Filing at a Glance

Company: The Chesapeake Life Insurance Company

Product Name: CH-26210-IP	SERFF Tr Num: MGCC-125949834	State: ArkansasLH
TOI: H15I Individual Health - Hospital/Surgical/Medical Expense	SERFF Status: Closed	State Tr Num: 41133
Sub-TOI: H15I.001 Health - Hospital/Surgical/Medical Expense	Co Tr Num: CH-26210-IP AR	State Status: Withdrawn
Filing Type: Form/Rate	Co Status:	Reviewer(s): Rosalind Minor
	Authors: Kathleen Allen, Jaime Butler, Courtney Sharp	Disposition Date: 03/23/2009
	Date Submitted: 12/16/2008	Disposition Status: Withdrawn
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile:
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 03/23/2009	Explanation for Other Group Market Type:
	State Status Changed: 03/23/2009
Deemer Date:	Corresponding Filing Tracking Number:

Filing Description:

Please refer to cover letter under Supporting Documentation Tab.

Company and Contact

Filing Contact Information

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

Filing Company Information

The Chesapeake Life Insurance Company
9151 Boulevard 26
North Richland Hills, TX 76180
(817) 255-3100 ext. [Phone]

CoCode: 61832
Group Code: 264
Group Name:
FEIN Number: 52-0676509

State of Domicile: Oklahoma
Company Type: Health
State ID Number:

Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The Chesapeake Life Insurance Company	$100.00	12/16/2008	24567581

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Withdrawn	Rosalind Minor	03/23/2009	03/23/2009

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	12/19/2008	12/19/2008	Kathleen Allen	01/09/2009	01/09/2009

Amendments

Item	Schedule	Created By	Created On	Date Submitted
Prescription Drug Expense Rider	Form	Kathleen Allen	12/16/2008	12/16/2008
Actuarial Memorandum and Rates	Rate	Kathleen Allen	12/16/2008	12/16/2008

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Withdrawal	Note To Reviewer	Courtney Sharp	03/19/2009	03/19/2009

Disposition

Disposition Date: 03/23/2009

Implementation Date:

Status: Withdrawn

Comment: As requested in your Note to Reviewer on 3/19/09, this submission is being withdrawn.

Rate data does NOT apply to filing.

SERFF Tracking Number:	*MGCC-125949834*	*State:*	*Arkansas*
Filing Company:	*The Chesapeake Life Insurance Company*	*State Tracking Number:*	*41133*
Company Tracking Number:	*CH-26210-IP AR*		
TOI:	*H15I Individual Health - Hospital/Surgical/Medical Expense*	*Sub-TOI:*	*H15I.001 Health - Hospital/Surgical/Medical Expense*
Product Name:	*CH-26210-IP*		
Project Name/Number:	*/*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Withdrawn	Yes
Supporting Document	Application	Withdrawn	Yes
Supporting Document	Health - Actuarial Justification	Withdrawn	No
Supporting Document *(revised)*	Outline of Coverage	Withdrawn	Yes
Supporting Document	Outline of Coverage	Withdrawn	Yes
Supporting Document	Variability Statements	Withdrawn	Yes
Supporting Document	Cover letter	Withdrawn	Yes
Form *(revised)*	CATASTROPHIC EXPENSE PREFERRED PROVIDER ORGANIZATION (PPO) POLICY	Withdrawn	Yes
Form	CATASTROPHIC EXPENSE PREFERRED PROVIDER ORGANIZATION (PPO) POLICY	Withdrawn	Yes
Form *(revised)*	CATASTROPHIC EXPENSE PREFERRED PROVIDER ORGANIZATION (PPO) POLICY	Withdrawn	Yes
Form	CATASTROPHIC EXPENSE PREFERRED PROVIDER ORGANIZATION (PPO) POLICY	Withdrawn	Yes
Form	Prescription Drug Expense Rider	Withdrawn	Yes
Rate *(revised)*	Actuarial Memorandum and Rates	Withdrawn	No
Rate	Actuarial Memorandum and Rates	Withdrawn	No
Rate *(revised)*	Actuarial Memorandum and Rates	Withdrawn	No
Rate	Actuarial Memorandum and Rates	Withdrawn	No
Rate	Actuarial Memorandum and Rates	Withdrawn	No

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	12/19/2008
Submitted Date	12/19/2008
Respond By Date	

Dear Kathleen Allen,

This will acknowledge receipt of the captioned filing.

Objection 1

- CATASTROPHIC EXPENSE PREFERRED PROVIDER ORGANIZATION (PPO) POLICY (Form)
- CATASTROPHIC EXPENSE PREFERRED PROVIDER ORGANIZATION (PPO) POLICY (Form)

Comment: Many of your benefits payable a PPO vs a Non-PPO provider to not comply with our Bulletin 9-85 which states that the difference in benefit levels, i.e., deductibles and co-pay 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 hopsital 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.

Also, will you market this product statewide in Arkansas? If so, do you have an adequate network statewide?

Objection 2

- Actuarial Memorandum and Rates (Rate)

Comment: Under item 17 of the actuarial memorandum, it is stated that an additional 1.8% will be added to the rates every 3 months to account for tread going forward.

Our Department does not allow automatic tread increases. Rate increases must be justified by the actual experience of the block of business.

Objection 3

- Actuarial Memorandum and Rates (Rate)
- Actuarial Memorandum and Rates (Rate)

Comment: Under item 1 of the actuarial memorandum, it is states that the coinsurance percentage will be a 30% spread. The 30% is not in compliance with our Bulletin 9-85.

Under item 17, it is stated that an additional 3.2% will be added to the rates every 3 months for trend going forward. Our Department does not allow automatic tread increases. Our rate approval is based on the actual experience of the block

of business.

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

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	01/09/2009
Submitted Date	01/09/2009

Dear Rosalind Minor,

Comments:
Thank you for your recent review. We have made the appropriate changes as stated below.

Response 1

Comments: As for trend increases of 1.8% for RX and 3.2% for bases, our Actuarial department states that these are not rate increases for existing customers, these are for New Business only. Our records reflect that your department has approved previous filings with these trend increases.

Related Objection 1

Applies To:

- Actuarial Memorandum and Rates (Rate)

Comment:
Under item 17 of the actuarial memorandum, it is stated that an additional 1.8% will be added to the rates every 3 months to account for tread going forward.

Our Department does not allow automatic tread increases. Rate increases must be justified by the actual experience of the block of business.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 2

Comments: This product will be marketed statewide in Arkansas. We use 3 networks in the state of Arkansas which are AMCO, PHCS and First Health.

Related Objection 1

Applies To:

- CATASTROPHIC EXPENSE PREFERRED PROVIDER ORGANIZATION (PPO) POLICY (Form)
- CATASTROPHIC EXPENSE PREFERRED PROVIDER ORGANIZATION (PPO) POLICY (Form)

Comment:

Many of your benefits payable a PPO vs a Non-PPO provider to not comply with our Bulletin 9-85 which states that the difference in benefit levels, i.e., deductibles and co-pay 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 hopsital 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.

Also, will you market this product statewide in Arkansas? If so, do you have an adequate network statewide?

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Response 3

Comments: I have revised the policies and outline of coverages accordingly to comply with Bulletin 9-85 to not exceed 25%. Please refer to attached.

Related Objection 1

Applies To:

- CATASTROPHIC EXPENSE PREFERRED PROVIDER ORGANIZATION (PPO) POLICY (Form)
- CATASTROPHIC EXPENSE PREFERRED PROVIDER ORGANIZATION (PPO) POLICY (Form)

Comment:

Many of your benefits payable a PPO vs a Non-PPO provider to not comply with our Bulletin 9-85 which states that the difference in benefit levels, i.e., deductibles and co-pay 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 hopsital 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.

Also, will you market this product statewide in Arkansas? If so, do you have an adequate network statewide?

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 (01/09) AR		Policy/Contract/Fraternal Certificate	Initial			CH-26210 PPO-IP _0109_AR .pdf
Previous Version							
CATASTROPHIC EXPENSE PREFERRED PROVIDER ORGANIZATION (PPO) POLICY	*CH-26210 PPO-IP (01/09) AR*		*Policy/Contract/Fraternal Certificate*	*Initial*			CH-26210 PPO-IP _0109_AR .pdf
CATASTROPHIC EXPENSE PREFERRED PROVIDER ORGANIZATION	CH-26210 HSA PPO-IP (01/09) AR		Policy/Contract/Fraternal Certificate	Initial			CH-26210 HSA PPO-IP _0109_AR .pdf

(PPO) POLICY

Previous Version

CATASTROPHIC EXPENSE PREFERRED PROVIDER ORGANIZATION (PPO) POLICY	*CH-26210 HSA PPO-IP (01/09) AR*	*Policy/Contract/Fraternal Certificate*	*Initial*	CH-26210 HSA PPO-IP _0109_AR .pdf

No Rate/Rule Schedule items changed.

Response 4

Comments: The Actuarial Memorandum has been changed to reflect the 25% spread rather than 30%.
Please see attached. The rates have not changed.

Related Objection 1

Applies To:

- Actuarial Memorandum and Rates (Rate)
- Actuarial Memorandum and Rates (Rate)

Comment:

Under item 1 of the actuarial memorandum, it is states that the coinsurance percentage will be a 30% spread. The 30% is not in compliance with our Bulletin 9-85.

Under item 17, it is stated that an additional 3.2% will be added to the rates every 3 months for trend going forward. Our Department does not allow automatic tread increases. Our rate approval is based on the actual experience of the block of business.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: Outline of Coverage
Comment: Please refer to attached.

No Form Schedule items changed.

Rate/Rule Schedule Item Changes

Document Name:	Affected Form Numbers:	Rate Action:	Rate Action Information:	Attach Document:
Actuarial Memorandum and AR Rates	CH-26210 PPO-IP (01/09)	New	*Previous State Filing Number* *Percent Rate Change Request* 0	
Previous Version				
Actuarial Memorandum and AR	*CH-26210 PPO-IP (01/09)*	*New*	*Previous State Filing Number*	

Rates

Percent Rate Change Request

0

Actuarial Memorandum and Rates | CH-26210 HSA PPO-IP (01/09) AR | New

Previous State Filing Number

Percent Rate Change Request

0

Previous Version

Actuarial Memorandum and Rates | *CH-26210 HSA PPO-IP (01/09) AR* | *New*

Previous State Filing Number

Percent Rate Change Request

0

We appreciate your consideration.

Sincerely,
Courtney Sharp, Jaime Butler, Kathleen Allen

Note To Reviewer

Created By:

Courtney Sharp on 03/19/2009 12:43 PM

Last Edited By:

Rosalind Minor

Submitted On:

03/23/2009 08:50 AM

Subject:

Withdrawal

Comments:

We would like to formally request to have this filing withdrawn.

We apologize for any inconvenience this may have caused.

Thank you.

Courtney Sharp

Amendment Letter

Amendment Date:

Submitted Date: 12/16/2008

Comments:

I apologize, I left off the Prescription Drug Expense Rider that is to be filed with this.

Please refer to attached.

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-26214-IR (01/09) AR	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Prescription Drug Expense Rider	Initial					CH-26214-IR_01-09_AR.pdf

Rate/Rule Schedule Item Changes:

Document Name:	Affected Form Numbers: (Comma Separated list)	Rate Action:	Rate Action Information:	Attach Document:
Actuarial Memorandum and Rates sCH-26214-IR (0109) AR (AR) 20081212.pdf	CH-26214-IR (01/09) AR	New		sCH-26214-IR (0109) AR (AR) 20081212.pdf

Form Schedule

Lead Form Number:

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Withdrawn	CH-26210 PPO-IP (01/09) AR	Policy/Contract/Fraternal Certificate	CATASTROPHIC EXPENSE PREFERRED PROVIDER ORGANIZATION (PPO) POLICY	Initial			CH-26210 PPO-IP _0109_AR.pdf
Withdrawn	CH-26210 HSA PPO-IP (01/09) AR	Policy/Contract/Fraternal Certificate	CATASTROPHIC EXPENSE PREFERRED PROVIDER ORGANIZATION (PPO) POLICY	Initial			CH-26210 HSA PPO-IP _0109_AR.pdf
Withdrawn	CH-26214-IR (01/09) AR	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Prescription Drug Expense Rider	Initial			CH-26214-IR _01-09_AR.pdf

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

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. 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 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 2 days 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 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.

POLICY SCHEDULE

COVERAGE IS PROVIDED UNDER POLICY NO: [XXXXX][XXXXX][XXXXX]

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. Benefits for Covered Services are based on the Allowable Amount. When Covered Services are received from a Non-Network Provider, the Allowable Amount may be less than the Allowable Amount that would have otherwise been considered for Covered Services received from a Network Provider. When You utilize a Non-Network Provider You are responsible for any balance due between the Non-Network Providers charge and the Allowable 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]

CALENDAR YEAR DEDUCTIBLE:	**NETWORK PROVIDER**	**NON-NETWORK PROVIDER**
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 the Allowable Amount or Maximum Allowable Amount for Covered Services incurred by each Insured Person, 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. [Covered Services incurred under any Riders will apply toward the Individual and Family Maximum Deductible, where applicable, unless specifically stated otherwise.] Deductibles do **not** include non-Covered Services, Covered Services in excess of the Allowable Amount or Maximum Allowable Amount, Facility Fees or Copayments.

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.

COINSURANCE MAXIMUM:	**NETWORK PROVIDER**	**NON-NETWORK PROVIDER**
Individual:	[$0][$2,500][$5,000][$10,000] [Not Applicable]	[$10,000]
Family:	[$5,000][$10,000][$20,000] [Not Applicable]	[$20,000]

The Coinsurance Maximum is the total Allowable Amount or Maximum Allowable Amount of Covered Services that Insured Persons must pay each Calendar Year after application of the Deductible and Coinsurance. Once the Individual Coinsurance Maximum is met, the Allowable Amount or Maximum Allowable Amount for Covered Services remaining thereafter for that Insured Person in the same Calendar Year will be paid at 100%, after the application of any Facility Fees or Copayments. Once the Family Coinsurance Maximum is met, the Allowable Amount or Maximum Allowable Amount for Covered Services remaining thereafter for all Insured Persons in the same Calendar Year will be paid at 100%, after the application of any Facility Fees or Copayments. **Facility Fees, Deductibles, Copayments and any charges exceeding the Allowable Amount or Maximum Allowable Amount do not count toward meeting the Coinsurance Maximum.**

POLICY SCHEDULE
SCHEDULE OF BENEFITS (Continued)

COVERED SERVICES	NETWORK PROVIDER	NON-NETWORK PROVIDER
INPATIENT SERVICES:		
Facility Fee:	[Facility Fee does not apply]	[$500] Per Insured Person, per Hospital Confinement
Inpatient Hospital:	[80%][90%][100%] Coinsurance	[55%][65%][75%] Coinsurance
Transplant Procedures:	[80%][90%][100%] Coinsurance	[55%][65%][75%] Coinsurance
	[$250,000] Maximum Allowable Amount, per Insured Person, per Transplant Procedure	[$175,000] Maximum Allowable Amount, per Insured Person, per Transplant Procedure
PRE-ADMISSION TESTING:	[80%][90%][100%] Coinsurance	[55%][65%][75%] Coinsurance
OUTPATIENT SURGERY FACILITY SERVICES:	[80%][90%][100%] Coinsurance	[55%][65%][75%] Coinsurance
Facility Fee:	[Facility Fee does not apply]	[$250] Per Insured Person, per Surgery
MEDICAL EMERGENCIES:	[80%][90%][100%] Coinsurance	[80%][90%][100%] Coinsurance
Hospital Emergency Room Facility Fee: *(Waived if Hospital Confined)*	[$100] [$500] Per Insured Person, per visit	[$100][$500] Per Insured Person, per visit
Urgent Care Center Facility Fee:	[$100] Per Insured Person, per visit	[$100] Per Insured Person, per visit
PHYSICIAN SERVICES:		
Second Surgical Opinion: *(Limited to one per Surgery)*	[80%][90%][100%] Coinsurance	[55%][65%][75%] Coinsurance
Inpatient / Outpatient Surgeon:	[80%][90%][100%] Coinsurance	[55%][65%][75%] Coinsurance
Assistant Surgeon:	[80%][90%][100%] Coinsurance	[55%][65%][75%] Coinsurance
Anesthesiologist:	[80%][90%][100%] Coinsurance	[55%][65%][75%] Coinsurance
Physician Visits while Hospital Confined (other than Surgeon): *(Limited to one visit per Physician, per day)*	[80%][90%][100%] Coinsurance	[55%][65%][75%] Coinsurance

POLICY SCHEDULE
SCHEDULE OF BENEFITS (Continued)

COVERED SERVICES	NETWORK PROVIDER	NON-NETWORK PROVIDER
{Option A} **PHYSICIAN SERVICES (Cont.)**		
Outpatient Physician Visits for Sickness or Injury:	[80%][90%][100%] Coinsurance	[55%][65%][75%] Coinsurance
Outpatient Preventive Care Physician Visits: (*Other than Well Child Visit)* *(Limited to one visit per Insured Person, per Calendar Year)*	[80%][90%][100%] Coinsurance	[55%][65%][75%] Coinsurance
Well Child Visits: *(For covered Dependent children from birth up to 24 months)*	[80%][90%][100%] Coinsurance	[55%][65%][75%] Coinsurance

POLICY SCHEDULE
SCHEDULE OF BENEFITS (Continued)

COVERED SERVICES	NETWORK PROVIDER	NON-NETWORK PROVIDER
{Option B} **PHYSICIAN SERVICES (Cont.)**		
Outpatient Physician Office Visits for Sickness or Injury: *(Limited to [2][4] visits per Insured Person, per Calendar Year)*	[100%] Coinsurance – [Deductible waived]	[75%] Coinsurance
Physician Home and Office Copayment:	[$50] per Insured Person, per visit	[Copayment does not apply]
Convenient Care Clinic Copayment:	[$25] per Insured Person, per visit	[Copayment does not apply]
Outpatient Preventive Care Physician Visits: *(Other than Well Child Visits) (Limited to one visit per Insured Person, per Calendar Year)*	[100%] Coinsurance after [$50] Copayment, per Insured Person, per visit – [Deductible waived]	[75%] Coinsurance
Well Child Visits: *(For covered Dependent children from birth up to 24 months:*	[100%] Coinsurance after [$50] Copayment, per Insured Person, per visit –[Deductible waived]	[75%] Coinsurance

POLICY SCHEDULE
SCHEDULE OF BENEFITS (Continued)

COVERED SERVICES	NETWORK PROVIDER	NON-NETWORK PROVIDER
{Option C} **PHYSICIAN SERVICES (Cont.)**		
Outpatient Physician Office Visits for Sickness or Injury:	[100%] Coinsurance – [Deductible waived]	[75%] Coinsurance
Physician Home and Office Copayment:	[$50] per Insured Person, per visit	[Copayment does not apply]
Convenient Care Clinic Copayment:	[$25] per Insured Person, per visit	[Copayment does not apply]
Outpatient Preventive Care Physician Visits: *(Other than Well Child Visits)* *(Limited to one visit per Insured Person, per Calendar Year)*	[100%] Coinsurance after [$50] Copayment, per Insured Person, per visit – [Deductible waived]	[75%] Coinsurance
Well Child Visits: *(For covered Dependent children from birth up to 24 months):*	[100%] Coinsurance after [$50] Copayment, per Insured Person, per visit – [Deductible waived]	[75%] Coinsurance

POLICY SCHEDULE
SCHEDULE OF BENEFITS (Continued)

COVERED SERVICES	NETWORK PROVIDER	NON-NETWORK PROVIDER
PREVENTIVE IMAGING SCREENING TESTS:		
Human Papillomavirus and Cervical Cancer Screening:	[80%][90%][100%] Coinsurance	[55%][65%][75%] Coinsurance
Prostate Cancer Screening:	[80%][90%][100%] Coinsurance	[55%][65%][75%] Coinsurance
Mammography Screening:	[80%][90%][100%] Coinsurance	[55%][65%][75%] Coinsurance
Colorectal Cancer Screening:	[80%][90%][100%] Coinsurance	[55%][65%][75%] Coinsurance
RECONSTRUCTIVE SURGERY IN CONNECTION WITH A MASTECTOMY:	[80%][90%][100%] Coinsurance	[55%][65%][75%] Coinsurance
COMPLICATIONS OF PREGNANCY:	[80%][90%][100%] Coinsurance	[55%][65%][75%] Coinsurance

POLICY SCHEDULE
SCHEDULE OF BENEFITS (Continued)

COVERED SERVICES	NETWORK PROVIDER	NON-NETWORK PROVIDER
CHEMOTHERAPY:	[80%][90%][100%] Coinsurance	[55%][65%][75%] Coinsurance
RADIATION THERAPY:	[80%][90%][100%] Coinsurance	[55%][65%][75%] Coinsurance
OUTPATIENT DIAGNOSTIC SERVICES:	[80%][90%][100%] of [Maximum] Allowable Amount	[55%][65%][75%] of [Maximum] Allowable Amount
CAT, MRI and/or PET Scans through Network / Non-Network Provider: [$2,500][$5,000] Maximum Allowable Amount per Insured Person, per Calendar Year		
Facility Fee:	[$0][$150][$250] per Insured Person, per visit	[$0][$150][$250] per Insured Person, per visit
All Other Outpatient Diagnostic Services through Network / Non-Network Provider: [$2,500][$5,000] Maximum Allowable Amount per Insured Person, per Calendar Year		
Facility Fee:	[$0][$50][$200] per Insured Person, per visit	[$0][$50][$200] per Insured Person, per visit

POLICY SCHEDULE
SCHEDULE OF BENEFITS (Continued)

COVERED SERVICES	NETWORK PROVIDER	NON-NETWORK PROVIDER
SKILLED NURSING CARE: **Network / Non-Network Provider:** limited to [30 visits] per Insured Person, per Calendar Year	[80%][90%][100%] Coinsurance	[55%][65%][75%] Coinsurance
HOME HEALTH CARE: **Network / Non-Network Provider:** limited to [30 visits] per Insured Person, per Calendar Year	[80%][90%][100%] Coinsurance	[55%][65%][75%] Coinsurance
HOSPICE CARE: **Network / Non-Network Provider:** [$5,000] Maximum Allowable Amount per Insured Person, per lifetime	[80%][90%][100%] Coinsurance	[55%][65%][75%] Coinsurance
PRIVATE DUTY NURSING: **Network / Non-Network Provider:** limited to [30 shifts] per Insured Person, per Calendar Year	[80%][90%][100%] Coinsurance	[55%][65%][75%] Coinsurance
DURABLE MEDICAL EQUIPMENT AND PROSTHETIC DEVICES: **Network / Non-Network Provider:** [$2,000] Maximum Allowable Amount per Insured Person, per Calendar Year	[80%][90%][100%] Coinsurance	[55%][65%][75%] Coinsurance

POLICY SCHEDULE
SCHEDULE OF BENEFITS (Continued)

COVERED SERVICES	NETWORK PROVIDER	NON-NETWORK PROVIDER
AMBULANCE SERVICES *(Payable only when Hospital Confined)*		
Ground Ambulance: Network/Non-Network Provider: $500 Maximum Allowable Amount per Insured Person, per trip	[80%][90%][100%] Coinsurance	[80%][90%][100%] Coinsurance
Air / Water Ambulance: Network / Non-Network Provider: $5,000 Maximum Allowable Amount per Insured Person, per trip	[80%][90%][100%] Coinsurance	[80%][90%][100%] Coinsurance
THERAPY SERVICES *(Limited to [40 combined visits] for all therapies per Insured Person, per Calendar Year)*		
Speech Therapy:	[80%][90%][100%] Coinsurance	[55%][65%][75%] Coinsurance
Facility Fee:	$50 per Insured Person, per visit	$50 per Insured Person, per visit
Physical Therapy:	[80%][90%][100%] Coinsurance	[55%][65%][75%] Coinsurance
Facility Fee:	$50 per Insured Person, per visit	$50 per Insured Person, per visit
Occupational Therapy:	[80%][90%][100%] Coinsurance	[55%][65%][75%] Coinsurance
Facility Fee:	$50 per Insured Person, per visit	$50 per Insured Person, per visit
Cardiac Rehabilitation (Phase I & II)	[80%][90%][100%] Coinsurance	[55%][65%][75%] Coinsurance
Facility Fee:	$50 per Insured Person, per visit	$50 per Insured Person, per visit
Child Health Supervision Services (*Immunizations only)*	[100%] of Covered Services	[100%] of Covered Services

POLICY SCHEDULE
SCHEDULE OF BENEFITS (Continued)

RIDER BENEFITS

PRESCRIPTION DRUG RIDER
(See Rider)

DEFINITIONS

Allowable Amount means the Provider charge that is considered for Covered Services under this Policy and any attached Riders after the application of the Facility Fee and Copayment, if any. For Network Providers, the Allowable Amount is the lesser of the contracted amount or the Maximum Allowable Amount shown in the POLICY SCHEDULE. For Non-Network Providers, the Allowable Amount is the lesser of Usual and Customary Charge, the billed amount or the Maximum Allowable Amount shown in the POLICY SCHEDULE. No amount in excess of the Allowable Amount or Maximum Allowable Amount will be considered under this Policy. The Allowable Amount is subject to:

- The Deductibles shown in the POLICY SCHEDULE, if any;
- The Network Coinsurance level or Non-Network Coinsurance level shown in the POLICY SCHEDULE; and
- The Calendar Year and Lifetime Maximum Amounts shown in the POLICY SCHEDULE.

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 the Allowable Amount or Maximum Allowable Amount of Covered Services that are paid by Us after application of the Facility Fees and Copayment, if any, and 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.

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

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

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 before the application of the Allowable Amount or Maximum Allowable Amount for specifically listed Covered Services and is in lieu of the Deductible. The Copayment, if any, is shown in the POLICY SCHEDULE. Copayments do not count toward [Facility Fees][, Deductibles][, or Coinsurance Maximums].

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

1. Reconstructive Surgery incidental to or following Surgery resulting from trauma, infection or other disease of the involved part, 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 mean 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. **Any charges in excess of the Allowable Amount or the Maximum Allowable Amount shown in the Policy Schedule, if any, will *not* be considered a Covered Service.**

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;
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 Allowable Amount or Maximum Allowable Amount 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].

Home Health Care means the provision of a health service for payment or other consideration in a patient's residence under a plan established, approved in writing, and reviewed at least every two months by the attending Physician and certified by the attending Physician as necessary for medical purposes.

Home Health Care Agency means a public or private agency or organization licensed in the state in which it is located, to provide home health care services.

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.

Hospice means an agency which provides limited periods of care for terminally ill persons and is licensed, certified or registered in accordance with state law.

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 Allowable Amounts or Maximum Amounts paid by Us will accumulate toward the Lifetime Maximum Amount from the Policy Date. The Lifetime Maximum Amount is shown in the POLICY SCHEDULE.

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 Allowable Amount means the maximum dollar amount that will be considered as an Allowable Amount for a Covered Service under this Policy and any attached Riders. The Maximum Allowable Amount is shown in the POLICY SCHEDULE.

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 Insured Person'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.

Occupational Therapy means the use of purposeful activities to restore and maximize independence, prevent associated disability, and maintain health. The practice encompasses assessment, treatment and consultation for individuals and groups in healthcare, educational, and community settings.

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.

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

Physician means a legally qualified licensed practitioner of the healing arts who provides care within the scope of his or her license, 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.

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 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.

Private Duty Nurse means a registered graduate professional nurse (R.N.), licensed vocational nurse (L.V.N), licensed practical nurse (L.P.N.) or any other legally licensed or certified nursing professional who provides care within the scope of his or her license or certificate. (A member of the Insured Person's Immediate Family will not be considered a Private Duty Nurse.)

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.

