Filing at a Glance

Company: Freedom Life Insurance Company of America

Product Name: USHG-2009-AR-FLIC	SERFF Tr Num: USHG-126216548	State: Arkansas
TOI: H16G Group Health - Major Medical	SERFF Status: Closed-Approved-Closed	State Tr Num: 42820
Sub-TOI: H16G.002A Large Group Only - PPO	Co Tr Num: USHG-2009-C-AR-FLIC	State Status: Approved-Closed
Filing Type: Form		Reviewer(s): Rosalind Minor
	Author: Shari McBride	Disposition Date: 08/18/2009
	Date Submitted: 07/06/2009	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name:
Project Number:
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 08/18/2009

Deemer Date:
Submitted By: Shari McBride
PPACA: Pre-PPACA Submission
Filing Description:
July 6, 2009

The Honorable Jay Bradford
Life and Health Division
Department of Insurance
1200 West 3rd Street
Little Rock, AR 72201-1904

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments: Filed concurrently.
Market Type: Group
Group Market Size: Large
Group Market Type: Association
Explanation for Other Group Market Type:
State Status Changed: 08/18/2009
Created By: Shari McBride
Corresponding Filing Tracking Number:

RE: Freedom Life Insurance Company of America
NAIC 62324 FEIN #61-1096685
New Submission

Forms – Product 1
USHG-2009-C-AR-FLIC Medical Surgical Expense Plan Certificate

PREVIOUSLY APROVED FORMS:
APP–FI-FLIC Application Family Information Page
APP-CS-FLIC Application Coverage Selection Page
APP-MH-FLIC Application Medical History Page
APP-NOARBNOTE-FLIC Application Notices Page
APP-AA-AR-FLIC Acknowledgements and Authorizations Page
GRP-P-06-FLIC Group Policy
GRP-SA-06-AR-FLIC Group Policy Supplemental Application

APP-09-NOARB-FLIC Application

Previously Approved Riders
GBMAT-06-OR-AR-FLIC Optional Maternity Rider
WAIVER-C-OR-FLIC Waiver of Renewal Premium During First Renewal Premium Rate Guaranteed Period Upon Death or Total Disability of Primary Insured
ALDDR-06-OR-AR-FLIC Optional Alcohol and Drug Dependency Rider -
LISH-06-OR-AR-FLIC Optional Loss or Impairment of Speech and Hearing Rider -
MED-06-0R-AR-FLIC Optional Mental or Emotional Disorders and Licensed Professional Counselors Rider -
MSD-06-OR-AR-FLIC Optional Musculoskeletal Disorder Rider
HA-OR-AR-FLIC Optional Hearing Aids Rider

Forms Previously Filed Exempt
GRP-APP-FLIC

Dear Commissioner Bradford:

Enclosed is the referenced form for your review and approval. The form is new and not intended to replace any forms

previously approved or filed with your Department. The form provides medical-surgical expenses on an inpatient and outpatient basis, subject to the provisions and limitations set forth therein. Benefits are provided for both participating and non-participating providers.

This form is substantially similar to form USHG-2007-C-AR-FLIC which was approved by your Department on 2/20/2007 state tracking # 35046. The major difference from the previous form is adding a Calendar Year Adult Wellness Maximum benefit

The group master policy, form GRP-P-06-FLIC, will be issued to any of the associations previously approved or that will be filed or approved in the future. The association and approval dates follow.

American Business Association- previously approved March 2, 2007.
Consumers Independent Association –previously approved February 24, 2007
Heartland Alliance of America – Previously approved September 20, 2006
Small Business Association – Previously approved January 9, 2007.

Please be advised these products are not employer/employee based. We are offering the products to individuals through the association. The products are fully underwritten on an individual basis. A certificate of insurance will be issued to members of the association to evidence coverage under the group policy.

All numbers (excluding form numbers) are variable. Numbers within a provision determined by the laws of the governing jurisdiction will be varied only within the confines of the law. Paragraphs and Definitions may vary to the extent that such paragraphs and definitions may be included, omitted or transferred to another page to suit the needs of a particular policyholder subject to: (a) any statutory or regulatory requirements; and (b) the condition that the language and benefit be within the intent and framework of the particular provisions. Additionally, there will also be items that customarily vary according to the certificateholder's specific plan of insurance. The schedule pages of the certificate and selection page of the application are variable.

We also reserve the right to amend the referenced forms to correct any minor typographical errors we may have neglected to find prior to submitting for approval, and to amend the language in order to clarify the intent within the confines of the law.

The appropriate transmittal documents are enclosed.

Your consideration of this filing is greatly appreciated. Should you have any questions, please contact me via mcbrides@ushealthgroup.com by telephone at (800) 387-9027, ext.422, or fax (817) 878-3810.

Sincerely,

Shari McBride, FLMI
Product Analyst
Product Development

Company and Contact

Filing Contact Information

Shari McBride, Product Analyst	mcbrides@ushealthgroup.com
801 Cherry Street, Unit 33	800-221-9039 [Phone] 422 [Ext]
Fort Worth, TX 76102	817-878-3422 [FAX]

Filing Company Information

Freedom Life Insurance Company of America	CoCode: 62324	State of Domicile: Texas
3100 Burnett Plaza	Group Code: 839	Company Type: Accident, Life and Health
801 Cherry Street, Unit 33	Group Name:	State ID Number:
Fort Worth, TX 76102	FEIN Number: 61-1096685	
(817) 878-3328 ext. [Phone]		

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	Yes
Fee Explanation:	Texas form filings are $50.
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Freedom Life Insurance Company of America	$50.00	07/06/2009	28983666

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	08/18/2009	08/18/2009

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	08/13/2009	08/13/2009	Shari McBride	08/17/2009	08/17/2009
Pending Industry Response	Rosalind Minor	07/13/2009	07/13/2009	Shari McBride	08/12/2009	08/12/2009
Pending Industry Response	Rosalind Minor	07/09/2009	07/09/2009			

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	USHG-2009-C-AR-FLIC	Shari McBride	07/13/2009	07/13/2009

Disposition

Disposition Date: 08/18/2009

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*USHG-126216548*	*State:*	*Arkansas*
Filing Company:	*Freedom Life Insurance Company of America*	*State Tracking Number:*	*42820*
Company Tracking Number:	*USHG-2009-C-AR-FLIC*		
TOI:	*H16G Group Health - Major Medical*	*Sub-TOI:*	*H16G.002A Large Group Only - PPO*
Product Name:	*USHG-2009-AR-FLIC*		
Project Name/Number:	*/*		

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Form *(revised)*	USHG-2009-C-AR-FLIC	Approved-Closed	Yes
Form	USHG-2009-C-AR-FLIC		Yes
Form	USHG-2009-C-AR-FLIC		Yes
Form	USHG-2009-C-AR-FLIC		Yes
Form	Mammography Rider	Approved-Closed	Yes

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	08/13/2009
Submitted Date	08/13/2009
Respond By Date	

Dear Shari McBride,

This will acknowledge receipt of the captioned filing.

Objection 1

- USHG-2009-C-AR-FLIC, USGH-2009-C-AR-FLIC (Form)

Comment:

You stated in your response that you added a 12 month wait for mammography screening. This limitation does not comply with our mandated offering as outlined under ACA 23-79-140.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	08/17/2009
Submitted Date	08/17/2009

Dear Rosalind Minor,

Comments:
Thank you for your prompt review and response.

Response 1

Comments: We are submitting form MAM-09-OR-AR-FLIC that will comply with the mandated offering under ACA 23-79-140.

Note: We have moved the Childhood Wellness and Screening from the Miscellaneous Benefit section into the Wellness and Screening section since this benefit can be applied to deductibles and coinsurance.

Related Objection 1

Applies To:

- USHG-2009-C-AR-FLIC, USGH-2009-C-AR-FLIC (Form)

Comment:

You stated in your response that you added a 12 month wait for mammography screening. This limitation does not comply with our mandated offering as outlined under ACA 23-79-140.

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
USHG-2009-C-AR-FLIC	USGH-2009-C-		Certificate	Initial		43.000	USHG-2009-C-

	AR-FLIC				AR-FLIC.pdf
Previous Version					
USHG-2009-C-AR-FLIC	*USGH-2009-C-AR-FLIC*	*Certificate*	*Initial*	*43.000*	USHG-2009-C-AR-FLIC.pdf
USHG-2009-C-AR-FLIC	*USGH-2009-C-AR-FLIC*	*Certificate*	*Initial*	*43.000*	USHG-2009-C-AR-FLIC.pdf
USHG-2009-C-AR-FLIC	*USGH-2009-C-AR-FLIC*	*Certificate*	*Initial*	*43.000*	USHG-2009-C-AR-FLIC.pdf
Mammography Rider	MAM-09-OR-AR-FLIC	Certificate Amendment, Insert Page, Endorsement or Rider	Initial	43.000	MAM-09-OR-AR-FLIC.pdf

No Rate/Rule Schedule items changed.

Thank you for your continued review. Have a great day!

Sincerely,
Shari McBride

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	07/13/2009
Submitted Date	07/13/2009
Respond By Date	

Dear Shari McBride,

This will acknowledge receipt of the captioned filing.

Objection 1

- USHG-2009-C-AR-FLIC, USGH-2009-C-AR-FLIC (Form)

Comment:

Under Section E, Page 24, it is stated that A Certificate of Continuation/Conversion Coverage is not available and will not be provided if: Item 4 -an Insured was not covered under this Certificate for the three (3) consecutive months immediately prior to the date the Group Policy terminates.

This statement can be used with the State Continuation language, but not with Conversion.

Objection 2

- USHG-2009-C-AR-FLIC, USGH-2009-C-AR-FLIC (Form)

Comment:

On Page 23, Section C. 4, with respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity as outlined under ACA 23-86-108(4) and Bulletin 14-81.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	08/12/2009
Submitted Date	08/12/2009

Dear Rosalind Minor,

Comments:
Thank you for your prompt review and response.

Response 1

Comments: The language has been revised and the 3 month period removed.

Related Objection 1

Applies To:

- USHG-2009-C-AR-FLIC, USGH-2009-C-AR-FLIC (Form)

Comment:

Under Section E, Page 24, it is stated that A Certificate of Continuation/Conversion Coverage is not available and will not be provided if: Item 4 -an Insured was not covered under this Certificate for the three (3) consecutive months immediately prior to the date the Group Policy terminates.

This statement can be used with the State Continuation language, but not with Conversion.

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
USHG-2009-C-AR-FLIC	*USGH-2009-C-AR-FLIC*		*Certificate*	*Initial*		*43.000*	USHG-2009-C-AR-FLIC.pdf

Previous Version

USHG-2009-C-AR-FLIC	*USGH-2009-C-AR-FLIC*	*Certificate*	*Initial*	*43.000*	USHG-2009-C-AR-FLIC.pdf
USHG-2009-C-AR-FLIC	*USGH-2009-C-AR-FLIC*	*Certificate*	*Initial*	*43.000*	USHG-2009-C-AR-FLIC.pdf

No Rate/Rule Schedule items changed.

Response 2

Comments: We have revised the language so that notice is "as soon as reasonably possible".

Please Note: We have added brackets for variability on Provider and Prescriptions in two benefits. We have also added a 12-month wait for screening mammography.

Related Objection 1

Applies To:

- USHG-2009-C-AR-FLIC, USGH-2009-C-AR-FLIC (Form)

Comment:

On Page 23, Section C. 4, with respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity as outlined under ACA 23-86-108(4) and Bulletin 14-81.

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
USHG-2009-C-AR-FLIC	*USGH-2009-C-*		*Certificate*	*Initial*		*43.000*	USHG-2009-C-

	AR-FLIC				AR-FLIC.pdf
Previous Version					
USHG-2009-C-AR-FLIC	*USGH-2009-C-AR-FLIC*	*Certificate*	*Initial*	*43.000*	USHG-2009-C-AR-FLIC.pdf
USHG-2009-C-AR-FLIC	*USGH-2009-C-AR-FLIC*	*Certificate*	*Initial*	*43.000*	USHG-2009-C-AR-FLIC.pdf

No Rate/Rule Schedule items changed.

Your consideration of this filing is greatly appreciated. Should you have any questions, please contact me via mcbrides@ushealthgroup.com by telephone at (800) 387-9027, ext.422, or fax (817) 878-3810.

Sincerely,
Shari McBride

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	07/09/2009
Submitted Date	07/09/2009
Respond By Date	

Dear Shari McBride,

This will acknowledge receipt of the captioned filing.

Objection 1

- USHG-2009-C-AR-FLIC, USGH-2009-C-AR-FLIC (Form)

Comment: Under the continuation/conversion section on Page 24, it is stated that your spouse and your unmarried children are to be covered for at lease three (3) consecutire months immediately prior to the Group Policy was terminated. The 3 month period is acceptable for continuation, but this is not a limitation that is allowed under our Converstion law. Refer to ACA 23-86-115.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

Amendment Letter

Submitted Date: 07/13/2009

Comments:

A corrected form is attached.

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
USGH-2009-C-AR-FLIC	Certificate	USHG-2009-C-AR-FLIC	Initial				43.000	USHG-2009-C-AR-FLIC.pdf

Form Schedule

Lead Form Number: USHG-2009-C-AR-FLIC

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 08/18/2009	USGH-2009-C-AR-FLIC	Certificate	USHG-2009-C-AR-FLIC	Initial		43.000	USHG-2009-C-AR-FLIC.pdf
Approved-Closed 08/18/2009	MAM-09-OR-AR-FLIC	Certificate Amendment, Insert Page, Endorsement or Rider	Mammography Rider	Initial		43.000	MAM-09-OR-AR-FLIC.pdf

FREEDOM LIFE INSURANCE COMPANY OF AMERICA

[3100 Burnett Plaza • 801 Cherry Street, Unit 33 • Fort Worth, Texas 76102 • 1-800-387-9027]

CERTIFICATE OF COVERAGE
ASSOCIATION GROUP MEDICAL-SURGICAL EXPENSE PLAN

This is **Your Certificate** of coverage under an association **Group Policy** issued to the **Group Policyholder**. The coverage of all **Insureds** is governed and determined by the terms, conditions, definitions, limitations and exclusions contained in this **Certificate.** This **Certificate** is a legal contract between **You** and the **Company.** Please read it carefully!

Your Certificate is guaranteed renewable, subject to the **Company's** right to adjust **Renewal Premiums** in accordance with Section IV.B. RENEWAL PREMIUM, and otherwise discontinue or terminate the **Certificate** as provided in Section III.C. TERMINATION OF COVERAGE. The **Initial Premium** for coverage of all **Insureds** under this **Certificate** is due and payable on or before the **Issue Date**. **Renewal Premiums** are due and payable in accordance with the Section IV.B. RENEWAL PREMIUM. You may renew coverage under this **Certificate**, as applicable, by timely payment of the proper amount of **Renewal Premium** when due.

Certain phrases and words have the first letter of each word capitalized and the entire word or phrase printed in bold face type. These are generally defined phrases and words, and as such have the express meaning set forth in Section II. DEFINITIONS.

IMPORTANT NOTICE ABOUT STATEMENTS IN THE APPLICATION: Please read the copy of **Your** application for coverage, which is attached to and part of this **Certificate**, to see if any medical history or other information inquired about or contained in the application is incorrect, incomplete or missing. Contact **Us** immediately if any information contained in the application is incorrect, incomplete or missing. Any incorrect or incomplete statements or answers, as well as any missing information could cause a claim to be denied or the coverage under this **Certificate** to be reformed or voided.

This **Certificate** was issued in consideration of (i) the payment of the **Initial Premium**, (ii) upon **Our** reliance upon **Your** representation that the answers to all questions in the application are correct and complete, and (iii) upon **Our** reliance upon the representation from **You** and any other applicable **Insureds**, that the content of any supplemental information provided to **Us** in the underwriting process, including information provided during any telephone verification of the application or by, e-mails, facsimiles and correspondence is in each instance correct and complete.

YOUR [10][30] DAY RIGHT TO RETURN THIS CERTIFICATE

If **You** are not satisfied with this **Certificate**, **You** may return it to **Us** within [ten (10)] [thirty (30)] days after **You** receive it. **You** may return it to **Us** by mail or to the agent who sold it. This **Certificate** will be voided as of the **Issue Date**, and We will refund any premium **We** have received prior to **Our** receipt of the returned **Certificate**.

SECRETARY

PRESIDENT

NEITHER THE GROUP POLICY NOR THIS CERTIFICATE IS A POLICY OF WORKERS' COMPENSATION INSURANCE.

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I. Certificate Schedule

A. GENERAL INFORMATION

Coverage is pursuant to a **Group Policy** form: [GRP-P-06-FLIC]

Issued to **Group Policyholder**: [ABC Association]

Certificate form: [USHG-2009-C-AR-FLIC]

Primary Insured: [ ]

Age at Issue: [ ]

Certificate Number: [ ]

Issue Date: [ ]

Other Insureds on **Issue Date**:
[ ]
[ ]

Beneficiary: [ ]

Initial Premium: **[ ]**

Amount	**Mode Of Premium Payment**	Method
$[ ]	[Monthly], [Quarterly], [Semi-Annual], [Annual]	[Credit Card], [Check]

First Renewal Date: **[**]

First Renewal Premium	**Mode Of Premium Payment**	Method
$[ ]	[Monthly], [Quarterly], [Semi-Annual], [Annual]	[Bank Draft]

Premium Rate Guarantee Period: **[**12] [24] [36] [48] months

B. COVERAGE SCHEDULES

1. **Lifetime Certificate Maximum Per Insured :** [$1,000,000 to $7,000,000]
2. **[Lifetime]Transplant Maximum [Per Organ] Per Insured:** [$100,000 to $1,000,000]

[3.] **Calendar Year Maximum Benefit Per Insured**:] [$100,000 to Lifetime Certificate Maximum Per Insured]

[4]. **Calendar Year Maximum Per Insured for Outpatient Treatment**] [$1,000 - $100,000]

[5.] **Calendar Year Maximum Per Insured for Prescription Drugs]** [$1,000 to $5,000] [or] [**Calendar Year Maximum Per Insured for Outpatient Treatment**] [or] [**Lifetime Maximum Per Insured]**

[6]. **DEDUCTIBLE SCHEDULES:**

The following deductibles are to be paid by the **Insured** in addition to the **Insured Coinsurance Percentage** before any **Sickness and Injury Benefits** or **Wellness and Screening Benefits** are payable by **Us** for **Covered Expenses**:

A. **Calendar Year Deductible** per **Insured**: [$1,000 to $50,000]
[Effective [Certificate Effective Date] [$1,000 to $50,000;]
[[Effective [Second Calendar Year]] [$1,000 to $50,000;]
[[Effective [Third Calendar Year]] [$1,000 to $50,000;]
[[Effective [Fourth Calendar Year]] [$1,000 to $50,000;]

[B.] [**Failure to Pre-Certify Treatment Deductible**:] **[**$1,000]; and

C. **Separate Deductible For Non-Participating Providers**: [$1,000 to $100,000]

[Effective [Certificate Effective Date] [$1,000 to $100,000;]
[[Effective [Second Calendar Year]] [$1,000 to $100,000;]
[[Effective [Third Calendar Year]] [$1,000 to $100,000;]
[[Effective [Fourth Calendar Year]] [$1,000 to $100,000;]

[7]. **COINSURANCE PAYMENT SCHEDULES – PARTICIPATING PROVIDERS [AND PARTICIPATING PHARMACIES]:**

For **Participating Providers [**and **Participating Pharmacies]**, after satisfaction of all applicable deductibles, the following **Company Insurance Percentage**, **Insured Coinsurance Percentage**, and **Insured Maximum Participating Provider Coinsurance Payment**, apply to all **Covered Expenses** in a **Calendar Year**:

A. **Company Insurance Percentage**: [50% to 100%]
(**Sickness and Injury Benefits** and **Wellness and Screening Benefits**)

[B. [**Company Insurance Percentage:**
(**Miscellaneous Benefits**)] [50% to 100%]]

C. **Insured Coinsurance Percentage**: [0% to 50%]; and
(**Sickness and Injury Benefits** and **Wellness and Screening Benefits**)

[D. [**Insured Coinsurance Percentage**:
(**Miscellaneous Benefits**)] [0% to 50%]]

E. **Insured Maximum Participating Provider Coinsurance Payment:** [$1,000 to $10,000]

[8]**. COINSURANCE PAYMENT SCHEDULES – NON-PARTICIPATING PROVIDERS [AND NON-PARTICIPATING PHARMACIES]:**

For **Non-Participating Providers [**and **Non-Participating Pharmacies]**, after satisfaction of all applicable deductibles, the following **Company Insurance Percentage**, **Insured Coinsurance Percentage**, **Insured Maximum Non-Participating Provider Coinsurance Payment**, and **Separate Deductible For Non-Participating Providers** apply to all **Covered Expenses** in a **Calendar Year**:

A. **Company Insurance Percentage** (**Sickness and Injury Benefits** and **Wellness and Screening Benefits**) [50% to 90%]

B. **Insured Coinsurance Percentage** (**Sickness and Injury Benefits** and **Wellness and Screening Benefits**) [10% to 50%]; and

C. **Insured Maximum Non-Participating Provider Coinsurance Payment** [$1,000 to $20,000]

[9]**. [PRESCRIPTION DRUGS]**

[A.] **[Prescription Drug Co-Pay** **[Generic Drug** **[**$0.00 to $35.00]
[Preferred Brand Drug **[**$25.00 to $40.00]]

[COVERED EXPENSES REMAINING AFTER SATISFACTION OF THE CALENDAR YEAR DEDUCTIBLES ARE SUBJECT TO COPAY]

[COVERED EXPENSES REMAINING AFTER SATISFACTION OF THE PRESCRIPTION DRUG CALENDAR YEAR DEDUCTIBLE PER INSURED ARE SUBJECT TO COPAY]

[COVERED EXPENSES REMAINING AFTER CO-PAY SUBJECT TO CALENDAR YEAR DEDUCTIBLES AND INSURED COINSURANCE PERCENTAGE]

[COVERED EXPENSES REMAINING AFTER CO-PAY SUBJECT TO PRESCRIPTION DRUG CALENDAR YEAR DEDUCTIBLE AND PRESCRIPTION DRUG COINSURANCE PERCENTAGE]

[COVERED EXPENSES FOR [GENERIC DRUG] [BRAND NAME DRUG] [AND] [PREFERRED BRAND DRUG] ARE SUBJECT TO CALENDAR YEAR DEDUCTIBLE AND INSURED COINSURANCE PERCENTAGE]

[B.] **[Prescription Drug Calendar Year Deductible Per Insured:**

[Generic Drug]	**[**$0 to $500]
[Preferred Brand Drug]	**] [**$0 to $500]
[Brand Name Drug]	**[**$0 to $500]

[C.] **[**Coinsurance Payments Schedules For **Participating Pharmacies:**

For **Participating Pharmacies** after satisfaction of all applicable deductibles, the following **Prescription Drug Company Insurance Percentage**, and the **Prescription Drug Insured Coinsurance Percentage**, applies to all **Covered Expenses** in a **Calendar Year**:

1**. Prescription Drug Company Insurance Percentage**: [0% to 100%]

2. **Prescription Drug Insured Coinsurance Percentage**: [0% to 100%]; [and]]

[D.] **[**Coinsurance Payments Schedules **Non-Participating Pharmacies:**

For **Non-Participating Pharmacies** after satisfaction of all applicable deductibles, the following **Prescription Drug Company Insurance Percentage**, applies to all **Covered Expenses** in a **Calendar Year**:

1. **Prescription Drug Company Insurance Percentage** [0% to 100%]

2. **Prescription Drug Insured Coinsurance Percentage** [0% to 100%]]

[10] **[DOCTOR OFFICE VISIT]**

[A.] **[Doctor Office Visit Co-Pay]**	[$25.00 to $50.00] [per visit] [per **Participating Provider**]
[B.] [**X-Ray, Laboratory And Diagnostic Testing Co-Pay]**	[25.00 to $50.00] [per service] [per type][per visit][per **Participating Provider**]

(If received during a Doctor Office Visit at a **Participating Provider)**

[This **Benefit** does not apply to **Covered Expenses** under any other **Benefit** provision or limitation such as ALLERGIES; SPINAL MANIPULATION; occupational, speech or physical therapy; and mental nervous disorders, if applicable. The **Doctor Office Visit Co-Pay** applies only to the actual office visit. The **X-Ray, Laboratory and Diagnostic Testing Co-Pay** is in addition to the **Doctor Office Visit Co-Pay**. **[Benefit** Payments by **Us** for the actual doctor office visit are limited to [$0 - $1,200] per **Insured** per **Calendar Year.]** Any services for the doctor office visit in excess of the [$0 - $1,200] limit or any other services, such as office surgeries, processing or reading charges, are subject to the **Calendar Year Deductible** and **Insured Coinsurance Percentage**.]

[All services received during the office visit are limited to [$0 - $1,000] per **Insured** per **Calendar Year]**

[Non-Participating Providers doctor office visits are subject to the [**Calendar Year Deductible]** [and] [or] [**Separate Deductible For Non-Participating Providers**] [[and] the **Insured Coinsurance Percentage**]]

[11] **[ACCESS FEES]**

[A. **Emergency Room Access Fee**] [(waived if **Insured** is **Confined** in a **Hospital** within twenty-four (24) hours following the **Emergency** room visit)]	[[$0 to $500] per **Insured** per visit to either a **Participating Provider** or a **Non-Participating Provider]**
[B. **[Laboratory and Diagnostic Testing Access Fee]**	[[$0 to $500] [per test] [per day] for either **Participating Provider** or **Non**- **Participating Provider** for each of the following **Inpatient** or **Outpatient** diagnostic tests: [MRI], [CAT Scan], [PET], [Myleogram] and [Nuclear Imaging Service] [(including Myocardial Perfusion Imaging - Thallium 201 Scintigraphy/Thallium Stress Tests)]**]**
[C. **Outpatient Therapy Access Fee]**	[[$0 to $500] per **Insured** per visit to a **Participating Provider** facility] [[$0 to $500] per **Insured** per visit to a **Non-Participating Provider** facility]
[12] [**Calendar Year Adult Wellness Maximum**	[$50 to $2,000]

[C. OPTIONAL RIDERS

[1]. **[MATERNITY AND IN VITRO FERTILIZATION BENEFIT RIDER***

Covered Expenses for services performed within [13-24] months from the effective date of coverage for such female **Insured**: [$1,500 to $3,000]

Covered Expenses for services performed [25] or more months from the effective date of coverage for such female **Insured**: [$1,000 to $5,000]

***** Note: Conception must begin [12] months after the effective date of coverage under this **Certificate**.]

In Vitro Fertilization **Benefits** are subject to a **Lifetime Certificate Maximum** of $15,000.

[2]**. [WAIVER OF RENEWAL PREMIUM DURING FIRST RENEWAL PREMIUM RATE GUARANTEE PERIOD UPON DEATH OR TOTAL DISABILITY OF PRIMARY INSURED]**

[Elimination Period:] [90 days]**]**

II. DEFINITIONS

The following terms or words that have the first letter of each word (including the plural form of such word) capitalized and the entire word or phrase printed in bold face type as used within any phrase, sentence, paragraph, provision or schedule in this **Certificate** shall have the express meaning set forth below:

["**Access Fee(s)**" means the [**Emergency Room Access Fee**,] [and] [the **Laboratory and Diagnostic Testing Access Fee**,] [and the **Outpatient Therapy Access Fee]**.

The remaining amount of **Covered Expenses** after the application and satisfaction of the designated **Access Fee** for applicable **Sickness and Injury Benefits** is subject to the **Calendar Year Deductible** and the **Insured Coinsurance Percentage.**

The amount of each applicable **Access Fee** is shown on the **Certificate Schedule**.]

"**Accident**", "**Accidentally**" means an event or occurrence that was unplanned and unintended by the **Insured** that was the sole cause of **Injuries** sustained or suffered by such **Insured** and that takes place on or after the **Issue Date**.

["**Adult Wellness Preventive Care**" means routine physicals, screenings and immunizations that are appropriate for the age and sex of the **Insured** and based on generally accepted standards of medical practice. **Adult Wellness Preventive Care** does not include: COLORECTAL CANCER SCREENING, PROSTATE CANCER SCREENING, MAMMOGRAPHY SCREENING, and PAP SMEAR SCREENING contained in the WELLNESS and SCREENING BENEFITS Section of this **Certificate.]**

"**Adverse Determination**" means a determination by **Us** that an admission, availability of care, continued stay or other **Health Care Service** has been reviewed and, based upon the information provided, the requested payment for the service is denied, reduced or terminated, because:

- the requested **Health Care Service** does not meet **Our Certificate** requirements for **Medical Necessity**; or
- the requested **Health Care Service** has been found to be "experimental/investigational".

To be considered as an **Adverse Determination**, the **Adverse Determination** must be a **Final Adverse Determination**, except as provided herein. The **Adverse Determination** must involve treatment, services, equipment, supplies or drugs that would require **Your Certificate** to expend five hundred dollars [$500] or more of expenditures.

Adverse Determination does NOT include a determination by **Us** to deny a **Health Care Service** or **Benefit** based upon:

- an express exclusion within the **Certificate**, other than a general exclusion for "**Medical Necessity**" or "experimental/investigational";
- an express limitation within the **Certificate** with respect to the number of visits, treatments, supplies or services for a covered **Benefit** in a given **Calendar Year** or due to the **Lifetime Certificate Maximum** for an Insured;
- an express limitation within the **Certificate** with respect to a maximum dollar limitation with respect to a covered **Benefit** in a given **Calendar Year** period or due to the **Lifetime Certificate Maximum** for an Insured;
- a determination by **Us** that an individual is not eligible to be an Insured;
- a determination by **Us** that treatment, service or supplies were requested or obtained by a **Covered Insured** through fraud or material misrepresentation;
- the procedure for determining the **Insured's** access to a **Provider**, including but not limited to any primary care gatekeeper, referral or network access provision;
- Illegality of services or the means or methods of administering them;
- FDA or other government agency determinations, reports or statements; or
- Licensure, permit or accreditation status of a **Provider**.

"**Alcoholism**" means the chronic and habitual use of alcoholic beverages by any person to the extent that such person has lost the power of self-control with respect to the use of such beverages.

"**Allowable Expense**" means, in connection with Section IX. COORDINATION OF BENEFITS, any necessary, reasonable and customary item of expense, at least a portion of which is covered under one or more of the **Plans** covering the applicable **Insured** for whom medical service was rendered and provided, and for which a **Benefit** claim was made. When a **Plan** provides benefits in the form of services, (for example an HMO) the reasonable cash value of each service rendered shall be deemed to be both an allowable expense and a benefit paid. A **Plan**, which takes **Medicare** or similar government benefits into consideration when determining the application of its coordination of benefits provision, does not expand the definition of an **Allowable Expense**.

"Ambulatory Surgical Center" means a state licensed public or private establishment with an organized medical staff of **Providers** with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures and continuous **Provider** services and registered professional nursing services whenever an **Insured** is in the center that does not provide services or other accommodations for the overnight stay of patients.

Ambulatory Surgical Center does not include a facility that primarily terminates pregnancies, a **Provider's** office maintained for the practice of medicine, or an office maintained for the practice of dentistry.

"Beneficiary" means the individual or organization listed on the **Certificate Schedule** as the **Beneficiary**.

"**Benefit(s)**" means **Sickness and Injury Benefits**, [and] **Wellness and Screening Benefits** [and] [**Miscellaneous Benefits]**.

"Bone Marrow Transplants" means the **Medically Necessary** transplantation, combined transplantation, and sequential transplantation procedures, sometimes referred to as "Bone Marrow Reconstitution or Support" in which Medically Necessary human blood precursor cells are administered following mylesuppressive or ablative therapy are received by an **Insured** while coverage for such **Insured** under this **Certificate** is in full force and effect. Such cells may be derived from such **Insured** in an autologous harvest, or from a matched donor for an allogenic transplant.

[**"Brand Name Drug"** means a **Prescription Drug** for which a pharmaceutical company possesses either (i) an active and valid registered patent or (ii) an active and valid registered trade name after expiration of such patent.]

"Breast Reconstruction" means reconstruction of a breast incident to a **Mastectomy** to restore or achieve breast symmetry. **Breast Reconstruction** includes surgical reconstruction of a breast on which **Mastectomy** surgery has been performed in order to establish symmetry, as well as prostheses and services and other supplies that are **Medically Necessary** for any physical complication, including lymphedemas, at all stages of the reconstruction incident to a **Mastectomy**.

"Calendar Year" means the period beginning on the **Issue Date** and ending on December 31 of that year. In subsequent years, it is the period from January 1 through December 31 of the same year.

"Calendar Year Deductible" means the amount of **Covered Expenses** each **Insured** must incur within a **Calendar Year** before any **Sickness and Injury Benefits** or **Wellness and Screening Benefits** are payable by **Us** for such **Insured**. No **Sickness and Injury Benefits** or **Wellness and Screening Benefits** are payable by **Us** for any **Covered Expenses** incurred by an **Insured**, until after all applicable [**Co-Pays** and] **Access Fees**, the **Failure to Pre-Certify Treatment Deductible**, if applicable, the **Separate Deductible for Non-Participating Providers**, if applicable, and the **Calendar Year Deductible** are each satisfied and fully payable by either **You** or such **Insured**.

None of the following expenses may be used to satisfy the **Calendar Year Deductible**: (i) the amount of any applicable [**Co-Pay** or] **Access Fee**; (ii) the amount of the **Separate Deductible For Non-Participating Providers**, (iii) [**Covered Expenses** that constitute **Miscellaneous Benefits** for which payment is made by **Us**,] and (iv) the amount of the **Failure to Pre-Certify Treatment Deductible**.

[When [three (3)] **Insureds** satisfy this **Calendar Year Deductible**, no additional **Calendar Year Deductible** per **Insured** will be required for the remainder of the **Calendar Year**.]

[If [two (2)] or more **Insureds** incur **Covered Expenses** for **Injuries** sustained in the same accident, only one (1) **Calendar Year Deductible** will be applied that **Calendar Year** to the combined **Covered Expenses** resulting from the **Injuries** sustained in such common accident by all **Insureds**.]

The amount of the **Calendar Year Deductible** is shown on the **Certificate Schedule**.

[**"Calendar Year Maximum Benefit Per Insured"** means the maximum dollar amount of **Covered Expenses** per **Calendar Year** per **Insured** that **We** are required to pay, after satisfaction of all applicable deductibles, [**Co-Pays**,] [**Access Fees]** and the amount of any **Insured Coinsurance Percentage**. The amount of the **Calendar Year Maximum Benefit Per Insured** is shown on the **Certificate Schedule**.]

[**"Calendar Year Maximum Per Insured For Prescription Drugs"** means the maximum dollar amount of **Covered Expenses** incurred per **Insured** per **Calendar Year** that **We** are required to pay for **Prescription Drugs** ,after the satisfaction by each applicable **Insured** of (i) [the amount of any applicable **Co-pays**;] **[ii)] [**the **Prescription Drug Calendar Year Deductible;]** and [(iii)] [the amount of the **Prescription Drug Insured Coinsurance Percentage]**. The amount of the **Calendar Year Maximum Per Insured for Prescription Drugs** is shown on the **Certificate Schedule**.]

["Calendar Year Maximum Per Insured For Outpatient Treatment" means the maximum dollar amount of **Covered Expenses** incurred per **Insured** per **Calendar Year** that **We** are required to pay, after the satisfaction by each applicable **Insured** of (i) the amount of all applicable deductibles and **Access Fees** (ii) the amount of the **Insured Coinsurance Percentage** for the **Outpatient** coverages listed in Section V. A. EMERGENCY ROOM AND OTHER OUTPATIENT BENEFITS. The amount of the **Calendar Year Maximum Per Insured** for **Outpatient Treatment** is shown on the **Certificate Schedule**.**]**

["Calendar Year Adult Wellness Maximum" means the maximum dollar amount of **Covered Expenses** per **Calendar Year** per **Insured** that **We** are required to pay, after satisfaction of all applicable deductibles, [**Co-Pays**,] [**Access Fees]** and the amount of any **Insured Coinsurance Percentage**. The amount of the **Calendar Year Maximum Adult Wellness Maximum** is shown on the **Certificate Schedule**.]

["Center of Excellence" means a **Participating Provider** who has agreed to provide organ transplants.]

"Certificate" means this contract of coverage between all **Insureds** and the **Company** that was issued under the **Group Policy**. This contract of coverage consists solely of (i) this written CERTIFICATE OF COVERAGE, (ii) the application for coverage of each **Insured**, which application is attached hereto and by this reference incorporated for all purposes, and (iii) any riders, endorsements or amendments attached hereto.

"Certificate Of Conversion Coverage" means the documents prepared by **Us** in accordance with the provisions of Section III.E. CONTINUATION OF COVERAGE AND CERTIFICATE OF CONVERSION, which on their effective date will replace this **Certificate** as the contract of coverage between the applicable **Insured** and the **Company**, consisting of (i) an endorsement removing each applicable **Insured** from this **Certificate**, and (ii) a new certificate of coverage for each applicable **Insured** with the same applicable provisions as this **Certificate**, including any riders or amendments attached hereto, but bearing a new certificate number.

"Certificate Schedule" means the schedule of **Certificate** information that commences on page 3 of this **Certificate**.

["Childhood Wellness Preventive Care" means a routine annual **Outpatient** physical examination of each **Insured** under the age of [19, or to age 24] if **Full-Time Student** performed by a **Participating Provider**, not in connection with any **Sickness** or **Injury**, but instead as an evaluation of the annual health status of such individual, including any necessary laboratory blood tests, urinalysis, and x-rays performed in connection with each routine annual **Outpatient** physical examination and at the order of such **Participating Provider**. Provided, however, that such ordered medical laboratory and diagnostic tests, services and supplies are:

1. reasonably designed to permit early diagnoses of certain **Sicknesses**;
2. appropriate and performed according to and within generally accepted standards for medical practice;
3. in the most cost effective setting and manner available;
4. not primarily for the convenience of an **Insured**, a **Family**, or a **Provider**; and

5. the costs incurred do not exceed the **Maximum Allowable Charge** for such services.]

"Claim Determination Period" means, in connection with Section IX. COORDINATION OF BENEFITS, a **Calendar Year**. However, it does not include any part of a year during which an **Insured** has no coverage under this **Certificate**, or before the date that Section IX. COORDINATION OF BENEFITS or a similar provision takes effect.

"Class" means the classification by **Us** of (i) individuals to whom **We** have issued new coverage for the purposes of the calculation of their **Initial Premium** rates, and (ii) individuals to whom **We** have previously issued coverage for purposes of the calculation of their **Renewal Premium** rates.

"Company" means Freedom Life Insurance Company of America.

"Company Insurance Percentage" means the portion of the **Covered Expenses We** must pay to or on behalf of an **Insured** for **Benefits** under this **Certificate**, after satisfaction by the **Insured** of (i) all applicable [**Co-Pays** and] **Access Fees**, (ii) all applicable deductibles and (iii) the amount of the applicable **Insured Coinsurance Percentage**. The **Company Insurance Percentage** is shown on the **Certificate Schedule** for **Covered Expenses** for **Sickness and Injury Benefits**, [and] **Wellness and Screening Benefits** [and] [**Miscellaneous Benefits]** at (i) **Participating Providers**; and (ii) **Non-Participating Providers**.

"Complications of Pregnancy" means:

1. Conditions (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy, including but not limited to, acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity; and
2. Non-elective **Emergency** cesarean sections, termination of ectopic pregnancy, and spontaneous termination of pregnancy occurring during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy does not include false labor, occasional spotting, **Provider** prescribed rest during the period of pregnancy, morning sickness, and hyperemesis gravidarum. Nor does it include pre-eclampsia and similar conditions associated with the management of a difficult pregnancy unless such condition constitutes a nosologically distinct complication.

"Complying Plan" means, in connection with Section IX. COORDINATION OF BENEFITS, a **Plan** with an order of benefit determination provision which complies with the ORDER OF BENEFIT DETERMINATION RULES contained is Section IX. A.

"Confinement or **Confined"** means **Inpatient** services received as a resident bed patient for not less than eight (8) hours in a **Hospital**. A period of **Confinement** begins on the date of admission to the **Hospital** as an **Inpatient** and ends on the date of discharge.

["Co-Pays" means the amount of each first dollar co-payment of **Covered Expenses** incurred by an **Insured** for the applicable service and care that is required to be applied to and satisfied by the **Insured** before the remaining portion of such **Covered Expenses** are eligible for payment consideration by **Us. Co-Pays** may not be used to satisfy the **Calendar Year Deductible**, the **Insured Coinsurance Percentage**, the **Separate Deductible for Non-Participating Providers**, [any applicable **Access Fees**,] the amount of **Covered Expenses** for which benefit payments are received by **You** under any optional rider issued with this **Certificate**, or the amount of any applicable **Failure to Pre-Certify Treatment Deductible**.

[The remaining amount of **Covered Expenses** after the application and satisfaction of the designated **Co-Pay** is subject to the **Calendar Year Deductible** [the **Separate Deductible for Non-Participating Providers**,] [any applicable **Access Fees**,] and the **Insured Coinsurance Percentage.]**

The amount of each **Co-Pay** is shown on the **Certificate Schedule**.]

"Covered Expenses" means for the covered items and services listed in the **Sickness and Injury Benefits**, [and] **Wellness and Screening Benefits [**and the] [**Miscellaneous Benefits]** Sections of this **Certificate** the amount of expenses actually incurred by an **Insured**, after the **Issue Date** of this **Certificate** and before **Termination of Coverage**, as a result of being **Provided** applicable medical, surgical, or diagnostic services, supplies, care,

Prescription Drugs and other applicable treatment, which in each event is **Medically Necessary**, up to but not exceeding the amount of each of the following:

1. the **Maximum Allowable Charge** for each applicable medical, surgical or diagnostic service, supply, care [**Prescription Drugs]** or other applicable treatment;
2. the **Lifetime Certificate Maximum Per Insured**;
3. the **[Lifetime] Transplant Maximum [Per Organ] Per Insured**; [and]
4. the amount of any other applicable coverage limit or excluded amount set forth in any limitation, exclusion or waiting period that is contained in any Section in this **Certificate** and**/**or in any exclusionary or limiting rider, amendment or endorsement attached hereto.
5. **[**the **Calendar Year Maximum Benefit Per Insured**; [and]]
6. **[**the **Calendar Year Maximum Per Insured For Prescription Drugs**;] [and]]
7. [the **Calendar Year Maximum Per Insured For Outpatient Treatment**.**]**

"CPT Code" means the applicable numeric code assigned to a particular medical procedure **Provided** consistent with the most current version of the *Physicians' Current Procedural Terminology,* published by the American Medical Association on the date charges for such procedure are incurred by an **Insured**.

"Custodial Care" means care given mainly to meet personal needs. It may be provided by persons without professional skills or training. "**Custodial Care**" includes, but is not limited to, help in walking, getting in and out of bed, bathing, dressing, eating and taking medicine.

"Diabetes Equipment" means blood glucose monitors, insulin pumps and associated appurtenances, insulin infusion devices, and podiatric appliances for the prevention of complications associated with diabetes.

