is endorsed and made part of the Policy/Certificate as of its Effective Date.

Nothing in this Amendatory Endorsement shall be held to vary, alter, waive or extend any of the terms, conditions, agreements, provisions or limitations of the Policy, other than as stated above.

INDEPENDENCE AMERICAN INSURANCE COMPANY



David Kettig
President



Adam C. Vandervoort
Secretary

INDEPENDENCE AMERICAN INSURANCE COMPANY
A Delaware Insurance Company

POLICYHOLDER ELECTION FORM
ARKANSAS RESIDENTS ONLY

As elected by the Policyholder, and in consideration of any applicable additional premium for each Arkansas resident Certificate holder for each benefit option selected, Covered Charges will include all or any of the following, which will be paid in lieu of any similar benefits described in the Policy. We will not duplicate benefits payable elsewhere under the Policy or any attached Rider.

[1.] Accept _____ Reject _____ Speech and Hearing Impairment (23-79-130)

[2.] Accept _____ Reject _____ Treatment of Alcohol and Drug Dependency (23-79-139)

[3.] Accept _____ Reject _____ Disorders of the face, neck and head (23-79-150)

Note to Policyholder: If you reject option (3), covered benefits to insureds or enrollees will not include temporomandibular joint disorder or craniomandibular disorder.

[4.] Accept _____ Reject _____ Mental Illness Benefit (23-86-113)(23-79-142)

As the Policyholder, we request that you indicate above whether you accept or reject these optional benefits:

Policyholder Name: _____

Signed for the Policyholder _____

Name _____ Title _____ Date _____

INDEPENDENCE AMERICAN INSURANCE COMPANY
a Delaware Insurance Company

**AMENDATORY ENDORSEMENT
FOR ARKANSAS RESIDENTS ONLY**

As elected by the Policyholder, and in consideration of any applicable premium, Covered Charges will include the following, which will be paid in lieu of any similar benefits described in the Policy. We will not duplicate benefits payable elsewhere under the Policy or any attached Rider.

A. SECTION 4 – BENEFITS – item [15] pertaining to Outpatient Chemical Dependency Disorders is deleted in its entirety and replaced with the following:

[15.] Outpatient treatment of Chemical Dependency Disorders.

Benefits for Chemical Dependency Disorders are subject to the following maximums:

- (1) for each 24-month period, benefits are limited to \$6,000 for the Medically Necessary care and treatment of Chemical Dependency Disorders;
- (2) for each 30-day period, benefits are limited to \$3,000 for the Medically Necessary care and treatment of Chemical Dependency Disorders; and
- (3) limited to \$12,000 per Covered Person per lifetime.

B. SECTION 5 – EXCLUSIONS AND LIMITATIONS FROM COVERAGE the following change[s] [is] [are] hereby made:

1. Item #36 pertaining to [Inpatient] Chemical Dependency Disorders is deleted in its entirety.

[2.] Item #[67] pertaining to [Outpatient] treatment of Chemical Dependency Disorders is deleted in its entirety.]

This Amendatory Endorsement is endorsed and made part of the Policy/Certificate as of its Effective Date.

Nothing in this Amendatory Endorsement shall be held to vary, alter, waive or extend any of the terms, conditions, agreements, provisions or limitations of the Policy, other than as stated above.

INDEPENDENCE AMERICAN INSURANCE COMPANY



David Kettig
President



Adam C. Vandervoort
Secretary

INDEPENDENCE AMERICAN INSURANCE COMPANY
a Delaware Insurance Company

**AMENDATORY ENDORSEMENT
FOR ARKANSAS RESIDENTS ONLY**

As elected by the Policyholder, and in consideration of any applicable premium, Covered Charges will include the following, which will be paid in lieu of any similar benefits described in the Policy. We will not duplicate benefits payable elsewhere under the Policy or any attached Rider.

A. SECTION 4 – BENEFITS – the following benefit is hereby added:

[25.] Care and treatment of loss or impairment of speech or hearing.

B. SECTION 5 – EXCLUSIONS AND LIMITATIONS FROM COVERAGE the following change[s] [is] [are] hereby made:

1. Item #24 pertaining to routine hearing exams and treatment for improvement of hearing is deleted in its entirety.

C. SECTION 10 – DEFINITIONS the following is hereby added:

Loss or Impairment of Speech or Hearing. Those communicative disorders generally treated by a speech pathologist or audiologist licensed by the State Board of Examiners in Speech Pathology and Audiology and which fall within the scope of his or her area of certification.

This Amendatory Endorsement is endorsed and made part of the Policy/Certificate as of its Effective Date.

Nothing in this Amendatory Endorsement shall be held to vary, alter, waive or extend any of the terms, conditions, agreements, provisions or limitations of the Policy, other than as stated above.

INDEPENDENCE AMERICAN INSURANCE COMPANY



David Kettig
President



Adam C. Vandervoort
Secretary

INDEPENDENCE AMERICAN INSURANCE COMPANY
a Delaware Insurance Company

**AMENDATORY ENDORSEMENT
FOR ARKANSAS RESIDENTS ONLY**

As elected by the Policyholder, and in consideration of any applicable premium, Covered Charges will include the following, which will be paid in lieu of any similar benefits described in the Policy. We will not duplicate benefits payable elsewhere under the Policy or any attached Rider.

A. SECTION 4 – BENEFITS – item [16] pertaining to [Inpatient] [and] [Outpatient] treatment of Mental or Nervous Disorders is deleted in its entirety and replaced with the following:

[16.] Mental or Nervous Disorders provided on an Inpatient, partial Hospitalization and Outpatient basis when services are provided in a Hospital, psychiatric hospital, or Outpatient psychiatric center licensed by the Department of Health or a community mental health center certified by the Division of Mental Health Services of the Department of Human Services.

Copayment and Coinsurance combined for Mental or Nervous Disorders will not exceed 20% of Usual and Reasonable Charges.

B. SECTION 5 – EXCLUSIONS AND LIMITATIONS FROM COVERAGE the following change is hereby made:

1. Item [#68] pertaining to [Inpatient] [and] [Outpatient] treatment of Mental or Nervous Disorders is deleted in its entirety.

C. SECTION 11 – DEFINITIONS the following changes are hereby made:

1. The following definition has been added:

“Partial hospitalization” means continuous treatment for at least 4 hours but not more than 16 hours in any 24-hour period.

2. The definition of Physician has been amended to include the following:

Professional counselors and Psychological Examiners.

This Amendatory Endorsement is endorsed and made part of the Policy/Certificate as of its Effective Date.

Nothing in this Amendatory Endorsement shall be held to vary, alter, waive or extend any of the terms, conditions, agreements, provisions or limitations of the Policy, other than as stated above.

INDEPENDENCE AMERICAN INSURANCE COMPANY



David Kettig
President



Adam C. Vandervoort
Secretary

INDEPENDENCE AMERICAN INSURANCE COMPANY
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[OPTIONAL] MATERNITY BENEFIT RIDER

This Rider is made a part of the Policy to which it is attached. [The consideration for this Rider is the application for the Rider and payment of any applicable premium.]

When You are covered under the [Optional] Maternity Benefit Rider, and if specified as applicable on the Schedule of Benefits, We will pay for maternity and normal childbirth Charges incurred by the Insured Person or the Insured Person's Covered Dependent spouse in connection with treatment, services or supplies described in this [Optional] Maternity Benefit Rider. [This benefit is not subject to the [Calendar Year Deductible] [Daily Deductible] [Copay] or [Coinsurance] requirements.] Payment for Covered Charges under this Rider are subject to:

1. [The Maximum Maternity Benefit specified in the Schedule of Benefits;] [and]
2. [The Maternity Benefit Deductible specified in the Schedule of Benefits;] [and]
3. [The [Calendar Year Deductible] [Daily Deductible] [Copay] and [Coinsurance] specified in the Schedule of Benefits in connection with Covered Charges for a covered Illness;] [and]
4. The Exclusions and Limitations contained in this Maternity Benefit Rider.

A. Benefits

Covered Charges include:

1. Treatment, services or supplies received in connection with a routine pregnancy and delivery by cesarean section, including the services of a duly licensed certified Nurse Midwife and the services of Birthing Center facilities;
2. The mother's prenatal Charges, will be considered Covered Charges under this Rider, provided benefits are payable in accordance with the limitations contained in this Rider; and
3. The newborn's well baby Hospital room and board Charges, including nursery Charges.

The newborn well baby care benefit includes Charges for medical treatment, services or supplies rendered to a newborn Covered Dependent solely for the purpose of health maintenance and not for the treatment of an Injury or Sickness. Included are charges for Physicians, medical examinations, special studies, x-rays and laboratory tests, circumcision, immunizations and supplies for preventative health care and routine care furnished from the moment of birth.

Covered Charges include Inpatient post-partum care for the mother and newborn child for:

1. A minimum of forty-eight (48) hours following a vaginal delivery; or
2. A minimum of ninety-six (96) hours following delivery by cesarean section.

The length of stay may be shortened at the discretion of the Attending Physician after conferring with the mother. If the length of stay is shortened, Covered Charges include one post-partum visit within forty-eight (48) hours following discharge.

If it is determined that a continued Hospital stay is required for the mother, We will pay benefits for routine nursery charges and pediatric charges for a well newborn child for up to 5 full days in a Hospital nursery or until the mother is discharged from the Hospital following the birth of the child, whichever is the lesser period of time.

Services during such post-partum visit may include, but are not limited to:

1. physical assessment of the newborn;
2. parent education;
3. assistance and training in breast or bottle feeding;
4. assessment of the home support system; and
5. any Medically Necessary and appropriate clinical tests.

Services must be according to the guidelines in the "Guidelines for Perinatal Care" by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists.

Covered Charges include in vitro fertilization procedures when:

1. the patient is the Insured Person or the spouse of the Insured Person and is covered under the Policy;
2. the patients oocytes are fertilized with the sperm of the patient's spouse;

3. the patient and the patients spouse have a history of unexplained infertility of at least 2 years duration; or the infertility is associated with one or more of the following medical conditions:
 - (a) endometriosis;
 - (b) exposure to utero to diethylstilbestrol, commonly know as DES;
 - (c) blockage of or removal of one or more fallopian tubes (lateral or bilateral salpingectomy) not a result of voluntary sterilization; or
 - (d) abnormal male factors contributing to the infertility; and
4. the in vitro fertilization procedures are performed at a medical facility, licensed or certified by the Arkansas Department of Health, a facility certified by the Arkansas Department of Health which conform to the American College of Obstetricians and Gynecologists' guidelines for in vitro fertilization clinics, or those performed at a facility certified by the Arkansas Department of Health which meet the American Fertility Society's minimal standards for programs of in vitro fertilization; or
5. the patient has been unable to obtain a successful pregnancy through any less costly applicable infertility treatment for which coverage is available under the Policy.

The benefits for in vitro fertilization are the same as the benefits provided under the [Optional] Maternity Benefit Rider and are subject to the same Deductibles, coinsurance and out-of-pocket limitations that apply to maternity benefits. The Pre-Existing Conditions limitation for in vitro fertilization is 12 months. The lifetime maximum benefit for in vitro fertilization procedures is \$15,000.

Cryopreservation is included as an in vitro fertilization procedure.

B. EXCLUSIONS AND LIMITATIONS:

The benefits set out in this Rider will be paid only:

- [1. When delivery occurs after the Insured Person or the Insured Person's Covered Dependent spouse has been continuously covered under this Rider for at least [12] months; and]
- [2.] When delivery occurs while coverage under this Rider is inforce; and
- [3.] When Covered Charges are incurred while coverage under this Rider is inforce; and
- [4.] If benefits are not payable under the terms of the Policy due to a Complication of Pregnancy, as defined.

No reimbursement will be made to a Physician for a service performed by a Nurse Midwife.

[C.] [Pre-certification of Pregnancy]

Pre-certification is not required for Pregnancy or for a post-delivery Inpatient Confinement of 48 hours or less for a vaginal delivery, or 96 hours or less for delivery by Cesarean Section. We recommend that You notify Us of a Pregnancy as early as possible following the date of Your or Your Covered Dependent spouse's diagnosis in order to allow Us to include the You or your Dependent spouse in the health care coordination program, if appropriate.

If You or Your Covered Dependent spouse or the Attending Physician knows in advance of the delivery that the Physician expects You or your Covered Dependent spouse to be Confined for more than 48 hours following vaginal delivery, or 96 hours following delivery by Cesarean Section, You or your Covered Dependent spouse or the Attending Physician must obtain Pre-certification for the portion of the Confinement that exceeds 48 hours following vaginal delivery, or 96 hours following delivery by Cesarean Section.

If, following delivery, the Attending Physician determines that You or your Covered Dependent spouse will need to remain Confined for more than 48 hours following vaginal delivery, or 96 hours following delivery by Cesarean Section, You or the Attending Physician must notify the Pre-certification service of the continuing Inpatient Confinement as soon as reasonably possible following the determination to continue the Inpatient Confinement. If You or Your Covered Dependent spouse does not comply with Pre-Certification as outlined in this Rider, Covered Charges are subject to the Pre-Certification penalty amount, as specified in the Schedule of Benefits.]

[D.] Definitions:

All capitalized terms used herein shall have the same meaning as in the Policy unless otherwise stated herein. The following definitions are applicable to this Maternity Benefit Rider. When used in this Rider these terms are capitalized:

Attending Physician: An individual licensed under state law who is directly responsible for providing maternity or pediatric care to a mother or newborn child. A Nurse Midwife or a Physician Assistant may be an Attending Physician if licensed in the state to provide maternity or pediatric care in connection with childbirth.

Birth Center: A facility licensed as such according to the statute in the state where the facility is located.

[Maternity Benefit Deductible: The amount of Covered Charges that the Insured Person or the Insured Person's covered spouse must satisfy in connection with each routine pregnancy before the Policy will begin payment for Covered Charges under this Rider. The Maternity Benefit Deductible is specified on the Schedule of Benefits. The Maternity Benefit Deductible is separate from the Policy's Calendar Year Deductible and any separate Deductibles required under any Rider providing additional benefits that may be attached to the Policy/Certificate.]

Nurse Midwife: A person who is licensed as such according to the statute in the state where the service is rendered.

Nurse Midwife Services. Services that would be payable if provided by a Physician, and within the area of practice for which the Midwife is licensed.

[E.] TERMINATION

Coverage under this Rider will end on [the earliest of:]

1. the date coverage under the Policy ends; or
2. the premium due date coinciding with or next following the date We receive a written request to terminate the Rider].

This Rider is endorsed and made part of the Policy/Certificate as of [its Effective Date] [[October 1, 2006] or] [Your coverage Effective Date] [whichever is later] [the Effective Date as specified by an attached Endorsement].

This Rider is subject to all provisions of the Policy which are not in conflict with the provisions of this Rider. Nothing in this Rider will be held to vary, alter, waive, or extend any of the terms, conditions, provisions, agreements, or limitations of the Policy other than stated above.

IN WITNESS WHEREOF, the Insurance Company has caused this Rider to be signed by its President.

INDEPENDENCE AMERICAN INSURANCE COMPANY



David Kettig
President



Adam C. Vandervoort
Secretary

INDEPENDENCE AMERICAN INSURANCE COMPANY
a Delaware Insurance Company

[OPTIONAL] MATERNITY SCHEDULED BENEFIT RIDER

This Rider is made a part of the Policy to which it is attached. [The consideration for this Rider is the application for the Rider and payment of any applicable premium.]

When You are covered under the [Optional] Maternity Scheduled Benefit Rider, and if specified as applicable on the Schedule of Benefits, We will pay for maternity and normal childbirth Charges incurred by the Insured Person or the Insured Person's Covered Dependent spouse in connection with treatment, services or supplies described in this [Optional] Maternity Scheduled Benefit Rider. [This benefit is not subject to the [Calendar Year Deductible] [Daily Deductible] [Copay] or [Coinsurance] requirements.] Payment for Covered Charges under this Rider are subject to:

1. [The Maximum Maternity Scheduled Benefit specified in [this Maternity Scheduled Benefit Rider] [the Schedule of Benefits;] [and]
2. [The Maternity Scheduled Benefit Deductible specified in [this Maternity Scheduled Benefit Rider] [the Schedule of Benefits;]] [and]
3. [The [Calendar Year Deductible] [Daily Deductible] [Copay] and [Coinsurance] specified in the Schedule of Benefits in connection with Covered Charges for a covered illness;] [and]
4. The Exclusions and Limitations contained in this Maternity Scheduled Benefit Rider.

