

SERFF Tracking Number: MGCC-126119576 State: Arkansas
 Filing Company: The Chesapeake Life Insurance Company State Tracking Number: 42199
 Company Tracking Number: CH-26210 PPO-IP (03/09) AR
 TOI: H15I Individual Health - Sub-TOI: H15I.001 Health - Hospital/Surgical/Medical
 Hospital/Surgical/Medical Expense Expense
 Product Name: CLICO 26210 (03/09)
 Project Name/Number: CLICO 26210 (03/09)/CH-26210 PPO-IP (03/09) AR

Filing at a Glance

Company: The Chesapeake Life Insurance Company

Product Name: CLICO 26210 (03/09) SERFF Tr Num: MGCC-126119576 State: Arkansas
 TOI: H15I Individual Health - SERFF Status: Closed-Approved- State Tr Num: 42199
 Hospital/Surgical/Medical Expense Closed
 Sub-TOI: H15I.001 Health - Co Tr Num: CH-26210 PPO-IP State Status: Approved-Closed
 Hospital/Surgical/Medical Expense (03/09) AR
 Filing Type: Form/Rate Reviewer(s): Rosalind Minor
 Authors: Trish Leal, Courtney Disposition Date: 10/22/2009
 Sharp, Kathleen Allen, Jaime Butler
 Date Submitted: 04/22/2009 Disposition Status: Approved-Closed
 Implementation Date Requested: On Approval Implementation Date:
 State Filing Description:

General Information

Project Name: CLICO 26210 (03/09) Status of Filing in Domicile:
 Project Number: CH-26210 PPO-IP (03/09) AR Date Approved in Domicile:
 Requested Filing Mode: Review & Approval Domicile Status Comments:
 Explanation for Combination/Other: Market Type: Individual
 Submission Type: New Submission Group Market Size:
 Overall Rate Impact: Group Market Type:
 Filing Status Changed: 10/22/2009 Explanation for Other Group Market Type:
 State Status Changed: 10/22/2009
 Deemer Date: Created By: Trish Leal
 Submitted By: Kathleen Allen Corresponding Filing Tracking Number:
 Filing Description:
 CH-26210 PPO-IP (03/09) AR - Catastrophic Expense Preferred Provider Organization (PPO) Policy

Company and Contact

Filing Contact Information

Kathleen Allen, Senior Compliance Analyst kathleen.allen@healthmarkets.com

SERFF Tracking Number: MGCC-126119576 State: Arkansas
 Filing Company: The Chesapeake Life Insurance Company State Tracking Number: 42199
 Company Tracking Number: CH-26210 PPO-IP (03/09) AR
 TOI: H151 Individual Health - Sub-TOI: H151.001 Health - Hospital/Surgical/Medical
 Hospital/Surgical/Medical Expense Expense
 Product Name: CLICO 26210 (03/09)
 Project Name/Number: CLICO 26210 (03/09)/CH-26210 PPO-IP (03/09) AR

9151 Boulevard 26 817-255-3590 [Phone]
 North Richland Hills, TX 76180 817-255-8153 [FAX]

Filing Company Information

The Chesapeake Life Insurance Company CoCode: 61832 State of Domicile: Oklahoma
 9151 Boulevard 26 Group Code: 264 Company Type: Health
 North Richland Hills, TX 76180 Group Name: State ID Number:
 (817) 255-3100 ext. [Phone] FEIN Number: 52-0676509

Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Chesapeake Life Insurance Company	\$100.00	04/22/2009	27339777

SERFF Tracking Number: MGCC-126119576 State: Arkansas
 Filing Company: The Chesapeake Life Insurance Company State Tracking Number: 42199
 Company Tracking Number: CH-26210 PPO-IP (03/09) AR
 TOI: H151 Individual Health - Sub-TOI: H151.001 Health - Hospital/Surgical/Medical
 Hospital/Surgical/Medical Expense Expense
 Product Name: CLICO 26210 (03/09)
 Project Name/Number: CLICO 26210 (03/09)/CH-26210 PPO-IP (03/09) AR

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/22/2009	10/22/2009
Approved-Closed	Rosalind Minor	10/12/2009	10/12/2009

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	10/12/2009	10/12/2009	Kathleen Allen	10/12/2009	10/12/2009
Pending Industry Response	Rosalind Minor	06/02/2009	06/02/2009	Kathleen Allen	10/06/2009	10/06/2009

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form Supporting Document	Amendatory Endorsement Redline of AE CH-26058-IR AR (10/09)	Kathleen Allen	10/22/2009	10/22/2009
Form	Mental Illness and Substance Use Disorder Rider	Kathleen Allen	10/09/2009	10/09/2009
Form	Amendatory Endorsement	Kathleen Allen	10/09/2009	10/09/2009

SERFF Tracking Number: MGCC-126119576 *State:* Arkansas
Filing Company: The Chesapeake Life Insurance Company *State Tracking Number:* 42199
Company Tracking Number: CH-26210 PPO-IP (03/09) AR
TOI: H151 Individual Health - *Sub-TOI:* H151.001 Health - Hospital/Surgical/Medical
Hospital/Surgical/Medical Expense Expense
Product Name: CLICO 26210 (03/09)
Project Name/Number: CLICO 26210 (03/09)/CH-26210 PPO-IP (03/09) AR

Disposition

Disposition Date: 10/22/2009

Implementation Date:

Status: Approved-Closed

Comment:

The replaced amendatory endorsement, Form AECH-26058-IR AR(10/09) is approved effective on this date.

The remainder of the filing will keep its original approval date of 10/12/09.

Rate data does NOT apply to filing.

SERFF Tracking Number: MGCC-126119576 State: Arkansas
 Filing Company: The Chesapeake Life Insurance Company State Tracking Number: 42199
 Company Tracking Number: CH-26210 PPO-IP (03/09) AR
 TOI: H151 Individual Health - Sub-TOI: H151.001 Health - Hospital/Surgical/Medical
 Hospital/Surgical/Medical Expense Expense
 Product Name: CLICO 26210 (03/09)
 Project Name/Number: CLICO 26210 (03/09)/CH-26210 PPO-IP (03/09) AR

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document (revised)	Variability Statement	Approved-Closed	Yes
Supporting Document (revised)	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document (revised)	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Health - Actuarial Justification	Replaced	No
Supporting Document	Cover letter	Approved-Closed	Yes
Supporting Document	Variability Statement	Replaced	Yes
Supporting Document	Outline of Coverage	Replaced	Yes
Supporting Document Form (revised)	Redline of AE CH-26058-IR AR (10/09) [CATASTROPHIC EXPENSE] PREFERRED PROVIDER ORGANIZATION (PPO) POLICY	Approved-Closed	Yes
Form	[CATASTROPHIC EXPENSE] PREFERRED PROVIDER ORGANIZATION (PPO) POLICY	Replaced	Yes
Form (revised)	Schedule Pages	Approved-Closed	Yes
Form	Schedule Pages	Replaced	Yes
Form (revised)	Schedule Pages	Approved-Closed	Yes
Form	[CATASTROPHIC EXPENSE] PREFERRED PROVIDER ORGANIZATION (PPO) POLICY	Replaced	Yes
Form	Schedule Pages	Replaced	Yes
Form	Mental Illness and Substance Use Disorder Rider	Approved-Closed	Yes
Form (revised)	Amendatory Endorsement	Approved-Closed	Yes
Form	Amendatory Endorsement	Approved-Closed	Yes
Rate (revised)	Rates	Approved-Closed	Yes
Rate	Rates	Replaced	Yes

SERFF Tracking Number: MGCC-126119576 *State:* Arkansas
Filing Company: The Chesapeake Life Insurance Company *State Tracking Number:* 42199
Company Tracking Number: CH-26210 PPO-IP (03/09) AR
TOI: H151 Individual Health - *Sub-TOI:* H151.001 Health - Hospital/Surgical/Medical
Hospital/Surgical/Medical Expense Expense
Product Name: CLICO 26210 (03/09)
Project Name/Number: CLICO 26210 (03/09)/CH-26210 PPO-IP (03/09) AR

Disposition

Disposition Date: 10/12/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: MGCC-126119576 State: Arkansas
 Filing Company: The Chesapeake Life Insurance Company State Tracking Number: 42199
 Company Tracking Number: CH-26210 PPO-IP (03/09) AR
 TOI: H151 Individual Health - Sub-TOI: H151.001 Health - Hospital/Surgical/Medical
 Hospital/Surgical/Medical Expense Expense
 Product Name: CLICO 26210 (03/09)
 Project Name/Number: CLICO 26210 (03/09)/CH-26210 PPO-IP (03/09) AR

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document (revised)	Variability Statement	Approved-Closed	Yes
Supporting Document (revised)	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document (revised)	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Health - Actuarial Justification	Replaced	No
Supporting Document	Cover letter	Approved-Closed	Yes
Supporting Document	Variability Statement	Replaced	Yes
Supporting Document	Outline of Coverage	Replaced	Yes
Supporting Document Form (revised)	Redline of AE CH-26058-IR AR (10/09) [CATASTROPHIC EXPENSE] PREFERRED PROVIDER ORGANIZATION (PPO) POLICY	Approved-Closed	Yes
Form	[CATASTROPHIC EXPENSE] PREFERRED PROVIDER ORGANIZATION (PPO) POLICY	Replaced	Yes
Form (revised)	Schedule Pages	Approved-Closed	Yes
Form	Schedule Pages	Replaced	Yes
Form (revised)	Schedule Pages	Approved-Closed	Yes
Form	[CATASTROPHIC EXPENSE] PREFERRED PROVIDER ORGANIZATION (PPO) POLICY	Replaced	Yes
Form	Schedule Pages	Replaced	Yes
Form	Mental Illness and Substance Use Disorder Rider	Approved-Closed	Yes
Form (revised)	Amendatory Endorsement	Approved-Closed	Yes
Form	Amendatory Endorsement	Approved-Closed	Yes
Rate (revised)	Rates	Approved-Closed	Yes
Rate	Rates	Replaced	Yes

SERFF Tracking Number: MGCC-126119576 State: Arkansas
Filing Company: The Chesapeake Life Insurance Company State Tracking Number: 42199
Company Tracking Number: CH-26210 PPO-IP (03/09) AR
TOI: H151 Individual Health - Sub-TOI: H151.001 Health - Hospital/Surgical/Medical
Hospital/Surgical/Medical Expense Expense
Product Name: CLICO 26210 (03/09)
Project Name/Number: CLICO 26210 (03/09)/CH-26210 PPO-IP (03/09) AR

Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 10/12/2009
Submitted Date 10/12/2009

Respond By Date

Dear Kathleen Allen,

This will acknowledge receipt of the captioned filing.

Objection 1

- [CATASTROPHIC EXPENSE] PREFERRED PROVIDER ORGANIZATION (PPO) POLICY, CH-26210 PPO-IP (03/09) AR (Form)

Comment:

Under the Newborn Children provision, the second to last sentence reads: This notice must be received by us within 90 days of the newborn child's date of birth.... ACA 23-79-129 (b) states that "The insurer may require that the insured give notice to his insurer of any newborn children within ninety (90) days of the birth or before the next premium due date, whichever is later.

Please revise this sentence.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

Response Letter

Response Letter Status Submitted to State
Response Letter Date 10/12/2009
Submitted Date 10/12/2009

Dear Rosalind Minor,

Comments:

Thank you for your recent review.

Response 1

SERFF Tracking Number: MGCC-126119576 State: Arkansas
 Filing Company: The Chesapeake Life Insurance Company State Tracking Number: 42199
 Company Tracking Number: CH-26210 PPO-IP (03/09) AR
 TOI: H151 Individual Health - Sub-TOI: H151.001 Health - Hospital/Surgical/Medical
 Hospital/Surgical/Medical Expense Expense
 Product Name: CLICO 26210 (03/09)
 Project Name/Number: CLICO 26210 (03/09)/CH-26210 PPO-IP (03/09) AR

Comments: I have revised the provision accordingly and have attached the corrected version of the policy for review.

Related Objection 1

Applies To:

- [CATASTROPHIC EXPENSE] PREFERRED PROVIDER ORGANIZATION (PPO) POLICY, CH-26210 PPO-IP (03/09) AR (Form)

Comment:

Under the Newborn Children provision, the second to last sentence reads: This notice must be received by us within 90 days of the newborn child's date of birth.... ACA 23-79-129 (b) states that "The insurer may require that the insured give notice to his insurer of any newborn children within ninety (90) days of the birth or before the next premium due date, whichever is later.

Please revise this sentence.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
[CATASTROPHIC EXPENSE] PREFERRED PROVIDER ORGANIZATION (PPO) POLICY	CH-26210 PPO-IP (03/09) AR		Policy/Contract/Fraternal Certificate	Initial			CH-26210 PPO-IP _0309_ AR [EF and CF].pdf
<i>Previous Version</i> [CATASTROPHIC EXPENSE] PREFERRED PROVIDER ORGANIZATION (PPO) POLICY	<i>CH-26210 PPO-IP (03/09) AR</i>		<i>Policy/Contract/Fraternal Certificate</i>	<i>Initial</i>			<i>CH-26210 PPO-IP _0309_ AR [EF and CF].pdf</i>

<i>SERFF Tracking Number:</i>	<i>MGCC-126119576</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>The Chesapeake Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>42199</i>
<i>Company Tracking Number:</i>	<i>CH-26210 PPO-IP (03/09) AR</i>		
<i>TOI:</i>	<i>H151 Individual Health - Hospital/Surgical/Medical Expense</i>	<i>Sub-TOI:</i>	<i>H151.001 Health - Hospital/Surgical/Medical Expense</i>
<i>Product Name:</i>	<i>CLICO 26210 (03/09)</i>		
<i>Project Name/Number:</i>	<i>CLICO 26210 (03/09)/CH-26210 PPO-IP (03/09) AR</i>		
<i>[CATASTROPHIC EXPENSE] PREFERRED PROVIDER ORGANIZATION (PPO) POLICY</i>	<i>CH-26210 PPO-IP (03/09) AR</i>	<i>Policy/Contract/Fraternal Initial Certificate</i>	<i>CH-26210 PPO-IP _0309_ AR [EF and CF].pdf</i>

No Rate/Rule Schedule items changed.

Thanks so much for your help with this submission!

Have a good day.

Sincerely,
Courtney Sharp, Jaime Butler, Kathleen Allen, Trish Leal

SERFF Tracking Number: MGCC-126119576 State: Arkansas
Filing Company: The Chesapeake Life Insurance Company State Tracking Number: 42199
Company Tracking Number: CH-26210 PPO-IP (03/09) AR
TOI: H151 Individual Health - Sub-TOI: H151.001 Health - Hospital/Surgical/Medical
Hospital/Surgical/Medical Expense Expense
Product Name: CLICO 26210 (03/09)
Project Name/Number: CLICO 26210 (03/09)/CH-26210 PPO-IP (03/09) AR

Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 06/02/2009
Submitted Date 06/02/2009

Respond By Date

Dear Kathleen Allen,

This will acknowledge receipt of the captioned filing.

Objection 1

- [CATASTROPHIC EXPENSE] PREFERRED PROVIDER ORGANIZATION (PPO) POLICY, CH-26210 PPO-IP (03/09) AR (Form)

Comment: Under the newborn children effective date, it is stated that "This notice must be received by Us within 90 days of the newborn child's date of birth and must be accompanied by an required additional premium. Our law, ACA 23-79-129(b) states that "The insurer may require that the insured give notice to his insurer of any newborn children within 90 days of the birth or before the next premium due date, whichever is later.

Objection 2

- Health - Actuarial Justification (Supporting Document)
- Variability Statement (Supporting Document)

Comment:

The co-insurance and deductible amounts listed on the outline of coverage are not in compliance with our Bulletin 9-85 which dates that the difference in benefit levels, i.e., deductibles and co-payment provisions, etc., offered to the insured must not be so great as to practically require that the health care service be rendered by a particular hospital or person. the Department will presume that a difference exceeding 25% in benefit levels effectively negates an insured's freedom to utilize non-panel providers.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

Response Letter

Response Letter Status Submitted to State
Response Letter Date 10/06/2009

SERFF Tracking Number: MGCC-126119576 State: Arkansas
 Filing Company: The Chesapeake Life Insurance Company State Tracking Number: 42199
 Company Tracking Number: CH-26210 PPO-IP (03/09) AR
 TOI: H151 Individual Health - Sub-TOI: H151.001 Health - Hospital/Surgical/Medical
 Hospital/Surgical/Medical Expense Expense
 Product Name: CLICO 26210 (03/09)
 Project Name/Number: CLICO 26210 (03/09)/CH-26210 PPO-IP (03/09) AR
 Submitted Date 10/06/2009

Dear Rosalind Minor,

Comments:

Thank you for your review of our submission.

Response 1

Comments: I have revised the policy language in this provision. I have attached the revised policy for your review.

Related Objection 1

Applies To:

- [CATASTROPHIC EXPENSE] PREFERRED PROVIDER ORGANIZATION (PPO) POLICY, CH-26210 PPO-IP (03/09) AR (Form)

Comment:

Under the newborn children effective date, it is stated that "This notice must be received by Us within 90 days of the newborn child's date of birth and must be accompanied by an required additional premium. Our law, ACA 23-79-129(b) states that "The insurer may require that the insured give notice to his insurer of any newborn children within 90 days of the birth or before the next premium due date, whichever is later.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Variability Statement

Comment: Please refer to attached.

Satisfied -Name: Outline of Coverage

Comment: Please refer to attached.

Satisfied -Name: Health - Actuarial Justification

Comment: Please refer to attached.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
[CATASTROPHIC EXPENSE] PREFERRED	CH-26210 PPO-IP (03/09)		Policy/Contract/Fraternal Certificate	Initial			CH-26210 PPO-IP _0309_

SERFF Tracking Number: MGCC-126119576 State: Arkansas
 Filing Company: The Chesapeake Life Insurance Company State Tracking Number: 42199
 Company Tracking Number: CH-26210 PPO-IP (03/09) AR
 TOI: H151 Individual Health - Sub-TOI: H151.001 Health - Hospital/Surgical/Medical
 Hospital/Surgical/Medical Expense Expense

Product Name: CLICO 26210 (03/09)
 Project Name/Number: CLICO 26210 (03/09)/CH-26210 PPO-IP (03/09) AR

PROVIDER AR AR [EF
 ORGANIZATION and
 (PPO) POLICY CF].pdf

Previous Version
 [CATASTROPHIC CH-26210 Policy/Contract/Fraternal Initial CH-26210
 EXPENSE] PPO-IP Certificate PPO-IP

PREFERRED (03/09) _0309_
 PROVIDER AR AR [EF
 ORGANIZATION and
 (PPO) POLICY CF].pdf

Schedule Pages CH-26210 Schedule Pages Initial CH-26210
 PPO-IP PPO-IP
 (SB-A) _SB-A_
 (03/09) _0309_
 AR AR
 [EF].pdf

Previous Version
 Schedule Pages CH-26210 Schedule Pages Initial CH-26210
 PPO-IP PPO-IP
 (SB-A) _SB-A_
 (03/09) _0309_
 AR AR
 [EF].pdf

Schedule Pages CH-26210 Schedule Pages Initial CH-26210
 PPO-IP PPO-IP
 (SB-B) _SB-B_
 (03/09) _0309_
 AR AR
 [CF].pdf

Previous Version
 Schedule Pages CH-26210 Schedule Pages Initial CH-26210
 PPO-IP PPO-IP
 (03/09) _SB-B_
 AR _0309_
 AR

SERFF Tracking Number: MGCC-126119576 State: Arkansas
 Filing Company: The Chesapeake Life Insurance Company State Tracking Number: 42199
 Company Tracking Number: CH-26210 PPO-IP (03/09) AR
 TOI: H151 Individual Health - Sub-TOI: H151.001 Health - Hospital/Surgical/Medical
 Hospital/Surgical/Medical Expense Expense
 Product Name: CLICO 26210 (03/09)
 Project Name/Number: CLICO 26210 (03/09)/CH-26210 PPO-IP (03/09) AR

[CF].pdf

Rate/Rule Schedule Item Changes

Document Name:	Affected Form Numbers:	Rate Action:	Rate Action Information:	Attach Document:
Rates	CH-26210 PPO-IP (03/09) AR	New	Previous State Filing Number 0	

Previous Version

Rates	CH-26210 PPO-IP (03/09) AR	New	Previous State Filing Number 0	
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Response 2

Comments: The appropriate changes have been made in the policy, outline of coverage, the rates and the actuarial memorandum to reflect no more than a 25% difference. Please review all that has been attached.

Related Objection 1

Applies To:

- Health - Actuarial Justification (Supporting Document)
- Variability Statement (Supporting Document)

Comment:

The co-insurance and deductible amounts listed on the outline of coverage are not in compliance with our Bulletin 9-85 which dates that the difference in benefit levels, i.e., deductibles and co-payment provisions, etc., offered to the insured must not be so great as to practically require that the health care service be rendered by a particular hospital or person. the Department will presume that a difference exceeding 25% in benefit levels effectively negates an insured's freedom to utilize non-panel providers.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Variability Statement

Comment: Please refer to attached.

Satisfied -Name: Outline of Coverage

Comment: Please refer to attached.

SERFF Tracking Number: MGCC-126119576 State: Arkansas
 Filing Company: The Chesapeake Life Insurance Company State Tracking Number: 42199
 Company Tracking Number: CH-26210 PPO-IP (03/09) AR
 TOI: H151 Individual Health - Sub-TOI: H151.001 Health - Hospital/Surgical/Medical
 Hospital/Surgical/Medical Expense Expense
 Product Name: CLICO 26210 (03/09)
 Project Name/Number: CLICO 26210 (03/09)/CH-26210 PPO-IP (03/09) AR

Satisfied -Name: Health - Actuarial Justification
 Comment: Please refer to attached.

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
[CATASTROPHIC EXPENSE] PREFERRED PROVIDER ORGANIZATION (PPO) POLICY	CH-26210 PPO-IP (03/09) AR		Policy/Contract/Fraternal Certificate	Initial			CH-26210 PPO-IP _0309_ AR [EF and CF].pdf
Previous Version							
[CATASTROPHIC EXPENSE] PREFERRED PROVIDER ORGANIZATION (PPO) POLICY	CH-26210 PPO-IP (03/09) AR		Policy/Contract/Fraternal Certificate	Initial			CH-26210 PPO-IP _0309_ AR [EF and CF].pdf
Schedule Pages	CH-26210 PPO-IP (SB-A) (03/09) AR		Schedule Pages	Initial			CH-26210 PPO-IP _SB-A_ _0309_ AR [EF].pdf
Previous Version							
Schedule Pages	CH-26210 PPO-IP (SB-A) (03/09) AR		Schedule Pages	Initial			CH-26210 PPO-IP _SB-A_ _0309_ AR [EF].pdf
Schedule Pages	CH-26210		Schedule Pages	Initial			CH-26210

SERFF Tracking Number: MGCC-126119576 State: Arkansas
 Filing Company: The Chesapeake Life Insurance Company State Tracking Number: 42199
 Company Tracking Number: CH-26210 PPO-IP (03/09) AR
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 Hospital/Surgical/Medical Expense Expense
 Product Name: CLICO 26210 (03/09)
 Project Name/Number: CLICO 26210 (03/09)/CH-26210 PPO-IP (03/09) AR
 PPO-IP PPO-IP
 (SB-B) _SB-B_
 (03/09) _0309_
 AR AR
 [CF].pdf

Previous Version

Schedule Pages	CH-26210	Schedule Pages	Initial	CH-26210
	PPO-IP			PPO-IP
	(03/09)			_SB-B_
	AR			_0309_
				AR
				[CF].pdf

Rate/Rule Schedule Item Changes

Document Name:	Affected Form Numbers:	Rate Action:	Rate Action Information:	Attach Document:
Rates	CH-26210 PPO-IP (03/09)	New	Previous State Filing Number	
	AR			
				0

Previous Version

Rates	CH-26210 PPO-IP (03/09)	New	Previous State Filing Number
	AR		
			0

If you have any further questions, please advise.

Thank you.

Sincerely,
 Courtney Sharp, Jaime Butler, Kathleen Allen, Trish Leal

SERFF Tracking Number: MGCC-126119576 State: Arkansas
 Filing Company: The Chesapeake Life Insurance Company State Tracking Number: 42199
 Company Tracking Number: CH-26210 PPO-IP (03/09) AR
 TOI: H151 Individual Health - Sub-TOI: H151.001 Health - Hospital/Surgical/Medical
 Hospital/Surgical/Medical Expense Expense
 Product Name: CLICO 26210 (03/09)
 Project Name/Number: CLICO 26210 (03/09)/CH-26210 PPO-IP (03/09) AR

Amendment Letter

Submitted Date: 10/22/2009

Comments:

Subject: Correction and revision of AE CH-26058-IR AR (10/09)

In the first paragraph of the AE, we have corrected it to read "Policy" vs. "Group Policy" and added more verbiage in the last sentence for further clarification. I have attached a copy of the revised AE under the Form Schedule tab and a redline version of the AE showing the changes under the Supporting Documentation tab.

Thank you for your attention to this matter.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
AE-CH-26058-IR AR (10/09)	Policy/Contr Certificate: t Amendment, Insert Page, Endorsemen t or Rider	Amendatory Initial Endorsemen	Initial					AE CH-26058-IR AR _1009_.pdf

Supporting Document Schedule Item Changes:

User Added -Name: Redline of AE CH-26058-IR AR (10/09)

Comment: I have attached a copy of a redline indicating the changes made to the previously submitted AE.
 Redline - AE CH-26058-IR AR _1009_.pdf

SERFF Tracking Number: MGCC-126119576 State: Arkansas
 Filing Company: The Chesapeake Life Insurance Company State Tracking Number: 42199
 Company Tracking Number: CH-26210 PPO-IP (03/09) AR
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 Hospital/Surgical/Medical Expense Expense
 Product Name: CLICO 26210 (03/09)
 Project Name/Number: CLICO 26210 (03/09)/CH-26210 PPO-IP (03/09) AR

Amendment Letter

Submitted Date: 10/09/2009

Comments:

In an effort to comply with HB 2195, we have attached a rider and an amendatory endorsement that would be included with this plan of coverage.

Rates for this rider will be filed under separate cover.

Thank you.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
CH-26058-IR AR (10/09)	Policy/Contract Amendment, Insert	Mental Illness and Substance Use Disorder Rider	Initial					CH-26058-IR AR _1009_.pdf
AE-CH-26058-IR AR (10/09)	Policy/Contract Amendment, Insert	Amendatory Endorsement	Initial					AE CH-26058-IR AR _1009_.pdf

SERFF Tracking Number: MGCC-126119576 *State:* Arkansas
Filing Company: The Chesapeake Life Insurance Company *State Tracking Number:* 42199
Company Tracking Number: CH-26210 PPO-IP (03/09) AR
TOI: H151 Individual Health - *Sub-TOI:* H151.001 Health - Hospital/Surgical/Medical
Hospital/Surgical/Medical Expense Expense
Product Name: CLICO 26210 (03/09)
Project Name/Number: CLICO 26210 (03/09)/CH-26210 PPO-IP (03/09) AR

Note To Reviewer

Created By:

Kathleen Allen on 10/08/2009 03:03 PM

Last Edited By:

Rosalind Minor

Submitted On:

10/12/2009 03:12 PM

Subject:

Additional information to be included in this submission...

Comments:

We are currently finalizing a rider with regard to HB 2195 that we would like to include in this filing.

I will have it attached before end of business day - Friday, 10/9/09.

SERFF Tracking Number: MGCC-126119576 *State:* Arkansas
Filing Company: The Chesapeake Life Insurance Company *State Tracking Number:* 42199
Company Tracking Number: CH-26210 PPO-IP (03/09) AR
TOI: H151 Individual Health - *Sub-TOI:* H151.001 Health - Hospital/Surgical/Medical
Hospital/Surgical/Medical Expense Expense
Product Name: CLICO 26210 (03/09)
Project Name/Number: CLICO 26210 (03/09)/CH-26210 PPO-IP (03/09) AR

Note To Filer

Created By:

Rosalind Minor on 09/30/2009 01:29 PM

Last Edited By:

Rosalind Minor

Submitted On:

10/12/2009 03:12 PM

Subject:

Objection letter of 6/2/09

Comments:

As of this date, we have not received a response to my objection letter of 6/2/09.

If a response is not received by October 7, 2009, the filing will be disapproved.

SERFF Tracking Number: MGCC-126119576 State: Arkansas
 Filing Company: The Chesapeake Life Insurance Company State Tracking Number: 42199
 Company Tracking Number: CH-26210 PPO-IP (03/09) AR
 TOI: H151 Individual Health - Sub-TOI: H151.001 Health - Hospital/Surgical/Medical
 Hospital/Surgical/Medical Expense Expense
 Product Name: CLICO 26210 (03/09)
 Project Name/Number: CLICO 26210 (03/09)/CH-26210 PPO-IP (03/09) AR

Form Schedule

Lead Form Number: CH-26210 PPO-IP (03/09) AR

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 10/12/2009	CH-26210 PPO-IP (03/09) AR	Policy/Contract Certificate	Policy/Contract/Fraternal Certificate [CATASTROPHIC EXPENSE] PREFERRED PROVIDER ORGANIZATION (PPO) POLICY	Initial			CH-26210 PPO-IP _0309_ AR [EF and CF].pdf
Approved-Closed 10/12/2009	CH-26210 PPO-IP (SB-A) (03/09) AR	Schedule Pages	Schedule Pages	Initial			CH-26210 PPO-IP _SB-A_ _0309_ AR [EF].pdf
Approved-Closed 10/12/2009	CH-26210 PPO-IP (SB-B) (03/09) AR	Schedule Pages	Schedule Pages	Initial			CH-26210 PPO-IP _SB-B_ _0309_ AR [CF].pdf
Approved-Closed 10/12/2009	CH-26058-IR AR (10/09)	Policy/Contract Certificate	Policy/Contract/Fraternal Certificate Mental Illness and Substance Use Disorder Rider	Initial			CH-26058-IR AR _1009_.pdf
Approved-Closed 10/22/2009	AE-CH-26058-IR AR (10/09)	Policy/Contract Certificate	Policy/Contract/Fraternal Certificate Amendments, Insert Page, Endorsement or Rider	Initial			AE CH-26058-IR AR _1009_.pdf

SERFF Tracking Number: MGCC-126119576 *State:* Arkansas
Filing Company: The Chesapeake Life Insurance Company *State Tracking Number:* 42199
Company Tracking Number: CH-26210 PPO-IP (03/09) AR
TOI: H151 Individual Health - *Sub-TOI:* H151.001 Health - Hospital/Surgical/Medical
Hospital/Surgical/Medical Expense Expense
Product Name: CLICO 26210 (03/09)
Project Name/Number: CLICO 26210 (03/09)/CH-26210 PPO-IP (03/09) AR
**Endorseme
nt or Rider**

THE CHESAPEAKE LIFE INSURANCE COMPANY

A Stock Company

(Hereinafter called: the Company, We, Our or Us)

Home Office: Oklahoma City, Oklahoma
Administrative Office: P.O. Box 982010
North Richland Hills, Texas 76182-8010
Customer Service: 1-800-733-1110

[CATASTROPHIC EXPENSE] PREFERRED PROVIDER ORGANIZATION (PPO) POLICY

IMPORTANT NOTICE ABOUT STATEMENTS IN THE APPLICATION

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

10 DAY RIGHT TO EXAMINE THE POLICY

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

RENEWABILITY

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

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



SECRETARY



PRESIDENT

IMPORTANT MESSAGE TO OUR POLICYHOLDERS

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

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INPATIENT MEDICAL MANAGEMENT

We or Our designated representative will, using industry standard clinical guidelines, provide review and monitoring of any inpatient admission upon notification by You, or Your admitting Physician or Hospital. We or Our designated representative will pre-certify Medically Necessary admissions, monitor care during the admission and arrange for Medically Necessary services upon discharge.

In order to receive Pre-Certification from Us or Our designated representative, Your Physician or Hospital should call the toll-free telephone number shown on Your I.D. card between 8:00 a.m. and 8:00 p.m. eastern time on Monday through Friday, at least [5] working days prior to a Hospital Confinement.

For emergency admissions, Your Physician or Hospital should call the toll-free telephone number shown on Your I.D. card within 48 hours following the admission, or as soon as reasonably possible, to provide notification of any admission due to a Medical Emergency.

IMPORTANT: PLEASE NOTE THAT PRE-CERTIFICATION OF TREATMENT IS NOT A VERIFICATION OR GUARANTEE OF BENEFITS. Covered Services are subject to all provisions, terms, DEFINITIONS and EXCLUSIONS AND LIMITATIONS of the Policy on the date the service is performed or the supply is furnished and while coverage is in force.

CASE MANAGEMENT

When meeting established clinical criteria, Case Management is a collaborative process where We or Our designated representative will review an eligible Insured Person's health condition(s), assess opportunities to provide alternative care and develop a plan designed to optimize the Insured Person's health.

If the Insured Person's medical condition meets the established clinical criteria, benefits will be provided for approved alternative methods of care, only for so long as is determined that the alternative services are Medically Necessary and cost effective. Case Management is not designed to extend extra-contractual benefits for alternative methods of care to persons who do not meet Our clinical criteria or for services not Pre-certified by Our designated representative. The approved alternative benefits will count toward the Insured Person's Calendar Year and Lifetime Maximum Amounts.

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

DEFINITIONS

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

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

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

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

Calendar Year Maximum Amount means the maximum amount payable under this Policy and its Riders, if any, each Calendar Year for each Insured Person, occurring while coverage is in effect under this Policy for such person. The Calendar Year Maximum Amount is shown in the POLICY SCHEDULE. This amount is included in and part of the Lifetime Maximum Amount for each Insured Person.

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

Coinsurance means the percentage of Covered Services that are paid by Us after application of the Copayment or satisfying the Deductible. The Coinsurance percentage We pay is shown in the POLICY SCHEDULE.

Complications of Pregnancy means:

1. Hospital Confinement or treatment in an Outpatient Surgery Facility (when the pregnancy is not terminated) required to treat conditions, such as the following, in a pregnant female Insured Person: (a) acute nephritis; (b) nephrosis; (c) cardiac decompensation; (d) HELLP syndrome; (e) uterine rupture; (f) amniotic fluid embolism; (g) chorioamnionitis; (h) fatty liver in pregnancy; (i) septic abortion; (j) placenta accreta; (k) gestational hypertension; (l) puerperal sepsis; (m) peripartum cardiomyopathy; (n) cholestasis in pregnancy; (o) thrombocytopenia in pregnancy; (p) placenta previa; (q) placental abruption; (r) acute cholecystitis and pancreatitis in pregnancy; (s) postpartum hemorrhage; (t) septic pelvic thrombophlebitis; (u) retained placenta; (v) venous air embolus associated with pregnancy; (w) miscarriage; or (x) an emergency c-section required because of (i) fetal or maternal distress during labor, or (ii) severe pre-eclampsia, or (iii) arrest of descent or dilatation, or (iv) obstruction of the birth canal by fibroids or ovarian tumors, or (v) necessary because of the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that, in the absence of immediate medical attention, will result in placing the life of the mother or fetus in jeopardy. For purposes of this paragraph, a c-section delivery is not considered to be an emergency c-section if it is merely for the convenience of the Insured Person and/or Physician or solely due to a previous c-section.
2. Treatment, diagnosis or care for conditions, including the following, in a pregnant female Insured Person when the condition was caused by, necessary because of, or aggravated by the pregnancy: (a) hyperthyroidism; (b) hepatitis B or C; (c) HIV; (d) Human papilloma virus; (e) abnormal PAP; (f) syphilis; (g) chlamydia; (h) herpes; (i) urinary tract infections; (j) thromboembolism; (k) appendicitis; (l) hypothyroidism; (m) pulmonary embolism; (n) sickle cell disease; (o) tuberculosis; (p) migraine headaches; (q) depression; (r) acute myocarditis; (s) asthma; (t) maternal cytomegalovirus; (u) urolithiasis; (v) DVT prophylaxis; (w) ovarian dermoid tumors; (x) biliary atresia and/or cirrhosis; (y) first trimester adnexal mass; (z) hydatidiform mole; or (aa) ectopic pregnancy.

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

A Complication of Pregnancy arising from, caused by, or associated with a pregnancy existing on the Effective Date of Coverage, will be deemed a Pre-Existing Condition and is subject to the Pre-existing Condition provision as shown in the EXCLUSIONS AND LIMITATIONS.

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

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

Convenient Care Clinic means health care clinics, based in retail stores and pharmacies that are staffed by nurse practitioners (NPs).

Copayment means the specific dollar amount the Insured Person is required to pay for specifically listed Covered Services [and is in lieu of any Deductible]. The Copayment, if any, is shown in the POLICY SCHEDULE. Copayments do not count toward satisfaction of any Deductibles.

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

1. Reconstructive Surgery incidental to or following Surgery resulting from trauma, infection or other disease of the involved part, provided the condition which necessitates the Surgery occurs while coverage is in force and remains in force through the Surgery;
2. Reconstructive Surgery in connection with a mastectomy;
3. With respect to a Covered Dependent under age 18, reconstructive Surgery for craniofacial abnormalities, to improve the function of, or attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease; and
4. With respect to a newborn child, reconstructive Surgery to improve the function of, or attempt to create a normal appearance of, an abnormal structure caused by congenital defects.

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

Covered Services means the Medically Necessary Usual and Customary Charges for services, supplies, care or treatment as described in this Policy which are performed, prescribed, directed or authorized by a Provider. To be a Covered Service, the service, supply or treatment must be:

1. Medically Necessary and/or specifically included as a Covered Service under this Policy;
2. Within the scope of the license of the Provider performing the service;
3. Rendered while coverage under this Policy is in force and for which the Insured Person is legally obligated to pay; and
4. Not considered Experimental or Investigative or otherwise excluded or limited under this Policy.

A charge for a Covered Service is incurred on the date the service, supply or treatment is furnished.

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

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

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

Experimental or Investigative means any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, Injury, Sickness, or other health condition which We determine in Our sole discretion to be Experimental/Investigative. We will deem any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if We determine that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply:

1. Cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
2. Has been determined by the FDA to be contraindicated for the specific use;
3. Is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply; and
4. Is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

The information considered or evaluated by Us to determine whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative under the above criteria may include one or more items from the following list which is not all inclusive:

1. Published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
2. Evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
3. Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
4. Consent documents and/or the written protocols used by the treating Physicians or other medical professional, or facilities or by other treatment, Physicians, other medical professionals, or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply; or
5. Medical records; or
6. The opinions of consulting Providers and other experts in the field.

Based on the criteria above, We have the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is Experimental/Investigative.

Facility Fee means the amount the Insured Person is required to pay before the application of the Coinsurance, Deductibles or Copayments, if any, for specifically listed Covered Services. The Facility Fee, if any, is shown in the POLICY SCHEDULE. Facility Fees do not count toward [Copayments][,Deductibles][,or Coinsurance Maximums].

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

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

The term "Hospital" does not include:

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

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

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

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

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

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

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

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

Low Dose Mammography means the x-ray, examination of the breast using equipment dedicated specially for mammography, including the x-ray tube, filter, compression device, screens, films, and cassettes with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast.

Maximum Benefit Amount means the maximum amount payable for a Covered Service(s) under this Policy and any attached Riders for each Insured Person, after the application of any Deductibles, Copayments and/or Coinsurance, where applicable. The Maximum Benefit Amount is shown in the POLICY SCHEDULE and applies to both Network and Non-Network Providers, unless specifically stated otherwise. ***You are responsible for the balance due (if any) on charges for Covered Services in excess of the Maximum Benefit Amount.***

Medical Emergency means medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the Insured Person's condition, Sickness, or Injury is of such a nature that failure to get immediate medical care could result in:

1. Placing the patient's health in serious jeopardy;
2. Serious impairment to bodily functions;
3. Serious dysfunction of any bodily organ or part;
4. Serious disfigurement; or
5. In the case pregnant woman, serious jeopardy to the health of the fetus.

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

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

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

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

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

Network Provider (or Preferred Provider Organization (PPO)) means a Provider that holds a valid contract with the network associated with this Policy, to provide health care services. A current list of the Network Providers in the network associated with this Policy is available to You upon request.

Non-authorization or Non-authorized means the Hospital Confinements, Transplant Procedures, Diagnostic Procedures or Outpatient Services that have been determined by Our designated representative as a non-Covered Service under this plan because they do not meet the Preauthorization criteria.

Non-Network Provider (or Non-Preferred Provider Organization (Non-PPO)) means a Provider who has not entered into a contractual agreement with the Network associated with this Policy.

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

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

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

The term "Outpatient Surgery Facility" does not include:

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

Period of Treatment means a period which begins on the date an Insured Person is admitted to a Hospital or the date services are rendered in an Outpatient Surgery Facility for the treatment of an Injury or Sickness and ends after 365 days. If the same or related Sickness or Injury continues beyond 365 days, a new Sickness or Injury Period of Treatment will begin, which includes a new Deductible. In no event will a single Period of Treatment exceed 365 days. A separate Period of Treatment will apply to each Injury or Sickness.

Physician means a legally qualified licensed practitioner of the healing arts who provides care within the scope of his or her license, including any other practitioner We are compelled by applicable law to recognize as legally qualified to provide a Covered Service. A member of the Insured Person's Immediate Family will not be considered a Physician (with the exception of dentists providing services which are considered Covered Services under this Policy).

Physician's Office means a location, other than a Hospital, Hospital emergency room, Urgent Care Center, skilled nursing facility (SNF), military treatment facility, community health center, state or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of Sickness or Injury on an ambulatory basis.

Policy means this written description of coverage provided to You by Us.

Pre-Certification means the procedure whereby We or Our designated representative determines, based on medically recognized criteria, whether or not a Hospital Confinement is reasonable for the type of services to be received.

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

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

Pre-Existing Condition will also include a pregnancy which exists on the Effective Date of Coverage.

Provider means a duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that We approve. This includes any Provider rendering services which are required by applicable state law to be covered when rendered by such Provider.

Sickness means an illness or disease which first manifests itself after the Insured Person's coverage becomes effective and while the coverage is in force. Sickness includes Complications of Pregnancy. Any condition which manifests itself prior to the Insured Person's Effective Date of Coverage and which meets the criteria of a Pre-Existing Condition, as defined herein, is subject to the Pre-Existing Condition provision as shown in the EXCLUSIONS AND LIMITATIONS.

Special Circumstances means a condition such that the treating Physician reasonably believes that discontinuing care by the treating Physician could cause harm to the Insured Person.

Surgery or Surgical Procedure means an invasive diagnostic procedure or the treatment of an Insured Person's Sickness or Injury by manual or instrumental operations, including any of the procedures designated by Current Procedural Terminological codes as Surgery, performed by a Physician while the Insured Person is under general or local anesthesia.

Total Disability or Totally Disabled means:

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

Transplant Benefit Period means the period of time:

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

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

- | | |
|---|--|
| <ol style="list-style-type: none">1. Heart transplant;2. Combined heart and lung transplant;3. Lung transplant;4. Kidney transplant;5. Kidney and pancreas transplant;6. Liver transplant;7. Bone marrow transplant, either allogenic or autologous, including high dose chemotherapy; or8. Peripheral stem cell transplant. | |
|---|--|

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

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

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

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

Usual and Customary Charge means the charge which is the lesser of:

1. The actual charge;
2. The charge usually made for the Covered Service by the provider who furnishes it;
3. The prevailing charge made for a Covered Service in a geographical area by those of similar professional standing; and
4. The contracted rate in effect with a Network Provider on the date it provides a Covered Service, when Covered Services are received from Network Provider.

Urgent Care Center means a free-standing facility, center or other entity that operates primarily to provide specialty medical treatment of an unforeseen, unexpected Sickness or Injury on an urgently needed or prompt basis.

We, Us and Our means The Chesapeake Life Insurance Company.

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

EFFECTIVE DATE OF COVERAGE

Beginning of Coverage

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

Newborn Children

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

Newly Adopted Children

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

Additional Dependents

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

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

PREMIUMS

Premium Due Date

Premiums are payable to Us at Our administrative office in North Richland Hills, Texas. The premium is payable monthly, quarterly, or annually, as indicated in the POLICY SCHEDULE. Payment of any premium will not maintain coverage in force beyond the next premium due date, except as provided by the Grace Period. Upon the payment of a claim under this Policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

Grace Period

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

Premium Changes

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

Unearned Premiums Refund

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

TERMINATION OF COVERAGE

You

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

1. At the end of the period for which premium has been paid (subject to the Grace Period);
2. If Your mode of premium is monthly, at the end of the period through which premium has been paid following Our receipt of Your request of termination;
3. If Your mode of premium is other than monthly, upon the next monthly anniversary day following Our receipt of Your request of termination. Premium will be refunded for any amounts paid beyond the termination date;
4. On the date We elect to discontinue this plan or type of coverage. We will give You at least 90 days written notice before the date coverage will be discontinued. You will be offered an option to purchase any other coverage that We offer without regard to health status;
5. On the date We elect to discontinue all health benefit plans in Your state. We will give You and the proper state authority at least 180 days written notice before the date coverage will be discontinued; or
6. On the date an Insured Person:
 - a. performs an act or practice that constitutes fraud; or
 - b. has made an intentional misrepresentation of material fact, relating in any way to the coverage provided under the Policy, including claims for benefits under the Policy.

Covered Dependents

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

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

3. The date We receive Your written request to terminate a dependent's coverage; or
4. On the date the Covered Dependent:
 - a. performs an act or practice that constitutes fraud; or
 - b. has made an intentional misrepresentation of material fact, relating in any way to the coverage provided under the Policy, including claims for benefits under the Policy.

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

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

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

Family Security Benefit

Beginning with the next premium due date following Our receipt of due proof of Your death, We will waive premiums for a period of 12 months for Your Covered Dependents. During this premium waiver period, no increase in benefits or addition of Eligible Dependents, except newborns, will be considered. Provisions for termination of coverage for Covered Dependents will also apply. Upon expiration of the 12-month premium waiver period, Your Covered Dependent spouse may continue coverage, as stated in the **Special Continuation Provision for Dependents** section and by making the required premium payments.

Special Continuation for Dependents

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

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

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

Reinstatement

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

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

Replacement of the Policy by Another Insurer

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

NETWORK PROVIDERS

Coverage under this Policy includes access to discounts and increased benefits through the use of Network Providers. Access to Network Providers is attained through the use of one or more non-overlapping networks.

Out-of-Network Treatment

If an Insured Person uses the services of a Non-Network Provider, the Coinsurance amount may be less than that which would have otherwise been considered for Covered Services received from a Network Provider. However, if an Insured Person goes to a Non-Network Provider solely because he or she requires Medically Necessary services that are not available from a Network Provider within a 50 mile radius of Your residence, then the Covered Services will be considered on the same basis as if the Insured Person had used the services of a Network Provider for the purposes of determining benefits. This will not apply when the Insured Person chooses to receive services from Providers other than Network Providers, solely for the Insured Person's convenience.

Medical Emergency

If an Insured Person cannot reasonably reach a Network Provider and goes to a Non-Network Provider solely for a Medical Emergency, Covered Services for the Medical Emergency will be considered on the same basis as if the Insured Person had used the services of a Network Provider. However, treatment by a Non-Network Provider for such Medical Emergency must consist of:

1. Any medical screening examination or other evaluation required by state or federal law to be provided in the emergency facility of a Hospital which is necessary to determine whether a Medical Emergency condition exists;
2. Necessary Medical Emergency services including the treatment and stabilization of a Medical Emergency condition; or
3. Services originating in a Hospital emergency facility following treatment or stabilization of a Medical Emergency condition.

Such Medical Emergency services will be reimbursed at the Network Provider benefit level until the Insured Person can reasonably be expected to transfer to a Network Provider.

Special Circumstances

If a network arrangement terminates and, at the time of termination, Special Circumstances exist in connection with the treatment being received by an Insured Person by such former Network Provider, the Covered Services by such former Network Provider will be considered as if they were provided by a Network Provider.

Special Circumstances must be identified by the treating Physician who must: make a request to Us that the Insured Person be permitted to continue treatment under the Physician's care as an outpatient or inpatient at a Hospital; and further provided such Physician and Hospital agree not to seek payment from either the Company or the Insured Person for any amounts in excess of the those Covered Service amounts which would have been considered for a Network Provider.

COVERED SERVICES

Covered Services include Medically Necessary Usual and Customary Charges for the services, supplies, care or treatment as described in this Policy which are performed, prescribed, directed or authorized by a Provider. To be a Covered Service, the service, supply or treatment must be:

1. Medically Necessary and/or specifically included as a Covered Service under this Policy;
2. Within the scope of the license of the Provider performing the service;
3. Rendered while coverage under this Policy is in force and for which the Insured Person is legally obligated to pay; and
4. Not considered Experimental or Investigative or otherwise excluded or limited under this Policy.

A charge for a Covered Service is incurred on the date the service, supply or treatment is furnished.

Unless otherwise stated herein, all Covered Services are subject to:

1. The Facility Fees shown in the POLICY SCHEDULE, if any;
2. The [Calendar Year Deductible][Deductible per [Period of Treatment] or the Deductible for all other Outpatient Covered Services] shown in the POLICY SCHEDULE;
3. The Copayments shown in the POLICY SCHEDULE, if any;
4. The Network Provider Coinsurance level or Non-Network Provider Coinsurance level Coinsurance level shown in the POLICY SCHEDULE;
5. The Maximum Benefit Amounts, visit limitations, if any, [Calendar Year][Aggregate Maximum Amount] and Lifetime Maximum Amount shown in the POLICY SCHEDULE;
6. The EXCLUSIONS AND LIMITATIONS; and
7. All other provisions of this Policy.

INPATIENT SERVICES:

Inpatient Hospital

Covered Services include services and supplies provided by a Hospital for semi-private accommodations and general nursing care furnished by the Hospital including Confinement in the Hospital's Intensive Care or Cardiac Care Unit; Physician visits and miscellaneous medical services and supplies necessary for the treatment of the Insured Person.

Covered Services will also include hemodialysis and the charges by a Hospital for processing and administration of blood or blood components, acute inpatient rehabilitation, x-ray, laboratory, diagnostic tests and services of a radiologist, radiology group, and the services of a pathologist or pathology group for interpretation of diagnostic tests or studies, performed while the Insured Person is Hospital Confined.

Covered Services will also include coverage for general anesthesia and associated Hospital Charges in conjunction with Dental Care provided to an Insured Person if such person is: (a) a Covered Dependent child who is developmentally disabled; or (b) an individual for whom a successful result cannot be expected from Dental Care provided under local anesthesia because of a neurological or other medically compromising condition.

The fees charged for take home drugs, personal convenience items such as lotions, shampoos, etc., or items not intended primarily for use by the Insured Person while Hospital Confined are not Covered Services.

Transplant Procedures

Covered Services include Transplant Procedures incurred during a Transplant Benefit Period. Covered Services for Transplant Procedures include the following when part of a Transplant Treatment Plan:

1. Inpatient and outpatient Hospital services;
2. Services of a Physician for diagnosis, treatment and Surgery for a Transplant Procedure;
3. Procurement of an organ or tissue, including services provided to a living donor of an organ or tissue for procurement of an organ or tissue, provided the donor and transplant recipient are both insured under this Policy. Covered Services are limited to the actual procurement expenses, and will not be more than any Maximum Benefit Amounts under the Policy applicable to the recipient;
4. Rental of durable medical equipment for use outside the Hospital. Covered Services are limited to the purchase price of the same equipment;
5. Prescription Drugs, including immunosuppressive drugs;
6. Oxygen;
7. Speech therapy, occupational therapy, Physical Therapy and chemotherapy;
8. Services and supplies for and related to high dose chemotherapy and bone marrow tissue transplantation when provided as part of a Transplant Treatment Plan which includes bone marrow transplantation and high dose chemotherapy;
9. Surgical dressings and supplies; and
10. Home Health Care.