"Diabetes Self-Management Training" means training provided by a health care practitioner or **Provider** who is licensed, registered or certified in this state to provide appropriate health care services for the treatment of diabetes.

Diabetes Self-Management Training includes:

1. training provided after the initial diagnosis of diabetes, including nutritional counseling and proper use of **Diabetes Equipment** and **Diabetes Supplies**;
2. training authorized on the diagnosis of a **Provider** or other health care practitioner due to a significant change in the **Insured's** symptoms or condition which necessitates changes in the self-management regime; and
3. periodic or episodic continuing education training when prescribed by an appropriate health care practitioner as warranted by the development of new techniques and treatments for diabetes.

"Diabetes Supplies" means (a) test strips for blood glucose monitors; (b) visual reading and urine test strips; (c) lancets and lancet devices; (d) insulin and insulin analogs; (e) injection aids; (f) syringes; (g) prescriptive oral agents for controlling blood sugar levels; and (h) glucagon emergency kits.

"Disability Period" means the period of time that the **Primary Insured** is continuously **Totally Disabled** while coverage under the **Certificate** for such **Primary Insured** is in full force and effect.

["Doctor Office Visit Co-Pay" means the **Co-Pay** payment that is required [per visit] [per **Insured]** [per type of service] toward the applicable amount of **Covered Expenses** incurred by an **Insured** for **Outpatient** visits per **Calendar Year** per **Insured** to the professional offices of a physician who is a **Participating Provider** as defined in the **Certificate. Co-Pays** may not be used to satisfy the **Calendar Year Deductible**, the **Insured Coinsurance Percentage**, the **Separate Deductible for Non-Participating Providers**, [any applicable **Access Fees**,] the amount of **Covered Expenses** for which benefit payments are received by **You** under any optional rider issued with this **Certificate**, or the amount of any applicable **Failure to Pre-Certify Treatment Deductible**.]

[The remaining amount of **Covered Expenses** after the application and satisfaction of the **Doctor Office Visit Co-Pay** is subject to the **Calendar Year Deductible** [the **Separate Deductible for Non-Participating Providers**,] [any applicable **Access Fees**,] and the **Insured Coinsurance Percentage.]**

[The amount of the **Doctor Office Visit Co-Pay** is shown on the **Certificate Schedule**.]

"Emergency" means the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:

1. placing the patient's health in severe jeopardy;
2. serious impairment to bodily functions; or
3. serious dysfunction of any bodily organ or part.

"Emergency Care Facility" means a state licensed public or private establishment with an organized medical staff of **Providers** with permanent facilities that are equipped and operated primarily for the purpose of rendering **Outpatient Emergency** medical services for **Sicknesses** and **Injuries**, and which facility does not render **Inpatient** services. **Emergency Care Facility** does not include the emergency room of a **Hospital**, an **Ambulatory Surgical Center**, a facility that primarily terminates pregnancies, a **Providers** office maintained for the practice of medicine, or an office maintained for the practice of dentistry.

["Emergency Room Access Fee" means the amount of **Covered Expenses** under Section V.A. EMERGENCY ROOM SERVICES, an **Insured** must incur before any **Benefits** are payable under this **Certificate** if such **Insured** receives and is charged for services rendered in the emergency room of a **Hospital**. No **Benefits** are payable under this **Certificate** for any **Covered Expenses** for such an emergency room visit, until after the amount of any applicable **Emergency Room Access Fee**, the amount of the **Calendar Year Deductible**, **Insured Coinsurance Percentage,** as well as the amount of all other applicable **Access Fees** are satisfied and fully payable either by **You** or such **Insured**. In addition to the **Emergency Room Access Fee**, the **Separate Deductible for Non-Participating Providers** may apply to services rendered by **Non-Participating Providers**. However, the **Emergency Room Access Fee** shall be waived by **Us** if such **Insured** is **Confined** in any **Hospital** within twenty-four (24) hours of such emergency room visit.

None of the following expenses may be used to satisfy the **Emergency Room Access Fee**: (i) [the amount of the **Laboratory and Diagnostic Testing Access Fee**,] [(ii)][the amount of the **Outpatient Therapy Access Fee**,][(iii)] t[he amount of the **Separate Deductible for Non-Participating Providers**,][(iv)] t[he amount of **Covered Expenses** for which benefit payments are received by **You** under any optional rider issued with this **Certificate**,] [(v)[]the amount of any applicable **Failure to Pre-Certify Treatment Deductible**,] [(vi)] [the amount of the **Calendar Year Deductible,][** and] [vii] the **Insured Coinsurance Percentage]**.

[The amount of the **Emergency Room Access Fee** is shown on the **Certificate Schedule**.]

"External Review" means a process, independent of all affected parties, to determine if a **Health Care Service** is **Medically Necessary** or experimental/investigational.

"Failure to Pre-Certify Treatment Deductible" means the additional amount of **Covered Expenses** an **Insured** must incur before any **Sickness and Injury Benefits** are payable under this **Certificate** if such **Insured** fails to properly obtain **Pre-Certification of Treatment** as required under Section V.D. PRE-CERTIFICATION OF TREATMENT. No **Sickness and Injury Benefits** are payable under this **Certificate** for any **Covered Expenses** until after the amount of any applicable **Failure to Pre-Certify Treatment Deductible**, and the amount of the **Calendar Year Deductible** are satisfied and fully payable either by **You** or such **Insured**. In addition to the **Failure to Pre-Certify Treatment Deductible**, the **Separate Deductible For Non-Participating Providers** will apply to services rendered by **Non-Participating Providers**.

The amount of the **Failure to Pre-Certify Treatment Deductible** is shown on the **Certificate Schedule**.

None of the following expenses may be used to satisfy the **Failure to Pre-Certify Treatment Deductible**: (i) the amount of the **Separate Deductible For Non-Participating Providers**, (ii) the amount of **Covered Expenses** that constitute **Wellness and Screening Benefits** for which payment is made by **Us**, and (iii) the amount of the **Calendar Year Deductible** , and (iv) the amount of any applicable [**Co-Pay][** or][and][**Access Fee]**.

"Family" means the spouse, son or daughter, brother or sister, parent, grandparent or grandchild of an **Insured**.

"Final Adverse Determination" means an **Adverse Determination** involving a covered **Benefit** that has been upheld by **Us** at the completion of **Our Internal Grievance Procedure**. "**First Certificate Year**" means for the

period beginning on the **Issue Date** and ending on the last day immediately preceding the first anniversary of the **Issue Date**.

"First Certificate Year" means for the period beginning on the **Issue Date** and ending on the last day immediately preceding the first anniversary of the **Issue Date**.

"First Renewal Date" means the first premium due date following payment of the **Initial Premium** which is shown on the **Certificate Schedule**.

"First Renewal Premium" means the amount of **Renewal Premium** due on the **First Renewal Date**. The amount of **First Renewal Premium**, if known on the **Issue Date**, is shown on the **Certificate Schedule**.

"Full-Time Student" means an individual, under the age of [24], who is enrolled in at least twelve (12) credit hours per semester at an accredited college or university.

[**"Generic Drug"** means a **Prescription Drug** that contains the same active ingredients as an equivalent former **Brand Name Drug** that is no longer protected by a patent, and the trade name, if any, associated with such former **Brand Name Drug** is not listed on the label of such **Prescription Drug**.]

"Group Policy" means the association group insurance contract issued to the **Group Policyholder** under which this **Certificate** is issued to the **Primary Insured**.

"Group Policyholder" means the association shown on the **Certificate Schedule** to whom the **Group Policy** was issued.

"Health Care Services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, **Sickness, Injury** or disease, as used within the Grievance Procedures section.

"Home Health Care Plan" means a **Medically Necessary** program of care, established by an **Insured's Provider**, taking place in a residential setting.

"Hospice" means an agency licensed by the appropriate licensing agency to provide **Hospice Care**, under an administered program for a terminally ill **Insured** and his or her **Family**, with the following services available twenty-four (24) hours a day, seven (7) days a week: (a) **Inpatient** services, (b) home services, and (c) follow-up bereavement services.

"Hospice Care" means a **Medically Necessary**, coordinated, interdisciplinary **Hospice**-provided program for meeting the physical, psychological, spiritual, and social needs of dying individuals and his or her **Family**. **Hospice Care** provides **Medically Necessary** nursing, medical, and other health services to relieve pain and provide support through home and **Inpatient** care during the **Sickness** and bereavement of an **Insured** and his or her **Family**.

"Hospital" means a place which:

1. is legally operated for the care and treatment of sick and injured persons at their expense;
2. is primarily engaged in providing medical, diagnostic and surgical facilities (either on its premises or in facilities available to it on a formal pre-arranged basis);
3. has continuous twenty-four (24) hour nursing services by or under the supervision of a registered nurse (R.N.); and
4. has a staff of one or more **Providers** available at all times.

It also means a place that may not meet the above requirements, but is accredited as a hospital by the Joint Commission on Accreditation of Healthcare Organizations, the American Osteopathic Association or the Commission on the Accreditation of Rehabilitation Facilities.

Hospital does not mean:

1. a convalescent home, nursing home, rest home or **Skilled Nursing Home**;

2. a place primarily operated for treatment of **Mental and Emotional Disorders**, drug addicts, alcoholics, or the aged;
3. a special unit or wing of a **Hospital** used by or for any of the above;
4. a long-term mental care facility; or
5. a facility primarily providing **Custodial Care**.

"Independent Review Organization" means an entity that conducts independent **External Reviews** of **Adverse Determinations** and **Final Adverse Determinations**.

"Inherited Metabolic Disorder" means a disease caused by an inherited abnormality of body chemistry and includes a disease tested under a newborn screening program.

"Initial Premium" means the amount charged for coverage under this **Certificate** for **You** and all **Other Insureds** for the period of time from the **Issue Date** through the day before the **First Renewal Date**. The amount of the **Initial Premium** is shown on the **Certificate Schedule**, and is payable in advance of the **Issue Date**.

"Injury" means damage or harm **Accidentally** sustained to the physical structure of the body of an **Insured** that is the direct cause of the loss independent of disease, bodily infirmity, or any other cause, which occurs while this **Certificate** is in force and effect for such **Insured**. A specific **Injury** from which disability continues or recurs shall be considered one and the same **Injury** or "any one **Injury**", unless periods of **Confinement** to a **Hospital** or service, treatment, or **Covered Expenses** incurred resulting from such **Injury** are separated by an interval of at least ninety (90) consecutive days between the end of one such period and the beginning of a subsequent such period.

"Inpatient" means an **Insured** who receives **Medically Necessary** services from a **Provider** in a **Hospital** when such **Insured** is **Confined** and receives room and board from such **Hospital** for not less than eight (8) hours. Treatment or services rendered or **Provided** in a **Hospital** emergency room is not an **Inpatient Confinement** for the purposes of this **Certificate**. A period of **Inpatient Confinement** begins on the date of admission to the **Hospital** as an **Inpatient** and ends on the date of discharge.

"Insured" means the following:

1. the **Primary Insured** whose coverage under this **Certificate** is still in force and effect,
2. any other individuals named as **Other Insureds** on the **Certificate Schedule** whose coverage under this **Certificate** is still in force and effect, and
3. any individual who is added to this **Certificate** after the **Issue Date** by proper endorsement after proper application and payment of any additional premium whose coverage under this **Certificate** is still in force and effect.

"Insured Coinsurance Percentage" means the portion of the **Covered Expenses** that **You** must pay after satisfaction of all applicable deductibles[,] [**Co-pays**] and **Access Fees**. The different **Insured Coinsurance Percentages** are shown on the **Certificate Schedule** at [(i]) **Participating Providers [.]** [(i]i) [**Participating Pharmacies][**,][and] [(iii)] **Non-Participating Providers**, and (iv) **Non-Participating Pharmacies]**. (

"Insured Maximum Participating Provider Coinsurance Payment" means the maximum amount, after the satisfaction of all applicable **Certificate** deductibles, **Access Fees** [and **Co-Pays]**, that an **Insured** is required to pay in a **Calendar Year** under the **Insured Coinsurance Percentage** for services rendered at **Participating Providers [**and **Participating Pharmacies]. Covered Expenses** incurred for services rendered at **Participating Providers [**and **Participating Pharmacies]** that are covered under the **Sickness and Injury Benefits** and the **Wellness and Screening Benefits** sections and applied by the **Company** toward satisfaction of the **Calendar Year Deductible**, the **Separate Deductible For Non-Participating Providers**, the **Failure to Pre-Certify Treatment Deductible** and/or any other deductible contained in this **Certificate** or any rider attached to this **Certificate**, shall not be credited or applied toward satisfaction of the **Insured Maximum Participating Provider Coinsurance Payment**. The amount of the **Insured Maximum Participating Provider Coinsurance Payment** is shown on the **Certificate Schedule**.

"Insured Maximum Non-Participating Provider Coinsurance Payment" means the maximum amount, after the satisfaction of all applicable **Certificate** deductibles and **Access Fees**, that an **Insured** is required to pay in a

Calendar Year under the **Insured Coinsurance Percentage** for services rendered at **Non-Participating Providers [**and **Non-Participating Pharmacies]**. **Covered Expenses** incurred for services rendered at **Non-Participating Providers [**and **Non-Participating Pharmacies]** that are covered under the **Sickness and Injury Benefits** and the **Wellness and Screening Benefits** Sections and applied by the **Company** toward satisfaction of the **Calendar Year Deductible**, the **Failure to Pre-Certify Treatment Deductible**, and/or any other deductible contained in this **Certificate** or any rider attached to this **Certificate** shall not be credited or applied toward satisfaction of the **Insured Maximum Non-Participating Provider Coinsurance Payment**. The amount of the **Insured Maximum Non-Participating Provider Coinsurance Payment** is shown on the **Certificate Schedule**.

"Intensive Care Unit" means only the specifically designed facility of a **Hospital** which provides the highest level of medical care and restricts admission to only patients who are physically critically ill or injured, and which is separate and distinct from the rooms, beds and wards of such **Hospital** customarily used for patients who are not critically ill. To be considered an **Intensive Care Unit** under this **Certificate**, such facility must be permanently equipped with special life-saving equipment for the care of the physically critically ill or injured, and patients in such unit must be under constant and continuous observation by nursing staffs assigned on a full-time basis, exclusively to such facility of the **Hospital**. A coronary care facility and a specialized burn unit of a **Hospital** shall be considered an **Intensive Care Unit** if it meets these requirements and is restricted to persons receiving critical coronary or specialized burn care. However, the following are not considered an **Intensive Care Unit** under this **Certificate**:

1. a **Hospital** emergency room, regardless of the services or supplies rendered in such emergency room,
2. a surgical recovery room,
3. a sub-acute intensive care unit,
4. a progressive care unit,
5. an intermediate care unit,
6. a private monitored room,
7. any other observation unit or other facilities in a **Hospital** that are step downs from the unit in such **Hospital** that provides the highest level of medical care to critically ill patients.

"Internal Grievance Procedure" means the procedure by which **We** handle and resolve grievances, and provide **Insureds** with prompt and meaningful review on the issue of denial, in whole or part, of **Health Care Services**.

"Issue Date" means the date on which coverage under this **Certificate** commences for **You** and **Other Insureds**. This date is shown on the **Certificate Schedule**.

["Laboratory and Diagnostic Testing Access Fee" means the amount of **Covered Expenses** an **Insured** must incur [either per test per day, (as set forth in the **Certificate Schedule** by test and service)], before any **Benefits** are payable by **Us** under this **Certificate** for [MRI], [CAT Scan], [PET], [Myleogram] and [Nuclear Imaging Service (including Myocardial Perfusion Imaging - Thallium 201 Scintigraphy/Thallium Stress Tests)]. No **Benefits** are payable under this **Certificate** for any **Covered Expenses** for [MRI], [CAT Scan], [PET], [Myleogram] and [Nuclear Imaging Service (including Myocardial Perfusion Imaging - Thallium 201 Scintigraphy/Thallium Stress Tests)] performed on or for such **Insured** until after the amount of the **Laboratory and Diagnostic Testing Access Fee,** the amount of the **Calendar Year Deductible**, the **Insured Coinsurance Percentage**, as well as the amount of all other applicable **Access Fees** are satisfied and fully payable by either **You** or such **Insured**. In addition to the **Laboratory and Diagnostic Testing Access Fee**, the **Separate Deductible for Non-Participating Providers** will apply to services rendered by **Non-Participating Providers**.]

[None of the following expenses may be used to satisfy the **Laboratory and Diagnostic Testing Access** Fee, (i) **Emergency Room Access Fee**, [(ii) the amount of the **Outpatient Therapy Access Fee**,][(iii)] the amount of the **Separate Deductible for Non-Participating Providers**,[(iv)] the amount of **Covered Expenses** for which benefit payments are received by **You** under any optional rider issued with this **Certificate**,[(v)]the amount of any applicable **Failure to Pre-Certify Treatment Deductible**, [(vi)] the amount of the **Calendar Year Deductible,** and [vii] the **Insured Coinsurance Percentage**.]

[The amount of the **Laboratory and Diagnostic Testing Access Fee** is shown on the **Certificate Schedule**.]

"Lifetime Certificate Maximum Per Insured" means the total dollar amount of **Covered Expenses** payable on behalf of an **Insured** under this **Certificate** for **Benefits**. The minimum amount of the **Lifetime Certificate**

Maximum Per Insured is shown on the **Certificate Schedule**. The amount of the **Lifetime Certificate Maximum Per Insured** may increase on an annual basis in accordance with the terms, limitations and exclusions of Section VIII. INCREASE IN LIFETIME CERTIFICATE MAXIMUM.

["[Lifetime] Transplant Maximum [Per Organ] Per Insured" means the total dollar amount of **Covered Expenses** payable by **Us** under the terms of this **Certificate** for services **Provided** to an **Insured** in connection with or attributable to all **Solid Organ Transplants**, **Bone Marrow Transplants**, and **Stem Cell Transplants** received by the **Insured**. This [lifetime] [per organ] maximum **Benefit** includes all related **Covered Expenses** incurred from 14 days before each applicable transplant surgery or procedure to 365 days after each such transplant surgery or procedure. The amount of the **[Lifetime] Transplant Maximum [Per Organ] Per Insured** is shown on the **Certificate Schedule** and shall not exceed the **Lifetime Certificate Maximum Per Insured**.]

"Mammogram" means the X-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression device, screens, and films and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast.

"Manifests" or **"Manifested"** means either the presentation of symptoms or the presence of a medical condition, whether physical or mental, and regardless of the cause:

1. for which medical advice, diagnosis, care or treatment was recommended or received; and/ or
2. which would have caused a reasonably prudent person to seek medical advice, diagnosis, care or treatment, and which condition would have been medically diagnosable after the receipt of the results of medical diagnostic and laboratory tests that would have been reasonably indicated and ordered by a reasonably prudent **Provider** under the same or similar circumstances.

"Mastectomy" means the surgical removal of all or part of the breast as a result of breast cancer. **Mastectomy** does not include biopsies or other exploratory or diagnostic procedures used to detect the presence of cancer.

"Maximum Allowable Charge" means the following:

1. For **Providers**, **Maximum Allowable Charge** is the actual expense incurred by an **Insured** for the applicable service, supplies, care, or treatment **Provided**, after any reduction, adjustment, and/or discount pursuant to any **Participating Provider** agreements or other network agreements, negotiated rates, fee schedules or arrangements that determine or prescribe the actual amount of charges or fees that the **Provider**:

   a) agreed to accept as payment in full for such services, supplies, care or treatment, and
   b) ultimately charged such **Insured**, regardless of any higher amount that may have been placed on the **Provider's** billing statement of charges.

2. For **Hospitals**, **Ambulatory Surgical Centers**, **Emergency Care Facility**, **Skilled Nursing Homes**, laboratories, pharmacies or other medical, diagnostic or treatment facilities, "**Maximum Allowable Charge**" is the actual amount charged by such entity for the applicable service or treatment **Provided** to an **Insured**, after a reduction, adjustment, and/or network discount pursuant to any **Participating Provider** agreements, [**Participating Pharmacy** agreements] or other network agreements, negotiated rates, fee schedules or other arrangements that determine or prescribe the actual amount of charges or fees that such entity:

   a) agreed to accept as payment in full for such applicable services, supplies, care, treatment[or **Prescription Drugs]**, and
   b) ultimately charged such **Insured** for such applicable services, supplies, care, treatment [or **Prescription Drugs]**, regardless of any higher amount that may have been placed on the entity's billing statement of charges.

However, the amount of the **Maximum Allowable Charge** under (1) and (2) above shall never exceed (i) the amount for which the applicable **Insured** has a legal liability and payment obligation for the receipt of such applicable services, supplies, care, treatment [or **Prescription Drugs]**, (ii) the amount of the **Medicare** allowable or approved charge for the receipt of such applicable services, supplies, care, treatment [or **Prescription Drugs]** with

respect to any **Insured** who is **Medicare** eligible, or (iii) the amount of **Usual and Customary Expense** for the receipt of such applicable services, supplies, care, treatment [or **Prescription Drugs]**.

"Medical Foods" means modified low protein foods and metabolic formulas. Metabolic formulas are foods that are all of the following: (i) formulated to be consumed or administered enterally under the supervision of a **Provider**; (ii) processed or formulated to be deficient in one or more of the nutrients present in typical foodstuffs; (iii) administered for the medical and nutritional management of a person who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrient requirements as established by medical evaluation; and (iv) essential to a person's optimal growth, health and metabolic homeostasis.

Modified low protein foods are foods that are all of the following: (i) formulated to be consumed or administered enterally under the supervision of a **Provider** (ii) processed or formulated to contain less than one gram of protein per unit of serving, but does not include a natural food that is naturally low in protein; (iii) administered for the medical and nutritional management of a person who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrient requirements as established by medical evaluation; and (iv) essential to a person's optimal growth, health and metabolic homeostasis.

"Medical Necessity" and **"Medically Necessary"** means:

1. For the covered items and services listed in the **Sickness and Injury Benefits** Section of this **Certificate**, **Medical Necessity** and **Medically Necessary** is any applicable **Confinement** of an **Insured**, as well as any other diagnostic test, laboratory test, examination, surgery, medical treatment, service or supply listed therein that is **Provided** to an **Insured**:

   a) by or at the appropriate order, or upon the approval of a **Provider**;
   b) for the medically recognized diagnosis or care and treatment of an **Injury** or **Sickness**;
   c) in a manner appropriate and necessary for the symptoms, diagnosis or treatment of such **Injury** or **Sickness**;
   d) according to and within generally accepted standards for medical practice;
   e) in the most cost effective setting and manner available to treat the **Injury** or **Sickness**;
   f) not primarily for the convenience of an **Insured**, **Family**, or a **Provider**; and
   g) not investigational or experimental in nature.

2. For the covered items and services listed in the **Wellness and Screening Benefits [**and the] [**Miscellaneous Benefits]** Section[s] of this **Certificate**, **Medical Necessity** and **Medically Necessary** is any applicable diagnostic test, laboratory test, examination, or medical treatment, service or supply listed therein that is **Provided** to an **Insured**:

   a) reasonably designed to either prevent certain future **Sickness** or permit early diagnoses of certain **Sickness**;
   b) prescribed, performed and/or ordered by a **Provider**;
   c) appropriate and performed according to and within generally accepted standards for medical practice;
   d) rendered in the most cost effective setting and manner available, and
   e) not primarily for the convenience of an **Insured**, a **Family**, or a **Provider**.

The fact that a **Provider** prescribed, ordered, recommended or approved a service, supply, treatment or **Confinement** does not in and of itself make it **Medically Necessary** or a **Medical Necessity**.

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

"Mental and Emotional Disorders" means a neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

[“Miscellaneous Benefits” means only treatments, procedures, services, and supplies that are specifically enumerated in Section V.C. MISCELLANEOUS BENEFITS. If a treatment, procedure, service, or supply is not specifically enumerated in the MISCELLANEOUS BENEFITS Section, then fees charged or expenses associated with such items are not covered under this **Certificate** as a **Miscellaneous Benefit.]**

“Mode Of Premium Payment” means the interval of time (monthly, quarterly, semi-annual or annual) that you have selected for payment of the **Initial Premium** and **Renewal Premium**. The premium payment interval selected by **You** as the **Mode Of Premium Payment** is shown on the **Certificate Schedule**. This **Mode Of Premium Payment** is subject to change at **Our** discretion.

“Non-Complying Plan” means, in connection with Section IX. COORDINATION OF BENEFITS, a **Plan** with an order of benefit determination provision which does not comply with Section IX. A. ORDER OF BENEFIT DETERMINATION RULES.

[“Non-Participating Pharmacy” means a pharmacy that at the time **Covered Expenses** are incurred, has not entered into or has terminated a prior agreement to provide services to **Insureds** under this **Certificate**.]

“Non-Participating Provider” means a **Hospital**, **Provider**, **Ambulatory Surgical Center, Skilled Nursing Home**, or other licensed practitioner of the healing arts for which **Sickness and Injury Benefits** or **Wellness and Screening Benefits** are payable under this **Certificate** that, at the time **Covered Expenses** are incurred, has not entered into or has terminated a prior agreement to provide health care services to **Insureds** under this **Certificate** form at discounted rates.

“**Orthotic Device**” means an external device that is (i) intended to restore physiological function or cosmesis to a patient; and (ii) custom-designed, fabricated, assembled, fitted or adjusted for the patient using the device prior to or concurrent with the delivery of the device to the patient.

“**Orthotic Service**” means the evaluation and treatment of a condition that requires the use of an orthotic device.

“Other Insureds” means those members of **Your Family** that are listed on the **Certificate Schedule** on the **Issue Date.**

“Our” means Freedom Life Insurance Company of America.

“Outpatient” means **Medically Necessary** medical care, treatment, services or supplies from a **Provider** at (i) a clinic, (ii) an emergency room of a **Hospital**, (iii) an **Ambulatory Surgical Center**, (iv) an **Emergency Care Facility**, or (v) the surgical facility of a **Hospital** which does not result in an **Inpatient Confinement** at such **Hospital** following such surgery.

[“Outpatient Therapy Access Fee” means the amount of **Covered Expenses** an **Insured** must incur **[**per **Outpatient** visit] [per service] [per type of service] to any medical facility for any **Outpatient** non-surgical medical therapy or treatment under Section V.A. OUTPATIENT THERAPY before any **Benefits** are payable by **Us** under this **Certificate** for any **Outpatient** non-surgical medical therapy or treatment received by such **Insured** during each such visit. No **Benefits** are payable under this **Certificate** for any **Covered Expenses** for any non-surgical medical therapy or treatment received by such **Insured** on an **Outpatient** basis after the amount of the **Outpatient Therapy Access Fee** , the amount of the **Calendar Year Deductible**, the **Insured Coinsurance Percentage**, as well as the amount of all other applicable **Access Fees** are satisfied and fully payable by either **You** or such **Insured**. In addition to the **Outpatient Therapy Access Fee**, the **Separate Deductible for Non-Participating Providers** will apply to services rendered by **Non-Participating Providers**.

None of the following expenses may be used to satisfy the Outpatient Therapy Access Fee (i) **Laboratory and Diagnostic Testing Access Fee**, (ii) **Emergency Room Access Fee**, [(iii)] the amount of the **Separate Deductible for Non-Participating Providers**,[(iv)] the amount of **Covered Expenses** for which benefit payments are received by **You** under any optional rider issued with this **Certificate**,[(v)]the amount of any applicable **Failure to Pre-Certify Treatment Deductible**, [(vi)] the amount of the **Calendar Year Deductible,** [(vii)] [the amount of any applicable **Co-Pay**,] and [(viii)] the **Insured Coinsurance Percentage**.

The amount of the **Outpatient Therapy Access Fee** is shown on the **Certificate Schedule**.]

[**"Participating Pharmacy"** means a pharmacy that has entered into, and not terminated by the date the **Covered Expenses** are incurred, an agreement to dispense **Prescriptions** to **Insureds** under this **Certificate**. A **Participating Pharmacy** can be either a retail store or mail order for home delivery.]

"Participating Provider" means a **Hospital**, **Provider**, **Ambulatory Surgical Center**, **Skilled Nursing Home,** or other licensed practitioner of the healing arts for which **Sickness and Injury Benefits**, [and/or] **Wellness and Screening Benefits** [and/or] [**Miscellaneous Benefits]** are payable under this **Certificate** that has entered into, and not terminated by the date the **Covered Expenses** are incurred, an agreement to provide health care services to **Insureds** under this **Certificate** at discounted rates.

"Periodic Preventive Care Visits" means the routine tests and procedures for the purpose of detection of abnormalities or malfunctions of bodily systems and parts according to accepted medical practice.

"Plan(s)" means, in connection with Section IX. COORDINATION OF BENEFITS, this **Certificate** and other types of coverage that **We** may consider in determining whether over insurance exists with respect to a specific claim. The ORDER OF BENEFIT DETERMINATION RULES determines whether this **Certificate** is a **Primary Plan** or **Secondary Plan** when compared to another **Plan** covering the applicable **Insured**.

"Pre-Certification of Treatment" means the process of obtaining prior verbal or written authorization from **Us** for **Medically Necessary Inpatient Confinement** or surgery. **Pre-Certification of Treatment** is not required for **Emergency Inpatient** admission.

"Pre-existing Condition" means a condition, whether physical or mental, and regardless of the cause:

1. for which medical advice, diagnosis, care or treatment was recommended or received during the [twelve (12)] [twenty-four (24)] month period immediately preceding the effective date of coverage under this **Certificate** for the **Insured** incurring the expense; or
2. which **Manifested** during the [twelve (12)] [twenty-four (24)] month period immediately preceding the effective date of coverage under the **Certificate** for the **Insured** incurring the expense.

This **Certificate** provides coverage as of the **Issue Date** for **Pre-existing Conditions**, disclosed on the application, provided they are not otherwise limited or excluded by this **Certificate** or any riders, amendments, or endorsements attached hereto.

This **Certificate** does not cover expenses for **Pre-existing Conditions**, that are not disclosed on the application, unless the expenses are incurred more than [twelve (12)] [twenty-four (24)] months after the **Insured's** coverage has been in effect, and are not otherwise limited or excluded by this **Certificate** or any riders, amendments, or endorsements attached hereto.

[**"Preferred Brand Drugs"** means each **Brand Name Drug** that is identified and listed upon the **Preferred Drug List**. In certain circumstances, a **Preferred Brand Drug** maybe a medically acceptable alternative medication to a **Brand Name Drug** that is not listed on the **Preferred Drug List** such that an **Insured** may want to consult with his/her **Provider** and the pharmacist of the **Participating Pharmacy** regarding whether such **Preferred Brand Drug** would be appropriate and proper in the treatment of such **Insured's** condition.]

[**"Preferred Drug List"** means a list either created or sponsored by **Us**, which identifies certain **Brand Name Drugs** that may be preferred. The **Preferred Drug List** is updated from time to time and may be found on the Internet at www.ushealthgroup.com in the prescription services location of the website. **You** may also call the toll free Rx Help Desk number on your ID card.]

"Premium Rate Guarantee Period" means the number of months [(that **We** guarantee **Your** premium will not increase more than [five-twenty percent][5%-20%] annually on **Your** anniversary)] immediately following the **Issue Date] [**that must expire before the amount of **Renewal Premium** charged by **Us]** (with the same **Mode of Premium Payment** as the **Mode of Premium Payment** selected for payment of the **Initial Premium**) [can be higher than the amount of the **Initial Premium] [**because of (i) a change by **Us** in the table of premium rates used to calculate the **Initial Premium**, or (ii) an increase in the attained age after the **Issue Date** of any **Insured** listed on the **Certificate Schedule**.] However, the amount of **Renewal Premium** required for this

Certificate may be increased by **Us**, even during the **Premium Rate Guarantee Period**, if after the **Issue Date**:

1. **You** add **Insureds** to this **Certificate**;
2. **You** change the amount of the **Calendar Year Deductible** shown on the **Certificate Schedule**;
3. **You** change the **Insured Coinsurance Percentage** shown on the **Certificate Schedule**;
4. **You** change any other coverage option;
5. **You** change residence to a different zip code;
6. **You** change the **Mode Of Premium Payment**;
7. **You** add optional coverage riders, if any;
8. **You** change to a different optional **Participating Provider** network available in **Your** state, if any;
9. a **change occurs in the relationship between US** and **Your Participating Provider** network;
10. the **Participating Provider** network availability changes for **Your** state;
11. the **Participating Provider** negotiated discounts change; and/ or
12. a change occurs in **Sickness and Injury Benefits**, [and/or] **Wellness and Screening Benefits**, [and/or the] [**Miscellaneous Benefits]** by amendatory endorsement pursuant to any federal or state law or regulation.

The length of the **Premium Rate Guarantee Period** is shown on the **Certificate Schedule**.

"Prescription" means the **Medically Necessary** authorization for a **Prescription Drug** to be dispensed to an **Insured** on an **Outpatient** basis pursuant to the order of a **Provider** who is acting within the scope of his or her license to treat an **Injury** or **Sickness**. [Retail store filled **Prescriptions** for which **Sickness and Injury Benefits** are payable under this **Certificate** will be limited to a single thirty (30) day supply for each new or refilled **Prescription Drug**, unless adjusted based on the drug manufacturer's packaging size or based on supply limits. Mail order for home delivery filled **Prescriptions** for which **Sickness and Injury Benefits** are payable under this **Certificate** will be limited to a single ninety (90) day supply for each new or refilled **Prescription Drug**.]

"Prescription Drug" means legend drugs and medications that by Federal law may only be legally obtained on an **Outpatient** basis with a **Prescription**.

["Prescription Drug Calendar Year Deductible Per Insured" means the amount of **Covered Expenses** an **Insured** must incur, [after satisfaction of any applicable **Co-Pay**,] within a **Calendar Year** before any **Outpatient Prescription Drug Benefit** is payable.]

["Prescription Drug Company Insurance Percentage" means the portion of the **Covered Expenses We** must pay to or on behalf of an **Insured** for **Prescription Drug Benefits** under this **Certificate**, after satisfaction by the **Insured** of (i) all applicable **Co-Pays**, (ii) all applicable deductibles and (iii) the amount of the applicable **Prescription Drug Insured Coinsurance Percentage**. The **Prescription Drug Company Insurance Percentage** is shown on the **Certificate Schedule** for **Covered Expenses** for **Prescription Drug Benefits** at (i) **Participating Pharmacies** ; and (ii) **Non-Participating Pharmacies**.]

["Prescription Drug Co-Pay" means the **Co-Pay** payment that is required toward the total amount of **Covered Expenses** per **Prescription** per **Insured** under Section V. A. OUTPATIENT PRESCRIPTIONS. **Co-Pays** may not be used to satisfy the **Calendar Year Deductible**, [**Prescription Drug Calendar Year Deductible Per Insured]**, the **Insured Coinsurance Percentage**, [**Prescription Drug Insured Coinsurance Percentage**] the **Separate Deductible for Non-Participating Providers**, any applicable **Access Fees**, the amount of **Covered Expenses** for which benefit payments are received by **You** under any optional rider issued with this **Certificate**, or the amount of any applicable **Failure to Pre-Certify Treatment Deductible**.**]**

[The remaining amount of **Covered Expenses** after the application and satisfaction of the designated **Prescription Drug Co-Pay** is subject to the **Calendar Year Deductible** [the **Separate Deductible for Non-Participating Providers**,] and the **Insured Coinsurance Percentage.]**

The amount of the **Prescription Drug Co-Pay** is shown on the **Certificate Schedule**]

["Prescription Drug Insured Coinsurance Percentage" means the portion of the **Covered Expenses** that **You** must pay after satisfaction of all applicable **Co-Pays** and deductibles. The different **Prescription Drug Insured**

Coinsurance Percentages are shown on the **Certificate Schedule** at (i) **Participating Pharmacies**, and (ii) **Non-Participating Pharmacies**.]

"Primary Insured" means the individual whose name is printed on the **Certificate Schedule** as the **Primary Insured** and whose coverage under this **Certificate** has not ended.

"Primary Plan" means, in connection with Section IX. COORDINATION OF BENEFITS, of this **Certificate** the **Plan** that pays first pursuant to the order of benefit determination rules contained in such Section without regard to the possibility that another **Plan** may cover some expenses of the applicable **Insured**.

"**Prosthetic Device**" means an external device that is (i) intended to replace an absent external body part for the purpose of restoring physiological function or cosmesis to a patient; and (ii) custom-designed, fabricated, assembled, fitted, or adjusted for the patient using the device prior to or concurrent with being delivered to the patient.

"**Prosthetic Service**" means the evaluation and treatment of a condition that requires the use of a prosthetic device.

"Provide", "Provided" or **"Providing"** means each medical, diagnostic and surgical test, service, care, treatment, supply, [including **Prescriptions**,] which is:

1. prescribed or ordered by a **Provider;**
2. rendered to and received by an **Insured** while coverage under this **Certificate** for such **Insured** is in full force and effect;
3. listed as a covered item, type of service and/or supply in the **Sickness and Injury Benefits**, [and/or] **Wellness and Screening Benefits**, and/or [**Miscellaneous Benefits]** Sections; and
4. not otherwise limited or excluded by any provision in this **Certificate** or rider, endorsement or amendment attached hereto.

"Provider" means a person who has successfully completed the prescribed course of studies in medicine at a medical school officially recognized and accredited in the country in which it is located, and which person has been licensed by the state in which the medical services are rendered to practice medicine. The **Provider** must be acting within the scope of such license while rendering **Medically Necessary** professional service to an **Insured**, and cannot be a member of the **Insured's Family**.

"Renewal Premium" means the amount charged for coverage of all **Insureds** under this **Certificate** for the period of time from the **First Renewal Date** through the day before each subsequent renewal coverage renewal date. **Renewal Premium** for each renewal period is payable in advance for each applicable renewal period.

"Retrospective Review" means a review of **Medical Necessity** conducted after services have been **Provided** to a **Covered Insured**, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment.

"Secondary Plan(s)" means, in connection with Section IX. COORDINATION OF BENEFITS, the **Plan** that pays after the **Primary Plan** pursuant to the order of benefit determination rules contained in such Section, and such **Secondary Plan** may reduce its benefit payments that the benefit payments from all **Plans** do not exceed 100% of the total **Allowable Expense**.

"Separate Deductible For Non-Participating Providers" meansthe amount of **Covered Expenses** an **Insured** must incur in a **Calendar Year** for services rendered by **Non-Participating Providers** before any applicable **Sickness and Injury Benefits** or **Wellness and Screening Benefits** are payable under this **Certificate**.

No **Sickness and Injury Benefits** or **Wellness and Screening Benefits** are payable under this **Certificate** for services rendered by **Non-Participating Providers** until after the **Separate Deductible For Non-Participating Providers** is satisfied and fully payable by either **You** or such **Insured**. The amount of the **Separate Deductible For Non-Participating Providers** is shown on the **Certificate Schedule** and applies per **Calendar Year** separately to each **Insured**.

None of the following expenses may be used to satisfy the **Separate Deductible For Non-Participating Providers**: (i) the amount of the **Calendar Year Deductible**; (ii) the amount of any applicable [**Co-Pays** and] **Access Fees**; (iii) [the amount of Covered **Expenses** that constitute **Miscellaneous Benefits** for which payment is made by **Us**;] and (iv) the amount of the **Failure to Pre-certify Treatment Deductible**.

[When [three (3)] **Insureds** satisfy this **Separate Deductible For Non-Participating Providers**, no additional **Separate Deductible For Non-Participating Providers** per **Insured** will be required for the remainder of the **Calendar Year**.]

[If [two (2)] or more **Insureds** incur **Covered Expenses** for **Injuries** sustained in the same accident, only one (1) **Separate Deductible For Non-Participating Providers** will be applied that **Calendar Year** to the combined **Covered Expenses** resulting from the **Injuries** sustained in such common accident by all **Insureds**.]

"Sickness" means illness or disease afflicting an **Insured**, including **Complications of Pregnancy**, which first **Manifests** itself on or after the **Issue Date** shown on the **Certificate Schedule** and while this **Certificate** is in force and effect for such **Insured**.

Provided, however, any expenses incurred by an **Insured** (from a condition which is not otherwise excluded by a rider, endorsement, or amendment attached to this **Certificate**), which results from hernia, disease or disorders of the reproductive organs, hemorrhoids, varicose veins, tonsils and/or adenoids, or otitis media, shall be eligible for consideration as **Covered Expenses** only if such expenses are incurred after the expiration of six (6) months from the **Issue Date** shown on the **Certificate Schedule** or are **Provided** on an **Emergency** basis.

"Sickness and Injury Benefit(s)" mean only treatments, procedures, services, and supplies that are specifically enumerated in Section V.A. SICKNESS AND INJURY BENEFITS. If a treatment, procedure, service, or supply is not specifically enumerated in the SICKNESS AND INJURY BENEFITS Section**,** then fees charged or expenses associated with such items are not covered under this **Certificate** as a **Sickness and Injury Benefit**. Payments by **Us** for **Sickness and Injury Benefits** are subject to all definitions, exclusions, limitations and provisions contained herein, including but not limited to the satisfaction and payability by **You** or the applicable **Insured** of all applicable deductibles, as well as the limitation of the **Company Insurance Percentage**.

"Skilled Nursing Home" means a place which:

1. charges patients for their services;
2. is legally operated in the state (or similar jurisdiction) in which it is located;
3. has beds for patients who need medical and skilled care;
4. operates under a doctor's supervision;
5. has continuous twenty-four (24) hour nursing service supervised by a registered nurse (R.N.); and
6. keeps complete medical records on each patient.

Skilled Nursing Home also means a wing, area or floor of a **Hospital** specifically set aside to provide care similar to that of a **Skilled Nursing Home**, but it does not mean a **Hospital**.

"Solid Organ Transplant(s)" means the **Medically Necessary** surgical transplantation, combined transplantation, sequential transplantation, (including grafts) of the following **Medically Necessary** organs received by an **Insured** while coverage for such **Insured** under this **Certificate** is in full force and effect:

1. heart;
2. lung;
3. kidney;
4. pancreas;
5. combined heart/lung;
6. combined kidney/pancreas;
7. skin;
8. eye or parts thereof (including lens and cornea); and
9. liver (**Insureds** who are candidates for liver transplantation must have abstained from the use of alcohol for one year immediately prior to such transplantation surgery in order for the planned liver transplantation to constitute a **Solid Organ Transplant**).

"Stem Cell Transplants" means the **Medically Necessary** insertion or transplantation, combined insertion or transplantation, sequential insertion or transplantation procedures, in which any **Medically Necessary** form of stem cells are received by an **Insured** while coverage for such **Insured** under this **Certificate** is in full force and effect.

"Subsequent Certificate Year(s)" means each twelve (12) month period ending on each anniversary of the **Issue Date** following the **First Certificate Year**.

"Termination of Coverage" means Section III.C. TERMINATION OF COVERAGE, that governs the conditions and circumstances under which the coverage provided by this **Certificate** may be terminated for any or all **Insureds**.

"Total Disability" or **"Totally Disabled"** means that, due to an **Injury** or **Sickness**, an **Insured** is:

1. under a **Provider's** continuous care; and
2. not able to perform the normal activities of a person of like age or sex who is in good health; and
3. unable to engage in any activity, occupation, or business for income or profit, for which such **Insured** is qualified by reason of training, education, or experience.