A. Benefits

Covered Charges include:

1. Treatment, services or supplies received in connection with a routine pregnancy and delivery by cesarean section, including the services of a duly licensed certified Nurse Midwife and the services of Birthing Center facilities;
2. The mother's prenatal Charges, will be considered Covered Charges under this Rider, provided benefits are payable in accordance with the limitations contained in this Rider; and
3. The newborn's well baby Hospital room and board Charges, including nursery Charges.

[MATERNITY BENEFIT PLAN SCHEDULE
Maternity Benefit Maximum

MAXIMUM BENEFIT

Consecutive Period of Time the Insured or the Insured Person's Covered Dependent spouse is covered under this Rider:

| | |
|--|-------------|
| [12] months but less than [24] months: | [\$2,000] |
| [24] months but less than [36] months | [\$3,000] |
| [[36] months but less than [48] months | [\$5,000]] |
| [48] months and longer | [\$7,500]]] |

The newborn well baby care benefit includes Charges for medical treatment, services or supplies rendered to a newborn Covered Dependent solely for the purpose of health maintenance and not for the treatment of an Injury or Sickness. Included are charges for Physicians, medical examinations, special studies, x-rays and laboratory tests, circumcision, immunizations and supplies for preventative health care and routine care furnished from the moment of birth.

Covered Charges include Inpatient post-partum care for the mother and newborn child for:

1. A minimum of forty-eight (48) hours following a vaginal delivery; or
2. A minimum of ninety-six (96) hours following delivery by cesarean section.

The length of stay may be shortened at the discretion of the Attending Physician after conferring with the mother. If the length of stay is shortened, Covered Charges include one post-partum visit within forty-eight (48) hours following discharge.

If it is determined that a continued Hospital stay is required for the mother, We will pay benefits for routine nursery charges and pediatric charges for a well newborn child for up to 5 full days in a Hospital nursery or until the mother is discharged for the Hospital following the birth of the child, whichever is the lesser period of time.

Services during such post-partum visit may include, but are not limited to:

1. physical assessment of the newborn;
2. parent education;
3. assistance and training in breast or bottle feeding;
4. assessment of the home support system; and
5. any Medically Necessary and appropriate clinical tests.

Services must be according to the guidelines in the "Guidelines for Perinatal Care" by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists.

Coverage is provided for invitro fertilization procedures when:

1. the patient is a Covered Person covered under the Policy;
2. the patients oocytes are fertilized with the sperm of the patient's spouse;
3. the patient and the patients spouse have a history of unexplained infertility of at least 2 years duration; or the infertility is associated with one or more of the following medical conditions:
 - (a) endometriosis;
 - (b) exposure to utero to diethylstilbestrol, commonly know as DES;
 - (c) blockage of or removal of one or more fallopian tubes (lateral or bilateral salpingectomy) not a result of voluntary sterilization; or
 - (d) abnormal male factors contributing to the infertility; and
4. the invitro fertilization procedures are performed at a medical facility, licensed or certified by the Arkansas Department of Health, a facility certified by the Arkansas Department of Health which conform to the American College of Obstetricians and Gynecologists' guidelines for invitro fertilization clinics, or those performed at a facility certified by the Arkansas Department of Health which meet the American Fertility Society's minimal standards for programs of invitro fertilization; or
5. the patient has been unable to obtain a successful pregnancy through any less costly applicable infertility treatment for which coverage is available under the Policy.

The benefits for in vitro fertilization are the same as the benefits provided under the [Optional] Maternity Benefit Rider and are subject to the same Deductibles, coinsurance and out-of-pocket limitations that apply to maternity benefits. The Pre-Existing Conditions limitation for in vitro fertilization is 12 months. The lifetime maximum benefit for in vitro fertilization procedures is \$15,000.

Cryopreservation is included as an invitro fertilization procedure.

B. EXCLUSIONS AND LIMITATIONS:

The benefits set out in this Rider will be paid only:

- [1. When delivery occurs after the Insured Person or the Insured Person's Covered Dependent spouse has been continuously covered under this Rider for at least [12] months; and]
- [2.] When delivery occurs while coverage under this Rider is inforce; and
- [3.] When Covered Charges are incurred while coverage under this Rider is inforce; and
- [4.] If benefits are not payable under the terms of the Policy due to a Complication of Pregnancy, as defined.

No reimbursement will be made to a Physician for a service performed by a Nurse Midwife.

[C.] [Pre-certification of Pregnancy

Pre-certification is not required for Pregnancy or for a post-delivery Inpatient Confinement of 48 hours or less for a vaginal delivery, or 96 hours or less for delivery by Cesarean Section. We recommend that You notify Us of a Pregnancy as early as possible following the date of Your or Your Covered Dependent spouse's diagnosis in order to allow Us to include the You or your Dependent spouse in the health care coordination program, if appropriate.

If You or Your Covered Dependent spouse or the Attending Physician knows in advance of the delivery that the Physician expects You or your Covered Dependent spouse to be Confined for more than 48 hours following vaginal delivery, or 96 hours following delivery by Cesarean Section, You or your Covered Dependent spouse or the Attending Physician must obtain Pre-certification for the portion of the Confinement that exceeds 48 hours following vaginal delivery, or 96 hours following delivery by Cesarean Section.

If, following delivery, the Attending Physician determines that You or your Covered Dependent spouse will need to remain Confined for more than 48 hours following vaginal delivery, or 96 hours following delivery by Cesarean Section, You or the Attending Physician must notify the Pre-certification service of the continuing Inpatient Confinement as soon as reasonably possible following the determination to continue the Inpatient Confinement. If You or Your Covered Dependent spouse does not comply with Pre-Certification as outlined in this Rider, Covered Charges are subject to the Pre-Certification penalty amount, as specified in the Schedule of Benefits.]

[D.] Definitions:

All capitalized terms used herein shall have the same meaning as in the Policy unless otherwise stated herein. The following definitions are applicable to this Maternity Scheduled Benefit Rider. When used in this Rider these terms are capitalized:

Attending Physician: An individual licensed under state law who is directly responsible for providing maternity or pediatric care to a mother or newborn child. A Nurse Midwife or a Physician Assistant may be an Attending Physician if licensed in the state to provide maternity or pediatric care in connection with childbirth.

Birthing Center: A facility licensed as such according to the statute in the state where the facility is located.

[Maternity Scheduled Benefit Deductible: The amount of Covered Charges that the Insured Person or the Insured Person's covered spouse must satisfy in connection with each routine pregnancy before the Policy will begin payment for Covered Charges under this Rider. The Maternity Scheduled Benefit Deductible is specified on the Schedule of Benefits. The Maternity Scheduled Benefit Deductible is separate from the Policy's Calendar Year Deductible and any separate Deductibles required under any Rider providing additional benefits that may be attached to the Policy/Certificate.]

Nurse Midwife: A person who is licensed as such according to the statute in the state where the service is rendered.

Nurse Midwife Services. Services that would be payable if provided by a Physician, and within the area of practice for which the Midwife is licensed.

[E.] TERMINATION

Coverage under this Rider will end on [the earliest of:]

1. the date coverage under the Policy ends[; or
2. the premium due date coinciding with or next following the date We receive a written request to terminate the Rider].

This Rider is endorsed and made part of the Policy/Certificate as of [its Effective Date] [[October 1, 2006] or] [Your coverage Effective Date] [whichever is later] [the Effective Date as specified by an attached Endorsement].

This Rider is subject to all provisions of the Policy which are not in conflict with the provisions of this Rider. Nothing in this Rider will be held to vary, alter, waive, or extend any of the terms, conditions, provisions, agreements, or limitations of the Policy other than stated above.

IN WITNESS WHEREOF, the Insurance Company has caused this Rider to be signed by its President.

INDEPENDENCE AMERICAN INSURANCE COMPANY



David Kettig
President



Adam C. Vandervoort
Secretary

INDEPENDENCE AMERICAN INSURANCE COMPANY
a Delaware Insurance Company

[OPTIONAL] PRESCRIPTION MEDICATION BENEFIT RIDER

This Rider is made a part of the Policy/Certificate to which it is attached. [The consideration for this Rider is the application for the Rider and payment of any applicable premium.]

A. OUTPATIENT COVERED PRESCRIPTION MEDICATION CHARGES

When You are covered under the [Optional] Prescription Medication Benefit Rider, and if specified as applicable on the Schedule of Benefits, Charges for covered Prescription Medications provided to a Covered Person through a[n In-Network] Pharmacy will be paid subject to [a [Co-payment], [Coinsurance] [and] [or] [a Outpatient Prescription Medication Calendar Year Deductible]] [the [Calendar Year Deductible] [Daily Deductible], Coinsurance [and Maximum Benefits] as applicable to other Covered Charges] as specified on the Schedule of Benefits. [A Maximum Calendar Year Prescription Medication Benefit will apply to all covered Prescription Medications as specified on the Schedule of Benefits.]

B. PRESCRIPTION BENEFIT

We will reimburse the Insured Person for Outpatient [Generic] Prescription Medication Charges incurred by a Covered Person for, or related to, the treatment of a covered Injury or Sickness. In order for Outpatient [Generic] Prescription Medication Charges to be reimbursed as Covered Charges, the Outpatient [Generic] Prescription Medication must be:

1. Approved by the United States Federal Drug Administration (FDA); and
2. Lawfully obtainable only upon the written prescription of a Physician; and
3. Prescribed by a Physician; and
4. Obtained from a licensed pharmacist.

Covered Charges include hormone replacement therapy when prescribed or order for treating symptoms and conditions of menopause.

[Covered Charges under this Prescription Medication Benefit Rider also include [Outpatient contraceptive [drugs] [and] [devices], [including injectable medications, implantable or intradermal patch contraceptives].]

[The [Outpatient Prescription Medication Calendar Year Deductible,] [Co-payment,] [and] [Coinsurance] may vary by the type of prescription being dispensed:

- [Generic Medications]
- [Formulary Brand Drugs]
- [Non-Formulary Brand Drugs]
- [Specialty Medications]

[If the Covered Person's Physician writes a prescription that indicates a Generic Prescription Medication may be substituted for a Brand-name Prescription Medication and the Covered Person elects to obtain the Brand-name Prescription Medication instead of the Generic Prescription Medication equivalent, the Covered Person will be responsible for the applicable Brand-name Prescription Medication [Outpatient Prescription Medication Calendar Year Deductible] [Co-payment] [and] [Coinsurance] plus the difference between the cost of the Generic Prescription Medication and the Brand-name Prescription Medication.]

[The list of Formulary Brand Drugs provided is subject to change without notice. In addition, some Formulary Brand Drugs listed on the formulary list may not be covered Prescription Medications in the Policy. Please refer to Exclusions below for the list Prescription Medications not covered.]

C. PHARMACY BENEFIT MANAGER

A Pharmacy Benefit Manager (PBM) administers Your Outpatient Prescription Medication Benefit Rider. The PBM has contracted with retail pharmacies across the United States to dispense Outpatient Prescription Medications at negotiated discounted rates. A pharmacy contracted with the PBM is an In-Network Pharmacy.

1. If the dispensing Pharmacy is an In-Network Pharmacy, the Covered Person must show his or her identification card to the Pharmacist (or where applicable, to the Physician) and pay the amount specified in the Schedule of Benefits based on the type of Outpatient Prescription Medication and the level of coverage available as specified in the Schedule of Benefits. The Pharmacy will then bill the PBM for the balance of the Covered Charges.

2. If the dispensing Pharmacy is an Out-of-Network Pharmacy, [or if the Covered Person uses an In-Network Pharmacy but elects not to use his or her identification card,] the Insured Person must complete a direct reimbursement claim form, which is available from the PBM upon request, and submit it to the PBM, which will then reimburse the Insured Person [up to the amount that would have been paid if the Prescription Medication was purchased through an In-Network Pharmacy or] as though the identification card had been utilized[, less the Covered Person's [Co-payment,] [Coinsurance] [and] [or] [Outpatient Prescription Medication Calendar Year Deductible]].

D. SPECIALTY MEDICATIONS

All Specialty Medications must be obtained from a Pharmacy Benefit Manager that We have retained and designated specifically for the purpose of providing Specialty Medications. Specialty Medications must be obtained from the Pharmacy Benefit Manager We have designated [in order for the Specialty Medication to be covered] *even if the Specialty Medication is to be administered by a Physician or at a Physician's office.* The Pharmacy Benefit Manager's telephone number is on Your identification card. You should call the Pharmacy Benefit Manager to arrange for delivery of any Specialty Medication that may be prescribed to a Covered Person.

[Specialty Medications as listed under the Policy's SECTION 6 – ACCESSING AND ADMINISTERING YOUR BENEFITS are subject to the Pre-Determination Program requirements. Pre-Determination is a screening process using established medical criteria to determine whether any proposed Specialty Medication is Medically Necessary. It may also include proposing alternative treatment plans. Pre-Determination does not guarantee payment of benefits. **NO BENEFITS WILL BE PAID FOR SPECIALTY MEDICATION IN THE ABSENCE OF PRE-DETERMINATION.**]

E. DISPENSING LIMITATION

In order for Charges for Outpatient Prescription Medication to be considered Covered Charges, the dispensing Pharmacy may not dispense more than the following at one time:

1. For other than prescription mail orders: a [34]-day supply, or [100] unit doses; or
2. For prescription mail orders: a [90]-day supply.

[If the Covered Person's Physician prescribes the medication for a period longer than [34 days] the Prescription Medication may be mail ordered through PBM. Mail order Prescription Medications are limited to a [90]-day supply; self-injectible Prescription Medications are limited to a [30-] day supply. [Mail order Prescription Medications are subject to [3] Co-Payments based on the type of Prescription Medication being dispensed].]

F. RIGHT OF RECOVERY

We have the right to recover by direct payment from an Insured Person any Charges for Outpatient Prescription Medication paid by Us to the extent of the number of days, or doses, dispensed to the Covered Person beyond the date of insurance termination by reason of non-payment of premium.

G. EXCLUSIONS

Charges for the following Outpatient Prescription Medication and supplies will not be considered as Covered Charges under this Outpatient Prescription Medication Rider and no benefit payments will be made for such Charges:

1. Over-the-Counter medications, supplies or products; or
2. Medications or other agents to increase or enhance fertility or the likelihood of conception; or
3. Medications for the treatment of erectile dysfunction or to assist in or enhance sexual performance; or
4. Vitamins; [however, pre-natal vitamins will be considered Covered Charges [if the [optional] Maternity Benefit is specified as applicable on the Schedule of Benefits]]; or
5. Medications to eliminate or reduce a dependency or an addiction to tobacco including, but not limited to, the cessation or termination of cigarette, cigar, or tobacco smoking or the use of smokeless tobacco, including nicotine products, gums and transdermal patches; or
6. Medications for the treatment of hair loss or for the purpose of regrowing lost hair, such as Rogaine, Minoxidil;
7. Immunization agents, biological sera, blood or blood plasma; or
8. Experimental or Investigational Medication, except for any drugs prescribed to treat a covered chronic, disabling, life-threatening illness if the drug: (a) has been approved by the FDA for at least one indication; and (b) is recognized for treatment of the indication for which the drug is prescribed in: (i) a standard drug reference compendia; or (ii) substantially accepted peer-reviewed medical literature; or
9. Medications that are dispensed to treat a Sickness or Injury which arises out of or in the course of any employment for wage or profit; or
10. Medications for the treatment or obesity or diet control; or

11. Medications taken, prescribed or administered while an Inpatient at a Hospital, Rest Home, Sanitarium, Skilled Nursing Facility, Convalescent Hospital, Nursing Home or similar institution which operates a facility for dispensing Drugs; or
12. Therapeutic devices or appliances, support garments and other non-medicinal substances regardless of intended use; or
13. Homeopathic medications; or
14. Any medication purchased outside the United States of America; or
15. [Any Prescription Medication, including Specialty Medication, which requires Pre-Determination and which is not Pre-Determined as defined under the Policy's SECTION 6 – ACCESSING AND ADMINISTERING YOUR BENEFITS; or]
17. Any Prescription Medication dispensed in excess of the dispensing limitation [or any refill dispensed after [twelve (12)] months from the date of the Physician's original order]; or
18. [Any Charges in excess of what the PBM would have paid an In-Network Pharmacy if the Prescription was dispensed by an Out-of-Network Pharmacy; [or]]
19. Charges which are excluded under the Policy as listed under the Policy's SECTION 5 – EXCLUSIONS AND LIMITATIONS FROM COVERAGE [or];
- [20. Charges incurred during the balance of the Calendar Year after the Maximum Calendar Year Prescription Medication Benefit has been paid.]