When the Insured Person's Physician advises the Insured Person that a Transplant Procedure is being considered, the Insured Person or the Insured Person's Physician should notify Us or Our designee.

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

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

Expenses incurred beyond the Transplant Benefit Period will not be considered Covered Services, unless covered elsewhere under the Policy.

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

PRE-ADMISSION TESTING:

Covered Services include pre-admission tests done on an outpatient basis before an authorized Hospital stay or Outpatient Surgery. These tests must be:

1. Made within 14 days prior to Hospital Confinement or within 14 days of an outpatient Surgery;
2. Related to the condition for which the Insured person is being Confined;
3. Not repeated in the Hospital or elsewhere; and
4. Ordered by a Physician.

OUTPATIENT SURGERY FACILITY SERVICES:

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

1. Use of operating room and recovery room;
2. Administration of drugs and medicines during Surgery;
3. Dressings, casts, splints;
4. Diagnostic services including radiology, laboratory or pathology performed at the time of the Surgery; and
5. General anesthesia and associated Outpatient Surgery Facility Charges in conjunction with Dental Care provided to an Insured Person if such person is: (a) a Covered Dependent child who is developmentally disabled; or (b) an individual for whom a successful result cannot be expected from Dental Care provided under local anesthesia because of a neurological or other medically compromising condition.

MEDICAL EMERGENCIES:

Covered Services include treatment of a Medical Emergency in a Hospital emergency room or Urgent Care facility.

PHYSICIAN SERVICES:

Second Surgical Opinion

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

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

Inpatient / Outpatient Surgeon

Covered Services include expenses incurred while Hospital Confined or in an Outpatient Surgery Facility for services by the Physician performing Surgery.

[When multiple surgical procedures are done at the same time, Covered Services will be considered for the first or highest cost procedure. No benefit is payable for incidental surgical procedures such as an appendectomy performed during a gall bladder surgery.]

Inpatient / Outpatient Assistant Surgeon

Covered Services include services by the Physician assisting the Physician performing Surgery.

Inpatient / Outpatient Anesthesiologist

Covered Services include services by the Physician providing anesthesia during Surgery.

Physician Visits while Hospital Confined

Covered Services include visits by a Physician, other than the surgeon, while Hospital Confined.

PREVENTIVE IMAGING SCREENING TESTS:

Human Papillomavirus and Cervical Cancer Screening

Covered Services include the following annual screenings, as approved by the United States Food and Drug Administration, for female Insured Persons 18 years of age or older:

1. A conventional Pap smear screening or a screening using liquid-based cytology methods; or
2. A conventional Pap smear screening in combination with a test for the detection of the Human Papillomavirus.

The screening test required under this benefit must be performed in accordance with the guidelines adopted by:

1. The American College of Obstetricians and Gynecologists; or
2. Another similar national organization of medical professionals recognized by the Commissioner.

Prostate Cancer Screening

Covered Services include the following services and supplies provided to an Insured Person for the detection of prostate cancer:

1. An annual physical examination for the detection of prostate cancer for each male Insured Person; and
2. An annual prostate-specific antigen (PSA) test used for the detection of prostate cancer for each male Insured Person who is:
 - (a) at least 50 years of age and asymptomatic; or
 - (b) at least 40 years of age with a family history of prostate cancer or another prostate cancer risk factor.

Mammography Screening

Covered Services include an annual Low Dose Mammography screening for each female Insured Person age 35 or older.

Colorectal Cancer Screening

Covered Services include colorectal cancer examinations and laboratory tests for Insured Persons who are 50 years of age or older; who are less than 50 years of age and at high risk for colorectal cancer according to American Cancer Society colorectal cancer screening guidelines as they existed on [January 1, 2005]; and experiencing bleeding from the rectum or blood in the stool or a change in bowel habits, such as diarrhea, constipation, or narrowing of the stool that lasts more than 5 days as determined by a licensed Physician.

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

SCREENING TEST FOR HEARING IMPAIRMENT:

Covered Services include a screening test of hearing loss for a Covered Dependent child from birth through the date the child is 30 days old. Covered Services also include the necessary diagnostic follow-up care related to the screening test from birth through the date the child is 24 months old.

[Deductibles do not apply.]

IMPAIRMENT OR LOSS OF SPEECH OR HEARING:

Covered Services include the necessary care and treatment of loss or impairment of speech or hearing which includes the communicative disorders generally treated by speech pathologist or audiologist licensed by the Board of Examiners in Speech-Language Pathology and Audiology and which fall within the scope of his/her area of certification. Coverage does not apply to hearing instruments or devices.

MINIMUM STAY REQUIREMENTS FOR MASTECTOMY AND LYMPH NODE DISSECTION

Covered Services include inpatient care if an Insured Person undergoes a covered mastectomy, for a minimum of the following:

1. 48 hours following a covered mastectomy; or
2. 24 hours following a covered lymph node dissection for the treatment of breast cancer.

A shorter period of Confinement will be covered if the Insured Person and her Physician determine that a shorter period of inpatient Hospital Confinement is appropriate.

CHEMOTHERAPY AND RADIATION THERAPY:

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

[(Deductibles do not apply)]

DURABLE MEDICAL EQUIPMENT AND PROSTHETIC DEVICES:

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

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

Routine maintenance and repairs of rental equipment are not considered Covered Services.

AMBULANCE SERVICES:

Covered Services include Ambulance transportation to the nearest Hospital that can provide Covered Services appropriate for the Insured person's condition.

Ambulance services are only considered Covered Services if the Insured Person is Confined to the Hospital.

Air or water Ambulance services are only considered a Covered Service in situations in which the Insured person is in a location that cannot be reached by ground Ambulance.

Ambulance usage for the convenience of the Insured Person is not a Covered Service. Non-Covered Services for Ambulance include but are not limited to trips to a Physician's Office or clinic; or a morgue or funeral home.

MATERNITY STAY REQUIREMENTS FOR COVERED MATERNITY CARE:

This provision applies to an Insured Person's coverage only when the Insured Person incurs Covered Services for a normal childbirth or cesarean section delivery that is covered for Complications of Pregnancy as defined in the Policy. A minimum of 48 hours of inpatient care will be provided to the mother and newborn child following a vaginal delivery and 96 hours following a cesarean section.

MUSCULOSKELETAL DISORDERS:

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

CHILD HEALTH SUPERVISION SERVICES:

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

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

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

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

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

MEDICAL FOODS AND LOW PROTEIN MODIFIED FOOD PRODUCTS:

Covered Services include the treatment of a Covered Dependent inflicted with phenylketonuria if:

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

DIABETES:

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

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

OUTPATIENT CONTRACEPTIVE SERVICES AND DEVICES:

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

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

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

EXCLUSIONS AND LIMITATIONS

We will not provide any benefits for charges arising directly or indirectly, in whole or in part, from:

1. Any care not Medically Necessary or services for which benefits are not specifically provided for in this Policy, including charges related to secondary medical conditions resulting directly or indirectly from conditions, treatment or services that are not considered a Covered Service and/or that are specifically excluded under this Policy;
2. Any charges exceeding the Maximum Benefit Amount, Calendar Year Maximum Amount or Lifetime Maximum Amount;
3. Any act of war, declared or undeclared;
4. Suicide, attempted suicide, or any intentionally self-inflicted injury, while sane or insane;
5. Care, treatment, services or supplies received in a Hospital emergency room for treatment of a Sickness or Injury that is not considered a Medical Emergency;
6. Any Injury or Sickness arising out of, or in the course of, employment for wage or profit, provided the Insured Person is covered under any Workers' Compensation Act, Occupational Disease Act, or similar act or law,
7. Mental or Nervous Disorders, unless otherwise stated herein;
8. Drug abuse or addiction including alcoholism, or overdose of drugs, narcotics, or hallucinogens, directly or indirectly, wholly or partially, unless taken as prescribed by a Physician;
9. An overdose of drugs, being intoxicated or under the influence of intoxicants, hallucinogens, narcotics or other drugs or controlled substances, directly or indirectly, wholly or partially, unless taken as prescribed by a Physician;
10. Any treatment including prescription drugs or non-prescription drugs, or procedure that promotes conception or prevents childbirth, including but not limited to: (a) artificial insemination; (b) in-vitro fertilization or other treatment for infertility; (c) treatment for impotency; (d) sterilization or reversal of sterilization; or (e) abortion (unless the life of the mother would be endangered if the fetus were carried to term), unless otherwise stated herein;
11. Laser vision correction, radial keratotomy or any eye Surgery when the primary purpose is to correct nearsightedness, farsightedness, astigmatism, or any other refractive error;
12. Spinal manipulations and manual manipulative treatment or therapy;
13. Mandibular or maxillofacial Surgery to correct growth defects after one year from the date of birth, jaw disproportions or malocclusions, or to increase vertical dimension or reconstruct occlusion, unless otherwise stated herein;
14. Weight loss or modification, or complications arising there from, or procedures resulting therefrom or for surgical treatment of obesity including but not limited to gastric by-pass, wiring of the teeth and all forms of Surgery performed for the purpose of weight loss or modification or the reversal/modification of such procedure;

15. Breast reduction or augmentation, or complications arising there from, unless necessary in connection with breast reconstructive Surgery following a mastectomy;
16. Modification of the physical body in order to improve the psychological, mental or emotional well-being of the Insured Person, such as but not limited to sex-change Surgery;
17. Marriage, family, or child counseling for the treatment of premarital, marriage, family or child relationship dysfunctions;
18. Directly or indirectly engaging in an illegal occupation or illegal activity;
19. Care in a nursing home, custodial institution or domiciliary care or rest cures;
20. Preparation and presentation of medical reports for appearance at trials or hearings;
21. Physical examinations required for school events, sports, camp, employment, licensing and insurance, unless otherwise stated herein;
22. Immunizations required for the sole purpose of travel outside of the U.S.A.;
23. Payment for care for military service connected disabilities for which the Insured Person is legally entitled to services and for which facilities are reasonably available to the Insured Person and payment for care for conditions that state or local law requires be treated in a public facility;
24. Experimental or Investigative medical, surgical or other health care procedures, treatments, products or services, unless otherwise stated herein;
25. Personal comfort items, such as television, telephone, lotions, shampoos, etc.;
26. Cosmetic Surgery, or complications arising there from, unless otherwise stated herein;
27. Dental Care, treatment or Surgery unless necessitated by Injury to sound natural teeth which occurs while insured under this Policy. (The expense must be incurred within one year from the date of Injury);
28. Corrective vision or hearing supplies or for the examination for prescribing or fitting such supplies;
29. The removal of warts, corns, calluses, the cutting and trimming of toenails, care for flat feet, fallen arches or chronic foot strain;
30. Expenses incurred for prescription drugs, except if added by Rider;
31. Normal pregnancy, except for Complications of Pregnancy, [except if added by Rider];
32. Any expenses related to a surrogate pregnancy; and
33. Treatment, services or supplies received outside the U.S. or Canada. However, treatment, services or supplies received as a result of an acute Sickness or Injury sustained during the first 30 days of travel outside of the U.S. or Canada will be considered a Covered Service. In no event will treatment, services or supplies received beyond the first 30 days of travel outside of the U.S. or Canada be considered a Covered Service.

Sickness Exclusion

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

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

Pre-Existing Condition

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

Coverage After Age 65 or Earlier Medicare Eligibility

When an Insured Person becomes covered under Medicare, the Covered Services of this Policy and its attachments, if any, are considered only to the extent that they are not paid by Medicare and they would otherwise be payable under this Policy. Covered Services will also be subject to any other EXCLUSIONS AND LIMITATIONS set forth in this Policy.

COORDINATION OF BENEFITS

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

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

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

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

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

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

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

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

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

would exceed the Allowable Expense.

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

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

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

The rules that set the order of benefit determination are:

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

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

4. In the case of divorced or separated parents, the benefits for a child will be determined as follows:
 - a) First the Plan of the parent with custody of the child;
 - b) Then the Plan of the spouse of the parent with the custody of the child;
 - c) Finally, the plan of the parent not having custody of the child;
 - d) If the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply with respect to any Claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge;
5. When Rules 1. and 2. do not establish an order of benefit determination, the benefits of a Plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a Plan which has covered such person for the shorter period of time.

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

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

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

Facility of Payment

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

Right of Recovery

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

Time Limit for Payment

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

GENERAL PROVISIONS

Entire Contract

The Entire Contract consists of:

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

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

Only Our President, a Vice President or Secretary has the power on Our behalf to execute or amend this Policy. No other person will have the authority to bind Us in any manner. No agent may accept risks, alter or amend

coverage or waive any provisions of this Policy. Any change in this Policy will be made by an amendment signed by Us. Such amendment will not require the consent of any Insured Person.

Notice of Claim

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

Claim Forms

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

Proof of Loss

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

Claim Payments

We will pay all benefits due under this Policy promptly upon receipt of due proof of loss.

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

Assignment of Claim Payments

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

Insurance with Other Insurers

You may have other valid coverage (with another insurer) which applies to a loss covered by this Policy. Other valid coverage may reduce the Benefits payable under this Policy. The Benefits payable under this Policy will not be reduced by other valid coverage if You have notified Us in writing that You do have other valid coverage. You must notify Us before a loss begins. The Benefits payable under this Policy will be reduced by other valid coverage if You have not notified Us in writing (before the loss begins) that You do have other valid coverage.

The amount of the reduced Benefits payable under this Policy will be for the proportion of the loss as the amount which would otherwise have been payable under this Policy plus the total of like amounts under all other valid coverages for the same loss of which We had notice bears to the total like amounts under all valid coverages for such loss.

Physical Examination

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

Legal Action

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

Age Misstatement

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

Incontestability

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

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

Conformity

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

Change of Residence (When Same or Similar Coverage is Available)

If You move, You must notify the Company. You may be issued a revised Policy that includes the mandated benefits required by the state to which You move, provided this same or similar plan is available in that state. Upon re-issuance of Your Policy, the mandated benefits required by the state from which You move will no longer apply.

Unless prohibited by law, rates under Your coverage will be adjusted where necessary, to reflect the rates in effect in the state to which You move.

Change of Residence (When Same or Similar Coverage is Not Available)

If You move, You must notify the Company. If this same or similar plan is not available in the state to which You move, You have the option to select other coverage under another plan, where available, or retain coverage under this Policy and any attached amendments to this Policy.

Unless prohibited by law, rates under Your coverage will be adjusted where necessary, to reflect the rates in effect in the state to which You move.

Subrogation

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

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

Right of Reimbursement

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

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

POLICY SCHEDULE

PRIMARY INSURED: [John Doe, Sr.] EFFECTIVE DATE OF COVERAGE: [01/02/09]

COVERED DEPENDENTS: EFFECTIVE DATE OF COVERAGE:

[Johnette Doe] [01/02/09]
[John Doe, Jr.] [03/12/09]
[Johnita Doe] [01/22/10]

POLICY NUMBER: [ABC1234567] POLICY DATE: [01/02/09]

INITIAL PREMIUM: \$[0.00] MODE OF PAYMENT: [Monthly]

**POLICY SCHEDULE
SCHEDULE OF BENEFITS**

Insured Persons have the right to obtain medical care from the Physicians, Hospitals and other health care Providers of their choice. However, in order to receive maximum benefits, all Covered Services must be obtained from Network Providers. When You utilize a Non-Network Provider You are responsible for any balance due above the Usual and Customary amount.

LIFETIME MAXIMUM AMOUNT: [\$2,000,000 / \$4,000,000 / \$8,000,000]

CALENDAR YEAR MAXIMUM AMOUNT: [\$1,000,000 / \$1,000,000 / \$2,000,000]

<u>CALENDAR YEAR DEDUCTIBLE:</u>	<u>NETWORK PROVIDER</u>	<u>NON-NETWORK PROVIDER</u>
Individual Deductible:	[\$2,500 / \$5,000 / \$7,500 / \$10,000 / \$15,000 / \$20,000]	[\$3,125 / \$6,250/ \$9,250/ \$12,500 / \$18,750 / \$25,000]
Family Deductible:	[\$5,000 / \$10,000 / \$15,000 / \$20,000 / \$30,000 / \$40,000]	[\$6,250 / \$12,500/ \$18,750/ \$25,000 / \$37,500 / \$50,000]

DEDUCTIBLE PROVISIONS:

The Individual Deductible amount will be deducted from expenses incurred by each Insured Person for Covered Services, each Calendar Year, subject to the Family Deductible. Once the Family Deductible is met, no other Deductibles are required for the rest of that [Calendar Year].

[Expenses incurred for Covered Services under any Riders will apply toward the Individual and Family Maximum Deductible, where applicable, unless specifically stated otherwise.]

Non-Covered Services, Facility Fees or Copayments, if any, do not apply toward the Deductible(s).

Common Accident Provision: Upon Your notification to Us that one or more Insured Persons in Your family has been injured in the same accident, We will only require that one Individual Deductible be satisfied each Calendar Year for Covered Services associated with that accident. Once one [individual] Deductible is satisfied under this Policy, the Deductible for all other Insured Persons will be waived for that common accident.

<u>COINSURANCE MAXIMUM:</u>	<u>NETWORK PROVIDER</u>	<u>NON-NETWORK PROVIDER</u>
Individual:	[\$0][\$2,500][\$5,000][\$10,000] / [\$15,000][Not Applicable]	[\$5,000][\$10,000][\$20,000][\$30,000]
Family:	[\$5,000][\$10,000][\$20,000] / [Not Applicable]	[\$10,000][\$20,000][\$40,000]

The Coinsurance Maximum is the total coinsurance portion an Insured Person must pay each [Calendar Year] after the application of any Facility Fees, Copayments, Deductibles and Coinsurance, for Covered Services under this Policy. Once the Individual Coinsurance Maximum is met Covered Services remaining thereafter for that Insured Person in the same [Calendar Year] will be paid at 100% Coinsurance, after the application of any Facility Fees or Copayments. [Once the Family Coinsurance Maximum is met, Covered Services remaining thereafter for all Insured Persons in the same Calendar Year will be paid at 100% Coinsurance, after the application of any Facility Fees or Copayments.] **Facility Fees, Deductibles and Copayments do not count toward meeting the Coinsurance Maximum.**

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

<u>COVERED SERVICES</u>	<u>NETWORK PROVIDER</u>	<u>NON-NETWORK PROVIDER</u>
INPATIENT SERVICES:		
Facility Fee:	[Facility Fee does not apply]	[\$500] per Insured Person, per [Hospital Confinement][Period of Treatment]
Inpatient Hospital: <i>(includes acute inpatient rehabilitation, limited to [10 days] per Insured Person, per [Calendar Year])</i>	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%][75%]Coinsurance
Transplant Procedures:	[70%][80%][90%][100%] Coinsurance Up to [\$250,000] Maximum Benefit Amount* per Insured Person, per Transplant Procedure	[50%][60%][70%][75%] Coinsurance Up to [\$175,000] Maximum Benefit Amount* per Insured Person, per Transplant Procedure
PRE-ADMISSION TESTING:	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%][75%]Coinsurance
OUTPATIENT SURGERY FACILITY SERVICES:	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%][75%]Coinsurance
Facility Fee:	[Facility Fee does not apply]	[\$250] Per Insured Person, per Surgery
MEDICAL EMERGENCIES:	[70%][80%][90%][100%] Coinsurance	[70%][80%][90%][100%] Coinsurance
Hospital Emergency Room Facility Fee: <i>[(Waived if Hospital Confined)]</i>	[\$100][\$250][\$500][\$750][\$1,000] Per Insured Person, per visit	[\$100][\$250][\$500][\$750][\$1,000] Per Insured Person, per visit
Urgent Care Center Facility Fee:	[\$100][\$250] Per Insured Person, per visit	[\$100][\$250] Per Insured Person, per visit
PHYSICIAN SERVICES		
Second Surgical Opinion: <i>(Limited to one per Surgery)</i>	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%][75%]Coinsurance
Inpatient / Outpatient Surgeon:	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%][75%]Coinsurance
Inpatient / Outpatient Assistant Surgeon:	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%][75%]Coinsurance
Inpatient / Outpatient Anesthesiologist:	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%][75%]Coinsurance

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

<u>COVERED SERVICES</u>	<u>NETWORK PROVIDER</u>	<u>NON-NETWORK PROVIDER</u>
PHYSICIAN SERVICES (Cont.)		
Physician Visits while Hospital Confined (other than Surgeon): <i>[(Limited to one visit per Physician, per day)]</i>	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%][75%]Coinsurance
PREVENTIVE IMAGING SCREENING TESTS		
Human Papillomavirus and Cervical Cancer Screening:	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%][75%]Coinsurance
Prostate Cancer Screening:	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%][75%]Coinsurance
Mammography Screening:	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%][75%]Coinsurance
Colorectal Cancer Screening:	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%][75%]Coinsurance
SCREENING TEST FOR HEARING IMPAIRMENT: <i>(Includes diagnostic follow-up care related to screening test from birth through age 24 months. Not subject to Deductible or a Maximum Benefit)</i>	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%][75%]Coinsurance
IMPAIRMENT OR LOSS OF SPEECH OR HEARING:	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%][75%]Coinsurance
MINIMUM STAY REQUIREMENTS FOR MASTECTOMY AND LYMPH NODE DISSECTION:	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%][75%]Coinsurance

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

<u>COVERED SERVICES</u>	<u>NETWORK PROVIDER</u>	<u>NON-NETWORK PROVIDER</u>
CHEMOTHERAPY AND RADIATION THERAPY:	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%][75%]Coinsurance
DURABLE MEDICAL EQUIPMENT AND PROSTHETIC DEVICES:	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%][75%]Coinsurance
<div style="border: 1px solid black; padding: 5px;"> <p>Network / Non-Network Provider: Up to [\$2,000] Maximum Benefit Amount* per Insured Person, per [Calendar Year]</p> </div>		
AMBULANCE SERVICES		
<i>(Payable only when Hospital Confined)</i>		
Ground Ambulance: <i>[(Deductible waived)]</i>	[70%][80%][90%][100%] Coinsurance	[70%][80%][90%][100%] Coinsurance
<div style="border: 1px solid black; padding: 5px;"> <p>Network/Non-Network Provider: Up to [\$500] Maximum Benefit Amount* per Insured Person, per trip</p> </div>		
Air / Water Ambulance: <i>[(Deductible waived)]</i>	[70%][80%][90%][100%] Coinsurance	[70%][80%][90%][100%] Coinsurance
<div style="border: 1px solid black; padding: 5px;"> <p>Network / Non-Network Provider: Up to [\$5,000] Maximum Benefit Amount* per Insured Person, per trip</p> </div>		
MATERNITY STAY REQUIREMENTS FOR COVERED MATERNITY CARE:	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%][75%]Coinsurance
MUSCULOSKELETAL DISORDERS:	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%][75%]Coinsurance
CHILD HEALTH SUPERVISION SERVICES: <i>(Immunizations only)</i> <i>(Deductible waived)</i>	[100%] Coinsurance	[100%] Coinsurance
MEDICAL FOODS AND LOW PROTEIN MODIFIED FOOD PRODUCTS:	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%][75%]Coinsurance
DIABETES:	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%][75%]Coinsurance
OUTPATIENT CONTRACEPTIVE SERVICES AND DEVICES:	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%][75%]Coinsurance

*You are responsible for the balance due (if any) on charges for Covered Services in excess of the Maximum Benefit Amount.

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

<u>RIDER BENEFITS</u>	<u>NETWORK PROVIDER</u>	<u>NON-NETWORK PROVIDER</u>
PHYSICIAN OFFICE SERVICES BENEFIT RIDER		
{Option A}		
Outpatient Physician Office Visits for Sickness or Injury:	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%][75%]Coinsurance
Outpatient Preventive Care Physician Visits - other than Well Child Visits: <i>(Limited to one visit per Insured Person, per [Calendar Year])</i>	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%][75%]Coinsurance
Well Child Visits: <i>(For covered Dependent children from birth up to 24 months)</i>	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%][75%]Coinsurance
{Option B}		
Outpatient Physician Office Visits for Sickness or Injury: <i>(Limited to [2][4] visits per Insured Person, per [Calendar Year])</i>	[100%] Coinsurance – [Deductible waived]	[100%] Coinsurance [Deductible waived]
Physician Home and Office Copayment:	[\$50] per Insured Person, per visit	[\$100] per Insured Person, per visit
Convenient Care Clinic Copayment:	[\$25] per Insured Person, per visit	[\$50] per Insured Person, per visit
Outpatient Preventive Care Physician Visits: <i>(Other than Well Child Visits) (Limited to one visit per Insured Person, per [Calendar Year])</i>	[100%] Coinsurance – [Deductible waived]	[100%] Coinsurance [Deductible waived]
Physician Home and Office Copayment:	[\$50] per Insured Person, per visit	[\$100] per Insured Person, per visit
Convenient Care Clinic Copayment:	[\$25] per Insured Person, per visit	[\$50] per Insured Person, per visit
Well Child Visits: <i>(For covered Dependent children from birth up to 24 months):</i>	[100%] Coinsurance – [Deductible waived]	[100%] Coinsurance [Deductible waived]
Physician Home and Office Copayment:	[\$50] per Insured Person, per visit	[\$100] per Insured Person, per visit
Convenient Care Clinic Copayment:	[\$25] per Insured Person, per visit	[\$50] per Insured Person, per visit

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

<u>RIDER BENEFITS</u>	<u>NETWORK PROVIDER</u>	<u>NON-NETWORK PROVIDER</u>
{Option C}		
Outpatient Physician Office Visits for Sickness or Injury:	[100%] Coinsurance – [Deductible waived]	[100%] Coinsurance [Deductible waived]
Physician Home and Office Copayment:	[\$50] per Insured Person, per visit	[\$100] per Insured Person, per visit
Convenient Care Clinic Copayment:	[\$25] per Insured Person, per visit	[\$50] per Insured Person, per visit
Outpatient Preventive Care Physician Visits: <i>(Other than Well Child Visits) (Limited to one visit per Insured Person, per [Calendar Year])</i>	[100%] Coinsurance – [Deductible waived]	[100%] Coinsurance [Deductible waived]
Physician Home and Office Copayment:	[\$50] per Insured Person, per visit	[\$100] per Insured Person, per visit
Convenient Care Clinic Copayment:	[\$25] per Insured Person, per visit	[\$50] per Insured Person, per visit
Well Child Visits: <i>(For covered Dependent children from birth up to 24 months):</i>	[100%] Coinsurance – [Deductible waived]	[100%] Coinsurance [Deductible waived]
Physician Home and Office Copayment:	[\$50] per Insured Person, per visit	[\$100] per Insured Person, per visit
Convenient Care Clinic Copayment:	[\$25] per Insured Person, per visit	[\$50] per Insured Person, per visit
OUTPATIENT DIAGNOSTIC SERVICES BENEFIT RIDER:	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%][75%] Coinsurance
CAT, MRI and/or PET Scans through Network / Non-Network Provider		
Facility Fee:	[\$75][\$150][\$250] per Insured Person, per visit	[\$75][\$150][\$250] per Insured Person, per visit
All other outpatient diagnostic services through Network / Non-Network Provider		
Facility Fee:	[\$50][\$200] per Insured Person, per visit	[\$50][\$200] per Insured Person, per visit

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

RIDER BENEFITS

NETWORK PROVIDER

NON-NETWORK PROVIDER

CONTINUED CARE BENEFIT RIDER

Skilled Nursing Care: <i>(Limited to [30][45][60] visits per Insured Person, per Calendar Year)</i>	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%][75%]Coinsurance
Home Health Care: <i>(Limited to [30][45][60] combined visits per Insured Person, per Calendar Year)</i>	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%][75%]Coinsurance
<i>Includes Home Health Care Home Infusion Therapy and Wound Care</i>		
Hospice Care: <i>(Not to exceed [\$5,000] Maximum Benefit Amount* per Insured Person, per lifetime)</i>	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%][75%]Coinsurance

OUTPATIENT SPEECH THERAPY, PHYSICAL THERAPY AND OCCUPATIONAL THERAPY SERVICES RIDER

(Limited to [40 combined visits] for all therapies per Insured Person, per Calendar Year)

Speech Therapy:	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%][75%]Coinsurance
Facility Fee:	[\$50] per Insured Person, per visit	[\$50] per Insured Person, per visit
Physical Therapy:	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%][75%]Coinsurance
Facility Fee:	[\$50] per Insured Person, per visit	[\$50] per Insured Person, per visit
Occupational Therapy:	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%][75%]Coinsurance
Facility Fee:	[\$50] per Insured Person, per visit	[\$50] per Insured Person, per visit

PRESCRIPTION DRUG EXPENSE RIDER

(See Rider)

*You are responsible for the balance due (if any) on charges for Covered Services in excess of the Maximum Benefit Amount.

POLICY SCHEDULE

PRIMARY INSURED: [John Doe, Sr.] EFFECTIVE DATE OF COVERAGE: [01/02/09]

COVERED DEPENDENTS: EFFECTIVE DATE OF COVERAGE:

[Johnette Doe] [01/02/09]
[John Doe, Jr.] [03/12/09]
[Johnita Doe] [01/22/10]

POLICY NUMBER: [ABC1234567] POLICY DATE: [01/02/09]

INITIAL PREMIUM: \$[0.00] MODE OF PAYMENT: [Monthly]

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

LIFETIME MAXIMUM AMOUNT: [\$2,000,000 / \$4,000,000 / \$8,000,000]
AGGREGATE MAXIMUM AMOUNT: [\$1,000,000 / \$1,000,000 / \$2,000,000]

<u>DEDUCTIBLE:</u>	<u>NETWORK PROVIDER</u>	<u>NON-NETWORK PROVIDER</u>
Deductible per Insured Person, per [Period of Treatment]: <i>(This Deductible amount will be reduced by one-half when Hospital Confined due to an Injury)</i>	[\$1,000 / \$1,500 / \$2,000 / \$2,500 / 3,000 / 3,500 / \$4,000 / \$4,500 / \$5,000 / \$5,500 / \$7,500 / \$10,000]	[\$2,000 / \$3,000 / \$4,000 / \$5,000 / \$6,000 / \$7,000 / \$8,000 / \$9,000 / \$10,000 / \$11,000 / \$15,000 / \$20,000]
Deductible for all other Outpatient Covered Services, per Insured Person, per [Calendar Year]:	[\$1,000 / \$1,500 / \$2,000 / \$2,500 / 3,000 / 3,500 / \$4,000 / \$4,500 / \$5,000 / \$5,500 / \$7,500 / \$10,000]	[\$2,000 / \$3,000 / \$4,000 / \$5,000 / \$6,000 / \$7,000 / \$8,000 / \$9,000 / \$10,000 / \$11,000 / \$15,000 / \$20,000]

DEDUCTIBLE PROVISIONS:

The Deductible amount per [Period of Treatment] will be deducted from expenses incurred by each Insured Person for Covered Services, **for each [Period of Treatment]**. This Deductible applies when Hospital Confined and to Outpatient Surgery. [A Period of Treatment begins on the date an Insured Person is admitted to a Hospital or the date services are rendered in an Outpatient Surgery Facility for the treatment of an Injury or Sickness and ends after 365 days. If the same or related Sickness or Injury continues beyond 365 days, a new Sickness or Injury Period of Treatment will begin, which includes a new Deductible. In no event will a single Period of Treatment exceed 365 days. A separate Period of Treatment will apply to each Injury or Sickness.]

[Expenses incurred for Covered Services under any Riders will apply toward the Deductible, where applicable, unless specifically stated otherwise.] Non-Covered Services, Facility Fees or Copayments, if any, do not apply toward the Deductible(s).

The Deductible for all other Outpatient Covered Services (except outpatient Surgery) will be deducted from each separate outpatient Covered Service incurred by each Insured Person per [Calendar Year], unless specifically stated otherwise herein.

Once three Deductibles have been met in a [Calendar Year] by any or all Insured Persons under Your Policy, no further Deductibles must be met for the remainder of that [Calendar Year] for any or all Insured Persons under Your Policy.

Non-Covered Services, Facility Fees or Copayments, if any, do not apply toward the Deductible(s).

Common Accident Provision: Upon Your notification to Us that one or more Insured Persons in Your family has been injured in the same accident, We will only require that one Deductible amount be satisfied for Covered Services associated with that accident. Once one Deductible amount is satisfied under this Policy, the Deductible amount for all other Insured Persons will be waived for that common accident.

<u>COINSURANCE MAXIMUM:</u>	<u>NETWORK PROVIDER</u>	<u>NON-NETWORK PROVIDER</u>
Per Insured Person, Per Period of Treatment:	[\$0][\$2,500][\$5,000][\$10,000] / [\$15,000][Not Applicable]	[\$5,000][\$10,000][\$20,000][\$30,000]

The Coinsurance Maximum is the total coinsurance portion an Insured Person must pay each [Period of Treatment] after the application of any Facility Fees, Copayments, Deductibles and Coinsurance, for Covered Services under this Policy. Once the Coinsurance Maximum is met Covered Services remaining thereafter for that Insured Person in the same [Period of Treatment] will be paid at 100% Coinsurance, after the application of any Facility Fees or Copayments. **Facility Fees, Deductibles and Copayments do not count toward meeting the Coinsurance Maximum.**

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

<u>COVERED SERVICES</u>	<u>NETWORK PROVIDER</u>	<u>NON-NETWORK PROVIDER</u>
INPATIENT SERVICES:		
Facility Fee:	[Facility Fee does not apply]	[\$500] per Insured Person, per [Hospital Confinement][Period of Treatment]
Inpatient Hospital: <i>(includes acute inpatient rehabilitation, limited to [10 days] per Insured Person, per [Calendar Year])</i>	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
Transplant Procedures:	[70%][80%][90%][100%] Coinsurance Up to [\$250,000] Maximum Benefit Amount* per Insured Person, per Transplant Procedure	[50%][60%][70%] Coinsurance Up to [\$175,000] Maximum Benefit Amount* per Insured Person, per Transplant Procedure
PRE-ADMISSION TESTING:	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
OUTPATIENT SURGERY FACILITY SERVICES:	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
Facility Fee:	[Facility Fee does not apply]	[\$250] Per Insured Person, per Surgery
MEDICAL EMERGENCIES:	[70%][80%][90%][100%] Coinsurance	[70%][80%][90%][100%] Coinsurance
Hospital Emergency Room Facility Fee: <i>[(Waived if Hospital Confined)]</i>	[\$100][\$250][\$500][\$750][\$1,000] Per Insured Person, per visit	[\$100][\$250][\$500][\$750][\$1,000] Per Insured Person, per visit
Urgent Care Center Facility Fee:	[\$100][\$250] Per Insured Person, per visit	[\$100][\$250] Per Insured Person, per visit
PHYSICIAN SERVICES		
Second Surgical Opinion: <i>(Limited to one per Surgery)</i>	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
Inpatient / Outpatient Surgeon:	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
Inpatient / Outpatient Assistant Surgeon:	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
Inpatient / Outpatient Anesthesiologist:	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance

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

<u>COVERED SERVICES</u>	<u>NETWORK PROVIDER</u>	<u>NON-NETWORK PROVIDER</u>
PHYSICIAN SERVICES (Cont.)		
Physician Visits while Hospital Confined (other than Surgeon): <i>[(Limited to one visit per Physician, per day)]</i>	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
PREVENTIVE IMAGING SCREENING TESTS		
Human Papillomavirus and Cervical Cancer Screening:	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
Prostate Cancer Screening:	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
Mammography Screening:	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
Colorectal Cancer Screening:	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
SCREENING TEST FOR HEARING IMPAIRMENT: <i>(Includes diagnostic follow-up care related to screening test from birth through age 24 months. Not subject to Deductible or a Maximum Benefit)</i>	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
IMPAIRMENT OR LOSS OF SPEECH OR HEARING:	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
MINIMUM STAY REQUIREMENTS FOR MASTECTOMY AND LYMPH NODE DISSECTION:	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance

POLICY SCHEDULE
SCHEDULE OF BENEFITS (Continued)

<u>COVERED SERVICES</u>	<u>NETWORK PROVIDER</u>	<u>NON-NETWORK PROVIDER</u>
CHEMOTHERAPY AND RADIATION THERAPY [(Deductible waived)]:	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance]
Network / Non-Network Provider: Up to [\$5,000 / \$7,500 / \$10,000 / \$12,500] Maximum Benefit Amount* per Insured Person, per Calendar Month Not to exceed a [\$50,000 / \$100,000 / \$150,000] Maximum Benefit Amount*, per Insured Person, per lifetime		
DURABLE MEDICAL EQUIPMENT AND PROSTHETIC DEVICES:	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
Network / Non-Network Provider: Up to [\$2,500] Maximum Benefit Amount* per Insured Person, per [Sickness or Injury]		
AMBULANCE SERVICES <i>(Payable only when Hospital Confined)</i>		
Ground Ambulance: <i>[(Deductible waived)]</i>	[70%][80%][90%][100%] Coinsurance	[70%][80%][90%][100%] Coinsurance
Network/Non-Network Provider: Up to [\$500] Maximum Benefit Amount* per Insured Person, per trip		
Air / Water Ambulance: <i>[(Deductible waived)]</i>	[70%][80%][90%][100%] Coinsurance	[70%][80%][90%][100%] Coinsurance
Network / Non-Network Provider: Up to [\$5,000] Maximum Benefit Amount* per Insured Person, per trip		

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

<u>COVERED SERVICES</u>	<u>NETWORK PROVIDER</u>	<u>NON-NETWORK PROVIDER</u>
MATERNITY STAY REQUIREMENTS FOR COVERED MATERNITY CARE:	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
MUSCULOSKELETAL DISORDERS:	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
CHILD HEALTH SUPERVISION SERVICES: <i>(Immunizations only)</i> <i>(Deductible waived)</i>	[100%] Coinsurance	[100%] Coinsurance
MEDICAL FOODS AND LOW PROTEIN MODIFIED FOOD PRODUCTS:	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
DIABETES:	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
OUTPATIENT CONTRACEPTIVE SERVICES AND DEVICES:	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance

*You are responsible for the balance due (if any) on charges for Covered Services in excess of the Maximum Benefit Amount.

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

RIDER BENEFITS

NETWORK PROVIDER

NON-NETWORK PROVIDER

**PHYSICIAN OFFICE SERVICES
BENEFIT RIDER**

{Option B or C}

**Outpatient Physician Office Visits
for Sickness or Injury:**
*(Limited to [2][4] visits per Insured
Person, per [Calendar Year])*

[100%] Coinsurance –
[Deductible waived]

[100%] Coinsurance –
[Deductible waived]

**Physician Home and Office
Copayment:**

[\$50] per Insured Person, per visit

[\$100] per Insured Person, per
visit

**Convenient Care Clinic
Copayment:**

[\$25] per Insured Person, per visit

[\$50] per Insured Person, per
visit

**Outpatient Preventive Care
Physician Visits:**
*(Other than Well Child Visits)
(Limited to one visit per Insured
Person, per [Calendar Year])*

[100%] Coinsurance –
[Deductible waived]

[100%] Coinsurance –
[Deductible waived]

**Physician Home and Office
Copayment:**

[\$50] per Insured Person, per visit

[\$100] per Insured Person, per
visit

**Convenient Care Clinic
Copayment:**

[\$25] per Insured Person, per visit

[\$50] per Insured Person, per
visit

Well Child Visits
*(For covered Dependent children
from birth up to 24 months):*

[100%] Coinsurance –
[Deductible waived]

[100%] Coinsurance –
[Deductible waived]

**Physician Home and Office
Copayment:**

[\$50] per Insured Person, per visit

[\$100] per Insured Person, per
visit

**Convenient Care Clinic
Copayment:**

[\$25] per Insured Person, per visit

[\$50] per Insured Person, per
visit

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

<u>RIDER BENEFITS</u>	<u>NETWORK PROVIDER</u>	<u>NON-NETWORK PROVIDER</u>
OUTPATIENT DIAGNOSTIC SERVICES BENEFIT RIDER:	[100%] Coinsurance – [Deductible waived]	[100%] Coinsurance – [Deductible waived]
[Up to [\$1,500] per Insured Person, per day]		
[Not to exceed [\$2,500] [\$5,000] [\$7,500] Maximum Benefit Amount* per Insured Person, per [Calendar Year]]		
Copayment:	[\$100] [\$250] per Insured Person, per visit	[\$200] [\$500] per Insured Person, per visit

CONTINUED CARE BENEFIT RIDER <i>[(Per Sickness or Injury)]</i>		
Skilled Nursing Care: <i>(Limited to [30] [45] [60] visits per Insured Person, per Calendar Year)</i>	[100%] Coinsurance – [Deductible waived]	[100%] Coinsurance – [Deductible waived]
<i>[(Not to exceed [\$200] Maximum Benefit Amount* per Insured Person, per day)]</i>		
Home Health Care: <i>(Limited to [30] [45] [60] combined visits per Insured Person, per [Calendar Year])</i>	[100%] Coinsurance – [Deductible waived]	[100%] Coinsurance – [Deductible waived]
Home Health care home infusion therapy and wound care: <i>(Not to exceed [\$100] Maximum Benefit Amount* per Insured Person, per visit)</i>		
All other Home Health Care Services: <i>(Not to exceed [\$100] [\$250] [\$500] [\$1,000] Maximum Benefit Amount* per Insured Person, per visit)</i>		
Hospice Care: <i>(Not to exceed [\$5,000] Maximum Benefit Amount* per Insured Person, per lifetime)</i>	[100%] Coinsurance – [Deductible waived]	[100%] Coinsurance – [Deductible waived]

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

<u>RIDER BENEFITS</u>	<u>NETWORK PROVIDER</u>	<u>NON-NETWORK PROVIDER</u>
OUTPATIENT SPEECH THERAPY, PHYSICAL THERAPY AND OCCUPATIONAL THERAPY SERVICES RIDER		
<i>(Limited to [40 combined visits] for all therapies per Insured Person, per Calendar Year)</i>		
Speech Therapy:	[100%] Coinsurance – [Deductible waived]	[100%] Coinsurance – [Deductible waived]
Copayment:	[\$50] per Insured Person, per visit	[\$50] per Insured Person, per visit
Physical Therapy:	[100%] Coinsurance – [Deductible waived]	[100%] Coinsurance – [Deductible waived]
Copayment:	[\$50] per Insured Person, per visit	[\$50] per Insured Person, per visit
Occupational Therapy:	[100%] Coinsurance – [Deductible waived]	[100%] Coinsurance – [Deductible waived]
Copayment:	[\$50] per Insured Person, per visit	[\$50] per Insured Person, per visit
PRESCRIPTION DRUG EXPENSE RIDER		
<i>(See Rider)</i>		
PREGNANCY/CHILDBIRTH BENEFIT RIDER		
<i>(See Rider)</i>		
OUTPATIENT ACCIDENT EXPENSE BENEFIT RIDER:	[100%] Coinsurance – [Deductible waived]	[100%] Coinsurance – [Deductible waived]
<i>Not to exceed [\$500] [\$1,000] [\$1,500] Maximum Benefit Amount per Insured Person, per [Calendar Year]</i>		
Copayment:	[\$50] [\$100] [\$150] per Insured Person, per Injury	[\$50] [\$100] [\$150] per Insured Person, per Injury

THE CHESAPEAKE LIFE INSURANCE COMPANY

A Stock Company

(Hereinafter called: the Company, We, Our or Us)

Home Office: Oklahoma City, Oklahoma

Administrative Office: P.O. Box 982010

North Richland Hills, Texas 76182-8010

Customer Service: 1-800-733-1110

MENTAL ILLNESS AND SUBSTANCE USE DISORDERS RIDER

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

The benefits provided by this Rider will not duplicate the benefits provided under the Policy and/or any other Rider, and are subject to the Policy Period of Treatment Deductible (if any), Calendar Year Deductible (if any), Deductible for all other Outpatient Covered Services (if any), Facility Fee(s) (if any), Copayment(s) (if any), Network or Non-Network Coinsurance level, Maximum Benefit Amount (if any), Visit Limitation(s) (if any), Calendar Year Maximum Amount (if any), Aggregate Maximum Amount (if any), and Lifetime Maximum Amount shown in the POLICY SCHEDULE.

COVERED SERVICES

Covered Services include the diagnosis and treatment of Mental Illness and Substance Use Disorders to the same extent that are provided for any other Sickness.

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

Rider Effective Date, if different from Policy Date:

THE CHESAPEAKE LIFE INSURANCE COMPANY



SECRETARY



PRESIDENT

THE CHESAPEAKE LIFE INSURANCE COMPANY

A Stock Company
(Hereinafter called: the Company, We, Our or Us)
Home Office: Oklahoma City, Oklahoma
Administrative Office: P.O. Box 982010
North Richland Hills, Texas 76180
Customer Service: 1-800-733-1110

AMENDATORY ENDORSEMENT

This Amendatory Endorsement is made a part of the Policy to which it is attached. It is subject to all the provisions of the Policy which are not inconsistent with this endorsement. It is applicable only to Insured Persons who are residents of the State of Arkansas and whom accept the offer of coverage for Mental Illness and Substance Use Disorders on their application for insurance.

1. The definition of "**Mental or Nervous Disorders**" under the **DEFINITIONS** section is hereby **deleted** and **revised** as follows:

Mental Illness and Substance Use Disorders means those illnesses and disorders that are covered by a health benefit plan listed in the International Classification of Diseases Manual and the Diagnostic and Statistical Manual of Mental Disorders; including substance use disorders, unless specifically stated otherwise.

2. The following Exclusions are hereby **deleted** under the **EXCLUSIONS AND LIMITATIONS** section:

7. Mental or Nervous Disorders, unless otherwise stated herein;
8. Drug abuse or addiction including alcoholism, or overdose of drugs, narcotics, or hallucinogens, directly or indirectly, wholly or partially, unless taken as prescribed by a Physician;

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

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

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

Signed for The Chesapeake Life Insurance Company at North Richland Hills, Texas.



SECRETARY



PRESIDENT

SERFF Tracking Number: MGCC-126119576 State: Arkansas
 Filing Company: The Chesapeake Life Insurance Company State Tracking Number: 42199
 Company Tracking Number: CH-26210 PPO-IP (03/09) AR
 TOI: H151 Individual Health - Sub-TOI: H151.001 Health - Hospital/Surgical/Medical
 Hospital/Surgical/Medical Expense Expense
 Product Name: CLICO 26210 (03/09)
 Project Name/Number: CLICO 26210 (03/09)/CH-26210 PPO-IP (03/09) AR

Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
Approved-Closed 10/12/2009	Rates	CH-26210 PPO-IP (03/09) AR	New		CH-26210 PPO-IP (0309) AR 20091001 EF Rates.pdf CH-26210 PPO-IP (0309) AR 200901001 CF Rates.pdf

The Chesapeake Life Insurance Company

Administration Office: P.O. Box 982010, North Richland Hills, TX 76182-8010

Catastrophic Expense Preferred Provider Organization (PPO)

CH-26210 PPO-IP (03/09) AR

EssentialFit

Formula
Round(AE x AgeSex x Area x Base x Inflation x Marital x Network x Tobacco x Aggregate Lifetime Max x Deductible Coinsurance x Deductible Coinsurance MOOP ,2)

Multiply the Base Rate by 3 for quarterly rates, 6 for semi-annual, and 11 for annual premium rates.

Inflation
1.000000000

A \$9 fee is added to the policies on a direct bill mode. A one time application fee of \$55 will be applied at time of application.

Base	Factor
Base	129.690

Based on underwriting results, final rates may range from 50% to the maximum percentage allowed by your state of the calculated rates. This adjustment may also apply to any rider(s) attached.

AE	Factor
Child	1.173000
Female	1.040400
Male	1.040400

Benefit Options	Factor
Deductible 7500 Coinsurance 80 MOOP 5000	1.023100
Deductible 7500 Coinsurance 80 MOOP 10000	0.991500
Deductible 7500 Coinsurance 90 MOOP 5000	1.055500
Deductible 7500 Coinsurance 90 MOOP 10000	1.040400
Deductible 7500 Coinsurance 100	1.119500
Deductible 10000 Coinsurance 80 MOOP 5000	0.939200
Deductible 10000 Coinsurance 80 MOOP 10000	0.909700
Deductible 10000 Coinsurance 90 MOOP 5000	0.964900
Deductible 10000 Coinsurance 90 MOOP 10000	0.950400
Deductible 10000 Coinsurance 100	1.020000
Deductible 15000 Coinsurance 80 MOOP 5000	0.819600
Deductible 15000 Coinsurance 80 MOOP 10000	0.793800
Deductible 15000 Coinsurance 90 MOOP 5000	0.836900
Deductible 15000 Coinsurance 90 MOOP 10000	0.823500
Deductible 15000 Coinsurance 100	0.880100
Deductible 20000 Coinsurance 80 MOOP 5000	0.737900
Deductible 20000 Coinsurance 80 MOOP 10000	0.714900
Deductible 20000 Coinsurance 90 MOOP 5000	0.750500
Deductible 20000 Coinsurance 90 MOOP 10000	0.738200
Deductible 20000 Coinsurance 100	0.786100
Aggregate 1000000 Lifetime Max 2000000	1.000000
Aggregate 1000000 Lifetime Max 4000000	1.050000
Aggregate 2000000 Lifetime Max 8000000	1.100000

Other values may be interpolated.

Demographic	Value	Factor
Marital	No	1.000
Marital	Yes	0.900
Tobacco	No	1.000

Marital discount only applies if both primary and spouse are insured.