"Us" means Freedom Life Insurance Company of America.

"Usual and Customary Expense" means the following:

1. For **Providers Usual and Customary Expense** is the seventieth (70th) percentile of the prevailing charges by all **Providers** in the same geographic area as such **Provider**, as determined by one of the current prevailing health care charges information systems in the insurance industry utilizing the applicable **CPT Code** for such services or treatment and the applicable zip code (first 3 or 5 digits) of such **Provider**.

2. For services or treatments **Provided** by **Hospitals**, **Ambulatory Surgical Centers**, **Emergency Care Facilities**, **Skilled Nursing Homes**, pharmacies or other applicable facilities, **Usual and Customary Expense** is average charge made for similar services or supplies in the locality where the service or supply is furnished, taking into consideration the nature and the severity of the **Injury** or **Sickness** suffered by the **Insured**.

Provided, however, that **Usual and Customary Expense** shall never exceed the **Medicare** allowable or approved charge with respect to **Insureds** who are **Medicare** eligible.

"Utilization Review" means a system for prospective or concurrent review of the **Medical Necessity** and appropriateness of health care services being **Provided,** or proposed to be **Provided,** to an **Insured** within this state. **Utilization Review** does not include elective requests for clarification of coverage.

"We" means Freedom Life Insurance Company of America.

"Wellness and Screening Benefit(s)" means only treatments, procedures, services, and supplies that are specifically enumerated in the Section V.B. WELLNESS AND SCREENING BENEFITS. If a treatment, procedure, service, or supply is not specifically enumerated in the WELLNESS AND SCREENING BENEFITS Section, then fees charged or expenses associated with such items are not covered under this **Certificate** as a **Wellness and Screening Benefit**.

["X-Ray, Laboratory and Diagnostic Testing Co-Pay" means the **Co-Pay** payment that is required [per visit per **Insured]** [per type of service] toward the applicable amount of **Covered Expenses** incurred by an **Insured** for **Outpatient** testing, per **Calendar Year** per **Insured,** at the professional offices of a physician who is a **Participating Provider** as defined in the **Certificate. Co-Pays** may not be used to satisfy the **Calendar Year Deductible**, the **Insured Coinsurance Percentage**, the **Separate Deductible for Non-Participating Providers**, [any applicable **Access Fees**,] the amount of **Covered Expenses** for which benefit payments are received by **You** under any optional rider issued with this **Certificate**, or the amount of any applicable **Failure to Pre-Certify Treatment Deductible**.]

[The remaining amount of **Covered Expenses** after the application and satisfaction of the **X-Ray, Laboratory and Diagnostic Testing Co-Pay** is subject to the **Calendar Year Deductible** [the **Separate Deductible for Non-Participating Providers**,] [any applicable **Access Fees**,] and the **Insured Coinsurance Percentage.]**

[The amount of the **X-Ray, Laboratory and Diagnostic Testing Co-Pay** is shown on the **Certificate Schedule**.]

"You", "Your" and **"Yours"** means the individual listed on the **Certificate Schedule** as the **Primary Insured**.

"Your Renewal Premium Class" means the **Class** in which this **Certificate** is placed for **Renewal Premium** purposes. **Your Renewal Premium Class** will be determined by **Us** based upon several factors, including, among other things, a combination of one or more of the following: (i) **Your** zip code (either first 3 or first 5 digits) at the commencement of such renewal period, (ii) **Your** county of residence at the commencement of such renewal period, (iii) **Your** state of residence at the commencement of such renewal period, (iv) the **Issue Date**, (v) **Your** state of residence on the **Issue Date**, (vi) the number, sex, attained age, and tobacco use of each **Insured** on each applicable renewal date, (vii) **Your** plan of coverage under this **Certificate** on each applicable renewal date, including its deductibles, **Benefits**, limits, exclusions, limitations, optional riders, and exclusionary endorsements (viii) the underwriting risk assessment of each **Insured**, (ix) discounted or preferred premium rate status of any **Insured**, (x) premium rate ups, if any, for any **Insured**, (xi) the amount of the **Initial Premium**, (xii) the amount of the **Renewal Premium** charged in the preceding renewal period, (xiii) **Mode of Premium Payment** for the renewal period and (xiv) the number and type other certificates of coverage issued by **Us** covering individuals in **Your** current state of residence with the same or similar factors described above.

"Your Spouse" means the spouse of the **Primary Insured** who (i) is either listed as an **Other Insured** on the **Certificate Schedule** or later added to this **Certificate,** and (ii) is an **Insured** whose coverage has not ended by the date of such spouse's death.

III. WHEN COVERAGE BEGINS AND ENDS

A. EFFECTIVE DATE

This **Certificate** is effective at 12:01 A.M. local time where **You** live on the **Issue Date** shown on the **Certificate Schedule**.

B. ELIGIBILITY AND ADDITIONS

Your spouse; **Your** unmarried, dependent children who are under the age of [19 (24 if a **Full-Time Student**]; and grandchildren who are considered **Your** dependents for federal income tax purposes and who are under age [19 (24 if a **Full-Time Student**]; any children which an **Insured** is required to insure under a medical support order; any child whom **You**, or **Your Spouse** (if listed as an **Other Insured** on the **Certificate Schedule**), intends to adopt and has become a party to a suit for that purpose; and any child who is in the custody of an **Insured** under a temporary court order that grants the **Insured** conservatorship of the child, are eligible for this coverage. Any eligible dependent (other than a newborn or adoptee) will be added to this **Certificate** when **We** approve the written application for such coverage, and accept payment of any necessary premium.

Newborn children born after the **Issue Date** to **You**, or **Your Spouse**, while this **Certificate** is in full force and effect (a newborn child) will be automatically insured under this **Certificate** from and after the moment of birth for a period of ninety (90) days or before the next premium due date, whichever is later. If **You** wish to continue such automatic coverage under this **Certificate** for any such newborn child past the initial ninety (90) day period or beyond the next premium due date, **You** must notify **Us** of such birth and **Your** desire for such continued coverage under this **Certificate** within ninety (90) days or before the next premium due date after the date of such newborn child's birth. **You** must also pay any additional premium required for such additional coverage within such ninety (90) day period or before the next premium due date. If **You** do not notify **Us** of such birth and **Your** desire for continued coverage under this **Certificate** within such ninety (90) day period or before the next premium due date, and timely pay any additional premium that may be due, then the automatic coverage under this **Certificate** for such newborn child will end after the expiration of ninety (90) days or the next premium due date, whichever is later, from the date of such newborn child's birth. **We** will notify **You** if more premium is needed.

Newborn children born after the **Issue Date** and immediately placed for adoption after birth with **You**, or **Your Spouse**, while this **Certificate** is in full force and effect (a newborn adoptee) will be automatically insured under this **Certificate** from and after the date of the adoption placement of such newborn adoptee for a period of sixty (60) days. If **You** wish to continue such automatic coverage under this **Certificate** for any such newborn adoptee past the initial sixty (60) day period, **You** must notify **Us** of such birth, adoption placement and **Your** desire for continued coverage under this **Certificate** within sixty (60) days after the date of the adoption placement of such newborn adoptee. **You** must also pay any additional premium required for such additional coverage within such sixty (60) day period. If **You** do not notify **Us** within such sixty (60) day period of the birth, adoption placement and Your desire for continued coverage under this **Certificate** for such newborn adoptee and timely pay any additional premium that may be due, then the automatic coverage under this **Certificate** for such newborn adoptee will end after the expiration of day from the date of such adoption placement of such newborn adoptee. **We** will notify **You** if more premium is needed.

If **You** wish to have automatic coverage under this **Certificate** after the **Issue Date** for any child not listed as an **Other Insured** on the **Certificate Schedule**, but for which adoption or custody of such child is sought by **You** or **Your Spouse** in a civil suit or other judicial custody proceeding filed or initiated after the **Issue Date**, **You** must notify **Us** within thirty-one (31) days after **You** or **Your Spouse**, as applicable: (i) become a party in such civil suit in which such adoption of the child is sought; or (ii) obtain custody of the child under the first court order (including temporary orders) that grants conservatorship and/or custody of the child. **You** must also pay any additional premium required for such additional coverage within such thirty-one (31) day period. If **You** do not notify **Us** within such applicable thirty-one (31) day period of **Your** desire for automatic coverage under this **Certificate** in the future for such child and timely pay any additional premium that may thereafter become due, then no automatic coverage will be afforded under this **Certificate** for such child. **We** will notify **You** if more premium is needed.

C. TERMINATION OF COVERAGE

1. TERMINATIONS SUBJECT TO RIGHT OF CONVERSION

Subject to the Section III. E. CONTINUATION OF COVERAGE AND CERTIFICATE OF CONVERSION below, an applicable **Insured's** coverage under this **Certificate** ends on the earlier of the following:

a. the premium due date in the month following the date the **Group Policy** is terminated by the **Group Policyholder**, in which case **You** will be given thirty (30) days prior written notice of the termination, mailed to **Your** last known address;
b. with respect to **Your** spouse who is covered under this **Certificate**, the premium due date in the month following the effective date of **Your** divorce decree, annulment or court approved separation;
c. with respect to **Your** child(ren) who are covered under this **Certificate**, the premium due date in the month following such **Insured's** 19th birthday (24th if a **Full-Time Student**).

2. TERMINATIONS BY PRIMARY INSURED NOT SUBJECT TO RIGHT OF CONVERSION

Section III.E. CONTINUATION OF COVERAGE AND CERTIFICATE OF CONVERSION notwithstanding, the following described actions by either the **Primary Insured** or other applicable **Insured** will result in a termination of each applicable **Insured's** coverage under this **Certificate** with no right of conversion, in which event the coverage ends on the earlier of the following:

a. the due date of any unpaid **Renewal Premium**, subject to the grace period; or
b. the date **You** terminate coverage by notifying **Us** of the date **You** desire coverage to terminate and specify the **Insured** whose coverage is to terminate.

3. TERMINATION OF THE CERTIFICATE BY THE COMPANY NOT SUBJECT TO RIGHT OF CONVERSION

Section III.E. CONTINUATION OF COVERAGE AND CERTIFICATE OF CONVERSION notwithstanding, **We** may refuse to renew and cancel coverage for all **Insureds** under this **Certificate** with no right of conversion for the following reasons:

a. **We** are required by the order of an appropriate regulatory authority to non-renew or cancel the **Certificate** or **Group Policy**;
b. **We** cease offering and renewing coverage of the same form of coverage as this **Certificate** in **Your** state upon a minimum of ninety (90) days prior written notice mailed to **Your** last known address with an opportunity for **You** to convert to any similar medical expense policy or certificate that **We** are then actively marketing and offering to new applicants in **Your** state;
c. **We** elect to discontinue offering all similar types of coverage under any association group or individual medical-surgical expense policy forms in **Your** state and to terminate all such certificates of coverage and individual policies in **Your** state, including **Your** form of coverage, in which case the commissioner of insurance for **Your** state, the **Group Policyholder** and **You** will be given a minimum of one hundred eighty (180) days prior written notice of the termination, mailed to **Your** last known address; or
d. the date **We** receive due proof that fraud or intentional misrepresentation of material fact existed in applying for this **Certificate** or in filing a claim for **Benefits** under this **Certificate**.

4. TERMINATION OF AN INSURED BY THE COMPANY NOT SUBJECT TO RIGHT OF CONVERSION

Section III.E. CONTINUATION OF COVERAGE AND CERTIFICATE OF CONVERSION notwithstanding, **We** may refuse to renew and cancel coverage for each **Insured** under this **Certificate** with no right of conversion for the following reasons:

a. the total amount of any **Benefit** payments made by **Us** are equal to the **Lifetime Certificate Maximum Per Insured**; or
b. the date **We** receive due proof that fraud or intentional misrepresentation of material fact existed in applying for this **Certificate** or in filing a claim for **Benefits** under this **Certificate**.

As long as this **Certificate** is in force for **You**, the coverage of **Your** child who is an **Insured** will not end if he or she is dependent upon **You** for support and maintenance and incapable of self-support because of a mental handicap or physical disability. Such dependent **Insured's** coverage under this **Certificate** will continue regardless of the dependent **Insured's** age, as long as **Renewal Premium** is timely and properly paid for **You** and the dependent **Insured** and such dependent **Insured** remains dependent upon **You** and incapable of self support because of such mental handicap or physical disability. Proof of such handicap or disability must be furnished to **Us** as soon as reasonably possible prior to the dependent **Insured** reaching the limiting age, and thereafter upon **Our** request, but not more frequently than annually after the two (2) year period following the attainment of the limiting age.

Any termination of coverage or of this **Certificate** will be effective at 11:59 P.M. local time where **You** live on the date(s) specified above.

If **You** die, **Your Spouse**, if then an **Insured** under this **Certificate**, will become the **Primary Insured**. If **You** and **Your** spouse (if any) are not covered under this **Certificate**, the oldest **Insured** will become the **Primary Insured**.

We will not accept premium for any **Insured** whose coverage has terminated. Premiums, which are sent to **Us** and include an amount to cover the **Insured** whose coverage has terminated, will be returned. **We** will only accept the correct premium to cover those **Insureds** who are eligible for coverage. If premiums are accepted in error, **Our** liability is limited to coverage for the period of time for which premiums were accepted in error.

Except for claims involving fraud or intentional misrepresentation of material fact, any termination will be without prejudice to any **Covered Expenses** incurred by an **Insured** for **Sickness and Injury Benefits**, [or] **Wellness and Screening Benefits** [or] [**Miscellaneous Benefits]** prior to the date of termination. If coverage is terminated, unearned premium will be computed pro-rata and any unearned premium will be refunded to **You**.

D. EXTENSION OF BENEFITS

If the **Group Policy** terminates while an **Insured** is **Totally Disabled**, **Sickness and Injury Benefits** will be extended for **Covered Expenses** incurred by such **Insured** after the date of termination of coverage under this **Certificate**. These extended **Sickness and Injury Benefits** are subject to the same terms that would have applied if the **Group Policy** had remained in force.

Extended **Sickness and Injury Benefits** are payable only (i) for **Covered Expenses** incurred for treatment of the specified **Injury** or **Sickness** that caused **Total Disability** of an **Insured** and while coverage under this **Certificate** for such **Insured** was in full force and effect and (ii) while the **Insured** remains **Totally Disabled** until the earlier of:

1. the day the **Total Disability** ends;
2. the date twelve (12) months after the date the **Group Policy** terminated; or
3. the day the person becomes covered under a replacement policy providing substantially equal or greater benefits which replaces coverage under the **Group Policy**.

Subject to the terms and conditions otherwise contained herein, Benefits shall be payable for Covered Expenses incurred by an **Insured** who is **Hospital Confined** on the date of termination, if the **Group Policy** is terminated and replaced by a group health insurance policy or contract issued by another insurer. **Benefits** are payable until the **Hospital Confinement** ends or **Hospital Benefits** under this contract have been exhausted, whichever is earlier.

E. CONTINUATION OF COVERAGE AND CERTIFICATE OF CONVERSION

A **Certificate Of Conversion Coverage**, whereby the coverage then afforded by this **Certificate** for an applicable **Insured** will continue without a requirement of any additional evidence of the insurability of such **Insured**, is available only:

1. for **Your** spouse who is covered under this **Certificate**, if his or her coverage ceases due to divorce, annulment or court approved separation;
2. for **Your** unmarried child(ren) who is covered under this **Certificate**, if his or her coverage ceases due to his or her reaching the limiting age of 19 (24 if enrolled as a **Full-Time Student**), or
3. for each applicable **Insured**, if coverage under this **Certificate** terminates because the **Group Policyholder** has terminated coverage under the **Group Policy**, and does not replace coverage with another group policy, in which case **You** will be given thirty (30) days prior written notice of the termination, mailed to **Your** last known address. Upon termination of the **Group Policy**, **You** may apply on behalf of all **Insureds** for a **Certificate Of Conversion Coverage**. The **Certificate Of Conversion Coverage** must be applied for and the first premium received by **Us** within thirty-one (31) days after the date that coverage under the **Group Policy** terminates. If a **Certificate Of Conversion Coverage** is issued, it will take effect on the day after coverage under the **Group Policy** terminates.

A **Certificate Of Conversion Coverage** is not available and will not be provided if:

1. an **Insured** has full coverage under any other group accident and health certificate or contract.
   a. to be full coverage the plan must provide benefits for all pre-existing conditions,
   b. an **Insured** may continue his or her previous group coverage until all pre-existing conditions are or would be covered under another group policy or contract or until termination;
2. an **Insured's** coverage under the **Group Policy** ceases because the **Group Policy** was terminated and was replaced by similar group coverage within thirty-one (31) days;
3. an **Insured's** coverage under this **Certificate** ceases because of failure to pay the required premiums in the time allowed;
5. an **Insured** is covered by similar benefits furnished by any:
   a. medical expense plan;
   b. medical service subscriber contract;
   c. medical pre-payment plan; or
   d. medical plan provided in accordance with the requirements of any state or federal law;
6. an **Insured** is eligible to be covered by any group plan, insured or uninsured:
   a. medical expense plan;
   b. medical service subscriber contract;

c. medical pre-payment plan; or
d. medical plan provided in accordance with the requirements of any state or federal law;

7. **We** were required by the order of an appropriate regulatory authority to non-renew or cancel the **Certificate** or **Group Policy**;
8. The total amount of **Benefit** payments made by **Us** are equal to the **Lifetime Certificate Maximum Per Insured**;
9. **We** cease offering and renewing coverage under the same form of coverage as this **Certificate** in **Your** state upon a minimum of ninety (90) days prior written notice mailed to **Your** last known address with an opportunity for **You** to convert to any similar medical expense policy or certificate that **We** are then actively marketing and offering to new applicants in **Your** state;
10. **We** elect to discontinue offering all similar types of coverage under any association group or individual medical-surgical expense policy forms in **Your** state and to terminate all such certificates of coverage and individual policies in **Your** state, including **Your** form of coverage, in which case the commissioner of insurance for **Your** state, the **Group Policyholder** and **You** will be given a minimum of one hundred eighty (180) days prior written notice of the termination, mailed to **Your** last known address;
11. **You** voluntarily terminated coverage under this **Certificate** for any **Insured** by notifying **Us** of the date **You** desired such coverage to terminate;
12. **We** received due proof that fraud or intentional misrepresentation of material fact existed in applying for this **Certificate** or in filing a claim for **Benefits** under this **Certificate**; or
13. The **Insured** is or could be covered by **Medicare**.

In order to be eligible for a **Certificate Of Conversion Coverage**, a written election of continuation of coverage via conversion must be made by the applicable **Insured**, on a form furnished by **Us**, and the first premium must be paid, in advance, to **Us** on or before the date on which the applicable coverage under this **Certificate** for such **Insured** would otherwise terminate. The amount of first premium required from the effective date through the end of the first renewal period of the **Certificate Of Conversion Coverage** shall not be more than **Our** full group premium rate then applicable for the applicable **Insured** under the **Certificate** with the same mode of payment. Applicable **Insureds** shall not be required to pay the **Renewal Premium** for a **Certificate Of Conversion Coverage** less often than monthly.

IV. PREMIUM

A. INITIAL PREMIUM

The **Initial Premium** specified on the **Certificate Schedule** is due and payable to the **Company** at its home office on or before the **Issue Date**. This **Initial Premium** payment will keep this **Certificate** in force until the **First Renewal Date**. The amount of the **Initial Premium** and the **First Renewal Date** are shown on the **Certificate Schedule**. **Initial Premium** has been determined by **Us** for this **Certificate** on a **Class** basis. **Your Class** for **Initial Premium** was determined by **Us** based upon several factors, including, among other things, a combination of the following: (i) **Your** zip code (either first 3 or first 5 digits); (ii) **Your** county of residence; (iii) **Your** state of residence; (iv) the number, age, sex and tobacco use of each **Insured** listed on the **Certificate Schedule**; (v) the plan of coverage contained in this **Certificate** on the **Issue Date**, including its deductibles, **Benefits**, limitations, and exclusions; (vi) the health status of each applicant, including the results of any required physical examination and laboratory test results; (vii) **Participating Provider** network selected on the application, (viii) the underwriting risk assessment of each **Insured**; (ix) the discounted or preferred premium rate status of any **Insured;** (x) premium rate ups, if any, for any **Insured**; (xi) **Mode Of Premium Payment** selected on the application; (xii) distribution channels; (xiii) administrative costs; (xiv) taxes; (xv) other economic factors; and/or (xvi) other certificates of coverage issued and to be issued by **Us** covering individuals in **Your** current state of residence with the same or similar factors described above.

B. RENEWAL PREMIUM

1. CALCULATION - PAYMENT

The current **Mode Of Premium Payment** is shown on the **Certificate Schedule**. **Renewal Premium** is payable on or before its due date, and must be paid to the **Company** at its home office. Any **Renewal Premium** not paid on or before its due date is a premium in default. If a **Renewal Premium** payment

default is not corrected and properly paid before the end of the grace period, coverage under this **Certificate** will terminate.

Renewal Premium rates for this **Certificate** may be increased by **Us** for any renewal period after the **Issue Date**, including during the **Premium Rate Guarantee Period**, if after the **Issue Date**:

a. **You** add **Insureds** to this **Certificate**;
b. **You** change the amount of the **Calendar Year Deductible** shown on the **Certificate Schedule**;
c. **You** change the **Insured Coinsurance Percentage** shown on the **Certificate Schedule**;
d. **You** change any other coverage option;
e. **You** change residence to a different zip code;
f. **You** change the **Mode Of Premium Payment**;
g. **You** add optional coverage riders, if any;
h. **You** change after the **Issue Date** to a different optional **Participating Provider** network available in **Your** state, if any;
i. a change occurs in the relationship between **Us** and **Your Participating Provider** network:
j. the **Participating Provider** network availability changes for Your state;
k. the **Participating Provider** negotiated discounts change; and/or
l. a change occurs in **Sickness and Injury Benefits**, [and/or] **Wellness and Screening Benefits**, [and/or the] [**Miscellaneous Benefits]** by amendatory endorsement pursuant to any federal or state law or regulation.

The current table of premium rates upon which the **Initial Premium** and the **First Renewal Premium** were calculated for this **Certificate** may include scheduled increases in the amount of **Renewal Premium** based upon the future attained age of each **Insured**. To be eligible for a discounted or preferred premium rate each **Insured** may be required to complete a preferred health risk assessment upon enrollment and at renewal. Additionally, the current table of premium rates upon which the **Initial Premium** and **First Renewal Premium** were calculated and any subsequent table of premium rates upon which the **Renewal Premium** for any renewal period is to be calculated may be changed from time to time by **Us**. Accordingly, after expiration of the **Premium Rate Guarantee Period**, the amount of **Renewal Premium** may be increased for any renewal period based upon items a. through i. above as well as the following:

a. a new attained age of any **Insured** reached prior to the first day of any renewal period,
b. change by **Us** in the table of premium rates used to calculate the **First Renewal Premium,** and
c. change by **Us** in the table of premium rates used to calculate **Renewal Premium** for any prior renewal period.

Any changes in the table of premium rates establishing the amount of required **Renewal Premium** during any renewal period will be implemented on a **Class** basis for all members of **Your Renewal Premium Class**. Factors that may be involved and considered by **Us** in determining the amount of **Renewal Premium** to be charged to **Your Renewal Premium Class** during any renewal period include, among other things, a combination of one or more of the following: (i) past claims experience of **Your Renewal Premium Class**; (ii) anticipated inflationary trends in the cost of future medical services; (iii) historical experience in the inflationary cost of medical services; (iv) anticipated inflationary trends in the cost of **Prescription Drugs**; (v) historical experience in the past inflationary cost of **Prescription Drugs**; (vi) anticipated future claims experience of **Your Renewal Premium Class**; (vii) other economic factors; (viii) anticipated advances in the medical diagnosis capabilities of injuries and illnesses, including the anticipated cost thereof; (ix) anticipated advances in the manner, method and delivery of medical care and treatment, including the anticipated cost thereof; and (x) any other reason permitted by applicable state law. **We** will tell **You** at least thirty (30) days in advance of the effective date of any **Renewal Premium** increase that occurs due to a change in the table of premium rates for **Renewal Premium**.

2. RENEWAL PREMIUM CHECK OR DRAFT NOT HONORED

Any premium payment made by a check or draft which is not honored at the bank upon which it is drawn shall be of no effect toward coverage under this **Certificate** unless and until valid restitution is made to **Us** within the time provided herein for making such premium payment.

3. GRACE PERIOD

Unless at least thirty-one (31) days prior to a **Renewal Premium** due date **We** have mailed to **You** written notice of **Our** intention not to renew this **Certificate** pursuant to the provisions of Section III. C. TERMINATION OF COVERAGE, a grace period of thirty-one (31) days from such due date is given for the late payment of the **Renewal Premium** due. If **You** make payment of the required **Renewal Premium** during such grace period, then this **Certificate** will remain in force for **Benefit** claims arising during such grace period. However, if the **Company** has received notification of **Your** intention to cancel any **Insured's** coverage under this **Certificate**, there is no grace period for the late payment of any **Renewal Premium** that would otherwise have been due for such **Insured** but for such cancellation.

4. REINSTATEMENT

If the **Renewal Premium** is not paid before the grace period ends, later acceptance of premium by **Us** (or by an agent authorized to accept payment) without requiring an application for reinstatement will reinstate this **Certificate** as of the date of acceptance of the late premium. If **We** require an application that will be fully underwritten by **Us**, **You** will be given a conditional receipt for the premium. If the application is approved after underwriting, this **Certificate** will be reinstated as of the approval date together with all back or past due premium permitted by applicable state law. Lacking such approval, this **Certificate** will be reinstated on the forty-fifth (45th) day after the date of the conditional receipt, unless **We** have previously notified **You**, in writing, of **Our** disapproval of the reinstatement.

The reinstated **Certificate** will cover only **Covered Expenses** that result from an **Injury** sustained after the date of reinstatement or from **Sickness** that begins more than ten (10) days after the date of reinstatement.

In all other respects **Your** rights and **Our** rights will remain the same subject to any provisions noted on or attached to the reinstated **Certificate**.

5. PREMIUM RATE GUARANTEE PERIOD

The amount of **Renewal Premium** with the same **Mode of Premium Payment** as the **Mode of Premium Payment** of the **Initial Premium** is guaranteed not to exceed [5%-20% annually][the amount of the **Initial Premium]** for each renewal period commencing prior to the expiration of the **Premium Rate Guarantee Period** as a result of any: (i) change in the table of premium rates used to calculate the **Initial Premium**; or (ii) increase in the attained age after the **Issue Date** of any **Insured** listed on the **Certificate Schedule**. The length of the **Premium Rate Guarantee Period** is shown on the **Certificate Schedule**. However, **Renewal Premium** rates may be increased by **Us** for any renewal period after the **Issue Date**, including during the **Premium Rate Guarantee Period**, if after the **Issue Date** (i) **You** either add or change coverage under this Certificate as provided in paragraphs a. through i. of the Calculation – Payment provision, or (ii) an amendatory endorsement is issued that changes any of the **Benefits** pursuant to any federal or state law or regulation

V. BENEFITS AND CLAIM PROCEDURES

Insureds have the right to obtain medical care from the **Provider** and **Hospital** of their choice[, as well as **Prescription Drugs** from a pharmacy of their choice]; however, all applicable **Benefit** payments by **Us** under this BENEFITS AND CLAIMS PROCEDURES Section of the **Certificate** are limited to the applicable **Company Insurance Percentage** of **Covered Expenses** incurred by an **Insured**. Coverage under this Section of the **Certificate** will be reduced for medical services, supplies, care or treatment obtained from a **Non-Participating Provider[**, as well as **Prescription Drugs** from a **Non-Participating Pharmacy]**. The difference between both the **Company Insurance Percentages** and the **Insured Coinsurance Percentages** for: (i) **Participating Providers** and **Non-Participating Providers**; [and (ii) **Participating Pharmacies** and **Non-Participating Pharmacies]** are shown in the **Certificate Schedule**. In addition, **We** shall never be required to make a payment for **Covered Expenses** incurred in excess of the amount of the **[Lifetime] Transplant Maximum [Per Organ] Per Insured** or the **Lifetime Certificate Maximum Per Insured**.

Covered Expenses incurred by an **Insured** for **Sickness and Injury Benefits** and **Wellness and Screening Benefits** are subject to the **Calendar Year Deductible,** the **Insured Coinsurance Percentage** and any applicable [**Co-Pays** and] **Access Fees,** unless otherwise specified.

A. SICKNESS AND INJURY BENEFITS

Subject to all applicable definitions, exclusions, limitations, non-waiver, waiting periods, and other provisions contained in this **Certificate**, as well as any riders, endorsements, or amendments attached to hereto, **We** promise to pay to or on behalf of each **Insured** the **Company Insurance Percentage** of the amount of professional fees and other applicable medical diagnostic or treatment expenses and charges that constitute **Covered Expenses** incurred by each **Insured** for the following described **Inpatient** and **Outpatient** services that are **Provided** as a result of **Sickness** or **Injuries**, but only after: (i) each applicable [**Co-Pay] [**and] **Access Fee** amount in this Section has been first satisfied and deducted from such **Covered Expenses** and applied to the applicable **Insured** for payment; (ii) each of the applicable deductibles has been first satisfied by deduction from such **Covered Expenses** and applied to the applicable **Insured** for payment; and (iii) the applicable **Insured Coinsurance Percentage** of the **Covered Expenses** remaining after satisfaction of all applicable deductibles is, likewise, satisfied by deduction from the remaining **Covered Expenses** and applied to the applicable **Insured** for payment:

1. INPATIENT HOSPITAL CONFINEMENT BENEFITS:

a. INPATIENT HOSPITAL CARE

The following services **Provided** by a **Hospital** or a **Provider** in connection with admission and **Confinement** of an **Insured** at the **Hospital** due to **Injuries** or **Sickness**:

1) **Hospital** - semi-private daily room and board [(if a semi-private room is not available, benefit will be limited to ninety (90) percent of the **Usual and Customary** private room rate)];

2) **Intensive Care Unit** of the **Hospital** - daily room and board (Note, daily room and board will be at the semi-private rate for admission to units or areas of the applicable **Hospital** which are step-down units from the **Intensive Care Unit**, including, sub-acute intensive care units, progressive care units, intermediate care units, private monitored rooms, observation units or other facilities not meeting the standards set forth in the definition of an **Intensive Care Unit**). [**Covered Expenses** incurred at a **Non-Participating Provider** will not exceed three times the **Usual and Customary** semi-private room charge of the **Hospital** and are limited to 30 continuous days of such **Confinement** for each type of **Confinement** during any one period of **Hospital Confinement**.;]

3) **Hospital** miscellaneous medications, **Prescription Drugs**, services and supplies - (Note, miscellaneous charges by a **Hospital** for personal convenience items, including but not limited to television, telephone, internet and radio are not considered **Covered Expenses**); and

4) **Provider** Visits – [(Note: limited [one (1)] **Provider** visit per treating **Provider** per day while the **Insured** is an **Inpatient** at a **Hospital**, and a maximum of [sixty (60)] **Provider** visits per **Hospital Confinement**.] **Sickness and Injury Benefits** are not payable for professional fees for visits at the **Hospital** following surgery by a Surgeon, Anesthesiologist or Nurse Anesthetist whose professional fees in connection with the surgery constitute **Covered Expenses**, unless the visit is to evaluate or treat an **Injury** or **Sickness** other than that which resulted in the **Insured's** covered surgery).

b. INPATIENT SURGERY

The following services **Provided** by a **Hospital** and **Providers** received by an **Insured** in connection with **Inpatient** surgery performed at the **Hospital** due to **Injuries** or **Sickness**:

1) Primary Surgeon;

2) Assistant Surgeon – (professional fees that constitute **Covered Expenses** will be considered for a **Sickness and Injury Benefit** payment for one assistant surgeon in connection with surgery for which **Sickness and Injury Benefits** are payable hereunder for the professional fees of the primary surgeon);

3) Anesthesiologist or Nurse Anesthetist – (professional fees that constitute **Covered Expenses** will be considered for a **Sickness and Injury Benefit** payment for either an anesthesiologist's or a nurse anesthetist's administration and monitoring of anesthesia administered during surgery for which **Sickness and Injury Benefits** are payable hereunder for the professional fees of the primary surgeon);

4) Pathologist Fees – (professional fees that constitute **Covered Expenses** will be considered for a **Sickness and Injury Benefit** payment for a pathologist's evaluation and/or interpretation of any tissue specimen removed during or in connection with such surgery); and

5) Second Surgical Opinion - Up to [$250] of professional fees for a second surgical opinion if:

a) the **Insured's Provider** determines that surgery is needed;

b) the surgery is not excluded from this **Certificate** or any riders, amendments or endorsements attached hereto;

c) the **Insured** is examined in person by another qualified **Provider** for the purpose of obtaining a second surgical opinion; and

d) the **Provider** issuing the second surgical opinion sends **Us** a written report.

However, **We** will not pay for the second surgical opinion if the **Provider** issuing the second surgical opinion performs or assists in the surgery.

c. BREAST RECONSTRUCTION

Services **Provided** by a **Hospital** and a **Provider** received by an **Insured** in connection with **Breast Reconstruction** performed at a **Hospital**.

d. INPATIENT THERAPY

Services **Provided** by a **Hospital** or a **Provider** in connection with the following types of therapy received by an **Insured** as an **Inpatient** at the **Hospital** due to **Injuries** or **Sickness**:

1) Radiation therapy;
2) Chemotherapy;
3) Occupational therapy;
4) Physical therapy and
5) Speech therapy.

[[Occupational,] [Physical] and [Speech] Therapy [are/is] limited to [[$50] per visit] [25] [visits] up to [$2,000] maximum per type of therapy per **Calendar Year** per **Insured**`] [This **Inpatient** therapy coverage does not include fees or expenses charged for spinal manipulations.]

e. INPATIENT LABORATORY AND DIAGNOSTIC TESTS

[Subject to **Laboratory and Diagnostic Testing Access Fee,** if applicable,**] [S][**s]ervices **Provided** by a **Hospital** or a **Provider** in connection with the performance and interpretation of laboratory and diagnostic tests received by an **Insured** as an **Inpatient** at the **Hospital** due to **Injuries** or **Sickness**

f. TRANSPLANTS

When generally accepted medical indications and standards for transplantation (including grafts) have been met and all assessments required by the treating institution are successfully completed, then services **Provided** by a **Hospital** and **Providers** in connection with the performance of **Solid Organ Transplants**, **Bone Marrow Transplants**, and/or **Stem Cell Transplants** that are received by an **Insured** are covered.

The maximum amount of **Covered Expenses** allowed for professional fees of a **Provider** and facility fees for the harvesting of applicable donor organs or donor bone marrow is [$5,000 to $50,000] per transplant, to the extent that any benefits hereunder remain and are available under the **Certificate** for the applicable **Insured** recipient. Any payment of donor expenses hereunder will be applied toward the satisfaction of the **[Lifetime] Transplant Maximum [Per Organ] Per Insured**.

[An **Insured** requiring a **Solid Organ Transplant**, **Bone Marrow Transplant**, and/or **Stem Cell Transplant** may elect to request participation in the **Centers of Excellence** program. To be considered for a **Centers of Excellence** transplant, an **Insured** must agree, in writing, to use **Centers of Excellence Providers** for all **Covered Expenses** related to a **Solid Organ Transplants**, **Bone Marrow Transplants**, and/or **Stem Cell Transplants**.

If a **Medically Necessary** transplant is performed in a designated **Center of Excellence**, **We** will **Provide Covered Expenses** for; (i) travel, (ii) food, and (iii) lodging, for a live donor, if applicable; and the **Insured** and one companion, or if the **Insured** is a dependent child, two parents. The maximum **Covered Expenses** allowed for (i) travel, (ii) food and (iii) lodging is [$5,000] per covered transplant.

If an **Insured** elects to use a **Center of Excellence**, approved by **Us**, for the transplant services, the **[Lifetime] Transplant Maximum [Per Organ] Per Insured** is increased to [$500,000 - $1,000,000].] [If the **Insured** elects to use a **Provider** that is not a **Center Of Excellence** the **[Lifetime] Transplant Maximum [Per Organ] Per Insured** is reduced to [$100,000 - $500,000]]

However, the amount of **Benefits** hereunder will be reduced by fifty (50%) percent for any **Solid Organ Transplants**, **Bone Marrow Transplants**, and **Stem Cell Transplants** received that were not reviewed by **Us** prior to transplantation evaluation, testing or donor search. In addition, the following items/procedures are not covered under this **Certificate**:

1) any non-human (including animal or mechanical) **Solid Organ Transplant**,
2) transplants approved for a specific medical condition, but applied to another condition,
3) the purchase price of any organ, tissue, blood, bone marrow, cells, or stem cells that are sold and not donated,
4) any donor charge or donor expense incurred that does not constitute **Covered Expenses** allowed for professional fees and facility fees incurred in connection with the harvesting of applicable donor organs or donor bone marrow, and
5) any transplantation (including grafts) that does not constitute **Solid Organ Transplants**, **Bone Marrow Transplants**, and/or **Stem Cell Transplants**.

[2. FOREIGN TRAVEL BENEFIT

Services for **Covered Expenses** incurred for **Medically Necessary Emergency Hospital**, **Provider** and medical care that an **Insured** receives outside the United States during the first [60] consecutive days of each trip up to a lifetime maximum **Benefit** of [$50,000 to $250,000].]

[3.] EMERGENCY ROOM AND OTHER OUTPATIENT BENEFITS:

a. EMERGENCY ROOM SERVICES

[Subject to the **Emergency Room Access Fee]**, [S][s]ervices **Provided** by a **Hospital** or a **Provider** in the emergency room of the **Hospital** for the following items received by an **Insured** on an **Emergency** basis:

1) Emergency room services and supplies;
2) **Provider** services for surgery in the emergency room of the **Hospital**, if **We** are notified of such surgery within seventy-two (72) hours after such surgical procedure has been performed, or as soon thereafter as reasonably possible;
3) X-ray and laboratory examinations;
4) **Prescription Drugs** administered prior to discharge from the emergency room;
5) [[Surgical dressings], [casts,] [splints,] [trusses,] [braces] [and] [crutches] received prior to discharge from the emergency room]; [and]
6) Services of a registered nurse (R.N.) in the emergency room of a **Hospital**.

The **Emergency Room Access Fee** will be waived if an Insured [is confined in a Hospital within [twenty-four (24) hours of the Emergency Room visit].[admitted directly from the emergency room into the Hospital as an Inpatient] .]

b. OUTPATIENT TREATMENT OF ACCIDENTAL INJURIES

Services **Provided** by a **Hospital**, [or] an **Emergency Care Facility** [or a **Provider]** in connection with the **Outpatient** treatment of **Injuries** received by an **Insured**. Services **Provided** by a **Hospital** or a **Provider** in the emergency room of the **Hospital** are subject to the **Emergency Room Access Fee**.

c. EMERGENCY TRANSPORTATION TO HOSPITAL BY AMBULANCE

Services **Provided** in connection with transportation of an **Insured** by either local ground ambulance or local air ambulance [(air ambulance is limited to [$1,000 to $10 ,000] per occurrence)] to the nearest **Hospital** that is appropriately staffed, equipped, available and suitable for the **Emergency** diagnosis, care and treatment of an **Insured's Injury** or **Sickness**. However, expenses charged for transportation to a **Hospital** by air ambulance are not payable or otherwise considered a **Sickness and Injury Benefit**, if such **Insured's** medical condition was not sufficiently acute or severe upon arrival at the **Hospital** to result in an **Inpatient** admission and **Confinement** in the **Hospital** immediately following the **Insured's** evaluation and treatment in the emergency room of such **Hospital.**

d. OUTPATIENT SURGERY AT A HOSPITAL OR AN AMBULATORY SURGICAL CENTER

The following services **Provided** by a **Hospital** or **Ambulatory Surgical Center** and **Providers** in connection with surgery performed on an **Insured** on an **Outpatient** basis:

1) **Hospital** or **Ambulatory Surgical Center** – (expenses that constitute **Covered Expenses** will be considered for **Sickness and Injury Benefit** payment for the pre-operation, operation and recovery rooms, as well as for medications, **Prescription Drugs**, and other miscellaneous items, services and supplies; provided that miscellaneous charges for any personal convenience items, including but not limited to television, telephone, and radio are not considered **Covered Expenses**);
2) Primary Surgeon;
3) Assistant Surgeon – (professional fees that constitute **Covered Expenses** will be considered for a **Sickness and Injury Benefit** payment for one assistant surgeon in connection with surgery for which **Sickness and Injury Benefits** are payable hereunder for the professional fees of the primary surgeon);
4) Anesthesiologist or Nurse Anesthetist – (professional fees that constitute **Covered Expenses** will be considered for a **Sickness and Injury Benefit** payment for either an anesthesiologist or a nurse anesthetist administration and monitoring of anesthesia, during surgery for which **Sickness and Injury Benefits** are payable hereunder for the professional fees of the primary surgeon);
5) Pathologist – (professional Fees that constitute **Covered Expenses** will be considered for a **Sickness and Injury Benefit** payment for a pathologist's evaluation and/or interpretation of any tissue specimen removed during or in connection with such surgery); and
6) Second Surgical Opinion - Up to [$250] of professional fees for a second surgical opinion if:
   a) the **Insured's Provider** determines that surgery is needed;
   b) the surgery is not excluded from this **Certificate** or any riders, amendments or endorsements attached hereto;
   c) the **Insured** is examined in person by another qualified **Provider** for the purpose of obtaining a second surgical opinion; and
   d) the **Provider** issuing the second surgical opinion sends **Us** a written report.

However, **We** will not pay for the second surgical opinion if the **Provider** issuing the second surgical opinion performs or assists in the surgery.