No benefits provided hereunder are considered as Covered Charges under the Policy's SECTION 4 - BENEFITS.

Payment of any benefits for a condition hereunder does not waive Our rights to deny coverage for that condition if We determine it was a Pre-existing Condition on the Covered Person's Effective Date or if We determine the condition is otherwise not covered under the Policy.

H. DEFINITIONS

All capitalized terms used herein shall have the same meaning as in the Policy unless otherwise stated herein. The following definitions are applicable to this Prescription Medication Benefit Rider. When used in this Rider these terms are capitalized:

[Formulary Brand Drugs: Brand-name Prescription Medications that have been determined to be superior or equal to Non-Formulary Brand Prescription Medication, but are more cost effective.]

Generic Medication: Prescription Medications that are chemically and therapeutically equivalent to Brand name Prescription Medications in the same class but are not protected by a patent. The FDA approves Generic Prescription Medication as bioequivalent- meaning they perform in your body the same as a Formulary Brand and/or Non-Formulary Brand Prescription Medication. These Prescription Medications are generally less costly than their Brand-name counterparts.

[In-Network Pharmacy: Any pharmacy having legal authority to fill prescriptions and which has a service agreement with the Pharmacy Benefit Manager to dispense Prescription Medications at negotiated prices.]

[Non-Formulary Brand Drugs: Brand-name Prescription Medications that have a more cost-effective therapeutic alternative.]

[Out-Of-Network Pharmacy: A pharmacy which does not have a service agreement with the Pharmacy Benefit Manager and does not provide Prescription Medications at agreed upon prices.]

[Outpatient Prescription Medication Calendar Year Deductible: The amount of Covered Outpatient Prescription Medications that each Covered Person must satisfy each Calendar Year before the Policy will begin payment for Covered Prescription Medications. The Outpatient Prescription Medication Calendar Year Deductible is shown on the Schedule of Benefits. [If [Generic Medication,] [Formulary Brand Drugs,] [or] [Non-Formulary Brand Drugs] are purchased, the Outpatient Prescription Medication Calendar Year Deductible is accumulated separately for each type of Prescription Medication purchased.] The Outpatient Prescription Medication Calendar Year Deductible is separate from the Policy's Calendar Year Deductible and any separate Deductibles required under any Rider providing additional benefits that may be attached to the Policy/Certificate.]]

[Outpatient Prescription Medication Calendar Year Deductible Carryover: Covered Outpatient Prescription Medications incurred during the last [[three] months of a Calendar Year] [[three] months of the first Calendar Year [following Your Effective Date]] and used to meet that Outpatient Prescription Medication Calendar Year Deductible, will also apply toward meeting the Covered Person's Outpatient Prescription Medication Calendar Year Deductible for the next Calendar Year.]

[Outpatient Prescription Medication Calendar Year Deductible Family Maximum: [When [3] Covered Persons under the Policy have each satisfied their Outpatient Prescription Medication Calendar Year Deductible] [When the sum of all Covered Person's covered Prescription Medications used toward the individual Outpatient Prescription Medication Calendar Year Deductible equals [3] times the [Generic Medication] Outpatient Prescription Medication Calendar Year Deductible], [When the amount as shown on the Schedule of Benefits is satisfied,] no further Outpatient Prescription Medication Calendar Year Deductible will apply for the remainder of that Calendar Year. [The Outpatient Prescription Medication Calendar Year Deductible Family Maximum does not apply to the Outpatient Prescription Medication Calendar Year Deductible for [Formulary Brand Drugs,] [or] [Non-Formulary Brand Drugs].]]

Pharmacy Benefit Manager {PBM}: The administrator contracted by Us to administer the Outpatient Prescription Medication Benefits. The PBM has contracted with retail Pharmacies across the United States to dispense Outpatient Prescription Medications at negotiated prices.

Specialty Medications: Prescription Medications that may be administered by a Physician as an Outpatient or self-administered in a home setting and are listed on the Specialty Drug List maintained by Us or Our designee as revised from time-to-time at Our discretion.

I. TERMINATION

Coverage under this Rider will end on [the earliest of:]

1. the date coverage under the Policy ends; or
2. the premium due date coinciding with or next following the date We receive a written request to terminate the Rider].

This Rider is endorsed and made a part of the Policy/Certificate as of [its Effective Date] [[October 1, 2006] or] [Your coverage Effective Date] [whichever is later] [the Effective Date as specified by an attached Endorsement].

This Rider is subject to all provisions of the Policy which are not in conflict with the terms of this Rider. Nothing in this Rider will be held to vary, alter, waive, or extend any of the terms, conditions, provisions, agreements, or limitations of the Policy other than stated above.

IN WITNESS WHEREOF, the Insurance Company has caused this Rider to be signed by its President.

INDEPENDENCE AMERICAN INSURANCE COMPANY



David Kettig
President



Adam C. Vandervoort
Secretary

INDEPENDENCE AMERICAN INSURANCE COMPANY

SCHEDULE OF BENEFITS

[PPO PLAN]

Lifetime Maximum Benefit For All Benefits While Covered under the Policy Per Covered Person [extract_itex]5,000,000]

[Lifetime Maximum Benefit While Covered under the Policy Per Covered Person:

| | |
|---|--|
| [In-Network covered Human Organ and Tissue Transplant Services in a Center of Excellence [includes Lodging and Transportation Allowance] | [\$1,000,000]] |
| [In-Network covered Human Organ and Tissue Transplant Services | [\$250,000]] |
| [Out-of-Network covered Human Organ and Tissue Transplant Services | [\$175,000]] |
| [Mental or Nervous Disorders | [\$10,000]] |
| [Chemical Dependency Disorders | [\$10,000]] |
| [Mental or Nervous Disorders and Chemical Dependency Disorders combined | [\$10,000]] |
| [Hospice Care | [\$5,000] [6 months of Covered Charges]] |

[Maximum Calendar Year Benefit for all Covered Charges for Outpatient Treatment Per Covered Person [extract_itex]20,000]]

[Maximum Calendar Year Benefit for all Covered Charges Combined Per Covered Person: [extract_itex]1,000,000]]

[[Individual] Calendar Year Deductible: [[\$1,500]] [[\$2,500] In-Network Providers [[\$5,000] Out-of-Network Providers] [The Out-of-Network Provider Calendar Year Deductible does not apply to the Calendar Year Deductible Family Maximum.]]

[[Individual] Daily Deductible: [[\$250] [for In-Network Providers; [extract_itex]500] for Out-of-Network Providers]]

[Individual Calendar Year Out-of-Pocket Maximum: [extract_itex]5,000] [for In-Network Providers; [extract_itex]10,000] for Out-of-Network Providers]]

[Individual Calendar Year Out-of-Pocket Maximum for Medical Services and Supplies: [extract_itex]3,000] [for In-Network Providers; [extract_itex]9,000] for Out-of-Network Providers]]

[Covered Charges accumulating to the Out-of-Pocket Maximum amount for medical services and supplies include the following, except for those Covered Charges incurred for services specifically designated to accumulate to the Out-of-Pocket Maximum for Inpatient and Surgical Services specified below:

- Outpatient Facility services;
- Surgery, assistant surgery and anesthesiology services, except when rendered at a Hospital or Ambulatory Surgical Center;
- Physician services [(not subject to a separate Co-pay)];
- Diagnostic Tests, Lab and X-ray [(not subject to a separate Co-pay)];
- Diagnostic Imaging Tests [(not subject to a separate Co-pay)]
- Outpatient Registered Nurse care visits and services;
- Physical, speech or occupational therapy;
- Emergency ambulance services;
- Durable Medical Equipment and medical supplies;
- Non-surgical back treatment;
- Emergency Room services (if not admitted as an Inpatient);
- Home Health Care;
- Covered Charges incurred for other medical services and supplies not specifically designated to accumulate to the Out-of-Pocket Maximum for Inpatient and surgical services]

[Pre-Certification Penalty Amounts:

| | |
|--|----------------------------|
| [Failure to Pre-Certify each Inpatient Hospital Confinement: | [Not Applicable] [\$500*]] |
| [Failure to Pre-Certify each Skilled Nursing Home Facility Inpatient Confinement | [Not Applicable] [\$500*]] |
| [Failure to Pre-Certify each Home Health Care Services | [Not Applicable] [\$500*]] |
| [Failure to Pre-Certify Hospice Care Services | [Not Applicable] [\$500*]] |
| [Failure to Pre-Certify [Complications of] Pregnancy | [Not Applicable] [\$500*]] |

| | |
|---|----------------------------|
| [Failure to Pre-Certify each Outpatient Diagnostic Imaging Test | [Not Applicable] [\$500*]] |
| [Failure to Pre-Certify Outpatient surgery in an Ambulatory Surgical Center | [Not Applicable] [\$500*]] |

*This Deductible does not apply when the Covered Person complies with the Pre-Certification Requirements

| | |
|--|--|
| [Failure to Pre-Determine Specialty Prescription Medications | [No coverage for the specified Medications]] |
| [Failure to Pre-Determine each Non-Emergency Care Ambulance Transportation | [No coverage for the Ambulance Services]] |
| [Failure to Pre-Determine Durable Medical Equipment In excess of [\$1,000] | [No coverage for the Durable Medical Equipment]] |

[COPAYS]

[Emergency Room Copay: [Not Applicable] [[\$500] per occurrence] [Not applicable if Hospital Confined as an Inpatient immediately following the Emergency Room visit.]

[Physician Office Visit or Physician Services at a Free Standing Urgent Care Center Copay: [Not applicable [subject to any applicable Calendar Year Deductible and Coinsurance]] [[\$35.00] Co-pay In-Network [[\$50.00] Copay Out-of-Network] [Out-of-Network subject to [Out-of-Network] Calendar Year Deductible and [Out-of-Network] Coinsurance] [Covered Physician office visit Charges in excess of the Physician office visit Copay are [paid at [100%] In-Network; [[80%] Out-of-Network] [subject to [Out-of-Network] Calendar Year Deductible and [Out-of-Network] Coinsurance]]]

[This Copay applies to each [In-Network] Physician office visit Charge, or the Physician's Charge at a Free Standing Urgent Care Center. [Additional Charges, including Charges for x-rays, lab and diagnostic tests, are [not] covered under this Copay [unless specifically provided for as specified on the Schedule of Benefits].] [This Copay also applies to Charges for x-rays, lab and diagnostic tests in the [In-Network] Physician's office during the same Physician office visit [subject to the maximum [\$200] benefit per visit. Covered Charges incurred in excess of the maximum benefit will be subject to any applicable Calendar Year Deductible and Coinsurance.]] [Other Covered Charges will be subject to any applicable Calendar Year Deductible and Coinsurance.]

[The Physician office visit or Physician services at a Free Standing Urgent Care Center Copay is limited to [5] visits per Calendar Year per Covered Person. Once this limit is exceeded, [no Copay will apply; Covered Charges will be subject to any applicable Calendar Year Deductible and Coinsurance] [the Copay required by the Covered Person during the balance of the Calendar Year is [\$50] In-Network, [and [\$60]] Out-of-Network [subject to the Out-of-Network Calendar Year Deductible and Coinsurance] [Charges incurred for Physician office visits or Physician services at a Free Standing Urgent Care Center will not be considered Covered Charges for the balance of that Calendar Year.]

[Outpatient X-Ray, Lab and Diagnostic Testing Copay:]
[Outpatient Diagnostic Testing Copay:]

[Not applicable [100%] [Designated Clinical Laboratory] [LabOne]]
[subject to any applicable [Calendar Year Deductible] [Daily
Deductible] and [80%] In-Network; [55%] Out-of-Network
Coinsurance]] [35] [per visit] [per test] for Outpatient [Diagnostic
Testing] [X-Ray, Laboratory and Diagnostic Testing] [by an In-Network
provider;]] [50] [per visit] [per test] [subject to Out-of-Network
[Calendar Year Deductible] [Daily Deductible] and Coinsurance] for
Outpatient [Diagnostic Testing] [X-Ray, Laboratory and Diagnostic
Testing] [by an Out-of-Network provider]] [maximum [In-Network]
benefit [200] [per visit] [per test] [per Calendar Year per Covered
Person] [maximum [In-Network] benefit [5] visits per Calendar Year
per Covered Person]. [Once the maximum benefit is exceeded [no
Copay will apply; Covered Charges will be subject to any applicable
[Calendar Year Deductible] [Daily Deductible] and Coinsurance] [the
Copay required by the Covered Person during the balance of the
Calendar Year is [50] In-Network, [and [60]] Out-of-Network [subject
to the Out-of-Network [Calendar Year Deductible] [Daily Deductible]
and Coinsurance] [Charges incurred for Outpatient [Diagnostic
Testing] [X-Ray, Laboratory and Diagnostic Testing] will not be
considered Covered Charges for the balance of that Calendar Year.]]
[The Outpatient [Diagnostic Testing] [X-Ray, Laboratory and
Diagnostic Testing] maximum benefit does not apply to Covered
Charges incurred for Screening Services as listed under the Section 4
– covered item 10.] [The Outpatient [Diagnostic Testing] [X-Ray,
Laboratory and Diagnostic Testing] does not apply to Charges subject
to the Outpatient Diagnostic Imaging Copay.]]

[Outpatient Diagnostic Imaging Copay:
((Includes, but not limited to: MRI, CAT Scan,
PET Scan, and Nuclear Imaging Tests))]

[Not applicable [subject to any applicable [Calendar Year Deductible]
[Daily Deductible] and [80%] In-Network; [55%] Out-of-Network
Coinsurance]] [35] [per visit] [per test] for [each] Outpatient
Diagnostic Imaging test, [by an In-Network provider]] [50] [per visit]
[per test] [subject to Out-of-Network [Calendar Year Deductible] [Daily
Deductible] and Coinsurance] for Outpatient Diagnostic Imaging
Testing [by an Out-of-Network provider]] [maximum [In-Network]
benefit [200] [per visit] [per test] [per Calendar Year per Covered
Person] [maximum [In-Network] benefit [5] [visits] [tests] per Calendar
Year per Covered Person]. [Once the maximum benefit is exceeded
[no Copay will apply; Covered Charges will be subject to any
applicable [Calendar Year Deductible] [Daily Deductible] and
Coinsurance] [the Copay required by the Covered Person during the
balance of the Calendar Year is [50] In-Network, [and [60]] Out-of-
Network [subject to the Out-of-Network [Calendar Year Deductible]
[Daily Deductible] and Coinsurance] [Charges incurred for Outpatient
Diagnostic Imaging Testing will not be considered Covered Charges
for the balance of that Calendar Year.]] [The Outpatient Diagnostic
Imaging Copay does not apply to Charges subject to the [Diagnostic
Testing] [X-Ray, Laboratory and Diagnostic Testing] Copay.]]