Skilled Nursing Facility means a facility which:

1. is licensed by the state;
2. provides skilled nursing care under the supervision of a Physician;
3. has 24 hour-a-day nursing services by or under the supervision of a registered graduate professional nurse (R.N.);
4. keeps a daily medical record of each patient; and
5. provides full-time bed care for resident patients.

It does not include a facility or any of its sections which is a place for persons suffering from a Mental or Nervous Disorder, alcohol or drug problems, or which is used mainly as a home for rest or for the aged. Nor does the term include an institution which is operated mainly for domiciliary or custodial care or as a school for the education of patients.

Speech Therapy means the application of principles, methods, and procedures for measurement, testing, identification, prediction, counseling, or instruction related to the development and disorders of speech, voice, or language for the purpose of identifying, preventing, managing, habilitating, or rehabilitating, ameliorating, or modifying such disorders and conditions in individuals or groups of individuals.

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:

1. Heart transplant;
2. Combined heart and lung transplant;
3. Lung transplant;
4. Kidney transplant;
5. Kidney and pancreas transplant;
6. Liver transplant;
7. Bone marrow transplant, either allogenic or autologous, including high dose chemotherapy; or
8. Peripheral stem cell transplant.

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

1. The condition requiring treatment, along with recommended procedures;
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 negotiated rate in effect with a Network Provider on the date it provides a Covered Service.

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.

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 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.

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 Provisions for Dependents

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

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

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

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.

COVERED SERVICES

Covered Services include 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. Any charges in excess of the Allowable Amount or the Maximum Allowable Amount shown in the Policy Schedule, if any, will not be considered a Covered Service

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

1. The Facility Fees and/or Copayments shown in the POLICY SCHEDULE, if any;
2. The Allowable Amount, Maximum Allowable Amount, Calendar Year and Lifetime Maximum Amounts shown in the POLICY SCHEDULE;
3. The Deductibles shown in the POLICY SCHEDULE, if any;
4. The Network Provider Coinsurance level or Non-Network Provider Coinsurance level shown in the POLICY SCHEDULE; and
5. The EXCLUSIONS AND LIMITATIONS.

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

The fees charged for take home drugs, personal convenience items 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 Allowable Amount under the Policy applicable to the recipient;
4. Rental of durable medical equipment for use outside the Hospital. The Allowable Amount is 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.

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; and
4. Diagnostic services including radiology, laboratory or pathology performed at the time of the Surgery.

MEDICAL EMERGENCIES:

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

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 include the Allowable Amount 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 an appendectomy performed during a gall bladder surgery.

Assistant Surgeon Benefit

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

Anesthesiologist Benefit

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.

Outpatient Physician Visits for Sickness or Injury

Covered Services include Medically Necessary Physician office visits related to a Sickness or Injury, including Physician Consultations and any treatment associated with such Physician's Office visit that is received in the Physician's Office or in a Convenient Care Clinic. Covered Services also include any Medically Necessary laboratory and x-ray services provided and billed by the Physician related to a Sickness or Injury.

Outpatient Preventive Care Physician Visits

Covered Services include office charges and routine physical examinations, health history and immunizations required for school or travel when received in a Physician's Office or in a Convenient Care Clinic and are not related to a Sickness or Injury. Covered Services will also include any routine laboratory and x-ray services performed in the Physician's Office and billed by the Physician that are not related to a Sickness or Injury.

Well Child Visits

Covered Services include well child Physician visits for covered Dependent Children from birth up to 24 months of age. Covered Services will also include any routine or preventive laboratory and x-ray services performed in the Physician's Office and billed by the Physician that are not related to a Sickness or Injury.

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

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

RECONSTRUCTIVE SURGERY IN CONNECTION WITH A MASTECTOMY:

Covered Services include services and supplies provided for reconstructive Surgery in connection with a mastectomy. The reconstructive Surgery will be provided in a manner determined to be appropriate in Consultation with the attending Physician and the Insured Person, and will include:

1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to achieve a symmetrical appearance; and
3. Prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.

COMPLICATIONS OF PREGNANCY:

Covered Services include treatment of Complications of Pregnancy while Hospital Confined or in an Outpatient Surgery Facility (when the pregnancy is not terminated).

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.

CHEMOTHERAPY:

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

RADIATION THERAPY:

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

OUTPATIENT DIAGNOSTIC SERVICES:

Covered Services include outpatient diagnostic services performed in a free-standing diagnostic center or Hospital (other than Hospital emergency room) for diagnostic x-rays and interpretation charges, and laboratory and pathological examinations received while not Confined to a Hospital and that are related to and necessary for the diagnosis and treatment of the Sickness or Injury. [Covered Services include but are not limited to CAT Scans, Magnetic Resonance Imaging (MRI), PET Scans, SPECT scans; Nuclear Medicine Imaging; Sleep studies; Mammogram, Upper/Lower G.I. Series, Electrocardiogram (EKG), Blood or serum analysis, Angiogram and Stress Tests.]

Covered Services include Central Supply (IV tubing) or pharmacy (dye) necessary to perform the tests.

Covered Services under this provision do not include routine physical examinations or checkups, and laboratory and x-ray services provided in and billed by a Hospital emergency room, Urgent Care Center or Physician's office.

SKILLED NURSING CARE:

Covered Services include charges incurred during Confinement in a Skilled Nursing Facility.

HOME HEALTH CARE:

Covered Services include services or supplies furnished by a Home Health Care Agency.

HOSPICE CARE:

Covered Services include the following services and supplies provided by a Hospice in the Insured Person's home or in a Hospice facility for medical, social and psychological services used as palliative treatment for patients with a life expectancy of not more than 6 months:

1. Skilled nursing services;
2. Diagnostic services;
3. Physical, speech and inhalation therapies;
4. Medical supplies, equipment and appliances;
5. Counseling services for the Insured Person regarding his or her terminal illness;
6. Inpatient Confinement at a Hospice Facility; and
7. Prescription Drugs obtained from the Hospice.

PRIVATE DUTY NURSING:

Covered Services include the services of a Private Duty Nurse.

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.

THERAPY SERVICES:

Speech Therapy, Physical Therapy, Occupational Therapy and Cardiac Rehabilitation (Phase I and II)

Covered Services include Speech Therapy, Physical Therapy, Occupational Therapy and Cardiac Rehabilitation (Phase I and II) that is related to and Medically Necessary for the treatment of a Sickness or Injury.

MUSCULOSKELETAL DISORDERS:

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

CHILD HEALTH SUPERVISION SERVICES:

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

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

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

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

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

MEDICAL FOODS AND LOW PROTEIN MODIFIED FOOD PRODUCTS:

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

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

DIABETES:

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

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

IMPAIRMENT OR LOSS OF SPEECH OR HEARING:

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

OUTPATIENT CONTRACEPTIVE SERVICES AND DEVICES:

Covered Services incurred for 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;
2. Any charges exceeding the Allowable Amount or Maximum Allowable 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. 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;
13. 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;
14. Breast reduction or augmentation, or complications arising there from, unless necessary in connection with breast reconstructive Surgery following a mastectomy;
15. Modification of the physical body in order to improve the psychological, mental or emotional well-being of the Insured Person, such as but not limited to sex-change Surgery;
16. Marriage, family, or child counseling for the treatment of premarital, marriage, family or child relationship dysfunctions;
17. Directly or indirectly engaging in an illegal occupation or illegal activity;
18. Care in a nursing home, custodial institution or domiciliary care or rest cures;
19. Preparation and presentation of medical reports for appearance at trials or hearings;
20. Physical examinations required for school events, sports, camp, employment, licensing and insurance, unless otherwise stated herein;
21. Immunizations required for the sole purpose of travel outside of the U.S.A.;
22. Payment for care for military service connected disabilities for which the Insured Person is legally entitled to services and for which facilities are reasonably available to the Insured Person and payment for care for conditions that state or local law requires be treated in a public facility;
23. Experimental or Investigative medical, surgical or other health care procedures, treatments, products or services, unless otherwise stated herein;
24. Personal comfort items, such as television, telephone, lotions, shampoos, etc.;
25. Cosmetic Surgery, or complications arising there from, unless otherwise stated herein;
26. Dental Care, treatment or Surgery unless necessitated by Injury to sound natural teeth which occurs while insured under this Policy. (The expense must be incurred within one year from the date of Injury);
27. Corrective vision or hearing supplies or for the examination for prescribing or fitting such supplies;
28. The removal of warts, corns, calluses, the cutting and trimming of toenails, care for flat feet, fallen arches or chronic foot strain;
29. Expenses incurred for prescription drugs, except if added by Rider;
30. Normal pregnancy, except for Complications of Pregnancy, except benefits added by Rider; and
31. 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.

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 the Policy. No other person will have the authority to bind Us in any manner. No agent may accept risks, alter or amend coverage or waive any provisions of the Policy. Any change in the Policy will be made by an amendment approved and signed by Us. Such amendment will not require the consent of any Insured Person.

Notice of Claim

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

Claim Forms

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

Proof of Loss

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

Claim Payments

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

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

Assignment of Claim Payments

Payment for services provided by the 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.

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

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

THE 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

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. 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 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 2 days 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 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.

POLICY SCHEDULE

COVERAGE IS PROVIDED UNDER POLICY NO: [XXXXX][XXXXX][XXXXX]

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)

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. Benefits for Covered Services are based on the Allowable Amount. When Covered Services are received from a Non-Network Provider, the Allowable Amount may be less than the Allowable Amount that would have otherwise been considered for Covered Services received from a Network Provider. When You utilize a Non-Network Provider You are responsible for any balance due between the Non-Network Providers charge and the Allowable 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] **]**

CALENDAR YEAR DEDUCTIBLE	NETWORK PROVIDER	NON-NETWORK PROVIDER
[Individual Deductible:	[$5,800]	[$11, 600] **]**
[Family Deductible:	[$11,600]	[$23,200] **]**

DEDUCTIBLE PROVISIONS:

The Deductible amount will be deducted from the Allowable Amount or Maximum Allowable Amount for Covered Services incurred by Insured Persons, each Calendar Year. Covered Services incurred under any Riders will apply toward the Individual and Family Maximum Deductible, where applicable, unless specifically stated otherwise. Deductibles do **not** include non-Covered Services, Covered Services in excess of the Allowable Amount or Maximum Allowable Amount, Facility Fees or Copayments.

MAXIMUM OUT-OF-POCKET AMOUNT	NETWORK PROVIDER	NON-NETWORK PROVIDER
[Individual:	[$5,800]	[Not Applicable] **]**
[Family	[$11,600]	[Not Applicable] **]**

MAXIMUM OUT-OF-POCKET AMOUNT is the total Allowable Amount of [Network Provider] expenses that must be paid by Insured Persons each Calendar Year for Covered Services, including the [Network Provider] Deductible, [Network Provider] Coinsurance, [Network Provider] Facility Fees and any [Network Provider] Copayments. Once this maximum is met, Covered Services [obtained through a Network Provider] remaining thereafter for the same Calendar Year will be paid at [100%], up to the Maximum Allowable shown in the POLICY SCHEDULE, if any. **Any charges exceeding any Maximum Allowable Amounts shown in the POLICY SCHEDULE and Covered Services obtained through a Non-Network Provider do not count toward meeting the Maximum Out-of-Pocket Amount.**

RULES FOR HEALTH SAVINGS ACCOUNTS:

The Deductible, Maximum Out-of-Pocket Amount, and premium may change if Insured Persons are added to or deleted from coverage under this Policy. The Deductible and Maximum Out-of-Pocket Amount is intended to satisfy government rules applicable to Health Savings Accounts (HSAs). The HSA rules may change annually. Deductible and Maximum Out-of-Pocket Amounts will be adjusted at the beginning of each year to comply with any changes in the HSA rules, when necessary. We will notify You of any changes as soon as reasonably possible.

POLICY SCHEDULE
SCHEDULE OF BENEFITS (Continued)

COVERED SERVICES	NETWORK PROVIDER	NON-NETWORK PROVIDER
INPATIENT SERVICES:		
Facility Fee:	[Facility Fee does not apply]	[$500] Per Insured Person, per Hospital Confinement
Inpatient Hospital:	[80%][90%][100%] Coinsurance	[55%][65%][75%] Coinsurance
Transplant Procedures:	[80%][90%][100%] Coinsurance	[55%][65%][75%] Coinsurance
	[$250,000] Maximum Allowable Amount, per Insured Person, per Transplant Procedure	[$175,000] Maximum Allowable Amount, per Insured Person, per Transplant Procedure
PRE-ADMISSION TESTING:	[80%][90%][100%] Coinsurance	[55%][65%][75%] Coinsurance
OUTPATIENT SURGERY FACILITY SERVICES:	[80%][90%][100%] Coinsurance	[55%][65%][75%] Coinsurance
Facility Fee:	[Facility Fee does not apply]	[$250] Per Insured Person, per Surgery
MEDICAL EMERGENCIES:	[80%][90%][100%] Coinsurance	[80%][90%][100%] Coinsurance
Hospital Emergency Room Facility Fee: *(Waived if Hospital Confined)*	[$100] [$500] Per Insured Person, per visit	[$100][$500] Per Insured Person, per visit
Urgent Care Center Facility Fee:	[$100] Per Insured Person, per visit	[$100] Per Insured Person, per visit
PHYSICIAN SERVICES:		
Second Surgical Opinion: *(Limited to one per Surgery)*	[80%][90%][100%] Coinsurance	[55%][65%][75%] Coinsurance
Inpatient / Outpatient Surgeon:	[80%][90%][100%] Coinsurance	[55%][65%][75%] Coinsurance
Assistant Surgeon:	[80%][90%][100%] Coinsurance	[55%][65%][75%] Coinsurance
Anesthesiologist:	[80%][90%][100%] Coinsurance	[55%][65%][75%] Coinsurance
Physician Visits while Hospital Confined (other than Surgeon): *(Limited to one visit per Physician, per day)*	[80%][90%][100%] Coinsurance	[55%][65%][75%] Coinsurance

POLICY SCHEDULE
SCHEDULE OF BENEFITS (Continued)

COVERED SERVICES	NETWORK PROVIDER	NON-NETWORK PROVIDER
{Option A} **PHYSICIAN SERVICES (Cont.)**		
Outpatient Physician Visits for Sickness or Injury:	[80%][90%][100%] Coinsurance	[55%][65%][75%] Coinsurance
Outpatient Preventive Care Physician Visits: (*Other than Well Child Visit)* *(Limited to one visit per Insured Person, per Calendar Year)*	[80%][90%][100%] Coinsurance	[55%][65%][75%] Coinsurance
Well Child Visits: *(For covered Dependent children from birth up to 24 months)*	[80%][90%][100%] Coinsurance	[55%][65%][75%] Coinsurance

POLICY SCHEDULE SCHEDULE OF BENEFITS (Continued)		
COVERED SERVICES	**NETWORK PROVIDER**	**NON-NETWORK PROVIDER**
{Option B} **PHYSICIAN SERVICES (Cont.)**		
Outpatient Physician Office Visits for Sickness or Injury:	[80%][90%][100%] Coinsurance	[55%][65%][75%] Coinsurance
Outpatient Preventive Care Physician Visits: *(Other than Well Child Visits)* *(Limited to one visit per Insured Person, per Calendar Year)*	[100%] Coinsurance after [$50] Copayment, per Insured Person, per visit – [Deductible waived]	[75%] Coinsurance
Well Child Visits: *(For covered Dependent children from birth up to 24 months:*	[100%] Coinsurance after [$50] Copayment, per Insured Person, per visit –[Deductible waived]	[75%] Coinsurance

POLICY SCHEDULE
SCHEDULE OF BENEFITS (Continued)

COVERED SERVICES	NETWORK PROVIDER	NON-NETWORK PROVIDER
PREVENTIVE IMAGING SCREENING TESTS:		
Human Papillomavirus and Cervical Cancer Screening:	[80%][90%][100%] Coinsurance	[55%][65%][75%] Coinsurance
Prostate Cancer Screening:	[80%][90%][100%] Coinsurance	[55%][65%][75%] Coinsurance
Mammography Screening:	[80%][90%][100%] Coinsurance	[55%][65%][75%] Coinsurance
Colorectal Cancer Screening:	[80%][90%][100%] Coinsurance	[55%][65%][75%] Coinsurance
RECONSTRUCTIVE SURGERY IN CONNECTION WITH A MASTECTOMY:	[80%][90%][100%] Coinsurance	[55%][65%][75%] Coinsurance
COMPLICATIONS OF PREGNANCY:	[80%][90%][100%] Coinsurance	[55%][65%][75%] Coinsurance

POLICY SCHEDULE
SCHEDULE OF BENEFITS (Continued)

COVERED SERVICES	NETWORK PROVIDER	NON-NETWORK PROVIDER
CHEMOTHERAPY:	[80%][90%][100%] Coinsurance	[55%][65%][75%] Coinsurance
RADIATION THERAPY:	[80%][90%][100%] Coinsurance	[55%][65%][75%] Coinsurance
OUTPATIENT DIAGNOSTIC SERVICES:	[80%][90%][100%] of [Maximum] Allowable Amount	[55%][65%][75%] of [Maximum] Allowable Amount
CAT, MRI and/or PET Scans through Network / Non-Network Provider: [$2,500][$5,000] Maximum Allowable Amount per Insured Person, per Calendar Year		
Facility Fee:	[$0][$150][$250] per Insured Person, per visit	[$0][$150][$250] per Insured Person, per visit
All Other Outpatient Diagnostic Services through Network / Non-Network Provider: [$2,500][$5,000] Maximum Allowable Amount per Insured Person, per Calendar Year		
Facility Fee:	[$0][$50][$200] per Insured Person, per visit	[$0][$50][$200] per Insured Person, per visit

POLICY SCHEDULE
SCHEDULE OF BENEFITS (Continued)

COVERED SERVICES	NETWORK PROVIDER	NON-NETWORK PROVIDER
SKILLED NURSING CARE: **Network / Non-Network Provider:** limited to [30 visits] per Insured Person, per Calendar Year	[80%][90%][100%] Coinsurance	[55%][65%][75%] Coinsurance
HOME HEALTH CARE: **Network / Non-Network Provider:** limited to [30 visits] per Insured Person, per Calendar Year	[80%][90%][100%] Coinsurance	[55%][65%][75%] Coinsurance
HOSPICE CARE: **Network / Non-Network Provider:** [$5,000] Maximum Allowable Amount per Insured Person, per lifetime	[80%][90%][100%] Coinsurance	[55%][65%][75%] Coinsurance
PRIVATE DUTY NURSING: **Network / Non-Network Provider:** limited to [30 shifts] per Insured Person, per Calendar Year	[80%][90%][100%] Coinsurance	[55%][65%][75%] Coinsurance
DURABLE MEDICAL EQUIPMENT AND PROSTHETIC DEVICES: **Network / Non-Network Provider:** [$2,000] Maximum Allowable Amount per Insured Person, per Calendar Year	[80%][90%][100%] Coinsurance	[55%][65%][75%] Coinsurance

POLICY SCHEDULE
SCHEDULE OF BENEFITS (Continued)

COVERED SERVICES	NETWORK PROVIDER	NON-NETWORK PROVIDER
AMBULANCE SERVICES *(Payable only when Hospital Confined)*		
Ground Ambulance: Network/Non-Network Provider: $500 Maximum Allowable Amount per Insured Person, per trip	[80%][90%][100%] Coinsurance	[80%][90%][100%] Coinsurance
Air / Water Ambulance: Network / Non-Network Provider: $5,000 Maximum Allowable Amount per Insured Person, per trip	[80%][90%][100%] Coinsurance	[80%][90%][100%] Coinsurance
THERAPY SERVICES *(Limited to [40 combined visits] for all therapies per Insured Person, per Calendar Year)*		
Speech Therapy:	[80%][90%][100%] Coinsurance	[55%][65%][75%] Coinsurance
Facility Fee:	$50 per Insured Person, per visit	$50 per Insured Person, per visit
Physical Therapy:	[80%][90%][100%] Coinsurance	[55%][65%][75%] Coinsurance
Facility Fee:	$50 per Insured Person, per visit	$50 per Insured Person, per visit
Occupational Therapy:	[80%][90%][100%] Coinsurance	[55%][65%][75%] Coinsurance
Facility Fee:	$50 per Insured Person, per visit	$50 per Insured Person, per visit
Cardiac Rehabilitation (Phase I & II)	[80%][90%][100%] Coinsurance	[55%][65%][75%] Coinsurance
Facility Fee:	$50 per Insured Person, per visit	$50 per Insured Person, per visit
Child Health Supervision Services (*Immunizations only)*	[100%] of Covered Services	[100%] of Covered Services

POLICY SCHEDULE
SCHEDULE OF BENEFITS (Continued)

RIDER BENEFITS

PRESCRIPTION DRUG RIDER
(See Rider)

DEFINITIONS

Allowable Amount means the Provider charge that is considered for Covered Services under this Policy and any attached Riders after the application of the Facility Fee and Copayment, if any. For Network Providers, the Allowable Amount is the lesser of the contracted amount or the Maximum Allowable Amount shown in the POLICY SCHEDULE. For Non-Network Providers, the Allowable Amount is the lesser of Usual and Customary Charge, the billed amount or the Maximum Allowable Amount shown in the POLICY SCHEDULE. No amount in excess of the Allowable Amount or Maximum Allowable Amount will be considered under this Policy. The Allowable Amount is subject to:

- The Deductibles shown in the POLICY SCHEDULE, if any;
- The Network Coinsurance level or Non-Network Coinsurance level shown in the POLICY SCHEDULE; and
- The Calendar Year and Lifetime Maximum Amounts shown in the POLICY SCHEDULE.

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 the Allowable Amount or Maximum Allowable Amount of Covered Services that are paid by Us after application of the Facility Fees and Copayment, if any, and 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.

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

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

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 before the application of the Allowable Amount or Maximum Allowable Amount for specifically listed Covered Services and is in lieu of the Deductible. The Copayment, if any, is shown in the POLICY SCHEDULE. Copayments do not count toward [Facility Fees][, Deductibles][, or Coinsurance Maximums].

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

1. Reconstructive Surgery incidental to or following Surgery resulting from trauma, infection or other disease of the involved part, 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 mean 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. **Any charges in excess of the Allowable Amount or the Maximum Allowable Amount shown in the Policy Schedule, if any, will *not* be considered a Covered Service.**

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;
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 Allowable Amount or Maximum Allowable Amount 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].

Home Health Care means the provision of a health service for payment or other consideration in a patient's residence under a plan established, approved in writing, and reviewed at least every two months by the attending Physician and certified by the attending Physician as necessary for medical purposes.

Home Health Care Agency means a public or private agency or organization licensed in the state in which it is located, to provide home health care services.

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.

Hospice means an agency which provides limited periods of care for terminally ill persons and is licensed, certified or registered in accordance with state law.

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 Allowable Amounts or Maximum Amounts paid by Us will accumulate toward the Lifetime Maximum Amount from the Policy Date. The Lifetime Maximum Amount is shown in the POLICY SCHEDULE.

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 Allowable Amount means the maximum dollar amount that will be considered as an Allowable Amount for a Covered Service under this Policy and any attached Riders. The Maximum Allowable Amount is shown in the POLICY SCHEDULE.

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 Insured Person'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.

Occupational Therapy means the use of purposeful activities to restore and maximize independence, prevent associated disability, and maintain health. The practice encompasses assessment, treatment and consultation for individuals and groups in healthcare, educational, and community settings.

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.

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

Physician means a legally qualified licensed practitioner of the healing arts who provides care within the scope of his or her license, 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.

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 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.

Private Duty Nurse means a registered graduate professional nurse (R.N.), licensed vocational nurse (L.V.N), licensed practical nurse (L.P.N.) or any other legally licensed or certified nursing professional who provides care within the scope of his or her license or certificate. (A member of the Insured Person's Immediate Family will not be considered a Private Duty Nurse.)

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.

Skilled Nursing Facility means a facility which:

1. is licensed by the state;
2. provides skilled nursing care under the supervision of a Physician;
3. has 24 hour-a-day nursing services by or under the supervision of a registered graduate professional nurse (R.N.);
4. keeps a daily medical record of each patient; and
5. provides full-time bed care for resident patients.

It does not include a facility or any of its sections which is a place for persons suffering from a Mental or Nervous Disorder, alcohol or drug problems, or which is used mainly as a home for rest or for the aged. Nor does the term include an institution which is operated mainly for domiciliary or custodial care or as a school for the education of patients.

Speech Therapy means the application of principles, methods, and procedures for measurement, testing, identification, prediction, counseling, or instruction related to the development and disorders of speech, voice, or language for the purpose of identifying, preventing, managing, habilitating, or rehabilitating, ameliorating, or modifying such disorders and conditions in individuals or groups of individuals.

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:

1. Heart transplant;
2. Combined heart and lung transplant;
3. Lung transplant;
4. Kidney transplant;
5. Kidney and pancreas transplant;
6. Liver transplant;
7. Bone marrow transplant, either allogenic or autologous, including high dose chemotherapy; or
8. Peripheral stem cell transplant.

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

1. The condition requiring treatment, along with recommended procedures;
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 negotiated rate in effect with a Network Provider on the date it provides a Covered Service.

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.

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 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.

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 Provisions for Dependents

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

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

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

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.

COVERED SERVICES

Covered Services include 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. Any charges in excess of the Allowable Amount or the Maximum Allowable Amount shown in the Policy Schedule, if any, will not be considered a Covered Service

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

1. The Facility Fees and/or Copayments shown in the POLICY SCHEDULE, if any;
2. The Allowable Amount, Maximum Allowable Amount, Calendar Year and Lifetime Maximum Amounts shown in the POLICY SCHEDULE;
3. The Deductibles shown in the POLICY SCHEDULE, if any;
4. The Network Provider Coinsurance level or Non-Network Provider Coinsurance level shown in the POLICY SCHEDULE; and
5. The EXCLUSIONS AND LIMITATIONS.

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

The fees charged for take home drugs, personal convenience items 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 Allowable Amount under the Policy applicable to the recipient;
4. Rental of durable medical equipment for use outside the Hospital. The Allowable Amount is 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.

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; and
4. Diagnostic services including radiology, laboratory or pathology performed at the time of the Surgery.

MEDICAL EMERGENCIES:

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

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 include the Allowable Amount 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 an appendectomy performed during a gall bladder surgery.

Assistant Surgeon Benefit

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

Anesthesiologist Benefit

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.

Outpatient Physician Visits for Sickness or Injury

Covered Services include Medically Necessary Physician office visits related to a Sickness or Injury, including Physician Consultations and any treatment associated with such Physician's Office visit that is received in the Physician's Office or in a Convenient Care Clinic. Covered Services also include any Medically Necessary laboratory and x-ray services provided and billed by the Physician related to a Sickness or Injury.

Outpatient Preventive Care Physician Visits

Covered Services include office charges and routine physical examinations, health history and immunizations required for school or travel when received in a Physician's Office or in a Convenient Care Clinic and are not related to a Sickness or Injury. Covered Services will also include any routine laboratory and x-ray services performed in the Physician's Office and billed by the Physician that are not related to a Sickness or Injury.

Well Child Visits

Covered Services include well child Physician visits for covered Dependent Children from birth up to 24 months of age. Covered Services will also include any routine or preventive laboratory and x-ray services performed in the Physician's Office and billed by the Physician that are not related to a Sickness or Injury.

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

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

RECONSTRUCTIVE SURGERY IN CONNECTION WITH A MASTECTOMY:

Covered Services include services and supplies provided for reconstructive Surgery in connection with a mastectomy. The reconstructive Surgery will be provided in a manner determined to be appropriate in Consultation with the attending Physician and the Insured Person, and will include:

1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to achieve a symmetrical appearance; and
3. Prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.