[e. OUTPATIENT PROVIDER OFFICE VISITS

Professional services **Provided** by a **Provider** during a **Medically Necessary** visit to the professional offices of such **Provider** for the purposes of evaluation, diagnosis and treatment of **Injuries** or **Sickness**. **]**

[f. [OUTPATIENT PRESCRIPTIONS

[Subject to the applicable] [**Calendar Year Deductible**][**Insured Coinsurance Percentage]**] [**Prescription Drug Co-Pay**][**Prescription Drug Calendar Year Deductible Per Insured**][**Prescription Drug Insured Coinsurance Percentage**] **We** will pay **Covered Expenses** incurred by an **Insured** for **Prescription Drugs** filled at a **Participating Pharmacy. [We** will pay, to or on behalf of the **Insured**, the **Covered Expenses** but not to exceed the **Calendar Year Maximum Per Insured For Prescription Drugs** as shown on the **Certificate Schedule**.] [If the charge for the **Prescription Drug** is less than the **Prescription Drug Co-pay** and/or [**Prescription Drug Insured Coinsurance Percentage]** [**Insured Coinsurance Percentage]**] shown on the **Certificate Schedule**, the **Insured** will be responsible for the full cost of the medication.] [If the **Insured's Provider** has not specified that a **Preferred Brand Drug** be used rather than a **Generic Drug,** but the **Insured** selects a **Preferred Brand Drug**, the **Insured** will pay the applicable [**Prescription Drug Co-pay]** [and/or] [**Prescription Drug Insured Coinsurance Percentage]** [**Insured Coinsurance Percentage]**], plus the difference in price between the **Generic Drug** and **Preferred Brand Drug.]** [**Covered Expenses** for such **Prescriptions** shall not exceed, the amount of the cost of the least expensive drug, medicine or **Prescription Drug** that may be used to treat the **Insured's Sickness** or **Injury**, all in accordance with the following schedule:

a. If a **Generic Drug** is available at the **Participating Pharmacy** selected by the **Insured** that may be taken by such **Insured** in substitute for either a **Brand Name Drug** or a **Preferred Brand Drug** that was prescribed for the **Insured**, the amount of **Covered Expenses** for such **Prescription** shall be limited to the cost of such **Generic Drug** at such pharmacy;

b. If a **Preferred Brand Drug** is available at the **Participating Pharmacy** selected by the **Insured** that may be taken by such **Insured** in substitute for a **Brand Name Drug** that was prescribed for the **Insured**, the amount of **Covered Expenses** for such **Prescription** shall be limited to the cost of the **Preferred Brand Drug** at such pharmacy; and

c. If both a **Generic Drug** and a **Preferred Brand Drug** are available at the **Participating Pharmacy** selected by the **Insured** that may be taken by such **Insured** in substitute for a **Brand Name Drug** that was prescribed for the **Insured**, the amount of **Covered Expenses** for such **Prescription** shall be limited to the cost of such **Generic Drug** at the pharmacy.]

[The **Prescription Drug Co-Pay** made to **Participating Pharmacies** may not be used to satisfy the [**Prescription Drug Calendar Year Deductible per Insured]**, [**Prescription Drug Insured Coinsurance Percentage],** [C**alendar Year Deductible]**, [the **Insured Coinsurance Percentage]**, the **Separate Deductible for Non-Participating Providers**, [the **Access Fees**] and the [**Failure to Pre-certify Treatment Deductible**.]

If **Prescription Drugs** are purchased by an **Insured** from a **Non-Participating Pharmacy**, then the amount of **Covered Expenses** for the purposes of calculating a benefit payment hereunder shall be limited to the amount of **Covered Expenses** that would have been incurred by such **Insured** if the **Prescription Drugs** had been purchased at a **Participating Pharmacy** instead of the **Non-Participating Pharmacy**.**]**

[g.] OUTPATIENT LABORATORY AND DIAGNOSTIC TESTS

[Subject to **Laboratory and Diagnostic Testing Access Fee**, if applicable,][S][s]ervices **Provided** by a **[Provider]**, **Hospital**, or other medical facility in connection with the performance and interpretation of laboratory and diagnostic tests received on an **Outpatient** basis by an **Insured** due to **Injuries** or **Sickness**.

[h.] OUTPATIENT THERAPY

[Subject to the **Outpatient Therapy Access Fee**] [S][s]ervices **Provided** by [**Providers**,] a **Hospital**, or other medical facility in connection with the following types of therapy received on an **Outpatient** basis by an **Insured** due to **Injuries** or **Sickness**:

1. Radiation therapy;

2. Chemotherapy;
3. Occupational therapy;
4. Physical therapy;
5. Rehabilitation therapy; and
6. Speech therapy.

[[Occupational,] [Physical] [and] [Speech] Therapy [are/is] limited to [[$50] per visit] [25] [visits] up to [$2,000] maximum [per type of therapy] per **Calendar Year** per **Insured**`] [This **Outpatient** therapy **Benefit** does not include fees or expenses charged for spinal manipulations.]

[i.] HOME HEALTH CARE

Services **Provided** to an **Insured** due to **Injuries** or **Sickness** for the care specified in a **Home Health Care Plan**, up to a **Covered Expense** maximum per day of 50% of the amount of the semi-private room rate of either (i) the **Hospital** where such **Insured** was **Confined** prior to the development of the **Home Health Care Plan**, or (ii) the **Skilled Nursing Home** where such **Insured** was a resident immediately prior to the development of the **Home Health Care Plan**. Such expenses incurred by an **Insured** as the result of a **Home Health Care Plan** are payable for an **Insured**, if:

1) The **Insured** had first been **Confined** in a **Hospital** or was a resident at a **Skilled Nursing Home** due to an **Injury** or **Sickness**;
2) The **Home Health Care Plan** of the **Insured** begins no later than thirty (30) days after discharge from the **Hospital** or **Skilled Nursing Home**; and
3) The **Home Health Care Plan** is for the same or related **Injury** or **Sickness** as the **Hospital** or **Skilled Nursing Home Confinement**.

A **Provider** must certify that the **Insured** would have to be in a **Hospital** or **Skilled Nursing Home** (and receive a level of care greater than **Custodial Care**) if **Home Health Care Plan** services had not been available.

Payment under this coverage is limited to a period of a maximum of [40-120] days during a twelve (12) consecutive month period.

[j.] HOSPICE CARE

Services **Provided** to an **Insured** for **Hospice Care** due to **Injuries** or **Sickness**, if:

1) such **Hospice Care** is provided as the result of **Injury** or **Sickness** for which **Covered Expenses** were incurred by such **Insured** for **Hospital Confinement**;
2) the **Insured's Provider** certifies the life expectancy of the **Insured** is six (6) months or less; and
3) the **Insured's Provider** recommends a **Hospice Care** program.

Payment under this coverage is limited to a period of a maximum of six (6) consecutive months.

[k.] MEDICAL EQUIPMENT AND SUPPLIES

Medical Equipment and supplies **Provided** to an **Insured** as a result of **Injury** or **Sickness** which are **Covered Expenses** includes:

1) Blood, plasma, and derivatives, if not replaced;
2) Initial replacement of natural limbs and eyes when loss occurs while this **Certificate** is in force;
3) Initial permanent lens immediately following cataract surgery, except the replacements will not be covered;
4) [Casts,] [non-dental splints,] [trusses,] [crutches] [and] [braces (except dental or orthodontic braces);]
5) Rental (not to exceed the purchase price) of a wheelchair, hospital bed, or other durable portable medical equipment **Provided** to an **Insured** in each event required for therapeutic treatment of **Injuries** or **Sickness** on an **Outpatient** basis; and
6) oxygen and its administration.

[l.] SKILLED NURSING HOME

Daily room and board and miscellaneous charges for other services **Provided** to an **Insured** due to **Injuries** or **Sickness** for residential care received in a **Skilled Nursing Home** for up to a maximum of [60-120] days in a twelve (12) month period, if:

1) the **Insured** has first been **Confined** in a **Hospital** for three (3) or more consecutive days;
2) the **Skilled Nursing Home** stay begins within thirty (30) days after discharge from the **Hospital**;
3) the **Skilled Nursing Home** stay is for the same or related **Injury** or **Sickness** as the **Hospital Confinement**; and
4) the **Insured's Provider** certifies the need for **Skilled Nursing Home Confinement**.

[m.] SUPPLIES AND SERVICES ASSOCIATED WITH THE TREATMENT OF DIABETES

The following **Outpatient** services **Provided** to an **Insured** for care received during for the treatment of diabetes and associated conditions:

1) **Diabetes Equipment**;
2) **Diabetes Supplies**; and
3) **Diabetes Self-Management Training**.

[n.] INHERITED METABOLIC DISORDERS

Benefits include **Covered Expenses** for **Medical Foods** prescribed or ordered under the supervision of a **Provider**, as **Medically Necessary** for the therapeutic treatment of an **Inherited Metabolic Disorder**. This **Benefit** is limited to a maximum of [$5,000] in a twelve (12) month period.

[o.] PROSTHETIC AND ORTHOTIC DEVICE BENEFIT

Benefits include **Covered Expenses** for **Medically Necessary** services and supplies for the effective use of a **Prosthetic** or **Orthotic Device**, including formulating its design, fabrication, material and component selection, measurements, fittings, static and dynamic alignments, and instructing the patient in the use of the device. The repair and replacement of a **Prosthetic** or **Orthotic Device** will be considered a covered **Benefit** unless necessitated by misuse or loss.

[p]. NEWBORN CARE

Benefits include, **Covered Expenses** for the care and treatment of **Your**, or **Your Spouse's** newborn child or newborn adoptee including care for **Injury**, **Sickness**, congenital defects, birth abnormalities, premature birth, tests for hypothyroidism, phenylketonuria, galactosemia, and in the case of non-Caucasian newborn infants, tests for sickle-cell anemia. Additionally, **Benefits** include **Covered Expenses** for well-baby care up to five (5) 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.

[p]. IMPAIRMENT OF SPEECH OR HEARING

Benefits include **Covered Expenses** for the care and treatment of loss or impairment of speech or hearing. Loss or impairment of speech or hearing shall include those communicative disorders generally treated by a licensed pathologist or audiologists. **Benefits** for the care and treatment of loss or impairment of speech or hearing shall not include hearing instruments or devices.

[q]. GENERAL ANESTHESIA FOR DENTAL PROCEDURES

Benefits include **Covered Expenses** incurred for general anesthesia and related hospitalization services for dental care if the **Provider** treating the **Insured** certifies that because of **the Insured's** age or condition or problem, hospitalization or general anesthesia is required to safely and effectively perform the procedures and the **Insured**:

1. is 6 years of age or younger, and is determined by two (2) dentists, licensed under the Arkansas Dental Practices Act §§ 17-82-101 et seq, to require **Medically Necessary** dental treatment in a **Hospital** or **Ambulatory Surgical Center** due to a significantly complex dental condition,
2. is a person with a diagnosed serious mental or physical condition; or
3. is a person with a significant behavioral problem as determined by the **Insured's** Provider as licensed under the Arkansas Medical Practices Act, §§17-95-201 et seq., and 17-95-401 et seq.

Covered Expenses do not include dental care benefits which may require general anesthesia in a **Hospital** or **Ambulatory Surgical Center**.

[r. STERILIZATION

[Commencing after the first anniversary of the **Issue Date]**, **Benefits** will be paid for **Covered Expenses** incurred for sterilization not to exceed a maximum lifetime **Benefit** of [$500 to $2,000] per **Insured**.]

[**s. ALLERGIES**

Benefits will be paid for **Covered Expenses** incurred for allergy testing and allergy injections, including, but not limit to, injectable antigens, and extracts, not to exceed a maximum of [$250 to $1,000] of **Covered Expense** per **Insured** per **Calendar Year.]**

[t. TREATMENT OF SLEEP APNEA

Benefits will be paid for **Covered Expenses** incurred for the treatment of sleep apnea, including, but not limited to: sleep study, durable medical equipment (CPAP or BiPAP), and surgery not to exceed a lifetime maximum of [$1,000 to $5,000] per **Insured**.]

[u. GROWTH DISORDERS

Benefits will be paid for **Covered Expenses** incurred for the treatment of a growth disorder or abnormally short stature, including, but not limited to, growth hormone deficiency therapy (GHDT) not to exceed a maximum lifetime **Benefit** of [$10,000 to $25,000] of **Covered Expenses** for each **Insured** child.]

[**v. SPINAL MANIPULATION**

Benefits will be paid for **Covered Expenses** incurred for spinal manipulation, including, but not limited to, manipulation for spinal subluxation and any associated treatment or services not to exceed a covered expense maximum of : (i) [$25 to $100] per day of treatment (does not include x-rays); and (ii) [$250 to $1,000] of **Covered Expense** per **Calendar Year** per **Insured,** for all treatments and x-rays**.]**

[w. BREAST IMPLANT REMOVAL

Benefits will be paid for **Covered Expenses** incurred for breast implant removal for the **Medically Necessary** treatment of a covered **Sickness** or **Injury**.]

B. [WELLNESS][AND][SCREENING BENEFITS]

[Subject to all applicable definitions, exclusions, limitations, waiting periods, and other provisions contained in this **Certificate**, as well as any riders, endorsements, or amendments attached to hereto, **We** promise to pay to or on behalf of each **Insured** the **Company Insurance Percentage** of the amount of professional fees and other applicable medical diagnostic or treatment expenses and charges that constitute **Covered Expenses** incurred by each **Insured** for the following described **[Wellness and Screening Benefit]** services, but only after (i) each of the applicable deductible has been first satisfied by deduction from such **Covered Expenses** and applied to the applicable **Insured** for payment, and (ii) the applicable **Insured Coinsurance Percentage** of

the **Covered Expenses** remaining after satisfaction of all applicable deductibles is, likewise, satisfied by deduction from the remaining **Covered Expenses** and applied to the applicable **Insured** for payment:]

[ANNUAL PHYSICAL EXAM][AND] SCREENING TESTS]:

[[a].ADULT WELLNESS AND PREVENTIVE CARE

[Commencing [twelve (12)] to [twenty-four (24)] months after the **Issue Date]** [S][s]ervices **Provided** to **You** and **Your Spouse** (if such spouse is listed as an **Other Insured**) for necessary **Adult Wellness Preventive Care** by a **Participating Provider** no more than [once] every [twelve (12) months][.] [up to] [the] [a] [[**Calendar Year]** [**Adult Wellness Maximum]]** [payment] [stated on the Certificate Schedule] [by **Us]** [of $50 to $250] [per adult **Insured** per **Calendar Year]**.

Adult Wellness Preventive Care does not include charges[(i)] by **Participating Providers** for COLORECTAL CANCER SCREENING, PROSTATE CANCER SCREENING, MAMMOGRAPHY SCREENING, PAP SMEAR SCREENING**,** any spinal manipulations, physical therapy, occupational therapy, or other **Outpatient** therapy or treatment, or any form of medical or surgical treatment of an **Injury** or **Sickness**[; or (ii) any service, care, test or treatment by a **Non-Participating Provider**.]]

[[b]. COLORECTAL CANCER SCREENING

[Commencing [twelve (12)] to [twenty-four (24)] months after the **Issue Date**] **[B][b]enefits** include **Covered Expenses** incurred by an **Insured** for colorectal cancer screening for a **Insured** who is fifty (50) years of age or older and at normal risk for developing colon cancer or has attained at least 30 years of age and has a history of, or a first degree family member with colorectal cancer, as follows:

1) a fecal occult blood test performed annually; and
2) a flexible sigmoidoscopy performed every five (5) years or a colonoscopy performed every ten (10) years.]

[d]. MAMMOGRAPHY SCREENING

[Commencing [twelve (12)] to [twenty-four (24)] [S][s]ervices **Provided** for screening by low dose **Mammogram** to detect the presence of occult breast cancer, as follows:

1) A single baseline **Mammogram** for female **Insureds** 35 to 39 years of age;
2) One **Mammogram** every two (2) years for female **Insureds** 40 to 49 years of age; and
3) An annual **Mammogram** for each female **Insured** 50 years of age or older.

[e.] PAP SMEAR SCREENING

[Commencing [twelve (12)] to [twenty-four (24)] months after the **Issue Date]** [S][s]ervices **Provided** for an annual Pap Smear **Provided** to female **Insureds**, including the examination by a **Provider**, the laboratory fee, and the **Provider**'**s** interpretation of the laboratory results.

[f.] [CHILDHOOD WELLNESS AND PREVENTIVE CARE

Services **Provided** to each **Insured** under the age of [19 (or 24 if a **Full-Time Student**)] for necessary **Childhood Wellness Preventive Care** up to a **Calendar Year** maximum payment by **Us** of [$100 to $500] per person per **Calendar Year**.]

Benefits include **Covered Expenses** for a child **Insured** for **Periodic Preventive Care Visits** to include twenty (20) visits at approximately the following age intervals: birth, 2 weeks, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years, 5 years, 6 years, 8 years, 10 years, 12 years, 14 years, 16 years, and 18 years. Services rendered during a periodic review shall only be covered to the extent that those services are **Provided** by or under the supervision of a single **Provider** during the course of one visit.

[Childhood Wellness Preventive Care does not include charges (i) by **Providers** for any spinal manipulations, physical therapy, occupational therapy, or other **Outpatient** therapy or treatment, or any form of medical or surgical treatment of an **Injury** or **Sickness**.

[C. MISCELLANEOUS BENEFITS

Miscellaneous Benefits are [not] subject to [either] [the [**Calendar Year Deductible]** [or] [and] [the **Insured Coinsurance Percentage**,] [but are subject to any applicable **Co-Pays**.] Therefore, subject to all applicable definitions, exclusions, limitations, waiting periods, and other provisions contained in this **Certificate**, as well as any riders, endorsements, or amendments attached to hereto, [including applicable **Co-Pays**,] **We** promise to pay to or on behalf of each **Insured** the **Company Insurance Percentage** of the amount of professional fees and other applicable medical diagnostic or treatment expenses and charges that constitute **Covered Expenses** incurred by each applicable **Insured** for the following described **Miscellaneous Benefits**:

[1]. [ADULT WELLNESS AND PREVENTIVE CARE

[Commencing [twelve (12)] to [twenty-four (24)] months after the **Issue Date]** [S][s]ervices **Provided** to **You** and **Your Spouse** (if such spouse is listed as an **Other Insured**) for necessary **Adult Wellness Preventive Care** by a **Participating Provider** no more than [once] every [twelve (12) months][.] [up to] [the] [a] [[**Calendar Year]** [**Adult Wellness Maximum]]** [payment] [stated on the Certificate Schedule] [by **Us]** [of $50 to $250] [per adult **Insured** per **Calendar Year]**.

Adult Wellness Preventive Care does not include charges [(i)] by **Participating Providers** for COLORECTAL CANCER SCREENING, PROSTATE CANCER SCREENING, MAMMOGRAPHY SCREENING, PAP SMEAR SCREENING**,** any spinal manipulations, physical therapy, occupational therapy, or other **Outpatient** therapy or treatment, or any form of medical or surgical treatment of an **Injury** or **Sickness** [; or (ii) any service, care, test or treatment by a **Non-Participating Provider**.]]

[2]. [PROSTATE CANCER SCREENING BENEFIT

Benefits include the following **Covered Expenses** incurred by male **Insureds** during a medically recognized diagnostic examination for the detection of prostate cancer. This **Benefit** shall include an annual physical examination for the detection of prostate cancer, and an prostate-specific antigen test used for the detection of prostate cancer for each male **Insured** who is at least forty (40) years of age or older.

The prostate cancer screening must be performed by a **Provider**, and shall consist of a prostate specific antigen blood test and a digital rectal examination.

The prostate cancer screening is not subject to any plan deductibles and shall not exceed the actual cost of the prostate cancer screening.] [Will appear after 1/1/2010.]

3. [CHILDHOOD IMMUNIZATIONS]

Services **Provided** for the following routine childhood immunizations **Provided** to each **Insured** under the age of 19: poliomyelitis, rubella, rubeola, mumps, tetanus, pertussis, diphtheria, hepatitis B, Haemophilus influenza type b (Hib) and varicella. Childhood immunizations are not subject to any deductibles, coinsurance or [**Co-Pays.]**

[4]. [VISITS TO PARTICIPATING PROVIDERS OFFICE

a. Doctor Office Visits Co-Pay

Subject to the **Doctor Office Visit Co-Pay** for **Outpatient** visits to the professional offices of a physician who is a **Participating Provider**, **We** will pay the remaining amount of **Covered Expenses** incurred for professional services **Provided** by the **Participating Provider** during each visit for **Medically Necessary** physical examinations, diagnosis [,][and] development of a treatment plan, [laboratory, x-ray or other diagnostic tests] [performed during such visit at such professional offices] for **Sickness** and **Injury**.

[**Covered Expenses** incurred for all services under this section are limited to [$1,200] per **Calendar Year** per **Insured**.]

[b. X-Ray Laboratory and Diagnostic Testing Co-Pay

After satisfaction of the **Doctor Office Visit Co-Pay** and the satisfaction of the **X-Ray, Laboratory and Diagnostic Testing Co-Pay We** will pay the remaining amount of **Covered Expenses** incurred during [the first [two (2)]] [an] **Outpatient** office visit at a **Participating Provider** per **Insured** per **Calendar Year** for laboratory, x-ray or other diagnostic tests performed during any such visit at such professional offices.[up to a maximum **Benefit** of [$50-$2,000][per **Insured** per **Calendar Year**.]]

However, the following limitations apply to this VISIT TO PARTICIPATING PROVIDER OFFICE coverage:

[a.] [Covered Expenses incurred by an **Insured** for any **Outpatient** therapy or treatment **Provided** for any **Injury** or **Sickness** during any visit to the professional offices of such **Participating Provider** are subject to satisfaction of (i) the **Calendar Year Deductible**, and (ii) the **Insured Coinsurance Percentage**;]

[b.] [Covered Expenses incurred by an **Insured** for any **Outpatient** diagnostic testing and laboratory services **Provided** at a location other than the professional offices of such **Participating Provider** are subject to satisfaction of (i) **Laboratory and Diagnostic Testing Access Fee**, and (ii) the **Calendar Year Deductible**, and(iii) the **Insured Coinsurance Percentage**;]

[c.] [Covered Expenses incurred by an **Insured** for any **Outpatient** surgery **Provided** during any visit to the professional offices of such **Participating Provider** are subject to satisfaction of (i) the **Calendar Year Deductible**, (ii) the **Insured Coinsurance Percentage**;]

[d.] [Covered Expenses incurred by an **Insured** for professional services **Provided** during any **Outpatient** office visit to the professional offices of a **Participating Provider** in excess of [$0 - $1,200] [two (2) visits] per **Calendar Year** are subject to satisfaction of (i) the **Calendar Year Deductible**, and (ii) the **Insured Coinsurance Percentage**;]

[e.] [Covered Expenses incurred by an **Insured** for any type of service provided during any visit to the professional offices of such **Non-Participating Provider** are subject to satisfaction of (i) the **Calendar Year Deductible**, (ii) the **Separate Deductible for Non-Participating Providers**, and (iii) the applicable **Insured Coinsurance Percentage** for **Non-Participating Providers**; and]

[f.] [Covered Expenses incurred by an **Insured** under any other provision or limitation such as [ADULT WELLNESS, [CHILDHOOD WELLNESS,] [CHILDHOOD IMMUNIZATIONS,] [TREATMENT FOR ALLERGIES,] [SPINAL MANIPULATION,] [OCCUPATION,] [SPEECH] [OR PHYSICAL THERAPY,] [COLORECTAL CANCER SCREENING,] [PROSTATE CANCER SCREENING,] [MAMMOGRAPHY SCREENING,] [and] [or] [PAP SMEAR SCREENING] are not considered **Covered Expenses** under this section.]

[5. [OUTPATIENT PRESCRIPTIONS

[Subject to the applicable] [**Calendar Year Deductible**][**Insured Coinsurance Percentage]**] [**Prescription Drug Co-Pay**][**Prescription Drug Calendar Year Deductible Per Insured**][**Prescription Drug Insured Coinsurance Percentage**] **We** will pay **Covered Expenses** incurred by an **Insured** for **Prescription Drugs** filled at a **Participating Pharmacy. [We** will pay, to or on behalf of the **Insured**, the **Covered Expenses** but not to exceed the **Calendar Year Maximum Per Insured For Prescription Drugs** as shown on the **Certificate Schedule**.] [If the charge for the **Prescription Drug** is less than the **Prescription Drug Co-pay** and/or [**Prescription Drug Insured Coinsurance Percentage]** [**Insured Coinsurance Percentage]**] shown on the **Certificate Schedule**, the **Insured** will be responsible for the full cost of the medication.] [If the **Insured's Provider** has not specified that a **Brand Name Drug** be used rather than a **Generic Drug,** but the **Insured** selects a **Brand Name Drug**, the **Insured** will pay the applicable [**Prescription Drug Co-pay]** [and/or] [**Prescription Drug Insured Coinsurance Percentage]** [**Insured Coinsurance Percentage]**], plus the difference in price between the **Generic Drug** and **Brand Name Drug.]** [**Covered Expenses** for such **Prescriptions** shall not exceed, the amount of the cost of the least expensive drug, medicine or **Prescription Drug** that may be used to treat the **Insured's Sickness** or **Injury**, all in accordance with the following schedule:

a. If a **Generic Drug** is available at the **Participating Pharmacy** selected by the **Insured** that may be taken by such **Insured** in substitute for either a **Brand Name Drug** or a **Preferred Brand Drug** that was prescribed for the **Insured**, the amount of **Covered Expenses** for such **Prescription** shall be limited to the cost of such **Generic Drug** at such pharmacy;
b. If a **Preferred Brand Drug** is available at the **Participating Pharmacy** selected by the **Insured** that may be taken by such **Insured** in substitute for a **Brand Name Drug** that was prescribed for the **Insured**, the amount of **Covered Expenses** for such **Prescription** shall be limited to the cost of the **Preferred Brand Drug** at such pharmacy; and
c. If both a **Generic Drug** and a **Preferred Brand Drug** are available at the **Participating Pharmacy** selected by the **Insured** that may be taken by such **Insured** in substitute for a **Brand Name Drug** that was prescribed for the **Insured**, the amount of **Covered Expenses** for such **Prescription** shall be limited to the cost of such **Generic Drug** at the pharmacy.]

[The **Prescription Drug Co-Pay** made to **Participating Pharmacies** may not be used to satisfy the [**Prescription Drug Calendar Year Deductible** per **Insured]**, [**Prescription Drug Insured Coinsurance Percentage],** [**Calendar Year Deductible]**, [the **Insured Coinsurance Percentage]**, the **Separate Deductible for Non-Participating Providers**, [the **Access Fees**] and the [**Failure to Pre-certify Treatment Deductible**.]

If **Prescription Drugs** are purchased by an **Insured** from a **Non-Participating Pharmacy**, then the amount of **Covered Expenses** for the purposes of calculating a benefit payment hereunder shall be limited to the amount of **Covered Expenses** that would have been incurred by such **Insured** if the **Prescription Drugs** had been purchased at a **Participating Pharmacy** instead of the **Non-Participating Pharmacy**.**]**

D. PRE-CERTIFICATION OF TREATMENT

If an **Insured** notifies and obtains from **Us** a certification that **Covered Expenses** are to be incurred due to a **Medically Necessary Hospital Confinement** or surgery, **We** will provide the **Sickness and Injury Benefits** for **Covered Expenses** as specified under the terms and provisions of this **Certificate** and any riders, amendments, or endorsements attached hereto.

Certification must be obtained prior to all **Inpatient** admissions, except in the case of an **Emergency** admission. In the event of an **Emergency Inpatient** admission, the **Insured** or his or her **Provider** must notify **Us** within seventy-two (72) hours of **Confinement**, or as soon thereafter as reasonably possible.

At the time notification of surgery is made, **We** will inform the **Insured** and his or her **Provider** if a second surgical opinion is required, at the expense of the **Company**, before certification will be given and will assign a length of stay if it is determined that **Inpatient Hospital** care is **Medically Necessary**. **We** may extend the length of stay upon the request of the **Insured** or **Provider** if **We** determine an extension is **Medically Necessary**. No **Sickness and Injury Benefits** will be provided under this **Certificate** for expenses that are determined not **Medically Necessary**.

Treatment provided at any time after initial certification that differs from the specific plan of care and treatment previously authorized requires re-certification by **Us**.

Pre-Certification of Treatment, services, and/or a length of stay is not a guarantee of **Sickness and Injury Benefits** under this **Certificate** or the **Group Policy**. All claims for **Sickness and Injury Benefits** under this **Certificate**, including claims for services and treatment that were pre-certified by **Us**, are subject to all terms, definitions, limitations, exclusions and restrictions contained in this **Certificate** and any riders, endorsements, or amendments attached hereto.

E. CLAIM PROCEDURES, INVESTIGATION AND PAYMENT

1. NOTICE OF CLAIM

Written notice of claim must be received by **Us** within thirty (30) days of the date that each **Covered Expense** is incurred by an **Insured**. If it is not reasonably possible for the notice of claim to be transmitted to **Us** so that it is received within such thirty (30) day period, then written notice of claim must be received by **Us** as soon thereafter as reasonably possible. A **Provider's** billing statement that is timely received by **Us** will suffice as a written notice of the claim under this Section. **Our** current address for providing a written notice of claim is shown on Page 1. A written notice of claim should include the applicable **Insured's** name, the **Primary Insured's** name, the applicable **Provider's** name, and the **Certificate** number.

2. CLAIM FORMS AND ADDITIONAL INFORMATION TO BE PROVIDED

When **We** receive timely written notice of claim, **We** will normally send **You** a claim form to be completed, signed and returned. The general purpose of the claim form is to provide **Us** with general background information about the nature of the claim, which information may be necessary in order to complete a proper proof of loss. If this claim form is not provided to **You** within fifteen (15) days, of **Our** timely receipt of written notice of the claim, then **You** will not be required to later complete, sign and return the written claim form, but may be required to provide other information, including a written authorization for the release of medical records and information, which in each event is necessary either for **Our** investigation of the claim or otherwise as part of the completion of a proper proof of loss. **We** must receive information requested within the time limit stated in the Section V E 3, PROOFS OF LOSS.

3. PROOFS OF LOSS

Written proof of a **Covered Expense** must be provided to **Us** within ninety (90) days after such **Covered Expense** is incurred by an **Insured**. If it was not reasonably possible for **You** to give **Us** proof in the time required, **We** will not reduce or deny the claim for this reason if the proof is filed as soon as possible. In any event, the proof of loss required must be provided no later than one (1) year from the date the **Covered Expense** was incurred by the **Insured** unless **You** are legally incompetent or otherwise physically unable to act.

4. CLAIMS REVIEW, INVESTIGATION, ADJUSTMENT AND ADJUDICATION

As written notice of claims, completed claim forms, signed authorizations for release of medical authorizations, medical records, and other written information from **Insureds** and **Providers** are received and reviewed additional investigation, requests for information and other matters may occur in connection with the completion of a proper proof of loss, adjustment and adjudication of the claim. At **Our** expense, **We** have the right to have the **Insured** examined by a **Provider** of **Our** choice as often as is reasonably necessary while a claim or other benefit determination is pending. Information received during the review and investigation of a claim will be considered, as applicable, in connection of whether a timely and proper proof of loss has been completed. After **Our** investigation has been completed, claims will be adjusted and adjudicated in accordance with the coverage under this **Certificate** that was in force on the date the applicable expense was incurred. Part of the adjustment and adjudication process includes a determination of the amount of **Covered Expense** incurred by the **Insured** for the applicable services rendered. This determination will normally require communication with the network with whom the applicable **Provider** was contracted at the time the service was rendered, as well as other matters. Once a decision has been made on a claim and this decision has been processed, an explanation of benefits form will be transmitted to the **Primary Insured** and each applicable **Provider**.

5. PAYMENT OF CLAIMS

The applicable portion of **Covered Expenses** incurred by an **Insured**, which are owed by the **Company** under this **Certificate**, will be paid to the **Primary Insured**, unless the right to such payment was previously assigned to a **Provider** for direct payment. Upon the death of the **Primary Insured**, the unpaid amount of any applicable **Covered Expenses** incurred by an **Insured**, which are owed by the **Company** under this **Certificate** will be paid to the **Beneficiary**, unless the right to such payment was previously assigned to a **Provider** for direct payment. Any claim payment made by **Us** in good faith will fully discharge **Our** liability under this **Certificate** for such claim to the extent of the amount of such good faith payment.

6. TIME OF PAYMENT OF CLAIMS

We will make payments due promptly once a decision has been made on a claim and this decision has been processed.

Payment shall be treated as being made on the date a draft or valid instrument was placed in the United States mail to the last known address of the applicable **Primary Insured**, **Provider**, or **Beneficiary** in a properly addressed, postpaid envelope, or, if not so posted, on the date of delivery.

A **Benefit** payment owed by **Us** under this **Certificate**, but not paid within thirty (30) days after the date of **Our** receipt of a proper proof of loss and the completion of **Our** investigation of the claim, will be considered past due. **We** will pay interest on any past due benefit payment amount at the rate of one and one-half percent per month commencing on the thirty first (31st) day after the completion and **Our** receipt of a proper proof of loss and the completion of **Our** investigation of the claim until the date such payment is tendered by **Us**.

VI. DEDUCTIBLES

A. CALENDAR YEAR DEDUCTIBLE

No **Sickness and Injury Benefits** or **Wellness and Screening Benefits** are payable under this **Certificate** for any **Covered Expenses** incurred by an **Insured**, until after the **Calendar Year Deductible** is satisfied and fully payable each **Calendar Year** by such **Insured**. In addition to the **Calendar Year Deductible**, the **Separate Deductible For Non-Participating Providers** will apply to services rendered by **Non-Participating Providers**.

Neither (i) the amount of the **Separate Deductible For Non-Participating Providers**, nor (ii) the amount of the **Failure to Pre-Certify Treatment Deductible** may be used to satisfy the **Calendar Year Deductible**.

B. SEPARATE DEDUCTIBLE FOR NON-PARTICIPATING PROVIDERS

No **Sickness and Injury Benefits** or **Wellness and Screening Benefits** are payable under this **Certificate** for services rendered by **Non-Participating Providers** until after the amount of the **Separate Deductible For Non-Participating Providers** is satisfied and fully payable. The amount of the **Separate Deductible For Non-Participating Providers** is shown on the **Certificate Schedule** and applies per **Calendar Year** separately to each **Insured**.

Neither (i) the amount of the **Calendar Year Deductible** nor (ii) the amount of the **Failure to Pre-Certify Treatment Deductible** may be used to satisfy the **Separate Deductible For Non-Participating Providers**.

C. SEPARATE DEDUCTIBLE FOR FAILURE TO PRE-CERTIFY TREATMENT

An additional deductible in the amount of [$1,000], the **Failure to Pre-Certify Treatment Deductible**, will be applied to **Covered Expenses** before the **Company Insurance Percentage** is payable under this **Certificate** for each (i) **Inpatient Hospital Confinement**, and (ii) surgery, if **Pre-Certification of Treatment** is not obtained. No **Sickness and Injury Benefits** are payable under this **Certificate** for any **Covered Expenses** that are subject to the **Failure to Pre-Certify Treatment Deductible** until after the amount of any such **Failure to Pre-Certify Treatment Deductible** is satisfied and fully payable by either **You** or such **Insured.**

[D. FAMILY CALENDAR YEAR DEDUCTIBLE MAXIMUM

Once a combined total of [three (3)] **Calendar Year Deductibles** [or **Separate Deductible for Non-Participating Providers]** have been satisfied in any **Calendar Year** by any [three (3)] **Insureds**, no additional **Calendar Year Deductible** [or **Separate Deductible for Non-Participating Provider]** will be assessed by **Us** in connection with medical treatment and services rendered to any other **Insured** during the remainder of such **Calendar Year**.]

[E.COMMON ACCIDENT CALENDAR YEAR DEDUCTIBLE MAXIMUM

If [two (2)] or more **Insureds** incur **Covered Expenses** for **Injuries** sustained in the same accident, only one (1) **Calendar Year Deductible** [or **Separate Deductible for Non-Participating Providers]** will be applied that **Calendar Year** to the combined **Covered Expenses** resulting from the **Injuries** sustained in such common accident by all **Insureds**.]

VII. LIMITATIONS, EXCLUSIONS AND NON-WAIVER

A. LIMITATIONS-WAITING PERIODS

Coverage under this **Certificate** is limited as provided by the definitions, limitations, exclusions, and terms contained in each and every Section of this **Certificate**, as well as the following limitations and waiting periods:

[1]. Any loss or expense incurred as a result of an **Insured's Pre-existing Condition [**not disclosed on the application] is not covered under this **Certificate** unless such loss or expense constitutes **Covered Expenses** incurred by such **Insured** more than [twelve (12)] [twenty-four (24)] months after the **Issue Date**, and are not otherwise limited or excluded by this **Certificate** or any riders, endorsements, or amendments attached to this **Certificate**;

[2]. Any loss or expense which results from the diagnosis, care or treatment of hernia, disease or disorders of the reproductive organs, hemorrhoids, varicose veins, tonsils and/or adenoids, or otitis media shall be covered under this **Certificate** only if (i) such loss or expense constitutes **Covered Expenses** incurred by an **Insured** after this **Certificate** has been in force for a period of six (6) months from the **Issue Date**, (ii) such **Sicknesses** are not otherwise limited or excluded by this **Certificate** or any riders, endorsements, or amendments attached to this Certificate, [(iii) care for such **Sicknesses** is **Provided** on an **Emergency** basis], and [(iv)] such **Sicknesses** are not **Pre-existing Conditions**;

[3]. [Insureds have the right to obtain **Prescriptions** from the pharmacy of their choice. However, if an **Insured**: (i) uses a **Non-Participating Pharmacy** to fill a **Prescription**; or (ii) does not present his/her correct ID card when the **Prescription** is filled at a **Participating Pharmacy**, then such **Insured** must pay the applicable pharmacy in full and file a claim form with the **Company** for reimbursement. In either event, the **Insured** will be reimbursed by the **Company** at the discounted or negotiated rate for such **Prescription** that would have been paid to a **Participating Pharmacy** by the **Company** under this **Certificate** if the **Insured** had used a **Participating Pharmacy** and properly presented the correct ID card at the time the **Prescription** was filled;]

[4]. [Pre-authorization may be required by the **Company** prior to the time that **Prescriptions** for certain **Prescription Drugs** are filled;]

[5.] If as the result of an **Emergency Sickness** or an **Emergency Injury** services are rendered for an **Insured** by a **Non-Participating Provider** when a **Participating Provider** was not reasonably available in connection with either (i) on an **Outpatient** basis in the emergency room of a **Hospital** or (ii) an **Emergency Inpatient** admission to a **Hospital**, then the **Covered Expenses** incurred will be reimbursed by **Us** as if such **Non-Participating Provider** were a **Participating Provider** up to the point when the **Insured** can be safely transferred to a **Participating Provider**. If the **Insured** refuses or is unwilling to be transferred to the care of a **Participating Provider** after such **Insured** can be safely transferred, then reimbursement shall thereafter be reduced to the **Company's Insurance Percentage for Non-Participating Providers**;

[6.] [Because the [**Calendar Year Deductible]** under this **Certificate** is calculated on the basis of **Covered Expenses**, it is possible that every dollar an **Insured** pays for **Prescription Drugs** at a **Participating Pharmacy** may not apply toward meeting the **[**applicable **Calendar Year Deductible]**;]

[7.] Sickness and Injury Benefits and **Wellness and Screening Benefits** under this **Certificate** for any **Insured** who is eligible for or has coverage under **Medicare**, and/or amendments thereto, regardless of whether such **Insured** is enrolled in **Medicare** shall be limited to only the **Usual and Customary** charges for services, supplies, care or treatment covered under this **Certificate** that are not or would not have been payable or reimbursable by **Medicare** and/or its amendments (assuming such enrollment), subject to all provisions, limitations, exclusions, reductions and maximum benefits set forth in this **Certificate**;

[8.] [[Two-Five million dollars ($2,000,000-$5,000,000)] is the maximum total amount of all applicable annual increases in the **Lifetime Certificate Maximum Per Insured** that can be conditionally received after the

Issue Date pursuant to SectionVIII. INCREASE IN THE LIFETIME CERTIFICATE MAXIMUM of this **Certificate**;] and

[9.] Except as contained and specifically set forth in the INCREASE IN THE LIFETIME CERTIFICATE MAXIMUM Section of this **Certificate**, there shall be no increase in the amount of the **Lifetime Certificate Maximum Per Insured**.

B. EXCLUSIONS

Coverage under this **Certificate** is limited as provided by the definitions, limitations, exclusions, and terms contained in each and every Section of this **Certificate**. In addition, this **Certificate** does not provide coverage for expenses charged to an **Insured** or any payment obligation for **Us** under this **Certificate** for any of the following, all of which are excluded from coverage:

[1]. the amount of any professional fees or other medical expenses or charges for treatments, care, procedures, services or supplies which do not constitute **Covered Expenses**;

[2]. **Covered Expenses** incurred before the **Certificate Issue Date**;

[3]. **Covered Expenses** incurred after this **Certificate** terminates, regardless of when the condition originated, except as **Provided** in the EXTENSION OF BENEFITS provision;

[4]. **Covered Expenses** which exceed the **Lifetime Certificate Maximum Per Insured**;

[5]. **Covered Expenses** which exceed the **[Lifetime] Transplant Maximum [Per Organ] Per Insured** for all **Solid Organ Transplants**, **Bone Marrow Transplants**, and **Stem Cell Transplants** received by each **Insured** including any applicable **Covered Expenses** for professional fees and facility fee incurred in connection with harvesting the applicable donor organ or donor bone marrow for the purposes of such transplantation;

[6]. **[[Prescription Drugs]** [that are immunosuppressants;]]

[7]. the amount of any professional fees or other medical expenses contained on a billing statement to a **Insured** which exceed the amount of the **Maximum Allowable Charge**;

[8]. any professional fees or other medical expenses for treatments, care, procedures, services or supplies which are not specifically enumerated in the SICKNESS AND INJURY BENEFITS,[or] WELLNESS AND SCREENING BENEFITS, [or] [MISCELLANEOUS BENEFITS] Sections of this **Certificate** and any optional coverage rider attached hereto;

[9]. **Covered Expenses You** or **Your** covered **Family** members are not required to pay, which are covered by other insurance, or that would not have been billed if no insurance existed;

[10]. any professional fees or expenses for which the **Insured** and/or any covered **Family** member are not legally liable for payment;

[11]. any professional fees or expenses for which the **Insured** and/or any covered **Family** member were once legally liable for payment, but from which liability the **Insured** and/or **Family** member were released;

[12]. treatment of the teeth, the surrounding tissue or structure, including the gums and tooth sockets. This exclusion does not apply to treatment: (a) due to **Injury** to natural teeth (treatment must be **Provided** within ninety (90) days of the date of the **Injury**); or (b) for malignant tumors;

[13]. **Injury** or **Sickness** due to any act of war (whether declared or undeclared);

[14]. services provided by any state or Federal government agency, including the Veterans Administration unless, by law, an **Insured** must pay for such services;

[15]. **Covered Expenses** that are payable under any motor vehicle no fault law insurance policy or certificate;

[16]. charges that are payable or reimbursable by either:

a) a plan or program of any governmental agency (except Medicaid), or

b) **Medicare** Part A, Part B and/or Part D (If the applicable **Insured** does not enroll in **Medicare**, **We** will estimate the charges that would have be paid if such enrollment had occurred);

[17]. [drugs or medication not used for an Food and Drug Administration (FDA) approved use or indication;]

[18]. [administration of experimental drugs or substances or investigational use or experimental use of **Prescription Drugs** except for any **Prescription Drug** prescribed to treat a covered chronic, disabling, life-threatening **Sickness** or **Injury,** but only if the investigational or experimental drug in question:

a) has been approved by the FDA for at least one indication; and

b) is recognized for treatment of the indication for which the drug is prescribed in:

1) a standard drug reference compendia; or

2) substantially accepted peer-reviewed medical literature.

c) drugs labeled “Caution –limited by Federal law to investigational use”;]

[19]. experimental procedures or treatment methods not approved by the American Medical Association or other appropriate medical society;

[20]. any **Injury** or **Sickness** covered by any Workers' Compensation insurance coverage, or similar coverage underwritten in connection with any Occupational Disease Law, or Employer's Liability Law, regardless of whether you file a claim for benefits thereunder;

[21]. eyeglasses, contact lenses, radial keratotomy, lasik surgery, hearing aids and exams for their prescription or fitting;

[22]. Cochlear implants;

[23]. any professional fees or other medical expenses incurred by an **Insured** which were caused or contributed to by such **Insured's** being intoxicated or under the influence of any drug, narcotic or hallucinogens unless administered on the advice of a **Provider**, and taken in accordance with the limits of such advice;

[24]. intentionally self-inflicted **Injury**, suicide or any suicide attempt while sane or insane;

[25]. serving in one of the branches of the armed forces of any foreign country or any international authority;

[26]. voluntary abortions, abortificants or any other drug or device that terminates a pregnancy;

[27]. services **Provided** by **You** or a **Provider** who is a member of an **Insured's Family**;

[28]. any medical condition excluded by name or specific description by either this **Certificate** or any riders, endorsements, or amendments attached to this **Certificate**;

[29]. any loss to which a contributing cause was the **Insured's** being engaged in or attempting to engage in an illegal occupation or illegal activity;

[30]. [participation in aviation, except as fare-paying passenger traveling on a regular scheduled commercial airline flight;]

[31]. cosmetic surgery or reconstructive procedures, except for **Medically Necessary** cosmetic surgery or reconstructive procedures performed under the following circumstances: (i) where such cosmetic surgery is incidental to or following surgery resulting from trauma or infection; (ii) to correct a normal bodily function; or (iii) such cosmetic surgery constitutes **Breast Reconstruction** that is incident to a **Mastectomy**; provided any of the above occurred while the **Insured** was covered under this **Certificate**.