Demographic	Value	Factor
Tobacco	Yes	1.300

Age	Factor	Gender	Adult/Dep
00	0.7700	Female	Adult
01	0.7700	Female	Adult
02	0.7700	Female	Adult
03	0.7700	Female	Adult
04	0.7700	Female	Adult
05	0.7700	Female	Adult
06	0.7700	Female	Adult
07	0.7700	Female	Adult
08	0.7700	Female	Adult
09	0.7700	Female	Adult
10	0.7700	Female	Adult
11	0.7700	Female	Adult
12	0.7700	Female	Adult
13	0.7700	Female	Adult
14	0.7700	Female	Adult
15	0.7700	Female	Adult
16	0.7700	Female	Adult
17	0.7700	Female	Adult
18	0.7700	Female	Adult
19	0.7700	Female	Adult
20	0.7700	Female	Adult
21	0.7700	Female	Adult
22	0.7730	Female	Adult
23	0.7790	Female	Adult
24	0.7850	Female	Adult
25	0.7910	Female	Adult
26	0.7970	Female	Adult
27	0.8230	Female	Adult
28	0.8510	Female	Adult
29	0.8790	Female	Adult
30	0.9070	Female	Adult
31	0.9380	Female	Adult
32	0.9700	Female	Adult
33	1.0020	Female	Adult
34	1.0370	Female	Adult
35	1.0710	Female	Adult
36	1.1080	Female	Adult
37	1.1430	Female	Adult
38	1.1810	Female	Adult
39	1.2190	Female	Adult
40	1.2600	Female	Adult
41	1.3010	Female	Adult
42	1.3380	Female	Adult
43	1.3740	Female	Adult
44	1.4130	Female	Adult
45	1.4520	Female	Adult
46	1.4930	Female	Adult
47	1.5320	Female	Adult
48	1.5730	Female	Adult
49	1.6130	Female	Adult

Age	Factor	Gender	Adult/Dep
50	1.6560	Female	Adult
51	1.6990	Female	Adult
52	1.7880	Female	Adult
53	1.8800	Female	Adult
54	1.9790	Female	Adult
55	2.0810	Female	Adult
56	2.1890	Female	Adult
57	2.2810	Female	Adult
58	2.3760	Female	Adult
59	2.4760	Female	Adult
60	2.5800	Female	Adult
61	2.6880	Female	Adult
62	2.7800	Female	Adult
63	2.8760	Female	Adult
64 - 99	2.9760	Female	Adult
00	0.5850	Male	Adult
01	0.5850	Male	Adult
02	0.5850	Male	Adult
03	0.5850	Male	Adult
04	0.5850	Male	Adult
05	0.5850	Male	Adult
06	0.5850	Male	Adult
07	0.5850	Male	Adult
08	0.5850	Male	Adult
09	0.5850	Male	Adult
10	0.5850	Male	Adult
11	0.5850	Male	Adult
12	0.5850	Male	Adult
13	0.5850	Male	Adult
14	0.5850	Male	Adult
15	0.5850	Male	Adult
16	0.5850	Male	Adult
17	0.5850	Male	Adult
18	0.5850	Male	Adult
19	0.5850	Male	Adult
20	0.5850	Male	Adult
21	0.5850	Male	Adult
22	0.5850	Male	Adult
23	0.5850	Male	Adult
24	0.5850	Male	Adult
25	0.5850	Male	Adult
26	0.5880	Male	Adult
27	0.6010	Male	Adult
28	0.6140	Male	Adult
29	0.6270	Male	Adult
30	0.6410	Male	Adult
31	0.6550	Male	Adult
32	0.6760	Male	Adult
33	0.6990	Male	Adult
34	0.7230	Male	Adult
35	0.7470	Male	Adult
36	0.7720	Male	Adult

Age	Factor	Gender	Adult/Dep
37	0.8040	Male	Adult
38	0.8350	Male	Adult
39	0.8690	Male	Adult
40	0.9030	Male	Adult
41	0.9400	Male	Adult
42	0.9870	Male	Adult
43	1.0380	Male	Adult
44	1.0910	Male	Adult
45	1.1450	Male	Adult
46	1.2040	Male	Adult
47	1.2630	Male	Adult
48	1.3240	Male	Adult
49	1.3880	Male	Adult
50	1.4560	Male	Adult
51	1.5270	Male	Adult
52	1.6450	Male	Adult
53	1.7720	Male	Adult
54	1.9090	Male	Adult
55	2.0570	Male	Adult
56	2.2160	Male	Adult
57	2.3580	Male	Adult
58	2.5100	Male	Adult
59	2.6710	Male	Adult
60	2.8430	Male	Adult
61	3.0260	Male	Adult
62	3.1500	Male	Adult
63	3.2780	Male	Adult
64 - 99	3.4120	Male	Adult
00	0.5140	Female	Dep Child
01	0.4900	Female	Dep Child
02	0.4490	Female	Dep Child
03	0.4100	Female	Dep Child
04	0.4100	Female	Dep Child
05	0.4100	Female	Dep Child
06	0.4100	Female	Dep Child
07	0.4100	Female	Dep Child
08	0.4100	Female	Dep Child
09	0.4100	Female	Dep Child
10	0.4100	Female	Dep Child
11	0.4100	Female	Dep Child
12	0.4100	Female	Dep Child
13	0.4100	Female	Dep Child
14	0.4290	Female	Dep Child
15	0.4500	Female	Dep Child
16	0.4710	Female	Dep Child
17	0.4940	Female	Dep Child
18	0.5170	Female	Dep Child
19	0.5420	Female	Dep Child
20	0.5680	Female	Dep Child
21	0.5950	Female	Dep Child
22	0.6240	Female	Dep Child
23	0.6530	Female	Dep Child

Age	Factor	Gender	Adult/Dep
24	0.6850	Female	Dep Child
25	0.7180	Female	Dep Child
26	0.7450	Female	Dep Child
27	0.7680	Female	Dep Child
28	0.7920	Female	Dep Child
29	0.8160	Female	Dep Child
30 - 99	0.8410	Female	Dep Child
00	0.5140	Male	Dep Child
01	0.4900	Male	Dep Child
02	0.4490	Male	Dep Child
03	0.4100	Male	Dep Child
04	0.4100	Male	Dep Child
05	0.4100	Male	Dep Child
06	0.4100	Male	Dep Child
07	0.4100	Male	Dep Child
08	0.4100	Male	Dep Child
09	0.4100	Male	Dep Child
10	0.4100	Male	Dep Child
11	0.4100	Male	Dep Child
12	0.4100	Male	Dep Child
13	0.4100	Male	Dep Child
14	0.4290	Male	Dep Child
15	0.4500	Male	Dep Child
16	0.4710	Male	Dep Child
17	0.4940	Male	Dep Child
18	0.5170	Male	Dep Child
19	0.5420	Male	Dep Child
20	0.5680	Male	Dep Child
21	0.5950	Male	Dep Child
22	0.6240	Male	Dep Child
23	0.6530	Male	Dep Child
24	0.6850	Male	Dep Child
25	0.7180	Male	Dep Child
26	0.7450	Male	Dep Child
27	0.7680	Male	Dep Child
28	0.7920	Male	Dep Child
29	0.8160	Male	Dep Child
30 - 99	0.8410	Male	Dep Child

Area	ID	Factor
71600 - 71699	AB	1.051
71700 - 71799	AB	1.051
71800 - 71899	AB	1.051
71900 - 71999	AD	1.104
72000 - 72099	ZA	0.976
72100 - 72199	AF	1.160
72200 - 72299	AA	1.025
72300 - 72399	AB	1.051
72400 - 72499	AB	1.051
72500 - 72599	AH	1.218
72600 - 72699	ZA	0.976
72700 - 72799	ZE	0.884
72800 - 72899	AF	1.160

Area	ID	Factor
72900 - 72999	ZE	0.884
All - Others	AH	1.218

Expected PPO Network Fee is approximately \$2-\$20. This is a mandatory monthly fee per policy/certificate.

The default network will have a factor of 1.0 and other alternative networks will have a factor between 0.75 and 1.25 depending on their discount and penetration compared to the default network.

The Chesapeake Life Insurance Company

Administration Office: P.O. Box 982010, North Richland Hills, TX 76182-8010

Catastrophic Expense Preferred Provider Organization (PPO)

CH-26210 PPO-IP (03/09) AR

Classic Fit

Formula
Round(AE x AgeSex x Area x Base x Inflation x Marital x Network x Tobacco x Aggregate Lifetime Max x Deductible Coinsurance MOOP ,2)

Multiply the Base Rate by 3 for quarterly rates, 6 for semi-annual, and 11 for annual premium rates.

Inflation
1.000000000

A \$9 fee is added to the policies on a direct bill mode. A one time application fee of \$55 will be applied at time of application.

Base	Factor
Base	142.380

Based on underwriting results, final rates may range from 50% to the maximum percentage allowed by your state of the calculated rates. This adjustment may also apply to any rider(s) attached.

AE	Factor
Child	1.173000
Female	1.040400
Male	1.040400

Benefit Options	Factor
Deductible 1000 Coinsurance 70 MOOP 5000	1.091900
Deductible 1000 Coinsurance 70 MOOP 10000	1.043000
Deductible 1000 Coinsurance 80 MOOP 5000	1.140400
Deductible 1000 Coinsurance 80 MOOP 10000	1.110700
Deductible 1500 Coinsurance 70 MOOP 5000	1.050200
Deductible 1500 Coinsurance 70 MOOP 10000	1.002400
Deductible 1500 Coinsurance 80 MOOP 5000	1.094100
Deductible 1500 Coinsurance 80 MOOP 10000	1.065000
Deductible 2500 Coinsurance 70 MOOP 5000	0.982800
Deductible 2500 Coinsurance 70 MOOP 10000	0.937200
Deductible 2500 Coinsurance 80 MOOP 5000	1.020000
Deductible 2500 Coinsurance 80 MOOP 10000	0.991700
Deductible 3000 Coinsurance 70 MOOP 5000	0.957800
Deductible 3500 Coinsurance 70 MOOP 5000	0.935200
Deductible 3500 Coinsurance 70 MOOP 10000	0.891400
Deductible 3500 Coinsurance 80 MOOP 5000	0.968100
Deductible 3500 Coinsurance 80 MOOP 10000	0.940600
Deductible 5000 Coinsurance 70 MOOP 5000	0.863900
Deductible 5000 Coinsurance 70 MOOP 10000	0.823000
Deductible 5000 Coinsurance 80 MOOP 5000	0.890600
Deductible 5000 Coinsurance 80 MOOP 10000	0.864500
Deductible 7500 Coinsurance 70 MOOP 5000	0.780800
Deductible 7500 Coinsurance 70 MOOP 10000	0.743900
Deductible 7500 Coinsurance 80 MOOP 5000	0.800900
Deductible 7500 Coinsurance 80 MOOP 10000	0.776600
Aggregate 1000000 Lifetime Max 2000000	1.000000
Aggregate 1000000 Lifetime Max 4000000	1.050000
Aggregate 2000000 Lifetime Max 8000000	1.100000

Other values may be interpolated.

Demographic	Value	Factor
Marital	No	1.000
Marital	Yes	0.900
Tobacco	No	1.000
Tobacco	Yes	1.300

Marital discount only applies if both primary and spouse are insured.

Age	Factor	Gender	Adult/Dep
00	0.7700	Female	Adult
01	0.7700	Female	Adult
02	0.7700	Female	Adult
03	0.7700	Female	Adult
04	0.7700	Female	Adult
05	0.7700	Female	Adult
06	0.7700	Female	Adult
07	0.7700	Female	Adult
08	0.7700	Female	Adult
09	0.7700	Female	Adult
10	0.7700	Female	Adult
11	0.7700	Female	Adult
12	0.7700	Female	Adult
13	0.7700	Female	Adult
14	0.7700	Female	Adult
15	0.7700	Female	Adult
16	0.7700	Female	Adult
17	0.7700	Female	Adult
18	0.7700	Female	Adult
19	0.7700	Female	Adult
20	0.7700	Female	Adult
21	0.7700	Female	Adult
22	0.7730	Female	Adult
23	0.7790	Female	Adult
24	0.7850	Female	Adult
25	0.7910	Female	Adult
26	0.7970	Female	Adult
27	0.8230	Female	Adult
28	0.8510	Female	Adult
29	0.8790	Female	Adult
30	0.9070	Female	Adult
31	0.9380	Female	Adult
32	0.9700	Female	Adult
33	1.0020	Female	Adult
34	1.0370	Female	Adult
35	1.0710	Female	Adult
36	1.1080	Female	Adult
37	1.1430	Female	Adult
38	1.1810	Female	Adult
39	1.2190	Female	Adult
40	1.2600	Female	Adult
41	1.3010	Female	Adult
42	1.3380	Female	Adult
43	1.3740	Female	Adult
44	1.4130	Female	Adult
45	1.4520	Female	Adult
46	1.4930	Female	Adult

Age	Factor	Gender	Adult/Dep
47	1.5320	Female	Adult
48	1.5730	Female	Adult
49	1.6130	Female	Adult
50	1.6560	Female	Adult
51	1.6990	Female	Adult
52	1.7880	Female	Adult
53	1.8800	Female	Adult
54	1.9790	Female	Adult
55	2.0810	Female	Adult
56	2.1890	Female	Adult
57	2.2810	Female	Adult
58	2.3760	Female	Adult
59	2.4760	Female	Adult
60	2.5800	Female	Adult
61	2.6880	Female	Adult
62	2.7800	Female	Adult
63	2.8760	Female	Adult
64 - 99	2.9760	Female	Adult
00	0.5850	Male	Adult
01	0.5850	Male	Adult
02	0.5850	Male	Adult
03	0.5850	Male	Adult
04	0.5850	Male	Adult
05	0.5850	Male	Adult
06	0.5850	Male	Adult
07	0.5850	Male	Adult
08	0.5850	Male	Adult
09	0.5850	Male	Adult
10	0.5850	Male	Adult
11	0.5850	Male	Adult
12	0.5850	Male	Adult
13	0.5850	Male	Adult
14	0.5850	Male	Adult
15	0.5850	Male	Adult
16	0.5850	Male	Adult
17	0.5850	Male	Adult
18	0.5850	Male	Adult
19	0.5850	Male	Adult
20	0.5850	Male	Adult
21	0.5850	Male	Adult
22	0.5850	Male	Adult
23	0.5850	Male	Adult
24	0.5850	Male	Adult
25	0.5850	Male	Adult
26	0.5880	Male	Adult
27	0.6010	Male	Adult
28	0.6140	Male	Adult
29	0.6270	Male	Adult
30	0.6410	Male	Adult
31	0.6550	Male	Adult
32	0.6760	Male	Adult
33	0.6990	Male	Adult

Age	Factor	Gender	Adult/Dep
34	0.7230	Male	Adult
35	0.7470	Male	Adult
36	0.7720	Male	Adult
37	0.8040	Male	Adult
38	0.8350	Male	Adult
39	0.8690	Male	Adult
40	0.9030	Male	Adult
41	0.9400	Male	Adult
42	0.9870	Male	Adult
43	1.0380	Male	Adult
44	1.0910	Male	Adult
45	1.1450	Male	Adult
46	1.2040	Male	Adult
47	1.2630	Male	Adult
48	1.3240	Male	Adult
49	1.3880	Male	Adult
50	1.4560	Male	Adult
51	1.5270	Male	Adult
52	1.6450	Male	Adult
53	1.7720	Male	Adult
54	1.9090	Male	Adult
55	2.0570	Male	Adult
56	2.2160	Male	Adult
57	2.3580	Male	Adult
58	2.5100	Male	Adult
59	2.6710	Male	Adult
60	2.8430	Male	Adult
61	3.0260	Male	Adult
62	3.1500	Male	Adult
63	3.2780	Male	Adult
64 - 99	3.4120	Male	Adult
00	0.5140	Female	Dep Child
01	0.4900	Female	Dep Child
02	0.4490	Female	Dep Child
03	0.4100	Female	Dep Child
04	0.4100	Female	Dep Child
05	0.4100	Female	Dep Child
06	0.4100	Female	Dep Child
07	0.4100	Female	Dep Child
08	0.4100	Female	Dep Child
09	0.4100	Female	Dep Child
10	0.4100	Female	Dep Child
11	0.4100	Female	Dep Child
12	0.4100	Female	Dep Child
13	0.4100	Female	Dep Child
14	0.4290	Female	Dep Child
15	0.4500	Female	Dep Child
16	0.4710	Female	Dep Child
17	0.4940	Female	Dep Child
18	0.5170	Female	Dep Child
19	0.5420	Female	Dep Child
20	0.5680	Female	Dep Child

Age	Factor	Gender	Adult/Dep
21	0.5950	Female	Dep Child
22	0.6240	Female	Dep Child
23	0.6530	Female	Dep Child
24	0.6850	Female	Dep Child
25	0.7180	Female	Dep Child
26	0.7450	Female	Dep Child
27	0.7680	Female	Dep Child
28	0.7920	Female	Dep Child
29	0.8160	Female	Dep Child
30 - 99	0.8410	Female	Dep Child
00	0.5140	Male	Dep Child
01	0.4900	Male	Dep Child
02	0.4490	Male	Dep Child
03	0.4100	Male	Dep Child
04	0.4100	Male	Dep Child
05	0.4100	Male	Dep Child
06	0.4100	Male	Dep Child
07	0.4100	Male	Dep Child
08	0.4100	Male	Dep Child
09	0.4100	Male	Dep Child
10	0.4100	Male	Dep Child
11	0.4100	Male	Dep Child
12	0.4100	Male	Dep Child
13	0.4100	Male	Dep Child
14	0.4290	Male	Dep Child
15	0.4500	Male	Dep Child
16	0.4710	Male	Dep Child
17	0.4940	Male	Dep Child
18	0.5170	Male	Dep Child
19	0.5420	Male	Dep Child
20	0.5680	Male	Dep Child
21	0.5950	Male	Dep Child
22	0.6240	Male	Dep Child
23	0.6530	Male	Dep Child
24	0.6850	Male	Dep Child
25	0.7180	Male	Dep Child
26	0.7450	Male	Dep Child
27	0.7680	Male	Dep Child
28	0.7920	Male	Dep Child
29	0.8160	Male	Dep Child
30 - 99	0.8410	Male	Dep Child

Area	ID	Factor
71600 - 71699	AB	1.051
71700 - 71799	AB	1.051
71800 - 71899	AB	1.051
71900 - 71999	AD	1.104
72000 - 72099	ZA	0.976
72100 - 72199	AF	1.160
72200 - 72299	AA	1.025
72300 - 72399	AB	1.051
72400 - 72499	AB	1.051
72500 - 72599	AH	1.218

Area	ID	Factor
72600 - 72699	ZA	0.976
72700 - 72799	ZE	0.884
72800 - 72899	AF	1.160
72900 - 72999	ZE	0.884
All - Others	AH	1.218

Expected PPO Network Fee is approximately \$2-\$20. This is a mandatory monthly fee per policy/certificate.

The default network will have a factor of 1.0 and other alternative networks will have a factor between 0.75 and 1.25 depending on their discount and penetration compared to the default network.

SERFF Tracking Number: MGCC-126119576 State: Arkansas
 Filing Company: The Chesapeake Life Insurance Company State Tracking Number: 42199
 Company Tracking Number: CH-26210 PPO-IP (03/09) AR
 TOI: H151 Individual Health - Sub-TOI: H151.001 Health - Hospital/Surgical/Medical
 Hospital/Surgical/Medical Expense Expense
 Product Name: CLICO 26210 (03/09)
 Project Name/Number: CLICO 26210 (03/09)/CH-26210 PPO-IP (03/09) AR

Supporting Document Schedules

	Item Status:	Status Date:
<p>Satisfied - Item: Variability Statement</p> <p>Comments: Please refer to attached.</p> <p>Attachments: _VAR STMT_ CH-26210 PPO-IP _0309_ SB-A.pdf _VAR STMT_ CH-26210 PPO-IP _0309_ SB-B.pdf</p>	Approved-Closed	10/12/2009

	Item Status:	Status Date:
<p>Satisfied - Item: Outline of Coverage</p> <p>Comments: Please refer to attached.</p> <p>Attachments: CH-26210 PPO-IP OC _SB-A_ _0309_ AR [EF].pdf CH-26210 PPO-IP OC _SB-B_ _0309_ AR [CF].pdf</p>	Approved-Closed	10/12/2009

	Item Status:	Status Date:
<p>Satisfied - Item: Flesch Certification</p> <p>Comments: Please refer to attached.</p> <p>Attachments: Cert Compl Rule-Reg19 -AR.pdf Cert Compliance AR-Readability.pdf</p>	Approved-Closed	10/12/2009

	Item Status:	Status Date:
<p>Satisfied - Item: Application</p> <p>Comments: We intend to use application form CH/MG-25098-APP (03/09) which will be submitted under separate cover to solicit</p>	Approved-Closed	10/12/2009

SERFF Tracking Number: MGCC-126119576 State: Arkansas
 Filing Company: The Chesapeake Life Insurance Company State Tracking Number: 42199
 Company Tracking Number: CH-26210 PPO-IP (03/09) AR
 TOI: H151 Individual Health - Sub-TOI: H151.001 Health - Hospital/Surgical/Medical
 Hospital/Surgical/Medical Expense Expense
 Product Name: CLICO 26210 (03/09)
 Project Name/Number: CLICO 26210 (03/09)/CH-26210 PPO-IP (03/09) AR

this product. Additionally, we may also use electronic application form CH/MG-25098-eAPP (03/09) AR, upon approval, which will be submitted under separate cover to solicit this product or any application approved by your Department in the future.

	Item Status:	Status Date:
Satisfied - Item: Cover letter Comments: Please refer to attached. Attachment: LTR CH-26210 PPO-IP _0309_ _EF-CF_ [Indiv].pdf	Approved-Closed	10/12/2009

	Item Status:	Status Date:
Satisfied - Item: Redline of AE CH-26058-IR AR (10/09) Comments: I have attached a copy of a redline indicating the changes made to the previously submitted AE. Attachment: Redline - AE CH-26058-IR AR _1009_.pdf		

THE CHESAPEAKE LIFE INSURANCE COMPANY

VARIABILITY STATEMENT

CATASTROPHIC EXPENSE PREFERRED PROVIDER ORGANIZATION (PPO) POLICY (FORMS: CH-26210 PPO-IP (03/09) AR with Policy Schedule CH-26210 PPO-IP (SB-A) (03/09) AR)

POLICY SCHEDULE

The amounts specified within brackets on the Policy Schedule pages are the ranges of amounts we intend to offer with this plan. Below is additional information regarding specific option combinations the applicant will have the ability to choose from, as well as how certain terms of the plan are intended to work.

1. LIFETIME and CALENDAR YEAR MAXIMUM AMOUNTS – Applicant will have a **choice** of the following options:
 - a. OPTION A: \$2,000,000 Lifetime / \$1,000,000 Calendar Year
 - b. OPTION B: \$4,000,000 Lifetime / \$1,000,000 Calendar Year
 - c. OPTION B: \$8,000,000 Lifetime / \$2,000,000 Calendar Year

2. CALENDAR YEAR DEDUCTIBLE AMOUNTS – Applicant will have a **choice** of the following options:
 - a. OPTION A: Network: \$7,500 Individual / \$15,000 Family...Non-Network: \$15,000 Individual / \$30,000 Family
 - b. OPTION B: Network: \$10,000 Individual / \$20,000 Family...Non-Network: \$20,000 Individual / \$40,000 Family
 - c. OPTION C: Network: \$15,000 Individual / \$30,000 Family...Non-Network: \$30,000 Individual / \$60,000 Family
 - d. OPTION D: Network: \$20,000 Individual / \$40,000 Family...Non-Network: \$40,000 Individual / \$80,000 Family
 - Family Deductible can be met by any combination of individual deductible accumulations in the family.
 - Non-Covered Services, Facility Fees or Covered Services in excess of the Maximum Benefit Amount, or any applicable Copayment amounts do not count toward meeting the Deductible.

3. NETWORK / NON-NETWORK COINSURANCE AMOUNTS – Applicant will have a **choice** of the following options:
 - a. OPTION A: 80% / 50%
 - b. OPTION B: 90% / 60%
 - c. OPTION C: 100% / 70%

4. CALENDAR YEAR COINSURANCE MAXIMUM AMOUNTS – We intend to market the following amounts to applicants:
 - Network: \$10,000 Individual / \$20,000 Family
 - Non-Network: \$20,000 Individual / \$40,000 Family
 - "Coinsurance Maximum" represents the total amount an insured must pay after satisfaction of the any Facility Fees, Copayments, Deductibles and Coinsurance.
 - Once the Individual Coinsurance Maximum is met, Covered Services will be paid at 100% Coinsurance after the application of Facility Fees and Copayments, within the same Calendar Year.
 - Once the Family Coinsurance Maximum is met, Covered Services will be paid at 100% for all Insured Persons in the same Calendar Year will be paid at 100% Coinsurance after the application of Facility Fees and Copayments.
 - Family Coinsurance Maximum can be met by any combination of individual coinsurance maximum accumulations in the family.

THE CHESAPEAKE LIFE INSURANCE COMPANY

VARIABILITY STATEMENT

CATASTROPHIC EXPENSE PREFERRED PROVIDER ORGANIZATION (PPO) POLICY (FORMS: CH-26210 PPO-IP (03/09) AR with Policy Schedule CH-26210 PPO-IP (SB-A) (03/09) AR)

ADDITIONAL COVERED SERVICES: *We intend to market the following benefits to applicants.*

5. INPATIENT SERVICES -

- a. **Non-Network** services: May be subject to \$500 Facility Fee amount, per Insured Person, per Hospital Confinement.
- b. Subject to chosen Network / Non-Network Deductible and Coinsurance amounts.
- c. Transplant Procedure Covered Services:
 - **Network** services: *subject to \$250,000 Maximum Benefit Amount, per Insured Person, per Transplant Procedure.*
 - **Non-Network** services: *subject to \$175,000 Maximum Benefit Amount, per Insured Person, per Transplant Procedure.*

6. OUTPATIENT SURGERY FACILITY SERVICES –

- a. **Non-Network** services: May be subject to \$250 Facility Fee amount, per Insured Person, per Surgery.
- b. Subject to chosen Network / Non-Network Deductible and Coinsurance amounts.

7. MEDICAL EMERGENCIES - Subject to chosen Network Deductible and Coinsurance only.

- a. Hospital Emergency Room:
 - May be subject to \$100 Facility Fee, per Insured Person, per visit. (*waived if Hospital Confined*).
- b. Urgent Care Center:
 - May be subject to \$100 Facility Fee, per Insured Person, per visit..

*Non-Medical Emergencies: Insured Person visits for Non-Medical Emergency, by definition, are **not covered**.*

8. DURABLE MEDICAL EQUIPMENT and PROSTHETIC DEVICES –

- Subject to chosen Network/Non-Network Deductible and Coinsurance.
- Up to a \$2,000 Maximum benefit Amount, per Insured Person, per Calendar Year.

9. AMBULANCE SERVICES –

- Subject to chosen Network Coinsurance.
- Deductible waived.
- Ground Ambulance – will offer \$500 Maximum Benefit Amount, per Insured Person, per trip
- Air or Water Ambulance – will offer \$5,000 Maximum Benefit Amount, per Insured Person, per trip.

THE CHESAPEAKE LIFE INSURANCE COMPANY

VARIABILITY STATEMENT

**CATASTROPHIC EXPENSE PREFERRED PROVIDER ORGANIZATION (PPO) POLICY
(FORMS: CH-26210 PPO-IP (03/09) AR with Policy Schedule CH-26210 PPO-IP (SB-A) (03/09) AR)**

RIDER BENEFIT COVERED SERVICES: *At this time, we intend to offer the following Riders. However, in the future, we may choose to offer a combination of other Riders previously approved in your state. At no time will any Riders be offered which have not been approved by your state.*

10. PHYSICIAN OFFICE SERVICES BENEFIT RIDER (form CH-26223-IR (03/09)):

- Applicant will have a **choice** of the following options:

PHYSICIAN OFFICE SERVICES BENEFIT	OPTION A		OPTION B		OPTION C	
	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK
Deductible	Base Plan	Base Plan	Waived	Waived	Waived	Waived
Outpatient Physician Office Visits for Sickness or Injury:						
Coinsurance	Base Plan	Base Plan	100%	100%	100%	100%
Physician Home and Office Copayment per visit:	N/A	N/A	\$50	\$100	\$50	\$100
Convenient Care Clinic Copayment per visit:	N/A	N/A	\$25	\$50	\$25	\$50
Visit Limitation, per Calendar Year	Unlimited	Unlimited	4		Unlimited	Unlimited
Outpatient Preventive Care Physician Visits - other than Well Child Visits: <i>(Limited to one visit per Insured Person, per Calendar Year)</i>	Base Plan Coinsurance	Base Plan Coinsurance	N/A	N/A	Deductible Waived; 100% Coinsurance	Deductible Waived; 100% Coinsurance
Physician Home and Office Copayment per visit:	N/A	N/A	\$50	\$100	\$50	\$100
Convenient Care Clinic Copayment per visit:	N/A	N/A	\$25	\$50	\$25	\$50
Well Child Visits: <i>(For covered Dependent children from birth up to 24 months)</i>	Base Plan Coinsurance	Base Plan Coinsurance	N/A	N/A	Deductible Waived; 100% Coinsurance	Deductible Waived; 100% Coinsurance
Physician Home and Office Copayment per visit:	N/A	N/A	\$50	\$100	\$50	\$100
Convenient Care Clinic Copayment per visit:	N/A	N/A	\$25	\$50	\$25	\$50

THE CHESAPEAKE LIFE INSURANCE COMPANY

VARIABILITY STATEMENT

CATASTROPHIC EXPENSE PREFERRED PROVIDER ORGANIZATION (PPO) POLICY (FORMS: CH-26210 PPO-IP (03/09) AR with Policy Schedule CH-26210 PPO-IP (SB-A) (03/09) AR)

11. OUTPATIENT DIAGNOSTIC SERVICES BENEFIT RIDER - (form CH-26226-IR (03/09)):

At this time, we intend to automatically attach this Rider and may apply the Facility Fee. However in the future, we may choose to make this Rider Optional, not offer it all or to offer a combination of other Riders previously approved in your state. At no time will any Riders be offers which have not been approved by your state.

- **CAT, MRI and/or PET Scans** – Subject to chosen Network / Non-Network Deductible and Coinsurance chosen by the applicant and \$150 Facility Fee, per Insured Person, per visit.
- **All other outpatient diagnostic services** – Subject to chosen Network / Non-Network Deductible and Coinsurance chosen by the applicant and \$50 Facility Fee, per Insured Person, per visit.

12. CONTINUED CARE BENEFIT RIDER - (form CH-26225-IR (03/09) AR):

At this time, we intend to automatically attach this Rider. However in the future, we may choose to make this Rider Optional, not offer it all or to offer a combination of other Riders previously approved in your state. At no time will any Riders be offers which have not been approved by your state.

- *Subject to chosen Network/Non-Network Deductible and Coinsurance.*

CONTINUED CARE	NETWORK	NON-NETWORK
<i>Skilled Nursing Facility</i>		
Day limitation, per Calendar Year, per Insured Person	30 Days	
<i>Home Health Care</i>		
Day limitation, per Calendar Year, per Insured Person	60 Visits	
<i>Hospice Care</i>		
Maximum Benefit Amount, per lifetime, per Insured Person	\$5,000	

13. OUTPATIENT SPEECH THERAPY, PHYSICAL THERAPY AND OCCUPATIONAL THERAPY-
(form CH-26224-IR (03/09)):

At this time, we intend to automatically attach this Ride and may apply the Facility Fee. However in the future, we may choose to make this Rider Optional, not offer it all or to offer a combination of other Riders previously approved in your state. At no time will any Riders be offers which have not been approved by your state.

- *Subject to chosen Network/Non-Network Deductible and Coinsurance.*

SPEECH, OCCUPATIONAL, & PHYSICAL THERAPY SERVICES	NETWORK	NON-NETWORK
Facility Payment, per Insured Person, per Visit	\$50	\$50
Visit limitation for all therapies, per Insured Person, per Calendar Year	40 combined visits	

THE CHESAPEAKE LIFE INSURANCE COMPANY

VARIABILITY STATEMENT

**CATASTROPHIC EXPENSE PREFERRED PROVIDER ORGANIZATION (PPO) POLICY
(FORMS: CH-26210 PPO-IP (03/09) AR with Policy Schedule CH-26210 PPO-IP (SB-A) (03/09) AR)**

14. PRESCRIPTION DRUG EXPENSE RIDER - (form CH-26214-IR (03/09) AR): *At this time, we intend to market the following benefit to applicants.*

{Option A}

PRESCRIPTIONS OBTAINED THROUGH A PHARMACY	PRESCRIPTIONS OBTAINED THROUGH A MAIL-ORDER VENDOR	GENERIC DEDUCTIBLE (PER PERSON, PER CALENDAR YEAR)	BRAND NAME DEDUCTIBLE (PER PERSON, PER CALENDAR YEAR)	MAXIMUM BENEFIT (PER PERSON, PER CALENDAR YEAR)
Preferred Generic Drugs – Insured will pay \$5 copayment	Preferred Generic Drugs – Insured will pay either \$15 copayment	\$0	Either \$50 or \$250	\$1,500
Non-Preferred Generic Drugs – Insured will pay \$15 copayment	Non-Preferred Generic Drugs – Insured will pay either \$45 copayment			
Brand Preferred Drugs – Insured pays 50% of drug cost	Brand Drugs – Insured pays 50% of drug cost			
Brand Preferred Drugs – Insured pays 75% of drug cost	Brand Drugs – Insured pays 75% of drug cost			

{Option B}

PRESCRIPTIONS OBTAINED THROUGH A PHARMACY / MAIL-ORDER VENDOR	Option A	Option B	Option C	Option D
Deductible:	Base Plan Network Deductible			
Network Coinsurance:	70%	80%	90%	100%
Maximum Benefit (Per Person, Per Calendar Year):	\$1,500			

THE CHESAPEAKE LIFE INSURANCE COMPANY

VARIABILITY STATEMENT

PREFERRED PROVIDER ORGANIZATION (PPO) POLICY

(FORMS: CH-26210 PPO-IP (03/09) AR with Policy Schedule CH-26210 PPO-IP (SB-B) (03/09)AR)

POLICY SCHEDULE

The amounts specified within brackets on the Policy Schedule pages are the ranges of amounts we intend to offer with this plan. Below is additional information regarding specific option combinations the applicant will have the ability to choose from, as well as how certain terms of the plan are intended to work.

1. LIFETIME and AGGREGATE MAXIMUM AMOUNTS – *We intend to offer one or more of the following options to applicants:*
 - a. OPTION A: \$2,000,000 Lifetime / \$1,000,000 Aggregate
 - b. OPTION B: \$4,000,000 Lifetime / \$1,000,000 Aggregate
 - c. OPTION B: \$8,000,000 Lifetime / \$2,000,000 Aggregate

2. DEDUCTIBLES: PERIOD OF TREATMENT & ALL OTHER OUTPATIENT COVERED SERVICES AMOUNTS – *We intend to offer one or more of the following Deductible options to applicants:*
 - a. OPTION A: Network: \$1,000...Non-Network: \$2,000
 - b. OPTION B: Network: \$1,500...Non-Network: \$3,000
 - c. OPTION C: Network: \$2,500...Non-Network: \$5,000
 - d. OPTION C: Network: \$3,500...Non-Network: \$7,000
 - e. OPTION D: Network: \$5,000...Non-Network: \$10,000
 - f. OPTION E: Network: \$7,500...Non-Network: \$15,000
 - *Period of Treatment Deductible is per Insured Person.*
 - *The Deductible for all other Outpatient Covered Services (except outpatient Surgery) will be deducted from each separate outpatient Covered Service incurred by each Insured Person, per Calendar Year.*
 - *Once deductible has been met 3 times by any or all Insured Persons, no other deductibles apply for the remainder of that Calendar Year.*
 - *Non-Covered Services, Facility Fees, or Covered Services in excess of the Maximum Benefit Amount, or any applicable Copayment amounts do not count toward meeting the Period of Treatment / Outpatient Covered Services Deductible.*

3. NETWORK / NON-NETWORK COINSURANCE AMOUNTS – *We initially intend to offer one or more of the following Coinsurance options to applicants:*
 - a. OPTION A: 80% / 60%
 - b. OPTION B: 70% / 50%

4. COINSURANCE MAXIMUM – *We initially intend to offer one or more of the following Coinsurance Maximums to applicants:*
 - a. Network: \$5,000...Non-Network: \$10,000
 - b. Network: \$10,000...Non-Network: \$20,000
 - *"Coinsurance Maximum" represents the total coinsurance an insured must pay for each Period of Treatment after satisfaction of the any Facility Fees, Copayments, Deductibles and Coinsurance*
 - *Once the Coinsurance Maximum is met in the same Period of Treatment, Covered Services will be paid at 100% Coinsurance after the application of Facility Fees and Copayments.*

THE CHESAPEAKE LIFE INSURANCE COMPANY

VARIABILITY STATEMENT

PREFERRED PROVIDER ORGANIZATION (PPO) POLICY

(FORMS: CH-26210 PPO-IP (03/09) AR with Policy Schedule CH-26210 PPO-IP (SB-B) (03/09)AR)

ADDITIONAL COVERED SERVICES: *We intend to offer the following benefits to applicants.*

5. INPATIENT SERVICES -

- a. **Non-Network** services: subject to \$500 Facility Fee amount, per Insured Person, per Hospital Confinement.
- b. Subject to chosen Network / Non-Network Deductible and Coinsurance amounts.
- c. Transplant Procedure Covered Services:
 - **Network** services: subject to \$250,000 Maximum Benefit Amount, per Insured Person, per Transplant Procedure.
 - **Non-Network** services: subject to \$175,000 Maximum Benefit Amount, per Insured Person, per Transplant Procedure.

6. OUTPATIENT SURGERY FACILITY SERVICES –

- a. **Non-Network** services: subject to \$250 Facility Fee amount, per Insured Person.
- b. Subject to chosen Network / Non-Network Deductible and Coinsurance amounts.

7. MEDICAL EMERGENCIES -

- a. Subject to chosen Network Deductible and Coinsurance.
- b. Hospital Emergency Room:
 - Facility Fee \$250, *waived if Hospital Confined.*
- c. Urgent Care Center:
 - Facility Fee \$100.

*Non-Medical Emergencies: Insured Person visits for Non-Medical Emergency, by definition, are **not covered**.*

8. CHEMOTHERAPY and RADIATION THERAPY -

- Subject to chosen Network / Non-Network Coinsurance.
- Deductible waived.
- Calendar Month Maximum of \$10,000.
- Lifetime Maximum of \$100,000.

9. DURABLE MEDICAL EQUIPMENT and PROSTHETIC DEVICES -

- Subject to chosen Network/Non-Network Deductible and Coinsurance.
- Up to a \$2,500 Maximum benefit Amount, per Insured Person, per Sickness or Injury.

10. AMBULANCE SERVICES -

- Subject to chosen Network Coinsurance only.
- Deductible waived.
- Ground Ambulance – will offer \$500 Maximum Benefit Amount, per Insured Person, per trip
- Air or Water Ambulance – will offer \$5,000 Maximum Benefit Amount, per Insured Person, per trip.

THE CHESAPEAKE LIFE INSURANCE COMPANY

VARIABILITY STATEMENT

PREFERRED PROVIDER ORGANIZATION (PPO) POLICY

(FORMS: CH-26210 PPO-IP (03/09) AR with Policy Schedule CH-26210 PPO-IP (SB-B) (03/09)AR)

RIDER BENEFIT COVERED SERVICES: *At this time, we intend to offer the following Riders. However, in the future, we may choose to offer a combination of other Riders previously approved in your state. At no time will any Riders be offered which have not been approved by your state.*

11. PHYSICIAN OFFICE SERVICES BENEFIT RIDER (form CH-26223-IR (03/09)):

- Applicant will have a **choice** of the following options. Deductible is waived and 100% Coinsurance.

PHYSICIAN OFFICE SERVICES BENEFIT	OPTION A		OPTION B	
	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK
Outpatient Physician Visits for Sickness or Injury:				
Physician Home and Office Copayment:	\$50	\$100	\$50	\$100
Convenient Care Clinic Copayment:	\$25	\$50	\$25	\$50
Visit Limitation, per Calendar Year	2		4	
Outpatient Preventive Care Physician Visits - other than Well Child Visits: <i>(Limited to one visit per Insured Person, per Calendar Year)</i>	Unlimited		Unlimited	
Physician Home and Office Copayment:	\$50		\$100	
Convenient Care Clinic Copayment:	\$25		\$50	
Well Child Visits: <i>(For covered Dependent children from birth up to 24 months)</i>	Unlimited		Unlimited	
Physician Home and Office Copayment:	\$50		\$100	
Convenient Care Clinic Copayment:	\$25		\$50	

12. OUTPATIENT DIAGNOSTIC SERVICES BENEFIT RIDER - (form CH-26226-IR (03/09)):

At this time, we intend to offer the following options for this Rider. Deductible is waived and 100%Coinsurance.

OUTPATIENT DIAGNOSTIC SERVICES	OPTION A		OPTION B	
	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK
Copayment, per Visit, per Insured	\$100	\$200	\$250	\$500
Maximum Benefit Amount, per Day	\$1,250 or \$1,500		\$1,250 or \$1,500	
Maximum Benefit Amount, per Calendar Year	EITHER \$2,500 / \$5,000 / \$7,500		EITHER \$2,500 / \$5,000 / \$7,500	

THE CHESAPEAKE LIFE INSURANCE COMPANY

VARIABILITY STATEMENT

PREFERRED PROVIDER ORGANIZATION (PPO) POLICY

(FORMS: CH-26210 PPO-IP (03/09) AR with Policy Schedule CH-26210 PPO-IP (SB-B) (03/09)AR)

13. CONTINUED CARE BENEFIT RIDER - (form CH-26225-IR (03/09) AR):

At this time, we intend to offer the following benefits for this Rider. Deductible is waived and 100% Coinsurance.

CONTINUED CARE	NETWORK	NON-NETWORK
<i>Skilled Nursing Facility</i>		
Visit limitation, per Calendar Year, per Insured Person	30 Visits	
Maximum Benefit Amount, per day, per Insured Person	\$200	
<i>Home Health Care</i>		
Visit limitation, per Calendar Year, per Insured Person	60 Visits	
Maximum Benefit Amount, per visit, per Insured Person for home infusion and wound care	\$100	
Maximum Benefit Amount, per visit, per Insured Person for all other Home Health Care Services	\$100	
<i>Hospice Care</i>		
Maximum Benefit Amount, per lifetime, per Insured Person	\$5,000	

14. OUTPATIENT SPEECH THERAPY, PHYSICAL THERAPY AND OCCUPATIONAL THERAPY-
(form CH-26224-IR (03/09)):

At this time, we intend to offer the following benefits for this Rider. Deductible is waived and 100% Coinsurance.

SPEECH, OCCUPATIONAL, & PHYSICAL THERAPY SERVICES	NETWORK	NON-NETWORK
Copayment, per Insured Person, per Visit	\$50	\$50
Visit limitation for all therapies, per Insured Person, per Calendar Year	40 combined visits	

THE CHESAPEAKE LIFE INSURANCE COMPANY

VARIABILITY STATEMENT

PREFERRED PROVIDER ORGANIZATION (PPO) POLICY

(FORMS: CH-26210 PPO-IP (03/09) AR with Policy Schedule CH-26210 PPO-IP (SB-B) (03/09)AR)

15. PREGNANCY/CHILDBIRTH BENEFIT RIDER- (form CH-26213-IR (03/09)AR). Deductible waived.

At this time, we intend to offer the following options for this Rider.

PREGNANCY/CHILDBIRTH BENEFIT	0-24 Months in force	25 Months in force and over
Maximum Benefit Options	\$1,000 / \$2,000 / \$3,000	\$2,000 / \$4,000 / \$6,000

16. PRESCRIPTION DRUG EXPENSE RIDER - (form CH-26214-IR (03/09) AR):

At this time, we intend to automatically attach this Rider. However in the future, we may choose to make this Rider Optional, not offer it all or to offer a combination of other Riders previously approved in your state. At no time will any Riders be offers which have not been approved by your state.

PRESCRIPTIONS OBTAINED THROUGH A PHARMACY	PRESCRIPTIONS OBTAINED THROUGH A MAIL-ORDER VENDOR	GENERIC DEDUCTIBLE (PER PERSON, PER CALENDAR YEAR)	BRAND NAME DEDUCTIBLE (PER PERSON, PER CALENDAR YEAR)	MAXIMUM BENEFIT (PER PERSON, PER CALENDAR YEAR)
Preferred Generic Drugs – Insured will pay \$5 copayment	Preferred Generic Drugs – Insured will pay either \$15 copayment	\$0	Either \$50 or \$250	\$1,500
Non-Preferred Generic Drugs – Insured will pay \$15 copayment	Non-Preferred Generic Drugs – Insured will pay either \$45 copayment			
Brand Preferred Drugs – Insured pays 50% of drug cost	Brand Drugs – Insured pays 50% of drug cost			
Brand Preferred Drugs – Insured pays 75% of drug cost	Brand Drugs – Insured pays 75% of drug cost			

17. OUTPATIENT ACCIDENT EXPENSE BENEFIT RIDER (form CH-26221-IR (03/09)): *Deductible is waived and 100% Coinsurance.*

OUTPATIENT ACCIDENT EXPENSE BENEFIT RIDER	OPTION A		OPTION B		OPTION C	
	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK
Copayment, per Insured Person, per Injury	\$50		\$100		\$150	
Maximum Benefit Amount, per Insured Person, per Calendar Year	\$500		\$1,000		\$1,500	

THE CHESAPEAKE LIFE INSURANCE COMPANY

A Stock Company
(Herein after called: the Company, We, Our or Us)
Home Office: Oklahoma City, Oklahoma
Administrative Office: P.O. Box 982010
North Richland Hills, Texas 76182-8010
Customer Service: 1-800-733-1110

[CATASTROPHIC EXPENSE] PREFERRED PROVIDER ORGANIZATION (PPO) POLICY

OUTLINE OF COVERAGE FOR FORM CH-26210 PPO-IP (03/09) AR

- 1. READ YOUR POLICY CAREFULLY!** This Outline of Coverage provides a very brief description of some of the important features of Your Policy. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth, in detail, the rights and obligations of both You and Us. It is, therefore, important that You **READ YOUR POLICY CAREFULLY**.
- 2. [CATASTROPHIC EXPENSE] PREFERRED PROVIDER ORGANIZATION (PPO) COVERAGE** - The plan pays for the Covered Services listed below, as described in the Policy, which are performed, prescribed, directed, or authorized by a Provider.
- 3. NETWORK / NON-NETWORK PROVIDERS** - Insured Persons have the right to obtain medical care from the Physicians, Hospitals and other health care Providers of their choice. However, in order to receive maximum benefits, all Covered Services must be obtained from Network Providers. When You utilize a Non-Network Provider You are responsible for any balance due above the Usual and Customary amount.
- 4. COVERED SERVICES** – for the purpose of this Outline of Coverage, "Covered Services" means the Medically Necessary Usual and Customary Charges for services, supplies, care or treatment as described in the Policy which are performed, prescribed, directed or authorized by a Provider. To be a Covered Service, the service, supply or treatment must be: 1) Medically Necessary and/or specifically included as a Covered Service under the Policy; 2) within the scope of the license of the Provider performing the service; 3) rendered while coverage under the Policy is in force and for which the Insured Person is legally obligated to pay; and 4) not considered Experimental or Investigative or otherwise excluded or limited under the Policy. A charge for a Covered Service is incurred on the date the service, supply or treatment is furnished.

Unless otherwise stated, all Covered Services are subject to:

- The Facility Fees shown in the POLICY SCHEDULE, if any;
- The Calendar Year Deductible shown in the POLICY SCHEDULE;
- The Copayments shown in the POLICY SCHEDULE, if any;
- The Network Provider Coinsurance level or Non-Network Provider Coinsurance level shown in the POLICY SCHEDULE;
- The Maximum Benefit Amounts, visit limitations, if any, [Calendar Year] and Lifetime Maximum Amount shown in the POLICY SCHEDULE;
- The EXCLUSIONS AND LIMITATIONS; and
- All other provisions of this Policy.

LIFETIME MAXIMUM AMOUNT and CALENDAR YEAR MAXIMUM AMOUNT (per Insured Person):

SELECT <input type="checkbox"/>	<u>OPTION</u> <u>A</u>	SELECT <input type="checkbox"/>	<u>OPTION</u> <u>B</u>	SELECT <input type="checkbox"/>	<u>OPTION</u> <u>C</u>
Lifetime Maximum Amount:	\$2,000,000	Lifetime Maximum Amount:	\$4,000,000	Lifetime Maximum Amount:	\$8,000,000
Calendar Year Maximum Amount:	\$1,000,000	Calendar Year Maximum Amount:	\$1,000,000	Calendar Year Maximum Amount:	\$2,000,000

COINSURANCE AMOUNTS:

SELECT <input type="checkbox"/> [OPTION A]	<u>PPO</u> 80%	<u>NON-PPO</u> 55%	SELECT <input type="checkbox"/> [OPTION B]	<u>PPO</u> 90%	<u>NON-PPO</u> 65%	SELECT <input type="checkbox"/> [OPTION C]	<u>PPO</u> 100%	<u>NON-PPO</u> 75%
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CALENDAR YEAR DEDUCTIBLE (per Individual / per Family):

SELECT <input type="checkbox"/> [OPTION D]	<u>PPO</u>	<u>NON-PPO</u>	SELECT <input type="checkbox"/> [OPTION B]	<u>PPO</u>	<u>NON-PPO</u>	SELECT <input type="checkbox"/> [OPTION C]	<u>PPO</u>	<u>NON-PPO</u>
Per			Per			Per		
Individual:	\$2,500	\$3,125	Individual:	\$5,000	\$6,250	Individual:	\$7,500	\$9,250
Per Family:	\$5,000	\$6,250	Per Family:	\$10,000	\$12,500	Per Family:	\$15,000	\$18,750

SELECT <input type="checkbox"/> [OPTION D]	<u>PPO</u>	<u>NON-PPO</u>	SELECT <input type="checkbox"/> [OPTION E]	<u>PPO</u>	<u>NON-PPO</u>	SELECT <input type="checkbox"/> [OPTION F]	<u>PPO</u>	<u>NON-PPO</u>
Per			Per			Per		
Individual:	\$10,000	\$12,500	Individual:	\$15,000	\$18,750	Individual:	\$20,000	\$25,000
Per Family:	\$20,000	\$25,000	Per Family:	\$30,000	\$37,500	Per Family:	\$40,000	\$50,000

COINSURANCE MAXIMUM (per Calendar Year):

SELECT <input type="checkbox"/> [OPTION A]	<u>PPO</u>	<u>NON-PPO</u>	SELECT <input type="checkbox"/> [OPTION B]	<u>PPO</u>	<u>NON-PPO</u>	SELECT <input type="checkbox"/> [OPTION C]	<u>PPO</u>	<u>NON-PPO</u>
Per			Per			Per		
Individual:	\$2,500	\$10,000	Individual:	\$5,000	\$10,000	Individual:	\$10,000	\$20,000
Per Family:	\$5,000	\$20,000	Per Family:	\$10,000	\$20,000	Per Family:	\$20,000	\$40,000

SELECT <input type="checkbox"/> [OPTION D]	<u>PPO</u>	<u>NON-PPO</u>
Per		
Individual:	\$0	\$20,000
Per Family:	\$0	\$20,000

The Individual Deductible amount will be deducted from expenses incurred by each Insured Person for Covered Services, each Calendar Year, subject to the Family Deductible. Once the Family Deductible is met, no other Deductibles are required for the rest of that [Calendar Year].

[Expenses incurred for Covered Services under any Riders will apply toward the Individual and Family Maximum Deductible, where applicable, unless specifically stated otherwise.]

Non-Covered Services, Facility Fees or Copayments, if any, do not apply toward the Deductible(s).

Common Accident Provision: Upon to Us that one or more Insured Persons in Your family has been injured in the same accident, We will only require that one Deductible amount be satisfied for Covered Services associated with that accident. Once one Deductible amount is satisfied under the Policy, the Deductible amount for all other Insured Persons will be waived for that common accident.

COVERED SERVICES –

A. Inpatient Hospital - Covered Services include services and supplies provided by a Hospital for semi-private accommodations and general nursing care furnished by the Hospital including Confinement in the Hospital's Intensive Care or Cardiac Care Unit; Physician visits and miscellaneous medical services and supplies necessary for the treatment of the Insured Person.

Covered Services will also include hemodialysis and the charges by a Hospital for processing and administration of blood or blood components, acute inpatient rehabilitation, x-ray, laboratory, diagnostic tests and services of a

radiologist, radiology group, and the services of a pathologist or pathology group for interpretation of diagnostic tests or studies, performed while the Insured Person is Hospital Confined.

Covered Services will also include coverage for general anesthesia and associated Hospital Charges in conjunction with Dental Care provided to an Insured Person if such person is: (a) a Covered Dependent child who is developmentally disabled; or (b) an individual for whom a successful result cannot be expected from Dental Care provided under local anesthesia because of a neurological or other medically compromising condition.

The fees charged for take home drugs, personal convenience items such as lotions, shampoos, etc., or items not intended primarily for use by the Insured Person while Hospital Confined are not Covered Services.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

- **Network Facility Fee:** [\$0]
- **Non-Network Facility Fee:** [\$500] per Insured Person, per [Hospital Confinement][Period of Treatment]

B. Transplant Procedures - Covered Services include Transplant Procedures incurred during a Transplant Benefit Period. Covered Services for Transplant Procedures include the following when part of a Transplant Treatment Plan: 1) inpatient and outpatient Hospital services; 2) services of a Physician for diagnosis, treatment and Surgery for a Transplant Procedure; 3) procurement of an organ or tissue, including services provided to a living donor of an organ or tissue for procurement of an organ or tissue, provided the donor and transplant recipient are both insured under the Policy. Covered Services are limited to the actual procurement expenses, and will not be more than any Maximum Benefit Amount under the Policy applicable to the recipient; 4) rental of durable medical equipment for use outside the Hospital. Covered Services are limited to the purchase price of the same equipment; 5) prescription drugs, including immunosuppressive drugs; 6) Oxygen; 7) Speech Therapy, Occupational Therapy, Physical Therapy and Chemotherapy; 8) services and supplies for and related to high dose chemotherapy and bone marrow tissue transplantation when provided as part of a Transplant Treatment Plan which includes bone marrow transplantation and high dose chemotherapy; 9) surgical dressings and supplies; and 10) Home Health Care.