COMPLICATIONS OF PREGNANCY:

Covered Services include treatment of Complications of Pregnancy while Hospital Confined or in an Outpatient Surgery Facility (when the pregnancy is not terminated).

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.

CHEMOTHERAPY:

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

RADIATION THERAPY:

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

OUTPATIENT DIAGNOSTIC SERVICES:

Covered Services include outpatient diagnostic services performed in a free-standing diagnostic center or Hospital (other than Hospital emergency room) for diagnostic x-rays and interpretation charges, and laboratory and pathological examinations received while not Confined to a Hospital and that are related to and necessary for the diagnosis and treatment of the Sickness or Injury. [Covered Services include but are not limited to CAT Scans, Magnetic Resonance Imaging (MRI), PET Scans, SPECT scans; Nuclear Medicine Imaging; Sleep studies; Mammogram, Upper/Lower G.I. Series, Electrocardiogram (EKG), Blood or serum analysis, Angiogram and Stress Tests.]

Covered Services include Central Supply (IV tubing) or pharmacy (dye) necessary to perform the tests.

Covered Services under this provision do not include routine physical examinations or checkups, and laboratory and x-ray services provided in and billed by a Hospital emergency room, Urgent Care Center or Physician's office.

SKILLED NURSING CARE:

Covered Services include charges incurred during Confinement in a Skilled Nursing Facility.

HOME HEALTH CARE:

Covered Services include services or supplies furnished by a Home Health Care Agency.

HOSPICE CARE:

Covered Services include the following services and supplies provided by a Hospice in the Insured Person's home or in a Hospice facility for medical, social and psychological services used as palliative treatment for patients with a life expectancy of not more than 6 months:

1. Skilled nursing services;
2. Diagnostic services;
3. Physical, speech and inhalation therapies;
4. Medical supplies, equipment and appliances;
5. Counseling services for the Insured Person regarding his or her terminal illness;
6. Inpatient Confinement at a Hospice Facility; and
7. Prescription Drugs obtained from the Hospice.

PRIVATE DUTY NURSING:

Covered Services include the services of a Private Duty Nurse.

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.

THERAPY SERVICES:

Speech Therapy, Physical Therapy, Occupational Therapy and Cardiac Rehabilitation (Phase I and II)

Covered Services include Speech Therapy, Physical Therapy, Occupational Therapy and Cardiac Rehabilitation (Phase I and II) that is related to and Medically Necessary for the treatment of a Sickness or Injury.

MUSCULOSKELETAL DISORDERS:

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

CHILD HEALTH SUPERVISION SERVICES:

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

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

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

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

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

MEDICAL FOODS AND LOW PROTEIN MODIFIED FOOD PRODUCTS:

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

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

DIABETES:

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

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

IMPAIRMENT OR LOSS OF SPEECH OR HEARING:

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

OUTPATIENT CONTRACEPTIVE SERVICES AND DEVICES:

Covered Services incurred for 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;
2. Any charges exceeding the Allowable Amount or Maximum Allowable 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. 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;
13. 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;
14. Breast reduction or augmentation, or complications arising there from, unless necessary in connection with breast reconstructive Surgery following a mastectomy;
15. Modification of the physical body in order to improve the psychological, mental or emotional well-being of the Insured Person, such as but not limited to sex-change Surgery;
16. Marriage, family, or child counseling for the treatment of premarital, marriage, family or child relationship dysfunctions;
17. Directly or indirectly engaging in an illegal occupation or illegal activity;
18. Care in a nursing home, custodial institution or domiciliary care or rest cures;
19. Preparation and presentation of medical reports for appearance at trials or hearings;
20. Physical examinations required for school events, sports, camp, employment, licensing and insurance, unless otherwise stated herein;
21. Immunizations required for the sole purpose of travel outside of the U.S.A.;
22. Payment for care for military service connected disabilities for which the Insured Person is legally entitled to services and for which facilities are reasonably available to the Insured Person and payment for care for conditions that state or local law requires be treated in a public facility;
23. Experimental or Investigative medical, surgical or other health care procedures, treatments, products or services, unless otherwise stated herein;
24. Personal comfort items, such as television, telephone, lotions, shampoos, etc.;
25. Cosmetic Surgery, or complications arising there from, unless otherwise stated herein;
26. Dental Care, treatment or Surgery unless necessitated by Injury to sound natural teeth which occurs while insured under this Policy. (The expense must be incurred within one year from the date of Injury);
27. Corrective vision or hearing supplies or for the examination for prescribing or fitting such supplies;
28. The removal of warts, corns, calluses, the cutting and trimming of toenails, care for flat feet, fallen arches or chronic foot strain;
29. Expenses incurred for prescription drugs, except if added by Rider;
30. Normal pregnancy, except for Complications of Pregnancy, except benefits added by Rider; and
31. 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.

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 the Policy. No other person will have the authority to bind Us in any manner. No agent may accept risks, alter or amend coverage or waive any provisions of the Policy. Any change in the Policy will be made by an amendment approved and signed by Us. Such amendment will not require the consent of any Insured Person.

Notice of Claim

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

Claim Forms

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

Proof of Loss

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

Claim Payments

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

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

Assignment of Claim Payments

Payment for services provided by the 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.

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

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

THE 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

PRESCRIPTION DRUG EXPENSE RIDER

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

Benefits paid under this Rider will not duplicate the benefits provided under the Policy and any other rider and are subject to the Benefit Payment Rate/Deductible/Copayment and Benefit Maximum stated herein.

BENEFITS

This Rider provides benefits for Legend Prescription Drugs. The Allowable Amount for Legend Prescription Drugs is equal to the actual charge based on Pharmacy prices, subject to the applicable Benefit Payment Rate/Deductible/Copayment shown below. Expenses are considered incurred on the date of Pharmacy service.

[We have adopted a list of preferred medications that meet quality, safety and efficacy standards and are more cost effective to the Plan. You may call Us if You wish to obtain a copy of the preferred list. All drugs which do not appear on Our preferred list are referred to as "non-preferred drugs." Non-preferred drugs require a higher cost sharing amount on Your part.] You have the option to receive drugs either retail or through Our Mail Service Legend Prescription Drug Program.

BENEFIT PAYMENT RATE/DEDUCTIBLE/COPAYMENT

BENEFIT PAYMENT RATE/DEDUCTIBLE/COPAYMENT
After the [Policy] Deductible is met, if applicable, We will pay benefits subject to the applicable Benefit Payment Rate and/or Copayment specified below.

DEDUCTIBLE	
Generic Drugs	[$0] per Insured Person, per Calendar Year
Brand Name Drugs	[$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	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

BENEFIT PAYMENT RATE/DEDUCTIBLE/COPAYMENT

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	[$2,000][$5,000] per Calendar Year]

LEGEND PRESCRIPTION DRUGS FROM A PHARMACY OR MAIL ORDER VENDOR:

Upon activation of this plan, You will be provided with a list of Pharmacies whom have entered into a participation agreement with Us to submit claims for You for generic [preferred and non-preferred] drugs and brand name preferred and non-preferred drugs. All Benefits payable are subject to the BENEFIT PAYMENT RATE/DEDUCTIBLE/COPAYMENT section, where applicable.

1. If You have a prescription filled through one of the Pharmacies that is included on the list, You must pay the Pharmacy the amount set forth above in the BENEFIT PAYMENT RATE/DEDUCTIBLE/COPAYMENT section for each separate prescription or refill. The Pharmacy will then be paid directly by Us for the remainder of the cost of the prescription or refill.

   If You have a prescription filled through a Pharmacy that is not included on the list, You will still receive the benefits set forth in the BENEFIT PAYMENT RATE/DEDUCTIBLE/COPAYMENT section above, however You must pay the Pharmacy the full amount for each separate prescription or refill at the time it is dispensed and then You must submit the claim for reimbursement to [“Caremark Claims Department, P.O. Box 52136, Phoenix, AZ 85072-2136”].

2. If You have a prescription filled with a **brand name** drug, and there is a therapeutic generic equivalent drug for that brand name drug, We have special payment rules regarding reimbursement when a therapeutic generic equivalent drug could have been prescribed. We have created a list of generic drugs that the FDA has categorized as therapeutic equivalents to the corresponding brand name drug.

   Our payment will be based on the therapeutic generic equivalent drug fee schedule, which We have created for these therapeutic generic equivalent drugs or the actual drug charge, whichever is less. **You will be responsible for the amount set forth above for generic drugs in the BENEFIT PAYMENT RATE/DEDUCTIBLE/COPAYMENT section and the difference in cost between Our payment and the actual cost of the brand name drug.**

   [For example, assume You have a prescription for a brand name drug that costs $100, and the therapeutic equivalent generic has a fee schedule of $25. We will pay the $25, less the applicable Copayment amount ($[15.00]). **You must pay the generic drug Copayment amount plus the [$75] balance remaining on the $100 charge.]**

DEFINITIONS

Allowable Amount means the actual charges for:

1. Legend Prescription Drugs.
2. Compounded medication of which at least one ingredient is a Legend Prescription Drug.
3. Any other drug which, under the applicable state law, may be only dispensed upon written prescription of a Physician or other lawful prescriber.

Copayment means the amount which may be charged to the Insured Person by the Pharmacy for the dispensing, including each refill, of any Legend Prescription Drug, before We will make any payments under this Rider.

Deductible means the portion of the cost for Legend Prescription Drugs covered under this Rider that an Insured Person must pay each [Calendar Year] before benefits will be paid.

Legend Prescription Drugs mean drugs, devices, biological and compounded prescriptions which can be dispensed only pursuant to a prescription; which by law are required to bear the legend "Caution – Federal Law prohibits dispensing without a prescription." The drug or device must be prescribed by an Insured Person's Physician or other licensed/authorized health care provider, and approved by the FDA for the treatment of the Insured Person's specific diagnosis or condition, or with regard to drugs for the treatment of cancer: (1) recognized as safe and effective for the treatment of that specific type of cancer in any of the following standard reference compendia, unless the use is identified as not indicated in one or more of such compendia: (a) the American Hospital Formulary Service drug information; (b) the United States Pharmacopoeia dispensing information; or (2) the drug has been recognized as safe and effective for the treatment of that specific type of cancer in two articles from the medical literature that have not had their recognition of the drug's safety and effectiveness contradicted by clear and convincing evidence presented in another article from medical literature.

In certain situations, Medical Necessity criteria may be established by Us and Our provider community, which defines whether certain drugs will be covered under this Rider.

We reserve the right to require prior authorization for any drug prior to payment under this Rider. You may call Us if You wish to obtain a list of drugs which require prior authorization.

Pharmacy means any Pharmacy which regularly dispenses Legend Prescription Drugs.

Prescription Order means the request for a drug or device issued by a Physician or other qualified provider duly licensed to make such a request in the ordinary course of his/her professional practice.

EXCLUSIONS

We will not provide any benefits for:

1. Expenses incurred after coverage terminates under this Rider;
2. Non-legend drugs;
3. Devices of any type, even though such devices may require a Prescription Order, such as, but not limited to, therapeutic devices, artificial appliances, hypodermic needles and syringes (except when used for Treatment of Diabetes as stated in Policy), support garments, ostomy supplies, and other non-medical substances, or similar devices, regardless of intended use;
4. Immunization agents, allergy sera, biological sera, blood or blood products administered on an outpatient basis;
5. Anti-smoking aids (e.g. Nicorette gum, nicotine patches);
6. Drugs labeled, "Caution – limited by federal law to Investigational use" or Experimental drugs, even though a charge is made to the Insured Person;
7. Products used for unapproved cosmetic indications;
8. Any illegal substance;
9. Drugs used to treat or cure baldness, and anabolic steroids used for body building;
10. Any charge for the administration of Legend Prescription Drugs or injectable insulin;
11. Non-injectable vitamins or fluorides or health foods, health and beauty aids, cosmetics, nutritional or dietary supplements;
12. Drugs determined to be "less than effective" by the Drug Efficacy Study Implementation (DESI) Program. For example: Equagesic, Midrin, Cyclospasmol, and Vasodilan have been rated less-than-effective. The Omnibus Budget Reconciliation Act of 1981 has mandated the Health Care Financing Administration to ban reimbursement for less-than-effective drug products by federal Medicare/Medicaid agencies;
13. Any medication, legend or not, which is consumed or administered at the place where it is dispensed;
14. Anorectic, Weight control drugs;
15. Fertility drugs; [or]
16. Abortifacients or any other drug or device that terminates pregnancy;
18. Sexual function, dysfunction, inadequacy or desire including but not limited to erectile dysfunction drugs;

19. All injectables (except emergency allergic reaction kits) plus the administration, unless required by law;
20. Drugs obtained outside of the United States for use within the United States;

21. Non-Generic psychotherapeutic agents, including but not limited to those prescribed for the treatment of anxiety, psychosis or depression; or][Psychotherapeutic agents, including but not limited to those prescribed for the treatment of a Mental or Nervous Disorder [except as otherwise noted];or]
22. Growth hormones;
23. Amphetamines;
24. Sleeping aids (sedative/hypnotic);
25. Attention Deficit Disorder (ADD)/Attention Hyperactivity Disorder (ADHD) medications (includes those drugs that have labeled indications for this medical condition;
26. The costs of compounding Federal Legend Prescription Drugs with non-Federal Legend Prescription Drug ingredients;
27. [Legend Prescription Drugs prescribed for "quality of life" or "lifestyle" concerns including but not limited to smoking cessation; obesity; hair loss; sexual function, dysfunction, inadequacy or desire; or cognitive enhancement.]

LIMITATIONS

The following dispensing limits will apply to each prescription:

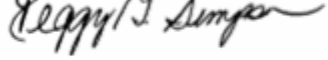
1. **Pharmacy** – No more than a [30 day] supply or [100 unit doses], whichever is less, may be dispensed. No more than two refills of the same prescription may be dispensed in any one Calendar Year. For certain drugs, less than a [30 day] supply or [100 unit doses] may be dispensed.

2. **Mail Service Legend Prescription Drugs** – No more than a [90 day] supply may be dispensed at any one time. For certain drugs, less than a [90 day] supply may be dispensed.

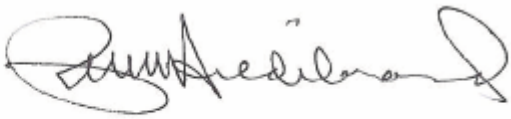
We will provide this benefit in consideration of the payment of the required premium for this Rider.

Rider effective date, if different from Policy Date:_____

THE CHESAPEAKE LIFE INSURANCE COMPANY



SECRETARY



PRESIDENT

Rate Information

Rate data does NOT apply to filing.

Supporting Document Schedules

Satisfied -Name: Certification/Notice

Review Status: Withdrawn 03/23/2009

Comments:

Please refer to attached.

Attachments:

ARGA 0104.pdf
Cert Compl Rule-Reg19 -AR.pdf
Cert Compliance AR-Readability.pdf

Satisfied -Name: Application

Review Status: Withdrawn 03/23/2009

Comments:

The application is being filed under separate cover. Form number CH-25098-INDAPP (09/08) under SERFF Tracking Number MGCC-125950178.

Satisfied -Name: Outline of Coverage

Review Status: Withdrawn 03/23/2009

Comments:

Please refer to attached.

Attachments:

CH-26210 PPO-IP OC _0109_AR.pdf
CH-26210 HSA PPO-IP OC _0109_AR.pdf

Satisfied -Name: Variability Statements

Review Status: Withdrawn 03/23/2009

Comments:

Please refer to attached.

Attachments:

VAR STMT CH-26210 PPO-IP _0109_AR.pdf
VAR STMT [HSA] CH-26210 PPO-IP _0109_AR.pdf

Satisfied -Name: Cover letter

Review Status:
Withdrawn 03/23/2009

Comments:

Please refer to attached.

Attachment:

LTR CH-26210-IP _0109_ ltr [Individual].pdf

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

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

DISCLAIMER

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

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

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

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

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

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

COVERAGE

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

EXCLUSIONS FROM COVERAGE

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

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

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

The Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administra6tion of a policy by a group contract holder;
- Employers' plans, to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders , not individuals);
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC") (whether the FPBC is yet liable or not);
- Portions of any unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments r4equired by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliated benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

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

Certificate of Compliance with
Arkansas Rule and Regulation 19

Insurer: The Chesapeake Life Insurance Company

Form Number(s):

CH-26210 PPO-IP (01/09) AR et.al
CH-26210 HSA PPO-IP (01/09) AR et.al

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

December 16, 2008

Date

Certificate of Compliance for Arkansas

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

Form Numbers and Form Names:

CH-26210 PPO-IP (01/09) AR
CATASTROPHIC EXPENSE PREFERRED PROVIDER ORGANIZATION (PPO) POLICY
Flesch Reading Score: 50.4

CH-26210 HSA PPO-IP (01/09) AR
CATASTROPHIC EXPENSE PREFERRED PROVIDER ORGANIZATION (PPO) POLICY
Flesch Reading Score: 51.5

CH-26214-IR (01/09) AR
PRESCRIPTION DRUG EXPENSE RIDER
Flesch Reading Score: 48.9

Susan E. Dew

Susan Dew, Senior Vice President, Associate General Counsel and Chief Compliance Officer

December 16, 2008

Date

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 (01/09) 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 Covered Services; including services, supplies, care or treatment as described in the Policy, which are performed, prescribed, directed, or authorized by a Network Provider. Unless otherwise stated within the Policy, all Covered Services are subject to: a) Facility Fees and/or Copayments; b) the Allowable Amount, Maximum Allowable Amount, Calendar Year, and Lifetime Maximum Amounts; c) the chosen Deductible; d) the chosen Network / Non-Network Provider Coinsurance; and e) the Exclusions and Limitations of the Policy.

3. **BENEFITS -** For the purpose of this Outline of Coverage:
"Insured Person" means You and Your Covered Dependents who are covered under the Policy.

"Allowable Amount" means the Provider charge that is considered for Covered Services under the Policy and any attached Riders after the application of the Facility Fee and Copayment, if any. The Allowable Amount is subject to the Deductibles, Network / Non-Network Coinsurance levels, and the Calendar Year and Lifetime Maximum Amounts.

"Maximum Allowable Amount" means the maximum dollar amount that will be considered as an Allowable Amount for a Covered Service under the Policy and any attached Riders.

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. Benefits for Covered Services are based on the Allowable Amount. When Covered Services are received from a Non-Network Provider, the Allowable Amount may be less than the Allowable Amount that would have otherwise been considered for Covered Services received from a Network Provider. When You utilize a Non-Network Provider, You are responsible for any balance due between the Non-Network Providers charge and the Allowable Amount.

To be a Covered Service, the service, supply or treatment must be a) Medically Necessary and/or specifically included as a Covered Service under the Policy; b) within the scope of the license of the Provider performing the service; c) rendered while coverage under the Policy is in force and for which the Insured Person is legally obligated to pay; and d) not considered Experimental / Investigative or otherwise excluded / limited under the Policy.

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

SELECT ☐	[OPTION A]	SELECT ☐	[OPTION B]	SELECT ☐	[OPTION C]
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 ☐ [OPTION A]	PPO	NON-PPO	SELECT ☐ [OPTION B]	PPO	NON-PPO	SELECT ☐ [OPTION C]	PPO	NON-PPO
	80%	55%		90%	65%		100%	75%

CALENDAR YEAR DEDUCTIBLE (per Insured Person / per Family):

SELECT ☐ [OPTION A]	PPO	NON-PPO
Per Insured Person:	$2,500	$5,000
Per Family:	$5,000	$10,000

SELECT ☐ [OPTION B]	PPO	NON-PPO
Per Insured Person:	$5,000	$10,000
Per Family:	$10,000	$20,000

SELECT ☐ [OPTION C]	PPO	NON-PPO
Per Insured Person:	$7,500	$15,000
Per Family:	$15,000	$30,000

SELECT ☐ [OPTION D]	PPO	NON-PPO
Per Insured Person:	$10,000	$20,000
Per Family:	$20,000	$40,000

SELECT ☐ [OPTION E]	PPO	NON-PPO
Per Insured Person:	$15,000	$30,000
Per Family:	$30,000	$60,000

SELECT ☐ [OPTION F]	PPO	NON-PPO
Per Insured Person:	$20,000	$40,000
Per Family:	$40,000	$80,000

COINSURANCE MAXIMUM (per Calendar Year):

SELECT ☐ [OPTION A]	PPO	NON-PPO
Per Insured Person:	$2,500	$10,000
Per Family:	$5,000	$20,000

SELECT ☐ [OPTION B]	PPO	NON-PPO
Per Insured Person:	$5,000	$10,000
Per Family:	$10,000	$20,000

SELECT ☐ [OPTION C]	PPO	NON-PPO
Per Insured Person:	$10,000	$10,000
Per Family:	$20,000	$20,000

SELECT ☐ [OPTION D]	PPO	NON-PPO
Per Insured Person:	$0	$0
Per Family:	$10,000	$20,000

4. **COVERED SERVICES** – for the purpose of this Outline of Coverage, "Covered Services" means the services, supplies, care or treatment as described in the Policy, which are performed, prescribed, directed, or authorized by a Network Provider. Unless otherwise stated within the Policy, all Covered Services are subject to: a) any Facility Fees and/or Copayments; b) the Allowable Amount, Maximum Allowable Amount, Calendar Year, and Lifetime Maximum Amounts; c) the chosen Deductible; d) the chosen Network / Non-Network Provider Coinsurance; and e) the Exclusions and Limitations of the Policy.

   A charge for a Covered Service is incurred on the date the service, supply or treatment is furnished. Any charges in excess of the Allowable Amount or the Maximum Allowable Amount shown in the Policy Schedule, if any, will **not** be considered a Covered Service.

   INPATIENT 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; 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, x-ray, laboratory, diagnostic tests and services of a radiologist, radiology group, and the services of a pathologist or pathology group for interpretation of diagnostic tests or studies, performed while the Insured Person is Hospital Confined. The fees charged for take home drugs, personal convenience items 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

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. The Allowable Amount is 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 Services 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. 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 Allowable Amount:** [$250,000] per Insured Person, per Transplant Procedure
- **Non-Network Maximum Allowable 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; and 4) diagnostic services including radiology, laboratory or pathology performed at the time of the Surgery.

- 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 amount shown above** (for both Network and Non-Network services).
- **Chosen Deductible amount is waived if Insured is admitted to the Hospital** (for both Network and Non-Network services).
- **Network Facility Fee:** [☐ $0] [☐ $100] [☐ $500] per Insured Person, per visit
- **Non-Network Facility Fee:** [☐ $100] [☐ $500] per Insured Person, per visit

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 amount shown above** (for both Network and Non-Network services).
- **Network Facility Fee:** [☐ $0] [☐ $100] per Insured Person, per visit
- **Non-Network Facility Fee:** [$100] 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 include the Allowable Amount 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.

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

C. 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. 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.

PHYSICIAN SERVICES – OUTPATIENT PHYSICIAN VISITS

A. Outpatient Physician Visits for Sickness or Injury – If elected, Covered Services include Medically Necessary Physician office visits related to a Sickness or Injury, including Physician Consultations and any treatment associated with such Physician's Office visit that is received in the Physician's Office or in a Convenient Care Clinic. Covered Services also include any Medically Necessary laboratory and x-ray services provided and billed by the Physician related to a Sickness or Injury. **Subject to Coinsurance, Deductible, Copayment amounts, and limitations shown below.**

B. Outpatient Preventive Care Physician Visits – If elected, Covered Services include office charges and routine physical examinations, health history and immunizations required for school or travel when received in a Physician's Office or in a Convenient Care Clinic and are not related to a Sickness or Injury. Covered Services will also include any routine laboratory and x-ray services performed in the Physician's Office and billed by the Physician that are not related to a Sickness or Injury. **Subject to Coinsurance, Deductible, Copayment amounts, and limitations shown below.**

C. Well Child Visits – If elected, Covered Services include well child Physician visits for covered Dependent Children from birth up to 24 months of age. Covered Services will also include any routine or preventive laboratory and x-ray services performed in the Physician's Office and billed by the Physician that are not related to a Sickness or Injury. **Subject to Coinsurance, Deductible, Copayment amounts, and limitations shown below.**

SELECT ☐

[OPTION A]	**NETWORK PROVIDER**	**NON-NETWORK PROVIDER**
OUTPATIENT PHYSICIAN OFFICE VISITS FOR SICKNESS OR INJURY		
Coinsurance:	[same as chosen amount shown above]	[same as chosen amount shown above]
Deductible:	[same as chosen amount shown above]	[same as chosen amount shown above]
OUTPATIENT PREVENTIVE CARE PHYSICIAN VISITS (other than Well Child Visits)		
Coinsurance:	[same as chosen amount shown above]	[same as chosen amount shown above]
Deductible:	[same as chosen amount shown above]	[same as chosen amount shown above]
Visit limitations:	[1] per Insured Person, per Calendar Year	
WELL CHILD VISITS (for Covered Dependent children from birth up to 24 months of age)		
Coinsurance:	[same as chosen amount shown above]	[same as chosen amount shown above]
Deductible:	[same as chosen amount shown above]	[same as chosen amount shown above]

SELECT ☐

[OPTION B]	**NETWORK PROVIDER**	**NON-NETWORK PROVIDER**
OUTPATIENT PHYSICIAN OFFICE VISITS FOR SICKNESS OR INJURY		
Coinsurance:	[100%]	[75%]
Deductible:	[waived]	[same as chosen amount shown above]
Visit limitations:	[☐ 2] [☐ 4] per Insured Person, per Calendar Year	
Physician Home and Office Copayment:	[$50] per Insured person, per visit	[waived]
Convenient Care Clinic Copayment:	[$25] per Insured person, per visit	[waived]
OUTPATIENT PREVENTIVE CARE PHYSICIAN VISITS (other than Well Child Visits)		
Coinsurance:	[100%]	[75%]
Deductible:	[waived]	[same as chosen amount shown above]
Copayment:	[$50] per Insured person, per visit	[waived]
Visit limitations:	[1] per Insured Person, per Calendar Year	
WELL CHILD VISITS (for Covered Dependent children from birth up to 24 months of age)		
Coinsurance:	[100%]	[75%]
Deductible:	[waived]	[same as chosen amount shown above]
Copayment:	[$50] per Insured person, per visit	[waived]

SELECT ☐
[OPTION C]

	NETWORK PROVIDER	NON-NETWORK PROVIDER
OUTPATIENT PHYSICIAN OFFICE VISITS FOR SICKNESS OR INJURY		
Coinsurance:	[100%]	[75%]
Deductible:	[waived]	[same as chosen amount shown above]
Physician Home and Office Copayment:	[$50] per Insured person, per visit	[waived]
Convenient Care Clinic Copayment:	[$25] per Insured person, per visit	[waived]
OUTPATIENT PREVENTIVE CARE PHYSICIAN VISITS (other than Well Child Visits)		
Coinsurance:	[100%]	[75%]
Deductible:	[waived]	[same as chosen amount shown above]
Copayment:	[$50] per Insured person, per visit	[waived]
Visit limitations:	[1] per Insured Person, per Calendar Year	
WELL CHILD VISITS (for Covered Dependent children from birth up to 24 months of age)		
Coinsurance:	[100%]	[75%]
Deductible:	[waived]	[same as chosen amount shown above]
Copayment:	[$50] per Insured person, per visit	[waived]

SELECT ☐
[OPTION D]

OUTPATIENT PHYSICIAN OFFICE VISITS FOR SICKNESS OR INJURY – NOT COVERED

OUTPATIENT PREVENTIVE CARE PHYSICIAN VISITS (other than Well Child Visits) – NOT COVERED

WELL CHILD VISITS (for Covered Dependent children from birth up to 24 months of age) – NOT COVERED

PREVENTIVE IMAGING SCREENING TESTS

A. 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: a) the American College of Obstetricians and Gynecologists; or b) another similar national organization of medical professionals recognized by the Commissioner.