[32]. Charges for breast reduction or augmentation or complications arising from these procedures;

[33]. **[Prescription Drugs** or other medicines and products used for cosmetic purposes or indications;]

[34]. [voluntary sterilization [except as **Provided** in the **Benefit** entitled Sterilization in the SICKNESS AND INJURY BENEFIT section of this **Certificate**], reversal or attempted reversal of a previous elective attempt to induce or facilitate sterilization;]

[35]. fertility hormone therapy and/or fertility devices for any type fertility therapy, artificial insemination or any other direct conception;

[36]. any operation or treatment performed, **Prescription** or medication prescribed in connection with sex transformations or any type of sexual or erectile dysfunction, including complications arising from any such operation or treatment;

[37]. appetite suppressants, including but not limited to, anorectics or any other drugs used for the purpose of weight control, or services, treatments, or surgical procedures rendered or performed in connection with an overweight condition or a condition of obesity or related conditions;

[38]. **[Prescriptions**, treatment or services for behavioral or learning disorders, Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD);]

[39]. any professional fees or other medical expenses incurred as the result of an **Injury** which was caused or contributed by an **Insured** racing any land or water vehicle;

[40]. any professional fees or other medical expenses incurred for the diagnosis, care or treatment of **Mental and Emotional Disorders**, **Alcoholism**, and drug addiction/abuse;

[41]. **[Prescription Drugs** that are classified as psychotherapeutic drugs, including antidepressants;]

[42]. Except for **Complications of Pregnancy**, routine maternity or any other expenses related to childbirth, including routine nursery charges and well baby care; [unless the optional MATERNITY BENEFIT RIDER was purchased and in force on the date said expenses related to childbirth, routine nursery charges, well baby care or maternity were incurred];

[43]. contraceptives, oral or otherwise, whether medication or device, regardless of intended use;

[44]. **[Outpatient Prescription Drugs** that are dispensed by a **Provider**, **Hospital** or other state-licensed facility;]

[45]. **[Prescription Drugs** produced from blood, blood plasma and blood products, derivatives, Hemofil M, Factor VIII, and synthetic blood products, or immunization agents, biological or allergy sera, hematinics, blood or blood products administered on an **Outpatient** basis;]

[46]. [level one controlled substances;]

[47]. **[Prescription Drugs** used to treat or cure hair loss or baldness;]

[48]. **[Prescription Drugs** that are classified as anabolic steroids or growth hormones [except as **Provided** in the **Benefit** entitled Growth Disorders in the SICKNESS AND INJURY BENEFIT section or this **Certificate**];]

[49]. [compounded **Prescription Drugs**;]

[50]. fluoride products;

[51]. [allergy kits intended for future emergency treatment of possible future allergic reactions;]

[52]. [replacement of a prior filled prescription for **Prescription Drugs** that was covered and is replaced because the original prescription was lost, stolen or damaged;]

[53]. **[Prescription Drugs**, which have an over the counter equivalent that may be obtained without a **Prescription**, even though such **Prescription Drugs** were prescribed by a **Provider**;]

[54]. [any intentional misuse or abuse of **Prescription Drugs**, including **Prescription Drugs** purchased by an **Insured** for consumption by someone other than such **Insured**;]

[55]. **[Prescription Drugs** that are classified as anti-fungal medication used for treatment of onychomycosis;]

[56]. [fees or expenses charged for spinal manipulations [except as **Provided** in the **Benefit** entitled Spinal Manipulation in the SICKNESS AND INJURY BENEFIT section of this **Certificate**];

[57]. Programs, treatment or procedures for tobacco use cessation;

[58]. **[Prescription Drugs** that are classified as tobacco cessation products;]

[59]. [drugs prescribed for the treatment of any disease, illness or condition that has been excluded from coverage under the **Certificate** by exclusionary rider, limitation or exclusion;]

[60]. [charges for blood, blood plasma, or derivatives that has been replaced;]

[61]. [treatment of autism;]

[62]. Temporomandibular Joint Disorder (TMJ) and Craniomandibular Disorder (CMD); and

[63]. treatment received outside of the United States, [except as provided for in the **Benefit** entitled Foreign Travel Benefit in the SICKNESS AND INJURY BENEFITS section of this **Certificate**;]

[64]. Services or supplies for personal convenience, including custodial care or homemaker services, except as provided for in this **Certificate**;

[65]. expenses for a cane, a crutch, a corset, a dental appliance, an elastic hose, an elastic support, a fabric support, a generic arch support, a low-temperature plastic splint, a soft cervical collar, a truss, or other similar device except as stated in the PROSTHETIC AND ORTHODIC DEVICE BENEFIT section of Your **Certificate** that: (i) is carried in stock and sold without therapeutic modification by a corset shop, department store, drug store, surgical supply facility, or similar retail entity; and (ii) has no significant impact on the neuromuscular, musculoskeletal, or neuromusculoskeletal functions of the body; and

[66]. expenses for artificial eyes, ears, dental appliances, a cosmetic device such as artificial eyelashes or wigs, a device used exclusively for athletic purposes, an artificial facial device, or other device except as stated in the PROSTHETIC AND ORTHODIC DEVICE BENEFIT section of **Your Certificate** that does not have significant impact on the neuromuscular, musculoskeletal, or neuromusculoskeletal functions of the body.

C. NON-WAIVER

1. Billed charges for medical care and treatment received by all **Insureds** during a **Calendar Year** that are considered and applied by **Us** under Section VIII. INCREASE IN LIFETIME CERTIFICATE MAXIMUM, does not mean **We** have any liability for coverage or the payment of any **Sickness and Injury Benefits** under the **Certificate** for the illness, injury or condition that resulted in such expenses, and any such mistake and error by **Us** shall not constitute a waiver of or modification to any of the conditions, terms, definitions, limitations or exclusions contained in either the **Certificate** or any exclusionary rider attached to the **Certificate**.

[2. Expenses that are mistakenly applied by **Us** to the **Calendar Year Deductible** or erroneously paid by **Us** under any Section or provision of this **Certificate [**including **Prescription Drugs]** shall not:

a) constitute a waiver of or modification to any conditions, terms, definitions or limitations contained in the **Certificate**, specifically including, but not by way of limitation, the definitions of **Sickness** and **Injury**, the limitation of coverage under the **Certificate** for **Pre-existing Conditions**, as well as any exclusion, limitation and/or exclusionary riders which may be attached to the **Certificate**, or otherwise operate to alter, amend, affect, abridge or modify the **Certificate** to which it is attached;

b) create or establish coverage of any medical condition illness, disease or injury under the **Certificate** or under any exclusion, limitation and/or exclusionary riders which may be attached to the **Certificate**; or

c) affect, alter, amend, abridge, constitute or act as a waiver of the **Company's** ability to rely upon, assert and apply such terms, definitions, limitations or exclusions of the **Certificate** or any amendments thereto.]

VIII. INCREASE IN LIFETIME CERTIFICATE MAXIMUM

A. CONDITIONAL ANNUAL INCREASE

Notwithstanding the amount of the **Lifetime Certificate Maximum Per Insured** stated on the **Certificate Schedule**, but subject to all applicable definitions, exclusions, limitations, non-waiver, and provisions contained in the **Certificate**, as well as all riders, endorsements, and amendments attached to the **Certificate**, **We** will automatically increase the amount of the **Lifetime Certificate Maximum Per Insured** on each anniversary of the **Issue Date** while coverage under the **Certificate** has remained in full force and effect on the following terms and conditions:

1. $125,000 FIRST ANNIVERSARY OF ISSUE DATE

$125,000 shall be added to the amount shown on the **Certificate Schedule** for the **Lifetime Certificate Maximum Per Insured** on the first anniversary of the **Issue Date**, if the total amount of all billed charges for medical care and treatment received by all **Insureds** and submitted to **Us** for consideration during the **First Certificate Year**, is greater than the amount of the **Calendar Year Deductible** applicable to such **Insureds** as shown on the **Certificate Schedule**, but the amount of such billed medical charges is less than twice the amount of such **Calendar Year Deductible** applicable to such **Insureds**.

2. $250,000 FIRST ANNIVERSARY OF ISSUE DATE

$250,000 shall be added to the amount shown on the **Certificate Schedule** for the **Lifetime Certificate Maximum Per Insured** on the first anniversary of the **Issue Date**, if the total amount of all billed charges for medical care and treatment received by all **Insureds** and submitted to **Us** for consideration during the **First Certificate Year** is less than the amount of the **Calendar Year Deductible** applicable to such **Insureds** as shown on the **Certificate Schedule**.

3. $125,000 SUBSEQUENT CERTIFCATE YEARS

$125,000 shall be added to the then current amount of the **Lifetime Certificate Maximum Per Insured** on each subsequent anniversary of the **Issue Date**, if the total amount of all billed charges for medical care and treatment received by all **Insureds** and submitted to **Us** for consideration during the **Subsequent Certificate Year** that immediately precedes such anniversary of the **Issue Date** is greater than the amount of the **Calendar Year Deductible** shown on the **Certificate Schedule**, but the amount of such billed medical charges is less than twice the amount of such **Calendar Year Deductible** applicable to such **Insureds**.

4. $250,000 SUBSEQUENT CERTIFCATE YEARS

$250,000 shall be added to the then current amount of the **Lifetime Certificate Maximum Per Insured** on each subsequent anniversary of the **Issue Date**, if the total amount of all billed medical charges received by all **Insureds** and submitted to **Us** for consideration during the **Subsequent Certificate Year** that immediately precedes such anniversary of the **Issue Date** is less than the amount of the **Calendar Year Deductible** applicable to such **Insureds** as shown on the **Certificate Schedule**.

However, the maximum total amount of all applicable annual increases in the **Lifetime Certificate Maximum Per Insured** pursuant to this Section shall not exceed the sum of two million dollars.

IX. GRIEVANCE PROCEDURES

The Arkansas External Review Regulation requires **Us** to provide **You** with the opportunity for an independent review of any **Adverse Determination** or **Final Adverse Determination**. **You** have the right to request an

External Review once **Your Internal Grievance Procedures** have been exhausted, unless otherwise stated. The criteria for the Grievance Procedures, including the **External Review** process by an **Independent Review Organization** to examine any **Adverse Determinations**, is outlined below.

INTERNAL GRIEVANCE PROCEDURES

You have the right to appeal any denial of a claim for **Benefits** by submitting a written request, via facsimile or mail, for reconsideration.

Requests for reconsideration must be filed within sixty (60) days of receipt of the written notification of denial. Within ten (10) days from receipt of the request for reconsideration, **We** will acknowledge receipt. Within thirty (30) days from receipt of the request for reconsideration, **We** will review **Your** request and provide a written response describing the final determination. If **You** are not satisfied with the **Final Adverse Determination**, **You** may request an **External Review**.

EXTERNAL GRIEVANCE PROCEDURES

I. Notice of Right to External Review -

Adverse Determinations: **You** may file a request for an expedited **External Review** to be conducted at the same time **You** file a request for a review of an appeal as set forth in the **Internal Grievance Procedure**, if:

(A) **You** have a medical condition where the timeframe for completion of an expedited review of an appeal in **Our Internal Grievance Procedures** would seriously jeopardize **Your** life or health or would jeopardize **Your** ability to regain maximum function; or

(B) The **Adverse Determination** involves a denial of coverage based on a determination that the recommended or requested **Health Care Service** or treatment is "experimental" or "investigational" and **Your Provider** certifies in writing and supports such certification with reasoning, rationale, or evidence that the recommended or requested **Health Care Service** or treatment would be significantly less effective if not promptly initiated.

The **Independent Review Organization** conducting the **External Review** will determine whether **You** will be required to complete the **Internal Grievance Procedures** prior to the expedited External Grievance Procedures. **You** may file an appeal under **Our Internal Grievance Procedures**, if **We** have not issued a written decision to **You** within thirty (30) days following the date **You** filed the appeal with **Us** for a pre-service claim or within sixty (60) days following the date **You** filed the appeal with **Us** for a post-service claim and **You** have not requested or agreed to a delay, **You** may file a request for **External Review** and shall be considered to have exhausted **Our Internal Grievance Procedures**.

Final Adverse Determinations: **You** may file a request for an expedited **External Review** to be conducted at the same time **You** file a request for a review of an appeal as set forth in the **Internal Grievance Procedure**, if:

(A) **You** have a medical condition where the timeframe for completion of an expedited review of an appeal in **Our Internal Grievance Procedures** would seriously jeopardize **Your** life or health or would jeopardize **Your** ability to regain maximum function.

(B) If the **Final Adverse Determination** concerns:

(i) an admission, availability of care, continued stay or **Health Care Service** for which **You** received **Emergency** services, but has not been discharged from a facility; or

(ii) a denial of coverage based on a determination that the recommended or requested **Health Care Service** or treatment is "experimental" or "investigational" and **Your Provider** certifies in writing and supports such certification with reasoning, rationale, or evidence that the recommended or requested **Health Care Service** or treatment would be significantly less effective if not promptly initiated.

You have the right to seek assistance from the Arkansas Department of Insurance at any time.

Commissioner [Jay Bradford]
Arkansas Dept. of Insurance
1200 West 3rd Street
Little Rock, Arkansas 72201

E-mail: insurance.Consumers@mail.state.ar.us
Phone: 501-371-2640 or 800-852-5494
Fax: 501-371-2749

All requests for **External Reviews** shall be made in writing or via electronic media to **Us** at the mailing address and facsimile telephone number identified below:

Freedom Life Insurance Company of America
Attn.: Vice President of Claims
Claims and Communications Dept.
3100 Burnett, 801 Cherry Street, Unit 33 Phone: 800-387-9027
Fort Worth, Texas 76102 Fax: 817-878-3440

Please be advised when filing a request for an **External Review**, **You** will be required to authorize the release of any of **Your** medical records that may be required to be reviewed for the purpose of reaching a decision on the **External Review**. This authorization will allow **Us** to disclose **Your** protected health information, including medical records, that are pertinent to the **External Review**.

II. Standard External Review -

Within sixty (60) days after the date of receipt of a notice of an **Adverse Determination** or **Final Adverse Determination**, **You** may file a request for an **External Review** with **Us**, as specified below:

(A) At the time **We** receive a request for an **External Review**, **We** shall assign an **Independent Review Organization** (from the list of approved **Independent Review Organizations** compiled and maintained by the Arkansas Insurance Commissioner) to conduct a preliminary review of the request to determine if:

- the request for the **External Review** meets the applicability standards as set out above;
- **You** have exhausted **Our Internal Grievance Procedures**; and
- **You** have provided all the information and forms required to process an **External Review**, including the authorization to release medical records.

(B) Within five (5) business days after receipt of the request for **External Review**, the **Independent Review Organization** assigned shall complete the preliminary review and notify **You**, **Your Provider** and Freedom Life Insurance Company of America in writing as to whether:

- the request is complete; and
- the request has been accepted for **External Review**.

The **Independent Review Organization** shall include in the notice provided a statement that **You**, **Your Provider** and Freedom Life Insurance Company of America may submit in writing to the **Independent Review Organization** within seven (7) business days following the date of receipt of the notice additional information and supporting documentation that the **Independent Review Organization** shall consider when conducting the **External Review**.

If the request:

- is not complete, the assigned **Independent Review Organization** shall, within five (5) business days, inform **You**, **Your Provider** and Freedom Life Insurance Company of America what information or materials are needed to make the request complete; or
- is not accepted for **External Review**, the assigned **Independent Review Organization** shall
- inform **You**, **Your Provider** and Freedom Life Insurance Company of America in writing within five (5) business days of the reasons for non-acceptance.

Upon receipt of any information submitted by **You**, the assigned **Independent Review Organization** shall forward copies of the information to **Us**.

(C) In reaching a decision to accept or reject a matter for **External Review**, the assigned **Independent Review Organization** is not bound by any decisions or conclusions reached during **Our Internal Grievance Procedures**.

(D) Within seven (7) business days after the receipt of the notice provided in part (B) above, **We** shall provide to the assigned **Independent Review Organization**, **You** and **Your Provider** the documents and any information considered in making the **Adverse Determination** or **Final Adverse Determination**, together with any additional information **We** deem necessary. If **We** fail to provide the documents or information, this will not delay the **External Review**; instead, the **Independent Review Organization** may terminate

the **External Review** and make a decision to reverse any **Adverse Determination** or **Final Adverse Determination**. Immediately upon making such a decision, the **Independent Review Organization** shall notify **You**, **Your Provider** and Freedom Life Insurance Company of America.

(E) Upon receipt of the information, if any, required to be forwarded to **Us** as stated in (B) above, **We** may reconsider any prior **Adverse Determination** or **Final Adverse Determination** for the **External Review**. This reconsideration by **Us** shall not delay or terminate the **External Review**. The **External Review** may only be terminated if **We** decide, upon completion of our reconsideration, to reverse **Our Adverse Determination** or **Final Adverse Determination** and provide coverage or payment for the **Health Care Services** that is the subject of the **Adverse Determination** or **Final Adverse Determination**.

Immediately upon making the decision to reverse **Our Adverse Determination** or **Final Adverse Determination**, **We** shall notify **You** and **Your Provider**, as well as the assigned **Independent Review Organization**, in writing of **Our** decision. The assigned **Independent Review Organization** shall terminate the **External Review** upon receipt of this notice from **Us**.

(F) In exercising its independent medical judgment in reviewing an **Adverse Determination**, in addition to the documents and information provided, the assigned **Independent Review Organization**, to the extent the information or documents are available, shall consider the following in reaching a decision:

- the **Insured's** medical records;
- the **Provider's** professional recommendation;
- consulting reports from appropriate health care professionals and other documents submitted by **Us**, **You** or **Your Provider**;
- the applicable terms of coverage under **Your** contract of insurance to ensure that the **Independent Review Organization's** decision is not contrary to the terms of the coverage;
- the most appropriate practice guidelines, which may include generally accepted practice guidelines, evidence-based practice guidelines or any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;
- any applicable written screening procedures, decision abstracts, clinical protocols and practice guidelines used by **Us** to determine the necessity and appropriateness of **Health Care Services**; and
- if the **Adverse Determination** involves a denial of coverage based on a determination that the recommended or requested **Health Care Service** is "experimental" or "investigational" , the **Independent Review Organization** shall also consider whether: (a) the recommended or requested **Health Care Service** or treatment has been approved by the federal Food and Drug Administration for the condition, while realizing that treatments or services are often legitimately used for purposes other than those listed in the FDA approval; or (b) medical or scientific evidence demonstrates that the expected benefits of the recommended or requested **Health Care Service** or treatment is more likely than not to be more beneficial to **You** than any available standard **Health Care Service** or treatment and the adverse risks of the recommended or requested **Health Care Service** or treatment would not be substantially increased over those of available standard **Health Care Services** or treatments.

(G) Within forty-five (45) calendar days after the date of receipt of the request for an **External Review**, the assigned **Independent Review Organization** shall provide written notice of its decision to uphold, reverse, or partially uphold or reverse the **Adverse Determination** or **Final Adverse Determination** to **You**, **Your Provider** and Freedom Life Insurance Company of America.

III. Expedited External Review -

(A) Except as provided under item (E) below, **You** may make a request for an expedited **External Review** with **Us** at the time **You** receive an **Adverse Determination** or **Final Adverse Determination**. At the time **You** elect to make a request for an expedited **External Review**, **You** and **Your Provider** shall submit additional information and supporting documentation that the **Independent Review Organization** shall consider when conducting the expedited **External Review**.

(B) An expedited **External Review** may NOT be provided for an **Adverse Determination** or **Final Adverse Determination** involving a **Retrospective Review**.

(C) At the time **We** receive a request for an expedited **External Review**, **We** immediately shall assign an **Independent Review Organization** (from the list compiled and maintained by the Arkansas Insurance Commissioner) to determine whether the request meets the reviewability requirements, and then initiate the expedited **External Review** if all the requirements are met.

(D) At the time **We** assign an **Independent Review Organization** to conduct the expedited **External Review**, **We** shall immediately provide or transmit all pertinent documentation and information to the assigned **Independent Review Organization**.

(E) As expeditiously as **Your** medical condition or circumstances require, but in no event more than seventy-two (72) hours after the date of receipt of the request for an expedited **External Review** that meets the reviewability requirements, the assigned **Independent Review Organization** shall:

- Make a decision to uphold or reverse the **Adverse Determination** or **Final Adverse Determination**; and
- Notify **You**, **Your Provider** and Freedom Life Insurance Company of America of the decision.

IV. Binding Nature of External Review Decision -

All **External Reviews** conducted will be fair and impartial, and in compliance with the standards approved by the Arkansas Insurance Commissioner.

An **External Review** decision is binding on **Us**, except to the extent that **We** have other remedies available under applicable federal or state law. An **External Review** decision is binding on the **Covered Insured**, except to the extent that **You** have other remedies available under applicable federal or state law. A **Covered Insured** may NOT file a subsequent request for an **External Review** involving the same **Adverse Determination** or **Final Adverse Determination** for which **You** have already received an **External Review** decision.

V. Filing Fees and Funding –

(A) Except in the case of a request for an expedited **External Review**, at the time of filing a request for **External Review**, the **Covered Insured** shall submit to the **Independent Review Organization** a filing fee of [$25.00], along with the information and documentation to be used by the **Independent Review Organization** in conducting the **External Review**. However, upon application by the **Covered Insured**, the Arkansas Insurance Commissioner may waive the filing fee upon a showing of undue financial hardship.

(B) The filing fee shall be refunded to the **Insured** who paid the fee if the **External Review** results in the reversal, in whole or part, of **Our Adverse Determination** or **Final Adverse Determination** that was subject of the **External Review**.

We shall pay the cost of the **Independent Review Organization** for conducting the **External Review** or expedited **External Review**, and shall not charge back the cost of any **External Review** to the **Covered Insured's Provider**.

X. COORDINATION OF BENEFITS

This Section regarding coordination of benefits applies when an **Insured** has health care coverage under more than one **Plan**. The ORDER OF BENEFIT DETERMINATION RULES below determine whether this **Certificate** is a **Primary Plan** or a **Secondary Plan** when compared to another **Plan** covering the **Insured**. If coverage for **Sickness and Injury Benefits**,[or] **Wellness and Screening Benefits**, [or] [**Miscellaneous Benefits]** under this **Certificate** is primary when considered in connection with other **Plans,** then such benefits are determined before the determination of benefits under any other **Plan** and without considering any other **Plan's** benefits. If coverage for **Sickness and Injury Benefits**, [or] **Wellness and Screening Benefits**, or [**Miscellaneous Benefits]** under this **Certificate** is secondary, when considered in connection with other **Plans**, then such benefits are determined after the determination of benefits under the other **Plan** and any such benefits under this **Certificate that** would have otherwise been payable in the absence of such other **Plan** may be reduced because of the **Primary Plan's** benefits.

A. ORDER OF BENEFIT DETERMINATION RULES

When a claim under a **Plan** with a coordination of benefits provision involves another **Plan**, which also has a coordination of benefits provision, the order of benefit determination shall be made as follows:

1. The benefits of a **Plan** that covers the person claiming benefits other than as a dependent shall be determined before those of the **Plan** which covers the person as a dependent.

2. The benefits of a **Plan** of a parent whose birthday occurs earlier in a **Calendar Year** shall cover a dependent child before the benefits of a **Plan** of a parent whose birthday occurs later in a **Calendar Year.** The word "birthday" as used in this paragraph refers only to the month and day in the **Calendar Year**, not the year in which the person was born.

3. If two or more **Plans** cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

a) First, the **Plan** of the parent with custody of the child;
b) Then, the **Plan** of the spouse of the parent with custody of the child; and
c) Finally, the **Plan** of the parent not having custody of the child.

However, notwithstanding the above, if the specific terms of a court decree state that one (1) 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.

4. The benefits of a **Plan** which covers a person as an employee (or as an employee's dependent) are determined before those of a **Plan** that covers that person as a laid off or retired employee (or as that employee's dependent). If the other **Plan** does not have this provision and if, as a result, the **Plans** do not agree on the order of benefits, this paragraph shall not apply.

5. If none of the provisions above determine the order of benefits, the benefits of the **Plan** which covered the claimant longer are determined before those of the **Plan** that covered the person for the shorter time.

6. If one of the **Plans** is issued out of this state and determines the order of benefits based upon the gender of a parent and, as a result, the **Plans** do not agree on the order of benefits, the **Plan** with the gender rule shall determine the order of benefits.

7. A **Complying Plan** may coordinate its benefits with a **Plan** which is "excess" or "always secondary" or with a **Non-Complying Plan** on the following basis:

a) If the **Complying Plan** is the **Primary Plan**, it shall pay or provide its benefits on a primary basis.
b) If the **Complying Plan** is the **Secondary Plan**, it shall, nevertheless, pay or provide its benefits first, as the **Secondary Plan**. In such a situation, such payment shall be the limit of the complying **Plan's** liability, except as provided in subparagraph (d).
c) If the **Non-Complying Plan** does not provide the information needed by the **Complying Plan** to determine its benefits within a reasonable time after it is requested to do so, the **Complying Plan** shall assume that the benefits of the **Non-Complying Plan** are identical to its own, and shall pay its benefits accordingly. However, the **Complying Plan** must adjust any payments it makes based on such assumption whether information becomes available as the actual benefits of the **Non-Complying Plan**.
d) If the **Non-Complying Plan** pays benefits so that the claimant receives less in benefits than he or she would have received had the **Non-Complying Plan** paid or provided its benefits as the **Primary Plan** then the complying **Plan** shall advance to or on behalf of the claimant an amount equal to such difference which advance shall not include a right to reimbursement from the claimant.

B. EFFECT ON THE BENEFITS OF THIS PLAN

When this **Certificate** is a **Secondary Plan**, it may reduce its **Sickness and Injury Benefits**, [and] **Wellness and Screening Benefits**, [and] [**Miscellaneous Benefits]** so that the total amount paid or provided by all **Plans** during a **Claim Determination Period** is not more than 100% of total **Allowable Expenses**. The difference between the covered benefit payments that this **Certificate** would have paid had it been the **Primary**

Plan, and the payments that it actually paid or provided shall be recorded as a benefit reserve for the **Insured** and used by this **Certificate** to pay any **Allowable Expenses**, not otherwise paid during the **Claim Determination Period**. As each claim is submitted, this **Certificate** will:

1. Determine its obligation to pay or provide covered benefits under the **Group Policy**;
2. Determine whether a benefit reserve has been recorded for the **Insured**; and
3. Determine whether there are any unpaid **Allowable Expenses** during that **Claims Determination Period**.

If there is a benefit reserve, the **Secondary Plan** will use the **Insured's** benefit reserve to pay up to 100% of total **Allowable Expenses** incurred during the **Claim Determination Period**. At the end of the **Claims Determination Period**, the benefit reserve returns to zero. A new benefit reserve must be created for each new **Claim Determination Period**.

C. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these coordination of benefit rules and to determine benefits payable under this **Certificate** and other **Plans**. **We** may get the facts **We** need from or give them to other organizations or persons for the purpose of applying these rules and determining **Sickness and Injury Benefits**, [and] **Wellness and Screening Benefits**, [and] [**Miscellaneous Benefits]** payable under this **Certificate** and other **Plans** covering the **Insured** claiming coverage for a claim. **We** need not tell, or get the consent of, any **Insured** to do this. Each **Insured** claiming **Sickness and Injury Benefits**, [and] **Wellness and Screening Benefits**, [and] [**Miscellaneous Benefits]** under this **Certificate** must give **Us** any facts **We** need to apply those rules and determine any amounts payable.

D. FACILITY OF PAYMENT

A payment made under another **Plan** may include an amount that should have been paid under this **Certificate**. If it does, **We** may pay that amount to the organization that made that payment. That amount will then be treated as though it was a **Sickness and Injury Benefit**, [or] **Wellness and Screening Benefit**, [or] [**Miscellaneous Benefit]** paid under this **Certificate**. **We** will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

E. RIGHT OF RECOVERY

If the amount of the payments made by **Us** is more than **We** should have paid under the coordination of benefits provision, **We** may recover the excess from one or more of the persons **We** have paid or for whom **We** have paid; or any other person or organization that may be responsible for the benefits or services provided for the **Insured**. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

XI. UNIFORM PROVISIONS

A. ENTIRE CONTRACT- CHANGES

The entire contract between **You** and the **Company** consists of the **Group Policy**, this **Certificate**, including **Your** application, which is attached hereto, and any amendments, riders, or endorsements attached to this **Certificate**. All statements made by **You** will, in the absence of fraud, be deemed representations and not warranties. No statement made by an applicant for insurance will be used to contest the insurance or reduce the **Sickness and Injury Benefits** or **Wellness and Screening Benefits**, unless contained in a written application, which is signed by the applicant. No agent may:

1. change, alter or modify the **Group Policy**, this **Certificate**, or any amendments, riders, or endorsements attached to this **Certificate**;
2. waive any provisions of the **Group Policy**, this **Certificate**, or any amendments, riders, or endorsements attached to this **Certificate**;

3. extend the time period for payment of premiums under this **Certificate**; or
4. waive any of the **Company's** rights or requirements.

No change in the **Group Policy** or this **Certificate** will be valid unless it is:

1. noted on or attached to the **Group Policy** or this **Certificate**;
2. signed by one of **Our** officers; and
3. delivered to the **Primary Insured**, as shown on the **Certificate Schedule**.

B. TIME LIMIT ON CERTAIN DEFENSES

After two (2) years from the effective date of coverage, only fraudulent misstatements in the enrollment application may be used to void this **Certificate** or deny any claim for a loss occurring after the two (2) year period.

No claim for a **Covered Expense** charged after two (2) years from the **Insured's** effective date of coverage will be reduced or denied because a medical condition, not excluded by name or specific description, existed before the effective date of coverage.

C. OTHER INSURANCE WITH US

You may have only one policy or certificate providing major medical or medical and surgical coverage with **Us**. If through error, **We** issue more than one like policy or certificate to **You**, only one policy or certificate chosen by **You** or **Your** estate, as the case may be, will stay in force. **We** will return the money **You** paid for the other policy(ies) or certificate(s).

D. CONFORMITY WITH STATE STATUTES

Any provision of this **Certificate** or the **Group Policy** which, on its effective date, is in conflict with the laws of the state in which **You** live on that date, is amended to conform to the minimum requirements of such laws.

E. MISSTATEMENT OF AGE

If the age of an **Insured** has not been stated correctly, his or her correct age will be used to determine (i) the amount of insurance for which he or she is entitled, (ii) the effective date of termination of insurance, and (iii) any other rights or **Sickness and Injury Benefits** under this **Certificate** or the **Group Policy**.

Premiums will be adjusted if too much or too little was paid due to the misstatement.

F. NONDISCLOSED MEDICAL HISTORY, MEDICAL CONDITIONS AND RELATED INFORMATION

During the first two (2) years coverage under this **Certificate** is in force it may be modified as provided below if, within that time, **We** discover that a medical condition or other material information was mistakenly not disclosed to **Us**:

1. The coverage under this **Certificate** will stay in force with no change in **Sickness and Injury Benefits, Wellness and Screening Benefits, [Miscellaneous Benefits**,] or premiums if the disclosure of such condition would not have affected the way the **Certificate** was issued.
2. If the disclosure would have resulted in coverage not being issued to an **Insured**, **We** will return all premium paid, less any **Benefits** paid for that person during the time the coverage was in force in error. The coverage for that person shall be void from the **Issue Date**.
3. If the disclosure would have resulted in coverage under this **Certificate** being issued either: (a) at an increased premium, or (b) with an endorsement eliminating that condition from coverage, **We** will either (i)

have **You** pay the increased rate beginning with the **Issue Date** (if **You** do not pay the increased premium within thirty (30) days after receiving **Our** notice, **We** will refund all premium paid less any **Benefits** paid, and the coverage under this **Certificate** will be void from the **Issue Date**); or (ii) add an endorsement to the **Certificate** to exclude that condition from coverage. The endorsement must be signed by **You** to put this change in effect. If **You** do not return a signed copy of the endorsement within thirty (30) days after receiving it, **We** will refund all premiums paid less any **Benefits** paid, and the **Certificate** will be void from the **Issue Date**.

This Section does not apply to any fraudulent misrepresentations that are made, which in all events can result in rescission of any coverage issued as a result of such fraudulent misrepresentations.

[G. LEGAL ACTION

No action at law or in equity will be brought to recover on this **Certificate** prior to the expiration of sixty (60) days after proof of loss has been filed as required by this **Certificate**; nor will any action be brought after three (3) years from the expiration of the time within which proof of loss is required by this **Certificate**.]

[H. SUBROGATION

We shall be subrogated to all rights of recovery which any **Insured** may acquire against any party for ordinary negligence, gross negligence, strict liability in tort or any willful or intentional act or omissions resulting in **Injury** or **Sickness** for which **We** pay **Sickness and Injury Benefits, [and] Wellness and Screening Benefits [**and] **[Miscellaneous Benefits]** but only to the extent of the **Benefits** provided. Any **Insured**, by receiving **Benefits** under this **Certificate**, in such case, shall be deemed to have assigned such rights of recovery to **Us** and have agreed to do whatever may be necessary to secure the recovery, including, but not limited to, the execution of any and all appropriate documents or papers. The **Insured** also agrees to execute and deliver all necessary instruments, to furnish such information and assistance, and to take any action **We** may require to facilitate enforcement of **Our** rights.**]**

[I. EXTRATERRITORIAL MEDICAL EXPENSES

Covered Expenses charged in any jurisdiction outside the United States of America (U.S.) or its territories or possessions shall be reimbursed under the terms and conditions of this **Certificate** in U.S. currency at the rate of exchange between the U.S. dollar and the benchmark currency of the foreign jurisdiction on the date such **Covered Expenses** were incurred.]

THIS CONCLUDES THIS CERTIFICATE

FREEDOM LIFE INSURANCE COMPANY OF AMERICA

[3100 Burnett Plaza • 801 Cherry Street, Unit 33 • Fort Worth, Texas 76102 • 1-800-387-9027]

STATE OF ARKANSAS
OPTIONAL BENEFIT RIDER

MAMMOGRAPHY BENEFIT

In consideration of any required premium due, this optional benefit rider will be attached to and made a part of the **Group Policy**. The **Benefits Provided** under this optional rider, if elected, shall be in lieu of any **Mammography Benefits Provided** in the **Group Policy**.

The following **Miscellaneous Benefit** is hereby added:

Miscellaneous Benefits are not subject to either the **Calendar Year Deductible** or the **Insured Coinsurance Percentage.** Therefore, subject to all applicable definitions, exclusions, limitations, waiting periods, and other provisions contained in this **Certificate**, as well as any riders, endorsements, or amendments attached to hereto, [including applicable **Co-Pays**,] **We** promise to pay to or on behalf of each **Insured** the **Company Insurance Percentage** of the amount of professional fees and other applicable medical diagnostic or treatment expenses and charges that constitute **Covered Expenses** incurred by each applicable **Insured** for the following described **Miscellaneous Benefits**:

BENEFIT

MAMMOGRAPHY SCREENING

Services Provided for screening by low dose **Mammogram** to detect the presence of occult breast cancer, as follows:

1) A single baseline **Mammogram** for female **Insureds** 35 to 39 years of age;
2) One **Mammogram** every two (2) years for female **Insureds** 40 to 49 years of age; and
3) An annual **Mammogram** for each female **Insured** 50 years of age or older.

This **Benefit** is limited to $50 per **Mammogram**.

This rider is subject to all of the terms, conditions, limitations, exclusions and definitions contained in the **Certificate** not inconsistent herewith. In all other respects **Your** coverage remains the same.

Signed for the **Company** in Fort Worth, Texas by its Secretary and President.

Secretary President

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	08/18/2009

Comments:

Attachment:

AR FLESCH.flic.pdf

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	08/18/2009

Bypass Reason: Previously approved:
APP-FI-FLIC, et al., 10/18/06
APP-09-NOARB-FLIC, 05/18/09

Comments:

FREEDOM LIFE INSURANCE COMPANY OF AMERICA

READABILITY CERTIFICATION

I hereby certify that the forms, listed below, have been properly scored and have achieved the Flesch Score, as indicated.

Form Number	Flesch Score
USGH-2009-C-AR-FLIC	43.25

Name: Ranita Grauwiler

Signature: _____

Title: Vice President – Product Development

Dated: July 6, 2009

Superseded Schedule Items

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

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
07/06/2009	Form	USHG-2009-C-AR-FLIC	07/13/2009	USHG-2009-C-AR-FLIC.pdf (Superceded)
08/12/2009	Form	USHG-2009-C-AR-FLIC	08/17/2009	USHG-2009-C-AR-FLIC.pdf (Superceded)
07/13/2009	Form	USHG-2009-C-AR-FLIC	08/12/2009	USHG-2009-C-AR-FLIC.pdf (Superceded)

FREEDOM LIFE INSURANCE COMPANY OF AMERICA

[3100 Burnett Plaza • 801 Cherry Street, Unit 33 • Fort Worth, Texas 76102 • 1-800-387-9027]

CERTIFICATE OF COVERAGE
ASSOCIATION GROUP MEDICAL-SURGICAL EXPENSE PLAN

This is **Your Certificate** of coverage under an association **Group Policy** issued to the **Group Policyholder**. The coverage of all **Insureds** is governed and determined by the terms, conditions, definitions, limitations and exclusions contained in this **Certificate.** This **Certificate** is a legal contract between **You** and the **Company.** Please read it carefully!

Your Certificate is guaranteed renewable, subject to the **Company's** right to adjust **Renewal Premiums** in accordance with Section IV.B. RENEWAL PREMIUM, and otherwise discontinue or terminate the **Certificate** as provided in Section III.C. TERMINATION OF COVERAGE. The **Initial Premium** for coverage of all **Insureds** under this **Certificate** is due and payable on or before the **Issue Date**. **Renewal Premiums** are due and payable in accordance with the Section IV.B. RENEWAL PREMIUM. You may renew coverage under this **Certificate**, as applicable, by timely payment of the proper amount of **Renewal Premium** when due.

Certain phrases and words have the first letter of each word capitalized and the entire word or phrase printed in bold face type. These are generally defined phrases and words, and as such have the express meaning set forth in Section II. DEFINITIONS.

IMPORTANT NOTICE ABOUT STATEMENTS IN THE APPLICATION: Please read the copy of **Your** application for coverage, which is attached to and part of this **Certificate**, to see if any medical history or other information inquired about or contained in the application is incorrect, incomplete or missing. Contact **Us** immediately if any information contained in the application is incorrect, incomplete or missing. Any incorrect or incomplete statements or answers, as well as any missing information could cause a claim to be denied or the coverage under this **Certificate** to be reformed or voided.

This **Certificate** was issued in consideration of (i) the payment of the **Initial Premium**, (ii) upon **Our** reliance upon **Your** representation that the answers to all questions in the application are correct and complete, and (iii) upon **Our** reliance upon the representation from **You** and any other applicable **Insureds**, that the content of any supplemental information provided to **Us** in the underwriting process, including information provided during any telephone verification of the application or by, e-mails, facsimiles and correspondence is in each instance correct and complete.

YOUR [10][30] DAY RIGHT TO RETURN THIS CERTIFICATE

If **You** are not satisfied with this **Certificate**, **You** may return it to **Us** within [ten (10)] [thirty (30)] days after **You** receive it. **You** may return it to **Us** by mail or to the agent who sold it. This **Certificate** will be voided as of the **Issue Date**, and We will refund any premium **We** have received prior to **Our** receipt of the returned **Certificate**.

SECRETARY

PRESIDENT

NEITHER THE GROUP POLICY NOR THIS CERTIFICATE IS A POLICY OF WORKERS' COMPENSATION INSURANCE.