[Outpatient Surgical Services Copay:

[Not applicable [subject to any applicable [Calendar Year
Deductible] [Daily Deductible] and Coinsurance]] [250.00] Co-pay
In-Network [500.00] Copay Out-of-Network [Out-of-Network
subject to [Out-of-Network] [Calendar Year Deductible] [Daily
Deductible] and [Out-of-Network] Coinsurance] [Covered Outpatient
Surgical Services Charges in excess of the Copay are paid at
[100%] In-Network; [80%] Out-of-Network [subject to [Out-of-
Network] [Calendar Year Deductible] [Daily Deductible] and [Out-of-
Network] Coinsurance]]. This Copay applies to Covered Charges
incurred for surgical services, including surgery, assistant surgery,
and anesthesiology services received in an Outpatient Hospital or
Ambulatory Surgical Center Facility.]]

| | |
|---|---|
| [Inpatient Hospital Confinement Copay: | [Not applicable [subject to any applicable [Calendar Year Deductible] [Daily Deductible] and Coinsurance]] [[\\$250.00] Co-pay In-Network [[\\$500.00] Copay Out-of-Network] [Out-of-Network subject to [Out-of-Network] [Calendar Year Deductible] [Daily Deductible] and [Out-of-Network] Coinsurance] [Covered Inpatient Hospital Confinement Charges in excess of the Copay are paid at [100%] In-Network; [80%] Out-of-Network] [subject to [Out-of-Network] [Calendar Year Deductible] [Daily Deductible] and [Out-of-Network] Coinsurance]]. This Copay applies to Covered Charges incurred for each Inpatient Hospital Confinement.]] |
| [Inpatient Skilled Nursing Confinement Copay: | [Not applicable [subject to any applicable [Calendar Year Deductible] [Daily Deductible] and Coinsurance]] [[\\$250.00] Co-pay In-Network [[\\$500.00] Copay Out-of-Network] [Out-of-Network subject to [Out-of-Network] [Calendar Year Deductible] [Daily Deductible] and [Out-of-Network] Coinsurance] [Covered Inpatient Skilled Nursing Confinement Charges in excess of the Copay are paid at [100%] In-Network; [80%] Out-of-Network] [subject to [Out-of-Network] [Calendar Year Deductible] [Daily Deductible] and [Out-of-Network] Coinsurance]]. This Copay applies to Covered Charges incurred for each Inpatient Skilled Nursing Confinement.]] |
| [Outpatient Ambulatory Surgical Center Copay: | [Not applicable [subject to any applicable [Calendar Year Deductible] [Daily Deductible] and Coinsurance]] [[\\$250.00] Co-pay In-Network [[\\$500.00] Copay Out-of-Network] [Out-of-Network subject to [Out-of-Network] [Calendar Year Deductible] [Daily Deductible] and [Out-of-Network] Coinsurance] [Covered Outpatient Ambulatory Surgical Center Charges in excess of the Copay are paid at [100%] In-Network; [80%] Out-of-Network] [subject to [Out-of-Network] [Calendar Year Deductible] [Daily Deductible] and [Out-of-Network] Coinsurance]]. This Copay applies to Covered Charges incurred for each Outpatient Ambulatory Surgical Center visit.]] |
| [Copay Family Maximum: | When the sum of all Covered Person's Covered Charges used to satisfy the Copay exceeds [\$2,500] no further Copays will apply for the remainder of that Calendar Year. [This does not apply to Physician Office Visit and Physician Services at a Free Standing Urgent Care Center Copay.] [This does not apply to Copays if Out-of-Network Providers are used.]] |

COINSURANCE AND BENEFIT LIMITATIONS

The Coinsurance is the percentage of Covered Charges paid by the Policy, after payment by the Covered Person of any applicable Co-payments, and [Calendar Year Deductibles] [Daily Deductibles].

| | |
|--|---|
| Coinsurance: | [80%] [In-Network; [55%] Out-of-Network] of Covered Charges. [After the [Individual] [Family] Calendar Year Out-of-Pocket Maximum is met, then the Policy pays [100%] of additional Covered Charges incurring during the calendar year.] [This does not apply to the Coinsurance for [Outpatient] Mental or Nervous Disorder and Chemical Dependency Disorders treatments.] |
| [Non-Surgical Back Treatment: | [Not Covered] [[80%] [In-Network; [55%] Out-of-Network] of Covered Charges, [up to the Maximum Calendar Year Benefit of [[\\$250] per Covered Person] [[\\$500] In-Network; [\$250] Out-of-Network per Covered Person] [[30] visits per Covered person]] |
| [Physical, Speech or Occupational Therapy: | [80%] [In-Network; [55%] Out-of-Network] of Covered Charges, [up to the Maximum Calendar Year Benefit of [[\\$250] per Covered Person] [[\\$500] In-Network; [\$250] Out-of-Network per Covered Person] [[30] treatments per Covered Person for any one type of therapy and up to [60] treatments per Covered Person combined for any combination of therapies]] |

| | |
|--|--|
| [Home Health Care: | [80%] [In-Network; [55%] Out-of-Network] of Covered Charges, [up to the Maximum Calendar Year Benefit of [[\$250] per Covered Person] [[\$500] In-Network; [\$250] Out-of-Network per Covered Person] [[30] visits per Covered Person]] |
| [Hospice Care: | [100%] of Covered Charges, up to the Lifetime Maximum Benefit While Covered under the Policy]] [Not subject to the [Calendar Year Deductible] [Daily Deductible] [Coinsurance] [and] [Copay]] |
| [Skilled Nursing Facility Services: | [80%] [In-Network; [55%] Out-of-Network] of Covered Charges, [up to the Maximum Calendar Year Benefit of [[\$100] per day and a maximum of [50] days per Covered Person]] |
| [Licensed Ambulance Service: | [80%] [up to a Maximum Benefit of [[\$500] [per occurrence] [per Calendar Year]] [[\$500] [per ground occurrence] [per Calendar Year for ground ambulance services]; [[\$500] [per water occurrence] [per Calendar Year for water ambulance services]; [[\$1,000] [per air occurrence] [per Calendar Year for air ambulance services] [[air] ambulance services Not Covered]]] |
| [Durable Medical Equipment: | [80%] [up to a Maximum Calendar Year Benefit of [\$2,000] per Covered Person]]] |
| [Oral Surgery: | [80%] up to a Maximum Calendar Year Benefit of [\$2,000] per Covered Person]] |
| [Human Organ and Tissue Transplant Services: | [100%] [[in Center of Excellence; [90%] [In-Network] [75%] [Out-of-Network]]] of Covered Charges, up to the Lifetime Maximum Benefit While Covered under the Policy]] |
| [Human Organ and Tissue Transplant Service Lodging and Transportation Allowance: | If Center of Excellence is used a maximum allowance of up to [\$5,000] per covered Transplant Service for transportation of recipient and companion and companion's room and board [up to the Lifetime Maximum Benefit While Covered under the Policy]] |
| [Inpatient] Mental or Nervous Disorders] | [Not Covered] [[80%] [In-Network; [55%] Out-of-Network] of Covered Charges, [up to the Maximum Calendar Year Benefit of [5] days of Inpatient Confinement [and] [or] [\$1,000] [whichever occurs first] per Covered Person] [and up to the Lifetime Maximum Benefit While Covered under the Policy]] |
| [Outpatient] Mental or Nervous Disorders] | [Not Covered] [[50%] [In-Network; [50%] Out-of-Network] of Covered Charges, [up to the Maximum Calendar Year Benefit of [\$50] per visit; maximum [10] visits per Covered Person] [and up to the Lifetime Maximum Benefit While Covered under the Policy]] |
| [Outpatient Chemical Dependency Disorders: | [Not Covered] [[50%] [In-Network; [50%] Out-of-Network] of Covered Charges, [up to the Maximum Calendar Year Benefit of [\$50] per visit; maximum [10] visits per Covered Person] [and up to the Lifetime Maximum Benefit While Covered under the Policy]] |
| [Outpatient Mental or Nervous Disorders and Outpatient Chemical Dependency Disorders: | [Not Covered] [[50%] [In-Network; [50%] Out-of-Network] of Covered Charges, [up to the combined Maximum Calendar Year Benefit of [\$50] per visit; maximum [10] visits per Covered Person] [and up to the Lifetime Maximum Benefit While Covered under the Policy]] |
| [Screening Services – See SECTION 4 – BENEFITS Covered Item 10: | |
| [Preventive and primary care services for covered Dependent Children from birth until [18] years of age: | [100%] [In-Network; [80%] Out-of-Network]] of Covered Charges. [[In[Out-of]-Network] [Not] subject to the [Calendar Year Deductible] [Daily Deductible] [and] [[Physician Office Visit] [\$35] Copay]]] |
| Low-dose screening Mammography: | 100% of Covered Charges. [[Out-of-Network] subject to the [Calendar Year Deductible] [Daily Deductible] [and] [[Diagnostic Testing] [\$35] [Copay]]] |
| [Cervical Smear or Pap Smear Test: | 100% of Covered Charges. [[Out-of-Network] subject to the [Calendar Year Deductible] [Daily Deductible] [and] [[Physician Office Visit] [Diagnostic Testing] [\$35] Copay]]] |

| | |
|----------------------------------|--|
| [Digital Screening and PSA Test: | [100%] [In-Network; 80%] Out-of-Network]] of Covered Charges. [[In[Out-of]-Network] [Not] subject to the [Calendar Year Deductible] [Daily Deductible] [and] [[Physician Office Visit] [Diagnostic Testing] [\$35] Copay]]] |
| [Colorectal Cancer Examination: | [100%] [In-Network; 80%] Out-of-Network]] of Covered Charges. [[In[Out-of]-Network] [Not] subject to the [Calendar Year Deductible] [Daily Deductible] [and] [[Physician Office Visit] [Diagnostic Testing] [\$35] Copay]]] |
| [Routine Physical Examination: | [Covered Charges are covered after the Covered Person has been covered under the Policy for [12] consecutive months] [100%] [In-Network; 80%] Out-of-Network]] of Covered Charges [up to a maximum benefit of [\$500] per Covered Person [In-Network; Out-of-Network [Not Covered] [\$250]]. [[In[Out-of]-Network] [Not] subject to the [Calendar Year Deductible] [Daily Deductible] [and] [[Physician Office Visit] [\$35] Copay]]]] |
| [Electronic Consultations: | [[In-Network] Physician Office Visit Copay as shown above] [then Policy pays] [[80%] of Covered Charges;] [up to the Maximum Benefit of [[[\$35] per Electronic Consultation] [[and a maximum of] [3] Electronic Consultations per [calendar week] [day] per Covered Person]]] |
| [Telephone Consultations: | [[[\$35] telephone consultation fee per consultation] [[In-Network] Physician Office Visit Copay as shown above] [then Policy pays] [[80%] of Covered Charges;] [up to the Maximum Benefit of [[[\$35] per telephone consultation] [[and a maximum of] [3] telephone Consultations per [calendar week] [day] per Covered Person]]] |

HOSPITAL ROOM/UNIT DAILY RATE SCHEDULE

| | |
|---------------------------------------|---|
| Semi-Private Room | Up to the Most Common Semi-Private Room Rate |
| Private Room | Up to the Most Common Semi-Private Room Rate |
| [Intensive Care Unit (In-Network) | [Up to the Most Common ICU Rate]] |
| [Intensive Care Unit (Out of Network) | [Up to [3] times the Most Common Semi-Private Room Rate]] |
| [Observation Room | [Up to [2] times the Most Common Semi-Private Room Rate]] |
| [Intermediate Care Unit | [Up to [2] times the Most Common Semi-Private Room Rate]] |

If the Hospital contains only Private rooms, the Semi-Private room rate will be the Usual and Reasonable Charge limited to [90%] of the Hospital's lowest priced Private room rate.

In the event Confinement in a Private room is necessary due to a contagious disease, Covered Charges will be payable at the [Hospital's lowest priced] Private room rate.

[[OPTIONAL] BENEFIT RIDERS]

| | |
|--|--|
| [Health Insurance Portability and Accountability Act (HIPAA) Rider: | [Not Included] [Applicable – See Attached Rider]] |
| [24-Hour Occupational Coverage Benefit Rider: | [Not Included] [[Applicable] for [Insured only] [Covered Dependent spouse only] [Insured and Covered Dependent spouse]]] |
| [Supplemental Accident Benefit Rider: | [Not Included] [Applicable]] |
| [Maximum Benefit Per Covered Injury: | [\$500]] |

[Preventive Care Benefit Rider: [Not Included] [Applicable] [Covered Charges are covered after the Covered Person has been covered under this Rider for [12] consecutive months]]

[Copay [per Covered Person Per [Calendar Year] [Office Visit]: [Not Applicable] [[[\$35] [[In-Network; Out-of-Network [Not Covered] [\$50]]

[Coinsurance: [80%]]

[Maximum Calendar Year Benefit For Preventive Care Benefits: [\$500] Per Covered Person [[In-Network; Out-of-Network [Not Covered] [\$250] [subject to Out-of-Network [Calendar Year Deductible] [Daily Deductible] and Coinsurance]]

[Prescription Medication Benefit Rider: [Not Included] [Applicable]

[Prescription Medication Benefit [Plan [1] [Subject to the [Calendar Year Deductible] [Daily Deductible], Coinsurance [and Maximum Benefits as applicable to other Covered Charges]]

**[Prescription Medication Benefit [Plan [2]]
[Prescription Medication Benefit Rider Schedule of Benefits**

[Outpatient Prescription Medication Calendar Year Deductible: [Not Applicable] [[[\$500] per Covered Person] [for each [Generic Medication] [Formulary Brand Drug] [Non-Formulary Brand Drug] [Specialty Medications]]

[Outpatient Prescription Medication Calendar Year Deductible Family Maximum: [Satisfied when [3] Covered Persons have each satisfied their Outpatient Prescription Medication Calendar Year Deductible] [Satisfied when the sum of all Covered Person's covered Prescription Medications used toward the individual Outpatient Prescription Medication Calendar Year Deductible equals [3] times the [Generic Medication] Outpatient Prescription Medication Calendar Year Deductible]]

[Copay [and] Coinsurance]: [Not Applicable] [subject to the Policy Calendar Year Deductible and Coinsurance]

[For each Generic Medication Dispensed: [[\$10] Copay; [and] [or]] [20%] of the [balance of the] cost of the Generic Medication [whichever is greater [up to a maximum benefit of [\$200] per [prescription] [Calendar Year for Generic Medications]]]

[For each Formulary Brand Drug Dispensed: [[\$40] Copay; [and] [or]] [30%] of the [balance of the] cost of the Formulary Brand [whichever is greater [up to a maximum benefit of [\$200] per [prescription] [Calendar Year for Formulary Brand Drug Medications]]]

[For each Non-Formulary Brand Drug Dispensed: [[\\$60] Copay; [and] [or]] [40%] of the [balance of the] cost of the Non-Formulary Brand [whichever is greater [up to a maximum benefit of [\\$200] per [prescription] [Calendar Year for Formulary Brand Drug Medications]]]

[Specialty Medications: [[\\$60] Copay; [and] [or]] [30%] of the [balance of the] cost of the Specialty Drug [whichever is greater [[up to a maximum benefit of [\\$200] per [prescription] [Calendar Year for Specialty Medications]]]

[Maximum Calendar Year Prescription Medication Benefit: [Not Applicable] [[\\$2,500] per Covered Person]]

[Certain Prescription Medications are subject to Pre-Determination. See SECTION 6 – ACCESSING AND ADMINISTERING YOUR BENEFITS.]