When the Insured Person's Physician advises the Insured Person that a Transplant Procedure is being considered, the Insured Person or the Insured Person's Physician should notify Us or Our designee. Covered Expenses for a live donor shall be paid to the extent that benefits remain and are available under the Policy for the Insured Person receiving the transplant, and after all Covered Expenses for the Insured Person has been paid. Covered Services will not include animal organ or artificial organ transplants or personal hygiene and convenience items. Expenses incurred beyond the Transplant Benefit Period will not be considered Covered Services, unless covered elsewhere under the Policy. Medically Necessary transplants not specifically defined as a Transplant Procedure under the Policy, which are not determined to be Experimental or Investigative will be payable the same as any other Transplant Procedure under the Policy.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

- **Network Facility Fee:** [\$0]
- **Non-Network Facility Fee:** [\$500] per Insured Person, per Hospital Confinement
- **Network Maximum Benefit Amount:** [\$250,000] per Insured Person, per Transplant Procedure
- **Non-Network Maximum Benefit Amount:** [\$175,000] per Insured Person, per Transplant Procedure

PRE-ADMISSION TESTING - Covered Services include pre-admission tests done on an outpatient basis before an authorized Hospital stay or Outpatient Surgery. These tests must be: 1) made within 14 days prior to Hospital Confinement or within 14 days of an outpatient Surgery; 2) related to the condition for which the Insured person is being Confined; 3) not repeated in the Hospital or elsewhere; and 4) ordered by a Physician.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above

OUTPATIENT SURGERY FACILITY SERVICES - Covered Services include services furnished by and supplies received for use in an Outpatient Surgery Facility, including but not limited to: 1) Use of operating room and recovery room; 2) Administration of drugs and medicines during Surgery; 3) Dressings, casts, splints; 4) Diagnostic services including radiology, laboratory or pathology performed at the time of the Surgery; and 5) General anesthesia and associated Outpatient Surgery Facility Charges in conjunction with Dental Care provided to an Insured Person if such person is: (a) a Covered Dependent child who is developmentally disabled; or (b) an individual for whom a successful result cannot be expected from Dental Care provided under local anesthesia because of a neurological or other medically compromising condition.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

- **Network Facility Fee:** [\$0]
- **Non-Network Facility Fee:** [\$250] per Insured Person, per Surgery

MEDICAL EMERGENCIES

A. Hospital Emergency Room – Covered Services include treatment of a Medical Emergency in a Hospital emergency room. Non-Medical Emergencies are not covered.

- **Subject to chosen Network Coinsurance and Deductible amount shown above** (for both Network and Non-Network services).
- **Network Facility Fee:** \$100 \$250 \$500 \$750 \$1,000 per Insured Person, per visit (waived if Hospital Confined)
- **Non-Network Facility Fee:** \$100 \$250 \$500 \$750 \$1,000 per Insured Person, per visit (waived if Hospital Confined)

B. Urgent Care Center – Covered Services include treatment of a Medical Emergency in an Urgent Care facility. Non-Medical Emergencies are not covered.

- **Subject to chosen Network Coinsurance and Deductible amount shown above** (for both Network and Non-Network services).
- **Network Facility Fee:** \$100 \$250 per Insured Person, per visit
- **Non-Network Facility Fee:** \$100 \$250 per Insured Person, per visit

PHYSICIAN SERVICES

A. Second Surgical Opinion – Covered Services include services by a Physician for a second opinion. The Physician providing the second opinion cannot be financially associated with the referring Physician or perform or assist in the Surgery in order for services to be considered a Covered Service under the Policy. If the second opinion disagrees with the first, a third opinion will also be considered a Covered Service.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.
- **Limited to:** one per Surgery.

B. Inpatient / Outpatient Surgeon – Covered Services include expenses incurred while Hospital Confined or in an Outpatient Surgery Facility for services by the Physician performing Surgery. [When multiple surgical procedures are done at the same time, Covered Services will be considered for the first or highest cost procedure, and one-half of the Allowable Amount for each additional procedure. No benefit is payable for incidental surgical procedures such as appendectomy performed during gall bladder surgery.]

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

C. Inpatient / Outpatient Assistant Surgeon – Covered Services include services by the Physician assisting the Physician performing Surgery.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

D. Inpatient / Outpatient Anesthesiologist – Covered Services include services by the Physician providing anesthesia during Surgery.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

E. Physician Visits while Hospital Confined (other than Surgeon) – Covered Services include visits by a Physician, other than the surgeon, while Hospital Confined.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.
- **[Limited to: one visit per Physician, per day.]**

PREVENTIVE IMAGING SCREENING TESTS:

Human Papillomavirus and Cervical Cancer Screening - Covered Services include the following annual screenings, as approved by the United States Food and Drug Administration, for female Insured Persons 18 years of age or older: 1) A conventional Pap smear screening or a screening using liquid-based cytology methods; or 2) A conventional Pap smear screening in combination with a test for the detection of the Human Papillomavirus. The screening test required under this benefit must be performed in accordance with the guidelines adopted by: 1) The American College of Obstetricians and Gynecologists; or 2) Another similar national organization of medical professionals recognized by the Commissioner.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

Prostate Cancer Screening - Covered Services include the following services and supplies provided to an Insured Person for the detection of prostate cancer: 1) An annual physical examination for the detection of prostate cancer for each male Insured Person; and 2) An annual prostate-specific antigen (PSA) test used for the detection of prostate cancer for each male Insured Person who is: a) at least 50 years of age and asymptomatic; or b) at least 40 years of age with a family history of prostate cancer or another prostate cancer risk factor.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

Mammography Screening - Covered Services include an annual Low Dose Mammography screening for each female Insured Person age 35 or older.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

Colorectal Cancer Screening - Covered Services include colorectal cancer examinations and laboratory tests for Insured Persons who are 50 years of age or older; who are less than 50 years of age and at high risk for colorectal cancer according to American Cancer Society colorectal cancer screening guidelines as they existed on [January 1, 2005]; and experiencing bleeding from the rectum or blood in the stool or a change in bowel habits, such as diarrhea, constipation, or narrowing of the stool that lasts more than 5 days as determined by a licensed Physician. For the purpose of this benefit "high risk for colorectal cancer" means: Individuals over 50 years of age or who face a high risk for colorectal cancer because of the presence of polyps on a previous colonoscopy, barium enema, or flexible sigmoidoscopy; family history of colorectal cancer in close relatives of parents, brothers, sisters, or children; genetic alterations of hereditary nonpolyposis colon cancer or familial adenomatous polyposis; personal history of colorectal cancer, ulcerative colitis, or Crohn's disease; or the presence of any appropriate recognized gene markers for colorectal cancer or other predisposing factors; and any definition recognized by medical science and determined by the Director of the Department of Health in consultation with the University of Arkansas for Medical Sciences.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

SCREENING TEST FOR HEARING IMPAIRMENT - Covered Services include a screening test of hearing loss for a Covered Dependent child from birth through the date the child is 30 days old. Covered Services also include the necessary diagnostic follow-up care related to the screening test from birth through the date the child is 24 months old.

- Subject to chosen Network / Non-Network Coinsurance amount shown above.
- **Deductibles do not apply.**

IMPAIRMENT OR LOSS OF SPEECH OR HEARING - Covered Services include the necessary care and treatment of loss or impairment of speech or hearing which includes the communicative disorders generally treated by speech pathologist or audiologist licensed by the Board of Examiners in Speech-Language Pathology and Audiology and which fall within the scope of his/her area of certification. Coverage does not apply to hearing instruments or devices.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

MINIMUM STAY REQUIREMENTS FOR MASTECTOMY AND LYMPH NODE DISSECTION - Covered Services include inpatient care if an Insured Person undergoes a covered mastectomy, for a minimum of the following: 1) 48 hours following a covered mastectomy; or 2) 24 hours following a covered lymph node dissection for the treatment of breast cancer. A shorter period of Confinement will be covered if the Insured Person and her Physician determine that a shorter period of inpatient Hospital Confinement is appropriate.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

CHEMOTHERAPY AND RADIATION THERAPY - Covered Services include chemotherapy and radiation therapy received while Hospital Confined or on an outpatient basis. The condition for which chemotherapy is provided must be first diagnosed and the treatment must be received while coverage is in force.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amount shown above.

DURABLE MEDICAL EQUIPMENT AND PROSTHETIC DEVICES - Covered Services include the rental of durable medical equipment not to exceed the actual purchase price of such equipment, and the purchase, fitting, repair and replacement of fitted prosthetic devices which replace a natural limb or eye, when ordered or prescribed by a Physician for use by the Insured Person. The durable medical equipment or prosthetic device must be for use solely by the Insured Person for the treatment of a Sickness or Injury which occurred while such Insured Person's coverage is in force. Routine maintenance and repairs of rental equipment are not considered Covered Services.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amount shown above.

- **Network/Non-Network Maximum Benefit Amount** [\$2,000] per Insured Person, per [Calendar Year]

AMBULANCE SERVICES - Covered Services include Ambulance transportation to the nearest Hospital that can provide Covered Services appropriate for the Insured person's condition. Ambulance services are only considered Covered Services if the Insured Person is Confined to the Hospital. Air or water Ambulance services are only considered a Covered Service in situations in which the Insured person is in a location that cannot be reached by ground Ambulance. Ambulance usage for the convenience of the Insured Person is not a Covered Service. Non-Covered Services for Ambulance include but are not limited to trips to a Physician's Office or clinic; or a morgue or funeral home.

- Subject to chosen Network Coinsurance amount shown above (for both Network and Non-Network services).

- **Deductibles do not apply.**
- **Ground Ambulance Maximum Benefit Amount:** [\$500] per Insured Person, per trip.
- **Air / Water Ambulance Maximum Benefit Amount:** [\$5,000] per Insured Person, per trip.
- **Benefit only payable when Hospital Confined.**

MATERNITY STAY REQUIREMENTS FOR COVERED MATERNITY CARE - This provision applies to an Insured Person's coverage only when the Insured Person incurs Covered Services for a normal childbirth or cesarean section delivery that is covered for Complications of Pregnancy as defined in the Policy. A minimum of 48 hours of inpatient care will be provided to the mother and newborn child following a vaginal delivery and 96 hours following a cesarean section.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

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

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

CHILD HEALTH SUPERVISION SERVICES - Covered Services include for each Covered Dependent from the moment of birth to age eighteen (18) years. In keeping with prevailing medical standards, such services shall include: 1) anticipatory guidance; 2) developmental assessment; 3) laboratory tests; 4) appropriate immunizations; 5) a medical history; and 6) physical examination. Benefits will be payable for 20 visits provided by or under the supervision of a single Physician during the course of one visit, at approximately the following intervals: birth; two weeks; two, four, six, nine, twelve, fifteen and eighteen months and two, three, four, five, six, eight, ten, twelve, fourteen, sixteen and eighteen years. Benefits payable will not exceed current reimbursement levels for the same services under the Medicaid Early Periodic Screening Diagnosis and Treatment program in the State of Arkansas. Benefits for recommended immunization services shall be exempt from any Coinsurance, Deductible or dollar limit provisions.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

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

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

DIABETES - Covered Services include diabetes self-management training, supplies and related services for the treatment of Type I, Type II and gestational diabetes when determined Medically Necessary by Your Physician or other licensed health care provider. Diabetes Self-Management Training means instructions in an inpatient or outpatient setting including medical nutrition therapy relating to diet, caloric intake and diabetes management, excluding any programs in which the only purpose is weight reduction, which enables diabetic patients to understand the diabetic management process and daily management of diabetic therapy as a method of avoiding frequent hospitalizations and complications when the instruction is provided in accordance with a program in compliance with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

OUTPATIENT CONTRACEPTIVE SERVICES AND DEVICES - Covered Services include Outpatient Contraceptive Services and Devices including closed formularies; however, formularies must include implant and injectable contraceptive drugs, and intrauterine devices. Covered Services do not include charges for abortion, an abortifacient or any U.S. Food and Drug Administration approved emergency contraception. Outpatient Contraceptive benefits are subject to the same Deductibles and Coinsurances as prescription drugs.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

5. RIDER BENEFITS – the following is a very brief description of some of the important features of Riders that may be attached to Your Policy. This is not the insurance contract and only the actual Rider provisions will control. The Riders themselves set forth, in detail, the rights and obligations of both You and Us. It is, therefore, important that You **READ YOUR RIDERS CAREFULLY**.

Riders are made a part of the Policy to which they are attached. Riders are subject to all provisions, terms and DEFINITIONS of the Policy which are not inconsistent with the provisions of the Riders. Benefits paid under the Riders will not duplicate the benefits provided under the Policy or any other rider, and are subject to the benefit schedule shown below.

PHYSICIAN OFFICE SERVICES BENEFIT RIDER (FORM: CH-26223-IR (03/09))

SELECT [OPTION A]

A. Outpatient Physician Office Visits for Sickness or Injury:

- Subject to chosen Network / Non-Network Deductible and Coinsurance amount shown above.

B. Outpatient Preventive Care Physician Visits: (other than Well Child Visits):

- Subject to chosen Network / Non-Network Deductible and Coinsurance amount shown above.
- Limited to one visit per Insured Person, per [Calendar Year].

C. Well Child Visits (for Covered Dependent children from birth up to 24 months of age)

- Subject to chosen Network / Non-Network Deductible and Coinsurance amount shown above.

PHYSICIAN OFFICE SERVICES BENEFIT RIDER (FORM: CH-26223-IR (03/09))

SELECT [OPTION B]

- [Deductibles do not apply]

A. Outpatient Physician Office Visits for Sickness or Injury:

- **Coinurance amount:** [100%] (for both Network and Non-Network services).
- **Visit Limitations:** [2] [4] visits per Insured Person, per [Calendar Year].
- **Physician Home and Office:**
- **Network Copayment:** [\$50] per Insured Person, per visit.
- **Non-Network Copayment:** [\$100] per Insured Person, per visit.

- **Convenient Care Clinic:**

5. RIDER BENEFITS (Continued)

Network Copayment: [\$25] per Insured Person, per visit.
Non-Network Copayment: [\$50] per Insured Person, per visit.

B. Outpatient Preventive Care Physician Visits: (other than Well Child Visits):

6. **Coinsurance amount:**[100%] (for both Network and Non-Network services).
7. Limited to one visit per Insured Person, per [Calendar Year].

8. **Physician Home and Office:**

Network Copayment: [\$50] per Insured Person, per visit.
Non-Network Copayment: [\$100] per Insured Person, per visit.

9. **Convenient Care Clinic:**

Network Copayment: [\$25] per Insured Person, per visit.
Non-Network Copayment: [\$50] per Insured Person, per visit.

C. Well Child Visits (for Covered Dependent children from birth up to 24 months of age)

10. **Coinsurance amount:**[100%] (for both Network and Non-Network services).

11. **Physician Home and Office:**

Network Copayment: [\$50] per Insured Person, per visit.
Non-Network Copayment: [\$100] per Insured Person, per visit.

12. **Convenient Care Clinic:**

Network Copayment: [\$25] per Insured Person, per visit.
Non-Network Copayment: [\$50] per Insured Person, per visit.

PHYSICIAN OFFICE SERVICES BENEFIT RIDER (FORM: CH-26223-IR (03/09))

SELECT [OPTION C]

- [Deductibles do not apply]

A. Outpatient Physician Office Visits for Sickness or Injury:

13. **Coinsurance amount:** [100%] (for both Network and Non-Network services).

14. **Physician Home and Office:**

Network Copayment: [\$50] per Insured Person, per visit.
Non-Network Copayment: [\$100] per Insured Person, per visit.

15. **Convenient Care Clinic:**

Network Copayment: [\$25] per Insured Person, per visit.
Non-Network Copayment: [\$50] per Insured Person, per visit.

B. Outpatient Preventive Care Physician Visits: (other than Well Child Visits):

16. **Coinsurance amount:**[100%] (for both Network and Non-Network services).
17. Limited to one visit per Insured Person, per [Calendar Year].

18. **Physician Home and Office:**

Network Copayment: [\$50] per Insured Person, per visit.
Non-Network Copayment: [\$100] per Insured Person, per visit.

19. **Convenient Care Clinic:**

Network Copayment: [\$25] per Insured Person, per visit.
Non-Network Copayment: [\$50] per Insured Person, per visit.

C. Well Child Visits (for Covered Dependent children from birth up to 24 months of age)

20. **Coinsurance amount:**[100%] (for both Network and Non-Network services).

21. **Physician Home and Office:**

Network Copayment: [\$50] per Insured Person, per visit.
Non-Network Copayment: [\$100] per Insured Person, per visit.

22. **Convenient Care Clinic:**

Network Copayment: [\$25] per Insured Person, per visit.
Non-Network Copayment: [\$50] per Insured Person, per visit.

23. _

5. RIDER BENEFITS (Continued)

OUTPATIENT DIAGNOSTIC SERVICES BENEFIT RIDER (FORM: CH-26226-IR (03/09))

24. Subject to chosen Network / Non-Network Deductible and Coinsurance amount shown above.

25. CAT, MRI and/or PET Scans:

[Network/Non-Network Facility Fee: \$75] \$150] \$250] per Insured Person, per visit.]

26. All other outpatient diagnostic services:

[Network/Non-Network Facility Fee: \$50] \$200] per Insured Person, per visit.]

CONTINUED CARE BENEFIT RIDER (FORM: CH-26225-IR (03/09) AR)

27. Subject to chosen Network / Non-Network Deductible and Coinsurance amount shown above.

28. **Skilled Nursing Facility -**

Day Limitations: [30][45][60] days, per Insured Person, per Calendar Year

• **Home Health Care -**

Visit Limitations: [30][45][60] visits, per Insured Person, per Calendar Year

• **Hospice Care -**

Maximum Benefit Amount: [\$5,000] per Insured Person, per lifetime

OUTPATIENT SPEECH THERAPY, PHYSICAL THERAPY AND OCCUPATIONAL THERAPY SERVICES RIDER (FORM: CH-26224-IR (03/09))

• Subject to chosen Network / Non-Network Deductible and Coinsurance amount shown above.

• [Network/Non-Network Facility Fee: [\$50] per Insured Person, per visit.]

• **Visit Limitations:** [40] combined visits for all therapies, per Insured Person, per Calendar Year

PRESCRIPTION DRUG RIDER (FORM: CH-26214-IR (03/09)AR)

SELECT [OPTION A]

DEDUCTIBLE [(for Brand drugs only)] \$50][\$250]
(per Insured Person, per Calendar Year)

PHARMACY BENEFITS

Generic Drugs (not to exceed a 30 day supply)

Generic preferred drugs We pay [100%] less the [\$5] Copayment

Generic non-preferred drugs We pay [100%] less the [\$15] Copayment

Brand Name Drugs (not to exceed a 30 day supply)

Brand preferred drugs We pay [50%], You pay the remainder

Brand non-preferred drugs We pay [25%] [50%], You pay the remainder

MAIL SERVICE LEGEND PRESCRIPTION DRUGS

Generic Drugs (not to exceed a 90 day supply)

Generic preferred drugs We pay [100%] less the [\$15] Copayment

Generic non-preferred drugs We pay [100%] less the [\$45] Copayment

Brand Name Drugs (not to exceed a 90 day supply)

Brand preferred drugs We pay [50%], You pay the remainder

Brand non-preferred drugs We pay [25%], You pay the remainder

BENEFIT MAXIMUM

Per Insured Person, per Calendar Year: [\$1,500][\$2,000][\$5,000]

PRESCRIPTION DRUG RIDER (FORM: CH-26214-IR (03/09)AR)

SELECT [OPTION B]

- Subject to chosen Network Deductible and Coinsurance amount shown above.
- **Pharmacy Benefits -**
 - Generic/Brand Named Drugs:** Limited to a 30 day supply
- **Mail Service Legend Prescription Drugs -**
 - Generic/Brand Named Drugs:** Limited to a 90 day supply
- **Maximum Benefit Amount:** [\$1,500] [\$2,000] [\$5,000] per Insured Person, Per Calendar Year

6. EXCLUSIONS AND LIMITATIONS – We will not provide any benefits for charges arising directly or indirectly, in whole or in part, from:

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

23. Payment for care for military service connected disabilities for which the Insured Person is legally entitled to services and for which facilities are reasonably available to the Insured Person and payment for care for conditions that state or local law requires be treated in a public facility;
24. Experimental or Investigative medical, surgical or other health care procedures, treatments, products or services, unless otherwise stated herein;
25. Personal comfort items, such as television, telephone, lotions, shampoos, etc.;
26. Cosmetic Surgery, or complications arising there from, unless otherwise stated herein;
27. Dental Care, treatment or Surgery unless necessitated by Injury to sound natural teeth which occurs while insured under this Policy. (The expense must be incurred within one year from the date of Injury);
28. Corrective vision or hearing supplies or for the examination for prescribing or fitting such supplies;
29. The removal of warts, corns, calluses, the cutting and trimming of toenails, care for flat feet, fallen arches or chronic foot strain;
30. Expenses incurred for prescription drugs, except if added by Rider;
31. Normal pregnancy, except for Complications of Pregnancy[, except if added by Rider];
32. Any expenses related to a surrogate pregnancy; and
33. Treatment, services or supplies received outside the U.S. or Canada. However, treatment, services or supplies received as a result of an acute Sickness or Injury sustained during the first 30 days of travel outside of the U.S. or Canada will be considered a Covered Service. In no event will treatment, services or supplies received beyond the first 30 days of travel outside of the U.S. or Canada be considered a Covered Service.

Sickness Exclusion

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

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

Pre-Existing Condition

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

Coverage After Age 65 or Earlier Medicare Eligibility

When an Insured Person becomes covered under Medicare, the Covered Services of the Policy and its attachments, if any, are considered only to the extent that they are not paid by Medicare and they would otherwise be payable under the Policy. Covered Services will also be subject to any other EXCLUSIONS AND LIMITATIONS set forth in the Policy.

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

8. TERMINATION OF COVERAGE –

You

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

1. At the end of the period for which premium has been paid (subject to the Grace Period);
2. If Your mode of premium is monthly, at the end of the period through which premium has been paid following Our receipt of Your request of termination;
3. If Your mode of premium is other than monthly, upon the next monthly anniversary day following Our receipt of Your request of termination. Premium will be refunded for any amounts paid beyond the termination date;
4. On the date We elect to discontinue this plan or type of coverage. We will give You at least 90 days written notice before the date coverage will be discontinued. You will be offered an option to purchase any other coverage that We offer without regard to health status;

5. On the date We elect to discontinue all health benefit plans in Your state. We will give You and the proper state authority at least 180 days written notice before the date coverage will be discontinued; or
6. On the date an Insured Person:
 - a. Performs an act or practice that constitutes fraud; or
 - b. Has made an intentional misrepresentation of material fact, relating in any way to the coverage provided under the Policy, including claims for Benefits under the Policy.

Covered Dependents

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

1. The date Your coverage terminates;
2. The date such dependent ceases to be an Eligible Dependent;
3. The date We receive Your written request to terminate a dependent's coverage; or
4. On the date the Covered Dependent:
 - a. Performs an act or practice that constitutes fraud; or
 - b. Has made an intentional misrepresentation of material fact, relating in any way to the coverage provided under the Policy, including claims for Benefits under the Policy.

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

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

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

Special Continuation Provision for Dependents

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

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

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

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

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

Premiums - based on the mode of payment, checked below, the initial premiums are as follows:

Monthly (Bank Draft) Quarterly Annually

Policy CH-26210 PPO-IP (03/09) AR - described above (includes automatic Policy Rider(s), if any):	\$ _____
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<u>RIDERS (if any)</u>	\$ _____
	\$ _____

TOTAL	\$ _____
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THE CHESAPEAKE LIFE INSURANCE COMPANY

A Stock Company
(Herein after called: the Company, We, Our or Us)
Home Office: Oklahoma City, Oklahoma
Administrative Office: P.O. Box 982010
North Richland Hills, Texas 76182-8010
Customer Service: 1-800-733-1110

[CATASTROPHIC EXPENSE] PREFERRED PROVIDER ORGANIZATION (PPO) POLICY

OUTLINE OF COVERAGE FOR FORM CH-26210 PPO-IP (03/09) AR

- 1. **READ YOUR POLICY CAREFULLY!** This Outline of Coverage provides a very brief description of some of the important features of Your Policy. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth, in detail, the rights and obligations of both You and Us. It is, therefore, important that You **READ YOUR POLICY CAREFULLY.**
- 2. **[CATASTROPHIC EXPENSE] PREFERRED PROVIDER ORGANIZATION (PPO) COVERAGE** - The plan pays for the Covered Services listed below, as described in the Policy, which are performed, prescribed, directed, or authorized by a Provider.
- 3. **NETWORK / NON-NETWORK PROVIDERS** - Insured Persons have the right to obtain medical care from the Physicians, Hospitals and other health care Providers of their choice. However, in order to receive maximum benefits, all Covered Services must be obtained from Network Providers. When You utilize a Non-Network Provider You are responsible for any balance due above the Usual and Customary amount.
- 4. **COVERED SERVICES** – for the purpose of this Outline of Coverage, "Covered Services" means the Medically Necessary Usual and Customary Charges for services, supplies, care or treatment as described in the Policy which are performed, prescribed, directed or authorized by a Provider. To be a Covered Service, the service, supply or treatment must be: 1) Medically Necessary and/or specifically included as a Covered Service under the Policy; 2) within the scope of the license of the Provider performing the service; 3) rendered while coverage under the Policy is in force and for which the Insured Person is legally obligated to pay; and 4) not considered Experimental or Investigative or otherwise excluded or limited under the Policy. A charge for a Covered Service is incurred on the date the service, supply or treatment is furnished.

Unless otherwise stated, all Covered Services are subject to:

- The Facility Fees shown in the POLICY SCHEDULE, if any;
- The [Deductible per [Period of Treatment] or the Deductible for all other Outpatient Covered Services] shown in the POLICY SCHEDULE;
- The Copayments shown in the POLICY SCHEDULE, if any;
- The Network Provider Coinsurance level or Non-Network Provider Coinsurance level Coinsurance level shown in the POLICY SCHEDULE;
- The Maximum Benefit Amounts, visit limitations, if any, [Aggregate Maximum Amount] and Lifetime Maximum Amount shown in the POLICY SCHEDULE;
- The EXCLUSIONS AND LIMITATIONS; and
- All other provisions of this Policy.

LIFETIME MAXIMUM AMOUNT (per Insured Person): \$2,000,000] \$4,000,000] \$8,000,000]

AGGREGATE MAXIMUM AMOUNT (per Insured Person): \$1,000,000] \$1,000,000] \$2,000,000]

COINSURANCE MAXIMUM (per Insured Person, per Period of Treatment):

Network Provider / Non-Network Provider

- \$2,500 / \$5,000]
- \$5,000 / \$10,000]
- \$10,000 / \$20,000]
- \$15,000 / \$30,000]

COINSURANCE AMOUNTS:

Network Provider / Non-Network Provider

- 70% / 50%
- 80% / 60%
- 90% / 70%

DEDUCTIBLES (both apply):

Deductible per Insured Person, per [Period of Treatment]:

Deductible for all other Outpatient Covered Services, per Insured Person, per [Calendar Year]:

Network Provider / Non-Network Provider

Network Provider / Non-Network Provider

- | | |
|--|---------------------|
| <input type="checkbox"/> \$1,000 / \$1,250 | \$1,000 / \$1,250 |
| <input type="checkbox"/> \$ 1,500 / \$1,850 | \$ 1,500 / \$1,850 |
| <input type="checkbox"/> \$2,000 / \$2,500 | \$2,000 / \$2,500 |
| <input type="checkbox"/> \$2,500 / \$3,125 | \$2,500 / \$3,125 |
| <input type="checkbox"/> \$3,000 / \$3,750 | \$3,000 / \$3,750 |
| <input type="checkbox"/> \$3,500 / \$4,250 | \$3,500 / \$4,250 |
| <input type="checkbox"/> \$4,000 / \$5,000 | \$4,000 / \$5,000 |
| <input type="checkbox"/> \$4,500 / \$5,625 | \$4,500 / \$5,625 |
| <input type="checkbox"/> \$5,000 / \$6,250 | \$5,000 / \$6,250 |
| <input type="checkbox"/> \$5,500 / \$6,875 | \$5,500 / \$6,875 |
| <input type="checkbox"/> \$7,500 / \$9,250 | \$7,500 / \$9,250 |
| <input type="checkbox"/> \$10,000 / \$12,500 | \$10,000 / \$12,500 |

The Deductible amount per [Period of Treatment] will be deducted [each Period of Treatment] from Covered Services incurred by each Insured Person while Hospital Confined and for Outpatient Surgery. [A Period of Treatment begins on the date an Insured Person is admitted to a Hospital or the date services are rendered in an Outpatient Surgery Facility for the treatment of an Injury or Sickness and ends after 365 days. If the same or related Sickness or Injury continues beyond 365 days, a new Sickness or Injury Period of Treatment will begin, which includes a new Deductible. In no event will a single Period of Treatment exceed 365 days. A separate Period of Treatment will apply to each Injury or Sickness.]

[Expenses incurred for Covered Services under any Riders will apply toward the Deductible, where applicable, unless specifically stated otherwise.] Non-Covered Services, Facility Fees or Copayments, if any, do not apply toward the Deductible(s).

The Deductible for all other Outpatient Covered Services (except outpatient Surgery) will be deducted from each separate outpatient Covered Service incurred by each Insured Person per [Calendar Year], unless specifically stated otherwise in the Policy.

Once three Deductibles have been met in a [Calendar Year] by any or all Insured Persons under the Policy, no further Deductibles must be met for the remainder of that [Calendar Year] for any or all Insured Persons under the Policy.

Common Accident Provision: Upon to Us that one or more Insured Persons in Your family has been injured in the same accident, We will only require that one Deductible amount be satisfied for Covered Services associated with that accident. Once one Deductible amount is satisfied under the Policy, the Deductible amount for all other Insured Persons will be waived for that common accident.

COVERED SERVICES –

A. Inpatient Hospital - Covered Services include services and supplies provided by a Hospital for semi-private accommodations and general nursing care furnished by the Hospital including Confinement in the Hospital's Intensive Care or Cardiac Care Unit; Physician visits and miscellaneous medical services and supplies necessary for the treatment of the Insured Person.

Covered Services will also include hemodialysis and the charges by a Hospital for processing and administration of blood or blood components, acute inpatient rehabilitation, x-ray, laboratory, diagnostic tests and services of a radiologist, radiology group, and the services of a pathologist or pathology group for interpretation of diagnostic tests or studies, performed while the Insured Person is Hospital Confined.

Covered Services will also include coverage for general anesthesia and associated Hospital Charges in conjunction with Dental Care provided to an Insured Person if such person is: (a) a Covered Dependent child who is developmentally disabled; or (b) an individual for whom a successful result cannot be expected from Dental Care provided under local anesthesia because of a neurological or other medically compromising condition.

The fees charged for take home drugs, personal convenience items such as lotions, shampoos, etc., or items not intended primarily for use by the Insured Person while Hospital Confined are not Covered Services.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.
- **Network Facility Fee:** [\$0]
- **Non-Network Facility Fee:** [\$500] per Insured Person, per [Hospital Confinement][Period of Treatment]

B. Transplant Procedures - Covered Services include Transplant Procedures incurred during a Transplant Benefit Period. Covered Services for Transplant Procedures include the following when part of a Transplant Treatment Plan: 1) inpatient and outpatient Hospital services; 2) services of a Physician for diagnosis, treatment and Surgery for a Transplant Procedure; 3) procurement of an organ or tissue, including services provided to a living donor of an organ or tissue for procurement of an organ or tissue, provided the donor and transplant recipient are both insured under the Policy. Covered Services are limited to the actual procurement expenses, and will not be more than any Maximum Benefit Amount under the Policy applicable to the recipient; 4) rental of durable medical equipment for use outside the Hospital. Covered Services are limited to the purchase price of the same equipment; 5) prescription drugs, including immunosuppressive drugs; 6) Oxygen; 7) Speech Therapy, Occupational Therapy, Physical Therapy and Chemotherapy; 8) services and supplies for and related to high dose chemotherapy and bone marrow tissue transplantation when provided as part of a Transplant Treatment Plan which includes bone marrow transplantation and high dose chemotherapy; 9) surgical dressings and supplies; and 10) Home Health Care.

When the Insured Person's Physician advises the Insured Person that a Transplant Procedure is being considered, the Insured Person or the Insured Person's Physician should notify Us or Our designee. Covered Expenses for a live donor shall be paid to the extent that benefits remain and are available under the Policy for the Insured Person receiving the transplant, and after all Covered Expenses for the Insured Person has been paid. Covered Services will not include animal organ or artificial organ transplants or personal hygiene and convenience items. Expenses incurred beyond the Transplant Benefit Period will not be considered Covered Services, unless covered elsewhere under the Policy. Medically Necessary transplants not specifically defined as a Transplant Procedure under the Policy, which are not determined to be Experimental or Investigative will be payable the same as any other Transplant Procedure under the Policy.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.
- **Network Facility Fee:** [\$0]
- **Non-Network Facility Fee:** [\$500] per Insured Person, per Hospital Confinement
- **Network Maximum Benefit Amount:** [\$250,000] per Insured Person, per Transplant Procedure
- **Non-Network Maximum Benefit Amount:** [\$175,000] per Insured Person, per Transplant Procedure

PRE-ADMISSION TESTING - Covered Services include pre-admission tests done on an outpatient basis before an authorized Hospital stay or Outpatient Surgery. These tests must be: 1) made within 14 days prior to Hospital Confinement or within 14 days of an outpatient Surgery; 2) related to the condition for which the Insured person is being Confined; 3) not repeated in the Hospital or elsewhere; and 4) ordered by a Physician.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above

OUTPATIENT SURGERY FACILITY SERVICES - Covered Services include services furnished by and supplies received for use in an Outpatient Surgery Facility, including but not limited to: 1) Use of operating room and recovery room; 2) Administration of drugs and medicines during Surgery; 3) Dressings, casts, splints; 4) Diagnostic services including radiology, laboratory or pathology performed at the time of the Surgery; and 5) General anesthesia and associated Outpatient Surgery Facility Charges in conjunction with Dental Care provided to an Insured Person if such person is: (a) a Covered Dependent child who is developmentally disabled; or (b) an individual for whom a successful result cannot be expected from Dental Care provided under local anesthesia because of a neurological or other medically compromising condition.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

- **Network Facility Fee:** [\$0]

- **Non-Network Facility Fee:** [\$250] per Insured Person, per Surgery

MEDICAL EMERGENCIES

A. Hospital Emergency Room – Covered Services include treatment of a Medical Emergency in a Hospital emergency room. Non-Medical Emergencies are not covered.

- **Subject to chosen Network Coinsurance and Deductible amount shown above** (for both Network and Non-Network services).
- **Network Facility Fee:** \$100 \$250 \$500 \$750 \$1,000 per Insured Person, per visit (waived if Hospital Confined)
- **Non-Network Facility Fee:** \$100 \$250 \$500 \$750 \$1,000 per Insured Person, per visit (waived if Hospital Confined)

B. Urgent Care Center – Covered Services include treatment of a Medical Emergency in an Urgent Care facility. Non-Medical Emergencies are not covered.

- **Subject to chosen Network Coinsurance and Deductible amount shown above** (for both Network and Non-Network services).
- **Network Facility Fee:** \$100 \$250 per Insured Person, per visit
- **Non-Network Facility Fee:** \$100 \$250 per Insured Person, per visit

PHYSICIAN SERVICES

A. Second Surgical Opinion – Covered Services include services by a Physician for a second opinion. The Physician providing the second opinion cannot be financially associated with the referring Physician or perform or assist in the Surgery in order for services to be considered a Covered Service under the Policy. If the second opinion disagrees with the first, a third opinion will also be considered a Covered Service.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.
- **Limited to:** one per Surgery.

B. Inpatient / Outpatient Surgeon – Covered Services include expenses incurred while Hospital Confined or in an Outpatient Surgery Facility for services by the Physician performing Surgery. [When multiple surgical procedures are done at the same time, Covered Services will be considered for the first or highest cost procedure, and one-half of the Allowable Amount for each additional procedure. No benefit is payable for incidental surgical procedures such as appendectomy performed during gall bladder surgery.]

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

C. Inpatient / Outpatient Assistant Surgeon – Covered Services include services by the Physician assisting the Physician performing Surgery.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

D. Inpatient / Outpatient Anesthesiologist – Covered Services include services by the Physician providing anesthesia during Surgery.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

E. Physician Visits while Hospital Confined (other than Surgeon) – Covered Services include visits by a Physician, other than the surgeon, while Hospital Confined.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.
- [Limited to: one visit per Physician, per day.]

PREVENTIVE IMAGING SCREENING TESTS:

Human Papillomavirus and Cervical Cancer Screening - Covered Services include the following annual screenings, as approved by the United States Food and Drug Administration, for female Insured Persons 18 years of age or older: 1) A conventional Pap smear screening or a screening using liquid-based cytology methods; or 2) A conventional Pap smear screening in combination with a test for the detection of the Human Papillomavirus. The screening test required under this benefit must be performed in accordance with the guidelines adopted by: 1) The American College of Obstetricians and Gynecologists; or 2) Another similar national organization of medical professionals recognized by the Commissioner.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

Prostate Cancer Screening - Covered Services include the following services and supplies provided to an Insured Person for the detection of prostate cancer: 1) An annual physical examination for the detection of prostate cancer for each male Insured Person; and 2) An annual prostate-specific antigen (PSA) test used for the detection of prostate cancer for each male Insured Person who is: a) at least 50 years of age and asymptomatic; or b) at least 40 years of age with a family history of prostate cancer or another prostate cancer risk factor.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

Mammography Screening - Covered Services include an annual Low Dose Mammography screening for each female Insured Person age 35 or older.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

Colorectal Cancer Screening - Covered Services include colorectal cancer examinations and laboratory tests for Insured Persons who are 50 years of age or older; who are less than 50 years of age and at high risk for colorectal cancer according to American Cancer Society colorectal cancer screening guidelines as they existed on [January 1, 2005]; and experiencing bleeding from the rectum or blood in the stool or a change in bowel habits, such as diarrhea, constipation, or narrowing of the stool that lasts more than 5 days as determined by a licensed Physician. For the purpose of this benefit "high risk for colorectal cancer" means: Individuals over 50 years of age or who face a high risk for colorectal cancer because of the presence of polyps on a previous colonoscopy, barium enema, or flexible sigmoidoscopy; family history of colorectal cancer in close relatives of parents, brothers, sisters, or children; genetic alterations of hereditary nonpolyposis colon cancer or familial adenomatous polyposis; personal history of colorectal cancer, ulcerative colitis, or Crohn's disease; or the presence of any appropriate recognized gene markers for colorectal cancer or other predisposing factors; and any definition recognized by medical science and determined by the Director of the Department of Health in consultation with the University of Arkansas for Medical Sciences.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

SCREENING TEST FOR HEARING IMPAIRMENT - Covered Services include a screening test of hearing loss for a Covered Dependent child from birth through the date the child is 30 days old. Covered Services also include the necessary diagnostic follow-up care related to the screening test from birth through the date the child is 24 months old.

- Subject to chosen Network / Non-Network Coinsurance amount shown above.
- **Deductibles do not apply.**

IMPAIRMENT OR LOSS OF SPEECH OR HEARING - Covered Services include the necessary care and treatment of loss or impairment of speech or hearing which includes the communicative disorders generally treated by speech pathologist or audiologist licensed by the Board of Examiners in Speech-Language Pathology and Audiology and which fall within the scope of his/her area of certification. Coverage does not apply to hearing instruments or devices.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

MINIMUM STAY REQUIREMENTS FOR MASTECTOMY AND LYMPH NODE DISSECTION - Covered Services include inpatient care if an Insured Person undergoes a covered mastectomy, for a minimum of the following: 1) 48 hours following a covered mastectomy; or 2) 24 hours following a covered lymph node dissection for the treatment of breast cancer. A shorter period of Confinement will be covered if the Insured Person and her Physician determine that a shorter period of inpatient Hospital Confinement is appropriate.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

CHEMOTHERAPY AND RADIATION THERAPY - Covered Services include chemotherapy and radiation therapy received while Hospital Confined or on an outpatient basis. The condition for which chemotherapy is provided must be first diagnosed and the treatment must be received while coverage is in force.

- Subject to chosen Network / Non-Network Coinsurance amount shown above.
- **Deductibles do not apply.**
- **Network/Non-Network Maximum Benefit Amount** \$5,000 \$7,500 \$10,000 \$12,500 per Insured Person, per Calendar Month
- **Network/Non-Network Maximum Benefit Amount** \$50,000 \$100,000 \$150,000 per Insured Person, per lifetime.

DURABLE MEDICAL EQUIPMENT AND PROSTHETIC DEVICES - Covered Services include the rental of durable medical equipment not to exceed the actual purchase price of such equipment, and the purchase, fitting, repair and replacement of fitted prosthetic devices which replace a natural limb or eye, when ordered or prescribed by a Physician for use by the Insured Person. The durable medical equipment or prosthetic device must be for use solely by the Insured Person for the treatment of a Sickness or Injury which occurred while such Insured Person's coverage is in force. Routine maintenance and repairs of rental equipment are not considered Covered Services.

- Subject to chosen Network / Non-Network Coinsurance amount shown above.
- **Network/Non-Network Maximum Benefit Amount** \$2,500 per Insured Person, per [Sickness or Injury]

AMBULANCE SERVICES - Covered Services include Ambulance transportation to the nearest Hospital that can provide Covered Services appropriate for the Insured person's condition. Ambulance services are only considered Covered Services if the Insured Person is Confined to the Hospital. Air or water Ambulance services are only considered a Covered Service in situations in which the Insured person is in a location that cannot be reached by ground Ambulance. Ambulance usage for the convenience of the Insured Person is not a Covered Service. Non-Covered Services for Ambulance include but are not limited to trips to a Physician's Office or clinic; or a morgue or funeral home.

- Subject to chosen Network Coinsurance amount shown above (for both Network and Non-Network services).
- **Deductibles do not apply.**
- **Ground Ambulance Maximum Benefit Amount:** [\$500] per Insured Person, per trip.
- **Air / Water Ambulance Maximum Benefit Amount:** [\$5,000] per Insured Person, per trip.
- **Benefit only payable when Hospital Confined.**

MATERNITY STAY REQUIREMENTS FOR COVERED MATERNITY CARE - This provision applies to an Insured Person's coverage only when the Insured Person incurs Covered Services for a normal childbirth or cesarean section delivery that is covered for Complications of Pregnancy as defined in the Policy. A minimum of 48 hours of inpatient care will be provided to the mother and newborn child following a vaginal delivery and 96 hours following a cesarean section.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

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

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

CHILD HEALTH SUPERVISION SERVICES - Covered Services include for each Covered Dependent from the moment of birth to age eighteen (18) years. In keeping with prevailing medical standards, such services shall include: 1) anticipatory guidance; 2) developmental assessment; 3) laboratory tests; 4) appropriate immunizations; 5) a medical history; and 6) physical examination. Benefits will be payable for 20 visits provided by or under the supervision of a single Physician during the course of one visit, at approximately the following intervals: birth; two weeks; two, four, six, nine, twelve, fifteen and eighteen months and two, three, four, five, six, eight, ten, twelve, fourteen, sixteen and eighteen years. Benefits payable will not exceed current reimbursement levels for the same services under the Medicaid Early Periodic Screening Diagnosis and Treatment program in the State of Arkansas. Benefits for recommended immunization services shall be exempt from any Coinsurance, Deductible or dollar limit provisions.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

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

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

DIABETES - Covered Services include diabetes self-management training, supplies and related services for the treatment of Type I, Type II and gestational diabetes when determined Medically Necessary by Your Physician or other licensed health care provider. Diabetes Self-Management Training means instructions in an inpatient or outpatient setting including medical nutrition therapy relating to diet, caloric intake and diabetes management, excluding any programs in which the only purpose is weight reduction, which enables diabetic patients to understand the diabetic management process and daily management of diabetic therapy as a method of avoiding frequent hospitalizations and complications when the instruction is provided in accordance with a program in compliance with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

OUTPATIENT CONTRACEPTIVE SERVICES AND DEVICES - Covered Services include Outpatient Contraceptive Services and Devices including closed formularies; however, formularies must include implant and injectable contraceptive drugs, and intrauterine devices. Covered Services do not include charges for abortion, an abortifacient or any U.S. Food and Drug Administration approved emergency contraception. Outpatient Contraceptive benefits are subject to the same Deductibles and Coinsurances as prescription drugs.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

5. RIDER BENEFITS – the following is a very brief description of some of the important features of Riders that may be attached to Your Policy. This is not the insurance contract and only the actual Rider provisions will control. The Riders themselves set forth, in detail, the rights and obligations of both You and Us. It is, therefore, important that You **READ YOUR RIDERS CAREFULLY**.

Riders are made a part of the Policy to which they are attached. Riders are subject to all provisions, terms and DEFINITIONS of the Policy which are not inconsistent with the provisions of the Riders. Benefits paid under the Riders will not duplicate the benefits provided under the Policy or any other rider, and are subject to the benefit schedule shown below.

PHYSICIAN OFFICE SERVICES BENEFIT RIDER (FORM: CH-26223-IR (03/09)) [Deductibles do not apply]

A. Outpatient Physician Office Visits for Sickness or Injury:

- **Coinsurance amount:** [100%] (for both Network and Non-Network services).
- **Visit Limitations:** [2] [4] visits per Insured Person, per [Calendar Year].
- **Physician Home and Office:**
- **Network Copayment:** [\$50] per Insured Person, per visit.
- **Non-Network Copayment:** [\$100] per Insured Person, per visit.
- **Convenient Care Clinic:**
- **Network Copayment:** [\$25] per Insured Person, per visit.
- **Non-Network Copayment:** [\$50] per Insured Person, per visit.

B. Outpatient Preventive Care Physician Visits: (other than Well Child Visits):

- **Coinsurance amount:**[100%] (for both Network and Non-Network services).
- Limited to one visit per Insured Person, per [Calendar Year].
- **Physician Home and Office:**
- **Network Copayment:** [\$50] per Insured Person, per visit.
- **Non-Network Copayment:** [\$100] per Insured Person, per visit.
- **Convenient Care Clinic:**
- **Network Copayment:** [\$25] per Insured Person, per visit.
- **Non-Network Copayment:** [\$50] per Insured Person, per visit.

C. Well Child Visits (for Covered Dependent children from birth up to 24 months of age)

- **Coinsurance amount:**[100%] (for both Network and Non-Network services).
- **Physician Home and Office:**
- **Network Copayment:** [\$50] per Insured Person, per visit.
- **Non-Network Copayment:** [\$100] per Insured Person, per visit.
- **Convenient Care Clinic:**
- **Network Copayment:** [\$25] per Insured Person, per visit.
- **Non-Network Copayment:** [\$50] per Insured Person, per visit.

OUTPATIENT DIAGNOSTIC SERVICES BENEFIT RIDER (FORM: CH-26226-IR (03/09)) [Deductibles do not apply]

- **Coinsurance amount:** [100%] (for both Network and Non-Network services).
- **Network Copayment:** [\$100] [\$250] per Insured Person, per visit.
- **Non-Network Copayment:** [\$200] [\$500] per Insured Person, per visit.
- **Maximum Benefit Amounts:**
- Per Insured Person,*
- Per Day:* [\$1,500]
- Per Insured Person,*
- Per Calendar Year:* [\$2,500] [\$5,000] [\$7,500]

5. RIDER BENEFITS (Continued)

CONTINUED CARE BENEFIT RIDER (FORM: CH-26225-IR (03/09)) [Deductibles do not apply]

- **Coinsurance amount:** [100%] (for both Network and Non-Network services).
- **Skilled Nursing Facility -**
 - Visit Limitation:** [30][45][60] visits, per Insured Person, per Calendar Year
 - Maximum Benefit Amount:** [\$200] per Insured Person, per day
- **Home Health Care -**
 - Visit Limitation:** [30][45][60] combined visits, per Insured Person, per [Calendar Year]
 - Maximum Benefit Amount:**
 - For home infusion therapy and wound care:* [\$100] per Insured Person, per visit
 - For all other Home Health Care services:* [\$100][\$250][\$500][\$1,000] per Insured Person, per visit
- **Hospice Care -**
 - Maximum Benefit Amount:** [\$5,000] per Insured Person, per lifetime

OUTPATIENT SPEECH THERAPY, PHYSICAL THERAPY AND OCCUPATIONAL THERAPY SERVICES RIDER (FORM: CH-26224-IR (03/09)) [Deductibles do not apply]

- **Coinsurance amount:** [100%] (for both Network and Non-Network services).
- **Network/Non-Network Copayment:** [\$50] per Insured Person, per visit.
- **Visit Limitation:** [40] combined visits for all therapies, per Insured Person, per Calendar Year

OUTPATIENT ACCIDENT EXPENSE BENEFIT RIDER - (FORM: CH-26221-IR (03/09)) (initial treatment must begin within [72] hours of the Injury and any treatment of the Injury beyond the initial treatment must be received within [45 days] of the Injury)

- **Coinsurance amount:** [100%] (for both Network and Non-Network services).
- **Network/Non-Network Copayment:** [\$50] [\$100] [\$150] per Insured Person, per Injury.
- **Maximum Benefit Amount:** [\$500] [\$1,000] [\$1,500] per Insured Person, per [Calendar Year]

5. RIDER BENEFITS (Continued)

**PRESCRIPTION DRUG RIDER (FORM: CH-26214-IR (03/09) AR) -
SELECT [OPTION A]**

DEDUCTIBLE [(for Brand Dugs only)] \$50][\$250]
(per Insured Person, per Calendar Year)

PHARMACY BENEFITS

Generic Drugs (not to exceed a 30 day supply)

Generic preferred drugs We pay [100%] less the [\$5] Copayment
Generic non-preferred drugs We pay [100%] less the [\$15] Copayment

Brand Name Drugs (not to exceed a 30 day supply)

Brand preferred drugs We pay [50%], You pay the remainder
Brand non-preferred drugs We pay [25%][50%], You pay the remainder

MAIL SERVICE LEGEND PRESCRIPTION DRUGS

Generic Drugs (not to exceed a 90 day supply)

Generic preferred drugs We pay [100%] less the [\$15] Copayment
Generic non-preferred drugs We pay [100%] less the [\$45] Copayment

Brand Name Drugs (not to exceed a 90 day supply)

Brand preferred drugs We pay [50%], You pay the remainder
Brand non-preferred drugs We pay [25%], You pay the remainder

BENEFIT MAXIMUM

Per Insured Person, per Calendar Year: \$1,500][\$2,000][\$5,000]

**PRESCRIPTION DRUG RIDER (FORM: CH-26214-IR (03/09) AR)
SELECT [OPTION B]**

- Subject to chosen Network Deductible and Coinsurance amount shown above.
- **Pharmacy Benefits -
Generic/Brand Named Drugs:** Limited to a 30 day supply
- **Mail Service Legend Prescription Drugs -
Generic/Brand Named Drugs:** Limited to a 90 day supply
- **Maximum Benefit Amount:** \$1,500] \$2,000][\$5,000] per Insured Person, Per Calendar Year

PREGNANCY/CHILDBIRTH BENEFIT RIDER- (form CH-26213-IR (03/09) AR). [(Deductibles do not apply)]

- 0-24 Months in Force Maximum Benefit: \$1,000][\$1,500][\$2,000][\$3,000]
- 25 Months in Force and over Maximum Benefit: \$2,000][\$3,000][\$4,000][\$6,000]

6. EXCLUSIONS AND LIMITATIONS – We will not provide any benefits for charges arising directly or indirectly, in whole or in part, from:

1. Any care not Medically Necessary or services for which benefits are not specifically provided for in this Policy, including charges related to secondary medical conditions resulting directly or indirectly from conditions, treatment or services that are not considered a Covered Service and/or that are specifically excluded under this Policy;
2. Any charges exceeding the Maximum Benefit Amount or Lifetime Maximum Amount;
3. Any act of war, declared or undeclared;
4. Suicide, attempted suicide, or any intentionally self-inflicted injury, while sane or insane;
5. Care, treatment, services or supplies received in a Hospital emergency room or Urgent Care Center for treatment of a Sickness or Injury that is not considered a Medical Emergency;
6. Any Injury or Sickness arising out of, or in the course of, employment for wage or profit, provided the Insured Person is covered under any Workers' Compensation Act, Occupational Disease Act, or similar act or law;
7. Mental or Nervous Disorders, unless otherwise stated herein;

8. Drug abuse or addiction including alcoholism, or overdose of drugs, narcotics, or hallucinogens, directly or indirectly, wholly or partially, unless taken as prescribed by a Physician;
9. An overdose of drugs, being intoxicated or under the influence of intoxicants, hallucinogens, narcotics or other drugs or controlled substances, directly or indirectly, wholly or partially, unless taken as prescribed by a Physician;
10. Any treatment including prescription drugs or non-prescription drugs, or procedure that promotes conception or prevents childbirth, including but not limited to: (a) artificial insemination; (b) in-vitro fertilization or other treatment for infertility; (c) treatment for impotency; (d) sterilization or reversal of sterilization; or (e) abortion (unless the life of the mother would be endangered if the fetus were carried to term), unless otherwise stated herein;
11. Laser vision correction, radial keratotomy or any eye Surgery when the primary purpose is to correct nearsightedness, farsightedness, astigmatism, or any other refractive error;
12. Spinal manipulations and manual manipulative treatment or therapy;
13. Mandibular or maxillofacial Surgery to correct growth defects after one year from the date of birth, jaw disproportions or malocclusions, or to increase vertical dimension or reconstruct occlusion, unless otherwise stated herein;
14. Weight loss or modification, or complications arising there from, or procedures resulting therefrom or for surgical treatment of obesity including but not limited to gastric by-pass, wiring of the teeth and all forms of Surgery performed for the purpose of weight loss or modification or the reversal/modification of such procedure;
15. Breast reduction or augmentation, or complications arising there from, unless necessary in connection with breast reconstructive Surgery following a mastectomy;
16. Modification of the physical body in order to improve the psychological, mental or emotional well-being of the Insured Person, such as but not limited to sex-change Surgery;
17. Marriage, family, or child counseling for the treatment of premarital, marriage, family or child relationship dysfunctions;
18. Directly or indirectly engaging in an illegal occupation or illegal activity;
19. Care in a nursing home, custodial institution or domiciliary care or rest cures;
20. Preparation and presentation of medical reports for appearance at trials or hearings;
21. Physical examinations required for school events, sports, camp, employment, licensing and insurance, unless otherwise stated herein;
22. Immunizations required for the sole purpose of travel outside of the U.S.A.;
23. Payment for care for military service connected disabilities for which the Insured Person is legally entitled to services and for which facilities are reasonably available to the Insured Person and payment for care for conditions that state or local law requires be treated in a public facility;
24. Experimental or Investigative medical, surgical or other health care procedures, treatments, products or services, unless otherwise stated herein;
25. Personal comfort items, such as television, telephone, lotions, shampoos, etc.;
26. Cosmetic Surgery, or complications arising there from, unless otherwise stated herein;
27. Dental Care, treatment or Surgery unless necessitated by Injury to sound natural teeth which occurs while insured under this Policy. (The expense must be incurred within one year from the date of Injury);
28. Corrective vision or hearing supplies or for the examination for prescribing or fitting such supplies;
29. The removal of warts, corns, calluses, the cutting and trimming of toenails, care for flat feet, fallen arches or chronic foot strain;
30. Expenses incurred for prescription drugs, except if added by Rider;
31. Normal pregnancy, except for Complications of Pregnancy[, except if added by Rider];
32. Any expenses related to a surrogate pregnancy; and
33. Treatment, services or supplies received outside the U.S. or Canada. However, treatment, services or supplies received as a result of an acute Sickness or Injury sustained during the first 30 days of travel outside of the U.S. or Canada will be considered a Covered Service. In no event will treatment, services or supplies received beyond the first 30 days of travel outside of the U.S. or Canada be considered a Covered Service.