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I. Certificate Schedule

A. GENERAL INFORMATION

Coverage is pursuant to a **Group Policy** form: [GRP-P-06-FLIC]

Issued to **Group Policyholder**: [ABC Association]

Certificate form: [USHG-2009-C-AR-FLIC]

Primary Insured: [ ]

Age at Issue: [ ]

Certificate Number: [ ]

Issue Date: [ ]

Other Insureds on **Issue Date**:
[ ]
[ ]

Beneficiary: [ ]

Initial Premium: **[ ]**

Amount	**Mode Of Premium Payment**	Method
$[ ]	[Monthly], [Quarterly], [Semi-Annual], [Annual]	[Credit Card], [Check]

First Renewal Date: **[**]

First Renewal Premium	**Mode Of Premium Payment**	Method
$[ ]	[Monthly], [Quarterly], [Semi-Annual], [Annual]	[Bank Draft]

Premium Rate Guarantee Period: **[**12] [24] [36] [48] months

B. COVERAGE SCHEDULES

1. **Lifetime Certificate Maximum Per Insured :** [$1,000,000 to $7,000,000]
2. **[Lifetime]Transplant Maximum [Per Organ] Per Insured:** [$100,000 to $1,000,000]

[3.] **Calendar Year Maximum Benefit Per Insured**:] [$100,000 to Lifetime Certificate Maximum Per Insured]

[4]. **Calendar Year Maximum Per Insured for Outpatient Treatment**] [$1,000 - $100,000]

[5.] **Calendar Year Maximum Per Insured for Prescription Drugs]** [$1,000 to $5,000] [or] [**Calendar Year Maximum Per Insured for Outpatient Treatment**] [or] [**Lifetime Maximum Per Insured]**

[6]. **DEDUCTIBLE SCHEDULES:**

The following deductibles are to be paid by the **Insured** in addition to the **Insured Coinsurance Percentage** before any **Sickness and Injury Benefits** or **Wellness and Screening Benefits** are payable by **Us** for **Covered Expenses**:

A. **Calendar Year Deductible** per **Insured**: [$1,000 to $50,000]
[Effective [Certificate Effective Date] [$1,000 to $50,000;]
[[Effective [Second Calendar Year]] [$1,000 to $50,000;]
[[Effective [Third Calendar Year]] [$1,000 to $50,000;]
[[Effective [Fourth Calendar Year]] [$1,000 to $50,000;]

[B.] [**Failure to Pre-Certify Treatment Deductible**:] **[**$1,000]; and

C. **Separate Deductible For Non-Participating Providers**: [$1,000 to $100,000]

[Effective [Certificate Effective Date] [$1,000 to $100,000;]
[[Effective [Second Calendar Year]] [$1,000 to $100,000;]
[[Effective [Third Calendar Year]] [$1,000 to $100,000;]
[[Effective [Fourth Calendar Year]] [$1,000 to $100,000;]

[7]. **COINSURANCE PAYMENT SCHEDULES – PARTICIPATING PROVIDERS [AND PARTICIPATING PHARMACIES]:**

For **Participating Providers [**and **Participating Pharmacies]**, after satisfaction of all applicable deductibles, the following **Company Insurance Percentage**, **Insured Coinsurance Percentage**, and **Insured Maximum Participating Provider Coinsurance Payment**, apply to all **Covered Expenses** in a **Calendar Year**:

A. **Company Insurance Percentage**: [50% to 100%]
(**Sickness and Injury Benefits** and **Wellness and Screening Benefits**)

[B. [**Company Insurance Percentage:**
(**Miscellaneous Benefits**)] [50% to 100%]]

C. **Insured Coinsurance Percentage**: [0% to 50%]; and
(**Sickness and Injury Benefits** and **Wellness and Screening Benefits**)

[D. [**Insured Coinsurance Percentage**:
(**Miscellaneous Benefits**)] [0% to 50%]]

E. **Insured Maximum Participating Provider Coinsurance Payment:** [$1,000 to $10,000]

[8]**. COINSURANCE PAYMENT SCHEDULES – NON-PARTICIPATING PROVIDERS [AND NON-PARTICIPATING PHARMACIES]:**

For **Non-Participating Providers [**and **Non-Participating Pharmacies]**, after satisfaction of all applicable deductibles, the following **Company Insurance Percentage**, **Insured Coinsurance Percentage**, **Insured Maximum Non-Participating Provider Coinsurance Payment**, and **Separate Deductible For Non-Participating Providers** apply to all **Covered Expenses** in a **Calendar Year**:

A. **Company Insurance Percentage** (**Sickness and Injury Benefits** and **Wellness and Screening Benefits**) [50% to 90%]

B. **Insured Coinsurance Percentage** (**Sickness and Injury Benefits** and **Wellness and Screening Benefits**) [10% to 50%]; and

C. **Insured Maximum Non-Participating Provider Coinsurance Payment** [$1,000 to $20,000]

[9]**. [PRESCRIPTION DRUGS]**

[A.] **[Prescription Drug Co-Pay** **[Generic Drug** **[**$0.00 to $35.00]
[Preferred Brand Drug **[**$25.00 to $40.00]]

[COVERED EXPENSES REMAINING AFTER SATISFACTION OF THE CALENDAR YEAR DEDUCTIBLES ARE SUBJECT TO COPAY]

[COVERED EXPENSES REMAINING AFTER SATISFACTION OF THE PRESCRIPTION DRUG CALENDAR YEAR DEDUCTIBLE PER INSURED ARE SUBJECT TO COPAY]

[COVERED EXPENSES REMAINING AFTER CO-PAY SUBJECT TO CALENDAR YEAR DEDUCTIBLES AND INSURED COINSURANCE PERCENTAGE]

[COVERED EXPENSES REMAINING AFTER CO-PAY SUBJECT TO PRESCRIPTION DRUG CALENDAR YEAR DEDUCTIBLE AND PRESCRIPTION DRUG COINSURANCE PERCENTAGE]

[COVERED EXPENSES FOR [GENERIC DRUG] [BRAND NAME DRUG] [AND] [PREFERRED BRAND DRUG] ARE SUBJECT TO CALENDAR YEAR DEDUCTIBLE AND INSURED COINSURANCE PERCENTAGE]

[B.] **[Prescription Drug Calendar Year Deductible Per Insured:**

[Generic Drug]	**[**$0 to $500]
[Preferred Brand Drug]	**] [**$0 to $500]
[Brand Name Drug]	**[**$0 to $500]

[C.] **[**Coinsurance Payments Schedules For **Participating Pharmacies:**

For **Participating Pharmacies** after satisfaction of all applicable deductibles, the following **Prescription Drug Company Insurance Percentage**, and the **Prescription Drug Insured Coinsurance Percentage**, applies to all **Covered Expenses** in a **Calendar Year**:

1**. Prescription Drug Company Insurance Percentage**: [0% to 100%]

2. **Prescription Drug Insured Coinsurance Percentage**: [0% to 100%]; [and]]

[D.] **[**Coinsurance Payments Schedules **Non-Participating Pharmacies:**

For **Non-Participating Pharmacies** after satisfaction of all applicable deductibles, the following **Prescription Drug Company Insurance Percentage**, applies to all **Covered Expenses** in a **Calendar Year**:

1. **Prescription Drug Company Insurance Percentage** [0% to 100%]

2. **Prescription Drug Insured Coinsurance Percentage** [0% to 100%]]

[10] **[DOCTOR OFFICE VISIT]**

[A.] **[Doctor Office Visit Co-Pay]**	[$25.00 to $50.00] [per visit] [per **Participating Provider**]
[B.] [**X-Ray, Laboratory And Diagnostic Testing Co-Pay]**	[25.00 to $50.00] [per service] [per type][per visit][per **Participating Provider**]

(If received during a Doctor Office Visit at a **Participating Provider)**

[This **Benefit** does not apply to **Covered Expenses** under any other **Benefit** provision or limitation such as ALLERGIES; SPINAL MANIPULATION; occupational, speech or physical therapy; and mental nervous disorders, if applicable. The **Doctor Office Visit Co-Pay** applies only to the actual office visit. The **X-Ray, Laboratory and Diagnostic Testing Co-Pay** is in addition to the **Doctor Office Visit Co-Pay**. **[Benefit** Payments by **Us** for the actual doctor office visit are limited to [$0 - $1,200] per **Insured** per **Calendar Year.]** Any services for the doctor office visit in excess of the [$0 - $1,200] limit or any other services, such as office surgeries, processing or reading charges, are subject to the **Calendar Year Deductible** and **Insured Coinsurance Percentage**.]

[All services received during the office visit are limited to [$0 - $1,000] per **Insured** per **Calendar Year]**

[Non-Participating Providers doctor office visits are subject to the [**Calendar Year Deductible]** [and] [or] [**Separate Deductible For Non-Participating Providers**] [[and] the **Insured Coinsurance Percentage**]]

[11] **[ACCESS FEES]**

[A. **Emergency Room Access Fee**] [(waived if **Insured** is **Confined** in a **Hospital** within twenty-four (24) hours following the **Emergency** room visit)]	[[$0 to $500] per **Insured** per visit to either a **Participating Provider** or a **Non-Participating Provider]**
[B. **[Laboratory and Diagnostic Testing Access Fee]**	[[$0 to $500] [per test] [per day] for either **Participating Provider** or **Non**- **Participating Provider** for each of the following **Inpatient** or **Outpatient** diagnostic tests: [MRI], [CAT Scan], [PET], [Myleogram] and [Nuclear Imaging Service] [(including Myocardial Perfusion Imaging - Thallium 201 Scintigraphy/Thallium Stress Tests)]**]**
[C. **Outpatient Therapy Access Fee]**	[[$0 to $500] per **Insured** per visit to a **Participating Provider** facility] [[$0 to $500] per **Insured** per visit to a **Non-Participating Provider** facility]
[12] [**Calendar Year Adult Wellness Maximum**	[$50 to $2,000]

[C. OPTIONAL RIDERS

[1]. **[MATERNITY AND IN VITRO FERTILIZATION BENEFIT RIDER***

Covered Expenses for services performed within [13-24] months from the effective date of coverage for such female **Insured**: [$1,500 to $3,000]

Covered Expenses for services performed [25] or more months from the effective date of coverage for such female **Insured**: [$1,000 to $5,000]

***** Note: Conception must begin [12] months after the effective date of coverage under this **Certificate**.]

In Vitro Fertilization **Benefits** are subject to a **Lifetime Certificate Maximum** of $15,000.

[2]**. [WAIVER OF RENEWAL PREMIUM DURING FIRST RENEWAL PREMIUM RATE GUARANTEE PERIOD UPON DEATH OR TOTAL DISABILITY OF PRIMARY INSURED]**

[Elimination Period:] [90 days]**]**

II. DEFINITIONS

The following terms or words that have the first letter of each word (including the plural form of such word) capitalized and the entire word or phrase printed in bold face type as used within any phrase, sentence, paragraph, provision or schedule in this **Certificate** shall have the express meaning set forth below:

["**Access Fee(s)**" means the [**Emergency Room Access Fee**,] [and] [the **Laboratory and Diagnostic Testing Access Fee**,] [and the **Outpatient Therapy Access Fee]**.

The remaining amount of **Covered Expenses** after the application and satisfaction of the designated **Access Fee** for applicable **Sickness and Injury Benefits** is subject to the **Calendar Year Deductible** and the **Insured Coinsurance Percentage.**

The amount of each applicable **Access Fee** is shown on the **Certificate Schedule**.]

"**Accident**", "**Accidentally**" means an event or occurrence that was unplanned and unintended by the **Insured** that was the sole cause of **Injuries** sustained or suffered by such **Insured** and that takes place on or after the **Issue Date**.

["**Adult Wellness Preventive Care**" means routine physicals, screenings and immunizations that are appropriate for the age and sex of the **Insured** and based on generally accepted standards of medical practice. **Adult Wellness Preventive Care** does not include: COLORECTAL CANCER SCREENING, PROSTATE CANCER SCREENING, MAMMOGRAPHY SCREENING, and PAP SMEAR SCREENING contained in the WELLNESS and SCREENING BENEFITS Section of this **Certificate.]**

"**Adverse Determination**" means a determination by **Us** that an admission, availability of care, continued stay or other **Health Care Service** has been reviewed and, based upon the information provided, the requested payment for the service is denied, reduced or terminated, because:

- the requested **Health Care Service** does not meet **Our Certificate** requirements for **Medical Necessity**; or
- the requested **Health Care Service** has been found to be "experimental/investigational".

To be considered as an **Adverse Determination**, the **Adverse Determination** must be a **Final Adverse Determination**, except as provided herein. The **Adverse Determination** must involve treatment, services, equipment, supplies or drugs that would require **Your Certificate** to expend five hundred dollars [$500] or more of expenditures.

Adverse Determination does NOT include a determination by **Us** to deny a **Health Care Service** or **Benefit** based upon:

- an express exclusion within the **Certificate**, other than a general exclusion for "**Medical Necessity**" or "experimental/investigational";
- an express limitation within the **Certificate** with respect to the number of visits, treatments, supplies or services for a covered **Benefit** in a given **Calendar Year** or due to the **Lifetime Certificate Maximum** for an Insured;
- an express limitation within the **Certificate** with respect to a maximum dollar limitation with respect to a covered **Benefit** in a given **Calendar Year** period or due to the **Lifetime Certificate Maximum** for an Insured;
- a determination by **Us** that an individual is not eligible to be an Insured;
- a determination by **Us** that treatment, service or supplies were requested or obtained by a **Covered Insured** through fraud or material misrepresentation;
- the procedure for determining the **Insured's** access to a **Provider**, including but not limited to any primary care gatekeeper, referral or network access provision;
- Illegality of services or the means or methods of administering them;
- FDA or other government agency determinations, reports or statements; or
- Licensure, permit or accreditation status of a **Provider**.

"**Alcoholism**" means the chronic and habitual use of alcoholic beverages by any person to the extent that such person has lost the power of self-control with respect to the use of such beverages.

"**Allowable Expense**" means, in connection with Section IX. COORDINATION OF BENEFITS, any necessary, reasonable and customary item of expense, at least a portion of which is covered under one or more of the **Plans** covering the applicable **Insured** for whom medical service was rendered and provided, and for which a **Benefit** claim was made. When a **Plan** provides benefits in the form of services, (for example an HMO) the reasonable cash value of each service rendered shall be deemed to be both an allowable expense and a benefit paid. A **Plan**, which takes **Medicare** or similar government benefits into consideration when determining the application of its coordination of benefits provision, does not expand the definition of an **Allowable Expense**.

"Ambulatory Surgical Center" means a state licensed public or private establishment with an organized medical staff of **Providers** with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures and continuous **Provider** services and registered professional nursing services whenever an **Insured** is in the center that does not provide services or other accommodations for the overnight stay of patients.

Ambulatory Surgical Center does not include a facility that primarily terminates pregnancies, a **Provider's** office maintained for the practice of medicine, or an office maintained for the practice of dentistry.

"Beneficiary" means the individual or organization listed on the **Certificate Schedule** as the **Beneficiary**.

"**Benefit(s)**" means **Sickness and Injury Benefits**, [and] **Wellness and Screening Benefits** [and] [**Miscellaneous Benefits]**.

"Bone Marrow Transplants" means the **Medically Necessary** transplantation, combined transplantation, and sequential transplantation procedures, sometimes referred to as "Bone Marrow Reconstitution or Support" in which Medically Necessary human blood precursor cells are administered following mylesuppressive or ablative therapy are received by an **Insured** while coverage for such **Insured** under this **Certificate** is in full force and effect. Such cells may be derived from such **Insured** in an autologous harvest, or from a matched donor for an allogenic transplant.

["Brand Name Drug" means a **Prescription Drug** for which a pharmaceutical company possesses either (i) an active and valid registered patent or (ii) an active and valid registered trade name after expiration of such patent.]

"Breast Reconstruction" means reconstruction of a breast incident to a **Mastectomy** to restore or achieve breast symmetry. **Breast Reconstruction** includes surgical reconstruction of a breast on which **Mastectomy** surgery has been performed in order to establish symmetry, as well as prostheses and services and other supplies that are **Medically Necessary** for any physical complication, including lymphedemas, at all stages of the reconstruction incident to a **Mastectomy**.

"Calendar Year" means the period beginning on the **Issue Date** and ending on December 31 of that year. In subsequent years, it is the period from January 1 through December 31 of the same year.

"Calendar Year Deductible" means the amount of **Covered Expenses** each **Insured** must incur within a **Calendar Year** before any **Sickness and Injury Benefits** or **Wellness and Screening Benefits** are payable by **Us** for such **Insured**. No **Sickness and Injury Benefits** or **Wellness and Screening Benefits** are payable by **Us** for any **Covered Expenses** incurred by an **Insured**, until after all applicable [**Co-Pays** and] **Access Fees**, the **Failure to Pre-Certify Treatment Deductible**, if applicable, the **Separate Deductible for Non-Participating Providers**, if applicable, and the **Calendar Year Deductible** are each satisfied and fully payable by either **You** or such **Insured**.

None of the following expenses may be used to satisfy the **Calendar Year Deductible**: (i) the amount of any applicable [**Co-Pay** or] **Access Fee**; (ii) the amount of the **Separate Deductible For Non-Participating Providers**, (iii) [**Covered Expenses** that constitute **Miscellaneous Benefits** for which payment is made by **Us**,] and (iv) the amount of the **Failure to Pre-Certify Treatment Deductible**.

[When [three (3)] **Insureds** satisfy this **Calendar Year Deductible**, no additional **Calendar Year Deductible** per **Insured** will be required for the remainder of the **Calendar Year**.]

[If [two (2)] or more **Insureds** incur **Covered Expenses** for **Injuries** sustained in the same accident, only one (1) **Calendar Year Deductible** will be applied that **Calendar Year** to the combined **Covered Expenses** resulting from the **Injuries** sustained in such common accident by all **Insureds**.]

The amount of the **Calendar Year Deductible** is shown on the **Certificate Schedule**.

[**"Calendar Year Maximum Benefit Per Insured"** means the maximum dollar amount of **Covered Expenses** per **Calendar Year** per **Insured** that **We** are required to pay, after satisfaction of all applicable deductibles, [**Co-Pays**,] [**Access Fees]** and the amount of any **Insured Coinsurance Percentage**. The amount of the **Calendar Year Maximum Benefit Per Insured** is shown on the **Certificate Schedule**.]

[**"Calendar Year Maximum Per Insured For Prescription Drugs"** means the maximum dollar amount of **Covered Expenses** incurred per **Insured** per **Calendar Year** that **We** are required to pay for **Prescription Drugs** ,after the satisfaction by each applicable **Insured** of (i) [the amount of any applicable **Co-pays**;] **[ii)] [**the **Prescription Drug Calendar Year Deductible;]** and [(iii)] [the amount of the **Prescription Drug Insured Coinsurance Percentage]**. The amount of the **Calendar Year Maximum Per Insured for Prescription Drugs** is shown on the **Certificate Schedule**.]

["Calendar Year Maximum Per Insured For Outpatient Treatment" means the maximum dollar amount of **Covered Expenses** incurred per **Insured** per **Calendar Year** that **We** are required to pay, after the satisfaction by each applicable **Insured** of (i) the amount of all applicable deductibles and **Access Fees** (ii) the amount of the **Insured Coinsurance Percentage** for the **Outpatient** coverages listed in Section V. A. EMERGENCY ROOM AND OTHER OUTPATIENT BENEFITS. The amount of the **Calendar Year Maximum Per Insured** for **Outpatient Treatment** is shown on the **Certificate Schedule**.**]**

["Calendar Year Adult Wellness Maximum" means the maximum dollar amount of **Covered Expenses** per **Calendar Year** per **Insured** that **We** are required to pay, after satisfaction of all applicable deductibles, [**Co-Pays**,] [**Access Fees]** and the amount of any **Insured Coinsurance Percentage**. The amount of the **Calendar Year Maximum Adult Wellness Maximum** is shown on the **Certificate Schedule**.]

["Center of Excellence" means a **Participating Provider** who has agreed to provide organ transplants.]

"Certificate" means this contract of coverage between all **Insureds** and the **Company** that was issued under the **Group Policy**. This contract of coverage consists solely of (i) this written CERTIFICATE OF COVERAGE, (ii) the application for coverage of each **Insured**, which application is attached hereto and by this reference incorporated for all purposes, and (iii) any riders, endorsements or amendments attached hereto.

"Certificate Of Continuation / Conversion Coverage" means the documents prepared by **Us** in accordance with the provisions of Section III.E. CONTINUATION OF COVERAGE AND CERTIFICATE OF CONTINUATION / CONVERSION, which on their effective date will replace this **Certificate** as the contract of coverage between the applicable **Insured** and the **Company**, consisting of (i) an endorsement removing each applicable **Insured** from this **Certificate**, and (ii) a new certificate of coverage for each applicable **Insured** with the same applicable provisions as this **Certificate**, including any riders or amendments attached hereto, but bearing a new certificate number.

"Certificate Schedule" means the schedule of **Certificate** information that commences on page 3 of this **Certificate**.

["Childhood Wellness Preventive Care" means a routine annual **Outpatient** physical examination of each **Insured** under the age of [19, or to age 24] if **Full-Time Student** performed by a **Participating Provider**, not in connection with any **Sickness** or **Injury**, but instead as an evaluation of the annual health status of such individual, including any necessary laboratory blood tests, urinalysis, and x-rays performed in connection with each routine annual **Outpatient** physical examination and at the order of such **Participating Provider**. Provided, however, that such ordered medical laboratory and diagnostic tests, services and supplies are:

1. reasonably designed to permit early diagnoses of certain **Sicknesses**;
2. appropriate and performed according to and within generally accepted standards for medical practice;
3. in the most cost effective setting and manner available;

4. not primarily for the convenience of an **Insured**, a **Family**, or a **Provider**; and
5. the costs incurred do not exceed the **Maximum Allowable Charge** for such services.]

"Claim Determination Period" means, in connection with Section IX. COORDINATION OF BENEFITS, a **Calendar Year**. However, it does not include any part of a year during which an **Insured** has no coverage under this **Certificate**, or before the date that Section IX. COORDINATION OF BENEFITS or a similar provision takes effect.

"Class" means the classification by **Us** of (i) individuals to whom **We** have issued new coverage for the purposes of the calculation of their **Initial Premium** rates, and (ii) individuals to whom **We** have previously issued coverage for purposes of the calculation of their **Renewal Premium** rates.

"Company" means Freedom Life Insurance Company of America.

"Company Insurance Percentage" means the portion of the **Covered Expenses We** must pay to or on behalf of an **Insured** for **Benefits** under this **Certificate**, after satisfaction by the **Insured** of (i) all applicable [**Co-Pays** and] **Access Fees**, (ii) all applicable deductibles and (iii) the amount of the applicable **Insured Coinsurance Percentage**. The **Company Insurance Percentage** is shown on the **Certificate Schedule** for **Covered Expenses** for **Sickness and Injury Benefits**, [and] **Wellness and Screening Benefits** [and] [**Miscellaneous Benefits]** at (i) **Participating Providers**; and (ii) **Non-Participating Providers**.

"Complications of Pregnancy" means:

1. Conditions (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy, including but not limited to, acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity; and
2. Non-elective **Emergency** cesarean sections, termination of ectopic pregnancy, and spontaneous termination of pregnancy occurring during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy does not include false labor, occasional spotting, **Provider** prescribed rest during the period of pregnancy, morning sickness, and hyperemesis gravidarum. Nor does it include pre-eclampsia and similar conditions associated with the management of a difficult pregnancy unless such condition constitutes a nosologically distinct complication.

"Complying Plan" means, in connection with Section IX. COORDINATION OF BENEFITS, a **Plan** with an order of benefit determination provision which complies with the ORDER OF BENEFIT DETERMINATION RULES contained is Section IX. A.

"Confinement or **Confined"** means **Inpatient** services received as a resident bed patient for not less than eight (8) hours in a **Hospital**. A period of **Confinement** begins on the date of admission to the **Hospital** as an **Inpatient** and ends on the date of discharge.

["Co-Pays" means the amount of each first dollar co-payment of **Covered Expenses** incurred by an **Insured** for the applicable service and care that is required to be applied to and satisfied by the **Insured** before the remaining portion of such **Covered Expenses** are eligible for payment consideration by **Us. Co-Pays** may not be used to satisfy the **Calendar Year Deductible**, the **Insured Coinsurance Percentage**, the **Separate Deductible for Non-Participating Providers**, [any applicable **Access Fees**,] the amount of **Covered Expenses** for which benefit payments are received by **You** under any optional rider issued with this **Certificate**, or the amount of any applicable **Failure to Pre-Certify Treatment Deductible**.

[The remaining amount of **Covered Expenses** after the application and satisfaction of the designated **Co-Pay** is subject to the **Calendar Year Deductible** [the **Separate Deductible for Non-Participating Providers**,] [any applicable **Access Fees**,] and the **Insured Coinsurance Percentage.]**

The amount of each **Co-Pay** is shown on the **Certificate Schedule**.]

"Covered Expenses" means for the covered items and services listed in the **Sickness and Injury Benefits**, [and] **Wellness and Screening Benefits [**and the] [**Miscellaneous Benefits]** Sections of this **Certificate** the amount of expenses actually incurred by an **Insured**, after the **Issue Date** of this **Certificate** and before **Termination of**

Coverage, as a result of being **Provided** applicable medical, surgical, or diagnostic services, supplies, care, **Prescription Drugs** and other applicable treatment, which in each event is **Medically Necessary**, up to but not exceeding the amount of each of the following:

1. the **Maximum Allowable Charge** for each applicable medical, surgical or diagnostic service, supply, care [**Prescription Drugs]** or other applicable treatment;
2. the **Lifetime Certificate Maximum Per Insured**;
3. the **[Lifetime] Transplant Maximum [Per Organ] Per Insured**; [and]
4. the amount of any other applicable coverage limit or excluded amount set forth in any limitation, exclusion or waiting period that is contained in any Section in this **Certificate** and**/**or in any exclusionary or limiting rider, amendment or endorsement attached hereto.
5. **[**the **Calendar Year Maximum Benefit Per Insured**; [and]]
6. **[**the **Calendar Year Maximum Per Insured For Prescription Drugs**;] [and]]
7. [the **Calendar Year Maximum Per Insured For Outpatient Treatment**.**]**

"CPT Code" means the applicable numeric code assigned to a particular medical procedure **Provided** consistent with the most current version of the *Physicians' Current Procedural Terminology,* published by the American Medical Association on the date charges for such procedure are incurred by an **Insured**.

"Custodial Care" means care given mainly to meet personal needs. It may be provided by persons without professional skills or training. "**Custodial Care**" includes, but is not limited to, help in walking, getting in and out of bed, bathing, dressing, eating and taking medicine.

"Diabetes Equipment" means blood glucose monitors, insulin pumps and associated appurtenances, insulin infusion devices, and podiatric appliances for the prevention of complications associated with diabetes.

"Diabetes Self-Management Training" means training provided by a health care practitioner or **Provider** who is licensed, registered or certified in this state to provide appropriate health care services for the treatment of diabetes.

Diabetes Self-Management Training includes:

1. training provided after the initial diagnosis of diabetes, including nutritional counseling and proper use of **Diabetes Equipment** and **Diabetes Supplies**;
2. training authorized on the diagnosis of a **Provider** or other health care practitioner due to a significant change in the **Insured's** symptoms or condition which necessitates changes in the self-management regime; and
3. periodic or episodic continuing education training when prescribed by an appropriate health care practitioner as warranted by the development of new techniques and treatments for diabetes.

"Diabetes Supplies" means (a) test strips for blood glucose monitors; (b) visual reading and urine test strips; (c) lancets and lancet devices; (d) insulin and insulin analogs; (e) injection aids; (f) syringes; (g) prescriptive oral agents for controlling blood sugar levels; and (h) glucagon emergency kits.

"Disability Period" means the period of time that the **Primary Insured** is continuously **Totally Disabled** while coverage under the **Certificate** for such **Primary Insured** is in full force and effect.

["Doctor Office Visit Co-Pay" means the **Co-Pay** payment that is required [per visit] [per **Insured]** [per type of service] toward the applicable amount of **Covered Expenses** incurred by an **Insured** for **Outpatient** visits per **Calendar Year** per **Insured** to the professional offices of a physician who is a **Participating Provider** as defined in the **Certificate. Co-Pays** may not be used to satisfy the **Calendar Year Deductible**, the **Insured Coinsurance Percentage**, the **Separate Deductible for Non-Participating Providers**, [any applicable **Access Fees**,] the amount of **Covered Expenses** for which benefit payments are received by **You** under any optional rider issued with this **Certificate**, or the amount of any applicable **Failure to Pre-Certify Treatment Deductible**.]

[The remaining amount of **Covered Expenses** after the application and satisfaction of the **Doctor Office Visit Co-Pay** is subject to the **Calendar Year Deductible** [the **Separate Deductible for Non-Participating Providers**,] [any applicable **Access Fees**,] and the **Insured Coinsurance Percentage.]**

[The amount of the **Doctor Office Visit Co-Pay** is shown on the **Certificate Schedule**.]

"Emergency" means the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:

1. placing the patient's health in severe jeopardy;
2. serious impairment to bodily functions; or
3. serious dysfunction of any bodily organ or part.

"Emergency Care Facility" means a state licensed public or private establishment with an organized medical staff of **Providers** with permanent facilities that are equipped and operated primarily for the purpose of rendering **Outpatient Emergency** medical services for **Sicknesses** and **Injuries**, and which facility does not render **Inpatient** services. **Emergency Care Facility** does not include the emergency room of a **Hospital**, an **Ambulatory Surgical Center**, a facility that primarily terminates pregnancies, a **Providers** office maintained for the practice of medicine, or an office maintained for the practice of dentistry.

["Emergency Room Access Fee" means the amount of **Covered Expenses** under Section V.A. EMERGENCY ROOM SERVICES, an **Insured** must incur before any **Benefits** are payable under this **Certificate** if such **Insured** receives and is charged for services rendered in the emergency room of a **Hospital**. No **Benefits** are payable under this **Certificate** for any **Covered Expenses** for such an emergency room visit, until after the amount of any applicable **Emergency Room Access Fee**, the amount of the **Calendar Year Deductible**, **Insured Coinsurance Percentage,** as well as the amount of all other applicable **Access Fees** are satisfied and fully payable either by **You** or such **Insured**. In addition to the **Emergency Room Access Fee**, the **Separate Deductible for Non-Participating Providers** may apply to services rendered by **Non-Participating Providers**. However, the **Emergency Room Access Fee** shall be waived by **Us** if such **Insured** is **Confined** in any **Hospital** within twenty-four (24) hours of such emergency room visit.

None of the following expenses may be used to satisfy the **Emergency Room Access Fee**: (i) [the amount of the **Laboratory and Diagnostic Testing Access Fee**,] [(ii)][the amount of the **Outpatient Therapy Access Fee**,][(iii)] t[he amount of the **Separate Deductible for Non-Participating Providers**,][(iv)] t[he amount of **Covered Expenses** for which benefit payments are received by **You** under any optional rider issued with this **Certificate**,] [(v)[]the amount of any applicable **Failure to Pre-Certify Treatment Deductible**,] [(vi)] [the amount of the **Calendar Year Deductible,][** and] [vii] the **Insured Coinsurance Percentage]**.

[The amount of the **Emergency Room Access Fee** is shown on the **Certificate Schedule**.]

"External Review" means a process, independent of all affected parties, to determine if a **Health Care Service** is **Medically Necessary** or experimental/investigational.

"Failure to Pre-Certify Treatment Deductible" means the additional amount of **Covered Expenses** an **Insured** must incur before any **Sickness and Injury Benefits** are payable under this **Certificate** if such **Insured** fails to properly obtain **Pre-Certification of Treatment** as required under Section V.D. PRE-CERTIFICATION OF TREATMENT. No **Sickness and Injury Benefits** are payable under this **Certificate** for any **Covered Expenses** until after the amount of any applicable **Failure to Pre-Certify Treatment Deductible**, and the amount of the **Calendar Year Deductible** are satisfied and fully payable either by **You** or such **Insured**. In addition to the **Failure to Pre-Certify Treatment Deductible**, the **Separate Deductible For Non-Participating Providers** will apply to services rendered by **Non-Participating Providers**.

The amount of the **Failure to Pre-Certify Treatment Deductible** is shown on the **Certificate Schedule**.

None of the following expenses may be used to satisfy the **Failure to Pre-Certify Treatment Deductible**: (i) the amount of the **Separate Deductible For Non-Participating Providers**, (ii) the amount of **Covered Expenses** that constitute **Wellness and Screening Benefits** for which payment is made by **Us**, and (iii) the amount of the **Calendar Year Deductible** , and (iv) the amount of any applicable [**Co-Pay][** or][and][**Access Fee]**.

"Family" means the spouse, son or daughter, brother or sister, parent, grandparent or grandchild of an **Insured**.

"Final Adverse Determination" means an **Adverse Determination** involving a covered **Benefit** that has been upheld by **Us** at the completion of **Our Internal Grievance Procedure**. "**First Certificate Year**" means for the

period beginning on the **Issue Date** and ending on the last day immediately preceding the first anniversary of the **Issue Date**.

"First Certificate Year" means for the period beginning on the **Issue Date** and ending on the last day immediately preceding the first anniversary of the **Issue Date**.

"First Renewal Date" means the first premium due date following payment of the **Initial Premium** which is shown on the **Certificate Schedule**.

"First Renewal Premium" means the amount of **Renewal Premium** due on the **First Renewal Date**. The amount of **First Renewal Premium**, if known on the **Issue Date**, is shown on the **Certificate Schedule**.

"Full-Time Student" means an individual, under the age of [24], who is enrolled in at least twelve (12) credit hours per semester at an accredited college or university.

[**"Generic Drug"** means a **Prescription Drug** that contains the same active ingredients as an equivalent former **Brand Name Drug** that is no longer protected by a patent, and the trade name, if any, associated with such former **Brand Name Drug** is not listed on the label of such **Prescription Drug**.]

"Group Policy" means the association group insurance contract issued to the **Group Policyholder** under which this **Certificate** is issued to the **Primary Insured**.

"Group Policyholder" means the association shown on the **Certificate Schedule** to whom the **Group Policy** was issued.

"Health Care Services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, **Sickness, Injury** or disease, as used within the Grievance Procedures section.

"Home Health Care Plan" means a **Medically Necessary** program of care, established by an **Insured's Provider**, taking place in a residential setting.

"Hospice" means an agency licensed by the appropriate licensing agency to provide **Hospice Care**, under an administered program for a terminally ill **Insured** and his or her **Family**, with the following services available twenty-four (24) hours a day, seven (7) days a week: (a) **Inpatient** services, (b) home services, and (c) follow-up bereavement services.

"Hospice Care" means a **Medically Necessary**, coordinated, interdisciplinary **Hospice**-provided program for meeting the physical, psychological, spiritual, and social needs of dying individuals and his or her **Family**. **Hospice Care** provides **Medically Necessary** nursing, medical, and other health services to relieve pain and provide support through home and **Inpatient** care during the **Sickness** and bereavement of an **Insured** and his or her **Family**.

"Hospital" means a place which:

1. is legally operated for the care and treatment of sick and injured persons at their expense;
2. is primarily engaged in providing medical, diagnostic and surgical facilities (either on its premises or in facilities available to it on a formal pre-arranged basis);
3. has continuous twenty-four (24) hour nursing services by or under the supervision of a registered nurse (R.N.); and
4. has a staff of one or more **Providers** available at all times.

It also means a place that may not meet the above requirements, but is accredited as a hospital by the Joint Commission on Accreditation of Healthcare Organizations, the American Osteopathic Association or the Commission on the Accreditation of Rehabilitation Facilities.

Hospital does not mean:

1. a convalescent home, nursing home, rest home or **Skilled Nursing Home**;

2. a place primarily operated for treatment of **Mental and Emotional Disorders**, drug addicts, alcoholics, or the aged;
3. a special unit or wing of a **Hospital** used by or for any of the above;
4. a long-term mental care facility; or
5. a facility primarily providing **Custodial Care**.

"Independent Review Organization" means an entity that conducts independent **External Reviews** of **Adverse Determinations** and **Final Adverse Determinations**.

"Inherited Metabolic Disorder" means a disease caused by an inherited abnormality of body chemistry and includes a disease tested under a newborn screening program.

"Initial Premium" means the amount charged for coverage under this **Certificate** for **You** and all **Other Insureds** for the period of time from the **Issue Date** through the day before the **First Renewal Date**. The amount of the **Initial Premium** is shown on the **Certificate Schedule**, and is payable in advance of the **Issue Date**.

"Injury" means damage or harm **Accidentally** sustained to the physical structure of the body of an **Insured** that is the direct cause of the loss independent of disease, bodily infirmity, or any other cause, which occurs while this **Certificate** is in force and effect for such **Insured**. A specific **Injury** from which disability continues or recurs shall be considered one and the same **Injury** or "any one **Injury**", unless periods of **Confinement** to a **Hospital** or service, treatment, or **Covered Expenses** incurred resulting from such **Injury** are separated by an interval of at least ninety (90) consecutive days between the end of one such period and the beginning of a subsequent such period.

"Inpatient" means an **Insured** who receives **Medically Necessary** services from a **Provider** in a **Hospital** when such **Insured** is **Confined** and receives room and board from such **Hospital** for not less than eight (8) hours. Treatment or services rendered or **Provided** in a **Hospital** emergency room is not an **Inpatient Confinement** for the purposes of this **Certificate**. A period of **Inpatient Confinement** begins on the date of admission to the **Hospital** as an **Inpatient** and ends on the date of discharge.

"Insured" means the following:

1. the **Primary Insured** whose coverage under this **Certificate** is still in force and effect,
2. any other individuals named as **Other Insureds** on the **Certificate Schedule** whose coverage under this **Certificate** is still in force and effect, and
3. any individual who is added to this **Certificate** after the **Issue Date** by proper endorsement after proper application and payment of any additional premium whose coverage under this **Certificate** is still in force and effect.

"Insured Coinsurance Percentage" means the portion of the **Covered Expenses** that **You** must pay after satisfaction of all applicable deductibles[,] [**Co-pays**] and **Access Fees**. The different **Insured Coinsurance Percentages** are shown on the **Certificate Schedule** at [(i]) **Participating Providers [.]** [(i]i) [**Participating Pharmacies][**,][and] [(iii)] **Non-Participating Providers**, and (iv) **Non-Participating Pharmacies]**. (

"Insured Maximum Participating Provider Coinsurance Payment" means the maximum amount, after the satisfaction of all applicable **Certificate** deductibles, **Access Fees** [and **Co-Pays]**, that an **Insured** is required to pay in a **Calendar Year** under the **Insured Coinsurance Percentage** for services rendered at **Participating Providers [**and **Participating Pharmacies]. Covered Expenses** incurred for services rendered at **Participating Providers [**and **Participating Pharmacies]** that are covered under the **Sickness and Injury Benefits** and the **Wellness and Screening Benefits** sections and applied by the **Company** toward satisfaction of the **Calendar Year Deductible**, the **Separate Deductible For Non-Participating Providers**, the **Failure to Pre-Certify Treatment Deductible** and/or any other deductible contained in this **Certificate** or any rider attached to this **Certificate**, shall not be credited or applied toward satisfaction of the **Insured Maximum Participating Provider Coinsurance Payment**. The amount of the **Insured Maximum Participating Provider Coinsurance Payment** is shown on the **Certificate Schedule**.

"Insured Maximum Non-Participating Provider Coinsurance Payment" means the maximum amount, after the satisfaction of all applicable **Certificate** deductibles and **Access Fees**, that an **Insured** is required to pay in a

Calendar Year under the **Insured Coinsurance Percentage** for services rendered at **Non-Participating Providers [**and **Non-Participating Pharmacies]**. **Covered Expenses** incurred for services rendered at **Non-Participating Providers [**and **Non-Participating Pharmacies]** that are covered under the **Sickness and Injury Benefits** and the **Wellness and Screening Benefits** Sections and applied by the **Company** toward satisfaction of the **Calendar Year Deductible**, the **Failure to Pre-Certify Treatment Deductible**, and/or any other deductible contained in this **Certificate** or any rider attached to this **Certificate** shall not be credited or applied toward satisfaction of the **Insured Maximum Non-Participating Provider Coinsurance Payment**. The amount of the **Insured Maximum Non-Participating Provider Coinsurance Payment** is shown on the **Certificate Schedule**.

"Intensive Care Unit" means only the specifically designed facility of a **Hospital** which provides the highest level of medical care and restricts admission to only patients who are physically critically ill or injured, and which is separate and distinct from the rooms, beds and wards of such **Hospital** customarily used for patients who are not critically ill. To be considered an **Intensive Care Unit** under this **Certificate**, such facility must be permanently equipped with special life-saving equipment for the care of the physically critically ill or injured, and patients in such unit must be under constant and continuous observation by nursing staffs assigned on a full-time basis, exclusively to such facility of the **Hospital**. A coronary care facility and a specialized burn unit of a **Hospital** shall be considered an **Intensive Care Unit** if it meets these requirements and is restricted to persons receiving critical coronary or specialized burn care. However, the following are not considered an **Intensive Care Unit** under this **Certificate**:

1. a **Hospital** emergency room, regardless of the services or supplies rendered in such emergency room,
2. a surgical recovery room,
3. a sub-acute intensive care unit,
4. a progressive care unit,
5. an intermediate care unit,
6. a private monitored room,
7. any other observation unit or other facilities in a **Hospital** that are step downs from the unit in such **Hospital** that provides the highest level of medical care to critically ill patients.

"Internal Grievance Procedure" means the procedure by which **We** handle and resolve grievances, and provide **Insureds** with prompt and meaningful review on the issue of denial, in whole or part, of **Health Care Services**.
"Issue Date" means the date on which coverage under this **Certificate** commences for **You** and **Other Insureds**. This date is shown on the **Certificate Schedule**.

["Laboratory and Diagnostic Testing Access Fee" means the amount of **Covered Expenses** an **Insured** must incur [either per test per day, (as set forth in the **Certificate Schedule** by test and service)], before any **Benefits** are payable by **Us** under this **Certificate** for [MRI], [CAT Scan], [PET], [Myleogram] and [Nuclear Imaging Service (including Myocardial Perfusion Imaging - Thallium 201 Scintigraphy/Thallium Stress Tests)]. No **Benefits** are payable under this **Certificate** for any **Covered Expenses** for [MRI], [CAT Scan], [PET], [Myleogram] and [Nuclear Imaging Service (including Myocardial Perfusion Imaging - Thallium 201 Scintigraphy/Thallium Stress Tests)] performed on or for such **Insured** until after the amount of the **Laboratory and Diagnostic Testing Access Fee,** the amount of the **Calendar Year Deductible**, the **Insured Coinsurance Percentage**, as well as the amount of all other applicable **Access Fees** are satisfied and fully payable by either **You** or such **Insured**. In addition to the **Laboratory and Diagnostic Testing Access Fee**, the **Separate Deductible for Non-Participating Providers** will apply to services rendered by **Non-Participating Providers**.]

[None of the following expenses may be used to satisfy the **Laboratory and Diagnostic Testing Access** Fee, (i) **Emergency Room Access Fee**, [(ii) the amount of the **Outpatient Therapy Access Fee**,][(iii)] the amount of the **Separate Deductible for Non-Participating Providers**,[(iv)] the amount of **Covered Expenses** for which benefit payments are received by **You** under any optional rider issued with this **Certificate**,[(v)]the amount of any applicable **Failure to Pre-Certify Treatment Deductible**, [(vi)] the amount of the **Calendar Year Deductible,** and [vii] the **Insured Coinsurance Percentage**.]

[The amount of the **Laboratory and Diagnostic Testing Access Fee** is shown on the **Certificate Schedule**.]

"Lifetime Certificate Maximum Per Insured" means the total dollar amount of **Covered Expenses** payable on behalf of an **Insured** under this **Certificate** for **Benefits**. The minimum amount of the **Lifetime Certificate Maximum Per Insured** is shown on the **Certificate Schedule**. The amount of the **Lifetime Certificate Maximum**

Per Insured may increase on an annual basis in accordance with the terms, limitations and exclusions of Section VIII. INCREASE IN LIFETIME CERTIFICATE MAXIMUM.

["[Lifetime] Transplant Maximum [Per Organ] Per Insured" means the total dollar amount of **Covered Expenses** payable by **Us** under the terms of this **Certificate** for services **Provided** to an **Insured** in connection with or attributable to all **Solid Organ Transplants**, **Bone Marrow Transplants**, and **Stem Cell Transplants** received by the **Insured**. This [lifetime] [per organ] maximum **Benefit** includes all related **Covered Expenses** incurred from 14 days before each applicable transplant surgery or procedure to 365 days after each such transplant surgery or procedure. The amount of the **[Lifetime] Transplant Maximum [Per Organ] Per Insured** is shown on the **Certificate Schedule** and shall not exceed the **Lifetime Certificate Maximum Per Insured**.]

"Mammogram" means the X-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression device, screens, and films and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast.

"Manifests" or **"Manifested"** means either the presentation of symptoms or the presence of a medical condition, whether physical or mental, and regardless of the cause:

1. for which medical advice, diagnosis, care or treatment was recommended or received; and/ or
2. which would have caused a reasonably prudent person to seek medical advice, diagnosis, care or treatment, and which condition would have been medically diagnosable after the receipt of the results of medical diagnostic and laboratory tests that would have been reasonably indicated and ordered by a reasonably prudent **Provider** under the same or similar circumstances.