[Dental Benefit Rider: [Not Included] [Applicable]
 [Optional Orthodontia Coverage [(limited to covered Dependent Children under age [19])] [Not Included] [Applicable]]

[Dental Benefit Rider Schedule of Benefits

| | [Plan 1] | [Plan 2] |
|--|----------|----------|
| Calendar Year Dental Deductible Per Covered Person | | |
| Basic [and] Major [and Orthodontia] Care Procedures combined | [\$ 50] | [\$ 50] |

[Calendar Year Dental Deductible Family Maximum is satisfied [when [3] Covered Persons have each satisfied their Calendar Year Dental Deductible] [when the sum of all Covered Person’s Covered Dental Charges used toward the individual Calendar Year Dental Deductible equals [3] times the Calendar Year Dental Deductible].]

| | | |
|--|--------|--------|
| Lifetime Deductible Per Covered Person | | |
| Preventive Care Procedures: | [\$25] | [\$25] |

| | | |
|---|----------------------|-----------------------|
| [Dental Coinsurance: | | |
| Preventive Care (Type I Procedures) | [100%] | [100%] |
| Basic Care (Type II Procedures) | [80%] | [80%] |
| Major Care (Type III Procedures) | [50%] | [50%] |
| [[Optional Orthodontia (Type IV Procedures) | [Not Included] [50%] | [Not Included] [50%]] |

| | | |
|---|----------------------------|-----------------------------|
| [Dental Benefit Waiting Period: | | |
| Preventive Care (Type I Procedures) | [None] [6 months] | [None] [6 months] |
| Basic Care (Type II Procedures) | [None] [6 months] | [None] [6 months] |
| Major Care (Type III Procedures) | [12 months] | [12 months] |
| [[Optional Orthodontia (Type IV Procedures) | [Not Included] [12 months] | [Not Included] [12 months]] |

| | | |
|---|---|---|
| [Maximum Calendar Year Dental Benefit | | |
| Preventive Care, Basic Care and Major Care [(combined)] | [\$1,500] | [\$1,000] |
| [Orthodontia | [Not Included] [Not Applicable*] [\$1,000] [*subject to Lifetime Maximum Benefit] | [Not Included] [Not Applicable*] [\$1,000]] |

| | | |
|--|---------|----------|
| [Pre-determination of Dental Treatment | | |
| Pre-determination Amount: | [\$300] | [\$300]] |

| | | |
|---|-----------|-----------|
| [Lifetime Maximum Benefit for Dental Benefits While Covered under the Policy: | | |
| Orthodontia: | [\$1,000] | [\$1,000] |

[Graduated Dental Benefit Rider: [Not Included] [Applicable]

**[GRADUATED DENTAL PLAN SCHEDULE
Dental Benefit Maximums and Dental Coinsurance
Per Each Benefit Year Covered**

COINSURANCE

**MAXIMUM BENEFIT
Per Covered Person Per All Covered Persons**

Consecutive Period of Time the Covered Person
is covered under this Rider:

| | | | |
|--|--------|---------|-----------|
| [12] months but less than [24] months: | [25%] | [\$125] | [\$ 250] |
| [24] months but less than [36] months | [50%] | [\$250] | [\$ 500] |
| [36] months but less than [48] months | [75%] | [\$375] | [\$ 750] |
| [48] months and longer | [100%] | [\$500] | [\$1,000] |

[[Maternity Benefit Rider] [Not Included] [Applicable]]
[Maternity Benefit Deductible [\$1,000] per each covered pregnancy]]
[Maternity Benefit Maximum Benefit: [\$5,000] per each covered pregnancy]]

[[Maternity Scheduled Benefit Rider: [Not Included] [Applicable]]
[Maternity Scheduled Benefit Deductible [\$1,000] per each covered pregnancy]

**[MATERNITY BENEFIT PLAN SCHEDULE
Maternity Benefit Maximum**

MAXIMUM BENEFIT

Consecutive Period of Time the Insured or the Insured Person's
Covered Dependent spouse is covered under this Rider:

| | |
|--|------------|
| [12] months but less than [24] months: | [\$2,000] |
| [24] months but less than [36] months | [\$3,000] |
| [[36] months but less than [48] months | [\$5,000]] |
| [48] months and longer | [\$7,500]] |

INDEPENDENCE AMERICAN INSURANCE COMPANY

SCHEDULE OF BENEFITS

[INDEMNITY PLAN]

Lifetime Maximum Benefit For All Benefits While Covered under the Policy Per Covered Person [\$5,000,000]

[Lifetime Maximum Benefit While Covered under the Policy Per Covered Person:

[Covered Human Organ and Tissue Transplant Services in a Center of Excellence
[includes Lodging and Transportation Allowance] [\$1,000,000]]

[Covered Human Organ and Tissue Transplant Services [\$250,000]]

[Mental or Nervous Disorders [\$10,000]]

[Chemical Dependency Disorders [\$10,000]]

[Mental or Nervous Disorders and Chemical Dependency Disorders combined [\$10,000]]

[Hospice Care [\$5,000] [6 months of Covered Charges]]

[Maximum Calendar Year Benefit for all Covered Charges for Outpatient Treatment Per Covered Person [\$20,000]]

[Maximum Calendar Year Benefit for all Covered Charges Combined Per Covered Person: [\$1,000,000]]

[[Individual] Calendar Year Deductible: [[\$1,500]]

[[Individual] Daily Deductible: [\$250]]

[Individual Calendar Year Out-of-Pocket
Maximum: [\$5,000]]

[Individual Calendar Year Out-of-Pocket
Maximum for Medical Services
and Supplies: [\$3,000]]

[Covered Charges accumulating to the Out-of-Pocket Maximum amount for medical services and supplies include the following, except for those Covered Charges incurred for services specifically designated to accumulate to the Out-of-Pocket Maximum for Inpatient and Surgical Services specified below:

- Outpatient Facility services;
- Surgery, assistant surgery and anesthesiology services, except when rendered at a Hospital or Ambulatory Surgical Center;
- Physician services [(not subject to a separate Co-pay)];
- Diagnostic Tests, Lab and X-ray [(not subject to a separate Co-pay)];
- Diagnostic Imaging Tests [(not subject to a separate Co-pay)];
- Outpatient Registered Nurse care visits and services;
- Physical, speech or occupational therapy;
- Emergency ambulance services;
- Durable Medical Equipment and medical supplies;
- Non-surgical back treatment;
- Emergency Room services (if not admitted as an Inpatient);
- Home Health Care;
- Covered Charges incurred for other medical services and supplies not specifically designated to accumulate to the Out-of-Pocket Maximum for Inpatient and surgical services]

[Individual Calendar Year Out-of-Pocket
Maximum for Inpatient
and Surgical Services: [\$6,000]]

[Covered Charges accumulating to the Out-of-Pocket Maximum amount for Inpatient and surgical services including the following:

- Inpatient treatment and services, including, but not limited to, Physician services, visits, consultations and diagnostic testing, when rendered to a Covered Person who is Confined as an Inpatient in a Facility, including a Hospital, Extended Care or Skilled Nursing Facility;
- Inpatient surgery and other services related to the surgery when rendered to a Covered Person as an Inpatient in a Facility, including, but not limited to, Charges for surgery, assistant surgery, anesthesiology services, Physician services, visits, consultations, and diagnostic testing;
- Surgery and related services, including, but not limited to, surgery, assistant surgery, and anesthesiology services, when rendered to a Covered Person as an Outpatient in a Hospital or Ambulatory Surgical Center]

[The Calendar Year Out-of-Pocket Maximum for medical services and supplies, and the Calendar Year Out-of-Pocket Maximum for Inpatient surgical services accumulate separately. The amounts paid by the Covered Person for Covered Charges that do not count towards the Out-of-Pocket Maximum are in addition to the Out-of-Pocket amounts specified above for medical services and supplies and for Inpatient and surgical services.]

[Family Calendar Year Deductible: [\$5,000]]

[[Family] Daily Deductible: [[\$500]]

[Family Calendar Year Out-of-Pocket Maximum: [\$10,000]] [Satisfied when [3] Covered Persons each satisfy their individual Calendar Year Out-of-Pocket Maximum].]

[The Calendar Year Deductible amounts and the Out-of-Pocket Maximum amounts are subject to annual cost of living adjustments as may be required by tax law [to maintain the plan's eligibility as an HSA qualified plan].]

[Calendar Year Deductible Family Maximum: [\$5,000] per Covered Family] [Satisfied when [3] Covered Persons each satisfy their individual Calendar Year Deductible] [Satisfied with the sum of all Covered Person's Covered Charges used toward the individual Calendar Year Deductible equals [3] times the Calendar Year Deductible]. [Satisfied for the balance of that Calendar Year once one Covered Person or any combination of Covered Persons has/have met the Family Calendar Year Out-of-Pocket Maximum.]]

[Daily Deductible Family Maximum: [\$5,000] per Covered Family] [Satisfied when [3] Covered Persons each satisfy their individual Daily Deductible] [Satisfied with the sum of all Covered Person's Covered Charges used toward the individual Daily Deductible equals [3] times the Daily Deductible].]]

[Pre-Certification Penalty Amounts:

| | |
|--|----------------------------|
| [Failure to Pre-Certify each Inpatient Hospital Confinement: | [Not Applicable] [\$500*]] |
| [Failure to Pre-Certify each Skilled Nursing Home Facility Inpatient Confinement | [Not Applicable] [\$500*]] |
| [Failure to Pre-Certify each Home Health Care Services | [Not Applicable] [\$500*]] |
| [Failure to Pre-Certify Hospice Care Services | [Not Applicable] [\$500*]] |
| [Failure to Pre-Certify [Complications of] Pregnancy | [Not Applicable] [\$500*]] |

| | |
|---|----------------------------|
| [Failure to Pre-Certify each Outpatient Diagnostic Imaging Test | [Not Applicable] [\$500*]] |
| [Failure to Pre-Certificate Outpatient surgery in an Ambulatory Surgical Center | [Not Applicable] [\$500*]] |

*This Deductible does not apply when the Covered Person complies with the Pre-Certification Requirements

| | |
|--|--|
| [Failure to Pre-Determine Specialty Prescription Medications | [No coverage for the specified Medications]] |
|--|--|

| | |
|--|---|
| [Failure to Pre-Determine each Non-Emergency Care Ambulance Transportation | [No coverage for the Ambulance Services]] |
|--|---|

| | |
|--|--|
| [Failure to Pre-Determine Durable Medical Equipment In excess of [\$1,000] | [No coverage for the Durable Medical Equipment]] |
|--|--|

[COPAYS]

[Emergency Room Copay: [Not Applicable] [[\$500] per occurrence] [Not applicable if Hospital Confined as an Inpatient immediately following the Emergency Room visit.]

[Physician Office Visit or Physician Services at a Free Standing Urgent Care Center Copay: [Not applicable [subject to any applicable Calendar Year Deductible and Coinsurance]] [[\$35.00]] [Covered Physician office visit Charges in excess of the Physician office visit Copay are [paid at [100%]]

[This Copay applies to each Physician office visit Charge, or the Physician's Charge at a Free Standing Urgent Care Center. [Additional Charges, including Charges for x-rays, lab and diagnostic tests, are [not] covered under this Copay [unless specifically provided for as specified on the Schedule of Benefits].] [This Copay also applies to Charges for x-rays, lab and diagnostic tests in the Physician's office during the same Physician office visit [subject to the maximum [\$200] benefit per visit. Covered Charges incurred in excess of the maximum benefit will be subject to any applicable Calendar Year Deductible and Coinsurance.]] [Other Covered Charges will be subject to any applicable Calendar Year Deductible and Coinsurance.]

[The Physician office visit or Physician services at a Free Standing Urgent Care Center Copay is limited to [5] visits per Calendar Year per Covered Person. Once this limit is exceeded, [no Copay will apply; Covered Charges will be subject to any applicable Calendar Year Deductible and Coinsurance] [the Copay required by the Covered Person during the balance of the Calendar Year is [\$50]] [Charges incurred for Physician office visits or Physician services at a Free Standing Urgent Care Center will not be considered Covered Charges for the balance of that Calendar Year.]

[[Outpatient X-Ray, Lab and Diagnostic Testing Copay:] [Not applicable [[100%] [Designated Clinical Laboratory] [LabOne]] [Outpatient Diagnostic Testing Copay:] [subject to any applicable [Calendar Year Deductible] [Daily Deductible] and [[80%] Coinsurance]] [[\$35] [per visit] [per test] for Outpatient [Diagnostic Testing] [X-Ray, Laboratory and Diagnostic Testing] [[maximum benefit [\$200] [per visit] [per test] [per Calendar Year per Covered Person] [maximum benefit [5] visits per Calendar Year per Covered Person]. [Once the maximum benefit is exceeded [no Copay will apply; Covered Charges will be subject to any applicable [Calendar Year Deductible] [Daily Deductible] and Coinsurance] [the Copay required by the Covered Person during the balance of the Calendar Year is [\$50] [Charges incurred for Outpatient [Diagnostic Testing] [X-Ray, Laboratory and Diagnostic Testing] will not be considered Covered Charges for the balance of that Calendar Year.]] [The Outpatient [Diagnostic Testing] [X-Ray, Laboratory and Diagnostic Testing] maximum benefit does not apply to Covered Charges incurred for Screening Services as listed under the Section 4 – covered item 10.] [The Outpatient [Diagnostic Testing] [X-Ray, Laboratory and Diagnostic Testing] does not apply to Charges subject to the Outpatient Diagnostic Imaging Copay.]]

[Outpatient Diagnostic Imaging Copay: [Not applicable [subject to any applicable [Calendar Year Deductible] [Daily Deductible] and [[80%] Coinsurance]] [[\$35] [per visit] [per test] for [each] Outpatient Diagnostic Imaging test] [maximum benefit [\$200] [per visit] [per test] [per Calendar Year per Covered Person] [maximum benefit [5] [visits] [tests] per Calendar Year per Covered Person]. [Once the maximum benefit is exceeded [no Copay will apply; Covered Charges will be subject to any applicable [Calendar Year Deductible] [Daily Deductible] and Coinsurance] [the Copay required by the Covered Person during the balance of the Calendar Year is [\$50] [Charges incurred for Outpatient Diagnostic Imaging Testing will not be considered Covered Charges for the balance of that Calendar Year.]] [The Outpatient Diagnostic Imaging Copay does not apply to Charges subject to the [Diagnostic Testing] [X-Ray, Laboratory and Diagnostic Testing] Copay.]]

| | |
|---|--|
| [Outpatient Surgical Services Copay: | [Not applicable [subject to any applicable [Calendar Year Deductible] [Daily Deductible] and Coinsurance]] [[\$250.00] Co-pay] [Covered Outpatient Surgical Services Charges in excess of the Copay are paid at [100%]]. This Copay applies to Covered Charges incurred for surgical services, including surgery, assistant surgery, and anesthesiology services received in an Outpatient Hospital or Ambulatory Surgical Center Facility.] |
| [Inpatient Hospital Confinement Copay: | [Not applicable [subject to any applicable [Calendar Year Deductible] [Daily Deductible] and Coinsurance]] [[\$250.00] Co-pay] [Covered Inpatient Hospital Confinement Charges in excess of the Copay are paid at [100%]]. This Copay applies to Covered Charges incurred for each Inpatient Hospital Confinement.] |
| [Inpatient Skilled Nursing Confinement Copay: | [Not applicable [subject to any applicable [Calendar Year Deductible] [Daily Deductible] and Coinsurance]] [[\$250.00] Co-pay] [Covered Inpatient Skilled Nursing Confinement Charges in excess of the Copay are paid at [100%]]. This Copay applies to Covered Charges incurred for each Inpatient Skilled Nursing Confinement.] |
| [Outpatient Ambulatory Surgical Center Copay: | [Not applicable [subject to any applicable [Calendar Year Deductible] [Daily Deductible] and Coinsurance]] [[\$250.00] Co-pay] [Covered Outpatient Ambulatory Surgical Center Charges in excess of the Copay are paid at [100%]]. This Copay applies to Covered Charges incurred for each Outpatient Ambulatory Surgical Center visit.] |
| [Copay Family Maximum: | When the sum of all Covered Person's Covered Charges used to satisfy the Copay exceeds [\$2,500] no further Copays will apply for the remainder of that Calendar Year. [This does not apply to Physician Office Visit and Physician Services at a Free Standing Urgent Care Center Copay.] |

COINSURANCE AND BENEFIT LIMITATIONS

The Coinsurance is the percentage of Covered Charges paid by the Policy, after payment by the Covered Person of any applicable Co-payments, and [Calendar Year Deductibles] [Daily Deductibles].