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

B. 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.

C. 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.

D. 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.

RECONSTRUCTIVE SURGERY IN CONNECTION WITH A MASTECTOMY

Covered Services include services and supplies provided for reconstructive Surgery in connection with a Mastectomy. The reconstructive Surgery will be provided in a manner determined to be appropriate in Consultation with the attending Physician and the Insured Person, and will include: 1) reconstruction of the breast on which the mastectomy has been performed; 2) Surgery and reconstruction of the other breast to achieve a symmetrical appearance; and 3) prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.

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

COMPLICATIONS OF PREGNANCY

Covered Services include treatment of Complications of Pregnancy while Hospital Confined or in an Outpatient Surgery Facility (when the pregnancy is not terminated).

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

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.

CHEMOTHERAPY

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

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

RADIATION THERAPY

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

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

OUTPATIENT DIAGNOSTIC SERVICES

Covered Services include outpatient diagnostic services performed in a free-standing diagnostic center or Hospital (other than Hospital emergency room) for diagnostic x-rays and interpretation charges, and laboratory and pathological examinations received while not Confined to a Hospital and that are related to and necessary for the diagnosis and treatment of the Sickness or Injury. [Covered Services include but are not limited to CAT Scans, Magnetic Resonance Imaging (MRI), PET Scans, SPECT scans; Nuclear Medicine Imaging; Sleep studies; Mammogram, Upper/Lower G.I. Series, Electrocardiogram (EKG), Blood or serum analysis, Angiogram and Stress Tests.] Covered Services include Central Supply (IV tubing) or pharmacy (dye) necessary to perform the tests.

Covered Services under this provision do not include routine physical examinations or checkups, and laboratory and x-ray services provided in and billed by a Hospital emergency room, Urgent Care Center or Physician's office.

A. CAT, MRI and/or PET Scans –

	NETWORK PROVIDER	NON-NETWORK PROVIDER
Coinsurance:	[same as chosen amount shown above]	[same as chosen amount shown above]
Deductible:	[same as chosen amount shown above]	[same as chosen amount shown above]
[Facility Fee:	[☐ $0] [☐ $150] [☐ $250] per Insured Person, per visit	[☐ $0] [☐ $150] [☐ $250] per Insured Person, per visit ***]***
Maximum Allowable Amount: [☐ $2,500] [☐ $5,000] per Insured Person, per Calendar Year		

B. All Other Outpatient Diagnostic Services –

	NETWORK PROVIDER	NON-NETWORK PROVIDER
Coinsurance:	[same as chosen amount shown above]	[same as chosen amount shown above]
Deductible:	[same as chosen amount shown above]	[same as chosen amount shown above]
[Facility Fee:	[☐ $0] [☐ $50] [☐ $200] per Insured Person, per visit	[☐ $0] [☐ $50] [☐ $200] per Insured Person, per visit ***]***
Maximum Allowable Amount: [☐ $2,500] [☐ $5,000] per Insured Person, per Calendar Year		

SKILLED NURSING CARE

Covered Services include charges incurred during Confinement in a Skilled Nursing Facility.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.
- **Limited to:** 30 visits per Insured Person, per Calendar Year.

HOME HEALTH CARE

Covered Services include services or supplies furnished by a Home Health Care Agency.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.
- **Limited to:** 30 visits per Insured Person, per Calendar Year.

HOSPICE CARE

Covered Services include the following services and supplies provided by a Hospice in the Insured Person's home or in a Hospice facility for medical, social and psychological services used as palliative treatment for patients with a life expectancy of not more than 6 months: 1) skilled nursing services; 2) diagnostic services; 3) physical, speech and inhalation therapies; 4) medical supplies, equipment and appliances; 5) counseling services for the Insured Person regarding his or her terminal illness; 6) inpatient Confinement at a Hospice Facility; and 7) prescription drugs obtained from the Hospice.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.
- **Maximum Allowable Amount:** $5,000 per Insured Person, per lifetime.

PRIVATE DUTY NURSING

Covered Services include the services of a Private Duty Nurse.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.
- **Limited to**: 30 shifts per Insured Person, per Calendar Year.

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 amounts shown above.
- **Maximum Allowable 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).
- **Ground Ambulance Maximum Allowable Amount:** $500 per Insured Person, per trip.
- **Air / Water Ambulance Maximum Allowable Amount:** $5,000 per Insured Person, per trip.
- **Benefit only payable when Hospital Confined.**

THERAPY SERVICES

Covered Services include Speech Therapy, Physical Therapy, Occupational Therapy and Cardiac Rehabilitation (Phase I and II) that is related to and Medically Necessary for the treatment of a Sickness or Injury.

	NETWORK PROVIDER	NON-NETWORK PROVIDER
Coinsurance:	[same as chosen amount shown above]	[same as chosen amount shown above]
Deductible:	[same as chosen amount shown above]	[same as chosen amount shown above]
[Facility Fee:	$50 per Insured Person, per visit	$50 per Insured Person, per visit ***]***
Visit Limitations:	[40 combined] for all therapies per Insured Person, per Calendar Year	

MUSCULOSKELETAL DISORDERS

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

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

CHILD HEALTH SUPERVISION SERVICES

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

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

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

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

- **Chosen Deductible and Coinsurance amount is waived.**

MEDICAL FOODS AND LOW PROTEIN MODIFIED FOOD PRODUCTS

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

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

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

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

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

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

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

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

OUTPATIENT CONTRACEPTIVE SERVICES AND DEVICES
Covered Services incurred for 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.

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.

PRESCRIPTION DRUG RIDER (FORM: CH-26214-IR (01/09)AR)
Rider provides benefits for Legend Prescription Drugs. The Allowable Amount for Legend Prescription Drugs is equal to the actual charge based on Pharmacy prices, subject to the applicable Benefit Payment Rate/Deductible/Copayment shown below. Expenses are considered incurred on the date of Pharmacy service.

SELECT ☐ [PLAN A]	**PHARMACY GENERIC DRUGS (You pay)**	**PHARMACY BRAND NAME DRUGS (You pay)**
Preferred Drug:	$5 Copayment	50% of actual cost of drug
Non-Preferred Drug:	$15 Copayment	75% of actual cost of drug
	MAIL ORDER VENDOR GENERIC DRUGS (You pay)	**MAIL ORDER VENDOR BRAND NAME DRUGS (You pay)**
Preferred Drug:	$15 Copayment	50% of actual cost of drug
Non-Preferred Drug:	$30 Copayment	75% of actual cost of drug
Deductible (per Insured Person, per Calendar Year):	$0	[$50]
Annual Maximum (We pay):	**[$2,000 per Insured Person, per Calendar Year]**	

SELECT ☐ [PLAN B]	PHARMACY GENERIC DRUGS (You pay)	PHARMACY BRAND NAME DRUGS (You pay)
Preferred Drug:	$5 Copayment	50% of actual cost of drug
Non-Preferred Drug:	$15 Copayment	75% of actual cost of drug
	MAIL ORDER VENDOR GENERIC DRUGS (You pay)	**MAIL ORDER VENDOR BRAND NAME DRUGS (You pay)**
Preferred Drug:	$15 Copayment	50% of actual cost of drug
Non-Preferred Drug:	$30 Copayment	75% of actual cost of drug
Deductible (per Insured Person, per Calendar Year:	$0	[$250]
Annual Maximum (We pay):	**[$2,000 per Insured Person, 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 the Policy;
2. Any charges exceeding the Allowable Amount or Maximum Allowable 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 in the Policy;
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 in the Policy;
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. 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 in the Policy;
13. 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;
14. Breast reduction or augmentation, or complications arising there from, unless necessary in connection with breast reconstructive Surgery following a mastectomy;
15. Modification of the physical body in order to improve the psychological, mental or emotional well-being of the Insured Person, such as but not limited to sex-change Surgery;
16. Marriage, family, or child counseling for the treatment of premarital, marriage, family or child relationship dysfunctions;
17. Directly or indirectly engaging in an illegal occupation or illegal activity;
18. Care in a nursing home, custodial institution or domiciliary care or rest cures;
19. Preparation and presentation of medical reports for appearance at trials or hearings;
20. Physical examinations required for school events, sports, camp, employment, licensing and insurance, unless otherwise stated in the Policy;
21. Immunizations required for the sole purpose of travel outside of the U.S.A.;

22. Payment for care for military service connected disabilities for which the Insured Person is legally entitled to services and for which facilities are reasonably available to the Insured Person and payment for care for conditions that state or local law requires be treated in a public facility;
23. Experimental or Investigative medical, surgical or other health care procedures, treatments, products or services, unless otherwise stated in the Policy;
24. Personal comfort items, such as television, telephone, lotions, shampoos, etc.;
25. Cosmetic Surgery, or complications arising there from, unless otherwise stated in the Policy;
26. Dental Care, treatment or Surgery unless necessitated by Injury to sound natural teeth which occurs while insured under in the Policy. (The expense must be incurred within one year from the date of Injury);
27. Corrective vision or hearing supplies or for the examination for prescribing or fitting such supplies;
28. The removal of warts, corns, calluses, the cutting and trimming of toenails, care for flat feet, fallen arches or chronic foot strain;
29. Expenses incurred for prescription drugs, except if added by Rider;
30. Normal pregnancy, except for Complications of Pregnancy, except benefits added by Rider; and
31. 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.

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 (01/09) AR - described above (includes automatic Policy Rider(s), if any):	**$** _____
RIDERS (if any)	
	$
	$
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

H.S.A COMPATIBLE
CATASTROPHIC EXPENSE PREFERRED PROVIDER ORGANIZATION (PPO) POLICY
OUTLINE OF COVERAGE FOR FORM CH-26210 PPO-IP (01/09) 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 Covered Services; including services, supplies, care or treatment as described in the Policy, which are performed, prescribed, directed, or authorized by a Network Provider. Unless otherwise stated within the Policy, all Covered Services are subject to: a) Facility Fees and/or Copayments; b) the Allowable Amount, Maximum Allowable Amount, Calendar Year, and Lifetime Maximum Amounts; c) the chosen Deductible; d) the chosen Network / Non-Network Provider Coinsurance; and e) the Exclusions and Limitations of the Policy.

3. **BENEFITS -** For the purpose of this Outline of Coverage:
"Insured Person" means You and Your Covered Dependents who are covered under the Policy.

"Allowable Amount" means the Provider charge that is considered for Covered Services under the Policy and any attached Riders after the application of the Facility Fee and Copayment, if any. The Allowable Amount is subject to the Deductibles, Network / Non-Network Coinsurance levels, and the Calendar Year and Lifetime Maximum Amounts.

"Maximum Allowable Amount" means the maximum dollar amount that will be considered as an Allowable Amount for a Covered Service under the Policy and any attached Riders.

"Maximum Out-of-Pocket" Amount means the total Allowable Amount of [Network Provider] expenses that must be paid by Insured Persons each Calendar Year for Covered Services, including the [Network Provider] Deductible, [Network Provider] Coinsurance, [Network Provider] Facility Fees and any [Network Provider] Copayments. Once this maximum is met, Covered Services [obtained through a Network Provider] remaining thereafter for the same Calendar Year will be paid at [100%], up to the Maximum Allowable, if any. **Any charges exceeding any Maximum Allowable Amounts and Covered Services obtained through a Non-Network Provider do not count toward meeting the Maximum Out-of-Pocket Amount.**

RULES FOR HEALTH SAVINGS ACCOUNTS:
The Deductible, Maximum Out-of-Pocket Amount, and premium may change if Insured Persons are added to or deleted from coverage under this Policy. The Deductible and Maximum Out-of-Pocket Amount is intended to satisfy government rules applicable to Health Savings Accounts (HSAs). The HSA rules may change annually. Deductible and Maximum Out-of-Pocket Amounts will be adjusted at the beginning of each year to comply with any changes in the HSA rules, when necessary. We will notify You of any changes as soon as reasonably possible

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. Benefits for Covered Services are based on the Allowable Amount. When Covered Services are received from a Non-Network Provider, the Allowable Amount may be less than the Allowable Amount that would have otherwise been considered for Covered Services received from a Network Provider. When You utilize a Non-Network Provider, You are responsible for any balance due between the Non-Network Providers charge and the Allowable Amount.

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. Benefits for Covered Services are based on the Allowable Amount. When Covered Services are received from a Non-Network Provider, the Allowable Amount may be less than the Allowable Amount that would have otherwise been considered for Covered Services received from a Network Provider. When You utilize a Non-Network Provider, You are responsible for any balance due between the Non-Network Providers charge and the Allowable Amount.

To be a Covered Service, the service, supply or treatment must be a) Medically Necessary and/or specifically included as a Covered Service under the Policy; b) within the scope of the license of the Provider performing the service; c) rendered while coverage under the Policy is in force and for which the Insured Person is legally obligated to pay; and d) not considered Experimental / Investigative or otherwise excluded / limited under the Policy.

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

SELECT ☐	**[OPTION A]**		**SELECT ☐**	**[OPTION B]**		**SELECT ☐**	**[OPTION C]**
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 ☐ [OPTION A]	**PPO**	**NON-PPO**		**SELECT ☐ [OPTION B]**	**PPO**	**NON-PPO**		**SELECT ☐ [OPTION C]**	**PPO**	**NON-PPO**
	80%	55%			90%	65%			100%	75%

CALENDAR YEAR DEDUCTIBLE (per Individual / per Family):

	NETWORK PROVIDER	**NON-NETWORK PROVIDER**
Individual:	[$5,800]	[$11,600]
Family:	[$11,600]	[$23,200]

MAXIMUM OUT-OF-POCKET AMOUNT (per Calendar Year):

	NETWORK PROVIDER	**NON-NETWORK PROVIDER**
Individual:	[$5,800]	[Not Applicable]
Family:	[$11,600]	[Not Applicable]

4. **COVERED SERVICES** – for the purpose of this Outline of Coverage, "Covered Services" means the services, supplies, care or treatment as described in the Policy, which are performed, prescribed, directed, or authorized by a Network Provider. Unless otherwise stated within the Policy, all Covered Services are subject to: a) any Facility Fees and/or Copayments; b) the Allowable Amount, Maximum Allowable Amount, Calendar Year, and Lifetime Maximum Amounts; c) the chosen Deductible; d) the chosen Network / Non-Network Provider Coinsurance; and e) the Exclusions and Limitations of the Policy.

A charge for a Covered Service is incurred on the date the service, supply or treatment is furnished. Any charges in excess of the Allowable Amount or the Maximum Allowable Amount shown in the Policy Schedule, if any, will **not** be considered a Covered Service.

INPATIENT 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; 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, x-ray, laboratory, diagnostic tests and services of a radiologist, radiology group, and the services of a pathologist or pathology group for

interpretation of diagnostic tests or studies, performed while the Insured Person is Hospital Confined. The fees charged for take home drugs, personal convenience items 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

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. The Allowable Amount is 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 Services 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. 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 Allowable Amount:** [$250,000] per Insured Person, per Transplant Procedure
- **Non-Network Maximum Allowable 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; and 4) diagnostic services including radiology, laboratory or pathology performed at the time of the Surgery.

- 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 amount shown above** (for both Network and Non-Network services).
- **Chosen Deductible amount is waived if Insured is admitted to the Hospital** (for both Network and Non-Network services).

- **Network Facility Fee:** [☐ $0] [☐ $100] [☐ $500] per Insured Person, per visit
- **Non-Network Facility Fee:** [☐ $100] [☐ $500] per Insured Person, per visit

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 amount shown above** (for both Network and Non-Network services).
- **Network Facility Fee:** [☐ $0] [☐ $100] per Insured Person, per visit
- **Non-Network Facility Fee:** [$100] 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 include the Allowable Amount 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.
- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

C. 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. 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.

PHYSICIAN SERVICES – OUTPATIENT PHYSICIAN VISITS

A. Outpatient Physician Visits for Sickness or Injury – If elected, Covered Services include Medically Necessary Physician office visits related to a Sickness or Injury, including Physician Consultations and any treatment associated with such Physician's Office visit that is received in the Physician's Office or in a Convenient Care Clinic. Covered Services also include any Medically Necessary laboratory and x-ray services provided and billed by the Physician related to a Sickness or Injury. **Subject to Coinsurance, Deductible, Copayment amounts, and limitations shown below.**

B. Outpatient Preventive Care Physician Visits – If elected, Covered Services include office charges and routine physical examinations, health history and immunizations required for school or travel when received in a Physician's Office or in a Convenient Care Clinic and are not related to a Sickness or Injury. Covered Services will also include any routine laboratory and x-ray services performed in the Physician's Office and billed by the Physician that are not related to a Sickness or Injury. **Subject to Coinsurance, Deductible, Copayment amounts, and limitations shown below.**

C. Well Child Visits – If elected, Covered Services include well child Physician visits for covered Dependent Children from birth up to 24 months of age. Covered Services will also include any routine or preventive laboratory and x-ray services performed in the Physician's Office and billed by the Physician that are not related to a Sickness or Injury. **Subject to Coinsurance, Deductible, Copayment amounts, and limitations shown below.**

SELECT ☐
[OPTION A]

	NETWORK PROVIDER	NON-NETWORK PROVIDER
OUTPATIENT PHYSICIAN OFFICE VISITS FOR SICKNESS OR INJURY		
Coinsurance:	[same as chosen amount shown above]	[same as chosen amount shown above]
Deductible:	[same as chosen amount shown above]	[same as chosen amount shown above]
OUTPATIENT PREVENTIVE CARE PHYSICIAN VISITS (other than Well Child Visits)		
Coinsurance:	[same as chosen amount shown above]	[same as chosen amount shown above]
Deductible:	[same as chosen amount shown above]	[same as chosen amount shown above]
Visit limitations:	[1] per Insured Person, per Calendar Year	
WELL CHILD VISITS (for Covered Dependent children from birth up to 24 months of age)		
Coinsurance:	[same as chosen amount shown above]	[same as chosen amount shown above]
Deductible:	[same as chosen amount shown above]	[same as chosen amount shown above]

SELECT ☐
[OPTION B]

	NETWORK PROVIDER	NON-NETWORK PROVIDER
OUTPATIENT PHYSICIAN OFFICE VISITS FOR SICKNESS OR INJURY		
Coinsurance:	[same as chosen amount shown above]	[same as chosen amount shown above]
Deductible:	[same as chosen amount shown above]	[same as chosen amount shown above]
OUTPATIENT PREVENTIVE CARE PHYSICIAN VISITS (other than Well Child Visits)		
Coinsurance:	[100%]	[75%]
Deductible:	[waived]	[same as chosen amount shown above]
Copayment:	[$50] per Insured person, per visit	[waived]
Visit limitations:	[1] per Insured Person, per Calendar Year	
WELL CHILD VISITS (for Covered Dependent children from birth up to 24 months of age)		
Coinsurance:	[100%]	[75%]
Deductible:	[waived]	[same as chosen amount shown above]
Copayment:	[$50] per Insured person, per visit	[waived]

SELECT ☐
[OPTION C]

OUTPATIENT PHYSICIAN OFFICE VISITS FOR SICKNESS OR INJURY – NOT COVERED

OUTPATIENT PREVENTIVE CARE PHYSICIAN VISITS (other than Well Child Visits) – NOT COVERED

WELL CHILD VISITS (for Covered Dependent children from birth up to 24 months of age) – NOT COVERED

PREVENTIVE IMAGING SCREENING TESTS

A. 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: a) the American College of Obstetricians and Gynecologists; or b) another similar national organization of medical professionals recognized by the Commissioner.

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

B. 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.

C. 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.

D. 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.

RECONSTRUCTIVE SURGERY IN CONNECTION WITH A MASTECTOMY

Covered Services include services and supplies provided for reconstructive Surgery in connection with a Mastectomy. The reconstructive Surgery will be provided in a manner determined to be appropriate in Consultation with the attending Physician and the Insured Person, and will include: 1) reconstruction of the breast on which the mastectomy has been performed; 2) Surgery and reconstruction of the other breast to achieve a symmetrical appearance; and 3) prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.

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

COMPLICATIONS OF PREGNANCY

Covered Services include treatment of Complications of Pregnancy while Hospital Confined or in an Outpatient Surgery Facility (when the pregnancy is not terminated).

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

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.

CHEMOTHERAPY

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

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

RADIATION THERAPY

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

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

OUTPATIENT DIAGNOSTIC SERVICES

Covered Services include outpatient diagnostic services performed in a free-standing diagnostic center or Hospital (other than Hospital emergency room) for diagnostic x-rays and interpretation charges, and laboratory and pathological examinations received while not Confined to a Hospital and that are related to and necessary for the diagnosis and treatment of the Sickness or Injury. [Covered Services include but are not limited to CAT Scans, Magnetic Resonance Imaging (MRI), PET Scans, SPECT scans; Nuclear Medicine Imaging; Sleep studies; Mammogram, Upper/Lower G.I. Series, Electrocardiogram (EKG), Blood or serum analysis, Angiogram and Stress Tests.] Covered Services include Central Supply (IV tubing) or pharmacy (dye) necessary to perform the tests. Covered Services under this provision do not include routine physical examinations or checkups, and laboratory and x-ray services provided in and billed by a Hospital emergency room, Urgent Care Center or Physician's office.

A. CAT, MRI and/or PET Scans –

	NETWORK PROVIDER	NON-NETWORK PROVIDER
Coinsurance:	[same as chosen amount shown above]	[same as chosen amount shown above]
Deductible:	[same as chosen amount shown above]	[same as chosen amount shown above]
[Facility Fee:	[☐ $0] [☐ $150] [☐ $250] per Insured Person, per visit	[☐ $0] [☐ $150] [☐ $250] per Insured Person, per visit ***]***
Maximum Allowable Amount: [☐ $2,500] [☐ $5,000] per Insured Person, per Calendar Year		

B. All Other Outpatient Diagnostic Services –

	NETWORK PROVIDER	NON-NETWORK PROVIDER
Coinsurance:	[same as chosen amount shown above]	[same as chosen amount shown above]
Deductible:	[same as chosen amount shown above]	[same as chosen amount shown above]
[Facility Fee:	[☐ $0] [☐ $50] [☐ $200] per Insured Person, per visit	[☐ $0] [☐ $50] [☐ $200] per Insured Person, per visit ***]***
Maximum Allowable Amount: [☐ $2,500] [☐ $5,000] per Insured Person, per Calendar Year		

SKILLED NURSING CARE

Covered Services include charges incurred during Confinement in a Skilled Nursing Facility.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.
- **Limited to:** 30 visits per Insured Person, per Calendar Year.

HOME HEALTH CARE

Covered Services include services or supplies furnished by a Home Health Care Agency.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.
- **Limited to:** 30 visits per Insured Person, per Calendar Year.

HOSPICE CARE

Covered Services include the following services and supplies provided by a Hospice in the Insured Person's home or in a Hospice facility for medical, social and psychological services used as palliative treatment for patients with a life expectancy of not more than 6 months: 1) skilled nursing services; 2) diagnostic services; 3) physical, speech and inhalation therapies; 4) medical supplies, equipment and appliances; 5) counseling services for the Insured Person regarding his or her terminal illness; 6) inpatient Confinement at a Hospice Facility; and 7) prescription drugs obtained from the Hospice.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.
- **Maximum Allowable Amount:** $5,000 per Insured Person, per lifetime.

PRIVATE DUTY NURSING

Covered Services include the services of a Private Duty Nurse.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.
- **Limited to**: 30 shifts per Insured Person, per Calendar Year.

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 amounts shown above.
- **Maximum Allowable 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).
- **Ground Ambulance Maximum Allowable Amount:** $500 per Insured Person, per trip.
- **Air / Water Ambulance Maximum Allowable Amount:** $5,000 per Insured Person, per trip.
- **Benefit only payable when Hospital Confined.**

THERAPY SERVICES

Covered Services include Speech Therapy, Physical Therapy, Occupational Therapy and Cardiac Rehabilitation (Phase I and II) that is related to and Medically Necessary for the treatment of a Sickness or Injury.

	NETWORK PROVIDER	**NON-NETWORK PROVIDER**
Coinsurance:	[same as chosen amount shown above]	[same as chosen amount shown above]
Deductible:	[same as chosen amount shown above]	[same as chosen amount shown above]
[Facility Fee:	$50 per Insured Person, per visit	$50 per Insured Person, per visit ***]***
Visit Limitations:	[40 combined] for all therapies per Insured Person, per Calendar Year	

MUSCULOSKELETAL DISORDERS

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

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

CHILD HEALTH SUPERVISION SERVICES

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

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

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

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

- **Chosen Deductible and Coinsurance amount is waived.**

MEDICAL FOODS AND LOW PROTEIN MODIFIED FOOD PRODUCTS

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

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

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

DIABETES

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

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

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

IMPAIRMENT OR LOSS OF SPEECH OR HEARING

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

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

OUTPATIENT CONTRACEPTIVE SERVICES AND DEVICES

Covered Services incurred for 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.

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.

PRESCRIPTION DRUG RIDER (FORM: CH-26214-IR (01/09) AR)

Rider provides benefits for Legend Prescription Drugs. The Allowable Amount for Legend Prescription Drugs is equal to the actual charge based on Pharmacy prices, subject to the applicable Benefit Payment Rate/Deductible/Copayment shown below. Expenses are considered incurred on the date of Pharmacy service.

SELECT ☐ [PLAN C]	**PHARMACY GENERIC DRUGS (You pay)**	**PHARMACY BRAND NAME DRUGS (You pay)**
Preferred Drug:	$5 Copayment	50% of actual cost of drug
Non-Preferred Drug:	$15 Copayment	75% of actual cost of drug
	MAIL ORDER VENDOR GENERIC DRUGS (You pay)	**MAIL ORDER VENDOR BRAND NAME DRUGS (You pay)**
Preferred Drug:	$15 Copayment	50% of actual cost of drug
Non-Preferred Drug:	$30 Copayment	75% of actual cost of drug
Annual Maximum (We pay):	**[$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 the Policy;
2. Any charges exceeding the Allowable Amount or Maximum Allowable 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 in the Policy;
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 in the Policy;
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. 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 in the Policy;
13. 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;
14. Breast reduction or augmentation, or complications arising there from, unless necessary in connection with breast reconstructive Surgery following a mastectomy;
15. Modification of the physical body in order to improve the psychological, mental or emotional well-being of the Insured Person, such as but not limited to sex-change Surgery;
16. Marriage, family, or child counseling for the treatment of premarital, marriage, family or child relationship dysfunctions;
17. Directly or indirectly engaging in an illegal occupation or illegal activity;
18. Care in a nursing home, custodial institution or domiciliary care or rest cures;
19. Preparation and presentation of medical reports for appearance at trials or hearings;
20. Physical examinations required for school events, sports, camp, employment, licensing and insurance, unless otherwise stated in the Policy;

21. Immunizations required for the sole purpose of travel outside of the U.S.A.;
22. Payment for care for military service connected disabilities for which the Insured Person is legally entitled to services and for which facilities are reasonably available to the Insured Person and payment for care for conditions that state or local law requires be treated in a public facility;
23. Experimental or Investigative medical, surgical or other health care procedures, treatments, products or services, unless otherwise stated in the Policy;
24. Personal comfort items, such as television, telephone, lotions, shampoos, etc.;
25. Cosmetic Surgery, or complications arising there from, unless otherwise stated in the Policy;
26. Dental Care, treatment or Surgery unless necessitated by Injury to sound natural teeth which occurs while insured under in the Policy. (The expense must be incurred within one year from the date of Injury);
27. Corrective vision or hearing supplies or for the examination for prescribing or fitting such supplies;
28. The removal of warts, corns, calluses, the cutting and trimming of toenails, care for flat feet, fallen arches or chronic foot strain;
29. Expenses incurred for prescription drugs, except if added by Rider;
30. Normal pregnancy, except for Complications of Pregnancy, except benefits added by Rider; and
31. 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.