"Mastectomy" means the surgical removal of all or part of the breast as a result of breast cancer. **Mastectomy** does not include biopsies or other exploratory or diagnostic procedures used to detect the presence of cancer.

"Maximum Allowable Charge" means the following:

1. For **Providers**, **Maximum Allowable Charge** is the actual expense incurred by an **Insured** for the applicable service, supplies, care, or treatment **Provided**, after any reduction, adjustment, and/or discount pursuant to any **Participating Provider** agreements or other network agreements, negotiated rates, fee schedules or arrangements that determine or prescribe the actual amount of charges or fees that the **Provider**:

   a) agreed to accept as payment in full for such services, supplies, care or treatment, and
   b) ultimately charged such **Insured**, regardless of any higher amount that may have been placed on the **Provider's** billing statement of charges.

2. For **Hospitals**, **Ambulatory Surgical Centers**, **Emergency Care Facility**, **Skilled Nursing Homes**, laboratories, pharmacies or other medical, diagnostic or treatment facilities, "**Maximum Allowable Charge**" is the actual amount charged by such entity for the applicable service or treatment **Provided** to an **Insured**, after a reduction, adjustment, and/or network discount pursuant to any **Participating Provider** agreements, [**Participating Pharmacy** agreements] or other network agreements, negotiated rates, fee schedules or other arrangements that determine or prescribe the actual amount of charges or fees that such entity:

   a) agreed to accept as payment in full for such applicable services, supplies, care, treatment[or **Prescription Drugs]**, and
   b) ultimately charged such **Insured** for such applicable services, supplies, care, treatment [or **Prescription Drugs]**, regardless of any higher amount that may have been placed on the entity's billing statement of charges.

However, the amount of the **Maximum Allowable Charge** under (1) and (2) above shall never exceed (i) the amount for which the applicable **Insured** has a legal liability and payment obligation for the receipt of such applicable services, supplies, care, treatment [or **Prescription Drugs]**, (ii) the amount of the **Medicare** allowable or approved charge for the receipt of such applicable services, supplies, care, treatment [or **Prescription Drugs]** with

respect to any **Insured** who is **Medicare** eligible, or (iii) the amount of **Usual and Customary Expense** for the receipt of such applicable services, supplies, care, treatment [or **Prescription Drugs]**.

"Medical Foods" means modified low protein foods and metabolic formulas. Metabolic formulas are foods that are all of the following: (i) formulated to be consumed or administered enterally under the supervision of a **Provider**; (ii) processed or formulated to be deficient in one or more of the nutrients present in typical foodstuffs; (iii) administered for the medical and nutritional management of a person who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrient requirements as established by medical evaluation; and (iv) essential to a person's optimal growth, health and metabolic homeostasis.

Modified low protein foods are foods that are all of the following: (i) formulated to be consumed or administered enterally under the supervision of a **Provider** (ii) processed or formulated to contain less than one gram of protein per unit of serving, but does not include a natural food that is naturally low in protein; (iii) administered for the medical and nutritional management of a person who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrient requirements as established by medical evaluation; and (iv) essential to a person's optimal growth, health and metabolic homeostasis.

"Medical Necessity" and **"Medically Necessary"** means:

1. For the covered items and services listed in the **Sickness and Injury Benefits** Section of this **Certificate**, **Medical Necessity** and **Medically Necessary** is any applicable **Confinement** of an **Insured**, as well as any other diagnostic test, laboratory test, examination, surgery, medical treatment, service or supply listed therein that is **Provided** to an **Insured**:

   a) by or at the appropriate order, or upon the approval of a **Provider**;
   b) for the medically recognized diagnosis or care and treatment of an **Injury** or **Sickness**;
   c) in a manner appropriate and necessary for the symptoms, diagnosis or treatment of such **Injury** or **Sickness**;
   d) according to and within generally accepted standards for medical practice;
   e) in the most cost effective setting and manner available to treat the **Injury** or **Sickness**;
   f) not primarily for the convenience of an **Insured**, **Family**, or a **Provider**; and
   g) not investigational or experimental in nature.

2. For the covered items and services listed in the **Wellness and Screening Benefits [**and the] [**Miscellaneous Benefits]** Section[s] of this **Certificate**, **Medical Necessity** and **Medically Necessary** is any applicable diagnostic test, laboratory test, examination, or medical treatment, service or supply listed therein that is **Provided** to an **Insured**:

   a) reasonably designed to either prevent certain future **Sickness** or permit early diagnoses of certain **Sickness**;
   b) prescribed, performed and/or ordered by a **Provider**;
   c) appropriate and performed according to and within generally accepted standards for medical practice;
   d) rendered in the most cost effective setting and manner available, and
   e) not primarily for the convenience of an **Insured**, a **Family**, or a **Provider**.

The fact that a **Provider** prescribed, ordered, recommended or approved a service, supply, treatment or **Confinement** does not in and of itself make it **Medically Necessary** or a **Medical Necessity**.

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

"Mental and Emotional Disorders" means a neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

[“Miscellaneous Benefits” means only treatments, procedures, services, and supplies that are specifically enumerated in Section V.C. MISCELLANEOUS BENEFITS. If a treatment, procedure, service, or supply is not specifically enumerated in the MISCELLANEOUS BENEFITS Section, then fees charged or expenses associated with such items are not covered under this **Certificate** as a **Miscellaneous Benefit.]**

“Mode Of Premium Payment” means the interval of time (monthly, quarterly, semi-annual or annual) that you have selected for payment of the **Initial Premium** and **Renewal Premium**. The premium payment interval selected by **You** as the **Mode Of Premium Payment** is shown on the **Certificate Schedule**. This **Mode Of Premium Payment** is subject to change at **Our** discretion.

“Non-Complying Plan” means, in connection with Section IX. COORDINATION OF BENEFITS, a **Plan** with an order of benefit determination provision which does not comply with Section IX. A. ORDER OF BENEFIT DETERMINATION RULES.

[“Non-Participating Pharmacy” means a pharmacy that at the time **Covered Expenses** are incurred, has not entered into or has terminated a prior agreement to provide services to **Insureds** under this **Certificate**.]

“Non-Participating Provider” means a **Hospital**, **Provider**, **Ambulatory Surgical Center, Skilled Nursing Home**, or other licensed practitioner of the healing arts for which **Sickness and Injury Benefits** or **Wellness and Screening Benefits** are payable under this **Certificate** that, at the time **Covered Expenses** are incurred, has not entered into or has terminated a prior agreement to provide health care services to **Insureds** under this **Certificate** form at discounted rates.

“**Orthotic Device**” means an external device that is (i) intended to restore physiological function or cosmesis to a patient; and (ii) custom-designed, fabricated, assembled, fitted or adjusted for the patient using the device prior to or concurrent with the delivery of the device to the patient.

“**Orthotic Service**” means the evaluation and treatment of a condition that requires the use of an orthotic device.

“Other Insureds” means those members of **Your Family** that are listed on the **Certificate Schedule** on the **Issue Date.**

“Our” means Freedom Life Insurance Company of America.

“Outpatient” means **Medically Necessary** medical care, treatment, services or supplies from a **Provider** at (i) a clinic, (ii) an emergency room of a **Hospital**, (iii) an **Ambulatory Surgical Center**, (iv) an **Emergency Care Facility**, or (v) the surgical facility of a **Hospital** which does not result in an **Inpatient Confinement** at such **Hospital** following such surgery.

[“Outpatient Therapy Access Fee” means the amount of **Covered Expenses** an **Insured** must incur **[**per **Outpatient** visit] [per service] [per type of service] to any medical facility for any **Outpatient** non-surgical medical therapy or treatment under Section V.A. OUTPATIENT THERAPY before any **Benefits** are payable by **Us** under this **Certificate** for any **Outpatient** non-surgical medical therapy or treatment received by such **Insured** during each such visit. No **Benefits** are payable under this **Certificate** for any **Covered Expenses** for any non-surgical medical therapy or treatment received by such **Insured** on an **Outpatient** basis after the amount of the **Outpatient Therapy Access Fee** , the amount of the **Calendar Year Deductible**, the **Insured Coinsurance Percentage**, as well as the amount of all other applicable **Access Fees** are satisfied and fully payable by either **You** or such **Insured**. In addition to the **Outpatient Therapy Access Fee**, the **Separate Deductible for Non-Participating Providers** will apply to services rendered by **Non-Participating Providers**.

None of the following expenses may be used to satisfy the Outpatient Therapy Access Fee (i) **Laboratory and Diagnostic Testing Access Fee**, (ii) **Emergency Room Access Fee**, [(iii)] the amount of the **Separate Deductible for Non-Participating Providers**,[(iv)] the amount of **Covered Expenses** for which benefit payments are received by **You** under any optional rider issued with this **Certificate**,[(v)]the amount of any applicable **Failure to Pre-Certify Treatment Deductible**, [(vi)] the amount of the **Calendar Year Deductible,** [(vii)] [the amount of any applicable **Co-Pay**,] and [(viii)] the **Insured Coinsurance Percentage**.

The amount of the **Outpatient Therapy Access Fee** is shown on the **Certificate Schedule**.]

[**"Participating Pharmacy"** means a pharmacy that has entered into, and not terminated by the date the **Covered Expenses** are incurred, an agreement to dispense **Prescriptions** to **Insureds** under this **Certificate**. A **Participating Pharmacy** can be either a retail store or mail order for home delivery.]

"Participating Provider" means a **Hospital**, **Provider**, **Ambulatory Surgical Center**, **Skilled Nursing Home,** or other licensed practitioner of the healing arts for which **Sickness and Injury Benefits**, [and/or] **Wellness and Screening Benefits** [and/or] [**Miscellaneous Benefits]** are payable under this **Certificate** that has entered into, and not terminated by the date the **Covered Expenses** are incurred, an agreement to provide health care services to **Insureds** under this **Certificate** at discounted rates.

"Periodic Preventive Care Visits" means the routine tests and procedures for the purpose of detection of abnormalities or malfunctions of bodily systems and parts according to accepted medical practice.

"Plan(s)" means, in connection with Section IX. COORDINATION OF BENEFITS, this **Certificate** and other types of coverage that **We** may consider in determining whether over insurance exists with respect to a specific claim. The ORDER OF BENEFIT DETERMINATION RULES determines whether this **Certificate** is a **Primary Plan** or **Secondary Plan** when compared to another **Plan** covering the applicable **Insured**.

"Pre-Certification of Treatment" means the process of obtaining prior verbal or written authorization from **Us** for **Medically Necessary Inpatient Confinement** or surgery. **Pre-Certification of Treatment** is not required for **Emergency Inpatient** admission.

"Pre-existing Condition" means a condition, whether physical or mental, and regardless of the cause:

1. for which medical advice, diagnosis, care or treatment was recommended or received during the [twelve (12)] [twenty-four (24)] month period immediately preceding the effective date of coverage under this **Certificate** for the **Insured** incurring the expense; or
2. which **Manifested** during the [twelve (12)] [twenty-four (24)] month period immediately preceding the effective date of coverage under the **Certificate** for the **Insured** incurring the expense.

This **Certificate** provides coverage as of the **Issue Date** for **Pre-existing Conditions**, disclosed on the application, provided they are not otherwise limited or excluded by this **Certificate** or any riders, amendments, or endorsements attached hereto.

This **Certificate** does not cover expenses for **Pre-existing Conditions**, that are not disclosed on the application, unless the expenses are incurred more than [twelve (12)] [twenty-four (24)] months after the **Insured's** coverage has been in effect, and are not otherwise limited or excluded by this **Certificate** or any riders, amendments, or endorsements attached hereto.

[**"Preferred Brand Drugs"** means each **Brand Name Drug** that is identified and listed upon the **Preferred Drug List**. In certain circumstances, a **Preferred Brand Drug** maybe a medically acceptable alternative medication to a **Brand Name Drug** that is not listed on the **Preferred Drug List** such that an **Insured** may want to consult with his/her **Provider** and the pharmacist of the **Participating Pharmacy** regarding whether such **Preferred Brand Drug** would be appropriate and proper in the treatment of such **Insured's** condition.]

[**"Preferred Drug List"** means a list either created or sponsored by **Us**, which identifies certain **Brand Name Drugs** that may be preferred. The **Preferred Drug List** is updated from time to time and may be found on the Internet at www.ushealthgroup.com in the prescription services location of the website. **You** may also call the toll free Rx Help Desk number on your ID card.]

"Premium Rate Guarantee Period" means the number of months [(that **We** guarantee **Your** premium will not increase more than [five-twenty percent][5%-20%] annually on **Your** anniversary)] immediately following the **Issue Date] [**that must expire before the amount of **Renewal Premium** charged by **Us]** (with the same **Mode of Premium Payment** as the **Mode of Premium Payment** selected for payment of the **Initial Premium**) [can be higher than the amount of the **Initial Premium] [**because of (i) a change by **Us** in the table of premium rates used to calculate the **Initial Premium**, or (ii) an increase in the attained age after the **Issue Date** of any **Insured** listed on the **Certificate Schedule**.] However, the amount of **Renewal Premium** required for this

Certificate may be increased by **Us**, even during the **Premium Rate Guarantee Period**, if after the **Issue Date**:

1. **You** add **Insureds** to this **Certificate**;
2. **You** change the amount of the **Calendar Year Deductible** shown on the **Certificate Schedule**;
3. **You** change the **Insured Coinsurance Percentage** shown on the **Certificate Schedule**;
4. **You** change any other coverage option;
5. **You** change residence to a different zip code;
6. **You** change the **Mode Of Premium Payment**;
7. **You** add optional coverage riders, if any;
8. **You** change to a different optional **Participating Provider** network available in **Your** state, if any;
9. a **change occurs in the relationship between US** and **Your Participating Provider** network;
10. the **Participating Provider** network availability changes for **Your** state;
11. the **Participating Provider** negotiated discounts change; and/ or
12. a change occurs in **Sickness and Injury Benefits**, [and/or] **Wellness and Screening Benefits**, [and/or the] [**Miscellaneous Benefits]** by amendatory endorsement pursuant to any federal or state law or regulation.

The length of the **Premium Rate Guarantee Period** is shown on the **Certificate Schedule**.

"Prescription" means the **Medically Necessary** authorization for a **Prescription Drug** to be dispensed to an **Insured** on an **Outpatient** basis pursuant to the order of a **Provider** who is acting within the scope of his or her license to treat an **Injury** or **Sickness**. [Retail store filled **Prescriptions** for which **Sickness and Injury Benefits** are payable under this **Certificate** will be limited to a single thirty (30) day supply for each new or refilled **Prescription Drug**, unless adjusted based on the drug manufacturer's packaging size or based on supply limits. Mail order for home delivery filled **Prescriptions** for which **Sickness and Injury Benefits** are payable under this **Certificate** will be limited to a single ninety (90) day supply for each new or refilled **Prescription Drug**.]

"Prescription Drug" means legend drugs and medications that by Federal law may only be legally obtained on an **Outpatient** basis with a **Prescription**.

["Prescription Drug Calendar Year Deductible Per Insured" means the amount of **Covered Expenses** an **Insured** must incur, [after satisfaction of any applicable **Co-Pay**,] within a **Calendar Year** before any **Outpatient Prescription Drug Benefit** is payable.]

["Prescription Drug Company Insurance Percentage" means the portion of the **Covered Expenses We** must pay to or on behalf of an **Insured** for **Prescription Drug Benefits** under this **Certificate**, after satisfaction by the **Insured** of (i) all applicable **Co-Pays**, (ii) all applicable deductibles and (iii) the amount of the applicable **Prescription Drug Insured Coinsurance Percentage**. The **Prescription Drug Company Insurance Percentage** is shown on the **Certificate Schedule** for **Covered Expenses** for **Prescription Drug Benefits** at (i) **Participating Pharmacies** ; and (ii) **Non-Participating Pharmacies**.]

["Prescription Drug Co-Pay" means the **Co-Pay** payment that is required toward the total amount of **Covered Expenses** per **Prescription** per **Insured** under Section V. A. OUTPATIENT PRESCRIPTIONS. **Co-Pays** may not be used to satisfy the **Calendar Year Deductible**, [**Prescription Drug Calendar Year Deductible Per Insured]**, the **Insured Coinsurance Percentage**, [**Prescription Drug Insured Coinsurance Percentage**] the **Separate Deductible for Non-Participating Providers**, any applicable **Access Fees**, the amount of **Covered Expenses** for which benefit payments are received by **You** under any optional rider issued with this **Certificate**, or the amount of any applicable **Failure to Pre-Certify Treatment Deductible**.**]**

[The remaining amount of **Covered Expenses** after the application and satisfaction of the designated **Prescription Drug Co-Pay** is subject to the **Calendar Year Deductible** [the **Separate Deductible for Non-Participating Providers**,] and the **Insured Coinsurance Percentage.]**

The amount of the **Prescription Drug Co-Pay** is shown on the **Certificate Schedule**]

["Prescription Drug Insured Coinsurance Percentage" means the portion of the **Covered Expenses** that **You** must pay after satisfaction of all applicable **Co-Pays** and deductibles. The different **Prescription Drug Insured**

Coinsurance Percentages are shown on the **Certificate Schedule** at (i) **Participating Pharmacies**, and (ii) **Non-Participating Pharmacies**.]

"Primary Insured" means the individual whose name is printed on the **Certificate Schedule** as the **Primary Insured** and whose coverage under this **Certificate** has not ended.

"Primary Plan" means, in connection with Section IX. COORDINATION OF BENEFITS, of this **Certificate** the **Plan** that pays first pursuant to the order of benefit determination rules contained in such Section without regard to the possibility that another **Plan** may cover some expenses of the applicable **Insured**.

"**Prosthetic Device**" means an external device that is (i) intended to replace an absent external body part for the purpose of restoring physiological function or cosmesis to a patient; and (ii) custom-designed, fabricated, assembled, fitted, or adjusted for the patient using the device prior to or concurrent with being delivered to the patient.

"**Prosthetic Service**" means the evaluation and treatment of a condition that requires the use of a prosthetic device.

"Provide", "Provided" or **"Providing"** means each medical, diagnostic and surgical test, service, care, treatment, supply, including **Prescriptions**, which is:

1. prescribed or ordered by a **Provider;**
2. rendered to and received by an **Insured** while coverage under this **Certificate** for such **Insured** is in full force and effect;
3. listed as a covered item, type of service and/or supply in the **Sickness and Injury Benefits**, [and/or] **Wellness and Screening Benefits**, and/or [**Miscellaneous Benefits]** Sections; and
4. not otherwise limited or excluded by any provision in this **Certificate** or rider, endorsement or amendment attached hereto.

"Provider" means a person who has successfully completed the prescribed course of studies in medicine at a medical school officially recognized and accredited in the country in which it is located, and which person has been licensed by the state in which the medical services are rendered to practice medicine. The **Provider** must be acting within the scope of such license while rendering **Medically Necessary** professional service to an **Insured**, and cannot be a member of the **Insured's Family**.

"Renewal Premium" means the amount charged for coverage of all **Insureds** under this **Certificate** for the period of time from the **First Renewal Date** through the day before each subsequent renewal coverage renewal date. **Renewal Premium** for each renewal period is payable in advance for each applicable renewal period.

"Retrospective Review" means a review of **Medical Necessity** conducted after services have been **Provided** to a **Covered Insured**, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment.

"Secondary Plan(s)" means, in connection with Section IX. COORDINATION OF BENEFITS, the **Plan** that pays after the **Primary Plan** pursuant to the order of benefit determination rules contained in such Section, and such **Secondary Plan** may reduce its benefit payments that the benefit payments from all **Plans** do not exceed 100% of the total **Allowable Expense**.

"Separate Deductible For Non-Participating Providers" meansthe amount of **Covered Expenses** an **Insured** must incur in a **Calendar Year** for services rendered by **Non-Participating Providers** before any applicable **Sickness and Injury Benefits** or **Wellness and Screening Benefits** are payable under this **Certificate**.

No **Sickness and Injury Benefits** or **Wellness and Screening Benefits** are payable under this **Certificate** for services rendered by **Non-Participating Providers** until after the **Separate Deductible For Non-Participating Providers** is satisfied and fully payable by either **You** or such **Insured**. The amount of the **Separate Deductible For Non-Participating Providers** is shown on the **Certificate Schedule** and applies per **Calendar Year** separately to each **Insured**.

None of the following expenses may be used to satisfy the **Separate Deductible For Non-Participating Providers**: (i) the amount of the **Calendar Year Deductible**; (ii) the amount of any applicable [**Co-Pays** and] **Access Fees**; (iii) [the amount of Covered **Expenses** that constitute **Miscellaneous Benefits** for which payment is made by **Us**;] and (iv) the amount of the **Failure to Pre-certify Treatment Deductible**.

[When [three (3)] **Insureds** satisfy this **Separate Deductible For Non-Participating Providers**, no additional **Separate Deductible For Non-Participating Providers** per **Insured** will be required for the remainder of the **Calendar Year**.]

[If [two (2)] or more **Insureds** incur **Covered Expenses** for **Injuries** sustained in the same accident, only one (1) **Separate Deductible For Non-Participating Providers** will be applied that **Calendar Year** to the combined **Covered Expenses** resulting from the **Injuries** sustained in such common accident by all **Insureds**.]

"Sickness" means illness or disease afflicting an **Insured**, including **Complications of Pregnancy**, which first **Manifests** itself on or after the **Issue Date** shown on the **Certificate Schedule** and while this **Certificate** is in force and effect for such **Insured**.

Provided, however, any expenses incurred by an **Insured** (from a condition which is not otherwise excluded by a rider, endorsement, or amendment attached to this **Certificate**), which results from hernia, disease or disorders of the reproductive organs, hemorrhoids, varicose veins, tonsils and/or adenoids, or otitis media, shall be eligible for consideration as **Covered Expenses** only if such expenses are incurred after the expiration of six (6) months from the **Issue Date** shown on the **Certificate Schedule** or are **Provided** on an **Emergency** basis.

"Sickness and Injury Benefit(s)" mean only treatments, procedures, services, and supplies that are specifically enumerated in Section V.A. SICKNESS AND INJURY BENEFITS. If a treatment, procedure, service, or supply is not specifically enumerated in the SICKNESS AND INJURY BENEFITS Section**,** then fees charged or expenses associated with such items are not covered under this **Certificate** as a **Sickness and Injury Benefit**. Payments by **Us** for **Sickness and Injury Benefits** are subject to all definitions, exclusions, limitations and provisions contained herein, including but not limited to the satisfaction and payability by **You** or the applicable **Insured** of all applicable deductibles, as well as the limitation of the **Company Insurance Percentage**.

"Skilled Nursing Home" means a place which:

1. charges patients for their services;
2. is legally operated in the state (or similar jurisdiction) in which it is located;
3. has beds for patients who need medical and skilled care;
4. operates under a doctor's supervision;
5. has continuous twenty-four (24) hour nursing service supervised by a registered nurse (R.N.); and
6. keeps complete medical records on each patient.

Skilled Nursing Home also means a wing, area or floor of a **Hospital** specifically set aside to provide care similar to that of a **Skilled Nursing Home**, but it does not mean a **Hospital**.

"Solid Organ Transplant(s)" means the **Medically Necessary** surgical transplantation, combined transplantation, sequential transplantation, (including grafts) of the following **Medically Necessary** organs received by an **Insured** while coverage for such **Insured** under this **Certificate** is in full force and effect:

1. heart;
2. lung;
3. kidney;
4. pancreas;
5. combined heart/lung;
6. combined kidney/pancreas;
7. skin;
8. eye or parts thereof (including lens and cornea); and
9. liver (**Insureds** who are candidates for liver transplantation must have abstained from the use of alcohol for one year immediately prior to such transplantation surgery in order for the planned liver transplantation to constitute a **Solid Organ Transplant**).

"Stem Cell Transplants" means the **Medically Necessary** insertion or transplantation, combined insertion or transplantation, sequential insertion or transplantation procedures, in which any **Medically Necessary** form of stem cells are received by an **Insured** while coverage for such **Insured** under this **Certificate** is in full force and effect.

"Subsequent Certificate Year(s)" means each twelve (12) month period ending on each anniversary of the **Issue Date** following the **First Certificate Year**.

"Termination of Coverage" means Section III.C. TERMINATION OF COVERAGE, that governs the conditions and circumstances under which the coverage provided by this **Certificate** may be terminated for any or all **Insureds**.

"Total Disability" or **"Totally Disabled"** means that, due to an **Injury** or **Sickness**, an **Insured** is:

1. under a **Provider's** continuous care; and
2. not able to perform the normal activities of a person of like age or sex who is in good health; and
3. unable to engage in any activity, occupation, or business for income or profit, for which such **Insured** is qualified by reason of training, education, or experience.

"Us" means Freedom Life Insurance Company of America.

"Usual and Customary Expense" means the following:

1. For **Providers Usual and Customary Expense** is the seventieth (70th) percentile of the prevailing charges by all **Providers** in the same geographic area as such **Provider**, as determined by one of the current prevailing health care charges information systems in the insurance industry utilizing the applicable **CPT Code** for such services or treatment and the applicable zip code (first 3 or 5 digits) of such **Provider**.

2. For services or treatments **Provided** by **Hospitals**, **Ambulatory Surgical Centers**, **Emergency Care Facilities**, **Skilled Nursing Homes**, pharmacies or other applicable facilities, **Usual and Customary Expense** is average charge made for similar services or supplies in the locality where the service or supply is furnished, taking into consideration the nature and the severity of the **Injury** or **Sickness** suffered by the **Insured**.

Provided, however, that **Usual and Customary Expense** shall never exceed the **Medicare** allowable or approved charge with respect to **Insureds** who are **Medicare** eligible.

"Utilization Review" means a system for prospective or concurrent review of the **Medical Necessity** and appropriateness of health care services being **Provided,** or proposed to be **Provided,** to an **Insured** within this state. **Utilization Review** does not include elective requests for clarification of coverage.

"We" means Freedom Life Insurance Company of America.

"Wellness and Screening Benefit(s)" means only treatments, procedures, services, and supplies that are specifically enumerated in the Section V.B. WELLNESS AND SCREENING BENEFITS. If a treatment, procedure, service, or supply is not specifically enumerated in the WELLNESS AND SCREENING BENEFITS Section, then fees charged or expenses associated with such items are not covered under this **Certificate** as a **Wellness and Screening Benefit**.

["X-Ray, Laboratory and Diagnostic Testing Co-Pay" means the **Co-Pay** payment that is required [per visit per **Insured]** [per type of service] toward the applicable amount of **Covered Expenses** incurred by an **Insured** for **Outpatient** testing, per **Calendar Year** per **Insured,** at the professional offices of a physician who is a **Participating Provider** as defined in the **Certificate. Co-Pays** may not be used to satisfy the **Calendar Year Deductible**, the **Insured Coinsurance Percentage**, the **Separate Deductible for Non-Participating Providers**, [any applicable **Access Fees**,] the amount of **Covered Expenses** for which benefit payments are received by **You** under any optional rider issued with this **Certificate**, or the amount of any applicable **Failure to Pre-Certify Treatment Deductible**.]

[The remaining amount of **Covered Expenses** after the application and satisfaction of the **X-Ray, Laboratory and Diagnostic Testing Co-Pay** is subject to the **Calendar Year Deductible** [the **Separate Deductible for Non-Participating Providers**,] [any applicable **Access Fees**,] and the **Insured Coinsurance Percentage.]**

[The amount of the **X-Ray, Laboratory and Diagnostic Testing Co-Pay** is shown on the **Certificate Schedule**.]

"You", "Your" and **"Yours"** means the individual listed on the **Certificate Schedule** as the **Primary Insured**.

"Your Renewal Premium Class" means the **Class** in which this **Certificate** is placed for **Renewal Premium** purposes. **Your Renewal Premium Class** will be determined by **Us** based upon several factors, including, among other things, a combination of one or more of the following: (i) **Your** zip code (either first 3 or first 5 digits) at the commencement of such renewal period, (ii) **Your** county of residence at the commencement of such renewal period, (iii) **Your** state of residence at the commencement of such renewal period, (iv) the **Issue Date**, (v) **Your** state of residence on the **Issue Date**, (vi) the number, sex, attained age, and tobacco use of each **Insured** on each applicable renewal date, (vii) **Your** plan of coverage under this **Certificate** on each applicable renewal date, including its deductibles, **Benefits**, limits, exclusions, limitations, optional riders, and exclusionary endorsements (viii) the underwriting risk assessment of each **Insured**, (ix) discounted or preferred premium rate status of any **Insured**, (x) premium rate ups, if any, for any **Insured**, (xi) the amount of the **Initial Premium**, (xii) the amount of the **Renewal Premium** charged in the preceding renewal period, (xiii) **Mode of Premium Payment** for the renewal period and (xiv) the number and type other certificates of coverage issued by **Us** covering individuals in **Your** current state of residence with the same or similar factors described above.

"Your Spouse" means the spouse of the **Primary Insured** who (i) is either listed as an **Other Insured** on the **Certificate Schedule** or later added to this **Certificate,** and (ii) is an **Insured** whose coverage has not ended by the date of such spouse's death.

III. WHEN COVERAGE BEGINS AND ENDS

A. EFFECTIVE DATE

This **Certificate** is effective at 12:01 A.M. local time where **You** live on the **Issue Date** shown on the **Certificate Schedule**.

B. ELIGIBILITY AND ADDITIONS

Your spouse; **Your** unmarried, dependent children who are under the age of [19 (24 if a **Full-Time Student**]; and grandchildren who are considered **Your** dependents for federal income tax purposes and who are under age [19 (24 if a **Full-Time Student**]; any children which an **Insured** is required to insure under a medical support order; any child whom **You**, or **Your Spouse** (if listed as an **Other Insured** on the **Certificate Schedule**), intends to adopt and has become a party to a suit for that purpose; and any child who is in the custody of an **Insured** under a temporary court order that grants the **Insured** conservatorship of the child, are eligible for this coverage. Any eligible dependent (other than a newborn or adoptee) will be added to this **Certificate** when **We** approve the written application for such coverage, and accept payment of any necessary premium.

Newborn children born after the **Issue Date** to **You**, or **Your Spouse**, while this **Certificate** is in full force and effect (a newborn child) will be automatically insured under this **Certificate** from and after the moment of birth for a period of ninety (90) days or before the next premium due date, whichever is later. If **You** wish to continue such automatic coverage under this **Certificate** for any such newborn child past the initial ninety (90) day period or beyond the next premium due date, **You** must notify **Us** of such birth and **Your** desire for such continued coverage under this **Certificate** within ninety (90) days or before the next premium due date after the date of such newborn child's birth. **You** must also pay any additional premium required for such additional coverage within such ninety (90) day period or before the next premium due date. If **You** do not notify **Us** of such birth and **Your** desire for continued coverage under this **Certificate** within such ninety (90) day period or before the next premium due date, and timely pay any additional premium that may be due, then the automatic coverage under this **Certificate** for such newborn child will end after the expiration of ninety (90) days or the next premium due date, whichever is later, from the date of such newborn child's birth. **We** will notify **You** if more premium is needed.

Newborn children born after the **Issue Date** and immediately placed for adoption after birth with **You**, or **Your Spouse**, while this **Certificate** is in full force and effect (a newborn adoptee) will be automatically insured under this **Certificate** from and after the date of the adoption placement of such newborn adoptee for a period of sixty (60) days. If **You** wish to continue such automatic coverage under this **Certificate** for any such newborn adoptee past the initial sixty (60) day period, **You** must notify **Us** of such birth, adoption placement and **Your** desire for continued coverage under this **Certificate** within sixty (60) days after the date of the adoption placement of such newborn adoptee. **You** must also pay any additional premium required for such additional coverage within such sixty (60) day period. If **You** do not notify **Us** within such sixty (60) day period of the birth, adoption placement and Your desire for continued coverage under this **Certificate** for such newborn adoptee and timely pay any additional premium that may be due, then the automatic coverage under this **Certificate** for such newborn adoptee will end after the expiration of day from the date of such adoption placement of such newborn adoptee. **We** will notify **You** if more premium is needed.

If **You** wish to have automatic coverage under this **Certificate** after the **Issue Date** for any child not listed as an **Other Insured** on the **Certificate Schedule**, but for which adoption or custody of such child is sought by **You** or **Your Spouse** in a civil suit or other judicial custody proceeding filed or initiated after the **Issue Date**, **You** must notify **Us** within thirty-one (31) days after **You** or **Your Spouse**, as applicable: (i) become a party in such civil suit in which such adoption of the child is sought; or (ii) obtain custody of the child under the first court order (including temporary orders) that grants conservatorship and/or custody of the child. **You** must also pay any additional premium required for such additional coverage within such thirty-one (31) day period. If **You** do not notify **Us** within such applicable thirty-one (31) day period of **Your** desire for automatic coverage under this **Certificate** in the future for such child and timely pay any additional premium that may thereafter become due, then no automatic coverage will be afforded under this **Certificate** for such child. **We** will notify **You** if more premium is needed.

C. TERMINATION OF COVERAGE

1. TERMINATIONS SUBJECT TO RIGHT OF CONVERSION

Subject to the Section III. E. CONTINUATION OF COVERAGE AND CERTIFICATE OF CONTINUATION / CONVERSION below, an applicable **Insured's** coverage under this **Certificate** ends on the earlier of the following:

a. the premium due date in the month following the date the **Group Policy** is terminated by the **Group Policyholder**, in which case **You** will be given thirty (30) days prior written notice of the termination, mailed to **Your** last known address;
b. with respect to **Your** spouse who is covered under this **Certificate**, the premium due date in the month following the effective date of **Your** divorce decree, annulment or court approved separation;
c. with respect to **Your** child(ren) who are covered under this **Certificate**, the premium due date in the month following such **Insured's** 19th birthday (24th if a **Full-Time Student**).

2. TERMINATIONS BY PRIMARY INSURED NOT SUBJECT TO RIGHT OF CONVERSION

Section III.E. CONTINUATION OF COVERAGE AND CERTIFICATE OF CONTINUATION / CONVERSION notwithstanding, the following described actions by either the **Primary Insured** or other applicable **Insured** will result in a termination of each applicable **Insured's** coverage under this **Certificate** with no right of conversion, in which event the coverage ends on the earlier of the following:

a. the due date of any unpaid **Renewal Premium**, subject to the grace period; or
b. the date **You** terminate coverage by notifying **Us** of the date **You** desire coverage to terminate and specify the **Insured** whose coverage is to terminate.

3. TERMINATION OF THE CERTIFICATE BY THE COMPANY NOT SUBJECT TO RIGHT OF CONVERSION

Section III.E. CONTINUATION OF COVERAGE AND CERTIFICATE OF CONTINUATION/ CONVERSION notwithstanding, **We** may refuse to renew and cancel coverage for all **Insureds** under this **Certificate** with no right of conversion for the following reasons:

a. **We** are required by the order of an appropriate regulatory authority to non-renew or cancel the **Certificate** or **Group Policy**;
b. **We** cease offering and renewing coverage of the same form of coverage as this **Certificate** in **Your** state upon a minimum of ninety (90) days prior written notice mailed to **Your** last known address with an opportunity for **You** to convert to any similar medical expense policy or certificate that **We** are then actively marketing and offering to new applicants in **Your** state;
c. **We** elect to discontinue offering all similar types of coverage under any association group or individual medical-surgical expense policy forms in **Your** state and to terminate all such certificates of coverage and individual policies in **Your** state, including **Your** form of coverage, in which case the commissioner of insurance for **Your** state, the **Group Policyholder** and **You** will be given a minimum of one hundred eighty (180) days prior written notice of the termination, mailed to **Your** last known address; or
d. the date **We** receive due proof that fraud or intentional misrepresentation of material fact existed in applying for this **Certificate** or in filing a claim for **Benefits** under this **Certificate**.

4. TERMINATION OF AN INSURED BY THE COMPANY NOT SUBJECT TO RIGHT OF CONVERSION

Section III.E. CONTINUATION OF COVERAGE AND CERTIFICATE OF CONVERSION notwithstanding, **We** may refuse to renew and cancel coverage for each **Insured** under this **Certificate** with no right of conversion for the following reasons:

a. the total amount of any **Benefit** payments made by **Us** are equal to the **Lifetime Certificate Maximum Per Insured**; or
b. the date **We** receive due proof that fraud or intentional misrepresentation of material fact existed in applying for this **Certificate** or in filing a claim for **Benefits** under this **Certificate**.

As long as this **Certificate** is in force for **You**, the coverage of **Your** child who is an **Insured** will not end if he or she is dependent upon **You** for support and maintenance and incapable of self-support because of a mental handicap or physical disability. Such dependent **Insured's** coverage under this **Certificate** will continue regardless of the dependent **Insured's** age, as long as **Renewal Premium** is timely and properly paid for **You** and the dependent **Insured** and such dependent **Insured** remains dependent upon **You** and incapable of self support because of such mental handicap or physical disability. Proof of such handicap or disability must be furnished to **Us** within thirty-one (31) days prior to the dependent **Insured** reaching the limiting age, and thereafter upon **Our** request, but not more frequently than annually after the two (2) year period following the attainment of the limiting age.

Any termination of coverage or of this **Certificate** will be effective at 11:59 P.M. local time where **You** live on the date(s) specified above.

If **You** die, **Your Spouse**, if then an **Insured** under this **Certificate**, will become the **Primary Insured**. If **You** and **Your** spouse (if any) are not covered under this **Certificate**, the oldest **Insured** will become the **Primary Insured**.

We will not accept premium for any **Insured** whose coverage has terminated. Premiums, which are sent to **Us** and include an amount to cover the **Insured** whose coverage has terminated, will be returned. **We** will only accept the correct premium to cover those **Insureds** who are eligible for coverage. If premiums are accepted in error, **Our** liability is limited to coverage for the period of time for which premiums were accepted in error.

Except for claims involving fraud or intentional misrepresentation of material fact, any termination will be without prejudice to any **Covered Expenses** incurred by an **Insured** for **Sickness and Injury Benefits**, [or] **Wellness and Screening Benefits** [or] [**Miscellaneous Benefits]** prior to the date of termination. If coverage is terminated, unearned premium will be computed pro-rata and any unearned premium will be refunded to **You**.

D. EXTENSION OF BENEFITS

If the **Group Policy** terminates while an **Insured** is **Totally Disabled**, **Sickness and Injury Benefits** will be extended for **Covered Expenses** incurred by such **Insured** after the date of termination of coverage under this **Certificate**. These extended **Sickness and Injury Benefits** are subject to the same terms that would have applied if the **Group Policy** had remained in force.

Extended **Sickness and Injury Benefits** are payable only (i) for **Covered Expenses** incurred for treatment of the specified **Injury** or **Sickness** that caused **Total Disability** of an **Insured** and while coverage under this **Certificate** for such **Insured** was in full force and effect and (ii) while the **Insured** remains **Totally Disabled** until the earlier of:

1. the day the **Total Disability** ends;
2. the date twelve (12) months after the date the **Group Policy** terminated; or
3. the day the person becomes covered under a replacement policy providing substantially equal or greater benefits which replaces coverage under the **Group Policy**.

Subject to the terms and conditions otherwise contained herein, Benefits shall be payable for Covered Expenses incurred by an **Insured** who is **Hospital Confined** on the date of termination, if the **Group Policy** is terminated and replaced by a group health insurance policy or contract issued by another insurer. **Benefits** are payable until the **Hospital Confinement** ends or **Hospital Benefits** under this contract have been exhausted, whichever is earlier.

E. CONTINUATION OF COVERAGE AND CERTIFICATE OF CONTINUATION / CONVERSION

A **Certificate Of Continuation / Conversion Coverage**, whereby the coverage then afforded by this **Certificate** for an applicable **Insured** will continue without a requirement of any additional evidence of the insurability of such **Insured**, is available only:

1. for **Your** spouse who is covered under this **Certificate** for at least three (3) consecutive months immediately prior to the date the **Group Policy** was terminated, if his or her coverage ceases due to divorce, annulment or court approved separation;
2. for **Your** unmarried child(ren) who is covered under this **Certificate** for at least three (3) consecutive months immediately prior to the date the **Group Policy** was terminated, if his or her coverage ceases due to his or her reaching the limiting age of 19 (24 if enrolled as a **Full-Time Student**), or
3. for each applicable **Insured**, if coverage under this **Certificate** terminates because the **Group Policyholder** has terminated coverage under the **Group Policy**, and does not replace coverage with another group policy, in which case **You** will be given thirty (30) days prior written notice of the termination, mailed to **Your** last known address. Upon termination of the **Group Policy**, **You** may apply on behalf of all **Insureds** for a **Certificate Of Continuation / Conversion Coverage**. The **Certificate Of Continuation / Conversion Coverage** must be applied for and the first premium received by **Us** within thirty-one (31) days after the date that coverage under the **Group Policy** terminates. If a **Certificate Of Conversion Coverage** is issued, it will take effect on the day after coverage under the **Group Policy** terminates.

A **Certificate Of Continuation / Conversion Coverage** is not available and will not be provided if:

1. an **Insured** has full coverage under any other group accident and health certificate or contract.
   a. to be full coverage the plan must provide benefits for all pre-existing conditions,
   b. an **Insured** may continue his or her previous group coverage until all pre-existing conditions are or would be covered under another group policy or contract or until termination;
2. an **Insured's** coverage under the **Group Policy** ceases because the **Group Policy** was terminated and was replaced by similar group coverage within thirty-one (31) days;
3. an **Insured's** coverage under this **Certificate** ceases because of failure to pay the required premiums in the time allowed;

4. an **Insured** was not covered under this **Certificate** for the three (3) consecutive months immediately prior to the date the **Group Policy** terminates;
5. an **Insured** is covered by similar benefits furnished by any:
   - **a**. medical expense plan;
   - **b**. medical service subscriber contract;
   - **c**. medical pre-payment plan; or
   - **d**. medical plan provided in accordance with the requirements of any state or federal law;
6. an **Insured** is eligible to be covered by any group plan, insured or uninsured:
   - **a**. medical expense plan;
   - **b**. medical service subscriber contract;
   - **c**. medical pre-payment plan; or
   - **d**. medical plan provided in accordance with the requirements of any state or federal law;
7. **We** were required by the order of an appropriate regulatory authority to non-renew or cancel the **Certificate** or **Group Policy**;
8. The total amount of **Benefit** payments made by **Us** are equal to the **Lifetime Certificate Maximum Per Insured**;
9. **We** cease offering and renewing coverage under the same form of coverage as this **Certificate** in **Your** state upon a minimum of ninety (90) days prior written notice mailed to **Your** last known address with an opportunity for **You** to convert to any similar medical expense policy or certificate that **We** are then actively marketing and offering to new applicants in **Your** state;
10. **We** elect to discontinue offering all similar types of coverage under any association group or individual medical-surgical expense policy forms in **Your** state and to terminate all such certificates of coverage and individual policies in **Your** state, including **Your** form of coverage, in which case the commissioner of insurance for **Your** state, the **Group Policyholder** and **You** will be given a minimum of one hundred eighty (180) days prior written notice of the termination, mailed to **Your** last known address;
11. **You** voluntarily terminated coverage under this **Certificate** for any **Insured** by notifying **Us** of the date **You** desired such coverage to terminate;
12. **We** received due proof that fraud or intentional misrepresentation of material fact existed in applying for this **Certificate** or in filing a claim for **Benefits** under this **Certificate**; or
13. The **Insured** is or could be covered by **Medicare**.