| | |
|--|--|
| Coinsurance: | [80%] of Covered Charges. [After the [Individual] [Family] Calendar Year Out-of-Pocket Maximum is met, then the Policy pays [100%] of additional Covered Charges incurring during the calendar year.] [This does not apply to the Coinsurance for [Outpatient] Mental or Nervous Disorder and Chemical Dependency Disorders treatments.] |
| [Non-Surgical Back Treatment: | [Not Covered] [[80%] of Covered Charges, [up to the Maximum Calendar Year Benefit of [[\$250] per Covered Person] [[30] visits per Covered Person]] |
| [Physical, Speech or Occupational Therapy: | [80%] of Covered Charges, [up to the Maximum Calendar Year Benefit of [[\$250] per Covered Person]] [[30] treatments per Covered Person for any one type of therapy and up to [60] treatments per Covered Person combined for any combination of therapies]] |
| [Home Health Care: | [80%] of Covered Charges, [up to the Maximum Calendar Year Benefit of [[\$250] per Covered Person]] [[30] visits per Covered Person]] |
| [Hospice Care: | [100%] of Covered Charges, up to the Lifetime Maximum Benefit While Covered under the Policy]] [Not subject to the [Calendar Year Deductible] [Daily Deductible] [Coinsurance] [and] [Copay]] |
| [Skilled Nursing Facility Services: | [80%] of Covered Charges, [up to the Maximum Calendar Year Benefit of [[\$100] per day and a maximum of [50] days per Covered Person]] |

| | |
|--|---|
| [Licensed Ambulance Service: | [80%] [up to a Maximum Benefit of [[\$500] per occurrence] [per Calendar Year]] [[\$500] [per ground occurrence] [per Calendar Year for ground ambulance services]; [500] [per water occurrence] [per Calendar Year for water ambulance services]; [1,000] [per air occurrence] [per Calendar Year for air ambulance services] [[air] ambulance services Not Covered]]] |
| [Durable Medical Equipment: | [80%] [up to a Maximum Calendar Year Benefit of [\$2,000] per Covered Person]]] |
| [Oral Surgery: | [80%] up to a Maximum Calendar Year Benefit of [\$2,000] per Covered Person]]] |
| [Human Organ and Tissue Transplant Services: | [100%] [[in Center of Excellence; 90%] of Covered Charges, up to the Lifetime Maximum Benefit While Covered under the Policy]]] |
| [Human Organ and Tissue Transplant Service Lodging and Transportation Allowance: | If Center of Excellence is used a maximum allowance of up to [\$5,000] per covered Transplant Service for transportation of recipient and companion and companion's room and board [up to the Lifetime Maximum Benefit While Covered under the Policy]]] |
| [Inpatient] Mental or Nervous Disorders] | [Not Covered] [[80%] of Covered Charges, [up to the Maximum Calendar Year Benefit of [5] days of Inpatient Confinement [and] [or] [\$1,000] [whichever occurs first] per Covered Person] [and up to the Lifetime Maximum Benefit While Covered under the Policy]]] |
| [Outpatient] Mental or Nervous Disorders] | [Not Covered] [[50%] of Covered Charges, [up to the Maximum Calendar Year Benefit of [\$50] per visit; maximum [10] visits per Covered Person] [and up to the Lifetime Maximum Benefit While Covered under the Policy]]] |
| [Outpatient Chemical Dependency Disorders: | [Not Covered] [[50%] of Covered Charges, [up to the Maximum Calendar Year Benefit of [\$50] per visit; maximum [10] visits per Covered Person] [and up to the Lifetime Maximum Benefit While Covered under the Policy]]] |
| [Outpatient Mental or Nervous Disorders and Outpatient Chemical Dependency Disorders: | [Not Covered] [[50%] of Covered Charges, [up to the combined Maximum Calendar Year Benefit of [\$50] per visit; maximum [10] visits per Covered Person] [and up to the Lifetime Maximum Benefit While Covered under the Policy]]] |
| [Screening Services – See SECTION 4 – BENEFITS Covered Item 10: | |
| [Preventive and primary care services for covered Dependent Children from birth until [18] years of age: | [100%] of Covered Charges. [[Not] subject to the [Calendar Year Deductible] [Daily Deductible] [and] [[Physician Office Visit] [\$35] Copay]]] |
| Low-dose screening Mammography: | 100% of Covered Charges. |
| [Cervical Smear or Pap Smear Test: | 100% of Covered Charges. |
| [Digital Screening and PSA Test: | [100%] of Covered Charges. [[Not] subject to the [Calendar Year Deductible] [Daily Deductible] [and] [[Physician Office Visit] [Diagnostic Testing] [\$35] Copay]]] |
| [Colorectal Cancer Examination: | [100%] of Covered Charges. [[Not] subject to the [Calendar Year Deductible] [Daily Deductible] [and] [[Physician Office Visit] [Diagnostic Testing] [\$35] Copay]]] |
| [Routine Physical Examination: | [Not Covered] [Covered Charges are covered after the Covered Person has been covered under the Policy for [12] consecutive months] [100%] of Covered Charges [up to a maximum benefit of [\$500] per Covered Person]. [[Not] subject to the [Calendar Year Deductible] [Daily Deductible] [and] [[Physician Office Visit] [\$35] Copay]]] |
| [Electronic Consultations: | [Physician Office Visit Copay as shown above] [then Policy pays] [[80%] of Covered Charges;] [up to the Maximum Benefit of [[\$35] per Electronic Consultation] [[and a maximum of] [3] Electronic Consultations per [calendar week] [day] per Covered Person]]] |

[Prescription Medication Benefit Rider: [Not Included] [Applicable]

[Prescription Medication Benefit [Plan 1] [Subject to the [Calendar Year Deductible] [Daily Deductible], Coinsurance [and Maximum Benefits as applicable to other Covered Charges]]

**[Prescription Medication Benefit [Plan 2]]
[Prescription Medication Benefit Rider Schedule of Benefits**

[Outpatient Prescription Medication Calendar Year Deductible: [Not Applicable] [[\$500] per Covered Person] [for each [Generic Medication] [Formulary Brand Drug] [Non-Formulary Brand Drug] [Specialty Medications]]

[Outpatient Prescription Medication Calendar Year Deductible Family Maximum: [Satisfied when [3] Covered Persons have each satisfied their Outpatient Prescription Medication Calendar Year Deductible] [Satisfied when the sum of all Covered Person's covered Prescription Medications used toward the individual Outpatient Prescription Medication Calendar Year Deductible equals [3] times the [Generic Medication] Outpatient Prescription Medication Calendar Year Deductible]]

[Copay [and] Coinsurance]: [Not Applicable] [subject to the Policy Calendar Year Deductible and Coinsurance]

[For each Generic Medication Dispensed: [[\$10] Copay; [and] [or]] [20%] of the [balance of the] cost of the Generic Medication [whichever is greater [up to a maximum benefit of [\$200] per [prescription] [Calendar Year for Generic Medications]]]

[For each Formulary Brand Drug Dispensed: [[\$40] Copay; [and] [or]] [30%] of the [balance of the] cost of the Formulary Brand [whichever is greater [up to a maximum benefit of [\$200] per [prescription] [Calendar Year for Formulary Brand Drug Medications]]]

[For each Non-Formulary Brand Drug Dispensed: [[\$60] Copay; [and] [or]] [40%] of the [balance of the] cost of the Non-Formulary Brand [whichever is greater [up to a maximum benefit of [\$200] per [prescription] [Calendar Year for Formulary Brand Drug Medications]]]

[Specialty Medications: [[\$60] Copay; [and] [or]] [30%] of the [balance of the] cost of the Specialty Drug [whichever is greater [up to a maximum benefit of [\$200] per [prescription] [Calendar Year for Specialty Medications]]]

[Maximum Calendar Year Prescription Medication Benefit: [Not Applicable] [[\$2,500] per Covered Person]]

[Certain Prescription Medications are subject to Pre-Determination. See SECTION 6 – ACCESSING AND ADMINISTERING YOUR BENEFITS.]

[Dental Benefit Rider: [Not Included] [Applicable]

[Optional Orthodontia Coverage [(limited to covered Dependent Children under age [19])] [Not Included] [Applicable]]

[Dental Benefit Rider Schedule of Benefits

| | [Plan 1] | [Plan 2] |
|--|----------|----------|
| Calendar Year Dental Deductible Per Covered Person | | |
| Basic [and] Major [and Orthodontia] Care Procedures combined | [\$ 50] | [\$ 50] |

[Calendar Year Dental Deductible Family Maximum is satisfied [when [3] Covered Persons have each satisfied their Calendar Year Dental Deductible] [when the sum of all Covered Person's Covered Dental Charges used toward the individual Calendar Year Dental Deductible equals [3] times the Calendar Year Dental Deductible].]

Lifetime Deductible Per Covered Person Preventive Care Procedures: [\$25] [\$25]

IAIC SOB IND AR 107 - [SB7] -

| | | | |
|--|--|-----------|---|
| [Dental Coinsurance: | | | |
| Preventive Care (Type I Procedures) | [100%] | | [100%] |
| Basic Care (Type II Procedures) | [80%] | | [80%] |
| Major Care (Type III Procedures) | [50%] | | [50%] |
| [[Optional Orthodontia (Type IV Procedures) | [Not Included] [50%] | | [Not Included] [50%]] |
| [Dental Benefit Waiting Period: | | | |
| Preventive Care (Type I Procedures) | [None] [6 months] | | [None] [6 months] |
| Basic Care (Type II Procedures) | [None] [6 months] | | [None] [6 months] |
| Major Care (Type III Procedures) | [12 months] | | [12 months] |
| [[Optional Orthodontia (Type IV Procedures) | [Not Included] [12 months] | | [Not Included] [12 months]] |
| [Maximum Calendar Year Dental Benefit | | | |
| Preventive Care, Basic Care and Major Care [(combined)] | | [\$1,500] | [\$1,000] |
| [Orthodontia | [Not Included] [Not Applicable*] [\$1,000] | | [Not Included] [Not Applicable*] [\$1,000]] |
| | [*subject to Lifetime Maximum Benefit] | | |
| [Pre-determination of Dental Treatment | | | |
| Pre-determination Amount: | | [\$300] | [\$300]] |
| [Lifetime Maximum Benefit for Dental Benefits While Covered under the Policy: | | | |
| Orthodontia: | | [\$1,000] | [\$1,000] |

[Graduated Dental Benefit Rider: [Not Included] [Applicable]

**[GRADUATED DENTAL PLAN SCHEDULE
Dental Benefit Maximums and Dental Coinsurance
Per Each Benefit Year Covered**

COINSURANCE

**MAXIMUM BENEFIT
Per Covered Person Per All Covered Persons**

Consecutive Period of Time the Covered Person
is covered under this Rider:

| | | | |
|--|--------|---------|------------|
| [12] months but less than [24] months: | [25%] | [\$125] | [\$ 250] |
| [24] months but less than [36] months | [50%] | [\$250] | [\$ 500] |
| [36] months but less than [48] months | [75%] | [\$375] | [\$ 750] |
| [48] months and longer | [100%] | [\$500] | [\$1,000]] |

[[Maternity Benefit Rider] [Not Included] [Applicable]]
[Maternity Benefit Deductible [\$1,000] per each covered pregnancy]]
[Maternity Benefit Maximum Benefit: [\$5,000] per each covered pregnancy]]

[[Maternity Scheduled Benefit Rider: [Not Included] [Applicable]]
[Maternity Scheduled Benefit Deductible [\$1,000] per each covered pregnancy]]

**[MATERNITY BENEFIT PLAN SCHEDULE
Maternity Benefit Maximum**

MAXIMUM BENEFIT

Consecutive Period of Time the Insured or the Insured Person's
Covered Dependent spouse is covered under this Rider:

| | |
|--|------------|
| [12] months but less than [24] months: | [\$2,000] |
| [24] months but less than [36] months | [\$3,000] |
| [[36] months but less than [48] months | [\$5,000]] |
| [48] months and longer | [\$7,500]] |

SERFF Tracking Number: *MADS-125643562* *State:* *Arkansas*
Filing Company: *Independence American Insurance Company* *State Tracking Number:* *39791*
Company Tracking Number: *IAIC-AR*
TOI: *H16G Group Health - Major Medical* *Sub-TOI:* *H16G.001A Any Size Group - PPO*
Product Name: *IAIC-AR*
Project Name/Number: *IAIC-AR/*

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: MADS-125643562 State: Arkansas
 Filing Company: Independence American Insurance Company State Tracking Number: 39791
 Company Tracking Number: IAIC-AR
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
 Product Name: IAIC-AR
 Project Name/Number: IAIC-AR/

Supporting Document Schedules

Satisfied -Name: Certification/Notice **Review Status:** Approved-Closed 08/26/2008
Comments:
Attachments:
 IAIC Certificate of Compliance AR.pdf
 IAIC Readability Certification (0708).pdf

Satisfied -Name: Application **Review Status:** Approved-Closed 08/26/2008
Comments:
Attachment:
 IAIC MED APP 0307 (General Application)Rev For Filing (3-12-07).pdf

Satisfied -Name: Cover Letter **Review Status:** Approved-Closed 08/26/2008
Comments:
Attachment:
 IAIC(AR)filing letter 072908.pdf

Satisfied -Name: AR Association Approval **Review Status:** Approved-Closed 08/26/2008
Comments:
 The association used for this policy was previously approved by the Department under our sister company, Madison National Life Insurance Company
Attachment:
 ARassociationapproval.pdf

Satisfied -Name: IAIC Authorization Letter **Review Status:** Approved-Closed 08/26/2008
Comments:
Attachment:
 IAIC Authorization Letter {IAC}.doc

Certificate of Compliance with Arkansas Rule and Regulation 19

Insurer: Independence American Insurance Company

Form Number(s): IAIC GP 107

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

Signature of Company Officer:



Adam Vandervoort
Name

Secretary
Title

07/29/08
Date



Independence American Insurance Company
485 Madison Avenue
New York, NY 10022-5872
Telephone: (212) 355-4141

READABILITY CERTIFICATION

NAIC Company Number: 26581
NAIC Group Number: 0450
FEIN Number: 74-1746542

| | |
|--------------------------|---|
| IAIC GA 107 | Policyholder Application for Group Insurance |
| IAIC GP 107 | Master Group Major Medical Insurance Policy |
| IAIC GC 107 | Group Health Insurance Certificate of Coverage |
| IAIC MED APP 0307 | Member Application for Insurance |
| IAIC MED BSF 0107 | Benefit Plan Selection Form |
| IAIC MED HHSF 0107 | Health History Supplemental to Application |
| IAIC MED AFPU 0307 | Application for Preferred Underwriting Classification |
| IAIC AE 107 | Amendatory Endorsement |
| IAIC DBR 107 | Dental Benefit Rider |
| IAIC EXCL AE 107 | Exclusion Endorsement |
| IAIC SABR 107 | Supplemental Accident Benefit Rider |
| IAIC PCBR 107 | Preventive Care Benefit Rider |
| IAIC OCR 107 | 24-Hour Occupational Coverage Benefit Rider |
| IAIC AMDAPP 1007 | Application Amendment (no signature) |
| IAIC AMDAPP-S 1007 | Application Amendment (signature) |
| IAIC GDBR 107 | Graduated Dental Benefit Rider |
| IAIC RE 107 | Rescission Endorsement |
| IAIC AEAR 107 | AR Amendatory Endorsement |
| IAIC AEAR OPT ELC AR 107 | AR Policyholder Election Form |
| IAIC AECD AR 107 | AR Amendatory Endorsement |
| IAIC AEHEAR AR 107 | AR Amendatory Endorsement |
| IAIC AEMI AR 107 | AR Amendatory Endorsement |
| IAIC MBR AR 107 | AR Maternity Benefit Rider |
| IAIC MSBR AR 107 | AR Maternity Scheduled Benefit Rider |
| IAIC PMBR AR 107 | AR Prescription Medication Benefit Rider |
| IAIC SOB AR 107 | AR Schedule of Benefits (PPO) |
| IAIC SOB IND AR 107 | AR Schedule of Benefits (Indemnity) |

I hereby certify that the above captioned forms have a combined Flesch Index Score of 43.9 and comply with the readability requirements of this State. Schedules, captions, indexes, defined terms and the Company references were deleted prior to determining the Flesch Index Score.