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 (01/09) AR - described above (includes automatic Policy Rider(s), if any):	**$** _____
RIDERS (if any)	
	$
	$
TOTAL	**$**

THE CHESAPEAKE LIFE INSURANCE COMPANY

VARIABILITY STATEMENT

CATASTROPHIC EXPENSE PREFERRED PROVIDER ORGANIZATION (PPO) POLICY
(FORM: CH-26210 PPO-IP (01/09) 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. ALLOWABLE AMOUNT –
   a. The amount in which the Deductible and Coinsurance will be deducted from.
   b. Network: it is the lesser of the contracted amount **or** the Maximum Allowable Amount specified on the Policy Schedule page.
   c. Non-Network: it is the lesser of the billed amount, the Usual & Customary amount, **or** the Maximum Allowable Amount specified on the Policy Schedule page.

2. MAXIMUM ALLOWABLE AMOUNT –
   a. The maximum dollar amount which will be considered for a Covered Service, as specified on the Policy Schedule page.
   b. If amount is not specified for the Covered Service on the Policy Schedule Page, it will follow the "Allowable Amount" as explained above.

3. 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 C: $8,000,000 Lifetime / $2,000,000 Calendar Year

4. CALENDAR YEAR DEDUCTIBLE AMOUNTS – *Applicant will have a **choice** of the following options:*
   a. OPTION A: Network: $2,500 Individual / $5,000 Family…Non-Network: $5,000 Individual / $10,000 Family
   b. OPTION B: Network: $5,000 Individual / $10,000 Family…Non-Network: $10,000 Individual / $20,000 Family
   c. OPTION C: Network: $7,500 Individual / $15,000 Family…Non-Network: $15,000 Individual / $30,000 Family
   d. OPTION D: Network: $10,000 Individual / $20,000 Family…Non-Network: $20,000 Individual / $40,000 Family
   e. OPTION E: Network: $15,000 Individual / $30,000 Family…Non-Network: $30,000 Individual / $60,000 Family
   f. OPTION F: 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, Covered Services in excess of the Allowable Amount, or any applicable Copayment or Facility Fee amounts do not count toward meeting the Calendar Year Deductible.*

5. 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%

THE CHESAPEAKE LIFE INSURANCE COMPANY

VARIABILITY STATEMENT

CATASTROPHIC EXPENSE PREFERRED PROVIDER ORGANIZATION (PPO) POLICY
(FORM: CH-26210 PPO-IP (01/09) AR **)**

6. CALENDAR YEAR COINSURANCE MAXIMUM AMOUNTS – *Applicant will have a **choice** of the following options:*
   a. OPTION A *WITH OPTION A (80% / 50%) FOR COINSURANCE*:
      Network: $2,500 Individual / $5,000 Family…Non-Network: $10,000 Individual / $20,000 Family
   b. OPTION B *WITH OPTION A (80% / 50%) FOR COINSURANCE:*
      Network: $5,000 Individual / $10,000 Family…Non-Network: $10,000 Individual / $20,000 Family
   c. OPTION C *WITH OPTION B (90% / 60%) FOR COINSURANCE:*
      Network: $10,000 Individual / $20,000 Family…Non-Network: $10,000 Individual / $20,000 Family
   d. OPTION D *WITH OPTION C (100% / 70%) FOR COINSURANCE:*
      Network: $0 Individual / $10,000 Family…Non-Network: $0 Individual / $20,000 Family

   - *"Coinsurance Maximum" represents the total amount an insured must pay after satisfaction of the Deductible.*
   - *Once the Family Coinsurance Maximum is met, no further Individual Coinsurance Maximums are required.*
   - *Family Coinsurance Maximum can be met by any combination of individual coinsurance maximum accumulations in the family.*
   - *After amount is satisfied, plan pays 100% of Allowable and Maximum Allowable Amounts for Covered Services for the remainder of that Calendar Year.*

7. COPAYMENT AMOUNTS –
   a. Intended to be used with "OPTION B" of the Physician Services benefit (outlined on page 3) only at this time.
   b. Charged **in lieu of** the Calendar Year Deductible.
   c. Are charged aside of and do not count toward meeting the Calendar Year Deductible, Coinsurance Maximum, or any applicable Facility Fee amounts.
   d. Will continue to be charged **after** the Coinsurance Maximum is met.

8. FACILITY FEE AMOUNTS –
   a. Applicable to Inpatient Services, Outpatient Surgery Facility Services, Medical Emergencies, Outpatient Diagnostic Services, and Therapy Services benefits only.
   b. Charged **in addition to** the Calendar Year Deductible.
   c. Are charged aside of and do not count toward meeting the Calendar Year Deductible, Coinsurance Maximum, or any applicable Copayment amounts.
   d. Will continue to be charged **after** the Coinsurance Maximum is met.

9. 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 Allowable Amount, per Insured Person, per Transplant Procedure (please refer to page 1 for outline of the term "Maximum Allowable Amount").*
      - ***Non-Network** services: subject to $175,000 Maximum Allowable Amount, per Insured Person, per Transplant Procedure (please refer to page 1 for outline of the term "Maximum Allowable Amount").*

10. OUTPATIENT SURGERY FACILITY SERVICES –
    a. **Non-Network** services: subject to $250 Facility Fee amount, per Insured Person, per Hospital Confinement.
    b. Subject to chosen Network / Non-Network Deductible and Coinsurance amounts.

THE CHESAPEAKE LIFE INSURANCE COMPANY

VARIABILITY STATEMENT

CATASTROPHIC EXPENSE PREFERRED PROVIDER ORGANIZATION (PPO) POLICY
(FORM: CH-26210 PPO-IP (01/09) AR **)**

11. MEDICAL EMERGENCIES –
    a. Hospital Emergency Room Covered Services:
       - ***Network*** *services: subject to $0, $100, or $500 Facility Fee amount, per Insured Person, per visit.*
       - ***Non-Network*** *services: subject to either $100 or $500 Facility Fee amount, per Insured Person, per visit.*
       - *Chosen* ***Deductible is waived*** *if Insured is admitted into the Hospital (for Network or Non-Network services).*
       - *Subject to chosen* ***Network Coinsurance amount only*** *(for Network or Non-Network services).*
    b. Urgent Care Center Covered Services:
       - ***Network*** *services: subject to either $0 or $100 Facility Fee amount, per Insured Person, per visit.*
       - ***Non-Network*** *services: subject to $100 Facility Fee amount, per Insured Person, per visit.*
       - *Subject to chosen* ***Network Coinsurance amount only*** *(for Network or Non-Network services).*
    c. Non-Medical Emergencies: Insured Person visits for Non-Medical Emergency, by definition, are **not covered.**

12. PHYSICIAN SERVICES-OUTPATIENT PHYSICIAN VISITS – *Applicant will have a* ***choice*** *of the following options:*
    a. OPTION A:
       - *Subject to chosen Network / Non-Network Deductible and Coinsurance amounts.*
       - *Unlimited Outpatient Physician Visits related to Sickness or Injury.*
       - *Unlimited Well Child Visits (up to 24 months of age).*
       - *Limited to one (1) Outpatient Preventive Care Physician Visit per Insured Person, per Calendar Year.*
    b. OPTION B:
       - *Limited to two (2) or four (4) Outpatient Physician Visits related to Sickness or Injury per Insured Person, per Calendar Year.*
       - ***Network Visits:*** *Coinsurance and Deductible amounts are* ***waived.***
         - *Physician Home / Office Visits Copayment = $50 per Insured, per visit*
         - *Convenient Care Clinic Visits Copayment = $25 per Insured, per visit*
       - ***Non-Network Visits:*** *70% Coinsurance (regardless of chosen Coinsurance) and chosen Non-Network Deductible amounts apply to Physician Home/Office and Convenient Care Clinic visits (****no Copayments apply****).*

       - *Limited to one (1) Outpatient Preventive Care Physician Visit per Insured Person, per Calendar Year.*
       - ***Network Visits:*** *$50 Copayment; Coinsurance and Deductible amounts are* ***waived.***
       - ***Non-Network Visits:*** *70% Coinsurance (regardless of chosen Coinsurance) and chosen Non-Network Deductible amounts applies (****no Copayments apply****).*

       - *Unlimited Well Child Visits (up to 24 months of age).*
       - ***Network Visits:*** *$50 Copayment; Coinsurance and Deductible amounts are* ***waived.***
       - ***Non-Network Visits:*** *70% Coinsurance (regardless of chosen Coinsurance) and chosen Non-Network Deductible amount applies (****no Copayments apply****).*

c. OPTION C:
- *Unlimited Outpatient Physician Visits related to Sickness or Injury per Insured Person, per Calendar Year.*
- ***Network Visits:*** *Coinsurance and Deductible amounts are* ***waived.***
  - *Physician Home / Office Visits Copayment = $50 per Insured, per visit*
  - *Convenient Care Clinic Visits Copayment = $25 per Insured, per visit*
- ***Non-Network Visits:*** *70% Coinsurance (regardless of chosen Coinsurance) and chosen Non-Network Deductible amounts apply to Physician Home/Office and Convenient Care Clinic visits (****no Copayments apply****).*

- *Limited to one (1) Outpatient Preventive Care Physician Visit per Insured Person, per Calendar Year.*
- ***Network Visits:*** *$50 Copayment; Coinsurance and Deductible amounts are* ***waived.***
- ***Non-Network Visits:*** *70% Coinsurance (regardless of chosen Coinsurance) and chosen Non-Network Deductible amounts applies (****no Copayments apply****).*

- *Unlimited Well Child Visits (up to 24 months of age).*
- ***Network Visits:*** *$50 Copayment; Coinsurance and Deductible amounts are* ***waived.***
- ***Non-Network Visits:*** *70% Coinsurance (regardless of chosen Coinsurance) and chosen Non-Network Deductible amount applies (****no Copayments apply****).*

d. OPTION D: **No benefits at all for outpatient Physician Services**.

13. <u>OUTPATIENT DIAGNOSTIC SERVICES</u> –
    a. CAT, MRI and/or PET SCANS:
    - *Subject to either a $2,500 or $5,000 Maximum Allowable Amount, per Insured Person, per Calendar Year (please refer to page 1 for outline of the term "Maximum Allowable Amount"). This section is bracketed because we may choose to not apply a Maximum Allowable Amount in the future.*
    - *Subject to $0, $150, or $250 Facility Fee amount. This section is bracketed because we may choose to not charge a Facility Fee amount in the future.*
    - *Subject to chosen Network / Non-Network Deductible and Coinsurance Amounts*

    b. All other Outpatient Diagnostic Services:
    - *Subject to either a $2,500 or $5,000 Maximum Allowable Amount, per Insured Person, per Calendar Year (please refer to page 1 for outline of the term "Maximum Allowable Amount"). This section is bracketed because we may choose to not apply a Maximum Allowable Amount in the future.*
    - *Subject to $0, $50, or $200 Facility Fee amount. This section is bracketed because we may choose to not charge a Facility Fee amount in the future.*
    - *Subject to chosen Network / Non-Network Deductible and Coinsurance Amounts*

14. <u>THERAPY SERVICES</u> –
    a. Subject to $50 Facility Fee amount
    b. Subject to chosen Network / Non-Network Deductible and Coinsurance Amounts
    c. Limited to 40 combined visits for Speech, Physical, Occupational and/or Cardiac Rehabilitation Therapies per Insured Person, per Calendar Year

THE CHESAPEAKE LIFE INSURANCE COMPANY

VARIABILITY STATEMENT

CATASTROPHIC EXPENSE PREFERRED PROVIDER ORGANIZATION (PPO) POLICY
(FORM: CH-26210 PPO-IP (01/09) AR **)**

15. RIDER – *At this time, we intend to automatically attach the following Rider in conjunction with this plan. 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 offered which have not been approved by your state.*

Prescription Drug Expense Rider (form CH-26214-IP (0109) AR)

PRESCRIPTIONS OBTAINED THROUGH A PHARMACY

- Preferred Generic Drugs – Insured pays $5 copayment
- Non-Preferred Generic Drugs – Insured pays $15 copayment
- Brand Preferred Drugs – Insured pays 50% of drug cost
- Brand Non-Preferred Drugs – Insured pays 75% of drug cost

PRESCRIPTIONS OBTAINED THROUGH A MAIL-ORDER VENDOR

- Preferred Generic Drugs – Insured pays $15 copayment
- Non-Preferred Generic Drugs – Insured pays $30 copayment
- Brand Preferred Drugs – Insured pays 50% of drug cost
- Brand Non-Preferred Drugs – Insured pays 75% of drug cost

In addition to the payment structure above, applicant will have a choice of the following options:

- PLAN A: $50 Deductible and $2,000 Maximum Benefit amount per Insured Person, per Calendar Year
- PLAN B: $250 Deductible and $2,000 Maximum Benefit amount per Insured Person, per Calendar Year

THE CHESAPEAKE LIFE INSURANCE COMPANY

VARIABILITY STATEMENT

CATASTROPHIC EXPENSE PREFERRED PROVIDER ORGANIZATION (PPO) POLICY {H.S.A. Compatible}
(FORM: CH-26210 HSA PPO-IP (01/09) AR **)**

POLICY SCHEDULE

We intend to offer a version of this plan that is considered a qualified Health Savings Account (or "HSA") plan in accordance with US Treasury Department regulations. A Health Savings Account (HSA) is a special account owned by an individual where contributions to the account are to pay for current and future medical expenses. HSAs are used in conjunction with "High Deductible Health Plans" (HDHP). Policy form CH-26210 HSA PPO-IP (01/09)AR meets qualification standards in order to be classified as true H.S.A. plans.

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. ALLOWABLE AMOUNT –
   a. The amount in which the Deductible and Coinsurance will be deducted from.
   b. Network: it is the lesser of the contracted amount **or** the Maximum Allowable Amount specified on the Policy Schedule page.
   c. Non-Network: it is the lesser of the billed amount, the Usual & Customary amount, **or** the Maximum Allowable Amount specified on the Policy Schedule page.

2. MAXIMUM ALLOWABLE AMOUNT –
   a. The maximum dollar amount which will be considered for a Covered Service, as specified on the Policy Schedule page.
   b. If amount is not specified for the Covered Service on the Policy Schedule Page, it will follow the "Allowable Amount" as explained above.

3. 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 C: $8,000,000 Lifetime / $2,000,000 Calendar Year

4. CALENDAR YEAR DEDUCTIBLE AMOUNTS –
   a. Individual Network / Non-Network Deductible amounts *("Individual" meaning, there is only one Insured Person covered under the Policy)*: $5,800 / $11,600
   b. Family Network / Non-Network Deductible amounts *("Family" meaning, there is more than one Insured Person covered under the Policy)*: $11,600 / $23,200
      - *Family Deductible can be met by any combination of individual deductible accumulations in the family.*

   - *Non-Covered Services, Covered Services in excess of the Allowable Amount, or any applicable Copayment or Facility Fee amounts do not count toward meeting the Calendar Year Deductible.*

5. 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%

THE CHESAPEAKE LIFE INSURANCE COMPANY

VARIABILITY STATEMENT

CATASTROPHIC EXPENSE PREFERRED PROVIDER ORGANIZATION (PPO) POLICY {H.S.A. Compatible}
(FORM: CH-26210 HSA PPO-IP (01/09) AR **)**

6. MAXIMUM OUT OF POCKET AMOUNT –
   a. Total Allowable Amount that must be paid by Insured Persons per Calendar Year.
   b. Includes Network / Non-Network Deductible and Coinsurance amounts, as well as any applicable Copayment or Facility Fee amounts.
   c. Charges in excess of the Maximum Allowable Amount does **not** count toward the Maximum Out of Pocket Amount.

7. COPAYMENT AMOUNTS –
   a. Intended to be used with "OPTION B" of the Physician Services benefit (outlined on page 3) only at this time.
   b. Charged **in lieu of** the Calendar Year Deductible.
   c. Are charged aside of and do not count toward meeting the Calendar Year Deductible, Coinsurance Maximum, or any applicable Facility Fee amounts.
   d. Will continue to be charged **after** the Coinsurance Maximum is met.

8. FACILITY FEE AMOUNTS –
   a. Applicable to Inpatient Services, Outpatient Surgery Facility Services, Medical Emergencies, Outpatient Diagnostic Services, and Therapy Services benefits only.
   b. Charged **in addition to** the Calendar Year Deductible.
   c. Are charged aside of and do not count toward meeting the Calendar Year Deductible, Coinsurance Maximum, or any applicable Copayment amounts.
   d. Will continue to be charged **after** the Coinsurance Maximum is met.

9. 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 Allowable Amount, per Insured Person, per Transplant Procedure (please refer to page 1 for outline of the term "Maximum Allowable Amount").*
      - ***Non-Network*** *services: subject to $175,000 Maximum Allowable Amount, per Insured Person, per Transplant Procedure (please refer to page 1 for outline of the term "Maximum Allowable Amount").*

10. OUTPATIENT SURGERY FACILITY SERVICES –
    a. **Non-Network** services: subject to $250 Facility Fee amount, per Insured Person, per Hospital Confinement.
    b. Subject to chosen Network / Non-Network Deductible and Coinsurance amounts.

11. MEDICAL EMERGENCIES –
    a. Hospital Emergency Room Covered Services:
       - ***Network*** *services: subject to $0, $100, or $500 Facility Fee amount, per Insured Person, per visit.*
       - ***Non-Network*** *services: subject to either $100 or $500 Facility Fee amount, per Insured Person, per visit.*
       - *Chosen* ***Deductible is waived*** *if Insured is admitted into the Hospital (for Network or Non-Network services).*
       - *Subject to chosen* ***Network Coinsurance amount only*** *(for Network or Non-Network services).*
    b. Urgent Care Center Covered Services:
       - ***Network*** *services: subject to either $0 or $100 Facility Fee amount, per Insured Person, per visit.*
       - ***Non-Network*** *services: subject to $100 Facility Fee amount, per Insured Person, per visit.*
       - *Subject to chosen* ***Network Coinsurance amount only*** *(for Network or Non-Network services).*
    c. Non-Medical Emergencies: Insured Person visits for Non-Medical Emergency, by definition, are **not covered.**

THE CHESAPEAKE LIFE INSURANCE COMPANY

VARIABILITY STATEMENT

CATASTROPHIC EXPENSE PREFERRED PROVIDER ORGANIZATION (PPO) POLICY {H.S.A. Compatible}
(FORM: CH-26210 HSA PPO-IP (01/09) AR **)**

12. PHYSICIAN SERVICES-OUTPATIENT PHYSICIAN VISITS – *Applicant will have a **choice** of the following options:*
    a. OPTION A:
    - *Subject to chosen Network / Non-Network Deductible and Coinsurance amounts.*
    - *Unlimited Outpatient Physician Visits related to Sickness or Injury.*
    - *Unlimited Well Child Visits (up to 24 months of age).*
    - *Limited to one (1) Outpatient Preventive Care Physician Visit per Insured Person, per Calendar Year.*

    b. OPTION B: *We may not choose to offer this Option initially.*
    - *Subject to chosen Network / Non-Network Deductible and Coinsurance amounts.*
    - *Unlimited Outpatient Physician Visits related to Sickness or Injury.*

    - *Limited to one (1) Outpatient Preventive Care Physician Visit per Insured Person, per Calendar Year.*
    - ***Network Visits:** $50 Copayment; Coinsurance and Deductible amounts are **waived.***
    - ***Non-Network Visits:** 70% Coinsurance (regardless of chosen Coinsurance) and chosen Non-Network Deductible amounts applies (**no Copayments apply**).*

    - *Unlimited Well Child Visits (up to 24 months of age).*
    - ***Network Visits:** $50 Copayment; Coinsurance and Deductible amounts are **waived.***
    - ***Non-Network Visits:** 70% Coinsurance (regardless of chosen Coinsurance) and chosen Non-Network Deductible amount applies (**no Copayments apply**).*

    c. OPTION C: No benefits at all for outpatient Physician Services.

13. OUTPATIENT DIAGNOSTIC SERVICES –
    a. CAT, MRI and/or PET SCANS:
    - *Subject to either a $2,500 or $5,000 Maximum Allowable Amount, per Insured Person, per Calendar Year (please refer to page 1 for outline of the term "Maximum Allowable Amount"). This section is bracketed because we may choose to not apply a Maximum Allowable Amount in the future.*
    - *Subject to $0, $150, or $250 Facility Fee amount. This section is bracketed because we may choose to not charge a Facility Fee amount in the future.*
    - *Subject to chosen Network / Non-Network Deductible and Coinsurance Amounts*

    b. All other Outpatient Diagnostic Services:
    - *Subject to either a $2,500 or $5,000 Maximum Allowable Amount, per Insured Person, per Calendar Year (please refer to page 1 for outline of the term "Maximum Allowable Amount"). This section is bracketed because we may choose to not apply a Maximum Allowable Amount in the future.*
    - *Subject to $0, $50, or $200 Facility Fee amount. This section is bracketed because we may choose to not charge a Facility Fee amount in the future.*
    - *Subject to chosen Network / Non-Network Deductible and Coinsurance Amounts*

14. THERAPY SERVICES –
    a. Subject to $50 Facility Fee amount
    b. Subject to chosen Network / Non-Network Deductible and Coinsurance Amounts
    c. Limited to 40 combined visits for Speech, Physical, Occupational and/or Cardiac Rehabilitation Therapies per Insured Person, per Calendar Year

THE CHESAPEAKE LIFE INSURANCE COMPANY

VARIABILITY STATEMENT

CATASTROPHIC EXPENSE PREFERRED PROVIDER ORGANIZATION (PPO) POLICY {H.S.A. Compatible}
(FORM: CH-26210 HSA PPO-IP (01/09) AR **)**

RIDER – *At this time, we intend to offer the following Rider in conjunction with this plan. However, in the future, we may choose to make this Rider automatically attached to this plan, to not offer it all, or 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.*

Prescription Drug Expense Rider (form CH-26214-IP (0109)AR)

PRESCRIPTIONS OBTAINED THROUGH A PHARMACY

- Preferred Generic Drugs – Insured pays $5 copayment
- Non-Preferred Generic Drugs – Insured pays $15 copayment
- Brand Preferred Drugs – Insured pays 50% of drug cost
- Brand Non-Preferred Drugs – Insured pays 75% of drug cost

PRESCRIPTIONS OBTAINED THROUGH A MAIL-ORDER VENDOR

- Preferred Generic Drugs – Insured pays $15 copayment
- Non-Preferred Generic Drugs – Insured pays $30 copayment
- Brand Preferred Drugs – Insured pays 50% of drug cost
- Brand Non-Preferred Drugs – Insured pays 75% of drug cost

In addition to the payment structure above, the insured will be responsible for:

- Chosen Network / Non-Network Deductible
- $5,000 Maximum Benefit amount per Insured Person, per Calendar Year

The Chesapeake
Life Insurance Company
Home Office: Oklahoma City, OK

9151 Boulevard 26
North Richland Hills, TX 76180

December 16, 2008

Arkansas Insurance Department
Life and Health Division
1200 W. 3rd Street
Little Rock, AR 72201-1904

The Chesapeake Life Insurance Company
NAIC#: 264-61832 / FEIN#: 52-0676509
SERFF Tracking Number: MGCC-125949834

FORM NUMBERS	DESCRIPTION
CH-26210 PPO-IP (01/09) AR	Catastrophic Expense Preferred Provider Organization (PPO) Policy
CH-26210 PPO-IP OC (01/09) AR	Outline of Coverage
CH-26210 HSA PPO-IP (01/09) AR	Catastrophic Expense Preferred Provider Organization (PPO) Group Policy *{H.S.A. Compatible}*
CH-26210 HSA PPO-IP OC (01/09) AR	Outline of Coverage
CH-26214-IR (01/09) AR	Prescription Drug Expense Rider
(VAR STMT) CH-26210 PPO-IP (01/09) AR	VARIABILITY STATEMENT
(VAR STMT) CH-26210 HSA PPO-IP (01/09) AR	VARIABILITY STATEMENT *{for H.S.A. Compatible plan}*

Dear Examiner:

The above referenced forms referenced 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 (01/09) AR** is Catastrophic Expense Preferred Provider Organization (PPO) form which provides coverage for Covered Services; including services, supplies, care or treatment as described in the Policy, which are performed, prescribed, directed, or authorized by a Network Provider. Unless otherwise stated within the Policy, all Covered Services are subject to: a) Facility Fees and/or Copayments; b) the Allowable Amount, Maximum Allowable Amount, Calendar Year, and Lifetime Maximum Amounts; c) the chosen Deductible; d) the chosen Network / Non-Network Provider Coinsurance; and e) the Exclusions and Limitations of the Policy.

Policy Form **CH-26210 HSA PPO-IP (01/09) AR** is a qualified Health Savings Account ("**HSA**") Catastrophic Expense Preferred Provider Organization (PPO) form which provides coverage for Covered Services; including services, supplies, care or treatment as described in the Policy, which are performed, prescribed, directed, or authorized by a Network Provider. Unless otherwise stated within the Policy, all Covered Services are subject to: a) Facility Fees and/or Copayments; b) the Allowable Amount, Maximum Allowable Amount, Calendar Year, and Lifetime Maximum Amounts; c) the chosen Deductible; d) the chosen Network / Non-Network Provider Coinsurance; and e) the Exclusions and Limitations of the Policy.

In addition, upon approval, Rider form CH-26214-IR (01/09) AR is intended to be offered with these plans.

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. Enclosed are **Variability Statements** for these new forms which provide explanation regarding how the options are intended to be made available to applicants.

We intend to use application form CH-25098-INDAPP (09/08), which is being submitted to your department under SERFF Tracking Number MGCC-125950178 to solicit these products.

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 included.

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,

Kathleen Allen
Corporate Compliance
HealthMarkets®
9151 Boulevard 26 • N Richland Hills • Texas 76180
(817) 255-3590 phone • (817) 255-8153 fax
• www.HealthMarkets.com

Superseded Attachments

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Original Date:	Schedule	Document Name	Replaced Date	Attach Document
No original date	Form	CATASTROPHIC EXPENSE PREFERRED PROVIDER ORGANIZATION (PPO) POLICY	12/16/2008	CH-26210 PPO-IP _0109_AR.pdf
No original date	Form	CATASTROPHIC EXPENSE PREFERRED PROVIDER ORGANIZATION (PPO) POLICY	12/16/2008	CH-26210 HSA PPO-IP _0109_AR.pdf
No original date	Supporting Document	Outline of Coverage	12/16/2008	CH-26210 PPO-IP OC _0109_AR.pdf CH-26210 HSA PPO-IP OC _0109_AR.pdf

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

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. 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 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 2 days 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 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.

POLICY SCHEDULE

COVERAGE IS PROVIDED UNDER POLICY NO: [XXXXX][XXXXX][XXXXX]

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. Benefits for Covered Services are based on the Allowable Amount. When Covered Services are received from a Non-Network Provider, the Allowable Amount may be less than the Allowable Amount that would have otherwise been considered for Covered Services received from a Network Provider. When You utilize a Non-Network Provider You are responsible for any balance due between the Non-Network Providers charge and the Allowable 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]

CALENDAR YEAR DEDUCTIBLE:	**NETWORK PROVIDER**	**NON-NETWORK PROVIDER**
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 the Allowable Amount or Maximum Allowable Amount for Covered Services incurred by each Insured Person, 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. [Covered Services incurred under any Riders will apply toward the Individual and Family Maximum Deductible, where applicable, unless specifically stated otherwise.] Deductibles do **not** include non-Covered Services, Covered Services in excess of the Allowable Amount or Maximum Allowable Amount, Facility Fees or Copayments.

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.