Sickness Exclusion

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

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

Pre-Existing Condition

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

Coverage After Age 65 or Earlier Medicare Eligibility

When an Insured Person becomes covered under Medicare, the Covered Services of the Policy and its attachments, if any, are considered only to the extent that they are not paid by Medicare and they would otherwise be payable under the Policy. Covered Services will also be subject to any other EXCLUSIONS AND LIMITATIONS set forth in the Policy.

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

8. TERMINATION OF COVERAGE –

You

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

1. At the end of the period for which premium has been paid (subject to the Grace Period);
2. If Your mode of premium is monthly, at the end of the period through which premium has been paid following Our receipt of Your request of termination;
3. If Your mode of premium is other than monthly, upon the next monthly anniversary day following Our receipt of Your request of termination. Premium will be refunded for any amounts paid beyond the termination date;
4. On the date We elect to discontinue this plan or type of coverage. We will give You at least 90 days written notice before the date coverage will be discontinued. You will be offered an option to purchase any other coverage that We offer without regard to health status;
5. On the date We elect to discontinue all health benefit plans in Your state. We will give You and the proper state authority at least 180 days written notice before the date coverage will be discontinued; or
6. On the date an Insured Person:
 - a. Performs an act or practice that constitutes fraud; or
 - b. Has made an intentional misrepresentation of material fact, relating in any way to the coverage provided under the Policy, including claims for Benefits under the Policy.

Covered Dependents

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

1. The date Your coverage terminates;
2. The date such dependent ceases to be an Eligible Dependent;
3. The date We receive Your written request to terminate a dependent's coverage; or
4. On the date the Covered Dependent:
 - a. Performs an act or practice that constitutes fraud; or
 - b. Has made an intentional misrepresentation of material fact, relating in any way to the coverage provided under the Policy, including claims for Benefits under the Policy.

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

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

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

Special Continuation Provision for Dependents

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

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

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

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

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

Premiums - based on the mode of payment, checked below, the initial premiums are as follows:	
<input type="checkbox"/> Monthly (Bank Draft)	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Annually	
Policy CH-26210 PPO-IP (03/09) AR - described above (includes automatic Policy Rider(s), if any):	\$ _____
<u>RIDERS (if any)</u>	\$ _____
	\$ _____
TOTAL	\$ _____

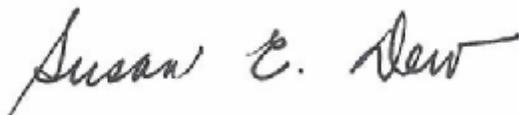
**Certificate of Compliance with
Arkansas Rule and Regulation 19**

Insurer: The Chesapeake Life Insurance Company

Form Number(s):

CH-26210 PPO-IP (03/09) AR

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



Signature of Company Officer

Susan Dew

Name

Senior Vice President, Associate General Counsel and Chief Compliance Officer

Title

April 21, 2009

Date

Certificate of Compliance for Arkansas

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

Form Numbers and Form Names:

CH-26210 PPO-IP (03/09) AR et al...
[CATASTROPHIC EXPENSE] PREFERRED PROVIDER ORGANIZATION (PPO) POLICY
Flesch Reading Score: 50.4



Susan Dew, Senior Vice President, Associate General Counsel and Chief Compliance Officer

April 21, 2009

Date



**The Chesapeake
Life Insurance Company**
Home Office: Oklahoma City, OK

9151 Boulevard 26
North Richland Hills, TX 76180

April 22, 2009

Arkansas Insurance Department
Life and Health Division
1200 W 3rd Street
Little Rock, AR 72201-1904
Attn.: Life & Health Division, A&H Form Filing Section

RE: SERFF Tracking Number: MGCC-126119576
The Chesapeake Life Insurance Company
NAIC#: 264-61832 / FEIN#: 52-0676509

NEW FORMS	DESCRIPTION
CH-26210 PPO-IP (03/09) AR	[Catastrophic Expense] Preferred Provider Organization (PPO) Policy
CH-26210 PPO-IP (SB-A) (03/09) AR	Policy Schedule {Option A}
CH-26210 PPO-IP (SB-B) (03/09) AR	Policy Schedule {Option B}
Additional Information	
Actuarial Documentation	
(VAR STMT) CH-26210 PPO-IP (03/09)	Variability Statement

Dear Examiner:

The above referenced forms are submitted for your review and approval. These forms are new and not intended to replace any forms previously approved by your Department.

Policy form **CH-26210 PPO--IP (03/09) AR** is intended to be a Catastrophic Expense Preferred Provider Organization (PPO) Policy. Unless otherwise stated within the Policy, all Covered Services are subject to: a) Lifetime Maximum, Calendar Year Maximum or Aggregate Maximum; b) Coinsurance Maximum; c) Calendar Year (per Insured Person and/or Family) or Period of Treatment Deductible; d) Copayments, if indicated; e) Facility Fees, if indicated; f) the chosen Network / Non-Network Provider Coinsurance amounts; and e) the Exclusions and Limitations of the Policy.

The Policy will have two (2) different benefit structure options available; one with a Calendar Year base plan deductible, and another with a Period of Treatment base plan deductible.

- Policy Schedule of Benefits form "CH-26210 PPO-IP (SB-A) (03/09) AR" will offer the Calendar Year Deductible with a Calendar Year Maximum; and
- Policy Schedule of Benefits form "CH-26210 PPO-IP (SB-B) (03/09) AR" will offer the Period of Treatment Deductible with an Aggregate Maximum.
- The applicable Policy Schedule of Benefits form (based on which option the applicant chooses) is intended to merge with the base Policy form CH-26210 PPO-IP (03/09) AR

Please note the bracketed items are intended as variable information, and the information enclosed in brackets is our standard for your state. At no time will this bracketed information be arranged in such a way to violate the laws of your state.

Additional rider benefits are intended to be made available under these plans, and are being submitted under separate cover.

We intend to use application form CH/MG-25098-APP (03/09) which will be submitted under separate cover to solicit this product. Additionally, we may also use *electronic* application form CH/MG-25098-eAPP (03/09) AR, upon approval, which will be submitted under separate cover to solicit this product or any application approved by your Department in the future.

To the best of our knowledge, information and belief, the forms submitted herewith are in compliance in all respects with the provisions of the insurance laws, rules and regulations of your state. The required certifications are attached herewith.

If you have any questions, or if anything further is needed to expedite the review of this filing, please contact me at (817) 255-3590. Your assistance in this matter is greatly appreciated.

Respectfully submitted,

A handwritten signature in blue ink that reads "Kathleen Allen". The signature is written in a cursive, flowing style.

Kathleen Allen
Senior Compliance Analyst

THE CHESAPEAKE LIFE INSURANCE COMPANY

A Stock Company
(Hereinafter called: the Company, We, Our or Us)
Home Office: Oklahoma City, Oklahoma
Administrative Office: P.O. Box 982010
North Richland Hills, Texas 76180
Customer Service: 1-800-733-1110

AMENDATORY ENDORSEMENT

This Amendatory Endorsement is made a part of the ~~Group~~-Policy to which it is attached. It is subject to all the provisions of the ~~Group~~-Policy which are not inconsistent with this endorsement. It is applicable only to Insured Persons who are residents of the State of Arkansas and whom accept the offer of coverage for Mental Illness and Substance Use Disorders on their application for insurance.

1. The definition of "**Mental or Nervous Disorders**" under the **DEFINITIONS** section is hereby **deleted** and **revised** as follows:

Mental Illness and Substance Use Disorders means those illnesses and disorders that are covered by a health benefit plan listed in the International Classification of Diseases Manual and the Diagnostic and Statistical Manual of Mental Disorders; including substance use disorders, unless specifically stated otherwise.

2. The following Exclusions are hereby **deleted** under the **EXCLUSIONS AND LIMITATIONS** section:

7. Mental or Nervous Disorders, unless otherwise stated herein;
8. Drug abuse or addiction including alcoholism, or overdose of drugs, narcotics, or hallucinogens, directly or indirectly, wholly or partially, unless taken as prescribed by a Physician;

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

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

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

Signed for The Chesapeake Life Insurance Company at North Richland Hills, Texas.



SECRETARY



PRESIDENT

SERFF Tracking Number: MGCC-126119576 State: Arkansas
 Filing Company: The Chesapeake Life Insurance Company State Tracking Number: 42199
 Company Tracking Number: CH-26210 PPO-IP (03/09) AR
 TOI: H151 Individual Health - Sub-TOI: H151.001 Health - Hospital/Surgical/Medical
 Hospital/Surgical/Medical Expense Expense
 Product Name: CLICO 26210 (03/09)
 Project Name/Number: CLICO 26210 (03/09)/CH-26210 PPO-IP (03/09) AR

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
10/09/2009	Form	Amendatory Endorsement	10/22/2009	AE CH-26058-IR AR _1009_.pdf (Superseded)
04/22/2009	Form	[CATASTROPHIC EXPENSE] PREFERRED PROVIDER ORGANIZATION (PPO) POLICY	10/12/2009	CH-26210 PPO-IP _0309_ AR [EF and CF].pdf (Superseded)
04/21/2009	Form	Schedule Pages	10/06/2009	CH-26210 PPO-IP _SB-A_ _0309_ AR [EF].pdf (Superseded)
04/21/2009	Form	[CATASTROPHIC EXPENSE] PREFERRED PROVIDER ORGANIZATION (PPO) POLICY	04/22/2009	CH-26210 PPO-IP _0309_ AR [EF and CF].pdf (Superseded)
04/21/2009	Form	Schedule Pages	04/22/2009	CH-26210 PPO-IP _SB-B_ _0309_ AR [CF].pdf
04/22/2009	Rate and Rule	Rates	10/06/2009	CH-26210 PPO-IP (0309) AR 20090417_Rates (CF).pdf (Superseded) CH-26210 PPO-IP (0309) AR 20090417_Rates (EF).pdf (Superseded)
04/21/2009	Supporting	Variability Statement	04/22/2009	_VAR STMT_ CH-26210

SERFF Tracking Number: MGCC-126119576 *State:* Arkansas
Filing Company: The Chesapeake Life Insurance Company *State Tracking Number:* 42199
Company Tracking Number: CH-26210 PPO-IP (03/09) AR
TOI: H151 Individual Health - *Sub-TOI:* H151.001 Health - Hospital/Surgical/Medical
Hospital/Surgical/Medical Expense Expense
Product Name: CLICO 26210 (03/09)
Project Name/Number: CLICO 26210 (03/09)/CH-26210 PPO-IP (03/09) AR

Document

PPO-IP_0309_SB-A.pdf
(Superceded)
VAR STMT CH-26210
PPO-IP_0309_SB-B.pdf
(Superceded)

04/17/2009

Supporting Outline of Coverage
Document

04/22/2009

CH-26210 PPO-IP OC _SB-
A_0309_AR [EF].pdf
(Superceded)
CH-26210 PPO-IP OC _SB-
B_0309_AR [CF].pdf
(Superceded)

THE CHESAPEAKE LIFE INSURANCE COMPANY

A Stock Company
(Hereinafter called: the Company, We, Our or Us)
Home Office: Oklahoma City, Oklahoma
Administrative Office: P.O. Box 982010
North Richland Hills, Texas 76180
Customer Service: 1-800-733-1110

AMENDATORY ENDORSEMENT

This Amendatory Endorsement is made a part of the Group Policy to which it is attached. It is subject to all the provisions of the Group Policy which are not inconsistent with this endorsement. It is applicable only to Insured Persons who are residents of the State of Arkansas.

1. The definition of "**Mental or Nervous Disorders**" under the **DEFINITIONS** section is hereby **deleted** and **revised** as follows:

Mental Illness and Substance Use Disorders means those illnesses and disorders that are covered by a health benefit plan listed in the International Classification of Diseases Manual and the Diagnostic and Statistical Manual of Mental Disorders; including substance use disorders, unless specifically stated otherwise.

2. The following Exclusions are hereby **deleted** under the **EXCLUSIONS AND LIMITATIONS** section:

7. Mental or Nervous Disorders, unless otherwise stated herein;
8. Drug abuse or addiction including alcoholism, or overdose of drugs, narcotics, or hallucinogens, directly or indirectly, wholly or partially, unless taken as prescribed by a Physician;

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

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

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

Signed for The Chesapeake Life Insurance Company at North Richland Hills, Texas.



SECRETARY



PRESIDENT

THE CHESAPEAKE LIFE INSURANCE COMPANY

A Stock Company

(Hereinafter called: the Company, We, Our or Us)

Home Office: Oklahoma City, Oklahoma
Administrative Office: P.O. Box 982010
North Richland Hills, Texas 76182-8010
Customer Service: 1-800-733-1110

[CATASTROPHIC EXPENSE] PREFERRED PROVIDER ORGANIZATION (PPO) POLICY

IMPORTANT NOTICE ABOUT STATEMENTS IN THE APPLICATION

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

10 DAY RIGHT TO EXAMINE THE POLICY

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

RENEWABILITY

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

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



SECRETARY



PRESIDENT

IMPORTANT MESSAGE TO OUR POLICYHOLDERS

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

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INPATIENT MEDICAL MANAGEMENT

We or Our designated representative will, using industry standard clinical guidelines, provide review and monitoring of any inpatient admission upon notification by You, or Your admitting Physician or Hospital. We or Our designated representative will pre-certify Medically Necessary admissions, monitor care during the admission and arrange for Medically Necessary services upon discharge.

In order to receive Pre-Certification from Us or Our designated representative, Your Physician or Hospital should call the toll-free telephone number shown on Your I.D. card between 8:00 a.m. and 8:00 p.m. eastern time on Monday through Friday, at least [5] working days prior to a Hospital Confinement.

For emergency admissions, Your Physician or Hospital should call the toll-free telephone number shown on Your I.D. card within 48 hours following the admission, or as soon as reasonably possible, to provide notification of any admission due to a Medical Emergency.

IMPORTANT: PLEASE NOTE THAT PRE-CERTIFICATION OF TREATMENT IS NOT A VERIFICATION OR GUARANTEE OF BENEFITS. Covered Services are subject to all provisions, terms, DEFINITIONS and EXCLUSIONS AND LIMITATIONS of the Policy on the date the service is performed or the supply is furnished and while coverage is in force.

CASE MANAGEMENT

When meeting established clinical criteria, Case Management is a collaborative process where We or Our designated representative will review an eligible Insured Person's health condition(s), assess opportunities to provide alternative care and develop a plan designed to optimize the Insured Person's health.

If the Insured Person's medical condition meets the established clinical criteria, benefits will be provided for approved alternative methods of care, only for so long as is determined that the alternative services are Medically Necessary and cost effective. Case Management is not designed to extend extra-contractual benefits for alternative methods of care to persons who do not meet Our clinical criteria or for services not Pre-certified by Our designated representative. The approved alternative benefits will count toward the Insured Person's Calendar Year and Lifetime Maximum Amounts.

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

DEFINITIONS

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

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

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

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

Calendar Year Maximum Amount means the maximum amount payable under this Policy and its Riders, if any, each Calendar Year for each Insured Person, occurring while coverage is in effect under this Policy for such person. The Calendar Year Maximum Amount is shown in the POLICY SCHEDULE. This amount is included in and part of the Lifetime Maximum Amount for each Insured Person.

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

Coinsurance means the percentage of Covered Services that are paid by Us after application of the Copayment or satisfying the Deductible. The Coinsurance percentage We pay is shown in the POLICY SCHEDULE.

Complications of Pregnancy means:

1. Hospital Confinement or treatment in an Outpatient Surgery Facility (when the pregnancy is not terminated) required to treat conditions, such as the following, in a pregnant female Insured Person: (a) acute nephritis; (b) nephrosis; (c) cardiac decompensation; (d) HELLP syndrome; (e) uterine rupture; (f) amniotic fluid embolism; (g) chorioamnionitis; (h) fatty liver in pregnancy; (i) septic abortion; (j) placenta accreta; (k) gestational hypertension; (l) puerperal sepsis; (m) peripartum cardiomyopathy; (n) cholestasis in pregnancy; (o) thrombocytopenia in pregnancy; (p) placenta previa; (q) placental abruption; (r) acute cholecystitis and pancreatitis in pregnancy; (s) postpartum hemorrhage; (t) septic pelvic thrombophlebitis; (u) retained placenta; (v) venous air embolus associated with pregnancy; (w) miscarriage; or (x) an emergency c-section required because of (i) fetal or maternal distress during labor, or (ii) severe pre-eclampsia, or (iii) arrest of descent or dilatation, or (iv) obstruction of the birth canal by fibroids or ovarian tumors, or (v) necessary because of the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that, in the absence of immediate medical attention, will result in placing the life of the mother or fetus in jeopardy. For purposes of this paragraph, a c-section delivery is not considered to be an emergency c-section if it is merely for the convenience of the Insured Person and/or Physician or solely due to a previous c-section.
2. Treatment, diagnosis or care for conditions, including the following, in a pregnant female Insured Person when the condition was caused by, necessary because of, or aggravated by the pregnancy: (a) hyperthyroidism; (b) hepatitis B or C; (c) HIV; (d) Human papilloma virus; (e) abnormal PAP; (f) syphilis; (g) chlamydia; (h) herpes; (i) urinary tract infections; (j) thromboembolism; (k) appendicitis; (l) hypothyroidism; (m) pulmonary embolism; (n) sickle cell disease; (o) tuberculosis; (p) migraine headaches; (q) depression; (r) acute myocarditis; (s) asthma; (t) maternal cytomegalovirus; (u) urolithiasis; (v) DVT prophylaxis; (w) ovarian dermoid tumors; (x) biliary atresia and/or cirrhosis; (y) first trimester adnexal mass; (z) hydatidiform mole; or (aa) ectopic pregnancy.

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

A Complication of Pregnancy arising from, caused by, or associated with a pregnancy existing on the Effective Date of Coverage, will be deemed a Pre-Existing Condition and is subject to the Pre-existing Condition provision as shown in the EXCLUSIONS AND LIMITATIONS.

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

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

Convenient Care Clinic means health care clinics, based in retail stores and pharmacies that are staffed by nurse practitioners (NPs).

Copayment means the specific dollar amount the Insured Person is required to pay for specifically listed Covered Services [and is in lieu of any Deductible]. The Copayment, if any, is shown in the POLICY SCHEDULE. Copayments do not count toward satisfaction of any Deductibles.

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

1. Reconstructive Surgery incidental to or following Surgery resulting from trauma, infection or other disease of the involved part, provided the condition which necessitates the Surgery occurs while coverage is in force and remains in force through the Surgery;
2. Reconstructive Surgery in connection with a mastectomy;
3. With respect to a Covered Dependent under age 18, reconstructive Surgery for craniofacial abnormalities, to improve the function of, or attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease; and
4. With respect to a newborn child, reconstructive Surgery to improve the function of, or attempt to create a normal appearance of, an abnormal structure caused by congenital defects.

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

Covered Services means the Medically Necessary Usual and Customary Charges for services, supplies, care or treatment as described in this Policy which are performed, prescribed, directed or authorized by a Provider. To be a Covered Service, the service, supply or treatment must be:

1. Medically Necessary and/or specifically included as a Covered Service under this Policy;
2. Within the scope of the license of the Provider performing the service;
3. Rendered while coverage under this Policy is in force and for which the Insured Person is legally obligated to pay; and
4. Not considered Experimental or Investigative or otherwise excluded or limited under this Policy.

A charge for a Covered Service is incurred on the date the service, supply or treatment is furnished.

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

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

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

Experimental or Investigative means any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, Injury, Sickness, or other health condition which We determine in Our sole discretion to be Experimental/Investigative. We will deem any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if We determine that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply:

1. Cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
2. Has been determined by the FDA to be contraindicated for the specific use;
3. Is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply; and
4. Is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

The information considered or evaluated by Us to determine whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative under the above criteria may include one or more items from the following list which is not all inclusive:

1. Published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
2. Evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
3. Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
4. Consent documents and/or the written protocols used by the treating Physicians or other medical professional, or facilities or by other treatment, Physicians, other medical professionals, or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply; or
5. Medical records; or
6. The opinions of consulting Providers and other experts in the field.

Based on the criteria above, We have the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is Experimental/Investigative.

Facility Fee means the amount the Insured Person is required to pay before the application of the Coinsurance, Deductibles or Copayments, if any, for specifically listed Covered Services. The Facility Fee, if any, is shown in the POLICY SCHEDULE. Facility Fees do not count toward [Copayments][,Deductibles][,or Coinsurance Maximums].

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

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

The term "Hospital" does not include:

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

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

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

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

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

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

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

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

Low Dose Mammography means the x-ray, examination of the breast using equipment dedicated specially for mammography, including the x-ray tube, filter, compression device, screens, films, and cassettes with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast.

Maximum Benefit Amount means the maximum amount payable for a Covered Service(s) under this Policy and any attached Riders for each Insured Person, after the application of any Deductibles, Copayments and/or Coinsurance, where applicable. The Maximum Benefit Amount is shown in the POLICY SCHEDULE and applies to both Network and Non-Network Providers, unless specifically stated otherwise. ***You are responsible for the balance due (if any) on charges for Covered Services in excess of the Maximum Benefit Amount.***

Medical Emergency means medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the Insured Person's condition, Sickness, or Injury is of such a nature that failure to get immediate medical care could result in:

1. Placing the patient's health in serious jeopardy;
2. Serious impairment to bodily functions;
3. Serious dysfunction of any bodily organ or part;
4. Serious disfigurement; or
5. In the case pregnant woman, serious jeopardy to the health of the fetus.

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

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

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

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

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

Network Provider (or Preferred Provider Organization (PPO)) means a Provider that holds a valid contract with the network associated with this Policy, to provide health care services. A current list of the Network Providers in the network associated with this Policy is available to You upon request.

Non-authorization or Non-authorized means the Hospital Confinements, Transplant Procedures, Diagnostic Procedures or Outpatient Services that have been determined by Our designated representative as a non-Covered Service under this plan because they do not meet the Preauthorization criteria.

Non-Network Provider (or Non-Preferred Provider Organization (Non-PPO)) means a Provider who has not entered into a contractual agreement with the Network associated with this Policy.

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

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

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

The term "Outpatient Surgery Facility" does not include:

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

Period of Treatment means a period which begins on the date an Insured Person is admitted to a Hospital or the date services are rendered in an Outpatient Surgery Facility for the treatment of an Injury or Sickness and ends after 365 days. If the same or related Sickness or Injury continues beyond 365 days, a new Sickness or Injury Period of Treatment will begin, which includes a new Deductible. In no event will a single Period of Treatment exceed 365 days. A separate Period of Treatment will apply to each Injury or Sickness.

Physician means a legally qualified licensed practitioner of the healing arts who provides care within the scope of his or her license, including any other practitioner We are compelled by applicable law to recognize as legally qualified to provide a Covered Service. A member of the Insured Person's Immediate Family will not be considered a Physician (with the exception of dentists providing services which are considered Covered Services under this Policy).

Physician's Office means a location, other than a Hospital, Hospital emergency room, Urgent Care Center, skilled nursing facility (SNF), military treatment facility, community health center, state or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of Sickness or Injury on an ambulatory basis.

Policy means this written description of coverage provided to You by Us.

Pre-Certification means the procedure whereby We or Our designated representative determines, based on medically recognized criteria, whether or not a Hospital Confinement is reasonable for the type of services to be received.

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

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

Pre-Existing Condition will also include a pregnancy which exists on the Effective Date of Coverage.

Provider means a duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that We approve. This includes any Provider rendering services which are required by applicable state law to be covered when rendered by such Provider.

Sickness means an illness or disease which first manifests itself after the Insured Person's coverage becomes effective and while the coverage is in force. Sickness includes Complications of Pregnancy. Any condition which manifests itself prior to the Insured Person's Effective Date of Coverage and which meets the criteria of a Pre-Existing Condition, as defined herein, is subject to the Pre-Existing Condition provision as shown in the EXCLUSIONS AND LIMITATIONS.

Special Circumstances means a condition such that the treating Physician reasonably believes that discontinuing care by the treating Physician could cause harm to the Insured Person.

Surgery or Surgical Procedure means an invasive diagnostic procedure or the treatment of an Insured Person's Sickness or Injury by manual or instrumental operations, including any of the procedures designated by Current Procedural Terminological codes as Surgery, performed by a Physician while the Insured Person is under general or local anesthesia.

Total Disability or Totally Disabled means:

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

Transplant Benefit Period means the period of time:

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

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

- | | |
|---|--|
| <ol style="list-style-type: none">1. Heart transplant;2. Combined heart and lung transplant;3. Lung transplant;4. Kidney transplant;5. Kidney and pancreas transplant;6. Liver transplant;7. Bone marrow transplant, either allogenic or autologous, including high dose chemotherapy; or8. Peripheral stem cell transplant. | |
|---|--|

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

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

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

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

Usual and Customary Charge means the charge which is the lesser of:

1. The actual charge;
2. The charge usually made for the Covered Service by the provider who furnishes it;
3. The prevailing charge made for a Covered Service in a geographical area by those of similar professional standing; and
4. The contracted rate in effect with a Network Provider on the date it provides a Covered Service, when Covered Services are received from Network Provider.

Urgent Care Center means a free-standing facility, center or other entity that operates primarily to provide specialty medical treatment of an unforeseen, unexpected Sickness or Injury on an urgently needed or prompt basis.

We, Us and Our means The Chesapeake Life Insurance Company.

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

EFFECTIVE DATE OF COVERAGE

Beginning of Coverage

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

Newborn Children

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

Newly Adopted Children

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

Additional Dependents

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

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

PREMIUMS

Premium Due Date

Premiums are payable to Us at Our administrative office in North Richland Hills, Texas. The premium is payable monthly, quarterly, or annually, as indicated in the POLICY SCHEDULE. Payment of any premium will not maintain coverage in force beyond the next premium due date, except as provided by the Grace Period. Upon the payment of a claim under this Policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

Grace Period

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

Premium Changes

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

Unearned Premiums Refund

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

TERMINATION OF COVERAGE

You

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

1. At the end of the period for which premium has been paid (subject to the Grace Period);
2. If Your mode of premium is monthly, at the end of the period through which premium has been paid following Our receipt of Your request of termination;
3. If Your mode of premium is other than monthly, upon the next monthly anniversary day following Our receipt of Your request of termination. Premium will be refunded for any amounts paid beyond the termination date;
4. On the date We elect to discontinue this plan or type of coverage. We will give You at least 90 days written notice before the date coverage will be discontinued. You will be offered an option to purchase any other coverage that We offer without regard to health status;
5. On the date We elect to discontinue all health benefit plans in Your state. We will give You and the proper state authority at least 180 days written notice before the date coverage will be discontinued; or
6. On the date an Insured Person:
 - a. performs an act or practice that constitutes fraud; or
 - b. has made an intentional misrepresentation of material fact, relating in any way to the coverage provided under the Policy, including claims for benefits under the Policy.

Covered Dependents

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

1. The date Your coverage terminates;
2. The date such dependent ceases to be an Eligible Dependent;
3. The date We receive Your written request to terminate a dependent's coverage; or
4. On the date the Covered Dependent:
 - a. performs an act or practice that constitutes fraud; or
 - b. has made an intentional misrepresentation of material fact, relating in any way to the coverage provided under the Policy, including claims for benefits under the Policy.

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

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

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

Family Security Benefit

Beginning with the next premium due date following Our receipt of due proof of Your death, We will waive premiums for a period of 12 months for Your Covered Dependents. During this premium waiver period, no increase in benefits or addition of Eligible Dependents, except newborns, will be considered. Provisions for termination of coverage for Covered Dependents will also apply. Upon expiration of the 12-month premium waiver period, Your Covered Dependent spouse may continue coverage, as stated in the **Special Continuation Provision for Dependents** section and by making the required premium payments.

Special Continuation for Dependents

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

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

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

Reinstatement

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

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

Replacement of the Policy by Another Insurer

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

NETWORK PROVIDERS

Coverage under this Policy includes access to discounts and increased benefits through the use of Network Providers. Access to Network Providers is attained through the use of one or more non-overlapping networks.

Out-of-Network Treatment

If an Insured Person uses the services of a Non-Network Provider, the Coinsurance amount may be less than that which would have otherwise been considered for Covered Services received from a Network Provider. However, if an Insured Person goes to a Non-Network Provider solely because he or she requires Medically Necessary services that are not available from a Network Provider within a 50 mile radius of Your residence, then the Covered Services will be considered on the same basis as if the Insured Person had used the services of a Network Provider for the purposes of determining benefits. This will not apply when the Insured Person chooses to receive services from Providers other than Network Providers, solely for the Insured Person's convenience.

Medical Emergency

If an Insured Person cannot reasonably reach a Network Provider and goes to a Non-Network Provider solely for a Medical Emergency, Covered Services for the Medical Emergency will be considered on the same basis as if the Insured Person had used the services of a Network Provider. However, treatment by a Non-Network Provider for such Medical Emergency must consist of:

1. Any medical screening examination or other evaluation required by state or federal law to be provided in the emergency facility of a Hospital which is necessary to determine whether a Medical Emergency condition exists;
2. Necessary Medical Emergency services including the treatment and stabilization of a Medical Emergency condition; or
3. Services originating in a Hospital emergency facility following treatment or stabilization of a Medical Emergency condition.

Such Medical Emergency services will be reimbursed at the Network Provider benefit level until the Insured Person can reasonably be expected to transfer to a Network Provider.

Special Circumstances

If a network arrangement terminates and, at the time of termination, Special Circumstances exist in connection with the treatment being received by an Insured Person by such former Network Provider, the Covered Services by such former Network Provider will be considered as if they were provided by a Network Provider.

Special Circumstances must be identified by the treating Physician who must: make a request to Us that the Insured Person be permitted to continue treatment under the Physician's care as an outpatient or inpatient at a Hospital; and further provided such Physician and Hospital agree not to seek payment from either the Company or the Insured Person for any amounts in excess of the those Covered Service amounts which would have been considered for a Network Provider.

COVERED SERVICES

Covered Services include Medically Necessary Usual and Customary Charges for the services, supplies, care or treatment as described in this Policy which are performed, prescribed, directed or authorized by a Provider. To be a Covered Service, the service, supply or treatment must be:

1. Medically Necessary and/or specifically included as a Covered Service under this Policy;
2. Within the scope of the license of the Provider performing the service;
3. Rendered while coverage under this Policy is in force and for which the Insured Person is legally obligated to pay; and
4. Not considered Experimental or Investigative or otherwise excluded or limited under this Policy.

A charge for a Covered Service is incurred on the date the service, supply or treatment is furnished.

Unless otherwise stated herein, all Covered Services are subject to:

1. The Facility Fees shown in the POLICY SCHEDULE, if any;
2. The [Calendar Year Deductible][Deductible per [Period of Treatment] or the Deductible for all other Outpatient Covered Services] shown in the POLICY SCHEDULE;
3. The Copayments shown in the POLICY SCHEDULE, if any;
4. The Network Provider Coinsurance level or Non-Network Provider Coinsurance level Coinsurance level shown in the POLICY SCHEDULE;
5. The Maximum Benefit Amounts, visit limitations, if any, [Calendar Year][Aggregate Maximum Amount] and Lifetime Maximum Amount shown in the POLICY SCHEDULE;
6. The EXCLUSIONS AND LIMITATIONS; and
7. All other provisions of this Policy.

INPATIENT SERVICES:

Inpatient Hospital

Covered Services include services and supplies provided by a Hospital for semi-private accommodations and general nursing care furnished by the Hospital including Confinement in the Hospital's Intensive Care or Cardiac Care Unit; Physician visits and miscellaneous medical services and supplies necessary for the treatment of the Insured Person.

Covered Services will also include hemodialysis and the charges by a Hospital for processing and administration of blood or blood components, acute inpatient rehabilitation, x-ray, laboratory, diagnostic tests and services of a radiologist, radiology group, and the services of a pathologist or pathology group for interpretation of diagnostic tests or studies, performed while the Insured Person is Hospital Confined.

Covered Services will also include coverage for general anesthesia and associated Hospital Charges in conjunction with Dental Care provided to an Insured Person if such person is: (a) a Covered Dependent child who is developmentally disabled; or (b) an individual for whom a successful result cannot be expected from Dental Care provided under local anesthesia because of a neurological or other medically compromising condition.

The fees charged for take home drugs, personal convenience items such as lotions, shampoos, etc., or items not intended primarily for use by the Insured Person while Hospital Confined are not Covered Services.

Transplant Procedures

Covered Services include Transplant Procedures incurred during a Transplant Benefit Period. Covered Services for Transplant Procedures include the following when part of a Transplant Treatment Plan:

1. Inpatient and outpatient Hospital services;
2. Services of a Physician for diagnosis, treatment and Surgery for a Transplant Procedure;
3. Procurement of an organ or tissue, including services provided to a living donor of an organ or tissue for procurement of an organ or tissue, provided the donor and transplant recipient are both insured under this Policy. Covered Services are limited to the actual procurement expenses, and will not be more than any Maximum Benefit Amounts under the Policy applicable to the recipient;
4. Rental of durable medical equipment for use outside the Hospital. Covered Services are limited to the purchase price of the same equipment;
5. Prescription Drugs, including immunosuppressive drugs;
6. Oxygen;
7. Speech therapy, occupational therapy, Physical Therapy and chemotherapy;
8. Services and supplies for and related to high dose chemotherapy and bone marrow tissue transplantation when provided as part of a Transplant Treatment Plan which includes bone marrow transplantation and high dose chemotherapy;
9. Surgical dressings and supplies; and
10. Home Health Care.

When the Insured Person's Physician advises the Insured Person that a Transplant Procedure is being considered, the Insured Person or the Insured Person's Physician should notify Us or Our designee.

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

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

Expenses incurred beyond the Transplant Benefit Period will not be considered Covered Services, unless covered elsewhere under the Policy.

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

PRE-ADMISSION TESTING:

Covered Services include pre-admission tests done on an outpatient basis before an authorized Hospital stay or Outpatient Surgery. These tests must be:

1. Made within 14 days prior to Hospital Confinement or within 14 days of an outpatient Surgery;
2. Related to the condition for which the Insured person is being Confined;
3. Not repeated in the Hospital or elsewhere; and
4. Ordered by a Physician.

OUTPATIENT SURGERY FACILITY SERVICES:

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

1. Use of operating room and recovery room;
2. Administration of drugs and medicines during Surgery;
3. Dressings, casts, splints;
4. Diagnostic services including radiology, laboratory or pathology performed at the time of the Surgery; and
5. General anesthesia and associated Outpatient Surgery Facility Charges in conjunction with Dental Care provided to an Insured Person if such person is: (a) a Covered Dependent child who is developmentally disabled; or (b) an individual for whom a successful result cannot be expected from Dental Care provided under local anesthesia because of a neurological or other medically compromising condition.

MEDICAL EMERGENCIES:

Covered Services include treatment of a Medical Emergency in a Hospital emergency room or Urgent Care facility.

PHYSICIAN SERVICES:

Second Surgical Opinion

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

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

Inpatient / Outpatient Surgeon

Covered Services include expenses incurred while Hospital Confined or in an Outpatient Surgery Facility for services by the Physician performing Surgery.

[When multiple surgical procedures are done at the same time, Covered Services will be considered for the first or highest cost procedure. No benefit is payable for incidental surgical procedures such as an appendectomy performed during a gall bladder surgery.]

Inpatient / Outpatient Assistant Surgeon

Covered Services include services by the Physician assisting the Physician performing Surgery.

Inpatient / Outpatient Anesthesiologist

Covered Services include services by the Physician providing anesthesia during Surgery.

Physician Visits while Hospital Confined

Covered Services include visits by a Physician, other than the surgeon, while Hospital Confined.

PREVENTIVE IMAGING SCREENING TESTS:

Human Papillomavirus and Cervical Cancer Screening

Covered Services include the following annual screenings, as approved by the United States Food and Drug Administration, for female Insured Persons 18 years of age or older:

1. A conventional Pap smear screening or a screening using liquid-based cytology methods; or
2. A conventional Pap smear screening in combination with a test for the detection of the Human Papillomavirus.

The screening test required under this benefit must be performed in accordance with the guidelines adopted by:

1. The American College of Obstetricians and Gynecologists; or
2. Another similar national organization of medical professionals recognized by the Commissioner.

Prostate Cancer Screening

Covered Services include the following services and supplies provided to an Insured Person for the detection of prostate cancer:

1. An annual physical examination for the detection of prostate cancer for each male Insured Person; and
2. An annual prostate-specific antigen (PSA) test used for the detection of prostate cancer for each male Insured Person who is:
 - (a) at least 50 years of age and asymptomatic; or
 - (b) at least 40 years of age with a family history of prostate cancer or another prostate cancer risk factor.

Mammography Screening

Covered Services include an annual Low Dose Mammography screening for each female Insured Person age 35 or older.

Colorectal Cancer Screening

Covered Services include colorectal cancer examinations and laboratory tests for Insured Persons who are 50 years of age or older; who are less than 50 years of age and at high risk for colorectal cancer according to American Cancer Society colorectal cancer screening guidelines as they existed on [January 1, 2005]; and experiencing bleeding from the rectum or blood in the stool or a change in bowel habits, such as diarrhea, constipation, or narrowing of the stool that lasts more than 5 days as determined by a licensed Physician.

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

recognized gene markers for colorectal cancer or other predisposing factors; and any definition recognized by medical science and determined by the Director of the Department of Health in consultation with the University of Arkansas for Medical Sciences.

SCREENING TEST FOR HEARING IMPAIRMENT:

Covered Services include a screening test of hearing loss for a Covered Dependent child from birth through the date the child is 30 days old. Covered Services also include the necessary diagnostic follow-up care related to the screening test from birth through the date the child is 24 months old.

[Deductibles do not apply.]

IMPAIRMENT OR LOSS OF SPEECH OR HEARING:

Covered Services include the necessary care and treatment of loss or impairment of speech or hearing which includes the communicative disorders generally treated by speech pathologist or audiologist licensed by the Board of Examiners in Speech-Language Pathology and Audiology and which fall within the scope of his/her area of certification. Coverage does not apply to hearing instruments or devices.

MINIMUM STAY REQUIREMENTS FOR MASTECTOMY AND LYMPH NODE DISSECTION

Covered Services include inpatient care if an Insured Person undergoes a covered mastectomy, for a minimum of the following:

1. 48 hours following a covered mastectomy; or
2. 24 hours following a covered lymph node dissection for the treatment of breast cancer.

A shorter period of Confinement will be covered if the Insured Person and her Physician determine that a shorter period of inpatient Hospital Confinement is appropriate.

CHEMOTHERAPY AND RADIATION THERAPY:

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

[(Deductibles do not apply)]

DURABLE MEDICAL EQUIPMENT AND PROSTHETIC DEVICES:

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

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

Routine maintenance and repairs of rental equipment are not considered Covered Services.

AMBULANCE SERVICES:

Covered Services include Ambulance transportation to the nearest Hospital that can provide Covered Services appropriate for the Insured person's condition.

Ambulance services are only considered Covered Services if the Insured Person is Confined to the Hospital.

Air or water Ambulance services are only considered a Covered Service in situations in which the Insured person is in a location that cannot be reached by ground Ambulance.

Ambulance usage for the convenience of the Insured Person is not a Covered Service. Non-Covered Services for Ambulance include but are not limited to trips to a Physician's Office or clinic; or a morgue or funeral home.

MATERNITY STAY REQUIREMENTS FOR COVERED MATERNITY CARE:

This provision applies to an Insured Person's coverage only when the Insured Person incurs Covered Services for a normal childbirth or cesarean section delivery that is covered for Complications of Pregnancy as defined in the Policy. A minimum of 48 hours of inpatient care will be provided to the mother and newborn child following a vaginal delivery and 96 hours following a cesarean section.

MUSCULOSKELETAL DISORDERS:

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

CHILD HEALTH SUPERVISION SERVICES:

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

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

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

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

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

MEDICAL FOODS AND LOW PROTEIN MODIFIED FOOD PRODUCTS:

Covered Services include the treatment of a Covered Dependent inflicted with phenylketonuria if:

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

DIABETES:

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

Diabetes Self-Management Training means instructions in an inpatient or outpatient setting including medical nutrition therapy relating to diet, caloric intake and diabetes management, excluding any programs in which the

only purpose is weight reduction, which enables diabetic patients to understand the diabetic management process and daily management of diabetic therapy as a method of avoiding frequent hospitalizations and complications when the instruction is provided in accordance with a program in compliance with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association.

OUTPATIENT CONTRACEPTIVE SERVICES AND DEVICES:

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

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

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

EXCLUSIONS AND LIMITATIONS

We will not provide any benefits for charges arising directly or indirectly, in whole or in part, from:

1. Any care not Medically Necessary or services for which benefits are not specifically provided for in this Policy, including charges related to secondary medical conditions resulting directly or indirectly from conditions, treatment or services that are not considered a Covered Service and/or that are specifically excluded under this Policy;
2. Any charges exceeding the Maximum Benefit Amount, Calendar Year Maximum Amount or Lifetime Maximum Amount;
3. Any act of war, declared or undeclared;
4. Suicide, attempted suicide, or any intentionally self-inflicted injury, while sane or insane;
5. Care, treatment, services or supplies received in a Hospital emergency room for treatment of a Sickness or Injury that is not considered a Medical Emergency;
6. Any Injury or Sickness arising out of, or in the course of, employment for wage or profit, provided the Insured Person is covered under any Workers' Compensation Act, Occupational Disease Act, or similar act or law,
7. Mental or Nervous Disorders, unless otherwise stated herein;
8. Drug abuse or addiction including alcoholism, or overdose of drugs, narcotics, or hallucinogens, directly or indirectly, wholly or partially, unless taken as prescribed by a Physician;
9. An overdose of drugs, being intoxicated or under the influence of intoxicants, hallucinogens, narcotics or other drugs or controlled substances, directly or indirectly, wholly or partially, unless taken as prescribed by a Physician;
10. Any treatment including prescription drugs or non-prescription drugs, or procedure that promotes conception or prevents childbirth, including but not limited to: (a) artificial insemination; (b) in-vitro fertilization or other treatment for infertility; (c) treatment for impotency; (d) sterilization or reversal of sterilization; or (e) abortion (unless the life of the mother would be endangered if the fetus were carried to term), unless otherwise stated herein;
11. Laser vision correction, radial keratotomy or any eye Surgery when the primary purpose is to correct nearsightedness, farsightedness, astigmatism, or any other refractive error;
12. Spinal manipulations and manual manipulative treatment or therapy;
13. Mandibular or maxillofacial Surgery to correct growth defects after one year from the date of birth, jaw disproportions or malocclusions, or to increase vertical dimension or reconstruct occlusion, unless otherwise stated herein;
14. Weight loss or modification, or complications arising there from, or procedures resulting therefrom or for surgical treatment of obesity including but not limited to gastric by-pass, wiring of the teeth and all forms of Surgery performed for the purpose of weight loss or modification or the reversal/modification of such procedure;
15. Breast reduction or augmentation, or complications arising there from, unless necessary in connection with breast reconstructive Surgery following a mastectomy;
16. Modification of the physical body in order to improve the psychological, mental or emotional well-being of the Insured Person, such as but not limited to sex-change Surgery;
17. Marriage, family, or child counseling for the treatment of premarital, marriage, family or child relationship dysfunctions;
18. Directly or indirectly engaging in an illegal occupation or illegal activity;
19. Care in a nursing home, custodial institution or domiciliary care or rest cures;

20. Preparation and presentation of medical reports for appearance at trials or hearings;
21. Physical examinations required for school events, sports, camp, employment, licensing and insurance, unless otherwise stated herein;
22. Immunizations required for the sole purpose of travel outside of the U.S.A.;
23. Payment for care for military service connected disabilities for which the Insured Person is legally entitled to services and for which facilities are reasonably available to the Insured Person and payment for care for conditions that state or local law requires be treated in a public facility;
24. Experimental or Investigative medical, surgical or other health care procedures, treatments, products or services, unless otherwise stated herein;
25. Personal comfort items, such as television, telephone, lotions, shampoos, etc.;
26. Cosmetic Surgery, or complications arising there from, unless otherwise stated herein;
27. Dental Care, treatment or Surgery unless necessitated by Injury to sound natural teeth which occurs while insured under this Policy. (The expense must be incurred within one year from the date of Injury);
28. Corrective vision or hearing supplies or for the examination for prescribing or fitting such supplies;
29. The removal of warts, corns, calluses, the cutting and trimming of toenails, care for flat feet, fallen arches or chronic foot strain;
30. Expenses incurred for prescription drugs, except if added by Rider;
31. Normal pregnancy, except for Complications of Pregnancy, [except if added by Rider];
32. Any expenses related to a surrogate pregnancy; and
33. Treatment, services or supplies received outside the U.S. or Canada. However, treatment, services or supplies received as a result of an acute Sickness or Injury sustained during the first 30 days of travel outside of the U.S. or Canada will be considered a Covered Service. In no event will treatment, services or supplies received beyond the first 30 days of travel outside of the U.S. or Canada be considered a Covered Service.

Sickness Exclusion

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

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

Pre-Existing Condition

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

Coverage After Age 65 or Earlier Medicare Eligibility

When an Insured Person becomes covered under Medicare, the Covered Services of this Policy and its attachments, if any, are considered only to the extent that they are not paid by Medicare and they would otherwise be payable under this Policy. Covered Services will also be subject to any other EXCLUSIONS AND LIMITATIONS set forth in this Policy.

COORDINATION OF BENEFITS

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

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

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

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

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

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

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

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

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

would exceed the Allowable Expense.

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

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

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

The rules that set the order of benefit determination are:

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

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

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

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

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

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

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

Facility of Payment

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

Right of Recovery

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

Time Limit for Payment

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

GENERAL PROVISIONS

Entire Contract

The Entire Contract consists of:

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

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

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

Notice of Claim

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

Claim Forms

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

Proof of Loss

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

Claim Payments

We will pay all benefits due under this Policy promptly upon receipt of due proof of loss.

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

Assignment of Claim Payments

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

Insurance with Other Insurers

You may have other valid coverage (with another insurer) which applies to a loss covered by this Policy. Other valid coverage may reduce the Benefits payable under this Policy. The Benefits payable under this Policy will not be reduced by other valid coverage if You have notified Us in writing that You do have other valid coverage. You must notify Us before a loss begins. The Benefits payable under this Policy will be reduced by other valid coverage if You have not notified Us in writing (before the loss begins) that You do have other valid coverage.

The amount of the reduced Benefits payable under this Policy will be for the proportion of the loss as the amount which would otherwise have been payable under this Policy plus the total of like amounts under all other valid coverages for the same loss of which We had notice bears to the total like amounts under all valid coverages for such loss.

Physical Examination

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

Legal Action

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

Age Misstatement

If the age of any Insured Person has been misstated, Our records will be changed to show the correct age. The benefits provided will not be affected if the Insured Person continues to be eligible for coverage at the correct age.

However, premium adjustments, including collection of any premium due Us because of past underpayments, will be made so that We receive the premiums due at the correct age payable on the premium due date following Our notification of an age correction.

Incontestability

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

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

Conformity

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

Change of Residence (When Same or Similar Coverage is Available)

If You move, You must notify the Company. You may be issued a revised Policy that includes the mandated benefits required by the state to which You move, provided this same or similar plan is available in that state. Upon re-issuance of Your Policy, the mandated benefits required by the state from which You move will no longer apply.

Unless prohibited by law, rates under Your coverage will be adjusted where necessary, to reflect the rates in effect in the state to which You move.