Adam C. Vandervoort
Secretary

INDEPENDENCE AMERICAN INSURANCE COMPANY
APPLICATION FOR MAJOR MEDICAL HEALTH INSURANCE
Underwritten by Independence American Insurance Company - A Delaware Corporation

[ATTENTION PRODUCER: Where do you want the Certificate of Coverage mailed? (Check one) Producer _____ Insured _____]

GENERAL INFORMATION

Applicant Information (Please print in blue or black ink)

| | | | | | |
|--|---|------------------|------------------------|---|---------------|
| Applicant's Name Last First Initial | | | Social Security Number | | |
| Applicant's Home Address Street City State Zip Code | | | | | |
| Billing Address Street City State Zip Code | | | | E-MAIL ADDRESS | |
| Home Telephone Number | Work Telephone Number | Fax Number | | Best Time and Place to Call <input type="checkbox"/> Home Time: <input type="checkbox"/> Work | |
| Occupation (Title & Industry) | Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married | Birthdate / / | Age | Height Ft In | Weight Lbs |

Dependent Information (Complete only for dependents to be covered under this plan)

| | | | | | |
|--|--------------|-----------------|------------------------|-----------|---------------------------------|
| Spouse's Name Last First Initial | | | Social Security Number | | |
| Spouse's Occupation (Title & Industry) | | Height Ft In | Weight Lbs | Birthdate | Age |
| Dependent(s) Name (First and Last) | Relationship | Sex | Birthdate | Height | Weight |
| | | | | | Full-time Student? Yes or No |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Tobacco Usage

| |
|---|
| Has the Applicant or Spouse (if applying for coverage) used tobacco or tobacco cessation products during the past [12] months? Applicant: <input type="checkbox"/> No <input type="checkbox"/> Yes – indicate types of tobacco/cessation products and the frequency of usage: _____ Spouse: <input type="checkbox"/> No <input type="checkbox"/> Yes – indicate types of tobacco/cessation products and the frequency of usage: _____ |
|---|

[Medical Qualifying Questions:

1. Is any applicant currently applying for coverage pregnant or undergoing infertility treatment? Yes No
2. In the past [5] years has any applicant for this health plan been aware of, had symptoms, been diagnosed or treated for any of the following conditions:
- | | | | |
|--|--|---|--|
| • AIDS, AIDS related complex or tested HIV positive? | <input type="checkbox"/> Yes <input type="checkbox"/> No | • Mental or nervous disorder requiring hospitalization? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Hepatitis C or Cirrhosis of the liver? | <input type="checkbox"/> Yes <input type="checkbox"/> No | • COPD or Emphysema? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Alcoholism or abuse, Drug addiction or abuse? | <input type="checkbox"/> Yes <input type="checkbox"/> No | • Bipolar Disorder, Schizophrenia or other psychotic disorder? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Internal Cancer, leukemia or melanoma? | <input type="checkbox"/> Yes <input type="checkbox"/> No | • Heart attack, or coronary disease? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Congestive heart failure of valvular disease? | <input type="checkbox"/> Yes <input type="checkbox"/> No | • Organ Transplant? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Kidney failure, polycystic kidney or dialysis? | <input type="checkbox"/> Yes <input type="checkbox"/> No | • Stroke or transient ischemic attack (TIA)? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| • Diabetes? | <input type="checkbox"/> Yes <input type="checkbox"/> No | • Brain disease, Multiple Sclerosis, Muscular dystrophy or ALS? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
3. In the past [5] years have you been convicted of a felony, or been cited on [two] or more occasions for driving while intoxicated (DUI)?

If you answered "Yes" to questions 1, 2, or 3, you are ineligible for coverage under this plan.

4. Have you been diagnosed or treated for the following conditions in the past [5] years: Please document details of "yes" answers on page [4].
Hypertension? Yes No High Cholesterol or triglycerides? Yes No

If the applicant answered yes to both of these conditions in question 4 above, please add an additional [25]% load to the standard premium for the individual(s) with these conditions. If both questions are answered yes and the applicant is a tobacco user, please add [40]% to the standard premium. Tobacco users who have one of these conditions will require a [25]% load in addition to the standard premium.]

Requested Effective Date (check one):

- I request the Company assign my effective date to be the 1st of the month following approval.
 I request an effective date of _____ (must be the [1st] or [15th] of the month).

If the Company is unable to approve the application within [60] days of the application date, the requested effective date will not be honored and a new, currently dated application may be required.

[Mode of Payment: Direct Bill: Select Monthly Quarterly or Semi-annually. Submit check for first premium payment with this application.
 Credit Card* Bank Draft*

*Drawn monthly only. Complete the IAC Monthly Automatic Payment Plan page.]

[24-hour Occupational Coverage [(complete only if applying for optional 24-hour Occupational Coverage):]

1. Is any person to be insured currently covered under Workers' Compensation? Applicant: Yes No Spouse: Yes No
2. [Are you eligible to opt out of Workers' Compensation and are you a Sole proprietor, Partner, or Owner?
Applicant: Yes No Spouse: Yes No]

Other Health Insurance In force or Pending (must be completed for primary and dependent applicants)

Yes No If yes, please provide the following information:
Carrier Name: _____ Policy No. _____ Effec. Date: _____ Termination Date: _____
Is this an employer-sponsored group health plan? Yes No
Is it your intent to be considered under HIPAA provisions? Yes No If yes, you must complete the HIPAA eligibility section of this application.

EVIDENCE OF INSURABILITY

| | |
|---|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 1. Excluding MO residents: Has any person to be insured ever been declined, postponed, rideder, or rated up for medical, disability, or life insurance with another insurance carrier? If yes, please indicate the action and explain: 1. MO residents: Has any person to be insured ever been postponed, rideder, or rated up for medical, disability, or life insurance with another insurance carrier? If yes, please indicate the action and explain: |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 2. Is any person to be insured receiving treatment, taking medication, or been advised of a condition that will require medical attention or to have medical test(s)? If yes, list names and provide details in the Health History section on the following page. |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 3. Has any person to be insured received or are currently receiving disability benefits? If yes, list names and type of coverage: |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 4. Has any person to be insured ever been diagnosed or tested positive for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex by a Physician or member of the medical profession? If yes, list names: |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 5. Has anyone to be insured had breast implants, pin, plate, or other implants? If yes, list names and provide details on the following page. |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 6. Has any person to be insured had any convictions for reckless driving or driving under the influence of alcohol or drugs? If yes, list name, violation(s) and date(s) of occurrence in the Health History section on the following page. |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 7. In the past [5] years, has any person to be insured engaged in, or plan to engage in, any hazardous sport including, but not limited to: scuba diving, rodeo activities, skydiving or auto, motorcycle or motor boat racing? If yes, please explain on the following page. |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 8. Is any person to be insured now pregnant, an expectant parent, or in the process of adopting a child, whether applying for coverage or not? If yes, list names and provide details in the Health History section on the following page. |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 9. Is any person to be insured currently taking or been prescribed medications within the past [12] months? List details/medications on the following page. |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 10. Has any person to be insured previously applied for a policy administered by Insurers Administrative Corporation? If yes, list the policy number: _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 11. Has any person to be insured been hospitalized within the last [7] years? If yes, list names and provide details on the following page. |

12. Within the past [seven] years, has any person to be insured had any symptoms, diagnosis, consultation, treatment, or taken any medication or received counseling for (MARK ALL THAT APPLY):

| Condition | Yes | No | Condition | Yes | No | Condition | Yes | No |
|--|-----|----|---|-----|----|--|-----|----|
| Abnormal Test Results | | | Eye Disorders | | | Neurological Disease | | |
| Alcoholism/Alcohol Abuse | | | Fractures/Dislocations | | | Pap Smear, Abnormal | | |
| Allergies | | | Gallbladder Disorder | | | Paralysis | | |
| Arthritis or Rheumatism | | | Headaches/Migraine | | | Prostate/Rectal Disorder | | |
| Asthma/Respiratory Disorder | | | Heart Disorder/Murmur/Heart Attack/Coronary Artery Disease | | | Reproductive Organs Disorder/Endometriosis | | |
| Back/Muscle or Joint Disorder | | | Hepatitis: A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> | | | Sexually Transmitted Diseases | | |
| Bladder Disorder | | | Hernia | | | Sinus Disorder | | |
| Blood Disorder/Hemophilia | | | High Blood Pressure/Hypertension | | | Skin Disorder | | |
| Bone Disease/Deformity | | | High Cholesterol | | | Sleep Disorders | | |
| Breast Disorder/Fibrocystic Breast Disease | | | Infertility Testing/Treatment | | | Spinal Disorder/Back/Neck Strain | | |
| Cancer | | | Kidney Disorder | | | Stroke | | |
| Colitis, Spastic Colon, Polyps | | | Liver Disorder | | | Thyroid or Goiter | | |
| Congenital Disorder | | | Lupus/Systemic or Discoid | | | Transplants | | |
| Cystic Fibrosis | | | Lymphadenopathy/Immune Disorder | | | Tuberculosis | | |
| Diabetes/Pancreatic Disorders | | | Menstrual Disorder | | | Tumors/Cysts/Polyps/Growths | | |
| Digestive Disorder/Reflux | | | Mental, Nervous, Emotional Disorder / Anxiety/Depression/Attention Deficit Disorder | | | Ulcerative Colitis/Crohn's/ Regional Ileitis | | |
| Drug Addiction | | | Mental Retardation | | | Ulcers | | |
| Ear/Throat Disorders | | | Down's Syndrome | | | Urinary Tract Disorder | | |
| Eating Disorder/Anorexia/ Bulimia | | | Muscular Dystrophy | | | Vascular Disorder | | |
| Emphysema/Lung Disorder/COPD | | | Cerebral Palsy | | | Other conditions | | |
| Epilepsy and/or Seizure | | | Brain or Nerve Disorder | | | | | |

If you answered "Yes" to any of the above conditions, list the condition and provide details in the Health History section on the following page.

[I attest that the information provided above is true, complete and correct.

Name of Applicant or parent, if applicant is under age [18] (print) _____ Name of Spouse if applying for coverage (print) _____ Date _____

Signature of Applicant or parent, if applicant is under age [18] _____ Signature of Spouse if applying for coverage _____ Date] _____

HEALTH HISTORY

INSTRUCTIONS: Provide complete details to any question marked "Yes" in the Evidence of Insurability section in the space provided below. We may need to request additional information regarding your or any of your dependents' health history from you or your or your dependents' attending physician. If you need more space, please use the Health History Supplementary Form located at the end of this application.

| Question # | Applicant's Name | Condition(s) & Treatment | Date of Onset and Last Office Visit Mo./Yr. | Recovery Date Mo./Yr. | Complete Names and Addresses of Physicians & Hospitals |
|------------|------------------|--------------------------|---|-----------------------|--|
| | | | / | / | |
| | | | / | / | |
| | | | / | / | |
| | | | / | / | |
| | | | / | / | |
| | | | / | / | |
| | | | / | / | |

LAST PHYSICIAN SEEN

INSTRUCTIONS: List the name of the last medical care provider you visited and the condition that was treated.

| Physician's Name | Applicant's Name | Address | Condition(s) & Treatment | Phone | Dates visited |
|------------------|------------------|---------|--------------------------|-------|---------------|
| | | | | | / |
| | | | | | / |
| | | | | | / |
| | | | | | / |

MEDICATIONS CURRENTLY PRESCRIBED OR BEING USED

INSTRUCTIONS: List all medications prescribed or taken by you or your dependents currently and in the past [12] months.

| Applicant's Name | Medications | Frequency & Dosage | Length of time on medication | Date medication was last taken | Complete Names and Addresses of Physicians |
|------------------|-------------|--------------------|------------------------------|--------------------------------|--|
| | | | | / | |
| | | | | / | |
| | | | | / | |
| | | | | / | |
| | | | | / | |

[I attest that the information provided above is true, complete and correct.

Name of Applicant or parent, if applicant is under age [18] (print)

Name of Spouse if applying for coverage (print)

Date

Signature of Applicant or parent, if applicant is under age [18]

Signature of Spouse if applying for coverage

Date]

FRAUD WARNING

The following states require that insurance applicants acknowledge a fraud warning statement.

Please refer to the fraud warning statement for your state as indicated below.

[For Proposed Insureds in ARKANSAS and WEST VIRGINIA

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For Proposed Insureds in COLORADO

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

For Proposed Insureds in DISTRICT OF COLUMBIA

It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

For Proposed Insureds in FLORIDA

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony in the third degree.

For Proposed Insureds in NEW MEXICO

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and criminal penalties.

For Proposed Insureds in OHIO

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

For Proposed Insureds in OKLAHOMA

Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

For Proposed Insureds in PENNSYLVANIA

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

For Proposed Insureds in TENNESSEE

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

For Proposed Insureds in VIRGINIA

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.]

PRODUCER / GENERAL AGENT INFORMATION

Producer's Name _____ Company Name _____

Producer # _____ Are you licensed in the state where the application was completed? Yes No

Are you currently appointed with IAIC in the state where the application was completed?

Yes No (If not, please refer to the Producers Guide for contracting rules.)

Address _____
Street City State Zip

Business Phone (_____) Fax (_____) E-Mail Address _____

PRODUCER'S STATEMENT: I certify that I have truly and accurately recorded all the information given to me by the applicant and I know of no other medical information about those persons applying for coverage other than that contained on this application. I understand that commissions cannot be paid unless appointed with Independence American Insurance Company.

Producer's Signature _____ Date _____ Date Application Sent to General Agent _____

[General Agent's Name: _____ General Agent's # _____

General Agent's Phone () General Agent's Fax () General Agent's E-Mail: _____

Date Application Received by General Agent: / / Date Application Sent to IAC: / /

PRODUCER'S FINAL CHECKLIST

- ✓ Are all the questions answered and boxes checked?
- ✓ Has the applicant (and spouse, if applying) signed *both* Medical and Agreement on the application?
- ✓ Have you obtained a personal check from the applicant payable to Insurers Administrative Corporation?
- ✓ Have you offered the applicant the option of the Monthly Automatic Payment Plan?
- ✓ Has the applicant enclosed a voided check for the Monthly Automatic Payment Plan, if applicable?

Submit to **Independence American Insurance Company**
P.O. Box 37457, Phoenix, AZ 85069-7457
Fax No. (602) 861-6068]

Authorization for Release of Health-Related Information.

I authorize the disclosure of health information regarding, or related to the following individuals for whom an application for insurance has been submitted:

| Print Name(s): (Last) | (First) | (MI) | Date of Birth (Month/Day/Year) |
|-----------------------|---------|------|--------------------------------|
| 1 | | | / / |
| 2 | | | / / |
| 3 | | | / / |
| 4 | | | / / |
| 5 | | | / / |
| 6 | | | / / |

I authorize the disclosure of any and all information that: (i) is created or received by a health care provider, health plan including health insurer or health insurance agent, public health authority, employer, life insurer, school or university, or health care clearinghouse; and (ii) relates to the past, present, or future physical or mental health or condition of an individual listed above; the provision of health care to an individual listed above; or the past, present, or future payment for the provision of health care to an individual listed above. This authorization permits the disclosure of all medical records including without limitation those containing information relating to diagnoses, treatments, consultation, care, advice, laboratory or diagnostic tests, physical examinations, recommendations for future care, and prescription drug information.

I specifically authorize the disclosure of information related to (i) communicable diseases, including HIV, AIDS or AIDS related complex (to the extent permitted by both state and federal law); (ii) drug and alcohol abuse and treatment; (iii) mental illness and treatment; and (iv) genetic conditions including genetic testing (to the extent permitted by both state and federal law). Notwithstanding the above, this authorization does not authorize the release of psychotherapy notes.

I authorize any and all health care providers including without limitation physicians, medical practitioners, hospitals, clinics, medical or medically-related facilities, pharmacy benefit managers, pharmacies or pharmacy-related facilities; and any and all health plans, insurance companies, insurance support organizations (such as MIB Group, Inc.), business associates of health plans or insurance companies and those persons or entities providing services to such business associates to disclose the information described above.

I authorize Independence American Insurance Company ("IAIC"), including its affiliated companies, subsidiaries and business associates, including those persons or entities providing services to its business associates, to receive the disclosure of information authorized herein and use the information disclosed pursuant to this authorization.

The purpose of the disclosure authorized herein is to permit IAIC, including its affiliated companies, subsidiaries and business associates, including those persons or entities providing services to its business associates, to obtain and use the information described above to make prospective and retrospective eligibility, underwriting and risk rating determinations, including whether the individual is subject to a pre-existing condition exclusion.

This authorization shall expire twenty-four (24) months after the date on which it is executed below.

I understand that eligibility for the health plan is conditioned on my execution of this authorization for the use or disclosure of the information described above for the purpose of making eligibility, underwriting and risk rating determinations. Except as otherwise stated herein, treatment, payment, enrollment in a health plan, or eligibility for benefits is not conditioned on an authorization for the use or disclosure of the information described above.

I understand that I may revoke this authorization by sending written notice of my intent to revoke this authorization to P.O. Box 37587, Phoenix, AZ 85069, Attention Privacy Officer.