COINSURANCE MAXIMUM:	**NETWORK PROVIDER**	**NON-NETWORK PROVIDER**
Individual:	[$0][$2,500][$5,000][$10,000] [Not Applicable]	[$10,000]
Family:	[$5,000][$10,000][$20,000] [Not Applicable]	[$20,000]

The Coinsurance Maximum is the total Allowable Amount or Maximum Allowable Amount of Covered Services that Insured Persons must pay each Calendar Year after application of the Deductible and Coinsurance. Once the Individual Coinsurance Maximum is met, the Allowable Amount or Maximum Allowable Amount for Covered Services remaining thereafter for that Insured Person in the same Calendar Year will be paid at 100%, after the application of any Facility Fees or Copayments. Once the Family Coinsurance Maximum is met, the Allowable Amount or Maximum Allowable Amount for Covered Services remaining thereafter for all Insured Persons in the same Calendar Year will be paid at 100%, after the application of any Facility Fees or Copayments. **Facility Fees, Deductibles, Copayments and any charges exceeding the Allowable Amount or Maximum Allowable Amount do not count toward meeting the Coinsurance Maximum.**

POLICY SCHEDULE
SCHEDULE OF BENEFITS (Continued)

COVERED SERVICES	NETWORK PROVIDER	NON-NETWORK PROVIDER
INPATIENT SERVICES:		
Facility Fee:	[Facility Fee does not apply]	[$500] Per Insured Person, per Hospital Confinement
Inpatient Hospital:	[80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
Transplant Procedures:	[80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
	[$250,000] Maximum Allowable Amount, per Insured Person, per Transplant Procedure	[$175,000] Maximum Allowable Amount, per Insured Person, per Transplant Procedure
Child Health Supervision Services (*Immunizations only)*	[100%] of Covered Services	[100%] of Covered Services
PRE-ADMISSION TESTING:	[80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
OUTPATIENT SURGERY FACILITY SERVICES:	[80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
Facility Fee:	[Facility Fee does not apply]	[$250] Per Insured Person, per Surgery
MEDICAL EMERGENCIES:	[80%][90%][100%] Coinsurance	[80%][90%][100%] Coinsurance
Hospital Emergency Room Facility Fee: *(Waived if Hospital Confined)*	[$100] [$500] Per Insured Person, per visit	[$100][$500] Per Insured Person, per visit
Urgent Care Center Facility Fee:	[$100] Per Insured Person, per visit	[$100] Per Insured Person, per visit
PHYSICIAN SERVICES:		
Second Surgical Opinion: *(Limited to one per Surgery)*	[80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
Inpatient / Outpatient Surgeon:	[80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
Assistant Surgeon:	[80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
Anesthesiologist:	[80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
Physician Visits while Hospital Confined (other than Surgeon): *(Limited to one visit per Physician, per day)*	[80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance

POLICY SCHEDULE
SCHEDULE OF BENEFITS (Continued)

COVERED SERVICES	NETWORK PROVIDER	NON-NETWORK PROVIDER
{Option A} **PHYSICIAN SERVICES (Cont.)**		
Outpatient Physician Visits for Sickness or Injury:	[80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
Outpatient Preventive Care Physician Visits: (*Other than Well Child Visit)* *(Limited to one visit per Insured Person, per Calendar Year)*	[80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
Well Child Visits: *(For covered Dependent children from birth up to 24 months)*	[80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance

POLICY SCHEDULE
SCHEDULE OF BENEFITS (Continued)

COVERED SERVICES	NETWORK PROVIDER	NON-NETWORK PROVIDER
{Option B} **PHYSICIAN SERVICES (Cont.)**		
Outpatient Physician Office Visits for Sickness or Injury: *(Limited to [2][4] visits per Insured Person, per Calendar Year)*	[100%] Coinsurance – [Deductible waived]	[70%] Coinsurance
Physician Home and Office Copayment:	[$50] per Insured Person, per visit	[Copayment does not apply]
Convenient Care Clinic Copayment:	[$25] per Insured Person, per visit	[Copayment does not apply]
Outpatient Preventive Care Physician Visits: *(Other than Well Child Visits) (Limited to one visit per Insured Person, per Calendar Year)*	[100%] Coinsurance after [$50] Copayment, per Insured Person, per visit – [Deductible waived]	[70%] Coinsurance
Well Child Visits: *(For covered Dependent children from birth up to 24 months:*	[100%] Coinsurance after [$50] Copayment, per Insured Person, per visit –[Deductible waived]	[70%] Coinsurance

POLICY SCHEDULE
SCHEDULE OF BENEFITS (Continued)

COVERED SERVICES	NETWORK PROVIDER	NON-NETWORK PROVIDER
{Option C} **PHYSICIAN SERVICES (Cont.)**		
Outpatient Physician Office Visits for Sickness or Injury:	[100%] Coinsurance – [Deductible waived]	[70%] Coinsurance
Physician Home and Office Copayment:	[$50] per Insured Person, per visit	[Copayment does not apply]
Convenient Care Clinic Copayment:	[$25] per Insured Person, per visit	[Copayment does not apply]
Outpatient Preventive Care Physician Visits: *(Other than Well Child Visits)* *(Limited to one visit per Insured Person, per Calendar Year)*	[100%] Coinsurance after [$50] Copayment, per Insured Person, per visit – [Deductible waived]	[70%] Coinsurance
Well Child Visits: *(For covered Dependent children from birth up to 24 months):*	[100%] Coinsurance after [$50] Copayment, per Insured Person, per visit – [Deductible waived]	[70%] Coinsurance

POLICY SCHEDULE
SCHEDULE OF BENEFITS (Continued)

COVERED SERVICES	NETWORK PROVIDER	NON-NETWORK PROVIDER
PREVENTIVE IMAGING SCREENING TESTS:		
Human Papillomavirus and Cervical Cancer Screening:	[80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
Prostate Cancer Screening:	[80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
Mammography Screening:	[80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
Colorectal Cancer Screening:	[80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
RECONSTRUCTIVE SURGERY IN CONNECTION WITH A MASTECTOMY:	[80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
COMPLICATIONS OF PREGNANCY:	[80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance

POLICY SCHEDULE
SCHEDULE OF BENEFITS (Continued)

COVERED SERVICES	NETWORK PROVIDER	NON-NETWORK PROVIDER
CHEMOTHERAPY:	[80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
RADIATION THERAPY:	[80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
OUTPATIENT DIAGNOSTIC SERVICES:	[80%][90%][100%] of [Maximum] Allowable Amount	[50%][60%][70%] of [Maximum] Allowable Amount
CAT, MRI and/or PET Scans through Network / Non-Network Provider: [$2,500][$5,000] Maximum Allowable Amount per Insured Person, per Calendar Year		
Facility Fee:	[$0][$150][$250] per Insured Person, per visit	[$0][$150][$250] per Insured Person, per visit
All Other Outpatient Diagnostic Services through Network / Non-Network Provider: [$2,500][$5,000] Maximum Allowable Amount per Insured Person, per Calendar Year		
Facility Fee:	[$0][$50][$200] per Insured Person, per visit	[$0][$50][$200] per Insured Person, per visit

POLICY SCHEDULE
SCHEDULE OF BENEFITS (Continued)

COVERED SERVICES	NETWORK PROVIDER	NON-NETWORK PROVIDER
SKILLED NURSING CARE: **Network / Non-Network Provider:** limited to [30 visits] per Insured Person, per Calendar Year	[80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
HOME HEALTH CARE: **Network / Non-Network Provider:** limited to [30 visits] per Insured Person, per Calendar Year	[80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
HOSPICE CARE: **Network / Non-Network Provider:** [$5,000] Maximum Allowable Amount per Insured Person, per lifetime	[80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
PRIVATE DUTY NURSING: **Network / Non-Network Provider:** limited to [30 shifts] per Insured Person, per Calendar Year	[80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
DURABLE MEDICAL EQUIPMENT AND PROSTHETIC DEVICES: **Network / Non-Network Provider:** [$2,000] Maximum Allowable Amount per Insured Person, per Calendar Year	[80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance

POLICY SCHEDULE
SCHEDULE OF BENEFITS (Continued)

COVERED SERVICES	NETWORK PROVIDER	NON-NETWORK PROVIDER
AMBULANCE SERVICES *(Payable only when Hospital Confined)*		
Ground Ambulance: **Network/Non-Network Provider:** $500 Maximum Allowable Amount per Insured Person, per trip	[80%][90%][100%] Coinsurance	[80%][90%][100%] Coinsurance
Air / Water Ambulance: **Network / Non-Network Provider:** $5,000 Maximum Allowable Amount per Insured Person, per trip	[80%][90%][100%] Coinsurance	[80%][90%][100%] Coinsurance
THERAPY SERVICES *(Limited to [40 combined visits] for all therapies per Insured Person, per Calendar Year)*		
Speech Therapy:	[80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
Facility Fee:	$50 per Insured Person, per visit	$50 per Insured Person, per visit
Physical Therapy:	[80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
Facility Fee:	$50 per Insured Person, per visit	$50 per Insured Person, per visit
Occupational Therapy:	[80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
Facility Fee:	$50 per Insured Person, per visit	$50 per Insured Person, per visit
Cardiac Rehabilitation (Phase I & II)	[80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
Facility Fee:	$50 per Insured Person, per visit	$50 per Insured Person, per visit

POLICY SCHEDULE
SCHEDULE OF BENEFITS (Continued)

RIDER BENEFITS

PRESCRIPTION DRUG RIDER
(See Rider)

DEFINITIONS

Allowable Amount means the Provider charge that is considered for Covered Services under this Policy and any attached Riders after the application of the Facility Fee and Copayment, if any. For Network Providers, the Allowable Amount is the lesser of the contracted amount or the Maximum Allowable Amount shown in the POLICY SCHEDULE. For Non-Network Providers, the Allowable Amount is the lesser of Usual and Customary Charge, the billed amount or the Maximum Allowable Amount shown in the POLICY SCHEDULE. No amount in excess of the Allowable Amount or Maximum Allowable Amount will be considered under this Policy. The Allowable Amount is subject to:

- The Deductibles shown in the POLICY SCHEDULE, if any;
- The Network Coinsurance level or Non-Network Coinsurance level shown in the POLICY SCHEDULE; and
- The Calendar Year and Lifetime Maximum Amounts shown in the POLICY SCHEDULE.

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 the Allowable Amount or Maximum Allowable Amount of Covered Services that are paid by Us after application of the Facility Fees and Copayment, if any, and 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.

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

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

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 before the application of the Allowable Amount or Maximum Allowable Amount for specifically listed Covered Services and is in lieu of the Deductible. The Copayment, if any, is shown in the POLICY SCHEDULE. Copayments do not count toward [Facility Fees][, Deductibles][, or Coinsurance Maximums].

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

1. Reconstructive Surgery incidental to or following Surgery resulting from trauma, infection or other disease of the involved part, 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 mean 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. **Any charges in excess of the Allowable Amount or the Maximum Allowable Amount shown in the Policy Schedule, if any, will *not* be considered a Covered Service.**

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;
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 Allowable Amount or Maximum Allowable Amount 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].

Home Health Care means the provision of a health service for payment or other consideration in a patient's residence under a plan established, approved in writing, and reviewed at least every two months by the attending Physician and certified by the attending Physician as necessary for medical purposes.

Home Health Care Agency means a public or private agency or organization licensed in the state in which it is located, to provide home health care services.

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.

Hospice means an agency which provides limited periods of care for terminally ill persons and is licensed, certified or registered in accordance with state law.

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 Allowable Amounts or Maximum Amounts paid by Us will accumulate toward the Lifetime Maximum Amount from the Policy Date. The Lifetime Maximum Amount is shown in the POLICY SCHEDULE.

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 Allowable Amount means the maximum dollar amount that will be considered as an Allowable Amount for a Covered Service under this Policy and any attached Riders. The Maximum Allowable Amount is shown in the POLICY SCHEDULE.

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 Insured Person'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.

Occupational Therapy means the use of purposeful activities to restore and maximize independence, prevent associated disability, and maintain health. The practice encompasses assessment, treatment and consultation for individuals and groups in healthcare, educational, and community settings.

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.

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

Physician means a legally qualified licensed practitioner of the healing arts who provides care within the scope of his or her license, 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.

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 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.

Private Duty Nurse means a registered graduate professional nurse (R.N.), licensed vocational nurse (L.V.N), licensed practical nurse (L.P.N.) or any other legally licensed or certified nursing professional who provides care within the scope of his or her license or certificate. (A member of the Insured Person's Immediate Family will not be considered a Private Duty Nurse.)

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.

Skilled Nursing Facility means a facility which:

1. is licensed by the state;
2. provides skilled nursing care under the supervision of a Physician;
3. has 24 hour-a-day nursing services by or under the supervision of a registered graduate professional nurse (R.N.);
4. keeps a daily medical record of each patient; and
5. provides full-time bed care for resident patients.

It does not include a facility or any of its sections which is a place for persons suffering from a Mental or Nervous Disorder, alcohol or drug problems, or which is used mainly as a home for rest or for the aged. Nor does the term include an institution which is operated mainly for domiciliary or custodial care or as a school for the education of patients.

Speech Therapy means the application of principles, methods, and procedures for measurement, testing, identification, prediction, counseling, or instruction related to the development and disorders of speech, voice, or language for the purpose of identifying, preventing, managing, habilitating, or rehabilitating, ameliorating, or modifying such disorders and conditions in individuals or groups of individuals.

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:

1. Heart transplant;
2. Combined heart and lung transplant;
3. Lung transplant;
4. Kidney transplant;
5. Kidney and pancreas transplant;
6. Liver transplant;
7. Bone marrow transplant, either allogenic or autologous, including high dose chemotherapy; or
8. Peripheral stem cell transplant.

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

1. The condition requiring treatment, along with recommended procedures;
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 negotiated rate in effect with a Network Provider on the date it provides a Covered Service.

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.

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 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.

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 Provisions for Dependents

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

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

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

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.

COVERED SERVICES

Covered Services include 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. Any charges in excess of the Allowable Amount or the Maximum Allowable Amount shown in the Policy Schedule, if any, will not be considered a Covered Service

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

1. The Facility Fees and/or Copayments shown in the POLICY SCHEDULE, if any;
2. The Allowable Amount, Maximum Allowable Amount, Calendar Year and Lifetime Maximum Amounts shown in the POLICY SCHEDULE;
3. The Deductibles shown in the POLICY SCHEDULE, if any;
4. The Network Provider Coinsurance level or Non-Network Provider Coinsurance level shown in the POLICY SCHEDULE; and
5. The EXCLUSIONS AND LIMITATIONS.

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

The fees charged for take home drugs, personal convenience items 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 Allowable Amount under the Policy applicable to the recipient;
4. Rental of durable medical equipment for use outside the Hospital. The Allowable Amount is 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.

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; and
4. Diagnostic services including radiology, laboratory or pathology performed at the time of the Surgery.

MEDICAL EMERGENCIES:

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

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 include the Allowable Amount 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 an appendectomy performed during a gall bladder surgery.

Assistant Surgeon Benefit

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

Anesthesiologist Benefit

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.

Outpatient Physician Visits for Sickness or Injury

Covered Services include Medically Necessary Physician office visits related to a Sickness or Injury, including Physician Consultations and any treatment associated with such Physician's Office visit that is received in the Physician's Office or in a Convenient Care Clinic. Covered Services also include any Medically Necessary laboratory and x-ray services provided and billed by the Physician related to a Sickness or Injury.

Outpatient Preventive Care Physician Visits

Covered Services include office charges and routine physical examinations, health history and immunizations required for school or travel when received in a Physician's Office or in a Convenient Care Clinic and are not related to a Sickness or Injury. Covered Services will also include any routine laboratory and x-ray services performed in the Physician's Office and billed by the Physician that are not related to a Sickness or Injury.

Well Child Visits

Covered Services include well child Physician visits for covered Dependent Children from birth up to 24 months of age. Covered Services will also include any routine or preventive laboratory and x-ray services performed in the Physician's Office and billed by the Physician that are not related to a Sickness or Injury.

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

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

RECONSTRUCTIVE SURGERY IN CONNECTION WITH A MASTECTOMY:

Covered Services include services and supplies provided for reconstructive Surgery in connection with a mastectomy. The reconstructive Surgery will be provided in a manner determined to be appropriate in Consultation with the attending Physician and the Insured Person, and will include:

1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to achieve a symmetrical appearance; and
3. Prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.

COMPLICATIONS OF PREGNANCY:

Covered Services include treatment of Complications of Pregnancy while Hospital Confined or in an Outpatient Surgery Facility (when the pregnancy is not terminated).

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.

CHEMOTHERAPY:

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

RADIATION THERAPY:

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

OUTPATIENT DIAGNOSTIC SERVICES:

Covered Services include outpatient diagnostic services performed in a free-standing diagnostic center or Hospital (other than Hospital emergency room) for diagnostic x-rays and interpretation charges, and laboratory and pathological examinations received while not Confined to a Hospital and that are related to and necessary for the diagnosis and treatment of the Sickness or Injury. [Covered Services include but are not limited to CAT Scans, Magnetic Resonance Imaging (MRI), PET Scans, SPECT scans; Nuclear Medicine Imaging; Sleep studies; Mammogram, Upper/Lower G.I. Series, Electrocardiogram (EKG), Blood or serum analysis, Angiogram and Stress Tests.]

Covered Services include Central Supply (IV tubing) or pharmacy (dye) necessary to perform the tests.

Covered Services under this provision do not include routine physical examinations or checkups, and laboratory and x-ray services provided in and billed by a Hospital emergency room, Urgent Care Center or Physician's office.

SKILLED NURSING CARE:

Covered Services include charges incurred during Confinement in a Skilled Nursing Facility.

HOME HEALTH CARE:

Covered Services include services or supplies furnished by a Home Health Care Agency.

HOSPICE CARE:

Covered Services include the following services and supplies provided by a Hospice in the Insured Person's home or in a Hospice facility for medical, social and psychological services used as palliative treatment for patients with a life expectancy of not more than 6 months:

1. Skilled nursing services;
2. Diagnostic services;
3. Physical, speech and inhalation therapies;
4. Medical supplies, equipment and appliances;
5. Counseling services for the Insured Person regarding his or her terminal illness;
6. Inpatient Confinement at a Hospice Facility; and
7. Prescription Drugs obtained from the Hospice.

PRIVATE DUTY NURSING:

Covered Services include the services of a Private Duty Nurse.

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.

THERAPY SERVICES:

Speech Therapy, Physical Therapy, Occupational Therapy and Cardiac Rehabilitation (Phase I and II)

Covered Services include Speech Therapy, Physical Therapy, Occupational Therapy and Cardiac Rehabilitation (Phase I and II) that is related to and Medically Necessary for the treatment of a Sickness or Injury.

MUSCULOSKELETAL DISORDERS:

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

CHILD HEALTH SUPERVISION SERVICES:

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

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

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

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

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

MEDICAL FOODS AND LOW PROTEIN MODIFIED FOOD PRODUCTS:

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

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

DIABETES:

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

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

IMPAIRMENT OR LOSS OF SPEECH OR HEARING:

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

OUTPATIENT CONTRACEPTIVE SERVICES AND DEVICES:

Covered Services incurred for 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;
2. Any charges exceeding the Allowable Amount or Maximum Allowable 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. 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;
13. 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;
14. Breast reduction or augmentation, or complications arising there from, unless necessary in connection with breast reconstructive Surgery following a mastectomy;
15. Modification of the physical body in order to improve the psychological, mental or emotional well-being of the Insured Person, such as but not limited to sex-change Surgery;
16. Marriage, family, or child counseling for the treatment of premarital, marriage, family or child relationship dysfunctions;
17. Directly or indirectly engaging in an illegal occupation or illegal activity;
18. Care in a nursing home, custodial institution or domiciliary care or rest cures;
19. Preparation and presentation of medical reports for appearance at trials or hearings;
20. Physical examinations required for school events, sports, camp, employment, licensing and insurance, unless otherwise stated herein;
21. Immunizations required for the sole purpose of travel outside of the U.S.A.;
22. Payment for care for military service connected disabilities for which the Insured Person is legally entitled to services and for which facilities are reasonably available to the Insured Person and payment for care for conditions that state or local law requires be treated in a public facility;
23. Experimental or Investigative medical, surgical or other health care procedures, treatments, products or services, unless otherwise stated herein;
24. Personal comfort items, such as television, telephone, lotions, shampoos, etc.;
25. Cosmetic Surgery, or complications arising there from, unless otherwise stated herein;
26. Dental Care, treatment or Surgery unless necessitated by Injury to sound natural teeth which occurs while insured under this Policy. (The expense must be incurred within one year from the date of Injury);
27. Corrective vision or hearing supplies or for the examination for prescribing or fitting such supplies;
28. The removal of warts, corns, calluses, the cutting and trimming of toenails, care for flat feet, fallen arches or chronic foot strain;
29. Expenses incurred for prescription drugs, except if added by Rider;
30. Normal pregnancy, except for Complications of Pregnancy, except benefits added by Rider; and
31. 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.

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 the Policy. No other person will have the authority to bind Us in any manner. No agent may accept risks, alter or amend coverage or waive any provisions of the Policy. Any change in the Policy will be made by an amendment approved and signed by Us. Such amendment will not require the consent of any Insured Person.

Notice of Claim

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

Claim Forms

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

Proof of Loss

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

Claim Payments

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

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

Assignment of Claim Payments

Payment for services provided by the 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.

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

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

THE 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

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. 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 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 2 days 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 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.

POLICY SCHEDULE

COVERAGE IS PROVIDED UNDER POLICY NO: [XXXXX][XXXXX][XXXXX]

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)

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. Benefits for Covered Services are based on the Allowable Amount. When Covered Services are received from a Non-Network Provider, the Allowable Amount may be less than the Allowable Amount that would have otherwise been considered for Covered Services received from a Network Provider. When You utilize a Non-Network Provider You are responsible for any balance due between the Non-Network Providers charge and the Allowable 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] **]**

CALENDAR YEAR DEDUCTIBLE	NETWORK PROVIDER	NON-NETWORK PROVIDER
[Individual Deductible:	[$5,800]	[$11, 600] **]**
[Family Deductible:	[$11,600]	[$23,200] **]**

DEDUCTIBLE PROVISIONS:

The Deductible amount will be deducted from the Allowable Amount or Maximum Allowable Amount for Covered Services incurred by Insured Persons, each Calendar Year. Covered Services incurred under any Riders will apply toward the Individual and Family Maximum Deductible, where applicable, unless specifically stated otherwise. Deductibles do **not** include non-Covered Services, Covered Services in excess of the Allowable Amount or Maximum Allowable Amount, Facility Fees or Copayments.

MAXIMUM OUT-OF-POCKET AMOUNT	NETWORK PROVIDER	NON-NETWORK PROVIDER
[Individual:	[$5,800]	[Not Applicable] **]**
[Family	[$11,600]	[Not Applicable] **]**

MAXIMUM OUT-OF-POCKET AMOUNT is the total Allowable Amount of [Network Provider] expenses that must be paid by Insured Persons each Calendar Year for Covered Services, including the [Network Provider] Deductible, [Network Provider] Coinsurance, [Network Provider] Facility Fees and any [Network Provider] Copayments. Once this maximum is met, Covered Services [obtained through a Network Provider] remaining thereafter for the same Calendar Year will be paid at [100%], up to the Maximum Allowable shown in the POLICY SCHEDULE, if any. **Any charges exceeding any Maximum Allowable Amounts shown in the POLICY SCHEDULE and Covered Services obtained through a Non-Network Provider do not count toward meeting the Maximum Out-of-Pocket Amount.**

RULES FOR HEALTH SAVINGS ACCOUNTS:

The Deductible, Maximum Out-of-Pocket Amount, and premium may change if Insured Persons are added to or deleted from coverage under this Policy. The Deductible and Maximum Out-of-Pocket Amount is intended to satisfy government rules applicable to Health Savings Accounts (HSAs). The HSA rules may change annually. Deductible and Maximum Out-of-Pocket Amounts will be adjusted at the beginning of each year to comply with any changes in the HSA rules, when necessary. We will notify You of any changes as soon as reasonably possible.