Change of Residence (When Same or Similar Coverage is Not Available)

If You move, You must notify the Company. If this same or similar plan is not available in the state to which You move, You have the option to select other coverage under another plan, where available, or retain coverage under this Policy and any attached amendments to this Policy.

Unless prohibited by law, rates under Your coverage will be adjusted where necessary, to reflect the rates in effect in the state to which You move.

Subrogation

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

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

Right of Reimbursement

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

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

The Chesapeake Life Insurance Company

Administration Office: P.O. Box 982010, North Richland Hills, TX 76182-8010

ClassicFit

CH-26210 PPO-IP (03/09) AR

Formula
Round(AE x AgeSex x Area x Base x Inflation x Marital x Network x Tobacco x Aggregate Lifetime Max x Deductible Coinsurance MOOP ,2)

Multiply the Base Rate by 3 for quarterly rates, 6 for semi-annual, and 11 for annual premium rates.

Inflation
1.00000000

A \$9 fee is added to the policies on a direct bill mode. A one time application fee of \$55 will be applied at time of application.

Base	Factor
Base	166.290

Based on underwriting results, final rates may range from 50% to the maximum percentage allowed by your state of the calculated rates. This adjustment may also apply to any rider(s) attached.

AE	Factor
Child	1.1500
Female	1.0200
Male	1.0200

Benefit Options	Factor
Deductible 1000 Coinsurance 70 MOOP 5000	1.070500
Deductible 1000 Coinsurance 70 MOOP 10000	1.022500
Deductible 1000 Coinsurance 80 MOOP 5000	1.118000
Deductible 1000 Coinsurance 80 MOOP 10000	1.088900
Deductible 1500 Coinsurance 70 MOOP 5000	1.029600
Deductible 1500 Coinsurance 70 MOOP 10000	0.982700
Deductible 1500 Coinsurance 80 MOOP 5000	1.072600
Deductible 1500 Coinsurance 80 MOOP 10000	1.044100
Deductible 2500 Coinsurance 70 MOOP 5000	0.963500
Deductible 2500 Coinsurance 70 MOOP 10000	0.918800
Deductible 2500 Coinsurance 80 MOOP 5000	1.000000
Deductible 2500 Coinsurance 80 MOOP 10000	0.972300
Deductible 3000 Coinsurance 70 MOOP 5000	0.939000
Deductible 3500 Coinsurance 70 MOOP 5000	0.916900
Deductible 3500 Coinsurance 70 MOOP 10000	0.873900
Deductible 3500 Coinsurance 80 MOOP 5000	0.949100
Deductible 3500 Coinsurance 80 MOOP 10000	0.922200
Deductible 5000 Coinsurance 70 MOOP 5000	0.847000
Deductible 5000 Coinsurance 70 MOOP 10000	0.806900
Deductible 5000 Coinsurance 80 MOOP 5000	0.873100
Deductible 5000 Coinsurance 80 MOOP 10000	0.847500
Deductible 7500 Coinsurance 70 MOOP 5000	0.765500
Deductible 7500 Coinsurance 70 MOOP 10000	0.729300
Deductible 7500 Coinsurance 80 MOOP 5000	0.785200
Deductible 7500 Coinsurance 80 MOOP 10000	0.761400
Aggregate 1000000 Lifetime Max 2000000	1.000000
Aggregate 1000000 Lifetime Max 4000000	1.050000
Aggregate 2000000 Lifetime Max 8000000	1.100000

Other values may be interpolated.

Demographic	Value	Factor
Marital	No	1.000
Marital	Yes	0.950
Tobacco	No	1.000
Tobacco	Yes	1.300

Marital discount only applies if both primary and spouse are insured.

Age	Factor	Gender	Adult/Dep
00	0.770	Female	Adult
01	0.770	Female	Adult
02	0.770	Female	Adult
03	0.770	Female	Adult
04	0.770	Female	Adult
05	0.770	Female	Adult
06	0.770	Female	Adult
07	0.770	Female	Adult
08	0.770	Female	Adult
09	0.770	Female	Adult
10	0.770	Female	Adult
11	0.770	Female	Adult
12	0.770	Female	Adult
13	0.770	Female	Adult
14	0.770	Female	Adult
15	0.770	Female	Adult
16	0.770	Female	Adult
17	0.770	Female	Adult
18	0.770	Female	Adult
19	0.770	Female	Adult
20	0.770	Female	Adult
21	0.770	Female	Adult
22	0.773	Female	Adult
23	0.779	Female	Adult
24	0.785	Female	Adult
25	0.791	Female	Adult
26	0.797	Female	Adult
27	0.823	Female	Adult
28	0.851	Female	Adult
29	0.879	Female	Adult
30	0.907	Female	Adult
31	0.938	Female	Adult
32	0.970	Female	Adult
33	1.002	Female	Adult
34	1.037	Female	Adult
35	1.071	Female	Adult
36	1.108	Female	Adult
37	1.143	Female	Adult
38	1.181	Female	Adult
39	1.219	Female	Adult
40	1.260	Female	Adult
41	1.301	Female	Adult
42	1.338	Female	Adult
43	1.374	Female	Adult
44	1.413	Female	Adult
45	1.452	Female	Adult
46	1.493	Female	Adult
47	1.532	Female	Adult
48	1.573	Female	Adult
49	1.613	Female	Adult
50	1.656	Female	Adult
51	1.699	Female	Adult
52	1.788	Female	Adult
53	1.880	Female	Adult
54	1.979	Female	Adult
55	2.081	Female	Adult
56	2.189	Female	Adult
57	2.281	Female	Adult
58	2.376	Female	Adult
59	2.476	Female	Adult

Age	Factor	Gender	Adult/Dep
60	2.580	Female	Adult
61	2.688	Female	Adult
62	2.780	Female	Adult
63	2.876	Female	Adult
64 - 99	2.976	Female	Adult
00	0.585	Male	Adult
01	0.585	Male	Adult
02	0.585	Male	Adult
03	0.585	Male	Adult
04	0.585	Male	Adult
05	0.585	Male	Adult
06	0.585	Male	Adult
07	0.585	Male	Adult
08	0.585	Male	Adult
09	0.585	Male	Adult
10	0.585	Male	Adult
11	0.585	Male	Adult
12	0.585	Male	Adult
13	0.585	Male	Adult
14	0.585	Male	Adult
15	0.585	Male	Adult
16	0.585	Male	Adult
17	0.585	Male	Adult
18	0.585	Male	Adult
19	0.585	Male	Adult
20	0.585	Male	Adult
21	0.585	Male	Adult
22	0.585	Male	Adult
23	0.585	Male	Adult
24	0.585	Male	Adult
25	0.585	Male	Adult
26	0.588	Male	Adult
27	0.601	Male	Adult
28	0.614	Male	Adult
29	0.627	Male	Adult
30	0.641	Male	Adult
31	0.655	Male	Adult
32	0.676	Male	Adult
33	0.699	Male	Adult
34	0.723	Male	Adult
35	0.747	Male	Adult
36	0.772	Male	Adult
37	0.804	Male	Adult
38	0.835	Male	Adult
39	0.869	Male	Adult
40	0.903	Male	Adult
41	0.940	Male	Adult
42	0.987	Male	Adult
43	1.038	Male	Adult
44	1.091	Male	Adult
45	1.145	Male	Adult
46	1.204	Male	Adult
47	1.263	Male	Adult
48	1.324	Male	Adult
49	1.388	Male	Adult
50	1.456	Male	Adult
51	1.527	Male	Adult
52	1.645	Male	Adult
53	1.772	Male	Adult
54	1.909	Male	Adult

Age	Factor	Gender	Adult/Dep
55	2.057	Male	Adult
56	2.216	Male	Adult
57	2.358	Male	Adult
58	2.510	Male	Adult
59	2.671	Male	Adult
60	2.843	Male	Adult
61	3.026	Male	Adult
62	3.150	Male	Adult
63	3.278	Male	Adult
64 - 99	3.412	Male	Adult
00	0.514	Female	Dep Child
01	0.490	Female	Dep Child
02	0.449	Female	Dep Child
03	0.410	Female	Dep Child
04	0.410	Female	Dep Child
05	0.410	Female	Dep Child
06	0.410	Female	Dep Child
07	0.410	Female	Dep Child
08	0.410	Female	Dep Child
09	0.410	Female	Dep Child
10	0.410	Female	Dep Child
11	0.410	Female	Dep Child
12	0.410	Female	Dep Child
13	0.410	Female	Dep Child
14	0.429	Female	Dep Child
15	0.450	Female	Dep Child
16	0.471	Female	Dep Child
17	0.494	Female	Dep Child
18	0.517	Female	Dep Child
19	0.542	Female	Dep Child
20	0.568	Female	Dep Child
21	0.595	Female	Dep Child
22	0.624	Female	Dep Child
23	0.653	Female	Dep Child
24	0.685	Female	Dep Child
25	0.718	Female	Dep Child
26	0.745	Female	Dep Child
27	0.768	Female	Dep Child
28	0.792	Female	Dep Child
29	0.816	Female	Dep Child
30 - 99	0.841	Female	Dep Child
00	0.514	Male	Dep Child
01	0.490	Male	Dep Child
02	0.449	Male	Dep Child
03	0.410	Male	Dep Child
04	0.410	Male	Dep Child
05	0.410	Male	Dep Child
06	0.410	Male	Dep Child
07	0.410	Male	Dep Child
08	0.410	Male	Dep Child
09	0.410	Male	Dep Child
10	0.410	Male	Dep Child
11	0.410	Male	Dep Child
12	0.410	Male	Dep Child
13	0.410	Male	Dep Child
14	0.429	Male	Dep Child
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Age	Factor	Gender	Adult/Dep
19	0.542	Male	Dep Child
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28	0.792	Male	Dep Child
29	0.816	Male	Dep Child
30 - 99	0.841	Male	Dep Child

Area	ID	Factor
71600 - 71699	AB	1.051
71700 - 71799	AB	1.051
71800 - 71899	AB	1.051
71900 - 71999	AD	1.104
72000 - 72099	ZA	0.976
72100 - 72199	AF	1.160
72200 - 72299	AA	1.025
72300 - 72399	AB	1.051
72400 - 72499	AB	1.051
72500 - 72599	AH	1.218
72600 - 72699	ZA	0.976
72700 - 72799	ZE	0.884
72800 - 72899	AF	1.160
72900 - 72999	ZE	0.884
All - Others	AH	1.218

Expected PPO Network Fee is approximately \$2-\$20. This is a mandatory monthly fee per policy/certificate.

The default network will have a factor of 1.0 and other alternative networks will have a factor between 0.75 and 1.25 depending on their discount and penetration compared to the default network.

The Chesapeake Life Insurance Company

Administration Office: P.O. Box 982010, North Richland Hills, TX 76182-8010

Catastrophic Expense Preferred Provider Organization (PPO)

CH-26210 PPO-IP (03/09) AR

Essential Fit

Formula
Round(AE x AgeSex x Area x Base x Inflation x Marital x Network x Tobacco x Aggregate Lifetime Max x Deductible Coinsurance x Deductible Coinsurance MOOP ,2)

Multiply the Base Rate by 3 for quarterly rates, 6 for semi-annual, and 11 for annual premium rates.

Inflation
1.000000000

A \$9 fee is added to the policies on a direct bill mode. A one time application fee of \$55 will be applied at time of application.

Base	Factor
Base	151.460

Based on underwriting results, final rates may range from 50% to the maximum percentage allowed by your state of the calculated rates. This adjustment may also apply to any rider(s) attached.

AE	Factor
Child	1.1500
Female	1.0200
Male	1.0200

Benefit Options	Factor
Deductible 7500 Coinsurance 80 MOOP 5000	1.003000
Deductible 7500 Coinsurance 80 MOOP 10000	0.972100
Deductible 7500 Coinsurance 90 MOOP 5000	1.034800
Deductible 7500 Coinsurance 90 MOOP 10000	1.020000
Deductible 7500 Coinsurance 100	1.097500
Deductible 10000 Coinsurance 80 MOOP 5000	0.920800
Deductible 10000 Coinsurance 80 MOOP 10000	0.891900
Deductible 10000 Coinsurance 90 MOOP 5000	0.946000
Deductible 10000 Coinsurance 90 MOOP 10000	0.931800
Deductible 10000 Coinsurance 100	1.000000
Deductible 15000 Coinsurance 80 MOOP 5000	0.803500
Deductible 15000 Coinsurance 80 MOOP 10000	0.778200
Deductible 15000 Coinsurance 90 MOOP 5000	0.820500
Deductible 15000 Coinsurance 90 MOOP 10000	0.807400
Deductible 15000 Coinsurance 100	0.862800
Deductible 20000 Coinsurance 80 MOOP 5000	0.723400
Deductible 20000 Coinsurance 80 MOOP 10000	0.700900
Deductible 20000 Coinsurance 90 MOOP 5000	0.735800
Deductible 20000 Coinsurance 90 MOOP 10000	0.723700
Deductible 20000 Coinsurance 100	0.770700
Aggregate 1000000 Lifetime Max 2000000	1.000000
Aggregate 1000000 Lifetime Max 4000000	1.050000
Aggregate 2000000 Lifetime Max 8000000	1.100000

Other values may be interpolated.

Demographic	Value	Factor
Marital	No	1.000
Marital	Yes	0.950
Tobacco	No	1.000
Tobacco	Yes	1.300

Marital discount only applies if both primary and spouse are insured.

Age	Factor	Gender	Adult/Dep
00	0.770	Female	Adult
01	0.770	Female	Adult
02	0.770	Female	Adult
03	0.770	Female	Adult
04	0.770	Female	Adult
05	0.770	Female	Adult
06	0.770	Female	Adult
07	0.770	Female	Adult
08	0.770	Female	Adult
09	0.770	Female	Adult
10	0.770	Female	Adult
11	0.770	Female	Adult
12	0.770	Female	Adult
13	0.770	Female	Adult
14	0.770	Female	Adult
15	0.770	Female	Adult
16	0.770	Female	Adult
17	0.770	Female	Adult
18	0.770	Female	Adult
19	0.770	Female	Adult
20	0.770	Female	Adult
21	0.770	Female	Adult
22	0.773	Female	Adult
23	0.779	Female	Adult
24	0.785	Female	Adult
25	0.791	Female	Adult
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07	0.585	Male	Adult
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10	0.585	Male	Adult
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12	0.585	Male	Adult
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17	0.585	Male	Adult
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02	0.449	Female	Dep Child
03	0.410	Female	Dep Child
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05	0.410	Female	Dep Child
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07	0.410	Female	Dep Child
08	0.410	Female	Dep Child
09	0.410	Female	Dep Child
10	0.410	Female	Dep Child
11	0.410	Female	Dep Child
12	0.410	Female	Dep Child
13	0.410	Female	Dep Child
14	0.429	Female	Dep Child
15	0.450	Female	Dep Child
16	0.471	Female	Dep Child
17	0.494	Female	Dep Child
18	0.517	Female	Dep Child
19	0.542	Female	Dep Child
20	0.568	Female	Dep Child
21	0.595	Female	Dep Child
22	0.624	Female	Dep Child
23	0.653	Female	Dep Child
24	0.685	Female	Dep Child
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03	0.410	Male	Dep Child
04	0.410	Male	Dep Child
05	0.410	Male	Dep Child
06	0.410	Male	Dep Child
07	0.410	Male	Dep Child
08	0.410	Male	Dep Child
09	0.410	Male	Dep Child
10	0.410	Male	Dep Child
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12	0.410	Male	Dep Child
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Area	ID	Factor
71600 - 71699	AB	1.051
71700 - 71799	AB	1.051
71800 - 71899	AB	1.051
71900 - 71999	AD	1.104
72000 - 72099	ZA	0.976
72100 - 72199	AF	1.160
72200 - 72299	AA	1.025
72300 - 72399	AB	1.051
72400 - 72499	AB	1.051
72500 - 72599	AH	1.218
72600 - 72699	ZA	0.976
72700 - 72799	ZE	0.884
72800 - 72899	AF	1.160
72900 - 72999	ZE	0.884
All - Others	AH	1.218

Expected PPO Network Fee is approximately \$2-\$20. This is a mandatory monthly fee per policy/certificate.

The default network will have a factor of 1.0 and other alternative networks will have a factor between 0.75 and 1.25 depending on their discount and penetration compared to the default network.

POLICY SCHEDULE

PRIMARY INSURED: [John Doe, Sr.] EFFECTIVE DATE OF COVERAGE: [01/02/09]

COVERED DEPENDENTS: EFFECTIVE DATE OF COVERAGE:

[Johnette Doe]	[01/02/09]
[John Doe, Jr.]	[03/12/09]
[Johnita Doe]	[01/22/10]

POLICY NUMBER: [ABC1234567] POLICY DATE: [01/02/09]

INITIAL PREMIUM: \$[0.00] MODE OF PAYMENT: [Monthly]

**POLICY SCHEDULE
SCHEDULE OF BENEFITS**

Insured Persons have the right to obtain medical care from the Physicians, Hospitals and other health care Providers of their choice. However, in order to receive maximum benefits, all Covered Services must be obtained from Network Providers. When You utilize a Non-Network Provider You are responsible for any balance due above the Usual and Customary amount.

LIFETIME MAXIMUM AMOUNT: [\$2,000,000 / \$4,000,000 / \$8,000,000]

CALENDAR YEAR MAXIMUM AMOUNT: [\$1,000,000 / \$1,000,000 / \$2,000,000]

<u>CALENDAR YEAR DEDUCTIBLE:</u>	<u>NETWORK PROVIDER</u>	<u>NON-NETWORK PROVIDER</u>
Individual Deductible:	[\$2,500 / \$5,000 / \$7,500 / \$10,000 / \$15,000 / \$20,000]	[\$5,000 / \$10,000/ \$15,000/ \$20,000 / \$30,000 / \$40,000]
Family Deductible:	[\$5,000 / \$10,000 / \$15,000 / \$20,000 / \$30,000 / \$40,000]	[\$10,000 / \$20,000/ \$30,000/ \$40,000 / \$60,000 / \$80,000]

DEDUCTIBLE PROVISIONS:

The Individual Deductible amount will be deducted from expenses incurred by each Insured Person for Covered Services, each Calendar Year, subject to the Family Deductible. Once the Family Deductible is met, no other Deductibles are required for the rest of that [Calendar Year].

[Expenses incurred for Covered Services under any Riders will apply toward the Individual and Family Maximum Deductible, where applicable, unless specifically stated otherwise.]

Non-Covered Services, Facility Fees or Copayments, if any, do not apply toward the Deductible(s).

Common Accident Provision: Upon Your notification to Us that one or more Insured Persons in Your family has been injured in the same accident, We will only require that one Individual Deductible be satisfied each Calendar Year for Covered Services associated with that accident. Once one [individual] Deductible is satisfied under this Policy, the Deductible for all other Insured Persons will be waived for that common accident.

<u>COINSURANCE MAXIMUM:</u>	<u>NETWORK PROVIDER</u>	<u>NON-NETWORK PROVIDER</u>
Individual:	[\$0][\$2,500][\$5,000][\$10,000] / [\$15,000][Not Applicable]	[\$5,000][\$10,000][\$20,000][\$30,000]
Family:	[\$5,000][\$10,000][\$20,000] / [Not Applicable]	[\$10,000][\$20,000][\$40,000]

The Coinsurance Maximum is the total coinsurance portion an Insured Person must pay each [Calendar Year] after the application of any Facility Fees, Copayments, Deductibles and Coinsurance, for Covered Services under this Policy. Once the Individual Coinsurance Maximum is met Covered Services remaining thereafter for that Insured Person in the same [Calendar Year] will be paid at 100% Coinsurance, after the application of any Facility Fees or Copayments. [Once the Family Coinsurance Maximum is met, Covered Services remaining thereafter for all Insured Persons in the same Calendar Year will be paid at 100% Coinsurance, after the application of any Facility Fees or Copayments.] **Facility Fees, Deductibles and Copayments do not count toward meeting the Coinsurance Maximum.**

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

<u>COVERED SERVICES</u>	<u>NETWORK PROVIDER</u>	<u>NON-NETWORK PROVIDER</u>
INPATIENT SERVICES:		
Facility Fee:	[Facility Fee does not apply]	[\$500] per Insured Person, per [Hospital Confinement][Period of Treatment]
Inpatient Hospital: <i>(includes acute inpatient rehabilitation, limited to [10 days] per Insured Person, per [Calendar Year])</i>	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
Transplant Procedures:	[70%][80%][90%][100%] Coinsurance Up to [\$250,000] Maximum Benefit Amount* per Insured Person, per Transplant Procedure	[50%][60%][70%] Coinsurance Up to [\$175,000] Maximum Benefit Amount* per Insured Person, per Transplant Procedure
PRE-ADMISSION TESTING:	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
OUTPATIENT SURGERY FACILITY SERVICES:	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
Facility Fee:	[Facility Fee does not apply]	[\$250] Per Insured Person, per Surgery
MEDICAL EMERGENCIES:	[70%][80%][90%][100%] Coinsurance	[70%][80%][90%][100%] Coinsurance
Hospital Emergency Room Facility Fee: <i>[(Waived if Hospital Confined)]</i>	[\$100][\$250][\$500][\$750][\$1,000] Per Insured Person, per visit	[\$100][\$250][\$500][\$750][\$1,000] Per Insured Person, per visit
Urgent Care Center Facility Fee:	[\$100][\$250] Per Insured Person, per visit	[\$100][\$250] Per Insured Person, per visit
PHYSICIAN SERVICES		
Second Surgical Opinion: <i>(Limited to one per Surgery)</i>	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
Inpatient / Outpatient Surgeon:	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
Inpatient / Outpatient Assistant Surgeon:	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
Inpatient / Outpatient Anesthesiologist:	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance

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

<u>COVERED SERVICES</u>	<u>NETWORK PROVIDER</u>	<u>NON-NETWORK PROVIDER</u>
PHYSICIAN SERVICES (Cont.)		
Physician Visits while Hospital Confined (other than Surgeon): <i>[(Limited to one visit per Physician, per day)]</i>	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
PREVENTIVE IMAGING SCREENING TESTS		
Human Papillomavirus and Cervical Cancer Screening:	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
Prostate Cancer Screening:	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
Mammography Screening:	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
Colorectal Cancer Screening:	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
SCREENING TEST FOR HEARING IMPAIRMENT: <i>(Includes diagnostic follow-up care related to screening test from birth through age 24 months. Not subject to Deductible or a Maximum Benefit)</i>	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
IMPAIRMENT OR LOSS OF SPEECH OR HEARING:	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
MINIMUM STAY REQUIREMENTS FOR MASTECTOMY AND LYMPH NODE DISSECTION:	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance

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

<u>COVERED SERVICES</u>	<u>NETWORK PROVIDER</u>	<u>NON-NETWORK PROVIDER</u>
CHEMOTHERAPY AND RADIATION THERAPY:	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
DURABLE MEDICAL EQUIPMENT AND PROSTHETIC DEVICES: Network / Non-Network Provider: Up to [\$2,000] Maximum Benefit Amount* per Insured Person, per [Calendar Year]	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
AMBULANCE SERVICES <i>(Payable only when Hospital Confined)</i>		
Ground Ambulance: <i>[(Deductible waived)]</i> Network/Non-Network Provider: Up to [\$500] Maximum Benefit Amount* per Insured Person, per trip	[70%][80%][90%][100%] Coinsurance	[70%][80%][90%][100%] Coinsurance
Air / Water Ambulance: <i>[(Deductible waived)]</i> Network / Non-Network Provider: Up to [\$5,000] Maximum Benefit Amount* per Insured Person, per trip	[70%][80%][90%][100%] Coinsurance	[70%][80%][90%][100%] Coinsurance
MATERNITY STAY REQUIREMENTS FOR COVERED MATERNITY CARE:	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
MUSCULOSKELETAL DISORDERS:	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
CHILD HEALTH SUPERVISION SERVICES: <i>(Immunizations only)</i> <i>(Deductible waived)</i>	[100%] Coinsurance	[100%] Coinsurance
MEDICAL FOODS AND LOW PROTEIN MODIFIED FOOD PRODUCTS:	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
DIABETES:	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
OUTPATIENT CONTRACEPTIVE SERVICES AND DEVICES:	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance

*You are responsible for the balance due (if any) on charges for Covered Services in excess of the Maximum Benefit Amount.

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

<u>RIDER BENEFITS</u>	<u>NETWORK PROVIDER</u>	<u>NON-NETWORK PROVIDER</u>
PHYSICIAN OFFICE SERVICES BENEFIT RIDER		
{Option A}		
Outpatient Physician Office Visits for Sickness or Injury:	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
Outpatient Preventive Care Physician Visits - other than Well Child Visits: <i>(Limited to one visit per Insured Person, per [Calendar Year])</i>	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
Well Child Visits: <i>(For covered Dependent children from birth up to 24 months)</i>	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
{Option B}		
Outpatient Physician Office Visits for Sickness or Injury: <i>(Limited to [2][4] visits per Insured Person, per [Calendar Year])</i>	[100%] Coinsurance – [Deductible waived]	[100%] Coinsurance [Deductible waived]
Physician Home and Office Copayment:	[\$50] per Insured Person, per visit	[\$100] per Insured Person, per visit
Convenient Care Clinic Copayment:	[\$25] per Insured Person, per visit	[\$50] per Insured Person, per visit
Outpatient Preventive Care Physician Visits: <i>(Other than Well Child Visits) (Limited to one visit per Insured Person, per [Calendar Year])</i>	[100%] Coinsurance – [Deductible waived]	[100%] Coinsurance [Deductible waived]
Physician Home and Office Copayment:	[\$50] per Insured Person, per visit	[\$100] per Insured Person, per visit
Convenient Care Clinic Copayment:	[\$25] per Insured Person, per visit	[\$50] per Insured Person, per visit
Well Child Visits: <i>(For covered Dependent children from birth up to 24 months):</i>	[100%] Coinsurance – [Deductible waived]	[100%] Coinsurance [Deductible waived]
Physician Home and Office Copayment:	[\$50] per Insured Person, per visit	[\$100] per Insured Person, per visit
Convenient Care Clinic Copayment:	[\$25] per Insured Person, per visit	[\$50] per Insured Person, per visit

POLICY SCHEDULE
SCHEDULE OF BENEFITS (Continued)

RIDER BENEFITS	NETWORK PROVIDER	NON-NETWORK PROVIDER
{Option C}		
Outpatient Physician Office Visits for Sickness or Injury:	[100%] Coinsurance – [Deductible waived]	[100%] Coinsurance [Deductible waived]
Physician Home and Office Copayment:	[\$50] per Insured Person, per visit	[\$100] per Insured Person, per visit
Convenient Care Clinic Copayment:	[\$25] per Insured Person, per visit	[\$50] per Insured Person, per visit
Outpatient Preventive Care Physician Visits: <i>(Other than Well Child Visits)</i> <i>(Limited to one visit per Insured Person, per [Calendar Year])</i>	[100%] Coinsurance – [Deductible waived]	[100%] Coinsurance [Deductible waived]
Physician Home and Office Copayment:	[\$50] per Insured Person, per visit	[\$100] per Insured Person, per visit
Convenient Care Clinic Copayment:	[\$25] per Insured Person, per visit	[\$50] per Insured Person, per visit
Well Child Visits: <i>(For covered Dependent children from birth up to 24 months):</i>	[100%] Coinsurance – [Deductible waived]	[100%] Coinsurance [Deductible waived]
Physician Home and Office Copayment:	[\$50] per Insured Person, per visit	[\$100] per Insured Person, per visit
Convenient Care Clinic Copayment:	[\$25] per Insured Person, per visit	[\$50] per Insured Person, per visit
OUTPATIENT DIAGNOSTIC SERVICES BENEFIT RIDER:	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
CAT, MRI and/or PET Scans through Network / Non-Network Provider		
Facility Fee:	[\$75][\$150][\$250] per Insured Person, per visit	[\$75][\$150][\$250] per Insured Person, per visit
All other outpatient diagnostic services through Network / Non-Network Provider		
Facility Fee:	[\$50][\$200] per Insured Person, per visit	[\$50][\$200] per Insured Person, per visit

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

RIDER BENEFITS

NETWORK PROVIDER

NON-NETWORK PROVIDER

CONTINUED CARE BENEFIT RIDER

Skilled Nursing Care: <i>(Limited to [30][45][60] visits per Insured Person, per Calendar Year)</i>	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
Home Health Care: <i>(Limited to [30][45][60] combined visits per Insured Person, per Calendar Year)</i>	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
<i>Includes Home Health Care Home Infusion Therapy and Wound Care</i>		
Hospice Care: <i>(Not to exceed [\$5,000] Maximum Benefit Amount* per Insured Person, per lifetime)</i>	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance

**OUTPATIENT SPEECH THERAPY, PHYSICAL THERAPY AND
OCCUPATIONAL THERAPY SERVICES RIDER**

(Limited to [40 combined visits] for all therapies per Insured Person, per Calendar Year)

Speech Therapy:	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
Facility Fee:	[\$50] per Insured Person, per visit	[\$50] per Insured Person, per visit
Physical Therapy:	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
Facility Fee:	[\$50] per Insured Person, per visit	[\$50] per Insured Person, per visit
Occupational Therapy:	[70%][80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
Facility Fee:	[\$50] per Insured Person, per visit	[\$50] per Insured Person, per visit

PRESCRIPTION DRUG EXPENSE RIDER

(See Rider)

*You are responsible for the balance due (if any) on charges for Covered Services in excess of the Maximum Benefit Amount.

THE CHESAPEAKE LIFE INSURANCE COMPANY

A Stock Company

(Hereinafter called: the Company, We, Our or Us)

Home Office: Oklahoma City, Oklahoma
Administrative Office: P.O. Box 982010
North Richland Hills, Texas 76182-8010
Customer Service: 1-800-733-1110

[CATASTROPHIC EXPENSE] PREFERRED PROVIDER ORGANIZATION (PPO) POLICY

IMPORTANT NOTICE ABOUT STATEMENTS IN THE APPLICATION

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

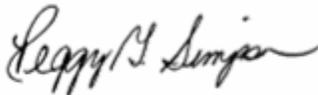
10 DAY RIGHT TO EXAMINE THE POLICY

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

RENEWABILITY

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

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



SECRETARY



PRESIDENT

IMPORTANT MESSAGE TO OUR CERTIFICATEHOLDERS

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

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INPATIENT MEDICAL MANAGEMENT

We or Our designated representative will, using industry standard clinical guidelines, provide review and monitoring of any inpatient admission upon notification by You, or Your admitting Physician or Hospital. We or Our designated representative will pre-certify Medically Necessary admissions, monitor care during the admission and arrange for Medically Necessary services upon discharge.

In order to receive Pre-Certification from Us or Our designated representative, Your Physician or Hospital should call the toll-free telephone number shown on Your I.D. card between 8:00 a.m. and 8:00 p.m. eastern time on Monday through Friday, at least [5] working days prior to a Hospital Confinement.

For emergency admissions, Your Physician or Hospital should call the toll-free telephone number shown on Your I.D. card within 48 hours following the admission, or as soon as reasonably possible, to provide notification of any admission due to a Medical Emergency.

IMPORTANT: PLEASE NOTE THAT PRE-CERTIFICATION OF TREATMENT IS NOT A VERIFICATION OR GUARANTEE OF BENEFITS. Covered Services are subject to all provisions, terms, DEFINITIONS and EXCLUSIONS AND LIMITATIONS of the Policy on the date the service is performed or the supply is furnished and while coverage is in force.

CASE MANAGEMENT

When meeting established clinical criteria, Case Management is a collaborative process where We or Our designated representative will review an eligible Insured Person's health condition(s), assess opportunities to provide alternative care and develop a plan designed to optimize the Insured Person's health.

If the Insured Person's medical condition meets the established clinical criteria, benefits will be provided for approved alternative methods of care, only for so long as is determined that the alternative services are Medically Necessary and cost effective. Case Management is not designed to extend extra-contractual benefits for alternative methods of care to persons who do not meet Our clinical criteria or for services not Pre-certified by Our designated representative. The approved alternative benefits will count toward the Insured Person's Calendar Year and Lifetime Maximum Amounts.

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

DEFINITIONS

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

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

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

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

Calendar Year Maximum Amount means the maximum amount payable under this Policy and its Riders, if any, each Calendar Year for each Insured Person, occurring while coverage is in effect under this Policy for such person. The Calendar Year Maximum Amount is shown in the POLICY SCHEDULE. This amount is included in and part of the Lifetime Maximum Amount for each Insured Person.

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

Coinsurance means the percentage of Covered Services that are paid by Us after application of the Copayment or satisfying the Deductible. The Coinsurance percentage We pay is shown in the POLICY SCHEDULE.

Complications of Pregnancy means:

1. Hospital Confinement or treatment in an Outpatient Surgery Facility (when the pregnancy is not terminated) required to treat conditions, such as the following, in a pregnant female Insured Person: (a) acute nephritis; (b) nephrosis; (c) cardiac decompensation; (d) HELLP syndrome; (e) uterine rupture; (f) amniotic fluid embolism; (g) chorioamnionitis; (h) fatty liver in pregnancy; (i) septic abortion; (j) placenta accreta; (k) gestational hypertension; (l) puerperal sepsis; (m) peripartum cardiomyopathy; (n) cholestasis in pregnancy; (o) thrombocytopenia in pregnancy; (p) placenta previa; (q) placental abruption; (r) acute cholecystitis and pancreatitis in pregnancy; (s) postpartum hemorrhage; (t) septic pelvic thrombophlebitis; (u) retained placenta; (v) venous air embolus associated with pregnancy; (w) miscarriage; or (x) an emergency c-section required because of (i) fetal or maternal distress during labor, or (ii) severe pre-eclampsia, or (iii) arrest of descent or dilatation, or (iv) obstruction of the birth canal by fibroids or ovarian tumors, or (v) necessary because of the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity that, in the absence of immediate medical attention, will result in placing the life of the mother or fetus in jeopardy. For purposes of this paragraph, a c-section delivery is not considered to be an emergency c-section if it is merely for the convenience of the Insured Person and/or Physician or solely due to a previous c-section.
2. Treatment, diagnosis or care for conditions, including the following, in a pregnant female Insured Person when the condition was caused by, necessary because of, or aggravated by the pregnancy: (a) hyperthyroidism; (b) hepatitis B or C; (c) HIV; (d) Human papilloma virus; (e) abnormal PAP; (f) syphilis; (g) chlamydia; (h) herpes; (i) urinary tract infections; (j) thromboembolism; (k) appendicitis; (l) hypothyroidism; (m) pulmonary embolism; (n) sickle cell disease; (o) tuberculosis; (p) migraine headaches; (q) depression; (r) acute myocarditis; (s) asthma; (t) maternal cytomegalovirus; (u) urolithiasis; (v) DVT prophylaxis; (w) ovarian dermoid tumors; (x) biliary atresia and/or cirrhosis; (y) first trimester adnexal mass; (z) hydatidiform mole; or (aa) ectopic pregnancy.

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

A Complication of Pregnancy arising from, caused by, or associated with a pregnancy existing on the Effective Date of Coverage, will be deemed a Pre-Existing Condition and is subject to the Pre-existing Condition provision as shown in the EXCLUSIONS AND LIMITATIONS.

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

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

Convenient Care Clinic means health care clinics, based in retail stores and pharmacies that are staffed by nurse practitioners (NPs).

Copayment means the specific dollar amount the Insured Person is required to pay for specifically listed Covered Services [and is in lieu of any Deductible]. The Copayment, if any, is shown in the POLICY SCHEDULE. Copayments do not count toward satisfaction of any Deductibles.

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

1. Reconstructive Surgery incidental to or following Surgery resulting from trauma, infection or other disease of the involved part, provided the condition which necessitates the Surgery occurs while coverage is in force and remains in force through the Surgery;
2. Reconstructive Surgery in connection with a mastectomy;
3. With respect to a Covered Dependent under age 18, reconstructive Surgery for craniofacial abnormalities, to improve the function of, or attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease; and
4. With respect to a newborn child, reconstructive Surgery to improve the function of, or attempt to create a normal appearance of, an abnormal structure caused by congenital defects.

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

Covered Services means the Medically Necessary Usual and Customary Charges for services, supplies, care or treatment as described in this Policy which are performed, prescribed, directed or authorized by a Provider. To be a Covered Service, the service, supply or treatment must be:

1. Medically Necessary and/or specifically included as a Covered Service under this Policy;
2. Within the scope of the license of the Provider performing the service;
3. Rendered while coverage under this Policy is in force and for which the Insured Person is legally obligated to pay; and
4. Not considered Experimental or Investigative or otherwise excluded or limited under this Policy.

A charge for a Covered Service is incurred on the date the service, supply or treatment is furnished.

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

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

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

Experimental or Investigative means any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply used in or directly related to the diagnosis, evaluation, or treatment of a disease, Injury, Sickness, or other health condition which We determine in Our sole discretion to be Experimental/Investigative. We will deem any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply to be Experimental/Investigative if We determine that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought. The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply:

1. Cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (FDA), or other licensing or regulatory agency, and such final approval has not been granted;
2. Has been determined by the FDA to be contraindicated for the specific use;
3. Is provided as part of a clinical research protocol or clinical trial or is provided in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply; and
4. Is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply as Experimental/Investigative, or otherwise indicate that the safety toxicity, or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is under evaluation.

The information considered or evaluated by Us to determine whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply is Experimental/Investigative under the above criteria may include one or more items from the following list which is not all inclusive:

1. Published authoritative, peer-reviewed medical or scientific literature, or the absence thereof; or
2. Evaluations of national medical associations, consensus panels, and other technology evaluation bodies; or
3. Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate, or investigate the use of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service, or supply; or
4. Consent documents and/or the written protocols used by the treating Physicians or other medical professional, or facilities or by other treatment, Physicians, other medical professionals, or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply; or
5. Medical records; or
6. The opinions of consulting Providers and other experts in the field.

Based on the criteria above, We have the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is Experimental/Investigative.

Facility Fee means the amount the Insured Person is required to pay before the application of the Coinsurance, Deductibles or Copayments, if any, for specifically listed Covered Services. The Facility Fee, if any, is shown in the POLICY SCHEDULE. Facility Fees do not count toward [Copayments][,Deductibles][,or Coinsurance Maximums].

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

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

The term "Hospital" does not include:

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

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

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

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

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

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

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

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

Low Dose Mammography means the x-ray, examination of the breast using equipment dedicated specially for mammography, including the x-ray tube, filter, compression device, screens, films, and cassettes with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast.

Maximum Benefit Amount means the maximum amount payable for a Covered Service(s) under this Policy and any attached Riders for each Insured Person, after the application of any Deductibles, Copayments and/or Coinsurance, where applicable. The Maximum Benefit Amount is shown in the POLICY SCHEDULE and applies to both Network and Non-Network Providers, unless specifically stated otherwise. ***You are responsible for the balance due (if any) on charges for Covered Services in excess of the Maximum Benefit Amount.***

Medical Emergency means medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that the Insured Person's condition, Sickness, or Injury is of such a nature that failure to get immediate medical care could result in:

1. Placing the patient's health in serious jeopardy;
2. Serious impairment to bodily functions;
3. Serious dysfunction of any bodily organ or part;
4. Serious disfigurement; or
5. In the case pregnant woman, serious jeopardy to the health of the fetus.

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

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

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

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

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

Network Provider (or Preferred Provider Organization (PPO)) means a Provider that holds a valid contract with the network associated with this Policy, to provide health care services. A current list of the Network Providers in the network associated with this Policy is available to You upon request.

Non-authorization or Non-authorized means the Hospital Confinements, Transplant Procedures, Diagnostic Procedures or Outpatient Services that have been determined by Our designated representative as a non-Covered Service under this plan because they do not meet the Preauthorization criteria.

Non-Network Provider (or Non-Preferred Provider Organization (Non-PPO)) means a Provider who has not entered into a contractual agreement with the Network associated with this Policy.

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

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

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

The term "Outpatient Surgery Facility" does not include:

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

Period of Treatment means a period which begins on the date an Insured Person is admitted to a Hospital or the date services are rendered in an Outpatient Surgery Facility for the treatment of an Injury or Sickness and ends after 365 days. If the same or related Sickness or Injury continues beyond 365 days, a new Sickness or Injury Period of Treatment will begin, which includes a new Deductible. In no event will a single Period of Treatment exceed 365 days. A separate Period of Treatment will apply to each Injury or Sickness.

Physician means a legally qualified licensed practitioner of the healing arts who provides care within the scope of his or her license, including any other practitioner We are compelled by applicable law to recognize as legally qualified to provide a Covered Service. A member of the Insured Person's Immediate Family will not be considered a Physician (with the exception of dentists providing services which are considered Covered Services under this Policy).

Physician's Office means a location, other than a Hospital, Hospital emergency room, Urgent Care Center, skilled nursing facility (SNF), military treatment facility, community health center, state or local public health clinic, or intermediate care facility (ICF), where the health professional routinely provides health examinations, diagnosis, and treatment of Sickness or Injury on an ambulatory basis.

Policy means this written description of coverage provided to You by Us.

Pre-Certification means the procedure whereby We or Our designated representative determines, based on medically recognized criteria, whether or not a Hospital Confinement is reasonable for the type of services to be received.

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

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

Pre-Existing Condition will also include a pregnancy which exists on the Effective Date of Coverage.

Provider means a duly licensed person or facility that provides services within the scope of an applicable license and is a person or facility that We approve. This includes any Provider rendering services which are required by applicable state law to be covered when rendered by such Provider.

Sickness means an illness or disease which first manifests itself after the Insured Person's coverage becomes effective and while the coverage is in force. Sickness includes Complications of Pregnancy. Any condition which manifests itself prior to the Insured Person's Effective Date of Coverage and which meets the criteria of a Pre-Existing Condition, as defined herein, is subject to the Pre-Existing Condition provision as shown in the EXCLUSIONS AND LIMITATIONS.

Special Circumstances means a condition such that the treating Physician reasonably believes that discontinuing care by the treating Physician could cause harm to the Insured Person.

Surgery or Surgical Procedure means an invasive diagnostic procedure or the treatment of an Insured Person's Sickness or Injury by manual or instrumental operations, including any of the procedures designated by Current Procedural Terminological codes as Surgery, performed by a Physician while the Insured Person is under general or local anesthesia.

Total Disability or Totally Disabled means:

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

Transplant Benefit Period means the period of time:

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

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

- | | |
|---|--|
| <ol style="list-style-type: none">1. Heart transplant;2. Combined heart and lung transplant;3. Lung transplant;4. Kidney transplant;5. Kidney and pancreas transplant;6. Liver transplant;7. Bone marrow transplant, either allogenic or autologous, including high dose chemotherapy; or8. Peripheral stem cell transplant. | |
|---|--|

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

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

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

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

Usual and Customary Charge means the charge which is the lesser of:

1. The actual charge;
2. The charge usually made for the Covered Service by the provider who furnishes it;
3. The prevailing charge made for a Covered Service in a geographical area by those of similar professional standing; and
4. The contracted rate in effect with a Network Provider on the date it provides a Covered Service, when Covered Services are received from Network Provider.

Urgent Care Center means a free-standing facility, center or other entity that operates primarily to provide specialty medical treatment of an unforeseen, unexpected Sickness or Injury on an urgently needed or prompt basis.

We, Us and Our means The Chesapeake Life Insurance Company.

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

EFFECTIVE DATE OF COVERAGE

Beginning of Coverage

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

Newborn Children

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

Newly Adopted Children

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

Additional Dependents

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

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

PREMIUMS

Premium Due Date

Premiums are payable to Us at Our administrative office in North Richland Hills, Texas. The premium is payable monthly, quarterly, or annually, as indicated in the POLICY SCHEDULE. Payment of any premium will not maintain coverage in force beyond the next premium due date, except as provided by the Grace Period. Upon the payment of a claim under this Policy, any premium then due and unpaid or covered by any note or written order may be deducted therefrom.

Grace Period

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

Premium Changes

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

Unearned Premiums Refund

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

TERMINATION OF COVERAGE

You

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

1. At the end of the period for which premium has been paid (subject to the Grace Period);
2. If Your mode of premium is monthly, at the end of the period through which premium has been paid following Our receipt of Your request of termination;
3. If Your mode of premium is other than monthly, upon the next monthly anniversary day following Our receipt of Your request of termination. Premium will be refunded for any amounts paid beyond the termination date;
4. On the date We elect to discontinue this plan or type of coverage. We will give You at least 90 days written notice before the date coverage will be discontinued. You will be offered an option to purchase any other coverage that We offer without regard to health status;
5. On the date We elect to discontinue all health benefit plans in Your state. We will give You and the proper state authority at least 180 days written notice before the date coverage will be discontinued; or
6. On the date an Insured Person:
 - a. performs an act or practice that constitutes fraud; or
 - b. has made an intentional misrepresentation of material fact, relating in any way to the coverage provided under the Policy, including claims for benefits under the Policy.

Covered Dependents

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

1. The date Your coverage terminates;
2. The date such dependent ceases to be an Eligible Dependent;
3. The date We receive Your written request to terminate a dependent's coverage; or
4. On the date the Covered Dependent:
 - a. performs an act or practice that constitutes fraud; or
 - b. has made an intentional misrepresentation of material fact, relating in any way to the coverage provided under the Policy, including claims for benefits under the Policy.

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

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

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

Family Security Benefit

Beginning with the next premium due date following Our receipt of due proof of Your death, We will waive premiums for a period of 12 months for Your Covered Dependents. During this premium waiver period, no increase in benefits or addition of Eligible Dependents, except newborns, will be considered. Provisions for termination of coverage for Covered Dependents will also apply. Upon expiration of the 12-month premium waiver period, Your Covered Dependent spouse may continue coverage, as stated in the **Special Continuation Provision for Dependents** section and by making the required premium payments.

Special Continuation for Dependents

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

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

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

Reinstatement

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

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

Replacement of the Policy by Another Insurer

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

NETWORK PROVIDERS

Coverage under this Policy includes access to discounts and increased benefits through the use of Network Providers. Access to Network Providers is attained through the use of one or more non-overlapping networks.

Out-of-Network Treatment

If an Insured Person uses the services of a Non-Network Provider, the Coinsurance amount may be less than that which would have otherwise been considered for Covered Services received from a Network Provider. However, if an Insured Person goes to a Non-Network Provider solely because he or she requires Medically Necessary services that are not available from a Network Provider within a 50 mile radius of Your residence, then the Covered Services will be considered on the same basis as if the Insured Person had used the services of a Network Provider for the purposes of determining benefits. This will not apply when the Insured Person chooses to receive services from Providers other than Network Providers, solely for the Insured Person's convenience.

Medical Emergency

If an Insured Person cannot reasonably reach a Network Provider and goes to a Non-Network Provider solely for a Medical Emergency, Covered Services for the Medical Emergency will be considered on the same basis as if the Insured Person had used the services of a Network Provider. However, treatment by a Non-Network Provider for such Medical Emergency must consist of:

1. Any medical screening examination or other evaluation required by state or federal law to be provided in the emergency facility of a Hospital which is necessary to determine whether a Medical Emergency condition exists;
2. Necessary Medical Emergency services including the treatment and stabilization of a Medical Emergency condition; or
3. Services originating in a Hospital emergency facility following treatment or stabilization of a Medical Emergency condition.

Such Medical Emergency services will be reimbursed at the Network Provider benefit level until the Insured Person can reasonably be expected to transfer to a Network Provider.

Special Circumstances

If a network arrangement terminates and, at the time of termination, Special Circumstances exist in connection with the treatment being received by an Insured Person by such former Network Provider, the Covered Services by such former Network Provider will be considered as if they were provided by a Network Provider.

Special Circumstances must be identified by the treating Physician who must: make a request to Us that the Insured Person be permitted to continue treatment under the Physician's care as an outpatient or inpatient at a Hospital; and further provided such Physician and Hospital agree not to seek payment from either the Company or the Insured Person for any amounts in excess of the those Covered Service amounts which would have been considered for a Network Provider.

COVERED SERVICES

Covered Services include Medically Necessary Usual and Customary Charges for the services, supplies, care or treatment as described in this Policy which are performed, prescribed, directed or authorized by a Provider. To be a Covered Service, the service, supply or treatment must be:

1. Medically Necessary and/or specifically included as a Covered Service under this Policy;
2. Within the scope of the license of the Provider performing the service;
3. Rendered while coverage under this Policy is in force and for which the Insured Person is legally obligated to pay; and
4. Not considered Experimental or Investigative or otherwise excluded or limited under this Policy.

A charge for a Covered Service is incurred on the date the service, supply or treatment is furnished.

Unless otherwise stated herein, all Covered Services are subject to:

1. The Facility Fees shown in the POLICY SCHEDULE, if any;
2. The [Calendar Year Deductible][Deductible per [Period of Treatment] or the Deductible for all other Outpatient Covered Services] shown in the POLICY SCHEDULE;
3. The Copayments shown in the POLICY SCHEDULE, if any;
4. The Network Provider Coinsurance level or Non-Network Provider Coinsurance level Coinsurance level shown in the POLICY SCHEDULE;
5. The Maximum Benefit Amounts, visit limitations, if any, [Calendar Year][Aggregate Maximum Amount] and Lifetime Maximum Amount shown in the POLICY SCHEDULE;
6. The EXCLUSIONS AND LIMITATIONS; and
7. All other provisions of this Policy.

INPATIENT SERVICES:

Inpatient Hospital

Covered Services include services and supplies provided by a Hospital for semi-private accommodations and general nursing care furnished by the Hospital including Confinement in the Hospital's Intensive Care or Cardiac Care Unit; Physician visits and miscellaneous medical services and supplies necessary for the treatment of the Insured Person.

Covered Services will also include hemodialysis and the charges by a Hospital for processing and administration of blood or blood components, acute inpatient rehabilitation, x-ray, laboratory, diagnostic tests and services of a radiologist, radiology group, and the services of a pathologist or pathology group for interpretation of diagnostic tests or studies, performed while the Insured Person is Hospital Confined.

Covered Services will also include coverage for general anesthesia and associated Hospital Charges in conjunction with Dental Care provided to an Insured Person if such person is: (a) a Covered Dependent child who is developmentally disabled; or (b) an individual for whom a successful result cannot be expected from Dental Care provided under local anesthesia because of a neurological or other medically compromising condition.

The fees charged for take home drugs, personal convenience items such as lotions, shampoos, etc., or items not intended primarily for use by the Insured Person while Hospital Confined are not Covered Services.

Transplant Procedures

Covered Services include Transplant Procedures incurred during a Transplant Benefit Period. Covered Services for Transplant Procedures include the following when part of a Transplant Treatment Plan:

1. Inpatient and outpatient Hospital services;
2. Services of a Physician for diagnosis, treatment and Surgery for a Transplant Procedure;
3. Procurement of an organ or tissue, including services provided to a living donor of an organ or tissue for procurement of an organ or tissue, provided the donor and transplant recipient are both insured under this Policy. Covered Services are limited to the actual procurement expenses, and will not be more than any Maximum Benefit Amounts under the Policy applicable to the recipient;
4. Rental of durable medical equipment for use outside the Hospital. Covered Services are limited to the purchase price of the same equipment;
5. Prescription Drugs, including immunosuppressive drugs;
6. Oxygen;
7. Speech therapy, occupational therapy, Physical Therapy and chemotherapy;
8. Services and supplies for and related to high dose chemotherapy and bone marrow tissue transplantation when provided as part of a Transplant Treatment Plan which includes bone marrow transplantation and high dose chemotherapy;
9. Surgical dressings and supplies; and
10. Home Health Care.

When the Insured Person's Physician advises the Insured Person that a Transplant Procedure is being considered, the Insured Person or the Insured Person's Physician should notify Us or Our designee.

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

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

Expenses incurred beyond the Transplant Benefit Period will not be considered Covered Services, unless covered elsewhere under the Policy.