I understand that there is a possibility of re-disclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.

A copy or facsimile of this authorization shall be as valid as the original.

Signature of each Individual over the age of 18 or the Individual's Legal Representative: _____ Date: _____
 X _____
 X _____
 X _____

If signed by the individual's legal representative (e.g. a parent on behalf of a child), please describe the representative's authority to sign on behalf of the individual:

Name: _____ Authority: _____



July 29, 2008

Honorable Julie Benafield-Bowman
Insurance Commissioner
State of Arkansas
Arkansas Department of Insurance
1200 W. Third St.
Little Rock, AR 72201-1904

RE: Independence American Insurance Company
NAIC Company Number: 26581
NAIC Group Number: 0450
FEIN Number: 74-1746542
Master Group Major Medical Insurance Policy – IAIC GP 107 and Related Forms
(see exhibit 1)

Dear Commissioner Benafield-Bowman :

We are submitting for your approval the above referenced out-of-state Group Policy forms on behalf of Independence American Insurance Company (IAIC). These forms are new and will not replace any existing forms on file with the Department.

Independence Holding Company (IHC) is the parent company of our company, Insurers Administrative Corporation (IAC). IHC also owns Madison National Life Insurance Company, Inc. (MNL), **Independence American Insurance Company (IAIC)**, and Standard Security Life Insurance Company (SSL). The content of the above policy forms is substantially similar to the SSL policy documents approved by the State of Arkansas on June 6, 2008 (SERFF Tracking No. MADS-125619508). We have changed the carrier information and form numbers on the policy forms in this submission to reflect IAIC as the carrier.

IAC has received authorization to file life, accident, and health forms on IAIC's behalf. We have enclosed the filing letter of authorization from IAIC. A Certification signed by an officer of IAIC is also included in accordance with Rule and Regulation 19.

Form IAIC GC 107 is the Group Health Insurance Certificate of Coverage evidencing coverage under the Master Group Policy.

The major medical coverage provides for a number of separate plans as indicated in the Schedule of Benefits. The variability in the Schedule of Benefits is predicated upon applicant election. The Schedule of Benefits are attached to the Certificate based on the benefit levels selected by the applicant. Coverage will be solicited by licensed agents and brokers, including solicitation via the Internet, to members of the group. Coverage will not be solicited as employer group coverage.

All variable information has been indicated by brackets to allow the group and the insurer flexibility in plan and benefit designs. Variability will never be used if it would conflict with the minimum requirements as mandated by State and/or Federal law. The officer's signatures may change to reflect the Company's officers at the time the forms are issued. The Application and related forms may be used on the Internet for the member's on-line form(s) completion and electronic submission. These applications may, at some time in the future, be converted to an electronic document. Such adaptation may slightly alter the appearance of the document, but we assure the State that its content will not change and its readability compliance will not be affected. Also, at some point, the insurer anticipates utilizing electronic and voice signatures in a form compliant with your laws and regulations.

The following Benefit Riders may also be offered to the group and each applicant:

- Supplemental Accident Benefit Rider
- Prescription Medication Benefit Rider
- Preventive Care Benefit Rider
- 24-Hour Occupational Coverage Benefit Rider
- Maternity Benefit Rider
- Maternity Scheduled Benefit Rider
- Dental Benefit Rider
- Graduated Dental Benefit Rider

We certify that to the best of our knowledge and belief, these forms do not violate any laws or regulations of your state and do not contain any previously disapproved provisions. We confirm that the forms meet the minimum required readability standards.

We have enclosed with our filing the Actuarial Memo certification demonstrating exemption from the Arkansas Mental Health Parity requirement.

For any questions or if any additional information is needed, please contact me at (602)-861-6070, or by email: howards@iacusa.com. Thank you for your prompt consideration of this filing.

Sincerely,

Shellie Howard

Shellie Howard
Forms Development and Compliance Specialist
Insurers Administrative Corporation

Exhibit 1 – Forms List

| | |
|--------------------------|---|
| IAIC GA 107 | Policyholder Application for Group Insurance |
| IAIC GP 107 | Master Group Major Medical Insurance Policy |
| IAIC GC 107 | Group Health Insurance Certificate of Coverage |
| IAIC MED APP 0307 | Member Application for Insurance |
| IAIC MED BSF 0107 | Benefit Plan Selection Form |
| IAIC MED HHSF 0107 | Health History Supplemental to Application |
| IAIC MED AFPU 0307 | Application for Preferred Underwriting Classification |
| IAIC AE 107 | Amendatory Endorsement |
| IAIC DBR 107 | Dental Benefit Rider |
| IAIC EXCL AE 107 | Exclusion Endorsement |
| IAIC SABR 107 | Supplemental Accident Benefit Rider |
| IAIC PCBR 107 | Preventive Care Benefit Rider |
| IAIC OCR 107 | 24-Hour Occupational Coverage Benefit Rider |
| IAIC AMDAPP 1007 | Application Amendment (no signature) |
| IAIC AMDAPP-S 1007 | Application Amendment (signature) |
| IAIC GDBR 107 | Graduated Dental Benefit Rider |
| IAIC RE 107 | Rescission Endorsement |
| IAIC AEAR 107 | AR Amendatory Endorsement |
| IAIC AEAR OPT ELC AR 107 | AR Policyholder Election Form |
| IAIC AECD AR 107 | AR Amendatory Endorsement |
| IAIC AEHEAR AR 107 | AR Amendatory Endorsement |
| IAIC AEMI AR 107 | AR Amendatory Endorsement |
| IAIC MBR AR 107 | AR Maternity Benefit Rider |
| IAIC MSBR AR 107 | AR Maternity Scheduled Benefit Rider |
| IAIC PMBR AR 107 | AR Prescription Medication Benefit Rider |
| IAIC SOB AR 107 | AR Schedule of Benefits (PPO) |
| IAIC SOB IND AR 107 | AR Schedule of Benefits (Indemnity) |

SERFF Tracking Number: ICCL-125266631 State: Arkansas
 Filing Company: Madison National Life Insurance Company, Inc. State Tracking Number: 36687
 Company Tracking Number: MNL GP 107
 TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
 Product Name: Group Major Medical Expense Policy
 Project Name/Number: Group Major Medical Expense Policy/MNL GP 107

| Item Type | Item Name | Item Status | Public Access |
|---------------------|---|-------------|---------------|
| Supporting Document | Certification/Notice | Approved | Yes |
| Supporting Document | Application | Approved | Yes |
| Supporting Document | Filing fee certification | Approved | Yes |
| Supporting Document | Authorization Letter | Approved | Yes |
| Supporting Document | Cover letter | Approved | Yes |
| Supporting Document | Cover letter | Approved | Yes |
| Supporting Document | Prior approval letter for the CA Association | Approved | Yes |
| Supporting Document | CA Association Certificate of Name Change | Approved | Yes |
| Form | Schedule of Benefits PPO | Approved | Yes |
| Form | Schedule of Benefits - Indemnity | Approved | Yes |
| Form | Benefit Plan Selection Form | Approved | Yes |
| Form | Amendatory Endorsement | Approved | Yes |
| Form | Policyholder Election Form | Approved | Yes |
| Form | Amendatory Endorsement | Approved | Yes |
| Form | Amendatory Endorsement | Approved | Yes |
| Form | Amendatory Endorsement | Approved | Yes |
| Form | Amendatory Endorsement | Approved | Yes |
| Form | Amendatory Endorsement | Approved | Yes |
| Form | Amendatory Endorsement | Approved | Yes |
| Form | Prescription Medication Rider | Approved | Yes |
| Form | Maternity Benefit Rider | Approved | Yes |
| Form | Maternity Scheduled Benefit Rider | Approved | Yes |
| Form | Group Major Medical Expense Policy | Approved | Yes |
| Form | Policyholder Application | Approved | Yes |
| Form | Group Health Certificate | Approved | Yes |
| Form | Member Application for Insurance | Approved | Yes |
| Form | Health History Supplement to Application | Approved | Yes |
| Form | Application for Preferred Underwriting Classification | Approved | Yes |
| Form | Supplemental Accident Benefit Rider | Approved | Yes |
| Form | Preventive Care Benefit Rider | Approved | Yes |

SERFF Tracking Number: ICCL-125266631 State: Arkansas
Filing Company: Madison National Life Insurance Company, Inc. State Tracking Number: 36687
Company Tracking Number: MNL GP 107
TOI: H16G Group Health - Major Medical Sub-TOI: H16G.001A Any Size Group - PPO
Product Name: Group Major Medical Expense Policy
Project Name/Number: Group Major Medical Expense Policy/MNL GP 107

Satisfied -Name: Prior approval letter for the CA Association

Review Status:

Approved 08/28/2007

Comments:

Attachment:

AR prior approval of CA Assoc 4-29-03.pdf

Satisfied -Name: CA Association Certificate of Name Change

Review Status:

Approved 08/28/2007

Comments:

Attachment:

CA Assoc name change effective 1-17-07.pdf



INSURANCE
COMPLIANCE
CONSULTANTS, INC.

519 Colman Center Drive
Rockford, Illinois 61108

Phone: (815) 316-6714
FAX: (815) 316-6720

August 28, 2007

Rosalind Minor
State of Arkansas
Arkansas Department of Insurance
1200 W. Third St.
Little Rock, AR 72201-1904

RE: Madison National Life Insurance Company, Inc.
NAIC Company Number: 65781
NAIC Group Number: 0450
FEIN Number: 39-0990296
Master Group Major Medical Insurance Policy – MNL GP 107 and Related Forms {See Exhibit 1}
Your letter dated August 24 2007
State Tracking Number: 36687

Dear Ms. Minor:

Thank you for your letter of the above date. This letter will certify that there will be no more than a 25% differential between In-Network and Out-of-Network Providers.

Communicating for America, Inc. Association is the same association as Communicating for Agriculture and the Self-Employed, Inc., (CA) Association, previously approved by the Department on April 29, 2003. Communicating for Agriculture and the Self-Employed changed their name to Communicating for America on January 17, 2007. A copy of the Department's prior approval and the Certificate of Name Change are enclosed for your convenience.

Your prompt review of this submission will be greatly appreciated. If you have any questions or need further information, please contact me at (815) 316-6714, fax me at (815) 316-6720, or email me at Brendadawson@inscompliance.com.

Sincerely,

Brenda Dawson, FLMI, AIRC, ACS
Insurance Compliance Consultants



April 15, 2003

INSURANCE
COMPLIANCE
CONSULTANTS, INC.

303 North Main Street
Rockford, Illinois 61101

Rosalind D. Minor
Certified Rate and Form Analyst
Life and Health Division
State of Arkansas
Department of Insurance
1200 West Third Street
Little Rock, Arkansas 72201-1904

RECEIVED

APR 16 2003

LIFE AND HEALTH
ARKANSAS INSURANCE DEPARTMENT

Phone: (815) 720-2
FAX: (815) 987-5

APPROVED
APR 29 2003
LIFE AND HEALTH
ARKANSAS INSURANCE DEPARTMENT

RE: LIFE INVESTORS INSURANCE COMPANY OF AMERICA - NAIC# 64130
FEIN# 42-0191090

Group Major Medical Expense Forms – Indemnity Plan includes:

Group Major Medical Expense Policy - CHP 1102
Group Major Medical Expense Certificate CHP 1102 CERT
Group Major Medical Expense Schedule of Benefits CHP 1102 SB AR
Group Master Application – CHP 1102 APP
AR Amendatory Endorsement AE 1542 AR
AR Amendatory Endorsement AE 1543 AR ADD
AR Amendatory Endorsement AE 1543 AR MID
AR Amendatory Endorsement AE 1543 AR TMJ
24-Hour Occupational Coverage Rider GOCR 1 1102
Outpatient Prescription Medication Card Benefit Rider GPDR 8 1102 AR
Optional Monthly Disability Income Benefit Rider GMIR 15 1102
Optional Outpatient Supplement Accident Benefit Rider GSAR 1 1102
Optional Wellness Benefit Rider GWCR 1 1102
Application 6400GRP R1102 14
Supplement to Application 6400GRP R1102 AA
Filing Fee and Transmittal Forms
Your letter dated March 28, 2003

Dear Ms. Minor

Thank you for your letter of the above date. Enclosed is a point by point response to the items addressed in your letter. All revisions have been highlighted for your convenience.

1. Please find enclosed revised Amendatory Endorsement form AE 1542 AR. On page 2 under Section 5 – Termination of Insurance, we have revised the definition of Chiefly Dependent.
2. With regard to exclusions numbered 10 and 11 on page 16 of the certificate, for Newborn Nursery Care and Routine Well Baby Care, respectively, we have revised page 1 of AE 1542 AR to add: Coverage will include the necessary care and treatment of medically diagnosed congenital birth defects, birth abnormalities and premature birth. Routine nursery care and pediatric care charges for a well newborn child are provided for up to five (5) full days in a Hospital nursery or until the mother is discharged from the Hospital following birth, whichever is earlier. Page 3 of AE 1542 AR, was also revised in order to delete exclusion number 10, in its entirety. The Optional Wellness Benefit Rider form GWCR 1 1102 is intended to provide only the benefits specified in the rider i.e., examination after Hospital discharge following birth, etc., therefore no revision was made to this optional coverage.
3. We have revised AR 1542 AR in order to add to page 3, additions to our extension of benefits provision, pursuant to ACA 23-86-116.

4

Rosalind Minor

Page 2

4. We have also revised AE 1542 AR in order to add to page 1, under Section 4 – Effective Date of Insurance, item 3., the second sentence "...or the premium due date whichever is greater;"; and to the last sentence "...at the end of the ninety (90) day period or the premium due date whichever is greater;".
5. With regard to Binding Arbitration, AE 1542 AR, we replaced Arbitration with Mediation.
6. Concerning the offer of coverage to the group policyholder for Musculoskeletal Disorders form AE 1543 AR TMJ, this offer of coverage has been rejected by the group policyholder. We have however revised form AE 1543 AR TMJ with the following "Note: If you reject this coverage, it means that covered benefits provided under the Policy will not include temporomandibular joint disorder or craniomandibular disorder."
7. We have revised AE 1542 AR, on page 2, to amend the provision for Continuation of Coverage, in the Certificate, pursuant to ACA 23-86-114.
8. We have also revised AE 1542 AR, on page 2, to include a conversion privilege pursuant to ACA 23-86-115.

Your continued review for approval is greatly appreciated. If you should have any further questions, please feel free to contact me at (815) 720-2117, or fax me at (815) 987-9858.

Sincerely,


Brenda Dawson, FLMI, AIRC, ACS
Authorized Representative
Insurance Compliance Consultants, Inc.

5

State of Minnesota

SECRETARY OF STATE

Certificate of Name Change

I, Mark Ritchie, Secretary of State of Minnesota, do certify that the corporation listed below filed an amendment of its articles of incorporation, or, in the case of a non-Minnesota corporation, a certificate of name change, changing its name with this office on the date listed below, and that the corporation has complied with the relevant laws of Minnesota with respect to that filing.

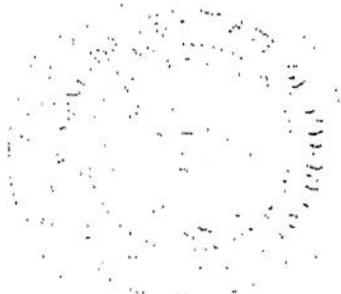
Old Name: COMMUNICATING FOR AGRICULTURE AND THE SELF
EMPLOYED, INC.

New Name: Communicating for America, Inc.

State of Incorporation: MN

Date Amendment filed: 12/26/2006

This certificate has been issued on 01/17/07.



Mark Ritchie
Secretary of State.

SERFF Tracking Number: *MADS-125643562* *State:* *Arkansas*
Filing Company: *Independence American Insurance Company* *State Tracking Number:* *39791*
Company Tracking Number: *IAIC-AR*
TOI: *H16G Group Health - Major Medical* *Sub-TOI:* *H16G.001A Any Size Group - PPO*
Product Name: *IAIC-AR*
Project Name/Number: *IAIC-AR/*

Attachment "IAIC Authorization Letter {IAC}.doc" is not a PDF document and cannot be reproduced here.