POLICY SCHEDULE
SCHEDULE OF BENEFITS (Continued)

COVERED SERVICES	NETWORK PROVIDER	NON-NETWORK PROVIDER
INPATIENT SERVICES:		
Facility Fee:	[Facility Fee does not apply]	[$500] Per Insured Person, per Hospital Confinement
Inpatient Hospital:	[80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
Transplant Procedures:	[80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
	[$250,000] Maximum Allowable Amount, per Insured Person, per Transplant Procedure	[$175,000] Maximum Allowable Amount, per Insured Person, per Transplant Procedure
Child Health Supervision Services (*Immunizations only)*	[100%] of Covered Services	[100%] of Covered Services
PRE-ADMISSION TESTING:	[80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
OUTPATIENT SURGERY FACILITY SERVICES:	[80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
Facility Fee:	[Facility Fee does not apply]	[$250] Per Insured Person, per Surgery
MEDICAL EMERGENCIES:	[80%][90%][100%] Coinsurance	[80%][90%][100%] Coinsurance
Hospital Emergency Room Facility Fee: *(Waived if Hospital Confined)*	[$100] [$500] Per Insured Person, per visit	[$100][$500] Per Insured Person, per visit
Urgent Care Center Facility Fee:	[$100] Per Insured Person, per visit	[$100] Per Insured Person, per visit
PHYSICIAN SERVICES:		
Second Surgical Opinion: *(Limited to one per Surgery)*	[80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
Inpatient / Outpatient Surgeon:	[80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
Assistant Surgeon:	[80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
Anesthesiologist:	[80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
Physician Visits while Hospital Confined (other than Surgeon): *(Limited to one visit per Physician, per day)*	[80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance

POLICY SCHEDULE
SCHEDULE OF BENEFITS (Continued)

COVERED SERVICES	NETWORK PROVIDER	NON-NETWORK PROVIDER
{Option A} **PHYSICIAN SERVICES (Cont.)**		
Outpatient Physician Visits for Sickness or Injury:	[80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
Outpatient Preventive Care Physician Visits: (*Other than Well Child Visit)* *(Limited to one visit per Insured Person, per Calendar Year)*	[80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
Well Child Visits: *(For covered Dependent children from birth up to 24 months)*	[80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance

POLICY SCHEDULE SCHEDULE OF BENEFITS (Continued)		
COVERED SERVICES	**NETWORK PROVIDER**	**NON-NETWORK PROVIDER**
{Option B} **PHYSICIAN SERVICES (Cont.)**		
Outpatient Physician Office Visits for Sickness or Injury:	[80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
Outpatient Preventive Care Physician Visits: *(Other than Well Child Visits)* *(Limited to one visit per Insured Person, per Calendar Year)*	[100%] Coinsurance after [$50] Copayment, per Insured Person, per visit – [Deductible waived]	[70%] Coinsurance
Well Child Visits: *(For covered Dependent children from birth up to 24 months:*	[100%] Coinsurance after [$50] Copayment, per Insured Person, per visit –[Deductible waived]	[70%] Coinsurance

POLICY SCHEDULE
SCHEDULE OF BENEFITS (Continued)

COVERED SERVICES	NETWORK PROVIDER	NON-NETWORK PROVIDER
PREVENTIVE IMAGING SCREENING TESTS:		
Human Papillomavirus and Cervical Cancer Screening:	[80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
Prostate Cancer Screening:	[80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
Mammography Screening:	[80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
Colorectal Cancer Screening:	[80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
RECONSTRUCTIVE SURGERY IN CONNECTION WITH A MASTECTOMY:	[80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
COMPLICATIONS OF PREGNANCY:	[80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance

POLICY SCHEDULE
SCHEDULE OF BENEFITS (Continued)

COVERED SERVICES	NETWORK PROVIDER	NON-NETWORK PROVIDER
CHEMOTHERAPY:	[80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
RADIATION THERAPY:	[80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
OUTPATIENT DIAGNOSTIC SERVICES:	[80%][90%][100%] of [Maximum] Allowable Amount	[50%][60%][70%] of [Maximum] Allowable Amount
CAT, MRI and/or PET Scans through Network / Non-Network Provider: [$2,500][$5,000] Maximum Allowable Amount per Insured Person, per Calendar Year		
Facility Fee:	[$0][$150][$250] per Insured Person, per visit	[$0][$150][$250] per Insured Person, per visit
All Other Outpatient Diagnostic Services through Network / Non-Network Provider: [$2,500][$5,000] Maximum Allowable Amount per Insured Person, per Calendar Year		
Facility Fee:	[$0][$50][$200] per Insured Person, per visit	[$0][$50][$200] per Insured Person, per visit

POLICY SCHEDULE
SCHEDULE OF BENEFITS (Continued)

COVERED SERVICES	NETWORK PROVIDER	NON-NETWORK PROVIDER
SKILLED NURSING CARE: **Network / Non-Network Provider:** limited to [30 visits] per Insured Person, per Calendar Year	[80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
HOME HEALTH CARE: **Network / Non-Network Provider:** limited to [30 visits] per Insured Person, per Calendar Year	[80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
HOSPICE CARE: **Network / Non-Network Provider:** [$5,000] Maximum Allowable Amount per Insured Person, per lifetime	[80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
PRIVATE DUTY NURSING: **Network / Non-Network Provider:** limited to [30 shifts] per Insured Person, per Calendar Year	[80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
DURABLE MEDICAL EQUIPMENT AND PROSTHETIC DEVICES: **Network / Non-Network Provider:** [$2,000] Maximum Allowable Amount per Insured Person, per Calendar Year	[80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance

POLICY SCHEDULE
SCHEDULE OF BENEFITS (Continued)

COVERED SERVICES	NETWORK PROVIDER	NON-NETWORK PROVIDER
AMBULANCE SERVICES *(Payable only when Hospital Confined)*		
Ground Ambulance: **Network/Non-Network Provider:** $500 Maximum Allowable Amount per Insured Person, per trip	[80%][90%][100%] Coinsurance	[80%][90%][100%] Coinsurance
Air / Water Ambulance: **Network / Non-Network Provider:** $5,000 Maximum Allowable Amount per Insured Person, per trip	[80%][90%][100%] Coinsurance	[80%][90%][100%] Coinsurance
THERAPY SERVICES *(Limited to [40 combined visits] for all therapies per Insured Person, per Calendar Year)*		
Speech Therapy:	[80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
Facility Fee:	$50 per Insured Person, per visit	$50 per Insured Person, per visit
Physical Therapy:	[80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
Facility Fee:	$50 per Insured Person, per visit	$50 per Insured Person, per visit
Occupational Therapy:	[80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
Facility Fee:	$50 per Insured Person, per visit	$50 per Insured Person, per visit
Cardiac Rehabilitation (Phase I & II)	[80%][90%][100%] Coinsurance	[50%][60%][70%] Coinsurance
Facility Fee:	$50 per Insured Person, per visit	$50 per Insured Person, per visit

POLICY SCHEDULE
SCHEDULE OF BENEFITS (Continued)

RIDER BENEFITS

PRESCRIPTION DRUG RIDER
(See Rider)

DEFINITIONS

Allowable Amount means the Provider charge that is considered for Covered Services under this Policy and any attached Riders after the application of the Facility Fee and Copayment, if any. For Network Providers, the Allowable Amount is the lesser of the contracted amount or the Maximum Allowable Amount shown in the POLICY SCHEDULE. For Non-Network Providers, the Allowable Amount is the lesser of Usual and Customary Charge, the billed amount or the Maximum Allowable Amount shown in the POLICY SCHEDULE. No amount in excess of the Allowable Amount or Maximum Allowable Amount will be considered under this Policy. The Allowable Amount is subject to:

- The Deductibles shown in the POLICY SCHEDULE, if any;
- The Network Coinsurance level or Non-Network Coinsurance level shown in the POLICY SCHEDULE; and
- The Calendar Year and Lifetime Maximum Amounts shown in the POLICY SCHEDULE.

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 the Allowable Amount or Maximum Allowable Amount of Covered Services that are paid by Us after application of the Facility Fees and Copayment, if any, and 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.

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

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

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 before the application of the Allowable Amount or Maximum Allowable Amount for specifically listed Covered Services and is in lieu of the Deductible. The Copayment, if any, is shown in the POLICY SCHEDULE. Copayments do not count toward [Facility Fees][, Deductibles][, or Coinsurance Maximums].

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

1. Reconstructive Surgery incidental to or following Surgery resulting from trauma, infection or other disease of the involved part, 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 mean 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. **Any charges in excess of the Allowable Amount or the Maximum Allowable Amount shown in the Policy Schedule, if any, will *not* be considered a Covered Service.**

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;
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 Allowable Amount or Maximum Allowable Amount 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].

Home Health Care means the provision of a health service for payment or other consideration in a patient's residence under a plan established, approved in writing, and reviewed at least every two months by the attending Physician and certified by the attending Physician as necessary for medical purposes.

Home Health Care Agency means a public or private agency or organization licensed in the state in which it is located, to provide home health care services.

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.

Hospice means an agency which provides limited periods of care for terminally ill persons and is licensed, certified or registered in accordance with state law.

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 Allowable Amounts or Maximum Amounts paid by Us will accumulate toward the Lifetime Maximum Amount from the Policy Date. The Lifetime Maximum Amount is shown in the POLICY SCHEDULE.

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 Allowable Amount means the maximum dollar amount that will be considered as an Allowable Amount for a Covered Service under this Policy and any attached Riders. The Maximum Allowable Amount is shown in the POLICY SCHEDULE.

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 Insured Person'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.

Occupational Therapy means the use of purposeful activities to restore and maximize independence, prevent associated disability, and maintain health. The practice encompasses assessment, treatment and consultation for individuals and groups in healthcare, educational, and community settings.

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.

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

Physician means a legally qualified licensed practitioner of the healing arts who provides care within the scope of his or her license, 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.

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 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.

Private Duty Nurse means a registered graduate professional nurse (R.N.), licensed vocational nurse (L.V.N), licensed practical nurse (L.P.N.) or any other legally licensed or certified nursing professional who provides care within the scope of his or her license or certificate. (A member of the Insured Person's Immediate Family will not be considered a Private Duty Nurse.)

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.

Skilled Nursing Facility means a facility which:

1. is licensed by the state;
2. provides skilled nursing care under the supervision of a Physician;
3. has 24 hour-a-day nursing services by or under the supervision of a registered graduate professional nurse (R.N.);
4. keeps a daily medical record of each patient; and
5. provides full-time bed care for resident patients.

It does not include a facility or any of its sections which is a place for persons suffering from a Mental or Nervous Disorder, alcohol or drug problems, or which is used mainly as a home for rest or for the aged. Nor does the term include an institution which is operated mainly for domiciliary or custodial care or as a school for the education of patients.

Speech Therapy means the application of principles, methods, and procedures for measurement, testing, identification, prediction, counseling, or instruction related to the development and disorders of speech, voice, or language for the purpose of identifying, preventing, managing, habilitating, or rehabilitating, ameliorating, or modifying such disorders and conditions in individuals or groups of individuals.

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:

1. Heart transplant;
2. Combined heart and lung transplant;
3. Lung transplant;
4. Kidney transplant;
5. Kidney and pancreas transplant;
6. Liver transplant;
7. Bone marrow transplant, either allogenic or autologous, including high dose chemotherapy; or
8. Peripheral stem cell transplant.

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

1. The condition requiring treatment, along with recommended procedures;
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 negotiated rate in effect with a Network Provider on the date it provides a Covered Service.

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.

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 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.

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 Provisions for Dependents

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

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

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

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.

COVERED SERVICES

Covered Services include 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. Any charges in excess of the Allowable Amount or the Maximum Allowable Amount shown in the Policy Schedule, if any, will not be considered a Covered Service

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

1. The Facility Fees and/or Copayments shown in the POLICY SCHEDULE, if any;
2. The Allowable Amount, Maximum Allowable Amount, Calendar Year and Lifetime Maximum Amounts shown in the POLICY SCHEDULE;
3. The Deductibles shown in the POLICY SCHEDULE, if any;
4. The Network Provider Coinsurance level or Non-Network Provider Coinsurance level shown in the POLICY SCHEDULE; and
5. The EXCLUSIONS AND LIMITATIONS.

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

The fees charged for take home drugs, personal convenience items 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 Allowable Amount under the Policy applicable to the recipient;
4. Rental of durable medical equipment for use outside the Hospital. The Allowable Amount is 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.

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; and
4. Diagnostic services including radiology, laboratory or pathology performed at the time of the Surgery.

MEDICAL EMERGENCIES:

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

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 include the Allowable Amount 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 an appendectomy performed during a gall bladder surgery.

Assistant Surgeon Benefit

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

Anesthesiologist Benefit

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.

Outpatient Physician Visits for Sickness or Injury

Covered Services include Medically Necessary Physician office visits related to a Sickness or Injury, including Physician Consultations and any treatment associated with such Physician's Office visit that is received in the Physician's Office or in a Convenient Care Clinic. Covered Services also include any Medically Necessary laboratory and x-ray services provided and billed by the Physician related to a Sickness or Injury.

Outpatient Preventive Care Physician Visits

Covered Services include office charges and routine physical examinations, health history and immunizations required for school or travel when received in a Physician's Office or in a Convenient Care Clinic and are not related to a Sickness or Injury. Covered Services will also include any routine laboratory and x-ray services performed in the Physician's Office and billed by the Physician that are not related to a Sickness or Injury.

Well Child Visits

Covered Services include well child Physician visits for covered Dependent Children from birth up to 24 months of age. Covered Services will also include any routine or preventive laboratory and x-ray services performed in the Physician's Office and billed by the Physician that are not related to a Sickness or Injury.

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

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

RECONSTRUCTIVE SURGERY IN CONNECTION WITH A MASTECTOMY:

Covered Services include services and supplies provided for reconstructive Surgery in connection with a mastectomy. The reconstructive Surgery will be provided in a manner determined to be appropriate in Consultation with the attending Physician and the Insured Person, and will include:

1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to achieve a symmetrical appearance; and
3. Prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.

COMPLICATIONS OF PREGNANCY:

Covered Services include treatment of Complications of Pregnancy while Hospital Confined or in an Outpatient Surgery Facility (when the pregnancy is not terminated).

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.

CHEMOTHERAPY:

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

RADIATION THERAPY:

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

OUTPATIENT DIAGNOSTIC SERVICES:

Covered Services include outpatient diagnostic services performed in a free-standing diagnostic center or Hospital (other than Hospital emergency room) for diagnostic x-rays and interpretation charges, and laboratory and pathological examinations received while not Confined to a Hospital and that are related to and necessary for the diagnosis and treatment of the Sickness or Injury. [Covered Services include but are not limited to CAT Scans, Magnetic Resonance Imaging (MRI), PET Scans, SPECT scans; Nuclear Medicine Imaging; Sleep studies; Mammogram, Upper/Lower G.I. Series, Electrocardiogram (EKG), Blood or serum analysis, Angiogram and Stress Tests.]

Covered Services include Central Supply (IV tubing) or pharmacy (dye) necessary to perform the tests.

Covered Services under this provision do not include routine physical examinations or checkups, and laboratory and x-ray services provided in and billed by a Hospital emergency room, Urgent Care Center or Physician's office.

SKILLED NURSING CARE:

Covered Services include charges incurred during Confinement in a Skilled Nursing Facility.

HOME HEALTH CARE:

Covered Services include services or supplies furnished by a Home Health Care Agency.

HOSPICE CARE:

Covered Services include the following services and supplies provided by a Hospice in the Insured Person's home or in a Hospice facility for medical, social and psychological services used as palliative treatment for patients with a life expectancy of not more than 6 months:

1. Skilled nursing services;
2. Diagnostic services;
3. Physical, speech and inhalation therapies;
4. Medical supplies, equipment and appliances;
5. Counseling services for the Insured Person regarding his or her terminal illness;
6. Inpatient Confinement at a Hospice Facility; and
7. Prescription Drugs obtained from the Hospice.

PRIVATE DUTY NURSING:

Covered Services include the services of a Private Duty Nurse.

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.

THERAPY SERVICES:

Speech Therapy, Physical Therapy, Occupational Therapy and Cardiac Rehabilitation (Phase I and II)

Covered Services include Speech Therapy, Physical Therapy, Occupational Therapy and Cardiac Rehabilitation (Phase I and II) that is related to and Medically Necessary for the treatment of a Sickness or Injury.

MUSCULOSKELETAL DISORDERS:

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

CHILD HEALTH SUPERVISION SERVICES:

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

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

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

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

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

MEDICAL FOODS AND LOW PROTEIN MODIFIED FOOD PRODUCTS:

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

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

DIABETES:

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

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

IMPAIRMENT OR LOSS OF SPEECH OR HEARING:

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

OUTPATIENT CONTRACEPTIVE SERVICES AND DEVICES:

Covered Services incurred for 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;
2. Any charges exceeding the Allowable Amount or Maximum Allowable 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. 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;
13. 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;
14. Breast reduction or augmentation, or complications arising there from, unless necessary in connection with breast reconstructive Surgery following a mastectomy;
15. Modification of the physical body in order to improve the psychological, mental or emotional well-being of the Insured Person, such as but not limited to sex-change Surgery;
16. Marriage, family, or child counseling for the treatment of premarital, marriage, family or child relationship dysfunctions;
17. Directly or indirectly engaging in an illegal occupation or illegal activity;
18. Care in a nursing home, custodial institution or domiciliary care or rest cures;
19. Preparation and presentation of medical reports for appearance at trials or hearings;
20. Physical examinations required for school events, sports, camp, employment, licensing and insurance, unless otherwise stated herein;
21. Immunizations required for the sole purpose of travel outside of the U.S.A.;
22. Payment for care for military service connected disabilities for which the Insured Person is legally entitled to services and for which facilities are reasonably available to the Insured Person and payment for care for conditions that state or local law requires be treated in a public facility;
23. Experimental or Investigative medical, surgical or other health care procedures, treatments, products or services, unless otherwise stated herein;
24. Personal comfort items, such as television, telephone, lotions, shampoos, etc.;
25. Cosmetic Surgery, or complications arising there from, unless otherwise stated herein;
26. Dental Care, treatment or Surgery unless necessitated by Injury to sound natural teeth which occurs while insured under this Policy. (The expense must be incurred within one year from the date of Injury);
27. Corrective vision or hearing supplies or for the examination for prescribing or fitting such supplies;
28. The removal of warts, corns, calluses, the cutting and trimming of toenails, care for flat feet, fallen arches or chronic foot strain;
29. Expenses incurred for prescription drugs, except if added by Rider;
30. Normal pregnancy, except for Complications of Pregnancy, except benefits added by Rider; and
31. 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.

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 the Policy. No other person will have the authority to bind Us in any manner. No agent may accept risks, alter or amend coverage or waive any provisions of the Policy. Any change in the Policy will be made by an amendment approved and signed by Us. Such amendment will not require the consent of any Insured Person.

Notice of Claim

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

Claim Forms

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

Proof of Loss

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

Claim Payments

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

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

Assignment of Claim Payments

Payment for services provided by the 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.

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

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

THE 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 (01/09) 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 Covered Services; including services, supplies, care or treatment as described in the Policy, which are performed, prescribed, directed, or authorized by a Network Provider. Unless otherwise stated within the Policy, all Covered Services are subject to: a) Facility Fees and/or Copayments; b) the Allowable Amount, Maximum Allowable Amount, Calendar Year, and Lifetime Maximum Amounts; c) the chosen Deductible; d) the chosen Network / Non-Network Provider Coinsurance; and e) the Exclusions and Limitations of the Policy.

3. **BENEFITS -** For the purpose of this Outline of Coverage:
"Insured Person" means You and Your Covered Dependents who are covered under the Policy.

"Allowable Amount" means the Provider charge that is considered for Covered Services under the Policy and any attached Riders after the application of the Facility Fee and Copayment, if any. The Allowable Amount is subject to the Deductibles, Network / Non-Network Coinsurance levels, and the Calendar Year and Lifetime Maximum Amounts.

"Maximum Allowable Amount" means the maximum dollar amount that will be considered as an Allowable Amount for a Covered Service under the Policy and any attached Riders.

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. Benefits for Covered Services are based on the Allowable Amount. When Covered Services are received from a Non-Network Provider, the Allowable Amount may be less than the Allowable Amount that would have otherwise been considered for Covered Services received from a Network Provider. When You utilize a Non-Network Provider, You are responsible for any balance due between the Non-Network Providers charge and the Allowable Amount.

To be a Covered Service, the service, supply or treatment must be a) Medically Necessary and/or specifically included as a Covered Service under the Policy; b) within the scope of the license of the Provider performing the service; c) rendered while coverage under the Policy is in force and for which the Insured Person is legally obligated to pay; and d) not considered Experimental / Investigative or otherwise excluded / limited under the Policy.

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

SELECT ☐	[OPTION A]	SELECT ☐	[OPTION B]	SELECT ☐	[OPTION C]
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 ☐ [OPTION A]	PPO	NON-PPO	SELECT ☐ [OPTION B]	PPO	NON-PPO	SELECT ☐ [OPTION C]	PPO	NON-PPO
	80%	50%		90%	60%		100%	70%

CALENDAR YEAR DEDUCTIBLE (per Insured Person / per Family):

SELECT ☐ [OPTION A]	PPO	NON-PPO
Per Insured Person:	$2,500	$5,000
Per Family:	$5,000	$10,000

SELECT ☐ [OPTION B]	PPO	NON-PPO
Per Insured Person:	$5,000	$10,000
Per Family:	$10,000	$20,000

SELECT ☐ [OPTION C]	PPO	NON-PPO
Per Insured Person:	$7,500	$15,000
Per Family:	$15,000	$30,000

SELECT ☐ [OPTION D]	PPO	NON-PPO
Per Insured Person:	$10,000	$20,000
Per Family:	$20,000	$40,000

SELECT ☐ [OPTION E]	PPO	NON-PPO
Per Insured Person:	$15,000	$30,000
Per Family:	$30,000	$60,000

SELECT ☐ [OPTION F]	PPO	NON-PPO
Per Insured Person:	$20,000	$40,000
Per Family:	$40,000	$80,000

COINSURANCE MAXIMUM (per Calendar Year):

SELECT ☐ [OPTION A]	PPO	NON-PPO
Per Insured Person:	$2,500	$10,000
Per Family:	$5,000	$20,000

SELECT ☐ [OPTION B]	PPO	NON-PPO
Per Insured Person:	$5,000	$10,000
Per Family:	$10,000	$20,000

SELECT ☐ [OPTION C]	PPO	NON-PPO
Per Insured Person:	$10,000	$10,000
Per Family:	$20,000	$20,000

SELECT ☐ [OPTION D]	PPO	NON-PPO
Per Insured Person:	$0	$0
Per Family:	$10,000	$20,000

4. **COVERED SERVICES** – for the purpose of this Outline of Coverage, "Covered Services" means the services, supplies, care or treatment as described in the Policy, which are performed, prescribed, directed, or authorized by a Network Provider. Unless otherwise stated within the Policy, all Covered Services are subject to: a) any Facility Fees and/or Copayments; b) the Allowable Amount, Maximum Allowable Amount, Calendar Year, and Lifetime Maximum Amounts; c) the chosen Deductible; d) the chosen Network / Non-Network Provider Coinsurance; and e) the Exclusions and Limitations of the Policy.

   A charge for a Covered Service is incurred on the date the service, supply or treatment is furnished. Any charges in excess of the Allowable Amount or the Maximum Allowable Amount shown in the Policy Schedule, if any, will **not** be considered a Covered Service.

   INPATIENT 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; 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, x-ray, laboratory, diagnostic tests and services of a radiologist, radiology group, and the services of a pathologist or pathology group for interpretation of diagnostic tests or studies, performed while the Insured Person is Hospital Confined. The fees charged for take home drugs, personal convenience items 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

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. The Allowable Amount is 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 Services 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. 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 Allowable Amount:** [$250,000] per Insured Person, per Transplant Procedure
- **Non-Network Maximum Allowable 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; and 4) diagnostic services including radiology, laboratory or pathology performed at the time of the Surgery.

- 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 amount shown above** (for both Network and Non-Network services).
- **Chosen Deductible amount is waived if Insured is admitted to the Hospital** (for both Network and Non-Network services).
- **Network Facility Fee:** [☐ $0] [☐ $100] [☐ $500] per Insured Person, per visit
- **Non-Network Facility Fee:** [☐ $100] [☐ $500] per Insured Person, per visit

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 amount shown above** (for both Network and Non-Network services).
- **Network Facility Fee:** [☐ $0] [☐ $100] per Insured Person, per visit
- **Non-Network Facility Fee:** [$100] 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 include the Allowable Amount 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.

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

C. 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. 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.

PHYSICIAN SERVICES – OUTPATIENT PHYSICIAN VISITS

A. Outpatient Physician Visits for Sickness or Injury – If elected, Covered Services include Medically Necessary Physician office visits related to a Sickness or Injury, including Physician Consultations and any treatment associated with such Physician's Office visit that is received in the Physician's Office or in a Convenient Care Clinic. Covered Services also include any Medically Necessary laboratory and x-ray services provided and billed by the Physician related to a Sickness or Injury. **Subject to Coinsurance, Deductible, Copayment amounts, and limitations shown below.**

B. Outpatient Preventive Care Physician Visits – If elected, Covered Services include office charges and routine physical examinations, health history and immunizations required for school or travel when received in a Physician's Office or in a Convenient Care Clinic and are not related to a Sickness or Injury. Covered Services will also include any routine laboratory and x-ray services performed in the Physician's Office and billed by the Physician that are not related to a Sickness or Injury. **Subject to Coinsurance, Deductible, Copayment amounts, and limitations shown below.**

C. Well Child Visits – If elected, Covered Services include well child Physician visits for covered Dependent Children from birth up to 24 months of age. Covered Services will also include any routine or preventive laboratory and x-ray services performed in the Physician's Office and billed by the Physician that are not related to a Sickness or Injury. **Subject to Coinsurance, Deductible, Copayment amounts, and limitations shown below.**

SELECT ☐

[OPTION A]	**NETWORK PROVIDER**	**NON-NETWORK PROVIDER**
OUTPATIENT PHYSICIAN OFFICE VISITS FOR SICKNESS OR INJURY		
Coinsurance:	[same as chosen amount shown above]	[same as chosen amount shown above]
Deductible:	[same as chosen amount shown above]	[same as chosen amount shown above]
OUTPATIENT PREVENTIVE CARE PHYSICIAN VISITS (other than Well Child Visits)		
Coinsurance:	[same as chosen amount shown above]	[same as chosen amount shown above]
Deductible:	[same as chosen amount shown above]	[same as chosen amount shown above]
Visit limitations:	[1] per Insured Person, per Calendar Year	
WELL CHILD VISITS (for Covered Dependent children from birth up to 24 months of age)		
Coinsurance:	[same as chosen amount shown above]	[same as chosen amount shown above]
Deductible:	[same as chosen amount shown above]	[same as chosen amount shown above]

SELECT ☐

[OPTION B]	**NETWORK PROVIDER**	**NON-NETWORK PROVIDER**
OUTPATIENT PHYSICIAN OFFICE VISITS FOR SICKNESS OR INJURY		
Coinsurance:	[100%]	[70%]
Deductible:	[waived]	[same as chosen amount shown above]
Visit limitations:	[☐ 2] [☐ 4] per Insured Person, per Calendar Year	
Physician Home and Office Copayment:	[$50] per Insured person, per visit	[waived]
Convenient Care Clinic Copayment:	[$25] per Insured person, per visit	[waived]
OUTPATIENT PREVENTIVE CARE PHYSICIAN VISITS (other than Well Child Visits)		
Coinsurance:	[100%]	[70%]
Deductible:	[waived]	[same as chosen amount shown above]
Copayment:	[$50] per Insured person, per visit	[waived]
Visit limitations:	[1] per Insured Person, per Calendar Year	
WELL CHILD VISITS (for Covered Dependent children from birth up to 24 months of age)		
Coinsurance:	[100%]	[70%]
Deductible:	[waived]	[same as chosen amount shown above]
Copayment:	[$50] per Insured person, per visit	[waived]

SELECT ☐
[OPTION C]

	NETWORK PROVIDER	NON-NETWORK PROVIDER
OUTPATIENT PHYSICIAN OFFICE VISITS FOR SICKNESS OR INJURY		
Coinsurance:	[100%]	[70%]
Deductible:	[waived]	[same as chosen amount shown above]
Physician Home and Office Copayment:	[$50] per Insured person, per visit	[waived]
Convenient Care Clinic Copayment:	[$25] per Insured person, per visit	[waived]
OUTPATIENT PREVENTIVE CARE PHYSICIAN VISITS (other than Well Child Visits)		
Coinsurance:	[100%]	[70%]
Deductible:	[waived]	[same as chosen amount shown above]
Copayment:	[$50] per Insured person, per visit	[waived]
Visit limitations:	[1] per Insured Person, per Calendar Year	
WELL CHILD VISITS (for Covered Dependent children from birth up to 24 months of age)		
Coinsurance:	[100%]	[70%]
Deductible:	[waived]	[same as chosen amount shown above]
Copayment:	[$50] per Insured person, per visit	[waived]

SELECT ☐
[OPTION D]

OUTPATIENT PHYSICIAN OFFICE VISITS FOR SICKNESS OR INJURY – NOT COVERED

OUTPATIENT PREVENTIVE CARE PHYSICIAN VISITS (other than Well Child Visits) – NOT COVERED

WELL CHILD VISITS (for Covered Dependent children from birth up to 24 months of age) – NOT COVERED

PREVENTIVE IMAGING SCREENING TESTS

A. 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: a) the American College of Obstetricians and Gynecologists; or b) another similar national organization of medical professionals recognized by the Commissioner.

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

B. 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.

C. 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.

D. 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.

RECONSTRUCTIVE SURGERY IN CONNECTION WITH A MASTECTOMY

Covered Services include services and supplies provided for reconstructive Surgery in connection with a Mastectomy. The reconstructive Surgery will be provided in a manner determined to be appropriate in Consultation with the attending Physician and the Insured Person, and will include: 1) reconstruction of the breast on which the mastectomy has been performed; 2) Surgery and reconstruction of the other breast to achieve a symmetrical appearance; and 3) prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.

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

COMPLICATIONS OF PREGNANCY

Covered Services include treatment of Complications of Pregnancy while Hospital Confined or in an Outpatient Surgery Facility (when the pregnancy is not terminated).

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

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.

CHEMOTHERAPY

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

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

RADIATION THERAPY

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

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

OUTPATIENT DIAGNOSTIC SERVICES

Covered Services include outpatient diagnostic services performed in a free-standing diagnostic center or Hospital (other than Hospital emergency room) for diagnostic x-rays and interpretation charges, and laboratory and pathological examinations received while not Confined to a Hospital and that are related to and necessary for the diagnosis and treatment of the Sickness or Injury. [Covered Services include but are not limited to CAT Scans, Magnetic Resonance Imaging (MRI), PET Scans, SPECT scans; Nuclear Medicine Imaging; Sleep studies; Mammogram, Upper/Lower G.I. Series, Electrocardiogram (EKG), Blood or serum analysis, Angiogram and Stress Tests.] Covered Services include Central Supply (IV tubing) or pharmacy (dye) necessary to perform the tests. Covered Services under this provision do not include routine physical examinations or checkups, and laboratory and x-ray services provided in and billed by a Hospital emergency room, Urgent Care Center or Physician's office.