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

PRE-ADMISSION TESTING:

Covered Services include pre-admission tests done on an outpatient basis before an authorized Hospital stay or Outpatient Surgery. These tests must be:

1. Made within 14 days prior to Hospital Confinement or within 14 days of an outpatient Surgery;
2. Related to the condition for which the Insured person is being Confined;
3. Not repeated in the Hospital or elsewhere; and
4. Ordered by a Physician.

OUTPATIENT SURGERY FACILITY SERVICES:

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

1. Use of operating room and recovery room;
2. Administration of drugs and medicines during Surgery;
3. Dressings, casts, splints;
4. Diagnostic services including radiology, laboratory or pathology performed at the time of the Surgery; and
5. General anesthesia and associated Outpatient Surgery Facility Charges in conjunction with Dental Care provided to an Insured Person if such person is: (a) a Covered Dependent child who is developmentally disabled; or (b) an individual for whom a successful result cannot be expected from Dental Care provided under local anesthesia because of a neurological or other medically compromising condition.

MEDICAL EMERGENCIES:

Covered Services include treatment of a Medical Emergency in a Hospital emergency room or Urgent Care facility.

PHYSICIAN SERVICES:

Second Surgical Opinion

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

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

Inpatient / Outpatient Surgeon

Covered Services include expenses incurred while Hospital Confined or in an Outpatient Surgery Facility for services by the Physician performing Surgery.

[When multiple surgical procedures are done at the same time, Covered Services will be considered for the first or highest cost procedure. No benefit is payable for incidental surgical procedures such as an appendectomy performed during a gall bladder surgery.]

Inpatient / Outpatient Assistant Surgeon

Covered Services include services by the Physician assisting the Physician performing Surgery.

Inpatient / Outpatient Anesthesiologist

Covered Services include services by the Physician providing anesthesia during Surgery.

Physician Visits while Hospital Confined

Covered Services include visits by a Physician, other than the surgeon, while Hospital Confined.

PREVENTIVE IMAGING SCREENING TESTS:

Human Papillomavirus and Cervical Cancer Screening

Covered Services include the following annual screenings, as approved by the United States Food and Drug Administration, for female Insured Persons 18 years of age or older:

1. A conventional Pap smear screening or a screening using liquid-based cytology methods; or
2. A conventional Pap smear screening in combination with a test for the detection of the Human Papillomavirus.

The screening test required under this benefit must be performed in accordance with the guidelines adopted by:

1. The American College of Obstetricians and Gynecologists; or
2. Another similar national organization of medical professionals recognized by the Commissioner.

Prostate Cancer Screening

Covered Services include the following services and supplies provided to an Insured Person for the detection of prostate cancer:

1. An annual physical examination for the detection of prostate cancer for each male Insured Person; and
2. An annual prostate-specific antigen (PSA) test used for the detection of prostate cancer for each male Insured Person who is:
 - (a) at least 50 years of age and asymptomatic; or
 - (b) at least 40 years of age with a family history of prostate cancer or another prostate cancer risk factor.

Mammography Screening

Covered Services include an annual Low Dose Mammography screening for each female Insured Person age 35 or older.

Colorectal Cancer Screening

Covered Services include colorectal cancer examinations and laboratory tests for Insured Persons who are 50 years of age or older; who are less than 50 years of age and at high risk for colorectal cancer according to American Cancer Society colorectal cancer screening guidelines as they existed on [January 1, 2005]; and experiencing bleeding from the rectum or blood in the stool or a change in bowel habits, such as diarrhea, constipation, or narrowing of the stool that lasts more than 5 days as determined by a licensed Physician.

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

recognized gene markers for colorectal cancer or other predisposing factors; and any definition recognized by medical science and determined by the Director of the Department of Health in consultation with the University of Arkansas for Medical Sciences.

SCREENING TEST FOR HEARING IMPAIRMENT:

Covered Services include a screening test of hearing loss for a Covered Dependent child from birth through the date the child is 30 days old. Covered Services also include the necessary diagnostic follow-up care related to the screening test from birth through the date the child is 24 months old.

[Deductibles do not apply.]

IMPAIRMENT OR LOSS OF SPEECH OR HEARING:

Covered Services include the necessary care and treatment of loss or impairment of speech or hearing which includes the communicative disorders generally treated by speech pathologist or audiologist licensed by the Board of Examiners in Speech-Language Pathology and Audiology and which fall within the scope of his/her area of certification. Coverage does not apply to hearing instruments or devices.

MINIMUM STAY REQUIREMENTS FOR MASTECTOMY AND LYMPH NODE DISSECTION

Covered Services include inpatient care if an Insured Person undergoes a covered mastectomy, for a minimum of the following:

1. 48 hours following a covered mastectomy; or
2. 24 hours following a covered lymph node dissection for the treatment of breast cancer.

A shorter period of Confinement will be covered if the Insured Person and her Physician determine that a shorter period of inpatient Hospital Confinement is appropriate.

CHEMOTHERAPY AND RADIATION THERAPY:

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

[(Deductibles do not apply)]

DURABLE MEDICAL EQUIPMENT AND PROSTHETIC DEVICES:

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

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

Routine maintenance and repairs of rental equipment are not considered Covered Services.

AMBULANCE SERVICES:

Covered Services include Ambulance transportation to the nearest Hospital that can provide Covered Services appropriate for the Insured person's condition.

Ambulance services are only considered Covered Services if the Insured Person is Confined to the Hospital.

Air or water Ambulance services are only considered a Covered Service in situations in which the Insured person is in a location that cannot be reached by ground Ambulance.

Ambulance usage for the convenience of the Insured Person is not a Covered Service. Non-Covered Services for Ambulance include but are not limited to trips to a Physician's Office or clinic; or a morgue or funeral home.

MATERNITY STAY REQUIREMENTS FOR COVERED MATERNITY CARE:

This provision applies to an Insured Person's coverage only when the Insured Person incurs Covered Services for a normal childbirth or cesarean section delivery that is covered for Complications of Pregnancy as defined in the Policy. A minimum of 48 hours of inpatient care will be provided to the mother and newborn child following a vaginal delivery and 96 hours following a cesarean section.

MUSCULOSKELETAL DISORDERS:

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

CHILD HEALTH SUPERVISION SERVICES:

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

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

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

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

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

MEDICAL FOODS AND LOW PROTEIN MODIFIED FOOD PRODUCTS:

Covered Services include the treatment of a Covered Dependent inflicted with phenylketonuria if:

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

DIABETES:

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

Diabetes Self-Management Training means instructions in an inpatient or outpatient setting including medical nutrition therapy relating to diet, caloric intake and diabetes management, excluding any programs in which the

only purpose is weight reduction, which enables diabetic patients to understand the diabetic management process and daily management of diabetic therapy as a method of avoiding frequent hospitalizations and complications when the instruction is provided in accordance with a program in compliance with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association.

OUTPATIENT CONTRACEPTIVE SERVICES AND DEVICES:

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

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

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

EXCLUSIONS AND LIMITATIONS

We will not provide any benefits for charges arising directly or indirectly, in whole or in part, from:

1. Any care not Medically Necessary or services for which benefits are not specifically provided for in this Policy, including charges related to secondary medical conditions resulting directly or indirectly from conditions, treatment or services that are not considered a Covered Service and/or that are specifically excluded under this Policy;
2. Any charges exceeding the Maximum Benefit Amount, Calendar Year Maximum Amount or Lifetime Maximum Amount;
3. Any act of war, declared or undeclared;
4. Suicide, attempted suicide, or any intentionally self-inflicted injury, while sane or insane;
5. Care, treatment, services or supplies received in a Hospital emergency room for treatment of a Sickness or Injury that is not considered a Medical Emergency;
6. Any Injury or Sickness arising out of, or in the course of, employment for wage or profit, provided the Insured Person is covered under any Workers' Compensation Act, Occupational Disease Act, or similar act or law,
7. Mental or Nervous Disorders, unless otherwise stated herein;
8. Drug abuse or addiction including alcoholism, or overdose of drugs, narcotics, or hallucinogens, directly or indirectly, wholly or partially, unless taken as prescribed by a Physician;
9. An overdose of drugs, being intoxicated or under the influence of intoxicants, hallucinogens, narcotics or other drugs or controlled substances, directly or indirectly, wholly or partially, unless taken as prescribed by a Physician;
10. Any treatment including prescription drugs or non-prescription drugs, or procedure that promotes conception or prevents childbirth, including but not limited to: (a) artificial insemination; (b) in-vitro fertilization or other treatment for infertility; (c) treatment for impotency; (d) sterilization or reversal of sterilization; or (e) abortion (unless the life of the mother would be endangered if the fetus were carried to term), unless otherwise stated herein;
11. Laser vision correction, radial keratotomy or any eye Surgery when the primary purpose is to correct nearsightedness, farsightedness, astigmatism, or any other refractive error;
12. Spinal manipulations and manual manipulative treatment or therapy;
13. Mandibular or maxillofacial Surgery to correct growth defects after one year from the date of birth, jaw disproportions or malocclusions, or to increase vertical dimension or reconstruct occlusion, unless otherwise stated herein;
14. Weight loss or modification, or complications arising there from, or procedures resulting therefrom or for surgical treatment of obesity including but not limited to gastric by-pass, wiring of the teeth and all forms of Surgery performed for the purpose of weight loss or modification or the reversal/modification of such procedure;
15. Breast reduction or augmentation, or complications arising there from, unless necessary in connection with breast reconstructive Surgery following a mastectomy;
16. Modification of the physical body in order to improve the psychological, mental or emotional well-being of the Insured Person, such as but not limited to sex-change Surgery;
17. Marriage, family, or child counseling for the treatment of premarital, marriage, family or child relationship dysfunctions;
18. Directly or indirectly engaging in an illegal occupation or illegal activity;
19. Care in a nursing home, custodial institution or domiciliary care or rest cures;

20. Preparation and presentation of medical reports for appearance at trials or hearings;
21. Physical examinations required for school events, sports, camp, employment, licensing and insurance, unless otherwise stated herein;
22. Immunizations required for the sole purpose of travel outside of the U.S.A.;
23. Payment for care for military service connected disabilities for which the Insured Person is legally entitled to services and for which facilities are reasonably available to the Insured Person and payment for care for conditions that state or local law requires be treated in a public facility;
24. Experimental or Investigative medical, surgical or other health care procedures, treatments, products or services, unless otherwise stated herein;
25. Personal comfort items, such as television, telephone, lotions, shampoos, etc.;
26. Cosmetic Surgery, or complications arising there from, unless otherwise stated herein;
27. Dental Care, treatment or Surgery unless necessitated by Injury to sound natural teeth which occurs while insured under this Policy. (The expense must be incurred within one year from the date of Injury);
28. Corrective vision or hearing supplies or for the examination for prescribing or fitting such supplies;
29. The removal of warts, corns, calluses, the cutting and trimming of toenails, care for flat feet, fallen arches or chronic foot strain;
30. Expenses incurred for prescription drugs, except if added by Rider;
31. Normal pregnancy, except for Complications of Pregnancy, [except if added by Rider];
32. Any expenses related to a surrogate pregnancy; and
33. Treatment, services or supplies received outside the U.S. or Canada. However, treatment, services or supplies received as a result of an acute Sickness or Injury sustained during the first 30 days of travel outside of the U.S. or Canada will be considered a Covered Service. In no event will treatment, services or supplies received beyond the first 30 days of travel outside of the U.S. or Canada be considered a Covered Service.

Sickness Exclusion

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

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

Pre-Existing Condition

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

Coverage After Age 65 or Earlier Medicare Eligibility

When an Insured Person becomes covered under Medicare, the Covered Services of this Policy and its attachments, if any, are considered only to the extent that they are not paid by Medicare and they would otherwise be payable under this Policy. Covered Services will also be subject to any other EXCLUSIONS AND LIMITATIONS set forth in this Policy.

COORDINATION OF BENEFITS

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

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

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

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

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

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

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

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

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

would exceed the Allowable Expense.

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

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

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

The rules that set the order of benefit determination are:

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

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

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

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

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

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

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

Facility of Payment

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

Right of Recovery

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

Time Limit for Payment

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

GENERAL PROVISIONS

Entire Contract

The Entire Contract consists of:

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

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

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

Notice of Claim

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

Claim Forms

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

Proof of Loss

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

Claim Payments

We will pay all benefits due under this Policy promptly upon receipt of due proof of loss.

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

Assignment of Claim Payments

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

Insurance with Other Insurers

You may have other valid coverage (with another insurer) which applies to a loss covered by this Policy. Other valid coverage may reduce the Benefits payable under this Policy. The Benefits payable under this Policy will not be reduced by other valid coverage if You have notified Us in writing that You do have other valid coverage. You must notify Us before a loss begins. The Benefits payable under this Policy will be reduced by other valid coverage if You have not notified Us in writing (before the loss begins) that You do have other valid coverage.

The amount of the reduced Benefits payable under this Policy will be for the proportion of the loss as the amount which would otherwise have been payable under this Policy plus the total of like amounts under all other valid coverages for the same loss of which We had notice bears to the total like amounts under all valid coverages for such loss.

Physical Examination

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

Legal Action

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

Age Misstatement

If the age of any Insured Person has been misstated, Our records will be changed to show the correct age. The benefits provided will not be affected if the Insured Person continues to be eligible for coverage at the correct age.

However, premium adjustments, including collection of any premium due Us because of past underpayments, will be made so that We receive the premiums due at the correct age payable on the premium due date following Our notification of an age correction.

Incontestability

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

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

Conformity

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

Change of Residence (When Same or Similar Coverage is Available)

If You move, You must notify the Company. You may be issued a revised Policy that includes the mandated benefits required by the state to which You move, provided this same or similar plan is available in that state. Upon re-issuance of Your Policy, the mandated benefits required by the state from which You move will no longer apply.

Unless prohibited by law, rates under Your coverage will be adjusted where necessary, to reflect the rates in effect in the state to which You move.

Change of Residence (When Same or Similar Coverage is Not Available)

If You move, You must notify the Company. If this same or similar plan is not available in the state to which You move, You have the option to select other coverage under another plan, where available, or retain coverage under this Policy and any attached amendments to this Policy.

Unless prohibited by law, rates under Your coverage will be adjusted where necessary, to reflect the rates in effect in the state to which You move.

Subrogation

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

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

Right of Reimbursement

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

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

THE CHESAPEAKE LIFE INSURANCE COMPANY

VARIABILITY STATEMENT

CATASTROPHIC EXPENSE PREFERRED PROVIDER ORGANIZATION (PPO) POLICY (FORMS: CH-26210 PPO-IP (03/09) AR with Policy Schedule CH-26210 PPO-IP (SB-A) (03/09) AR)

POLICY SCHEDULE

The amounts specified within brackets on the Policy Schedule pages are the ranges of amounts we intend to offer with this plan. Below is additional information regarding specific option combinations the applicant will have the ability to choose from, as well as how certain terms of the plan are intended to work.

1. LIFETIME and CALENDAR YEAR MAXIMUM AMOUNTS – Applicant will have a **choice** of the following options:
 - a. OPTION A: \$2,000,000 Lifetime / \$1,000,000 Calendar Year
 - b. OPTION B: \$4,000,000 Lifetime / \$1,000,000 Calendar Year
 - c. OPTION B: \$8,000,000 Lifetime / \$2,000,000 Calendar Year

2. CALENDAR YEAR DEDUCTIBLE AMOUNTS – Applicant will have a **choice** of the following options:
 - a. OPTION A: Network: \$7,500 Individual / \$15,000 Family...Non-Network: \$15,000 Individual / \$30,000 Family
 - b. OPTION B: Network: \$10,000 Individual / \$20,000 Family...Non-Network: \$20,000 Individual / \$40,000 Family
 - c. OPTION C: Network: \$15,000 Individual / \$30,000 Family...Non-Network: \$30,000 Individual / \$60,000 Family
 - d. OPTION D: Network: \$20,000 Individual / \$40,000 Family...Non-Network: \$40,000 Individual / \$80,000 Family
 - Family Deductible can be met by any combination of individual deductible accumulations in the family.
 - Non-Covered Services, Facility Fees or Covered Services in excess of the Maximum Benefit Amount, or any applicable Copayment amounts do not count toward meeting the Deductible.

3. NETWORK / NON-NETWORK COINSURANCE AMOUNTS – Applicant will have a **choice** of the following options:
 - a. OPTION A: 80% / 50%
 - b. OPTION B: 90% / 60%
 - c. OPTION C: 100% / 70%

4. CALENDAR YEAR COINSURANCE MAXIMUM AMOUNTS – We intend to market the following amounts to applicants:
 - Network: \$10,000 Individual / \$20,000 Family
 - Non-Network: \$20,000 Individual / \$40,000 Family
 - "Coinsurance Maximum" represents the total amount an insured must pay after satisfaction of the any Facility Fees, Copayments, Deductibles and Coinsurance.
 - Once the Individual Coinsurance Maximum is met, Covered Services will be paid at 100% Coinsurance after the application of Facility Fees and Copayments, within the same Calendar Year.
 - Once the Family Coinsurance Maximum is met, Covered Services will be paid at 100% for all Insured Persons in the same Calendar Year will be paid at 100% Coinsurance after the application of Facility Fees and Copayments.
 - Family Coinsurance Maximum can be met by any combination of individual coinsurance maximum accumulations in the family.

THE CHESAPEAKE LIFE INSURANCE COMPANY

VARIABILITY STATEMENT

CATASTROPHIC EXPENSE PREFERRED PROVIDER ORGANIZATION (PPO) POLICY (FORMS: CH-26210 PPO-IP (03/09) AR with Policy Schedule CH-26210 PPO-IP (SB-A) (03/09) AR)

ADDITIONAL COVERED SERVICES: *We intend to market the following benefits to applicants.*

5. INPATIENT SERVICES -

- a. **Non-Network** services: May be subject to \$500 Facility Fee amount, per Insured Person, per Hospital Confinement.
- b. Subject to chosen Network / Non-Network Deductible and Coinsurance amounts.
- c. Transplant Procedure Covered Services:
 - **Network** services: *subject to \$250,000 Maximum Benefit Amount, per Insured Person, per Transplant Procedure.*
 - **Non-Network** services: *subject to \$175,000 Maximum Benefit Amount, per Insured Person, per Transplant Procedure.*

6. OUTPATIENT SURGERY FACILITY SERVICES –

- a. **Non-Network** services: May be subject to \$250 Facility Fee amount, per Insured Person, per Surgery.
- b. Subject to chosen Network / Non-Network Deductible and Coinsurance amounts.

7. MEDICAL EMERGENCIES - Subject to chosen Network Deductible and Coinsurance only.

- a. Hospital Emergency Room:
 - May be subject to \$100 Facility Fee, per Insured Person, per visit. (*waived if Hospital Confined*).
- b. Urgent Care Center:
 - May be subject to \$100 Facility Fee, per Insured Person, per visit..

*Non-Medical Emergencies: Insured Person visits for Non-Medical Emergency, by definition, are **not covered**.*

8. DURABLE MEDICAL EQUIPMENT and PROSTHETIC DEVICES –

- Subject to chosen Network/Non-Network Deductible and Coinsurance.
- Up to a \$2,000 Maximum benefit Amount, per Insured Person, per Calendar Year.

9. AMBULANCE SERVICES –

- Subject to chosen Network Coinsurance.
- Deductible waived.
- Ground Ambulance – will offer \$500 Maximum Benefit Amount, per Insured Person, per trip
- Air or Water Ambulance – will offer \$5,000 Maximum Benefit Amount, per Insured Person, per trip.

THE CHESAPEAKE LIFE INSURANCE COMPANY

VARIABILITY STATEMENT

**CATASTROPHIC EXPENSE PREFERRED PROVIDER ORGANIZATION (PPO) POLICY
(FORMS: CH-26210 PPO-IP (03/09) AR with Policy Schedule CH-26210 PPO-IP (SB-A) (03/09) AR)**

RIDER BENEFIT COVERED SERVICES: *At this time, we intend to offer the following Riders. However, in the future, we may choose to offer a combination of other Riders previously approved in your state. At no time will any Riders be offered which have not been approved by your state.*

10. PHYSICIAN OFFICE SERVICES BENEFIT RIDER (form CH-26223-IR (03/09)):

- Applicant will have a **choice** of the following options:

PHYSICIAN OFFICE SERVICES BENEFIT	OPTION A		OPTION B		OPTION C	
	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK
Deductible	Base Plan	Base Plan	Waived	Waived	Waived	Waived
Outpatient Physician Office Visits for Sickness or Injury:						
Coinsurance	Base Plan	Base Plan	100%	100%	100%	100%
Physician Home and Office Copayment per visit:	N/A	N/A	\$50	\$100	\$50	\$100
Convenient Care Clinic Copayment per visit:	N/A	N/A	\$25	\$50	\$25	\$50
Visit Limitation, per Calendar Year	Unlimited	Unlimited	4		Unlimited	Unlimited
Outpatient Preventive Care Physician Visits - other than Well Child Visits: <i>(Limited to one visit per Insured Person, per Calendar Year)</i>	Base Plan Coinsurance	Base Plan Coinsurance	N/A	N/A	Deductible Waived; 100% Coinsurance	Deductible Waived; 100% Coinsurance
Physician Home and Office Copayment per visit:	N/A	N/A	\$50	\$100	\$50	\$100
Convenient Care Clinic Copayment per visit:	N/A	N/A	\$25	\$50	\$25	\$50
Well Child Visits: <i>(For covered Dependent children from birth up to 24 months)</i>	Base Plan Coinsurance	Base Plan Coinsurance	N/A	N/A	Deductible Waived; 100% Coinsurance	Deductible Waived; 100% Coinsurance
Physician Home and Office Copayment per visit:	N/A	N/A	\$50	\$100	\$50	\$100
Convenient Care Clinic Copayment per visit:	N/A	N/A	\$25	\$50	\$25	\$50

THE CHESAPEAKE LIFE INSURANCE COMPANY

VARIABILITY STATEMENT

CATASTROPHIC EXPENSE PREFERRED PROVIDER ORGANIZATION (PPO) POLICY (FORMS: CH-26210 PPO-IP (03/09) AR with Policy Schedule CH-26210 PPO-IP (SB-A) (03/09) AR)

11. OUTPATIENT DIAGNOSTIC SERVICES BENEFIT RIDER - (form CH-26226-IR (03/09)):

At this time, we intend to automatically attach this Rider and may apply the Facility Fee. However in the future, we may choose to make this Rider Optional, not offer it all or to offer a combination of other Riders previously approved in your state. At no time will any Riders be offers which have not been approved by your state.

- **CAT, MRI and/or PET Scans** – Subject to chosen Network / Non-Network Deductible and Coinsurance chosen by the applicant and \$150 Facility Fee, per Insured Person, per visit.
- **All other outpatient diagnostic services** – Subject to chosen Network / Non-Network Deductible and Coinsurance chosen by the applicant and \$50 Facility Fee, per Insured Person, per visit.

12. CONTINUED CARE BENEFIT RIDER - (form CH-26225-IR (03/09) AR):

At this time, we intend to automatically attach this Rider. However in the future, we may choose to make this Rider Optional, not offer it all or to offer a combination of other Riders previously approved in your state. At no time will any Riders be offers which have not been approved by your state.

- *Subject to chosen Network/Non-Network Deductible and Coinsurance.*

CONTINUED CARE	NETWORK	NON-NETWORK
<i>Skilled Nursing Facility</i>		
Day limitation, per Calendar Year, per Insured Person	30 Days	
<i>Home Health Care</i>		
Day limitation, per Calendar Year, per Insured Person	60 Visits	
<i>Hospice Care</i>		
Maximum Benefit Amount, per lifetime, per Insured Person	\$5,000	

13. OUTPATIENT SPEECH THERAPY, PHYSICAL THERAPY AND OCCUPATIONAL THERAPY-
(form CH-26224-IR (03/09)):

At this time, we intend to automatically attach this Ride and may apply the Facility Fee. However in the future, we may choose to make this Rider Optional, not offer it all or to offer a combination of other Riders previously approved in your state. At no time will any Riders be offers which have not been approved by your state.

- *Subject to chosen Network/Non-Network Deductible and Coinsurance.*

SPEECH, OCCUPATIONAL, & PHYSICAL THERAPY SERVICES	NETWORK	NON-NETWORK
Facility Payment, per Insured Person, per Visit	\$50	\$50
Visit limitation for all therapies, per Insured Person, per Calendar Year	40 combined visits	

THE CHESAPEAKE LIFE INSURANCE COMPANY

VARIABILITY STATEMENT

**CATASTROPHIC EXPENSE PREFERRED PROVIDER ORGANIZATION (PPO) POLICY
(FORMS: CH-26210 PPO-IP (03/09) AR with Policy Schedule CH-26210 PPO-IP (SB-A) (03/09) AR)**

14. PRESCRIPTION DRUG EXPENSE RIDER - (form CH-26214-IR (03/09) AR): *At this time, we intend to market the following benefit to applicants.*

PRESCRIPTIONS OBTAINED THROUGH A PHARMACY	PRESCRIPTIONS OBTAINED THROUGH A MAIL-ORDER VENDOR	GENERIC DEDUCTIBLE (PER PERSON, PER CALENDAR YEAR)	BRAND NAME DEDUCTIBLE (PER PERSON, PER CALENDAR YEAR)	MAXIMUM BENEFIT (PER PERSON, PER CALENDAR YEAR)
Preferred Generic Drugs – Insured will pay \$5 copayment	Preferred Generic Drugs – Insured will pay either \$15 copayment	\$0	Either \$50 or \$250	\$1,500
Non-Preferred Generic Drugs – Insured will pay \$15 copayment	Non-Preferred Generic Drugs – Insured will pay either \$45 copayment			
Brand Preferred Drugs – Insured pays 50% of drug cost	Brand Drugs – Insured pays 50% of drug cost			
Brand Preferred Drugs – Insured pays 75% of drug cost	Brand Drugs – Insured pays 75% of drug cost			

THE CHESAPEAKE LIFE INSURANCE COMPANY

VARIABILITY STATEMENT

PREFERRED PROVIDER ORGANIZATION (PPO) POLICY

(FORMS: CH-26210 PPO-IP (03/09) AR with Policy Schedule CH-26210 PPO-IP (SB-B) (03/09) AR)

POLICY SCHEDULE

The amounts specified within brackets on the Policy Schedule pages are the ranges of amounts we intend to offer with this plan. Below is additional information regarding specific option combinations the applicant will have the ability to choose from, as well as how certain terms of the plan are intended to work.

1. LIFETIME and AGGREGATE MAXIMUM AMOUNTS – We intend to offer one or more of the following options to applicants:
 - a. OPTION A: \$2,000,000 Lifetime / \$1,000,000 Aggregate
 - b. OPTION B: \$4,000,000 Lifetime / \$1,000,000 Aggregate
 - c. OPTION B: \$8,000,000 Lifetime / \$2,000,000 Aggregate

2. DEDUCTIBLES: PERIOD OF TREATMENT & ALL OTHER OUTPATIENT COVERED SERVICES AMOUNTS – We intend to offer one or more of the following Deductible options to applicants:
 - a. OPTION A: Network: \$1,000...Non-Network: \$2,000
 - b. OPTION B: Network: \$1,500...Non-Network: \$3,000
 - c. OPTION C: Network: \$2,500...Non-Network: \$5,000
 - d. OPTION D: Network: \$5,000...Non-Network: \$10,000
 - e. OPTION E: Network: \$7,500...Non-Network: \$15,000
 - *Period of Treatment Deductible is per Insured Person.*
 - *The Deductible for all other Outpatient Covered Services (except outpatient Surgery) will be deducted from each separate outpatient Covered Service incurred by each Insured Person, per Calendar Year.*
 - *Once deductible has been met 3 times by any or all Insured Persons, no other deductibles apply for the remainder of that Calendar Year.*
 - *Non-Covered Services, Facility Fees, or Covered Services in excess of the Maximum Benefit Amount, or any applicable Copayment amounts do not count toward meeting the Period of Treatment / Outpatient Covered Services Deductible.*

3. NETWORK / NON-NETWORK COINSURANCE AMOUNTS – We initially intend to offer one or more of the following Coinsurance options to applicants:
 - a. OPTION A: 80% / 60%
 - b. OPTION B: 70% / 50%

4. COINSURANCE MAXIMUM – We initially intend to offer one or more of the following Coinsurance Maximums to applicants:
 - a. Network: \$5,000...Non-Network: \$10,000
 - b. Network: \$10,000...Non-Network: \$20,000
 - *"Coinsurance Maximum" represents the total coinsurance an insured must pay for each Period of Treatment after satisfaction of the any Facility Fees, Copayments, Deductibles and Coinsurance*
 - *Once the Coinsurance Maximum is met in the same Period of Treatment, Covered Services will be paid at 100% Coinsurance after the application of Facility Fees and Copayments.*

THE CHESAPEAKE LIFE INSURANCE COMPANY

VARIABILITY STATEMENT

PREFERRED PROVIDER ORGANIZATION (PPO) POLICY

(FORMS: CH-26210 PPO-IP (03/09) AR with Policy Schedule CH-26210 PPO-IP (SB-B) (03/09) AR)

ADDITIONAL COVERED SERVICES: *We intend to offer the following benefits to applicants.*

5. INPATIENT SERVICES -

- a. **Non-Network** services: subject to \$500 Facility Fee amount, per Insured Person, per Hospital Confinement.
- b. Subject to chosen Network / Non-Network Deductible and Coinsurance amounts.
- c. Transplant Procedure Covered Services:
 - **Network** services: subject to \$250,000 Maximum Benefit Amount, per Insured Person, per Transplant Procedure.
 - **Non-Network** services: subject to \$175,000 Maximum Benefit Amount, per Insured Person, per Transplant Procedure.

6. OUTPATIENT SURGERY FACILITY SERVICES -

- a. **Non-Network** services: subject to \$250 Facility Fee amount, per Insured Person.
- b. Subject to chosen Network / Non-Network Deductible and Coinsurance amounts.

7. MEDICAL EMERGENCIES -

- a. Subject to chosen Network Deductible and Coinsurance.
- b. Hospital Emergency Room:
 - Facility Fee \$250, *waived if Hospital Confined.*
- c. Urgent Care Center:
 - Facility Fee \$100.

*Non-Medical Emergencies: Insured Person visits for Non-Medical Emergency, by definition, are **not covered**.*

8. CHEMOTHERAPY and RADIATION THERAPY -

- Subject to chosen Network / Non-Network Coinsurance.
- Deductible waived.
- Calendar Month Maximum of \$10,000.
- Lifetime Maximum of \$100,000.

9. DURABLE MEDICAL EQUIPMENT and PROSTHETIC DEVICES -

- Subject to chosen Network/Non-Network Deductible and Coinsurance.
- Up to a \$2,500 Maximum benefit Amount, per Insured Person, per Sickness or Injury.

10. AMBULANCE SERVICES -

- Subject to chosen Network Coinsurance only.
- Deductible waived.
- Ground Ambulance – will offer \$500 Maximum Benefit Amount, per Insured Person, per trip
- Air or Water Ambulance – will offer \$5,000 Maximum Benefit Amount, per Insured Person, per trip.

THE CHESAPEAKE LIFE INSURANCE COMPANY

VARIABILITY STATEMENT

PREFERRED PROVIDER ORGANIZATION (PPO) POLICY

(FORMS: CH-26210 PPO-IP (03/09) AR with Policy Schedule CH-26210 PPO-IP (SB-B) (03/09) AR)

RIDER BENEFIT COVERED SERVICES: *At this time, we intend to offer the following Riders. However, in the future, we may choose to offer a combination of other Riders previously approved in your state. At no time will any Riders be offered which have not been approved by your state.*

11. PHYSICIAN OFFICE SERVICES BENEFIT RIDER (form CH-26223IR (03/09)):

- Applicant will have a **choice** of the following options. Deductible is waived and 100% Coinsurance.

PHYSICIAN OFFICE SERVICES BENEFIT	OPTION A		OPTION B	
	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK
Outpatient Physician Visits for Sickness or Injury:				
Physician Home and Office Copayment:	\$50	\$100	\$50	\$100
Convenient Care Clinic Copayment:	\$25	\$50	\$25	\$50
Visit Limitation, per Calendar Year	2		4	
Outpatient Preventive Care Physician Visits - other than Well Child Visits: <i>(Limited to one visit per Insured Person, per Calendar Year)</i>	Unlimited		Unlimited	
Physician Home and Office Copayment:	\$50		\$100	
Convenient Care Clinic Copayment:	\$25		\$50	
Well Child Visits: <i>(For covered Dependent children from birth up to 24 months)</i>	Unlimited		Unlimited	
Physician Home and Office Copayment:	\$50		\$100	
Convenient Care Clinic Copayment:	\$25		\$50	

12. OUTPATIENT DIAGNOSTIC SERVICES BENEFIT RIDER - (form CH-26226-IR (03/09)):

At this time, we intend to offer the following options for this Rider. Deductible is waived and 100%Coinsurance.

OUTPATIENT DIAGNOSTIC SERVICES	OPTION A		OPTION B	
	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK
Copayment, per Visit, per Insured	\$100	\$200	\$250	\$500
Maximum Benefit Amount, per Day	\$1,250 or \$1,500		\$1,250 or \$1,500	
Maximum Benefit Amount, per Calendar Year	EITHER \$2,500 / \$5,000 / \$7,500		EITHER \$2,500 / \$5,000 / \$7,500	

THE CHESAPEAKE LIFE INSURANCE COMPANY

VARIABILITY STATEMENT

PREFERRED PROVIDER ORGANIZATION (PPO) POLICY

(FORMS: CH-26210 PPO-IP (03/09) AR with Policy Schedule CH-26210 PPO-IP (SB-B) (03/09) AR)

13. CONTINUED CARE BENEFIT RIDER - (form CH-26225-IR (03/09) AR):

At this time, we intend to offer the following benefits for this Rider. Deductible is waived and 100% Coinsurance.

CONTINUED CARE	NETWORK	NON-NETWORK
<i>Skilled Nursing Facility</i>		
Visit limitation, per Calendar Year, per Insured Person	30 Visits	
Maximum Benefit Amount, per day, per Insured Person	\$200	
<i>Home Health Care</i>		
Visit limitation, per Calendar Year, per Insured Person	60 Visits	
Maximum Benefit Amount, per visit, per Insured Person for home infusion and wound care	\$100	
Maximum Benefit Amount, per visit, per Insured Person for all other Home Health Care Services	\$100	
<i>Hospice Care</i>		
Maximum Benefit Amount, per lifetime, per Insured Person	\$5,000	

14. OUTPATIENT SPEECH THERAPY, PHYSICAL THERAPY AND OCCUPATIONAL THERAPY- (form CH-26224-IR (03/09)):

At this time, we intend to offer the following benefits for this Rider. Deductible is waived and 100% Coinsurance.

SPEECH, OCCUPATIONAL, & PHYSICAL THERAPY SERVICES	NETWORK	NON-NETWORK
Copayment, per Insured Person, per Visit	\$50	\$50
Visit limitation for all therapies, per Insured Person, per Calendar Year	40 combined visits	

THE CHESAPEAKE LIFE INSURANCE COMPANY

VARIABILITY STATEMENT

PREFERRED PROVIDER ORGANIZATION (PPO) POLICY

(FORMS: CH-26210 PPO-IP (03/09) AR with Policy Schedule CH-26210 PPO-IP (SB-B) (03/09) AR)

15. PREGNANCY/CHILDBIRTH BENEFIT RIDER- (form CH-26213-IR (03/09) AR). Deductible waived.

At this time, we intend to offer the following options for this Rider.

PREGNANCY/CHILDBIRTH BENEFIT	0-24 Months in force	25 Months in force and over
Maximum Benefit Options	\$1,000 / \$2,000 / \$3,000	\$2,000 / \$3,000 / \$4,000

16. PRESCRIPTION DRUG EXPENSE RIDER - (form CH-26214-IR (03/09) AR):

At this time, we intend to automatically attach this Rider. However in the future, we may choose to make this Rider Optional, not offer it all or to offer a combination of other Riders previously approved in your state. At no time will any Riders be offers which have not been approved by your state.

PRESCRIPTIONS OBTAINED THROUGH A PHARMACY	PRESCRIPTIONS OBTAINED THROUGH A MAIL-ORDER VENDOR	GENERIC DEDUCTIBLE (PER PERSON, PER CALENDAR YEAR)	BRAND NAME DEDUCTIBLE (PER PERSON, PER CALENDAR YEAR)	MAXIMUM BENEFIT (PER PERSON, PER CALENDAR YEAR)
Preferred Generic Drugs – Insured will pay \$5 copayment	Preferred Generic Drugs – Insured will pay either \$15 copayment	\$0	Either \$50 or \$250	\$1,500
Non-Preferred Generic Drugs – Insured will pay \$15 copayment	Non-Preferred Generic Drugs – Insured will pay either \$45 copayment			
Brand Preferred Drugs – Insured pays 50% of drug cost	Brand Drugs – Insured pays 50% of drug cost			
Brand Preferred Drugs – Insured pays 75% of drug cost	Brand Drugs – Insured pays 75% of drug cost			

17. OUTPATIENT ACCIDENT EXPENSE BENEFIT RIDER (form CH-26221-IR (03/09)): *Deductible is waived and 100% Coinsurance.*

OUTPATIENT ACCIDENT EXPENSE BENEFIT RIDER	OPTION A		OPTION B		OPTION C	
	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK	NETWORK	NON-NETWORK
Copayment, per Insured Person, per Injury	\$50		\$100		\$150	
Maximum Benefit Amount, per Insured Person, per Calendar Year	\$500		\$1,000		\$1,500	

THE CHESAPEAKE LIFE INSURANCE COMPANY

A Stock Company
(Herein after called: the Company, We, Our or Us)
Home Office: Oklahoma City, Oklahoma
Administrative Office: P.O. Box 982010
North Richland Hills, Texas 76182-8010
Customer Service: 1-800-733-1110

[CATASTROPHIC EXPENSE] PREFERRED PROVIDER ORGANIZATION (PPO) POLICY

OUTLINE OF COVERAGE FOR FORM CH-26210 PPO-IP (03/09) AR

- 1. READ YOUR POLICY CAREFULLY!** This Outline of Coverage provides a very brief description of some of the important features of Your Policy. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth, in detail, the rights and obligations of both You and Us. It is, therefore, important that You **READ YOUR POLICY CAREFULLY**.
- 2. [CATASTROPHIC EXPENSE] PREFERRED PROVIDER ORGANIZATION (PPO) COVERAGE** - The plan pays for the Covered Services listed below, as described in the Policy, which are performed, prescribed, directed, or authorized by a Provider.
- 3. NETWORK / NON-NETWORK PROVIDERS** - Insured Persons have the right to obtain medical care from the Physicians, Hospitals and other health care Providers of their choice. However, in order to receive maximum benefits, all Covered Services must be obtained from Network Providers. When You utilize a Non-Network Provider You are responsible for any balance due above the Usual and Customary amount.
- 4. COVERED SERVICES** – for the purpose of this Outline of Coverage, "Covered Services" means the Medically Necessary Usual and Customary Charges for services, supplies, care or treatment as described in the Policy which are performed, prescribed, directed or authorized by a Provider. To be a Covered Service, the service, supply or treatment must be: 1) Medically Necessary and/or specifically included as a Covered Service under the Policy; 2) within the scope of the license of the Provider performing the service; 3) rendered while coverage under the Policy is in force and for which the Insured Person is legally obligated to pay; and 4) not considered Experimental or Investigative or otherwise excluded or limited under the Policy. A charge for a Covered Service is incurred on the date the service, supply or treatment is furnished.

Unless otherwise stated, all Covered Services are subject to:

- The Facility Fees shown in the POLICY SCHEDULE, if any;
- The Calendar Year Deductible shown in the POLICY SCHEDULE;
- The Copayments shown in the POLICY SCHEDULE, if any;
- The Network Provider Coinsurance level or Non-Network Provider Coinsurance level shown in the POLICY SCHEDULE;
- The Maximum Benefit Amounts, visit limitations, if any, [Calendar Year] and Lifetime Maximum Amount shown in the POLICY SCHEDULE;
- The EXCLUSIONS AND LIMITATIONS; and
- All other provisions of this Policy.

LIFETIME MAXIMUM AMOUNT and CALENDAR YEAR MAXIMUM AMOUNT (per Insured Person):

SELECT <input type="checkbox"/>	<u>OPTION A</u>	SELECT <input type="checkbox"/>	<u>OPTION B</u>	SELECT <input type="checkbox"/>	<u>OPTION C</u>
Lifetime Maximum Amount:	\$2,000,000	Lifetime Maximum Amount:	\$4,000,000	Lifetime Maximum Amount:	\$8,000,000
Calendar Year Maximum Amount:	\$1,000,000	Calendar Year Maximum Amount:	\$1,000,000	Calendar Year Maximum Amount:	\$2,000,000

COINSURANCE AMOUNTS:

SELECT <input type="checkbox"/> [OPTION A]	<u>PPO</u> 80%	<u>NON-PPO</u> 50%	SELECT <input type="checkbox"/> [OPTION B]	<u>PPO</u> 90%	<u>NON-PPO</u> 60%	SELECT <input type="checkbox"/> [OPTION C]	<u>PPO</u> 100%	<u>NON-PPO</u> 70%
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CALENDAR YEAR DEDUCTIBLE (per Individual / per Family):

SELECT <input type="checkbox"/> [OPTION D]	<u>PPO</u>	<u>NON-PPO</u>	SELECT <input type="checkbox"/> [OPTION B]	<u>PPO</u>	<u>NON-PPO</u>	SELECT <input type="checkbox"/> [OPTION C]	<u>PPO</u>	<u>NON-PPO</u>
Per			Per			Per		
Individual:	\$2,500	\$5,000	Individual:	\$5,000	\$10,000	Individual:	\$7,500	\$15,000
Per Family:	\$5,000	\$10,000	Per Family:	\$10,000	\$20,000	Per Family:	\$15,000	\$30,000

SELECT <input type="checkbox"/> [OPTION D]	<u>PPO</u>	<u>NON-PPO</u>	SELECT <input type="checkbox"/> [OPTION E]	<u>PPO</u>	<u>NON-PPO</u>	SELECT <input type="checkbox"/> [OPTION F]	<u>PPO</u>	<u>NON-PPO</u>
Per			Per			Per		
Individual:	\$10,000	\$20,000	Individual:	\$15,000	\$30,000	Individual:	\$20,000	\$40,000
Per Family:	\$20,000	\$40,000	Per Family:	\$30,000	\$60,000	Per Family:	\$40,000	\$80,000

COINSURANCE MAXIMUM (per Calendar Year):

SELECT <input type="checkbox"/> [OPTION A]	<u>PPO</u>	<u>NON-PPO</u>	SELECT <input type="checkbox"/> [OPTION B]	<u>PPO</u>	<u>NON-PPO</u>	SELECT <input type="checkbox"/> [OPTION C]	<u>PPO</u>	<u>NON-PPO</u>
Per			Per			Per		
Individual:	\$2,500	\$10,000	Individual:	\$5,000	\$10,000	Individual:	\$10,000	\$20,000
Per Family:	\$5,000	\$20,000	Per Family:	\$10,000	\$20,000	Per Family:	\$20,000	\$40,000

SELECT <input type="checkbox"/> [OPTION D]	<u>PPO</u>	<u>NON-PPO</u>
Per		
Individual:	\$0	\$20,000
Per Family:	\$0	\$20,000

The Individual Deductible amount will be deducted from expenses incurred by each Insured Person for Covered Services, each Calendar Year, subject to the Family Deductible. Once the Family Deductible is met, no other Deductibles are required for the rest of that [Calendar Year].

[Expenses incurred for Covered Services under any Riders will apply toward the Individual and Family Maximum Deductible, where applicable, unless specifically stated otherwise.]

Non-Covered Services, Facility Fees or Copayments, if any, do not apply toward the Deductible(s).

Common Accident Provision: Upon to Us that one or more Insured Persons in Your family has been injured in the same accident, We will only require that one Deductible amount be satisfied for Covered Services associated with that accident. Once one Deductible amount is satisfied under the Policy, the Deductible amount for all other Insured Persons will be waived for that common accident.

COVERED SERVICES –

A. Inpatient Hospital - Covered Services include services and supplies provided by a Hospital for semi-private accommodations and general nursing care furnished by the Hospital including Confinement in the Hospital's Intensive Care or Cardiac Care Unit; Physician visits and miscellaneous medical services and supplies necessary for the treatment of the Insured Person.

Covered Services will also include hemodialysis and the charges by a Hospital for processing and administration of blood or blood components, acute inpatient rehabilitation, x-ray, laboratory, diagnostic tests and services of a

radiologist, radiology group, and the services of a pathologist or pathology group for interpretation of diagnostic tests or studies, performed while the Insured Person is Hospital Confined.

Covered Services will also include coverage for general anesthesia and associated Hospital Charges in conjunction with Dental Care provided to an Insured Person if such person is: (a) a Covered Dependent child who is developmentally disabled; or (b) an individual for whom a successful result cannot be expected from Dental Care provided under local anesthesia because of a neurological or other medically compromising condition.

The fees charged for take home drugs, personal convenience items such as lotions, shampoos, etc., or items not intended primarily for use by the Insured Person while Hospital Confined are not Covered Services.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.
- **Network Facility Fee:** [\$0]
- **Non-Network Facility Fee:** [\$500] per Insured Person, per [Hospital Confinement][Period of Treatment]

B. Transplant Procedures - Covered Services include Transplant Procedures incurred during a Transplant Benefit Period. Covered Services for Transplant Procedures include the following when part of a Transplant Treatment Plan: 1) inpatient and outpatient Hospital services; 2) services of a Physician for diagnosis, treatment and Surgery for a Transplant Procedure; 3) procurement of an organ or tissue, including services provided to a living donor of an organ or tissue for procurement of an organ or tissue, provided the donor and transplant recipient are both insured under the Policy. Covered Services are limited to the actual procurement expenses, and will not be more than any Maximum Allowable Amount under the Policy applicable to the recipient; 4) rental of durable medical equipment for use outside the Hospital. Covered Services are limited to the purchase price of the same equipment; 5) prescription drugs, including immunosuppressive drugs; 6) Oxygen; 7) Speech Therapy, Occupational Therapy, Physical Therapy and Chemotherapy; 8) services and supplies for and related to high dose chemotherapy and bone marrow tissue transplantation when provided as part of a Transplant Treatment Plan which includes bone marrow transplantation and high dose chemotherapy; 9) surgical dressings and supplies; and 10) Home Health Care.

When the Insured Person's Physician advises the Insured Person that a Transplant Procedure is being considered, the Insured Person or the Insured Person's Physician should notify Us or Our designee. Covered Expenses for a live donor shall be paid to the extent that benefits remain and are available under the Policy for the Insured Person receiving the transplant, and after all Covered Expenses for the Insured Person has been paid. Covered Services will not include animal organ or artificial organ transplants or personal hygiene and convenience items. Expenses incurred beyond the Transplant Benefit Period will not be considered Covered Services, unless covered elsewhere under the Policy. Medically Necessary transplants not specifically defined as a Transplant Procedure under the Policy, which are not determined to be Experimental or Investigative will be payable the same as any other Transplant Procedure under the Policy.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.
- **Network Facility Fee:** [\$0]
- **Non-Network Facility Fee:** [\$500] per Insured Person, per Hospital Confinement
- **Network Maximum Benefit Amount:** [\$250,000] per Insured Person, per Transplant Procedure
- **Non-Network Maximum Benefit Amount:** [\$175,000] per Insured Person, per Transplant Procedure

PRE-ADMISSION TESTING - Covered Services include pre-admission tests done on an outpatient basis before an authorized Hospital stay or Outpatient Surgery. These tests must be: 1) made within 14 days prior to Hospital Confinement or within 14 days of an outpatient Surgery; 2) related to the condition for which the Insured person is being Confined; 3) not repeated in the Hospital or elsewhere; and 4) ordered by a Physician.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above

OUTPATIENT SURGERY FACILITY SERVICES - Covered Services include services furnished by and supplies received for use in an Outpatient Surgery Facility, including but not limited to: 1) Use of operating room and recovery room; 2) Administration of drugs and medicines during Surgery; 3) Dressings, casts, splints; 4) Diagnostic services including radiology, laboratory or pathology performed at the time of the Surgery; and 5) General anesthesia and associated Outpatient Surgery Facility Charges in conjunction with Dental Care provided to an Insured Person if such person is: (a) a Covered Dependent child who is developmentally disabled; or (b) an individual for whom a successful result cannot be expected from Dental Care provided under local anesthesia because of a neurological or other medically compromising condition.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

- **Network Facility Fee:** [\$0]
- **Non-Network Facility Fee:** [\$250] per Insured Person, per Surgery

MEDICAL EMERGENCIES

A. Hospital Emergency Room – Covered Services include treatment of a Medical Emergency in a Hospital emergency room. Non-Medical Emergencies are not covered.

- **Subject to chosen Network Coinsurance and Deductible amount shown above** (for both Network and Non-Network services).
- **Network Facility Fee:** \$100 \$250 \$500 \$750 \$1,000 per Insured Person, per visit (waived if Hospital Confined)
- **Non-Network Facility Fee:** \$100 \$250 \$500 \$750 \$1,000 per Insured Person, per visit (waived if Hospital Confined)

B. Urgent Care Center – Covered Services include treatment of a Medical Emergency in an Urgent Care facility. Non-Medical Emergencies are not covered.

- **Subject to chosen Network Coinsurance and Deductible amount shown above** (for both Network and Non-Network services).
- **Network Facility Fee:** \$100 \$250 per Insured Person, per visit
- **Non-Network Facility Fee:** \$100 \$250 per Insured Person, per visit

PHYSICIAN SERVICES

A. Second Surgical Opinion – Covered Services include services by a Physician for a second opinion. The Physician providing the second opinion cannot be financially associated with the referring Physician or perform or assist in the Surgery in order for services to be considered a Covered Service under the Policy. If the second opinion disagrees with the first, a third opinion will also be considered a Covered Service.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.
- **Limited to:** one per Surgery.

B. Inpatient / Outpatient Surgeon – Covered Services include expenses incurred while Hospital Confined or in an Outpatient Surgery Facility for services by the Physician performing Surgery. [When multiple surgical procedures are done at the same time, Covered Services will be considered for the first or highest cost procedure, and one-half of the Allowable Amount for each additional procedure. No benefit is payable for incidental surgical procedures such as appendectomy performed during gall bladder surgery.]

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

C. Inpatient / Outpatient Assistant Surgeon – Covered Services include services by the Physician assisting the Physician performing Surgery.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

D. Inpatient / Outpatient Anesthesiologist – Covered Services include services by the Physician providing anesthesia during Surgery.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

E. Physician Visits while Hospital Confined (other than Surgeon) – Covered Services include visits by a Physician, other than the surgeon, while Hospital Confined.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.
- **[Limited to: one visit per Physician, per day.]**

PREVENTIVE IMAGING SCREENING TESTS:

Human Papillomavirus and Cervical Cancer Screening - Covered Services include the following annual screenings, as approved by the United States Food and Drug Administration, for female Insured Persons 18 years of age or older: 1) A conventional Pap smear screening or a screening using liquid-based cytology methods; or 2) A conventional Pap smear screening in combination with a test for the detection of the Human Papillomavirus. The screening test required under this benefit must be performed in accordance with the guidelines adopted by: 1) The American College of Obstetricians and Gynecologists; or 2) Another similar national organization of medical professionals recognized by the Commissioner.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

Prostate Cancer Screening - Covered Services include the following services and supplies provided to an Insured Person for the detection of prostate cancer: 1) An annual physical examination for the detection of prostate cancer for each male Insured Person; and 2) An annual prostate-specific antigen (PSA) test used for the detection of prostate cancer for each male Insured Person who is: a) at least 50 years of age and asymptomatic; or b) at least 40 years of age with a family history of prostate cancer or another prostate cancer risk factor.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

Mammography Screening - Covered Services include an annual Low Dose Mammography screening for each female Insured Person age 35 or older.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

Colorectal Cancer Screening - Covered Services include colorectal cancer examinations and laboratory tests for Insured Persons who are 50 years of age or older; who are less than 50 years of age and at high risk for colorectal cancer according to American Cancer Society colorectal cancer screening guidelines as they existed on [January 1, 2005]; and experiencing bleeding from the rectum or blood in the stool or a change in bowel habits, such as diarrhea, constipation, or narrowing of the stool that lasts more than 5 days as determined by a licensed Physician. For the purpose of this benefit "high risk for colorectal cancer" means: Individuals over 50 years of age or who face a high risk for colorectal cancer because of the presence of polyps on a previous colonoscopy, barium enema, or flexible sigmoidoscopy; family history of colorectal cancer in close relatives of parents, brothers, sisters, or children; genetic alterations of hereditary nonpolyposis colon cancer or familial adenomatous polyposis; personal history of colorectal cancer, ulcerative colitis, or Crohn's disease; or the presence of any appropriate recognized gene markers for colorectal cancer or other predisposing factors; and any definition recognized by medical science and determined by the Director of the Department of Health in consultation with the University of Arkansas for Medical Sciences.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

SCREENING TEST FOR HEARING IMPAIRMENT - Covered Services include a screening test of hearing loss for a Covered Dependent child from birth through the date the child is 30 days old. Covered Services also include the necessary diagnostic follow-up care related to the screening test from birth through the date the child is 24 months old.