A. CAT, MRI and/or PET Scans –

	NETWORK PROVIDER	NON-NETWORK PROVIDER
Coinsurance:	[same as chosen amount shown above]	[same as chosen amount shown above]
Deductible:	[same as chosen amount shown above]	[same as chosen amount shown above]
[Facility Fee:	[☐ $0] [☐ $150] [☐ $250] per Insured Person, per visit	[☐ $0] [☐ $150] [☐ $250] per Insured Person, per visit ***]***
Maximum Allowable Amount: [☐ $2,500] [☐ $5,000] per Insured Person, per Calendar Year		

B. All Other Outpatient Diagnostic Services –

	NETWORK PROVIDER	NON-NETWORK PROVIDER
Coinsurance:	[same as chosen amount shown above]	[same as chosen amount shown above]
Deductible:	[same as chosen amount shown above]	[same as chosen amount shown above]
[Facility Fee:	[☐ $0] [☐ $50] [☐ $200] per Insured Person, per visit	[☐ $0] [☐ $50] [☐ $200] per Insured Person, per visit ***]***
Maximum Allowable Amount: [☐ $2,500] [☐ $5,000] per Insured Person, per Calendar Year		

SKILLED NURSING CARE

Covered Services include charges incurred during Confinement in a Skilled Nursing Facility.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.
- **Limited to:** 30 visits per Insured Person, per Calendar Year.

HOME HEALTH CARE

Covered Services include services or supplies furnished by a Home Health Care Agency.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.
- **Limited to:** 30 visits per Insured Person, per Calendar Year.

HOSPICE CARE

Covered Services include the following services and supplies provided by a Hospice in the Insured Person's home or in a Hospice facility for medical, social and psychological services used as palliative treatment for patients with a life expectancy of not more than 6 months: 1) skilled nursing services; 2) diagnostic services; 3) physical, speech and inhalation therapies; 4) medical supplies, equipment and appliances; 5) counseling services for the Insured Person regarding his or her terminal illness; 6) inpatient Confinement at a Hospice Facility; and 7) prescription drugs obtained from the Hospice.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.
- **Maximum Allowable Amount:** $5,000 per Insured Person, per lifetime.

PRIVATE DUTY NURSING

Covered Services include the services of a Private Duty Nurse.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.
- **Limited to**: 30 shifts per Insured Person, per Calendar Year.

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 amounts shown above.
- **Maximum Allowable 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).
- **Ground Ambulance Maximum Allowable Amount:** $500 per Insured Person, per trip.
- **Air / Water Ambulance Maximum Allowable Amount:** $5,000 per Insured Person, per trip.
- **Benefit only payable when Hospital Confined.**

THERAPY SERVICES

Covered Services include Speech Therapy, Physical Therapy, Occupational Therapy and Cardiac Rehabilitation (Phase I and II) that is related to and Medically Necessary for the treatment of a Sickness or Injury.

	NETWORK PROVIDER	NON-NETWORK PROVIDER
Coinsurance:	[same as chosen amount shown above]	[same as chosen amount shown above]
Deductible:	[same as chosen amount shown above]	[same as chosen amount shown above]
[Facility Fee:	$50 per Insured Person, per visit	$50 per Insured Person, per visit ***]***
Visit Limitations:	[40 combined] for all therapies per Insured Person, per Calendar Year	

MUSCULOSKELETAL DISORDERS

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

CHILD HEALTH SUPERVISION SERVICES

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

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

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

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

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

MEDICAL FOODS AND LOW PROTEIN MODIFIED FOOD PRODUCTS

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

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

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

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

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

OUTPATIENT CONTRACEPTIVE SERVICES AND DEVICES
Covered Services incurred for 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.

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.

PRESCRIPTION DRUG RIDER (FORM: CH-26214-IR (01/09)AR)
Rider provides benefits for Legend Prescription Drugs. The Allowable Amount for Legend Prescription Drugs is equal to the actual charge based on Pharmacy prices, subject to the applicable Benefit Payment Rate/Deductible/Copayment shown below. Expenses are considered incurred on the date of Pharmacy service.

SELECT ☐ [PLAN A]	**PHARMACY GENERIC DRUGS (You pay)**	**PHARMACY BRAND NAME DRUGS (You pay)**
Deductible:	$0	[$50]
Preferred Drug Coinsurance:	100%	50%
Preferred Drug Copayment:	$5	$0
Non-Preferred Drug Coinsurance:	100%	25%
Non-Preferred Drug Copayment:	$15	$0
Annual Maximum (We pay):	**[$2,000]**	
	MAIL ORDER VENDOR GENERIC DRUGS (You pay)	**MAIL ORDER VENDOR BRAND NAME DRUGS (You pay)**
Deductible:	$0	[$50]
Preferred Drug Coinsurance:	100%	50%
Preferred Drug Copayment:	$15	$0
Non-Preferred Drug Coinsurance:	100%	25%
Non-Preferred Drug Copayment:	$30	$0
Annual Maximum (We pay):	**[$2,000]**	

SELECT ☐ [PLAN B]	PHARMACY GENERIC DRUGS (You pay)	PHARMACY BRAND NAME DRUGS (You pay)
Deductible:	$0	[$250]
Preferred Drug Coinsurance:	100%	50%
Preferred Drug Copayment:	$5	$0
Non-Preferred Drug Coinsurance:	100%	25%
Non-Preferred Drug Copayment:	$15	$0
Annual Maximum (We pay):	**[$2,000]**	
	MAIL ORDER VENDOR GENERIC DRUGS (You pay)	**MAIL ORDER VENDOR BRAND NAME DRUGS (You pay)**
Deductible:	$0	[$250]
Preferred Drug Coinsurance:	100%	50%
Preferred Drug Copayment:	$15	$0
Non-Preferred Drug Coinsurance:	100%	25%
Non-Preferred Drug Copayment:	$30	$0
Annual Maximum (We pay):	**[$2,000]**	

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 the Policy;
2. Any charges exceeding the Allowable Amount or Maximum Allowable 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 in the Policy;
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 in the Policy;
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. 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 in the Policy;
13. 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;
14. Breast reduction or augmentation, or complications arising there from, unless necessary in connection with breast reconstructive Surgery following a mastectomy;
15. Modification of the physical body in order to improve the psychological, mental or emotional well-being of the Insured Person, such as but not limited to sex-change Surgery;
16. Marriage, family, or child counseling for the treatment of premarital, marriage, family or child relationship dysfunctions;
17. Directly or indirectly engaging in an illegal occupation or illegal activity;
18. Care in a nursing home, custodial institution or domiciliary care or rest cures;
19. Preparation and presentation of medical reports for appearance at trials or hearings;
20. Physical examinations required for school events, sports, camp, employment, licensing and insurance, unless otherwise stated in the Policy;
21. Immunizations required for the sole purpose of travel outside of the U.S.A.;
22. Payment for care for military service connected disabilities for which the Insured Person is legally entitled to services and for which facilities are reasonably available to the Insured Person and payment for care for conditions that state or local law requires be treated in a public facility;
23. Experimental or Investigative medical, surgical or other health care procedures, treatments, products or services, unless otherwise stated in the Policy;
24. Personal comfort items, such as television, telephone, lotions, shampoos, etc.;
25. Cosmetic Surgery, or complications arising there from, unless otherwise stated in the Policy;
26. Dental Care, treatment or Surgery unless necessitated by Injury to sound natural teeth which occurs while insured under in the Policy. (The expense must be incurred within one year from the date of Injury);
27. Corrective vision or hearing supplies or for the examination for prescribing or fitting such supplies;
28. The removal of warts, corns, calluses, the cutting and trimming of toenails, care for flat feet, fallen arches or chronic foot strain;
29. Expenses incurred for prescription drugs, except if added by Rider;
30. Normal pregnancy, except for Complications of Pregnancy, except benefits added by Rider; and
31. 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.

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 (01/09) AR - described above (includes automatic Policy Rider(s), if any):	**$** _____
RIDERS (if any)	
	$
	$
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

H.S.A COMPATIBLE
CATASTROPHIC EXPENSE PREFERRED PROVIDER ORGANIZATION (PPO) POLICY
OUTLINE OF COVERAGE FOR FORM CH-26210 PPO-IP (01/09) 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 Covered Services; including services, supplies, care or treatment as described in the Policy, which are performed, prescribed, directed, or authorized by a Network Provider. Unless otherwise stated within the Policy, all Covered Services are subject to: a) Facility Fees and/or Copayments; b) the Allowable Amount, Maximum Allowable Amount, Calendar Year, and Lifetime Maximum Amounts; c) the chosen Deductible; d) the chosen Network / Non-Network Provider Coinsurance; and e) the Exclusions and Limitations of the Policy.

3. **BENEFITS -** For the purpose of this Outline of Coverage:
"Insured Person" means You and Your Covered Dependents who are covered under the Policy.

"Allowable Amount" means the Provider charge that is considered for Covered Services under the Policy and any attached Riders after the application of the Facility Fee and Copayment, if any. The Allowable Amount is subject to the Deductibles, Network / Non-Network Coinsurance levels, and the Calendar Year and Lifetime Maximum Amounts.

"Maximum Allowable Amount" means the maximum dollar amount that will be considered as an Allowable Amount for a Covered Service under the Policy and any attached Riders.

"Maximum Out-of-Pocket" Amount means the total Allowable Amount of [Network Provider] expenses that must be paid by Insured Persons each Calendar Year for Covered Services, including the [Network Provider] Deductible, [Network Provider] Coinsurance, [Network Provider] Facility Fees and any [Network Provider] Copayments. Once this maximum is met, Covered Services [obtained through a Network Provider] remaining thereafter for the same Calendar Year will be paid at [100%], up to the Maximum Allowable, if any. **Any charges exceeding any Maximum Allowable Amounts and Covered Services obtained through a Non-Network Provider do not count toward meeting the Maximum Out-of-Pocket Amount.**

RULES FOR HEALTH SAVINGS ACCOUNTS:
The Deductible, Maximum Out-of-Pocket Amount, and premium may change if Insured Persons are added to or deleted from coverage under this Policy. The Deductible and Maximum Out-of-Pocket Amount is intended to satisfy government rules applicable to Health Savings Accounts (HSAs). The HSA rules may change annually. Deductible and Maximum Out-of-Pocket Amounts will be adjusted at the beginning of each year to comply with any changes in the HSA rules, when necessary. We will notify You of any changes as soon as reasonably possible

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. Benefits for Covered Services are based on the Allowable Amount. When Covered Services are received from a Non-Network Provider, the Allowable Amount may be less than the Allowable Amount that would have otherwise been considered for Covered Services received from a Network Provider. When You utilize a Non-Network Provider, You are responsible for any balance due between the Non-Network Providers charge and the Allowable Amount.

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. Benefits for Covered Services are based on the Allowable Amount. When Covered Services are received from a Non-Network Provider, the Allowable Amount may be less than the Allowable Amount that would have otherwise been considered for Covered Services received from a Network Provider. When You utilize a Non-Network Provider, You are responsible for any balance due between the Non-Network Providers charge and the Allowable Amount.

To be a Covered Service, the service, supply or treatment must be a) Medically Necessary and/or specifically included as a Covered Service under the Policy; b) within the scope of the license of the Provider performing the service; c) rendered while coverage under the Policy is in force and for which the Insured Person is legally obligated to pay; and d) not considered Experimental / Investigative or otherwise excluded / limited under the Policy.

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

SELECT ☐	**[OPTION A]**		**SELECT ☐**	**[OPTION B]**		**SELECT ☐**	**[OPTION C]**
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 ☐ [OPTION A]	**PPO**	**NON-PPO**		**SELECT ☐ [OPTION B]**	**PPO**	**NON-PPO**		**SELECT ☐ [OPTION C]**	**PPO**	**NON-PPO**
	80%	50%			90%	60%			100%	70%

CALENDAR YEAR DEDUCTIBLE (per Individual / per Family):

	NETWORK PROVIDER	**NON-NETWORK PROVIDER**
Individual:	[$5,800]	[$11,600]
Family:	[$11,600]	[$23,200]

MAXIMUM OUT-OF-POCKET AMOUNT (per Calendar Year):

	NETWORK PROVIDER	**NON-NETWORK PROVIDER**
Individual:	[$5,800]	[Not Applicable]
Family:	[$11,600]	[Not Applicable]

4. **COVERED SERVICES** – for the purpose of this Outline of Coverage, "Covered Services" means the services, supplies, care or treatment as described in the Policy, which are performed, prescribed, directed, or authorized by a Network Provider. Unless otherwise stated within the Policy, all Covered Services are subject to: a) any Facility Fees and/or Copayments; b) the Allowable Amount, Maximum Allowable Amount, Calendar Year, and Lifetime Maximum Amounts; c) the chosen Deductible; d) the chosen Network / Non-Network Provider Coinsurance; and e) the Exclusions and Limitations of the Policy.

A charge for a Covered Service is incurred on the date the service, supply or treatment is furnished. Any charges in excess of the Allowable Amount or the Maximum Allowable Amount shown in the Policy Schedule, if any, will **not** be considered a Covered Service.

INPATIENT 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; 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, x-ray, laboratory, diagnostic tests and services of a radiologist, radiology group, and the services of a pathologist or pathology group for

interpretation of diagnostic tests or studies, performed while the Insured Person is Hospital Confined. The fees charged for take home drugs, personal convenience items 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

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. The Allowable Amount is 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 Services 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. 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 Allowable Amount:** [$250,000] per Insured Person, per Transplant Procedure
- **Non-Network Maximum Allowable 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; and 4) diagnostic services including radiology, laboratory or pathology performed at the time of the Surgery.

- 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 amount shown above** (for both Network and Non-Network services).
- **Chosen Deductible amount is waived if Insured is admitted to the Hospital** (for both Network and Non-Network services).

- **Network Facility Fee:** [☐ $0] [☐ $100] [☐ $500] per Insured Person, per visit
- **Non-Network Facility Fee:** [☐ $100] [☐ $500] per Insured Person, per visit

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 amount shown above** (for both Network and Non-Network services).
- **Network Facility Fee:** [☐ $0] [☐ $100] per Insured Person, per visit
- **Non-Network Facility Fee:** [$100] 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 include the Allowable Amount 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.
- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.

C. 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. 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.

PHYSICIAN SERVICES – OUTPATIENT PHYSICIAN VISITS

A. Outpatient Physician Visits for Sickness or Injury – If elected, Covered Services include Medically Necessary Physician office visits related to a Sickness or Injury, including Physician Consultations and any treatment associated with such Physician's Office visit that is received in the Physician's Office or in a Convenient Care Clinic. Covered Services also include any Medically Necessary laboratory and x-ray services provided and billed by the Physician related to a Sickness or Injury. **Subject to Coinsurance, Deductible, Copayment amounts, and limitations shown below.**

B. Outpatient Preventive Care Physician Visits – If elected, Covered Services include office charges and routine physical examinations, health history and immunizations required for school or travel when received in a Physician's Office or in a Convenient Care Clinic and are not related to a Sickness or Injury. Covered Services will also include any routine laboratory and x-ray services performed in the Physician's Office and billed by the Physician that are not related to a Sickness or Injury. **Subject to Coinsurance, Deductible, Copayment amounts, and limitations shown below.**

C. Well Child Visits – If elected, Covered Services include well child Physician visits for covered Dependent Children from birth up to 24 months of age. Covered Services will also include any routine or preventive laboratory and x-ray services performed in the Physician's Office and billed by the Physician that are not related to a Sickness or Injury. **Subject to Coinsurance, Deductible, Copayment amounts, and limitations shown below.**

SELECT ☐
[OPTION A]

	NETWORK PROVIDER	NON-NETWORK PROVIDER
OUTPATIENT PHYSICIAN OFFICE VISITS FOR SICKNESS OR INJURY		
Coinsurance:	[same as chosen amount shown above]	[same as chosen amount shown above]
Deductible:	[same as chosen amount shown above]	[same as chosen amount shown above]
OUTPATIENT PREVENTIVE CARE PHYSICIAN VISITS (other than Well Child Visits)		
Coinsurance:	[same as chosen amount shown above]	[same as chosen amount shown above]
Deductible:	[same as chosen amount shown above]	[same as chosen amount shown above]
Visit limitations:	[1] per Insured Person, per Calendar Year	
WELL CHILD VISITS (for Covered Dependent children from birth up to 24 months of age)		
Coinsurance:	[same as chosen amount shown above]	[same as chosen amount shown above]
Deductible:	[same as chosen amount shown above]	[same as chosen amount shown above]

SELECT ☐
[OPTION B]

	NETWORK PROVIDER	NON-NETWORK PROVIDER
OUTPATIENT PHYSICIAN OFFICE VISITS FOR SICKNESS OR INJURY		
Coinsurance:	[same as chosen amount shown above]	[same as chosen amount shown above]
Deductible:	[same as chosen amount shown above]	[same as chosen amount shown above]
OUTPATIENT PREVENTIVE CARE PHYSICIAN VISITS (other than Well Child Visits)		
Coinsurance:	[100%]	[70%]
Deductible:	[waived]	[same as chosen amount shown above]
Copayment:	[$50] per Insured person, per visit	[waived]
Visit limitations:	[1] per Insured Person, per Calendar Year	
WELL CHILD VISITS (for Covered Dependent children from birth up to 24 months of age)		
Coinsurance:	[100%]	[70%]
Deductible:	[waived]	[same as chosen amount shown above]
Copayment:	[$50] per Insured person, per visit	[waived]

SELECT ☐
[OPTION C]

OUTPATIENT PHYSICIAN OFFICE VISITS FOR SICKNESS OR INJURY – NOT COVERED

OUTPATIENT PREVENTIVE CARE PHYSICIAN VISITS (other than Well Child Visits) – NOT COVERED

WELL CHILD VISITS (for Covered Dependent children from birth up to 24 months of age) – NOT COVERED

PREVENTIVE IMAGING SCREENING TESTS

A. 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: a) the American College of Obstetricians and Gynecologists; or b) another similar national organization of medical professionals recognized by the Commissioner.

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

B. 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.

C. 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.

D. 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.

RECONSTRUCTIVE SURGERY IN CONNECTION WITH A MASTECTOMY

Covered Services include services and supplies provided for reconstructive Surgery in connection with a Mastectomy. The reconstructive Surgery will be provided in a manner determined to be appropriate in Consultation with the attending Physician and the Insured Person, and will include: 1) reconstruction of the breast on which the mastectomy has been performed; 2) Surgery and reconstruction of the other breast to achieve a symmetrical appearance; and 3) prostheses and treatment of physical complications, including lymphedemas, at all stages of mastectomy.

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

COMPLICATIONS OF PREGNANCY

Covered Services include treatment of Complications of Pregnancy while Hospital Confined or in an Outpatient Surgery Facility (when the pregnancy is not terminated).

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

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.

CHEMOTHERAPY

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

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

RADIATION THERAPY

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

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

OUTPATIENT DIAGNOSTIC SERVICES

Covered Services include outpatient diagnostic services performed in a free-standing diagnostic center or Hospital (other than Hospital emergency room) for diagnostic x-rays and interpretation charges, and laboratory and pathological examinations received while not Confined to a Hospital and that are related to and necessary for the diagnosis and treatment of the Sickness or Injury. [Covered Services include but are not limited to CAT Scans, Magnetic Resonance Imaging (MRI), PET Scans, SPECT scans; Nuclear Medicine Imaging; Sleep studies; Mammogram, Upper/Lower G.I. Series, Electrocardiogram (EKG), Blood or serum analysis, Angiogram and Stress Tests.] Covered Services include Central Supply (IV tubing) or pharmacy (dye) necessary to perform the tests. Covered Services under this provision do not include routine physical examinations or checkups, and laboratory and x-ray services provided in and billed by a Hospital emergency room, Urgent Care Center or Physician's office.

A. CAT, MRI and/or PET Scans –

	NETWORK PROVIDER	NON-NETWORK PROVIDER
Coinsurance:	[same as chosen amount shown above]	[same as chosen amount shown above]
Deductible:	[same as chosen amount shown above]	[same as chosen amount shown above]
[Facility Fee:	[☐ $0] [☐ $150] [☐ $250] per Insured Person, per visit	[☐ $0] [☐ $150] [☐ $250] per Insured Person, per visit ***]***
Maximum Allowable Amount: [☐ $2,500] [☐ $5,000] per Insured Person, per Calendar Year		

B. All Other Outpatient Diagnostic Services –

	NETWORK PROVIDER	NON-NETWORK PROVIDER
Coinsurance:	[same as chosen amount shown above]	[same as chosen amount shown above]
Deductible:	[same as chosen amount shown above]	[same as chosen amount shown above]
[Facility Fee:	[☐ $0] [☐ $50] [☐ $200] per Insured Person, per visit	[☐ $0] [☐ $50] [☐ $200] per Insured Person, per visit ***]***
Maximum Allowable Amount: [☐ $2,500] [☐ $5,000] per Insured Person, per Calendar Year		

SKILLED NURSING CARE

Covered Services include charges incurred during Confinement in a Skilled Nursing Facility.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.
- **Limited to:** 30 visits per Insured Person, per Calendar Year.

HOME HEALTH CARE

Covered Services include services or supplies furnished by a Home Health Care Agency.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.
- **Limited to:** 30 visits per Insured Person, per Calendar Year.

HOSPICE CARE

Covered Services include the following services and supplies provided by a Hospice in the Insured Person's home or in a Hospice facility for medical, social and psychological services used as palliative treatment for patients with a life expectancy of not more than 6 months: 1) skilled nursing services; 2) diagnostic services; 3) physical, speech and inhalation therapies; 4) medical supplies, equipment and appliances; 5) counseling services for the Insured Person regarding his or her terminal illness; 6) inpatient Confinement at a Hospice Facility; and 7) prescription drugs obtained from the Hospice.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.
- **Maximum Allowable Amount:** $5,000 per Insured Person, per lifetime.

PRIVATE DUTY NURSING

Covered Services include the services of a Private Duty Nurse.

- Subject to chosen Network / Non-Network Deductible and Coinsurance amounts shown above.
- **Limited to**: 30 shifts per Insured Person, per Calendar Year.

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 amounts shown above.
- **Maximum Allowable 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).
- **Ground Ambulance Maximum Allowable Amount:** $500 per Insured Person, per trip.
- **Air / Water Ambulance Maximum Allowable Amount:** $5,000 per Insured Person, per trip.
- **Benefit only payable when Hospital Confined.**

THERAPY SERVICES

Covered Services include Speech Therapy, Physical Therapy, Occupational Therapy and Cardiac Rehabilitation (Phase I and II) that is related to and Medically Necessary for the treatment of a Sickness or Injury.

	NETWORK PROVIDER	**NON-NETWORK PROVIDER**
Coinsurance:	[same as chosen amount shown above]	[same as chosen amount shown above]
Deductible:	[same as chosen amount shown above]	[same as chosen amount shown above]
[Facility Fee:	$50 per Insured Person, per visit	$50 per Insured Person, per visit ***]***
Visit Limitations:	[40 combined] for all therapies per Insured Person, per Calendar Year	

MUSCULOSKELETAL DISORDERS

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

CHILD HEALTH SUPERVISION SERVICES

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

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

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

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

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

MEDICAL FOODS AND LOW PROTEIN MODIFIED FOOD PRODUCTS

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

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

DIABETES

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

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

IMPAIRMENT OR LOSS OF SPEECH OR HEARING

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

OUTPATIENT CONTRACEPTIVE SERVICES AND DEVICES

Covered Services incurred for 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.

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.

PRESCRIPTION DRUG RIDER (FORM: CH-26214-IR (01/09) AR)

Rider provides benefits for Legend Prescription Drugs. The Allowable Amount for Legend Prescription Drugs is equal to the actual charge based on Pharmacy prices, subject to the applicable Benefit Payment Rate/Deductible/Copayment shown below. Expenses are considered incurred on the date of Pharmacy service.

SELECT ☐ [PLAN A]	**PHARMACY GENERIC DRUGS (You pay)**	**PHARMACY BRAND NAME DRUGS (You pay)**
Deductible:	$0	[$50]
Preferred Drug Coinsurance:	100%	50%
Preferred Drug Copayment:	$5	$0
Non-Preferred Drug Coinsurance:	100%	25%
Non-Preferred Drug Copayment:	$15	$0
Annual Maximum (We pay):	**[$2,000]**	
	MAIL ORDER VENDOR GENERIC DRUGS (You pay)	**MAIL ORDER VENDOR BRAND NAME DRUGS (You pay)**
Deductible:	$0	[$50]
Preferred Drug Coinsurance:	100%	50%
Preferred Drug Copayment:	$15	$0
Non-Preferred Drug Coinsurance:	100%	25%
Non-Preferred Drug Copayment:	$30	$0
Annual Maximum (We pay):	**[$2,000]**	

SELECT ☐ [PLAN B]	**PHARMACY GENERIC DRUGS (You pay)**	**PHARMACY BRAND NAME DRUGS (You pay)**
Deductible:	$0	[$250]
Preferred Drug Coinsurance:	100%	50%
Preferred Drug Copayment:	$5	$0
Non-Preferred Drug Coinsurance:	100%	25%
Non-Preferred Drug Copayment:	$15	$0
Annual Maximum (We pay):	**[$2,000]**	
	MAIL ORDER VENDOR GENERIC DRUGS (You pay)	**MAIL ORDER VENDOR BRAND NAME DRUGS (You pay)**
Deductible:	$0	[$250]
Preferred Drug Coinsurance:	100%	50%
Preferred Drug Copayment:	$15	$0
Non-Preferred Drug Coinsurance:	100%	25%
Non-Preferred Drug Copayment:	$30	$0
Annual Maximum (We pay):	**[$2,000]**	

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 the Policy;
2. Any charges exceeding the Allowable Amount or Maximum Allowable 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 in the Policy;
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 in the Policy;
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. 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 in the Policy;
13. 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;
14. Breast reduction or augmentation, or complications arising there from, unless necessary in connection with breast reconstructive Surgery following a mastectomy;
15. Modification of the physical body in order to improve the psychological, mental or emotional well-being of the Insured Person, such as but not limited to sex-change Surgery;
16. Marriage, family, or child counseling for the treatment of premarital, marriage, family or child relationship dysfunctions;
17. Directly or indirectly engaging in an illegal occupation or illegal activity;
18. Care in a nursing home, custodial institution or domiciliary care or rest cures;
19. Preparation and presentation of medical reports for appearance at trials or hearings;
20. Physical examinations required for school events, sports, camp, employment, licensing and insurance, unless otherwise stated in the Policy;
21. Immunizations required for the sole purpose of travel outside of the U.S.A.;
22. Payment for care for military service connected disabilities for which the Insured Person is legally entitled to services and for which facilities are reasonably available to the Insured Person and payment for care for conditions that state or local law requires be treated in a public facility;
23. Experimental or Investigative medical, surgical or other health care procedures, treatments, products or services, unless otherwise stated in the Policy;
24. Personal comfort items, such as television, telephone, lotions, shampoos, etc.;
25. Cosmetic Surgery, or complications arising there from, unless otherwise stated in the Policy;
26. Dental Care, treatment or Surgery unless necessitated by Injury to sound natural teeth which occurs while insured under in the Policy. (The expense must be incurred within one year from the date of Injury);
27. Corrective vision or hearing supplies or for the examination for prescribing or fitting such supplies;
28. The removal of warts, corns, calluses, the cutting and trimming of toenails, care for flat feet, fallen arches or chronic foot strain;
29. Expenses incurred for prescription drugs, except if added by Rider;
30. Normal pregnancy, except for Complications of Pregnancy, except benefits added by Rider; and
31. 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.

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 (01/09) AR - described above (includes automatic Policy Rider(s), if any):	**$** _____
RIDERS (if any)	
	$
	$
TOTAL	**$**