- Subject to chosen Network / Non-Network Coinsurance amount shown above.
- **Deductibles do not apply.**

IMPAIRMENT OR LOSS OF SPEECH OR HEARING - Covered Services include the necessary care and treatment of loss or impairment of speech or hearing which includes the communicative disorders generally treated by speech pathologist or audiologist licensed by the Board of Examiners in Speech-Language Pathology and Audiology and which fall within the scope of his/her area of certification. Coverage does not apply to hearing instruments or devices.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

MINIMUM STAY REQUIREMENTS FOR MASTECTOMY AND LYMPH NODE DISSECTION - Covered Services include inpatient care if an Insured Person undergoes a covered mastectomy, for a minimum of the following: 1) 48 hours following a covered mastectomy; or 2) 24 hours following a covered lymph node dissection for the treatment of breast cancer. A shorter period of Confinement will be covered if the Insured Person and her Physician determine that a shorter period of inpatient Hospital Confinement is appropriate.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

CHEMOTHERAPY AND RADIATION THERAPY - Covered Services include chemotherapy and radiation therapy received while Hospital Confined or on an outpatient basis. The condition for which chemotherapy is provided must be first diagnosed and the treatment must be received while coverage is in force.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amount shown above.

DURABLE MEDICAL EQUIPMENT AND PROSTHETIC DEVICES - Covered Services include the rental of durable medical equipment not to exceed the actual purchase price of such equipment, and the purchase, fitting, repair and replacement of fitted prosthetic devices which replace a natural limb or eye, when ordered or prescribed by a Physician for use by the Insured Person. The durable medical equipment or prosthetic device must be for use solely by the Insured Person for the treatment of a Sickness or Injury which occurred while such Insured Person's coverage is in force. Routine maintenance and repairs of rental equipment are not considered Covered Services.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amount shown above.

- **Network/Non-Network Maximum Benefit Amount** [\$2,000] per Insured Person, per [Calendar Year]

AMBULANCE SERVICES - Covered Services include Ambulance transportation to the nearest Hospital that can provide Covered Services appropriate for the Insured person's condition. Ambulance services are only considered Covered Services if the Insured Person is Confined to the Hospital. Air or water Ambulance services are only considered a Covered Service in situations in which the Insured person is in a location that cannot be reached by ground Ambulance. Ambulance usage for the convenience of the Insured Person is not a Covered Service. Non-Covered Services for Ambulance include but are not limited to trips to a Physician's Office or clinic; or a morgue or funeral home.

- Subject to chosen Network Coinsurance amount shown above (for both Network and Non-Network services).

- **Deductibles do not apply.**
- **Ground Ambulance Maximum Benefit Amount:** [\$500] per Insured Person, per trip.
- **Air / Water Ambulance Maximum Benefit Amount:** [\$5,000] per Insured Person, per trip.
- **Benefit only payable when Hospital Confined.**

MATERNITY STAY REQUIREMENTS FOR COVERED MATERNITY CARE - This provision applies to an Insured Person's coverage only when the Insured Person incurs Covered Services for a normal childbirth or cesarean section delivery that is covered for Complications of Pregnancy as defined in the Policy. A minimum of 48 hours of inpatient care will be provided to the mother and newborn child following a vaginal delivery and 96 hours following a cesarean section.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

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

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

CHILD HEALTH SUPERVISION SERVICES - Covered Services include for each Covered Dependent from the moment of birth to age eighteen (18) years. In keeping with prevailing medical standards, such services shall include: 1) anticipatory guidance; 2) developmental assessment; 3) laboratory tests; 4) appropriate immunizations; 5) a medical history; and 6) physical examination. Benefits will be payable for 20 visits provided by or under the supervision of a single Physician during the course of one visit, at approximately the following intervals: birth; two weeks; two, four, six, nine, twelve, fifteen and eighteen months and two, three, four, five, six, eight, ten, twelve, fourteen, sixteen and eighteen years. Benefits payable will not exceed current reimbursement levels for the same services under the Medicaid Early Periodic Screening Diagnosis and Treatment program in the State of Arkansas. Benefits for recommended immunization services shall be exempt from any Coinsurance, Deductible or dollar limit provisions.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

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

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

DIABETES - Covered Services include diabetes self-management training, supplies and related services for the treatment of Type I, Type II and gestational diabetes when determined Medically Necessary by Your Physician or other licensed health care provider. Diabetes Self-Management Training means instructions in an inpatient or outpatient setting including medical nutrition therapy relating to diet, caloric intake and diabetes management, excluding any programs in which the only purpose is weight reduction, which enables diabetic patients to understand the diabetic management process and daily management of diabetic therapy as a method of avoiding frequent hospitalizations and complications when the instruction is provided in accordance with a program in compliance with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

OUTPATIENT CONTRACEPTIVE SERVICES AND DEVICES - Covered Services include Outpatient Contraceptive Services and Devices including closed formularies; however, formularies must include implant and injectable contraceptive drugs, and intrauterine devices. Covered Services do not include charges for abortion, an abortifacient or any U.S. Food and Drug Administration approved emergency contraception. Outpatient Contraceptive benefits are subject to the same Deductibles and Coinsurances as prescription drugs.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

5. RIDER BENEFITS – the following is a very brief description of some of the important features of Riders that may be attached to Your Policy. This is not the insurance contract and only the actual Rider provisions will control. The Riders themselves set forth, in detail, the rights and obligations of both You and Us. It is, therefore, important that You **READ YOUR RIDERS CAREFULLY**.

Riders are made a part of the Policy to which they are attached. Riders are subject to all provisions, terms and DEFINITIONS of the Policy which are not inconsistent with the provisions of the Riders. Benefits paid under the Riders will not duplicate the benefits provided under the Policy or any other rider, and are subject to the benefit schedule shown below.

PHYSICIAN OFFICE SERVICES BENEFIT RIDER (FORM: CH-26223-IR (03/09))

SELECT [OPTION A]

A. Outpatient Physician Office Visits for Sickness or Injury:

- Subject to chosen Network / Non-Network Deductible and Coinsurance amount shown above.

B. Outpatient Preventive Care Physician Visits: (other than Well Child Visits):

- Subject to chosen Network / Non-Network Deductible and Coinsurance amount shown above.
- Limited to one visit per Insured Person, per [Calendar Year].

C. Well Child Visits (for Covered Dependent children from birth up to 24 months of age)

- Subject to chosen Network / Non-Network Deductible and Coinsurance amount shown above.

PHYSICIAN OFFICE SERVICES BENEFIT RIDER (FORM: CH-26223-IR (03/09))

SELECT [OPTION B]

- [Deductibles do not apply]

A. Outpatient Physician Office Visits for Sickness or Injury:

- **Coinurance amount:** [100%] (for both Network and Non-Network services).
- **Visit Limitations:** [2] [4] visits per Insured Person, per [Calendar Year].
- **Physician Home and Office:**
- **Network Copayment:** [\$50] per Insured Person, per visit.
- **Non-Network Copayment:** [\$100] per Insured Person, per visit.

- **Convenient Care Clinic:**

5. RIDER BENEFITS (Continued)

Network Copayment: [\$25] per Insured Person, per visit.
Non-Network Copayment: [\$50] per Insured Person, per visit.

B. Outpatient Preventive Care Physician Visits: (other than Well Child Visits):

6. **Coinsurance amount:**[100%] (for both Network and Non-Network services).
7. Limited to one visit per Insured Person, per [Calendar Year].

8. **Physician Home and Office:**

Network Copayment: [\$50] per Insured Person, per visit.
Non-Network Copayment: [\$100] per Insured Person, per visit.

9. **Convenient Care Clinic:**

Network Copayment: [\$25] per Insured Person, per visit.
Non-Network Copayment: [\$50] per Insured Person, per visit.

C. Well Child Visits (for Covered Dependent children from birth up to 24 months of age)

10. **Coinsurance amount:**[100%] (for both Network and Non-Network services).

11. **Physician Home and Office:**

Network Copayment: [\$50] per Insured Person, per visit.
Non-Network Copayment: [\$100] per Insured Person, per visit.

12. **Convenient Care Clinic:**

Network Copayment: [\$25] per Insured Person, per visit.
Non-Network Copayment: [\$50] per Insured Person, per visit.

PHYSICIAN OFFICE SERVICES BENEFIT RIDER (FORM: CH-26223-IR (03/09))

SELECT [OPTION C]

- [Deductibles do not apply]

A. Outpatient Physician Office Visits for Sickness or Injury:

13. **Coinsurance amount:** [100%] (for both Network and Non-Network services).

14. **Physician Home and Office:**

Network Copayment: [\$50] per Insured Person, per visit.
Non-Network Copayment: [\$100] per Insured Person, per visit.

15. **Convenient Care Clinic:**

Network Copayment: [\$25] per Insured Person, per visit.
Non-Network Copayment: [\$50] per Insured Person, per visit.

B. Outpatient Preventive Care Physician Visits: (other than Well Child Visits):

16. **Coinsurance amount:**[100%] (for both Network and Non-Network services).
17. Limited to one visit per Insured Person, per [Calendar Year].

18. **Physician Home and Office:**

Network Copayment: [\$50] per Insured Person, per visit.
Non-Network Copayment: [\$100] per Insured Person, per visit.

19. **Convenient Care Clinic:**

Network Copayment: [\$25] per Insured Person, per visit.
Non-Network Copayment: [\$50] per Insured Person, per visit.

C. Well Child Visits (for Covered Dependent children from birth up to 24 months of age)

20. **Coinsurance amount:**[100%] (for both Network and Non-Network services).

21. **Physician Home and Office:**

Network Copayment: [\$50] per Insured Person, per visit.
Non-Network Copayment: [\$100] per Insured Person, per visit.

22. **Convenient Care Clinic:**

Network Copayment: [\$25] per Insured Person, per visit.
Non-Network Copayment: [\$50] per Insured Person, per visit.

23. _

6. EXCLUSIONS AND LIMITATIONS – We will not provide any benefits for charges arising directly or indirectly, in whole or in part, from:

1. Any care not Medically Necessary or services for which benefits are not specifically provided for in this Policy, including charges related to secondary medical conditions resulting directly or indirectly from conditions, treatment or services that are not considered a Covered Service and/or that are specifically excluded under this Policy;
2. Any charges exceeding the Maximum Benefit Amount or Lifetime Maximum Amount;
3. Any act of war, declared or undeclared;
4. Suicide, attempted suicide, or any intentionally self-inflicted injury, while sane or insane;
5. Care, treatment, services or supplies received in a Hospital emergency room or Urgent Care Center for treatment of a Sickness or Injury that is not considered a Medical Emergency;
6. Any Injury or Sickness arising out of, or in the course of, employment for wage or profit, provided the Insured Person is covered under any Workers' Compensation Act, Occupational Disease Act, or similar act or law;
7. Mental or Nervous Disorders, unless otherwise stated herein;
8. Drug abuse or addiction including alcoholism, or overdose of drugs, narcotics, or hallucinogens, directly or indirectly, wholly or partially, unless taken as prescribed by a Physician;
9. An overdose of drugs, being intoxicated or under the influence of intoxicants, hallucinogens, narcotics or other drugs or controlled substances, directly or indirectly, wholly or partially, unless taken as prescribed by a Physician;
10. Any treatment including prescription drugs or non-prescription drugs, or procedure that promotes conception or prevents childbirth, including but not limited to: (a) artificial insemination; (b) in-vitro fertilization or other treatment for infertility; (c) treatment for impotency; (d) sterilization or reversal of sterilization; or (e) abortion (unless the life of the mother would be endangered if the fetus were carried to term), unless otherwise stated herein;
11. Laser vision correction, radial keratotomy or any eye Surgery when the primary purpose is to correct nearsightedness, farsightedness, astigmatism, or any other refractive error;
12. Spinal manipulations and manual manipulative treatment or therapy;
13. Mandibular or maxillofacial Surgery to correct growth defects after one year from the date of birth, jaw disproportions or malocclusions, or to increase vertical dimension or reconstruct occlusion, unless otherwise stated herein;
14. Weight loss or modification, or complications arising there from, or procedures resulting therefrom or for surgical treatment of obesity including but not limited to gastric by-pass, wiring of the teeth and all forms of Surgery performed for the purpose of weight loss or modification or the reversal/modification of such procedure;
15. Breast reduction or augmentation, or complications arising there from, unless necessary in connection with breast reconstructive Surgery following a mastectomy;
16. Modification of the physical body in order to improve the psychological, mental or emotional well-being of the Insured Person, such as but not limited to sex-change Surgery;
17. Marriage, family, or child counseling for the treatment of premarital, marriage, family or child relationship dysfunctions;
18. Directly or indirectly engaging in an illegal occupation or illegal activity;
19. Care in a nursing home, custodial institution or domiciliary care or rest cures;
20. Preparation and presentation of medical reports for appearance at trials or hearings;
21. Physical examinations required for school events, sports, camp, employment, licensing and insurance, unless otherwise stated herein;
22. Immunizations required for the sole purpose of travel outside of the U.S.A.;
23. Payment for care for military service connected disabilities for which the Insured Person is legally entitled to services and for which facilities are reasonably available to the Insured Person and payment for care for conditions that state or local law requires be treated in a public facility;
24. Experimental or Investigative medical, surgical or other health care procedures, treatments, products or services, unless otherwise stated herein;
25. Personal comfort items, such as television, telephone, lotions, shampoos, etc.;
26. Cosmetic Surgery, or complications arising there from, unless otherwise stated herein;
27. Dental Care, treatment or Surgery unless necessitated by Injury to sound natural teeth which occurs while insured under this Policy. (The expense must be incurred within one year from the date of Injury);
28. Corrective vision or hearing supplies or for the examination for prescribing or fitting such supplies;
29. The removal of warts, corns, calluses, the cutting and trimming of toenails, care for flat feet, fallen arches or chronic foot strain;
30. Expenses incurred for prescription drugs, except if added by Rider;

31. Normal pregnancy, except for Complications of Pregnancy[, except if added by Rider];
32. Any expenses related to a surrogate pregnancy; and
33. Treatment, services or supplies received outside the U.S. or Canada. However, treatment, services or supplies received as a result of an acute Sickness or Injury sustained during the first 30 days of travel outside of the U.S. or Canada will be considered a Covered Service. In no event will treatment, services or supplies received beyond the first 30 days of travel outside of the U.S. or Canada be considered a Covered Service.

Sickness Exclusion

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

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

Pre-Existing Condition

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

Coverage After Age 65 or Earlier Medicare Eligibility

When an Insured Person becomes covered under Medicare, the Covered Services of the Policy and its attachments, if any, are considered only to the extent that they are not paid by Medicare and they would otherwise be payable under the Policy. Covered Services will also be subject to any other EXCLUSIONS AND LIMITATIONS set forth in the Policy.

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

8. TERMINATION OF COVERAGE –

You

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

1. At the end of the period for which premium has been paid (subject to the Grace Period);
2. If Your mode of premium is monthly, at the end of the period through which premium has been paid following Our receipt of Your request of termination;
3. If Your mode of premium is other than monthly, upon the next monthly anniversary day following Our receipt of Your request of termination. Premium will be refunded for any amounts paid beyond the termination date;
4. On the date We elect to discontinue this plan or type of coverage. We will give You at least 90 days written notice before the date coverage will be discontinued. You will be offered an option to purchase any other coverage that We offer without regard to health status;
5. On the date We elect to discontinue all health benefit plans in Your state. We will give You and the proper state authority at least 180 days written notice before the date coverage will be discontinued; or
6. On the date an Insured Person:
 - a. Performs an act or practice that constitutes fraud; or
 - b. Has made an intentional misrepresentation of material fact, relating in any way to the coverage provided under the Policy, including claims for Benefits under the Policy.

Covered Dependents

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

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

3. The date We receive Your written request to terminate a dependent's coverage; or
4. On the date the Covered Dependent:
 - a. Performs an act or practice that constitutes fraud; or
 - b. Has made an intentional misrepresentation of material fact, relating in any way to the coverage provided under the Policy, including claims for Benefits under the Policy.

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

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

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

Special Continuation Provision for Dependents

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

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

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

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

Premiums - based on the mode of payment, checked below, the initial premiums are as follows:	
<input type="checkbox"/> Monthly (Bank Draft)	<input type="checkbox"/> Quarterly
<input type="checkbox"/> Annually	
Policy CH-26210 PPO-IP (03/09) AR - described above (includes automatic Policy Rider(s), if any):	\$ _____
<u>RIDERS (if any)</u>	\$ _____
	\$ _____
TOTAL	\$ _____

THE CHESAPEAKE LIFE INSURANCE COMPANY

A Stock Company
(Herein after called: the Company, We, Our or Us)
Home Office: Oklahoma City, Oklahoma
Administrative Office: P.O. Box 982010
North Richland Hills, Texas 76182-8010
Customer Service: 1-800-733-1110

[CATASTROPHIC EXPENSE] PREFERRED PROVIDER ORGANIZATION (PPO) POLICY

OUTLINE OF COVERAGE FOR FORM CH-26210 PPO-IP (03/09) AR

- 1. READ YOUR POLICY CAREFULLY!** This Outline of Coverage provides a very brief description of some of the important features of Your Policy. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth, in detail, the rights and obligations of both You and Us. It is, therefore, important that You **READ YOUR POLICY CAREFULLY.**
- 2. [CATASTROPHIC EXPENSE] PREFERRED PROVIDER ORGANIZATION (PPO) COVERAGE** - The plan pays for the Covered Services listed below, as described in the Policy, which are performed, prescribed, directed, or authorized by a Provider.
- 3. NETWORK / NON-NETWORK PROVIDERS** - Insured Persons have the right to obtain medical care from the Physicians, Hospitals and other health care Providers of their choice. However, in order to receive maximum benefits, all Covered Services must be obtained from Network Providers. When You utilize a Non-Network Provider You are responsible for any balance due above the Usual and Customary amount.
- 4. COVERED SERVICES** – for the purpose of this Outline of Coverage, "Covered Services" means the Medically Necessary Usual and Customary Charges for services, supplies, care or treatment as described in the Policy which are performed, prescribed, directed or authorized by a Provider. To be a Covered Service, the service, supply or treatment must be: 1) Medically Necessary and/or specifically included as a Covered Service under the Policy; 2) within the scope of the license of the Provider performing the service; 3) rendered while coverage under the Policy is in force and for which the Insured Person is legally obligated to pay; and 4) not considered Experimental or Investigative or otherwise excluded or limited under the Policy. A charge for a Covered Service is incurred on the date the service, supply or treatment is furnished.

Unless otherwise stated, all Covered Services are subject to:

- The Facility Fees shown in the POLICY SCHEDULE, if any;
- The [Deductible per [Period of Treatment] or the Deductible for all other Outpatient Covered Services] shown in the POLICY SCHEDULE;
- The Copayments shown in the POLICY SCHEDULE, if any;
- The Network Provider Coinsurance level or Non-Network Provider Coinsurance level shown in the POLICY SCHEDULE;
- The Maximum Benefit Amounts, visit limitations, if any, [Aggregate Maximum Amount] and Lifetime Maximum Amount shown in the POLICY SCHEDULE;
- The EXCLUSIONS AND LIMITATIONS; and
- All other provisions of this Policy.

LIFETIME MAXIMUM AMOUNT (per Insured Person): \$2,000,000] \$4,000,000] \$8,000,000]

AGGREGATE MAXIMUM AMOUNT (per Insured Person): \$1,000,000] \$1,000,000] \$2,000,000]

COINSURANCE MAXIMUM (per Insured Person, per Period of Treatment):

Network Provider / Non-Network Provider

 \$2,500 / \$5,000]

 \$5,000 / \$10,000]

 \$10,000 / \$20,000]

 \$15,000 / \$30,000]

COINSURANCE AMOUNTS:

Network Provider / Non-Network Provider

- 70% / 50%
- 80% / 60%
- 90% / 70%

DEDUCTIBLES (both apply):

Deductible per Insured Person, per [Period of Treatment]:

Deductible for all other Outpatient Covered Services, per Insured Person, per [Calendar Year]:

Network Provider / Non-Network Provider

Network Provider / Non-Network Provider

- | | |
|--|---------------------|
| <input type="checkbox"/> \$1,000 / \$2,000 | \$1,000 / \$2,000 |
| <input type="checkbox"/> \$ 1,500 / \$3,000 | \$ 1,500 / \$3,000 |
| <input type="checkbox"/> \$2,000 / \$4,000 | \$2,000 / \$4,000 |
| <input type="checkbox"/> \$2,500 / \$5,000 | \$2,500 / \$5,000 |
| <input type="checkbox"/> \$3,000 / \$6,000 | \$3,000 / \$6,000 |
| <input type="checkbox"/> \$3,500 / \$7,000 | \$3,500 / \$7,000 |
| <input type="checkbox"/> \$4,000 / \$8,000 | \$4,000 / \$8,000 |
| <input type="checkbox"/> \$4,500 / \$9,000 | \$4,500 / \$9,000 |
| <input type="checkbox"/> \$5,000 / \$10,000 | \$5,000 / \$10,000 |
| <input type="checkbox"/> \$5,500 / \$11,000 | \$5,500 / \$11,000 |
| <input type="checkbox"/> \$7,500 / \$15,000 | \$7,500 / \$15,000 |
| <input type="checkbox"/> \$10,000 / \$20,000 | \$10,000 / \$20,000 |

The Deductible amount per [Period of Treatment] will be deducted [each Period of Treatment] from Covered Services incurred by each Insured Person while Hospital Confined and for Outpatient Surgery. [A Period of Treatment begins on the date an Insured Person is admitted to a Hospital or the date services are rendered in an Outpatient Surgery Facility for the treatment of an Injury or Sickness and ends after 365 days. If the same or related Sickness or Injury continues beyond 365 days, a new Sickness or Injury Period of Treatment will begin, which includes a new Deductible. In no event will a single Period of Treatment exceed 365 days. A separate Period of Treatment will apply to each Injury or Sickness.]

[Expenses incurred for Covered Services under any Riders will apply toward the Deductible, where applicable, unless specifically stated otherwise.] Non-Covered Services, Facility Fees or Copayments, if any, do not apply toward the Deductible(s).

The Deductible for all other Outpatient Covered Services (except outpatient Surgery) will be deducted from each separate outpatient Covered Service incurred by each Insured Person per [Calendar Year], unless specifically stated otherwise in the Policy.

Once three Deductibles have been met in a [Calendar Year] by any or all Insured Persons under the Policy, no further Deductibles must be met for the remainder of that [Calendar Year] for any or all Insured Persons under the Policy.

Common Accident Provision: Upon to Us that one or more Insured Persons in Your family has been injured in the same accident, We will only require that one Deductible amount be satisfied for Covered Services associated with that accident. Once one Deductible amount is satisfied under the Policy, the Deductible amount for all other Insured Persons will be waived for that common accident.

COVERED SERVICES –

A. Inpatient Hospital - Covered Services include services and supplies provided by a Hospital for semi-private accommodations and general nursing care furnished by the Hospital including Confinement in the Hospital's Intensive Care or Cardiac Care Unit; Physician visits and miscellaneous medical services and supplies necessary for the treatment of the Insured Person.

Covered Services will also include hemodialysis and the charges by a Hospital for processing and administration of blood or blood components, acute inpatient rehabilitation, x-ray, laboratory, diagnostic tests and services of a radiologist, radiology group, and the services of a pathologist or pathology group for interpretation of diagnostic tests or studies, performed while the Insured Person is Hospital Confined.

Covered Services will also include coverage for general anesthesia and associated Hospital Charges in conjunction with Dental Care provided to an Insured Person if such person is: (a) a Covered Dependent child who is developmentally disabled; or (b) an individual for whom a successful result cannot be expected from Dental Care provided under local anesthesia because of a neurological or other medically compromising condition.

The fees charged for take home drugs, personal convenience items such as lotions, shampoos, etc., or items not intended primarily for use by the Insured Person while Hospital Confined are not Covered Services.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.
- **Network Facility Fee:** [\$0]
- **Non-Network Facility Fee:** [\$500] per Insured Person, per [Hospital Confinement][Period of Treatment]

B. Transplant Procedures - Covered Services include Transplant Procedures incurred during a Transplant Benefit Period. Covered Services for Transplant Procedures include the following when part of a Transplant Treatment Plan: 1) inpatient and outpatient Hospital services; 2) services of a Physician for diagnosis, treatment and Surgery for a Transplant Procedure; 3) procurement of an organ or tissue, including services provided to a living donor of an organ or tissue for procurement of an organ or tissue, provided the donor and transplant recipient are both insured under the Policy. Covered Services are limited to the actual procurement expenses, and will not be more than any Maximum Allowable Amount under the Policy applicable to the recipient; 4) rental of durable medical equipment for use outside the Hospital. Covered Services are limited to the purchase price of the same equipment; 5) prescription drugs, including immunosuppressive drugs; 6) Oxygen; 7) Speech Therapy, Occupational Therapy, Physical Therapy and Chemotherapy; 8) services and supplies for and related to high dose chemotherapy and bone marrow tissue transplantation when provided as part of a Transplant Treatment Plan which includes bone marrow transplantation and high dose chemotherapy; 9) surgical dressings and supplies; and 10) Home Health Care.

When the Insured Person's Physician advises the Insured Person that a Transplant Procedure is being considered, the Insured Person or the Insured Person's Physician should notify Us or Our designee. Covered Expenses for a live donor shall be paid to the extent that benefits remain and are available under the Policy for the Insured Person receiving the transplant, and after all Covered Expenses for the Insured Person has been paid. Covered Services will not include animal organ or artificial organ transplants or personal hygiene and convenience items. Expenses incurred beyond the Transplant Benefit Period will not be considered Covered Services, unless covered elsewhere under the Policy. Medically Necessary transplants not specifically defined as a Transplant Procedure under the Policy, which are not determined to be Experimental or Investigative will be payable the same as any other Transplant Procedure under the Policy.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.
- **Network Facility Fee:** [\$0]
- **Non-Network Facility Fee:** [\$500] per Insured Person, per Hospital Confinement
- **Network Maximum Benefit Amount:** [\$250,000] per Insured Person, per Transplant Procedure
- **Non-Network Maximum Benefit Amount:** [\$175,000] per Insured Person, per Transplant Procedure

PRE-ADMISSION TESTING - Covered Services include pre-admission tests done on an outpatient basis before an authorized Hospital stay or Outpatient Surgery. These tests must be: 1) made within 14 days prior to Hospital Confinement or within 14 days of an outpatient Surgery; 2) related to the condition for which the Insured person is being Confined; 3) not repeated in the Hospital or elsewhere; and 4) ordered by a Physician.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above

OUTPATIENT SURGERY FACILITY SERVICES - Covered Services include services furnished by and supplies received for use in an Outpatient Surgery Facility, including but not limited to: 1) Use of operating room and recovery room; 2) Administration of drugs and medicines during Surgery; 3) Dressings, casts, splints; 4) Diagnostic services including radiology, laboratory or pathology performed at the time of the Surgery; and 5) General anesthesia and associated Outpatient Surgery Facility Charges in conjunction with Dental Care provided to an Insured Person if such person is: (a) a Covered Dependent child who is developmentally disabled; or (b) an individual for whom a successful result cannot be expected from Dental Care provided under local anesthesia because of a neurological or other medically compromising condition.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

- **Network Facility Fee:** [\$0]
- **Non-Network Facility Fee:** [\$250] per Insured Person, per Surgery

MEDICAL EMERGENCIES

A. Hospital Emergency Room – Covered Services include treatment of a Medical Emergency in a Hospital emergency room. Non-Medical Emergencies are not covered.

- **Subject to chosen Network Coinsurance and Deductible amount shown above** (for both Network and Non-Network services).
- **Network Facility Fee:** \$100 \$250 \$500 \$750 \$1,000 per Insured Person, per visit (waived if Hospital Confined)
- **Non-Network Facility Fee:** \$100 \$250 \$500 \$750 \$1,000 per Insured Person, per visit (waived if Hospital Confined)

B. Urgent Care Center – Covered Services include treatment of a Medical Emergency in an Urgent Care facility. Non-Medical Emergencies are not covered.

- **Subject to chosen Network Coinsurance and Deductible amount shown above** (for both Network and Non-Network services).
- **Network Facility Fee:** \$100 \$250 per Insured Person, per visit
- **Non-Network Facility Fee:** \$100 \$250 per Insured Person, per visit

PHYSICIAN SERVICES

A. Second Surgical Opinion – Covered Services include services by a Physician for a second opinion. The Physician providing the second opinion cannot be financially associated with the referring Physician or perform or assist in the Surgery in order for services to be considered a Covered Service under the Policy. If the second opinion disagrees with the first, a third opinion will also be considered a Covered Service.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.
- **Limited to:** one per Surgery.

B. Inpatient / Outpatient Surgeon – Covered Services include expenses incurred while Hospital Confined or in an Outpatient Surgery Facility for services by the Physician performing Surgery. [When multiple surgical procedures are done at the same time, Covered Services will be considered for the first or highest cost procedure, and one-half of the Allowable Amount for each additional procedure. No benefit is payable for incidental surgical procedures such as appendectomy performed during gall bladder surgery.]

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

C. Inpatient / Outpatient Assistant Surgeon – Covered Services include services by the Physician assisting the Physician performing Surgery.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

D. Inpatient / Outpatient Anesthesiologist – Covered Services include services by the Physician providing anesthesia during Surgery.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

E. Physician Visits while Hospital Confined (other than Surgeon) – Covered Services include visits by a Physician, other than the surgeon, while Hospital Confined.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.
- **[Limited to: one visit per Physician, per day.]**

PREVENTIVE IMAGING SCREENING TESTS:

Human Papillomavirus and Cervical Cancer Screening - Covered Services include the following annual screenings, as approved by the United States Food and Drug Administration, for female Insured Persons 18 years of age or older: 1) A conventional Pap smear screening or a screening using liquid-based cytology methods; or 2) A conventional Pap smear screening in combination with a test for the detection of the Human Papillomavirus. The screening test required under this benefit must be performed in accordance with the guidelines adopted by: 1) The American College of Obstetricians and Gynecologists; or 2) Another similar national organization of medical professionals recognized by the Commissioner.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

Prostate Cancer Screening - Covered Services include the following services and supplies provided to an Insured Person for the detection of prostate cancer: 1) An annual physical examination for the detection of prostate cancer for each male Insured Person; and 2) An annual prostate-specific antigen (PSA) test used for the detection of prostate cancer for each male Insured Person who is: a) at least 50 years of age and asymptomatic; or b) at least 40 years of age with a family history of prostate cancer or another prostate cancer risk factor.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

Mammography Screening - Covered Services include an annual Low Dose Mammography screening for each female Insured Person age 35 or older.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

Colorectal Cancer Screening - Covered Services include colorectal cancer examinations and laboratory tests for Insured Persons who are 50 years of age or older; who are less than 50 years of age and at high risk for colorectal cancer according to American Cancer Society colorectal cancer screening guidelines as they existed on [January 1, 2005]; and experiencing bleeding from the rectum or blood in the stool or a change in bowel habits, such as diarrhea, constipation, or narrowing of the stool that lasts more than 5 days as determined by a licensed Physician. For the purpose of this benefit "high risk for colorectal cancer" means: Individuals over 50 years of age or who face a high risk for colorectal cancer because of the presence of polyps on a previous colonoscopy, barium enema, or flexible sigmoidoscopy; family history of colorectal cancer in close relatives of parents, brothers, sisters, or children; genetic alterations of hereditary nonpolyposis colon cancer or familial adenomatous polyposis; personal history of colorectal cancer, ulcerative colitis, or Crohn's disease; or the presence of any appropriate recognized gene markers for colorectal cancer or other predisposing factors; and any definition recognized by medical science and determined by the Director of the Department of Health in consultation with the University of Arkansas for Medical Sciences.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

SCREENING TEST FOR HEARING IMPAIRMENT - Covered Services include a screening test of hearing loss for a Covered Dependent child from birth through the date the child is 30 days old. Covered Services also include the necessary diagnostic follow-up care related to the screening test from birth through the date the child is 24 months old.

- Subject to chosen Network / Non-Network Coinsurance amount shown above.
- **Deductibles do not apply.**

IMPAIRMENT OR LOSS OF SPEECH OR HEARING - Covered Services include the necessary care and treatment of loss or impairment of speech or hearing which includes the communicative disorders generally treated by speech pathologist or audiologist licensed by the Board of Examiners in Speech-Language Pathology and Audiology and which fall within the scope of his/her area of certification. Coverage does not apply to hearing instruments or devices.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

MINIMUM STAY REQUIREMENTS FOR MASTECTOMY AND LYMPH NODE DISSECTION - Covered Services include inpatient care if an Insured Person undergoes a covered mastectomy, for a minimum of the following: 1) 48 hours following a covered mastectomy; or 2) 24 hours following a covered lymph node dissection for the treatment of breast cancer. A shorter period of Confinement will be covered if the Insured Person and her Physician determine that a shorter period of inpatient Hospital Confinement is appropriate.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

CHEMOTHERAPY AND RADIATION THERAPY - Covered Services include chemotherapy and radiation therapy received while Hospital Confined or on an outpatient basis. The condition for which chemotherapy is provided must be first diagnosed and the treatment must be received while coverage is in force.

- Subject to chosen Network / Non-Network Coinsurance amount shown above.
- **Deductibles do not apply.**
- **Network/Non-Network Maximum Benefit Amount** \$5,000 \$7,500 \$10,000 \$12,500 per Insured Person, per Calendar Month
- **Network/Non-Network Maximum Benefit Amount** \$50,000 \$100,000 \$150,000 per Insured Person, per lifetime.

DURABLE MEDICAL EQUIPMENT AND PROSTHETIC DEVICES - Covered Services include the rental of durable medical equipment not to exceed the actual purchase price of such equipment, and the purchase, fitting, repair and replacement of fitted prosthetic devices which replace a natural limb or eye, when ordered or prescribed by a Physician for use by the Insured Person. The durable medical equipment or prosthetic device must be for use solely by the Insured Person for the treatment of a Sickness or Injury which occurred while such Insured Person's coverage is in force. Routine maintenance and repairs of rental equipment are not considered Covered Services.

- Subject to chosen Network / Non-Network Coinsurance amount shown above.
- **Network/Non-Network Maximum Benefit Amount** \$2,500 per Insured Person, per [Sickness or Injury]

AMBULANCE SERVICES - Covered Services include Ambulance transportation to the nearest Hospital that can provide Covered Services appropriate for the Insured person's condition. Ambulance services are only considered Covered Services if the Insured Person is Confined to the Hospital. Air or water Ambulance services are only considered a Covered Service in situations in which the Insured person is in a location that cannot be reached by ground Ambulance. Ambulance usage for the convenience of the Insured Person is not a Covered Service. Non-Covered Services for Ambulance include but are not limited to trips to a Physician's Office or clinic; or a morgue or funeral home.

- Subject to chosen Network Coinsurance amount shown above (for both Network and Non-Network services).
- **Deductibles do not apply.**
- **Ground Ambulance Maximum Benefit Amount:** [\$500] per Insured Person, per trip.
- **Air / Water Ambulance Maximum Benefit Amount:** [\$5,000] per Insured Person, per trip.
- **Benefit only payable when Hospital Confined.**

MATERNITY STAY REQUIREMENTS FOR COVERED MATERNITY CARE - This provision applies to an Insured Person's coverage only when the Insured Person incurs Covered Services for a normal childbirth or cesarean section delivery that is covered for Complications of Pregnancy as defined in the Policy. A minimum of 48 hours of inpatient care will be provided to the mother and newborn child following a vaginal delivery and 96 hours following a cesarean section.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

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

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

CHILD HEALTH SUPERVISION SERVICES - Covered Services include for each Covered Dependent from the moment of birth to age eighteen (18) years. In keeping with prevailing medical standards, such services shall include: 1) anticipatory guidance; 2) developmental assessment; 3) laboratory tests; 4) appropriate immunizations; 5) a medical history; and 6) physical examination. Benefits will be payable for 20 visits provided by or under the supervision of a single Physician during the course of one visit, at approximately the following intervals: birth; two weeks; two, four, six, nine, twelve, fifteen and eighteen months and two, three, four, five, six, eight, ten, twelve, fourteen, sixteen and eighteen years. Benefits payable will not exceed current reimbursement levels for the same services under the Medicaid Early Periodic Screening Diagnosis and Treatment program in the State of Arkansas. Benefits for recommended immunization services shall be exempt from any Coinsurance, Deductible or dollar limit provisions.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

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

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

DIABETES - Covered Services include diabetes self-management training, supplies and related services for the treatment of Type I, Type II and gestational diabetes when determined Medically Necessary by Your Physician or other licensed health care provider. Diabetes Self-Management Training means instructions in an inpatient or outpatient setting including medical nutrition therapy relating to diet, caloric intake and diabetes management, excluding any programs in which the only purpose is weight reduction, which enables diabetic patients to understand the diabetic management process and daily management of diabetic therapy as a method of avoiding frequent hospitalizations and complications when the instruction is provided in accordance with a program in compliance with the National Standards for Diabetes Self-Management Education Program as developed by the American Diabetes Association.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

OUTPATIENT CONTRACEPTIVE SERVICES AND DEVICES - Covered Services include Outpatient Contraceptive Services and Devices including closed formularies; however, formularies must include implant and injectable contraceptive drugs, and intrauterine devices. Covered Services do not include charges for abortion, an abortifacient or any U.S. Food and Drug Administration approved emergency contraception. Outpatient Contraceptive benefits are subject to the same Deductibles and Coinsurances as prescription drugs.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

5. RIDER BENEFITS – the following is a very brief description of some of the important features of Riders that may be attached to Your Policy. This is not the insurance contract and only the actual Rider provisions will control. The Riders themselves set forth, in detail, the rights and obligations of both You and Us. It is, therefore, important that You **READ YOUR RIDERS CAREFULLY**.

Riders are made a part of the Policy to which they are attached. Riders are subject to all provisions, terms and DEFINITIONS of the Policy which are not inconsistent with the provisions of the Riders. Benefits paid under the Riders will not duplicate the benefits provided under the Policy or any other rider, and are subject to the benefit schedule shown below.

PHYSICIAN OFFICE SERVICES BENEFIT RIDER (FORM: CH-26223-IR (03/09)) [Deductibles do not apply]

A. Outpatient Physician Office Visits for Sickness or Injury:

- **Coinsurance amount:** [100%] (for both Network and Non-Network services).
- **Visit Limitations:** [2] [4] visits per Insured Person, per [Calendar Year].
- **Physician Home and Office:**
- **Network Copayment:** [\$50] per Insured Person, per visit.
- **Non-Network Copayment:** [\$100] per Insured Person, per visit.
- **Convenient Care Clinic:**
- **Network Copayment:** [\$25] per Insured Person, per visit.
- **Non-Network Copayment:** [\$50] per Insured Person, per visit.

B. Outpatient Preventive Care Physician Visits: (other than Well Child Visits):

- **Coinsurance amount:** [100%] (for both Network and Non-Network services).
- Limited to one visit per Insured Person, per [Calendar Year].
- **Physician Home and Office:**
- **Network Copayment:** [\$50] per Insured Person, per visit.
- **Non-Network Copayment:** [\$100] per Insured Person, per visit.
- **Convenient Care Clinic:**
- **Network Copayment:** [\$25] per Insured Person, per visit.
- **Non-Network Copayment:** [\$50] per Insured Person, per visit.

C. Well Child Visits (for Covered Dependent children from birth up to 24 months of age)

- **Coinsurance amount:** [100%] (for both Network and Non-Network services).
- **Physician Home and Office:**
- **Network Copayment:** [\$50] per Insured Person, per visit.
- **Non-Network Copayment:** [\$100] per Insured Person, per visit.
- **Convenient Care Clinic:**
- **Network Copayment:** [\$25] per Insured Person, per visit.
- **Non-Network Copayment:** [\$50] per Insured Person, per visit.

OUTPATIENT DIAGNOSTIC SERVICES BENEFIT RIDER (FORM: CH-26226-IR (03/09)) [Deductibles do not apply]

- **Coinsurance amount:** [100%] (for both Network and Non-Network services).
- **Network Copayment:** [\$100] [\$250] per Insured Person, per visit.
- **Non-Network Copayment:** [\$200] [\$500] per Insured Person, per visit.
- **Maximum Benefit Amounts:**
- Per Insured Person,*
- Per Day:* [\$1,500]
- Per Insured Person,*
- Per Calendar Year:* [\$2,500] [\$5,000] [\$7,500]

5. RIDER BENEFITS (Continued)

CONTINUED CARE BENEFIT RIDER (FORM: CH-26225-IR (03/09)) [Deductibles do not apply]

- **Coinsurance amount:** [100%] (for both Network and Non-Network services).
- **Skilled Nursing Facility -**
 - Visit Limitation:** [30][45][60] visits, per Insured Person, per Calendar Year
 - [Maximum Benefit Amount:** [\$200] per Insured Person, per day]

- **Home Health Care -**
 - Visit Limitation:** [30][45][60] combined visits, per Insured Person, per [Calendar Year]
 - Maximum Benefit Amount:**
 - For home infusion therapy and wound care:* [\$100] per Insured Person, per visit
 - For all other Home Health Care services:* [\$100][\$250][\$500][\$1,000] per Insured Person, per visit

- **Hospice Care -**
 - Maximum Benefit Amount:** [\$5,000] per Insured Person, per lifetime

OUTPATIENT SPEECH THERAPY, PHYSICAL THERAPY AND OCCUPATIONAL THERAPY SERVICES RIDER (FORM: CH-26224-IR (03/09)) [Deductibles do not apply]

- **Coinsurance amount:** [100%] (for both Network and Non-Network services).
- **Network/Non-Network Copayment:** [\$50] per Insured Person, per visit.
- **Visit Limitation:** [40] combined visits for all therapies, per Insured Person, per Calendar Year

OUTPATIENT ACCIDENT EXPENSE BENEFIT RIDER - (FORM: CH-26221-IR (03/09)) (initial treatment must begin within [72] hours of the Injury and any treatment of the Injury beyond the initial treatment must be received within [45 days] of the Injury)

- **Coinsurance amount:** [100%] (for both Network and Non-Network services).
- **Network/Non-Network Copayment:** [\$50] [\$100] [\$150] per Insured Person, per Injury.
- **Maximum Benefit Amount:** [\$500] [\$1,000] [\$1,500] per Insured Person, per [Calendar Year]

5. RIDER BENEFITS (Continued)

PRESCRIPTION DRUG RIDER (FORM: CH-26214-IR (03/09)) -

DEDUCTIBLE [(for Brand Dugs only)] \$50\$250
(per Insured Person, per Calendar Year)

PHARMACY BENEFITS

Generic Drugs (not to exceed a 30 day supply)

Generic preferred drugs We pay [100%] less the [\$5] Copayment
Generic non-preferred drugs We pay [100%] less the [\$15] Copayment

Brand Name Drugs (not to exceed a 30 day supply)

Brand preferred drugs We pay [50%], You pay the remainder
Brand non-preferred drugs We pay [25%][50%], You pay the remainder

MAIL SERVICE LEGEND PRESCRIPTION DRUGS

Generic Drugs (not to exceed a 90 day supply)

Generic preferred drugs We pay [100%] less the [\$15] Copayment
Generic non-preferred drugs We pay [100%] less the [\$45] Copayment

Brand Name Drugs (not to exceed a 90 day supply)

Brand preferred drugs We pay [50%], You pay the remainder
Brand non-preferred drugs We pay [25%], You pay the remainder

BENEFIT MAXIMUM

Per Insured Person, per Calendar Year: \$1,500\$2,000\$5,000

PREGNANCY/CHILDBIRTH BENEFIT RIDER- (form CH-26213-IR (03/09)). [(Deductibles do not apply)]

- 0-24 Months in Force Maximum Benefit: \$1,000[\$1,500][\$2,000][\$3,000]
- 25 Months in Force and over Maximum Benefit: \$2,000][\$3,000][\$4,000][\$6,000]

6. EXCLUSIONS AND LIMITATIONS – We will not provide any benefits for charges arising directly or indirectly, in whole or in part, from:

1. Any care not Medically Necessary or services for which benefits are not specifically provided for in this Policy, including charges related to secondary medical conditions resulting directly or indirectly from conditions, treatment or services that are not considered a Covered Service and/or that are specifically excluded under this Policy;
2. Any charges exceeding the Maximum Benefit Amount or Lifetime Maximum Amount;
3. Any act of war, declared or undeclared;
4. Suicide, attempted suicide, or any intentionally self-inflicted injury, while sane or insane;
5. Care, treatment, services or supplies received in a Hospital emergency room or Urgent Care Center for treatment of a Sickness or Injury that is not considered a Medical Emergency;
6. Any Injury or Sickness arising out of, or in the course of, employment for wage or profit, provided the Insured Person is covered under any Workers' Compensation Act, Occupational Disease Act, or similar act or law;
7. Mental or Nervous Disorders, unless otherwise stated herein;
8. Drug abuse or addiction including alcoholism, or overdose of drugs, narcotics, or hallucinogens, directly or indirectly, wholly or partially, unless taken as prescribed by a Physician;
9. An overdose of drugs, being intoxicated or under the influence of intoxicants, hallucinogens, narcotics or other drugs or controlled substances, directly or indirectly, wholly or partially, unless taken as prescribed by a Physician;
10. Any treatment including prescription drugs or non-prescription drugs, or procedure that promotes conception or prevents childbirth, including but not limited to: (a) artificial insemination; (b) in-vitro fertilization or other treatment for infertility; (c) treatment for impotency; (d) sterilization or reversal of sterilization; or (e) abortion (unless the life of the mother would be endangered if the fetus were carried to term), unless otherwise stated herein;
11. Laser vision correction, radial keratotomy or any eye Surgery when the primary purpose is to correct nearsightedness, farsightedness, astigmatism, or any other refractive error;
12. Spinal manipulations and manual manipulative treatment or therapy;
13. Mandibular or maxillofacial Surgery to correct growth defects after one year from the date of birth, jaw disproportions or malocclusions, or to increase vertical dimension or reconstruct occlusion, unless otherwise stated herein;
14. Weight loss or modification, or complications arising there from, or procedures resulting therefrom or for surgical treatment of obesity including but not limited to gastric by-pass, wiring of the teeth and all forms of Surgery performed for the purpose of weight loss or modification or the reversal/modification of such procedure;
15. Breast reduction or augmentation, or complications arising there from, unless necessary in connection with breast reconstructive Surgery following a mastectomy;
16. Modification of the physical body in order to improve the psychological, mental or emotional well-being of the Insured Person, such as but not limited to sex-change Surgery;
17. Marriage, family, or child counseling for the treatment of premarital, marriage, family or child relationship dysfunctions;
18. Directly or indirectly engaging in an illegal occupation or illegal activity;
19. Care in a nursing home, custodial institution or domiciliary care or rest cures;
20. Preparation and presentation of medical reports for appearance at trials or hearings;
21. Physical examinations required for school events, sports, camp, employment, licensing and insurance, unless otherwise stated herein;
22. Immunizations required for the sole purpose of travel outside of the U.S.A.;
23. Payment for care for military service connected disabilities for which the Insured Person is legally entitled to services and for which facilities are reasonably available to the Insured Person and payment for care for conditions that state or local law requires be treated in a public facility;
24. Experimental or Investigative medical, surgical or other health care procedures, treatments, products or services, unless otherwise stated herein;
25. Personal comfort items, such as television, telephone, lotions, shampoos, etc.;
26. Cosmetic Surgery, or complications arising there from, unless otherwise stated herein;
27. Dental Care, treatment or Surgery unless necessitated by Injury to sound natural teeth which occurs while insured under this Policy. (The expense must be incurred within one year from the date of Injury);
28. Corrective vision or hearing supplies or for the examination for prescribing or fitting such supplies;
29. The removal of warts, corns, calluses, the cutting and trimming of toenails, care for flat feet, fallen arches or chronic foot strain;
30. Expenses incurred for prescription drugs, except if added by Rider;

31. Normal pregnancy, except for Complications of Pregnancy[, except if added by Rider];
32. Any expenses related to a surrogate pregnancy; and
33. Treatment, services or supplies received outside the U.S. or Canada. However, treatment, services or supplies received as a result of an acute Sickness or Injury sustained during the first 30 days of travel outside of the U.S. or Canada will be considered a Covered Service. In no event will treatment, services or supplies received beyond the first 30 days of travel outside of the U.S. or Canada be considered a Covered Service.

Sickness Exclusion

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

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

Pre-Existing Condition

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

Coverage After Age 65 or Earlier Medicare Eligibility

When an Insured Person becomes covered under Medicare, the Covered Services of the Policy and its attachments, if any, are considered only to the extent that they are not paid by Medicare and they would otherwise be payable under the Policy. Covered Services will also be subject to any other EXCLUSIONS AND LIMITATIONS set forth in the Policy.

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

8. TERMINATION OF COVERAGE –

You

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

1. At the end of the period for which premium has been paid (subject to the Grace Period);
2. If Your mode of premium is monthly, at the end of the period through which premium has been paid following Our receipt of Your request of termination;
3. If Your mode of premium is other than monthly, upon the next monthly anniversary day following Our receipt of Your request of termination. Premium will be refunded for any amounts paid beyond the termination date;
4. On the date We elect to discontinue this plan or type of coverage. We will give You at least 90 days written notice before the date coverage will be discontinued. You will be offered an option to purchase any other coverage that We offer without regard to health status;
5. On the date We elect to discontinue all health benefit plans in Your state. We will give You and the proper state authority at least 180 days written notice before the date coverage will be discontinued; or
6. On the date an Insured Person:
 - a. Performs an act or practice that constitutes fraud; or
 - b. Has made an intentional misrepresentation of material fact, relating in any way to the coverage provided under the Policy, including claims for Benefits under the Policy.

Covered Dependents

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

1. The date Your coverage terminates;
2. The date such dependent ceases to be an Eligible Dependent;
3. The date We receive Your written request to terminate a dependent’s coverage; or
4. On the date the Covered Dependent:
 - a. Performs an act or practice that constitutes fraud; or
 - b. Has made an intentional misrepresentation of material fact, relating in any way to the coverage provided under the Policy, including claims for Benefits under the Policy.

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

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

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

Special Continuation Provision for Dependents

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

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

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

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

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

Premiums - based on the mode of payment, checked below, the initial premiums are as follows:	
<input type="checkbox"/> Monthly (Bank Draft) <input type="checkbox"/> Quarterly <input type="checkbox"/> Annually	
Policy CH-26210 PPO-IP (03/09) AR - described above (includes automatic Policy Rider(s), if any):	\$ _____
<u>RIDERS (if any)</u>	\$ _____
	\$ _____
TOTAL	\$ _____