In order to be eligible for a **Certificate Of Continuation / Conversion Coverage**, a written election of continuation of coverage via conversion must be made by the applicable **Insured**, on a form furnished by **Us**, and the first premium must be paid, in advance, to **Us** on or before the date on which the applicable coverage under this **Certificate** for such **Insured** would otherwise terminate. The amount of first premium required from the effective date through the end of the first renewal period of the **Certificate Of Continuation / Conversion Coverage** shall not be more than **Our** full group premium rate then applicable for the applicable **Insured** under the **Certificate** with the same mode of payment. Applicable **Insureds** shall not be required to pay the **Renewal Premium** for a **Certificate Of Continuation / Conversion Coverage** less often than monthly.

IV. PREMIUM

A. INITIAL PREMIUM

The **Initial Premium** specified on the **Certificate Schedule** is due and payable to the **Company** at its home office on or before the **Issue Date**. This **Initial Premium** payment will keep this **Certificate** in force until the **First Renewal Date**. The amount of the **Initial Premium** and the **First Renewal Date** are shown on the **Certificate Schedule**. **Initial Premium** has been determined by **Us** for this **Certificate** on a **Class** basis. **Your Class** for **Initial Premium** was determined by **Us** based upon several factors, including, among other things, a combination of the following: (i) **Your** zip code (either first 3 or first 5 digits); (ii) **Your** county of residence; (iii) **Your** state of residence; (iv) the number, age, sex and tobacco use of each **Insured** listed on the **Certificate Schedule**; (v) the plan of coverage contained in this **Certificate** on the **Issue Date**, including its deductibles, **Benefits**, limitations, and exclusions; (vi) the health status of each applicant, including the results of any required physical examination and laboratory test results; (vii) **Participating Provider** network selected on the application, (viii) the underwriting risk assessment of each **Insured**; (ix) the discounted or preferred premium rate status of any **Insured;** (x) premium rate ups, if any, for any **Insured**; (xi) **Mode Of Premium Payment**

selected on the application; (xii) distribution channels; (xiii) administrative costs; (xiv) taxes; (xv) other economic factors; and/or (xvi) other certificates of coverage issued and to be issued by **Us** covering individuals in **Your** current state of residence with the same or similar factors described above.

B. RENEWAL PREMIUM

1. CALCULATION - PAYMENT

The current **Mode Of Premium Payment** is shown on the **Certificate Schedule**. **Renewal Premium** is payable on or before its due date, and must be paid to the **Company** at its home office. Any **Renewal Premium** not paid on or before its due date is a premium in default. If a **Renewal Premium** payment default is not corrected and properly paid before the end of the grace period, coverage under this **Certificate** will terminate.

Renewal Premium rates for this **Certificate** may be increased by **Us** for any renewal period after the **Issue Date**, including during the **Premium Rate Guarantee Period**, if after the **Issue Date**:

a. **You** add **Insureds** to this **Certificate**;
b. **You** change the amount of the **Calendar Year Deductible** shown on the **Certificate Schedule**;
c. **You** change the **Insured Coinsurance Percentage** shown on the **Certificate Schedule**;
d. **You** change any other coverage option;
e. **You** change residence to a different zip code;
f. **You** change the **Mode Of Premium Payment**;
g. **You** add optional coverage riders, if any;
h. **You** change after the **Issue Date** to a different optional **Participating Provider** network available in **Your** state, if any;
i. a change occurs in the relationship between **Us** and **Your Participating Provider** network:
j. the **Participating Provider** network availability changes for Your state;
k. the **Participating Provider** negotiated discounts change; and/or
l. a change occurs in **Sickness and Injury Benefits**, [and/or] **Wellness and Screening Benefits**, [and/or the] [**Miscellaneous Benefits]** by amendatory endorsement pursuant to any federal or state law or regulation.

The current table of premium rates upon which the **Initial Premium** and the **First Renewal Premium** were calculated for this **Certificate** may include scheduled increases in the amount of **Renewal Premium** based upon the future attained age of each **Insured**. To be eligible for a discounted or preferred premium rate each **Insured** may be required to complete a preferred health risk assessment upon enrollment and at renewal. Additionally, the current table of premium rates upon which the **Initial Premium** and **First Renewal Premium** were calculated and any subsequent table of premium rates upon which the **Renewal Premium** for any renewal period is to be calculated may be changed from time to time by **Us**. Accordingly, after expiration of the **Premium Rate Guarantee Period**, the amount of **Renewal Premium** may be increased for any renewal period based upon items a. through i. above as well as the following:

a. a new attained age of any **Insured** reached prior to the first day of any renewal period,
b. change by **Us** in the table of premium rates used to calculate the **First Renewal Premium,** and
c. change by **Us** in the table of premium rates used to calculate **Renewal Premium** for any prior renewal period.

Any changes in the table of premium rates establishing the amount of required **Renewal Premium** during any renewal period will be implemented on a **Class** basis for all members of **Your Renewal Premium Class**. Factors that may be involved and considered by **Us** in determining the amount of **Renewal Premium** to be charged to **Your Renewal Premium Class** during any renewal period include, among other things, a combination of one or more of the following: (i) past claims experience of **Your Renewal Premium Class**; (ii) anticipated inflationary trends in the cost of future medical services; (iii) historical experience in the inflationary cost of medical services; (iv) anticipated inflationary trends in the cost of **Prescription Drugs**; (v) historical experience in the past inflationary cost of **Prescription Drugs**; (vi) anticipated future claims experience of **Your Renewal Premium Class**; (vii) other economic factors; (viii) anticipated advances in the medical diagnosis capabilities of injuries and illnesses, including the anticipated

cost thereof; (ix) anticipated advances in the manner, method and delivery of medical care and treatment, including the anticipated cost thereof; and (x) any other reason permitted by applicable state law. **We** will tell **You** at least thirty (30) days in advance of the effective date of any **Renewal Premium** increase that occurs due to a change in the table of premium rates for **Renewal Premium**.

2. RENEWAL PREMIUM CHECK OR DRAFT NOT HONORED

Any premium payment made by a check or draft which is not honored at the bank upon which it is drawn shall be of no effect toward coverage under this **Certificate** unless and until valid restitution is made to **Us** within the time provided herein for making such premium payment.

3. GRACE PERIOD

Unless at least thirty-one (31) days prior to a **Renewal Premium** due date **We** have mailed to **You** written notice of **Our** intention not to renew this **Certificate** pursuant to the provisions of Section III. C. TERMINATION OF COVERAGE, a grace period of thirty-one (31) days from such due date is given for the late payment of the **Renewal Premium** due. If **You** make payment of the required **Renewal Premium** during such grace period, then this **Certificate** will remain in force for **Benefit** claims arising during such grace period. However, if the **Company** has received notification of **Your** intention to cancel any **Insured's** coverage under this **Certificate**, there is no grace period for the late payment of any **Renewal Premium** that would otherwise have been due for such **Insured** but for such cancellation.

4. REINSTATEMENT

If the **Renewal Premium** is not paid before the grace period ends, later acceptance of premium by **Us** (or by an agent authorized to accept payment) without requiring an application for reinstatement will reinstate this **Certificate** as of the date of acceptance of the late premium. If **We** require an application that will be fully underwritten by **Us**, **You** will be given a conditional receipt for the premium. If the application is approved after underwriting, this **Certificate** will be reinstated as of the approval date together with all back or past due premium permitted by applicable state law. Lacking such approval, this **Certificate** will be reinstated on the forty-fifth (45th) day after the date of the conditional receipt, unless **We** have previously notified **You**, in writing, of **Our** disapproval of the reinstatement.

The reinstated **Certificate** will cover only **Covered Expenses** that result from an **Injury** sustained after the date of reinstatement or from **Sickness** that begins more than ten (10) days after the date of reinstatement.

In all other respects **Your** rights and **Our** rights will remain the same subject to any provisions noted on or attached to the reinstated **Certificate**.

5. PREMIUM RATE GUARANTEE PERIOD

The amount of **Renewal Premium** with the same **Mode of Premium Payment** as the **Mode of Premium Payment** of the **Initial Premium** is guaranteed not to exceed [5%-20% annually][the amount of the **Initial Premium]** for each renewal period commencing prior to the expiration of the **Premium Rate Guarantee Period** as a result of any: (i) change in the table of premium rates used to calculate the **Initial Premium**; or (ii) increase in the attained age after the **Issue Date** of any **Insured** listed on the **Certificate Schedule**. The length of the **Premium Rate Guarantee Period** is shown on the **Certificate Schedule**. However, **Renewal Premium** rates may be increased by **Us** for any renewal period after the **Issue Date**, including during the **Premium Rate Guarantee Period**, if after the **Issue Date** (i) **You** either add or change coverage under this Certificate as provided in paragraphs a. through i. of the Calculation – Payment provision, or (ii) an amendatory endorsement is issued that changes any of the **Benefits** pursuant to any federal or state law or regulation

V. BENEFITS AND CLAIM PROCEDURES

Insureds have the right to obtain medical care from the **Provider** and **Hospital** of their choice[, as well as **Prescription Drugs** from a pharmacy of their choice]; however, all applicable **Benefit** payments by **Us** under this BENEFITS AND CLAIMS PROCEDURES Section of the **Certificate** are limited to the applicable **Company Insurance Percentage** of **Covered Expenses** incurred by an **Insured**. Coverage under this Section of the **Certificate** will be reduced for medical services, supplies, care or treatment obtained from a **Non-Participating Provider[**, as well as **Prescription Drugs** from a **Non-Participating Pharmacy]**. The difference between both the **Company Insurance Percentages** and the **Insured Coinsurance Percentages** for: (i) **Participating Providers** and **Non-Participating Providers**; [and (ii) **Participating Pharmacies** and **Non-Participating Pharmacies]** are shown in the **Certificate Schedule**. In addition, **We** shall never be required to make a payment for **Covered Expenses** incurred in excess of the amount of the **[Lifetime] Transplant Maximum [Per Organ] Per Insured** or the **Lifetime Certificate Maximum Per Insured**.

Covered Expenses incurred by an **Insured** for **Sickness and Injury Benefits** and **Wellness and Screening Benefits** are subject to the **Calendar Year Deductible,** the **Insured Coinsurance Percentage** and any applicable [**Co-Pays** and] **Access Fees,** unless otherwise specified.

A. SICKNESS AND INJURY BENEFITS

Subject to all applicable definitions, exclusions, limitations, non-waiver, waiting periods, and other provisions contained in this **Certificate**, as well as any riders, endorsements, or amendments attached to hereto, **We** promise to pay to or on behalf of each **Insured** the **Company Insurance Percentage** of the amount of professional fees and other applicable medical diagnostic or treatment expenses and charges that constitute **Covered Expenses** incurred by each **Insured** for the following described **Inpatient** and **Outpatient** services that are **Provided** as a result of **Sickness** or **Injuries**, but only after: (i) each applicable [**Co-Pay] [**and] **Access Fee** amount in this Section has been first satisfied and deducted from such **Covered Expenses** and applied to the applicable **Insured** for payment; (ii) each of the applicable deductibles has been first satisfied by deduction from such **Covered Expenses** and applied to the applicable **Insured** for payment; and (iii) the applicable **Insured Coinsurance Percentage** of the **Covered Expenses** remaining after satisfaction of all applicable deductibles is, likewise, satisfied by deduction from the remaining **Covered Expenses** and applied to the applicable **Insured** for payment:

1. INPATIENT HOSPITAL CONFINEMENT BENEFITS:

a. INPATIENT HOSPITAL CARE

The following services **Provided** by a **Hospital** or a **Provider** in connection with admission and **Confinement** of an **Insured** at the **Hospital** due to **Injuries** or **Sickness**:

1) **Hospital** - semi-private daily room and board [(if a semi-private room is not available, benefit will be limited to ninety (90) percent of the **Usual and Customary** private room rate)];
2) **Intensive Care Unit** of the **Hospital** - daily room and board (Note, daily room and board will be at the semi-private rate for admission to units or areas of the applicable **Hospital** which are step-down units from the **Intensive Care Unit**, including, sub-acute intensive care units, progressive care units, intermediate care units, private monitored rooms, observation units or other facilities not meeting the standards set forth in the definition of an **Intensive Care Unit**). [**Covered Expenses** incurred at a **Non-Participating Provider** will not exceed three times the **Usual and Customary** semi-private room charge of the **Hospital** and are limited to 30 continuous days of such **Confinement** for each type of **Confinement** during any one period of **Hospital Confinement**.;]
3) **Hospital** miscellaneous medications, **Prescription Drugs**, services and supplies - (Note, miscellaneous charges by a **Hospital** for personal convenience items, including but not limited to television, telephone, internet and radio are not considered **Covered Expenses**); and
4) **Provider** Visits – [(Note: limited [one (1)] **Provider** visit per treating **Provider** per day while the **Insured** is an **Inpatient** at a **Hospital**, and a maximum of [sixty (60)] **Provider** visits per **Hospital Confinement**.] **Sickness and Injury Benefits** are not payable for professional fees for visits at the **Hospital** following surgery by a Surgeon, Anesthesiologist or Nurse Anesthetist whose

professional fees in connection with the surgery constitute **Covered Expenses**, unless the visit is to evaluate or treat an **Injury** or **Sickness** other than that which resulted in the **Insured**'**s** covered surgery).

b. INPATIENT SURGERY

The following services **Provided** by a **Hospital** and **Providers** received by an **Insured** in connection with **Inpatient** surgery performed at the **Hospital** due to **Injuries** or **Sickness**:

1) Primary Surgeon;
2) Assistant Surgeon – (professional fees that constitute **Covered Expenses** will be considered for a **Sickness and Injury Benefit** payment for one assistant surgeon in connection with surgery for which **Sickness and Injury Benefits** are payable hereunder for the professional fees of the primary surgeon);
3) Anesthesiologist or Nurse Anesthetist – (professional fees that constitute **Covered Expenses** will be considered for a **Sickness and Injury Benefit** payment for either an anesthesiologist's or a nurse anesthetist's administration and monitoring of anesthesia administered during surgery for which **Sickness and Injury Benefits** are payable hereunder for the professional fees of the primary surgeon);
4) Pathologist Fees – (professional fees that constitute **Covered Expenses** will be considered for a **Sickness and Injury Benefit** payment for a pathologist's evaluation and/or interpretation of any tissue specimen removed during or in connection with such surgery); and
5) Second Surgical Opinion - Up to [$250] of professional fees for a second surgical opinion if:
   a) the **Insured's Provider** determines that surgery is needed;
   b) the surgery is not excluded from this **Certificate** or any riders, amendments or endorsements attached hereto;
   c) the **Insured** is examined in person by another qualified **Provider** for the purpose of obtaining a second surgical opinion; and
   d) the **Provider** issuing the second surgical opinion sends **Us** a written report.

However, **We** will not pay for the second surgical opinion if the **Provider** issuing the second surgical opinion performs or assists in the surgery.

c. BREAST RECONSTRUCTION

Services **Provided** by a **Hospital** and a **Provider** received by an **Insured** in connection with **Breast Reconstruction** performed at a **Hospital**.

d. INPATIENT THERAPY

Services **Provided** by a **Hospital** or a **Provider** in connection with the following types of therapy received by an **Insured** as an **Inpatient** at the **Hospital** due to **Injuries** or **Sickness**:

1) Radiation therapy;
2) Chemotherapy;
3) Occupational therapy;
4) Physical therapy and
5) Speech therapy.

[[Occupational,] [Physical] and [Speech] Therapy [are/is] limited to [[$50] per visit] [25] [visits] up to [$2,000] maximum per type of therapy per **Calendar Year** per **Insured**`] [This **Inpatient** therapy coverage does not include fees or expenses charged for spinal manipulations.]

e. INPATIENT LABORATORY AND DIAGNOSTIC TESTS

[Subject to **Laboratory and Diagnostic Testing Access Fee,** if applicable,**] [S][**s]ervices **Provided** by a **Hospital** or a **Provider** in connection with the performance and interpretation of laboratory and diagnostic tests received by an **Insured** as an **Inpatient** at the **Hospital** due to **Injuries** or **Sickness**

f. TRANSPLANTS

When generally accepted medical indications and standards for transplantation (including grafts) have been met and all assessments required by the treating institution are successfully completed, then services **Provided** by a **Hospital** and **Providers** in connection with the performance of **Solid Organ Transplants**, **Bone Marrow Transplants**, and/or **Stem Cell Transplants** that are received by an **Insured** are covered.

The maximum amount of **Covered Expenses** allowed for professional fees of a **Provider** and facility fees for the harvesting of applicable donor organs or donor bone marrow is [$5,000 to $50,000] per transplant, to the extent that any benefits hereunder remain and are available under the **Certificate** for the applicable **Insured** recipient. Any payment of donor expenses hereunder will be applied toward the satisfaction of the **[Lifetime] Transplant Maximum [Per Organ] Per Insured**.

[An **Insured** requiring a **Solid Organ Transplant**, **Bone Marrow Transplant**, and/or **Stem Cell Transplant** may elect to request participation in the **Centers of Excellence** program. To be considered for a **Centers of Excellence** transplant, an **Insured** must agree, in writing, to use **Centers of Excellence Providers** for all **Covered Expenses** related to a **Solid Organ Transplants**, **Bone Marrow Transplants**, and/or **Stem Cell Transplants**.

If a **Medically Necessary** transplant is performed in a designated **Center of Excellence**, **We** will **Provide Covered Expenses** for; (i) travel, (ii) food, and (iii) lodging, for a live donor, if applicable; and the **Insured** and one companion, or if the **Insured** is a dependent child, two parents. The maximum **Covered Expenses** allowed for (i) travel, (ii) food and (iii) lodging is [$5,000] per covered transplant.

If an **Insured** elects to use a **Center of Excellence**, approved by **Us**, for the transplant services, the **[Lifetime] Transplant Maximum [Per Organ] Per Insured** is increased to [$500,000 - $1,000,000].] [If the **Insured** elects to use a **Provider** that is not a **Center Of Excellence** the **[Lifetime] Transplant Maximum [Per Organ] Per Insured** is reduced to [$100,000 - $500,000]]

However, the amount of **Benefits** hereunder will be reduced by fifty (50%) percent for any **Solid Organ Transplants**, **Bone Marrow Transplants**, and **Stem Cell Transplants** received that were not reviewed by **Us** prior to transplantation evaluation, testing or donor search. In addition, the following items/procedures are not covered under this **Certificate**:

1) any non-human (including animal or mechanical) **Solid Organ Transplant**,
2) transplants approved for a specific medical condition, but applied to another condition,
3) the purchase price of any organ, tissue, blood, bone marrow, cells, or stem cells that are sold and not donated,
4) any donor charge or donor expense incurred that does not constitute **Covered Expenses** allowed for professional fees and facility fees incurred in connection with the harvesting of applicable donor organs or donor bone marrow, and
5) any transplantation (including grafts) that does not constitute **Solid Organ Transplants**, **Bone Marrow Transplants**, and/or **Stem Cell Transplants**.

[2. FOREIGN TRAVEL BENEFIT

Services for **Covered Expenses** incurred for **Medically Necessary Emergency Hospital**, **Provider** and medical care that an **Insured** receives outside the United States during the first [60] consecutive days of each trip up to a lifetime maximum **Benefit** of [$50,000 to $250,000].]

[3.] EMERGENCY ROOM AND OTHER OUTPATIENT BENEFITS:

a. EMERGENCY ROOM SERVICES

[Subject to the **Emergency Room Access Fee]**, [S][s]ervices **Provided** by a **Hospital** or a **Provider** in the emergency room of the **Hospital** for the following items received by an **Insured** on an **Emergency** basis:

1) Emergency room services and supplies;
2) **Provider** services for surgery in the emergency room of the **Hospital**, if **We** are notified of such surgery within seventy-two (72) hours after such surgical procedure has been performed, or as soon thereafter as reasonably possible;
3) X-ray and laboratory examinations;
4) **Prescription Drugs** administered prior to discharge from the emergency room;
5) [[Surgical dressings], [casts,] [splints,] [trusses,] [braces] [and] [crutches] received prior to discharge from the emergency room]; [and]
6) Services of a registered nurse (R.N.) in the emergency room of a **Hospital**.

The **Emergency Room Access Fee** will be waived if an Insured [is confined in a Hospital within [twenty-four (24) hours of the Emergency Room visit].[admitted directly from the emergency room into the Hospital as an Inpatient] .]

b. OUTPATIENT TREATMENT OF ACCIDENTAL INJURIES

Services **Provided** by a **Hospital**, an **Emergency Care Facility** or a **Provider** in connection with the **Outpatient** treatment of **Injuries** received by an **Insured**. Services **Provided** by a **Hospital** or a **Provider** in the emergency room of the **Hospital** are subject to the **Emergency Room Access Fee**.

c. EMERGENCY TRANSPORTATION TO HOSPITAL BY AMBULANCE

Services **Provided** in connection with transportation of an **Insured** by either local ground ambulance or local air ambulance [(air ambulance is limited to [$1,000 to $10 ,000] per occurrence)] to the nearest **Hospital** that is appropriately staffed, equipped, available and suitable for the **Emergency** diagnosis, care and treatment of an **Insured's Injury** or **Sickness**. However, expenses charged for transportation to a **Hospital** by air ambulance are not payable or otherwise considered a **Sickness and Injury Benefit**, if such **Insured's** medical condition was not sufficiently acute or severe upon arrival at the **Hospital** to result in an **Inpatient** admission and **Confinement** in the **Hospital** immediately following the **Insured's** evaluation and treatment in the emergency room of such **Hospital.**

d. OUTPATIENT SURGERY AT A HOSPITAL OR AN AMBULATORY SURGICAL CENTER

The following services **Provided** by a **Hospital** or **Ambulatory Surgical Center** and **Providers** in connection with surgery performed on an **Insured** on an **Outpatient** basis:

1) **Hospital** or **Ambulatory Surgical Center** – (expenses that constitute **Covered Expenses** will be considered for **Sickness and Injury Benefit** payment for the pre-operation, operation and recovery rooms, as well as for medications, **Prescription Drugs**, and other miscellaneous items, services and supplies; provided that miscellaneous charges for any personal convenience items, including but not limited to television, telephone, and radio are not considered **Covered Expenses**);
2) Primary Surgeon;
3) Assistant Surgeon – (professional fees that constitute **Covered Expenses** will be considered for a **Sickness and Injury Benefit** payment for one assistant surgeon in connection with surgery for which **Sickness and Injury Benefits** are payable hereunder for the professional fees of the primary surgeon);
4) Anesthesiologist or Nurse Anesthetist – (professional fees that constitute **Covered Expenses** will be considered for a **Sickness and Injury Benefit** payment for either an anesthesiologist or a nurse anesthetist administration and monitoring of anesthesia, during surgery for which **Sickness and Injury Benefits** are payable hereunder for the professional fees of the primary surgeon);
5) Pathologist – (professional Fees that constitute **Covered Expenses** will be considered for a **Sickness and Injury Benefit** payment for a pathologist's evaluation and/or interpretation of any tissue specimen removed during or in connection with such surgery); and
6) Second Surgical Opinion - Up to [$250] of professional fees for a second surgical opinion if:
   a) the **Insured's Provider** determines that surgery is needed;

b) the surgery is not excluded from this **Certificate** or any riders, amendments or endorsements attached hereto;
c) the **Insured** is examined in person by another qualified **Provider** for the purpose of obtaining a second surgical opinion; and
d) the **Provider** issuing the second surgical opinion sends **Us** a written report.

However, **We** will not pay for the second surgical opinion if the **Provider** issuing the second surgical opinion performs or assists in the surgery.

[e. OUTPATIENT PROVIDER OFFICE VISITS

Professional services **Provided** by a **Provider** during a **Medically Necessary** visit to the professional offices of such **Provider** for the purposes of evaluation, diagnosis and treatment of **Injuries** or **Sickness**. **]**

[f. [OUTPATIENT PRESCRIPTIONS

[Subject to the applicable] [**Calendar Year Deductible**][**Insured Coinsurance Percentage]**] [**Prescription Drug Co-Pay**][**Prescription Drug Calendar Year Deductible Per Insured**][**Prescription Drug Insured Coinsurance Percentage**] **We** will pay **Covered Expenses** incurred by an **Insured** for **Prescription Drugs** filled at a **Participating Pharmacy. [We** will pay, to or on behalf of the **Insured**, the **Covered Expenses** but not to exceed the **Calendar Year Maximum Per Insured For Prescription Drugs** as shown on the **Certificate Schedule**.] [If the charge for the **Prescription Drug** is less than the **Prescription Drug Co-pay** and/or [**Prescription Drug Insured Coinsurance Percentage]** [**Insured Coinsurance Percentage]**] shown on the **Certificate Schedule**, the **Insured** will be responsible for the full cost of the medication.] [If the **Insured's Provider** has not specified that a **Preferred Brand Drug** be used rather than a **Generic Drug,** but the **Insured** selects a **Preferred Brand Drug**, the **Insured** will pay the applicable [**Prescription Drug Co-pay]** [and/or] [**Prescription Drug Insured Coinsurance Percentage]** [**Insured Coinsurance Percentage]**], plus the difference in price between the **Generic Drug** and **Preferred Brand Drug.]** [**Covered Expenses** for such **Prescriptions** shall not exceed, the amount of the cost of the least expensive drug, medicine or **Prescription Drug** that may be used to treat the **Insured's Sickness** or **Injury**, all in accordance with the following schedule:

a. If a **Generic Drug** is available at the **Participating Pharmacy** selected by the **Insured** that may be taken by such **Insured** in substitute for either a **Brand Name Drug** or a **Preferred Brand Drug** that was prescribed for the **Insured**, the amount of **Covered Expenses** for such **Prescription** shall be limited to the cost of such **Generic Drug** at such pharmacy;
b. If a **Preferred Brand Drug** is available at the **Participating Pharmacy** selected by the **Insured** that may be taken by such **Insured** in substitute for a **Brand Name Drug** that was prescribed for the **Insured**, the amount of **Covered Expenses** for such **Prescription** shall be limited to the cost of the **Preferred Brand Drug** at such pharmacy; and
c. If both a **Generic Drug** and a **Preferred Brand Drug** are available at the **Participating Pharmacy** selected by the **Insured** that may be taken by such **Insured** in substitute for a **Brand Name Drug** that was prescribed for the **Insured**, the amount of **Covered Expenses** for such **Prescription** shall be limited to the cost of such **Generic Drug** at the pharmacy.]

[The **Prescription Drug Co-Pay** made to **Participating Pharmacies** may not be used to satisfy the [**Prescription Drug Calendar Year Deductible per Insured]**, [**Prescription Drug Insured Coinsurance Percentage],** [C**alendar Year Deductible]**, [the **Insured Coinsurance Percentage]**, the **Separate Deductible for Non-Participating Providers**, [the **Access Fees**] and the [**Failure to Pre-certify Treatment Deductible**.]

If **Prescription Drugs** are purchased by an **Insured** from a **Non-Participating Pharmacy**, then the amount of **Covered Expenses** for the purposes of calculating a benefit payment hereunder shall be limited to the amount of **Covered Expenses** that would have been incurred by such **Insured** if the **Prescription Drugs** had been purchased at a **Participating Pharmacy** instead of the **Non-Participating Pharmacy**.**]**

[g.] OUTPATIENT LABORATORY AND DIAGNOSTIC TESTS

[Subject to **Laboratory and Diagnostic Testing Access Fee**, if applicable,][S][s]ervices **Provided** by a **[Provider]**, **Hospital**, or other medical facility in connection with the performance and interpretation of laboratory and diagnostic tests received on an **Outpatient** basis by an **Insured** due to **Injuries** or **Sickness**.

[h.] OUTPATIENT THERAPY

[Subject to the **Outpatient Therapy Access Fee**] [S][s]ervices **Provided** by **Providers**, a **Hospital**, or other medical facility in connection with the following types of therapy received on an **Outpatient** basis by an **Insured** due to **Injuries** or **Sickness**:

1. Radiation therapy;
2. Chemotherapy;
3. Occupational therapy;
4. Physical therapy;
5. Rehabilitation therapy; and
6. Speech therapy.

[[Occupational,] [Physical] [and] [Speech] Therapy [are/is] limited to [[$50] per visit] [25] [visits] up to [$2,000] maximum [per type of therapy] per **Calendar Year** per **Insured**`] [This **Outpatient** therapy **Benefit** does not include fees or expenses charged for spinal manipulations.]

[i.] HOME HEALTH CARE

Services **Provided** to an **Insured** due to **Injuries** or **Sickness** for the care specified in a **Home Health Care Plan**, up to a **Covered Expense** maximum per day of 50% of the amount of the semi-private room rate of either (i) the **Hospital** where such **Insured** was **Confined** prior to the development of the **Home Health Care Plan**, or (ii) the **Skilled Nursing Home** where such **Insured** was a resident immediately prior to the development of the **Home Health Care Plan**. Such expenses incurred by an **Insured** as the result of a **Home Health Care Plan** are payable for an **Insured**, if:

1) The **Insured** had first been **Confined** in a **Hospital** or was a resident at a **Skilled Nursing Home** due to an **Injury** or **Sickness**;
2) The **Home Health Care Plan** of the **Insured** begins no later than thirty (30) days after discharge from the **Hospital** or **Skilled Nursing Home**; and
3) The **Home Health Care Plan** is for the same or related **Injury** or **Sickness** as the **Hospital** or **Skilled Nursing Home Confinement**.

A **Provider** must certify that the **Insured** would have to be in a **Hospital** or **Skilled Nursing Home** (and receive a level of care greater than **Custodial Care**) if **Home Health Care Plan** services had not been available.

Payment under this coverage is limited to a period of a maximum of [40-120] days during a twelve (12) consecutive month period.

[j.] HOSPICE CARE

Services **Provided** to an **Insured** for **Hospice Care** due to **Injuries** or **Sickness**, if:

1) such **Hospice Care** is provided as the result of **Injury** or **Sickness** for which **Covered Expenses** were incurred by such **Insured** for **Hospital Confinement**;
2) the **Insured's Provider** certifies the life expectancy of the **Insured** is six (6) months or less; and
3) the **Insured's Provider** recommends a **Hospice Care** program.

Payment under this coverage is limited to a period of a maximum of six (6) consecutive months.

[k.] MEDICAL EQUIPMENT AND SUPPLIES

Medical Equipment and supplies **Provided** to an **Insured** as a result of **Injury** or **Sickness** which are **Covered Expenses** includes:

1) Blood, plasma, and derivatives, if not replaced;
2) Initial replacement of natural limbs and eyes when loss occurs while this **Certificate** is in force;
3) Initial permanent lens immediately following cataract surgery, except the replacements will not be covered;
4) [Casts,] [non-dental splints,] [trusses,] [crutches] [and] [braces (except dental or orthodontic braces);]
5) Rental (not to exceed the purchase price) of a wheelchair, hospital bed, or other durable portable medical equipment **Provided** to an **Insured** in each event required for therapeutic treatment of **Injuries** or **Sickness** on an **Outpatient** basis; and
6) oxygen and its administration.

[l.] SKILLED NURSING HOME

Daily room and board and miscellaneous charges for other services **Provided** to an **Insured** due to **Injuries** or **Sickness** for residential care received in a **Skilled Nursing Home** for up to a maximum of [60-120] days in a twelve (12) month period, if:

1) the **Insured** has first been **Confined** in a **Hospital** for three (3) or more consecutive days;
2) the **Skilled Nursing Home** stay begins within thirty (30) days after discharge from the **Hospital**;
3) the **Skilled Nursing Home** stay is for the same or related **Injury** or **Sickness** as the **Hospital Confinement**; and
4) the **Insured's Provider** certifies the need for **Skilled Nursing Home Confinement**.

[m.] SUPPLIES AND SERVICES ASSOCIATED WITH THE TREATMENT OF DIABETES

The following **Outpatient** services **Provided** to an **Insured** for care received during for the treatment of diabetes and associated conditions:

1) Diabetes Equipment;
2) Diabetes Supplies; and
3) Diabetes Self-Management Training.

[n.] INHERITED METABOLIC DISORDERS

Benefits include **Covered Expenses** for **Medical Foods** prescribed or ordered under the supervision of a **Provider**, as **Medically Necessary** for the therapeutic treatment of an **Inherited Metabolic Disorder**. This **Benefit** is limited to a maximum of [$5,000] in a twelve (12) month period.

[o.] PROSTHETIC AND ORTHOTIC DEVICE BENEFIT

Benefits include **Covered Expenses** for **Medically Necessary** services and supplies for the effective use of a **Prosthetic** or **Orthotic Device**, including formulating its design, fabrication, material and component selection, measurements, fittings, static and dynamic alignments, and instructing the patient in the use of the device. The repair and replacement of a **Prosthetic** or **Orthotic Device** will be considered a covered **Benefit** unless necessitated by misuse or loss.

[p]. NEWBORN CARE

Benefits include, **Covered Expenses** for the care and treatment of **Your**, or **Your Spouse's** newborn child or newborn adoptee including care for **Injury**, **Sickness**, congenital defects, birth abnormalities, premature birth, tests for hypothyroidism, phenylketonuria, galactosemia, and in the case of non-Caucasian newborn infants, tests for sickle-cell anemia. Additionally, **Benefits** include **Covered**

Expenses for well-baby care up to five (5) 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.

[**p]. IMPAIRMENT OF SPEECH OR HEARING**

Benefits include **Covered Expenses** for the care and treatment of loss or impairment of speech or hearing. Loss or impairment of speech or hearing shall include those communicative disorders generally treated by a licensed pathologist or audiologists. **Benefits** for the care and treatment of loss or impairment of speech or hearing shall not include hearing instruments or devices.

[q]. GENERAL ANESTHESIA FOR DENTAL PROCEDURES

Benefits include **Covered Expenses** incurred for general anesthesia and related hospitalization services for dental care if the **Provider** treating the **Insured** certifies that because of **the Insured's** age or condition or problem, hospitalization or general anesthesia is required to safely and effectively perform the procedures and the **Insured**:

1. is 6 years of age or younger, and is determined by two (2) dentists, licensed under the Arkansas Dental Practices Act §§ 17-82-101 et seq, to require **Medically Necessary** dental treatment in a **Hospital** or **Ambulatory Surgical Center** due to a significantly complex dental condition,
2. is a person with a diagnosed serious mental or physical condition; or
3. is a person with a significant behavioral problem as determined by the **Insured's** Provider as licensed under the Arkansas Medical Practices Act, §§17-95-201 et seq., and 17-95-401 et seq.

Covered Expenses do not include dental care benefits which may require general anesthesia in a **Hospital** or **Ambulatory Surgical Facility Center**.

[r. STERILIZATION

[Commencing after the first anniversary of the **Issue Date]**, **Benefits** will be paid for **Covered Expenses** incurred for sterilization not to exceed a maximum lifetime **Benefit** of [$500 to $2,000] per **Insured**.]

[**s. ALLERGIES**

Benefits will be paid for **Covered Expenses** incurred for allergy testing and allergy injections, including, but not limit to, injectable antigens, and extracts, not to exceed a maximum of [$250 to $1,000] of **Covered Expense** per **Insured** per **Calendar Year.]**

[t. TREATMENT OF SLEEP APNEA

Benefits will be paid for **Covered Expenses** incurred for the treatment of sleep apnea, including, but not limited to: sleep study, durable medical equipment (CPAP or BiPAP), and surgery not to exceed a lifetime maximum of [$1,000 to $5,000] per **Insured**.]

[u. GROWTH DISORDERS

Benefits will be paid for **Covered Expenses** incurred for the treatment of a growth disorder or abnormally short stature, including, but not limited to, growth hormone deficiency therapy (GHDT) not to exceed a maximum lifetime **Benefit** of [$10,000 to $25,000] of **Covered Expenses** for each **Insured** child.]

[**v. SPINAL MANIPULATION**

Benefits will be paid for **Covered Expenses** incurred for spinal manipulation, including, but not limited to, manipulation for spinal subluxation and any associated treatment or services not to exceed a covered expense maximum of : (i) [$25 to $100] per day of treatment (does not include x-rays); and (ii) [$250 to $1,000] of **Covered Expense** per **Calendar Year** per **Insured,** for all treatments and x-rays**.**]

[w. BREAST IMPLANT REMOVAL

Benefits will be paid for **Covered Expenses** incurred for breast implant removal for the **Medically Necessary** treatment of a covered **Sickness** or **Injury**.]

B. [WELLNESS][AND][SCREENING BENEFITS]

[Subject to all applicable definitions, exclusions, limitations, waiting periods, and other provisions contained in this **Certificate**, as well as any riders, endorsements, or amendments attached to hereto, **We** promise to pay to or on behalf of each **Insured** the **Company Insurance Percentage** of the amount of professional fees and other applicable medical diagnostic or treatment expenses and charges that constitute **Covered Expenses** incurred by each **Insured** for the following described **[Wellness and Screening Benefit]** services, but only after (i) each of the applicable deductible has been first satisfied by deduction from such **Covered Expenses** and applied to the applicable **Insured** for payment, and (ii) the applicable **Insured Coinsurance Percentage** of the **Covered Expenses** remaining after satisfaction of all applicable deductibles is, likewise, satisfied by deduction from the remaining **Covered Expenses** and applied to the applicable **Insured** for payment:]

[ANNUAL PHYSICAL EXAM][AND] SCREENING TESTS]:

[[a].ADULT WELLNESS AND PREVENTIVE CARE

[Commencing [twelve (12)] to [twenty-four (24)] months after the **Issue Date]** [S][s]ervices **Provided** to **You** and **Your Spouse** (if such spouse is listed as an **Other Insured**) for necessary **Adult Wellness Preventive Care** by a **Participating Provider** no more than [once] every [twelve (12) months][.] [up to] [the] [a] [[**Calendar Year]** [**Adult Wellness Maximum]]** [payment] [stated on the Certificate Schedule] [by **Us]** [of $50 to $250] [per adult **Insured** per **Calendar Year]**.

Adult Wellness Preventive Care does not include charges[(i)] by **Participating Providers** for COLORECTAL CANCER SCREENING, PROSTATE CANCER SCREENING, MAMMOGRAPHY SCREENING, PAP SMEAR SCREENING**,** any spinal manipulations, physical therapy, occupational therapy, or other **Outpatient** therapy or treatment, or any form of medical or surgical treatment of an **Injury** or **Sickness**[; or (ii) any service, care, test or treatment by a **Non-Participating Provider**.]]

[[b]. COLORECTAL CANCER SCREENING

[Commencing [twelve (12)] to [twenty-four (24)] months after the **Issue Date**] **[B][b]enefits** include **Covered Expenses** incurred by an **Insured** for colorectal cancer screening for a **Insured** who is fifty (50) years of age or older and at normal risk for developing colon cancer or has attained at least 30 years of age and has a history of, or a first degree family member with colorectal cancer, as follows:

1) a fecal occult blood test performed annually; and
2) a flexible sigmoidoscopy performed every five (5) years or a colonoscopy performed every ten (10) years.]

[d]. MAMMOGRAPHY SCREENING

Services **Provided** for screening by low dose **Mammogram** to detect the presence of occult breast cancer, as follows:

1) A single baseline **Mammogram** for female **Insureds** 35 to 39 years of age;
2) One **Mammogram** every two (2) years for female **Insureds** 40 to 49 years of age; and
3) An annual **Mammogram** for each female **Insured** 50 years of age or older.

[e.] PAP SMEAR SCREENING

[Commencing [twelve (12)] to [twenty-four (24)] months after the **Issue Date]** [S][s]ervices **Provided** for an annual Pap Smear **Provided** to female **Insureds**, including the examination by a **Provider**, the laboratory fee, and the **Provider's** interpretation of the laboratory results.

[C. MISCELLANEOUS BENEFITS

Miscellaneous Benefits are [not] subject to [either] [the [**Calendar Year Deductible]** [or] [and] [the **Insured Coinsurance Percentage**,] [but are subject to any applicable **Co-Pays**.] Therefore, subject to all applicable definitions, exclusions, limitations, waiting periods, and other provisions contained in this **Certificate**, as well as any riders, endorsements, or amendments attached to hereto, [including applicable **Co-Pays**,] **We** promise to pay to or on behalf of each **Insured** the **Company Insurance Percentage** of the amount of professional fees and other applicable medical diagnostic or treatment expenses and charges that constitute **Covered Expenses** incurred by each applicable **Insured** for the following described **Miscellaneous Benefits**:

[1]. [ADULT WELLNESS AND PREVENTIVE CARE

[Commencing [twelve (12)] to [twenty-four (24)] months after the **Issue Date]** [S][s]ervices **Provided** to **You** and **Your Spouse** (if such spouse is listed as an **Other Insured**) for necessary **Adult Wellness Preventive Care** by a **Participating Provider** no more than [once] every [twelve (12) months][.] [up to] [the] [a] [[**Calendar Year]** [**Adult Wellness Maximum]]** [payment] [stated on the Certificate Schedule] [by **Us]** [of $50 to $250] [per adult **Insured** per **Calendar Year]**.

Adult Wellness Preventive Care does not include charges [(i)] by **Participating Providers** for COLORECTAL CANCER SCREENING, PROSTATE CANCER SCREENING, MAMMOGRAPHY SCREENING, PAP SMEAR SCREENING**,** any spinal manipulations, physical therapy, occupational therapy, or other **Outpatient** therapy or treatment, or any form of medical or surgical treatment of an **Injury** or **Sickness** [; or (ii) any service, care, test or treatment by a **Non-Participating Provider**.]]

[2]. PROSTATE CANCER SCREENING BENEFIT

Benefits include the following **Covered Expenses Incurred** by male **Insureds** during a medically recognized diagnostic examination for the detection of prostate cancer. This **Benefit** shall include an annual physical examination for the detection of prostate cancer, and an prostate-specific antigen test used for the detection of prostate cancer for each male **Insured** who is at least forty (40) years of age or older.

The prostate cancer screening must be performed by a **Provider**, and shall consist of a prostate specific antigen blood test and a digital rectal examination.

The prostate cancer screening is not subject to any plan deductibles and shall not exceed the actual cost of the prostate cancer screening.

[2]. [CHILDHOOD WELLNESS AND PREVENTIVE CARE

Services **Provided** to each **Insured** under the age of [19 (or 24 if a **Full-Time Student**)] for necessary **Childhood Wellness Preventive Care** up to a **Calendar Year** maximum payment by **Us** of [$100 to $500] per person per **Calendar Year**.]

Benefits include **Covered Expenses** for a child **Insured** for **Periodic Preventive Care Visits** to include twenty (20) visits at approximately the following age intervals: birth, 2 weeks, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years, 5 years, 6 years, 8 years, 10 years, 12 years, 14 years, 16 years, and 18 years. Services rendered during a periodic review shall only be covered to the extent that those services are **Provided** by or under the supervision of a single **Provider** during the course of one visit.

[Childhood Wellness Preventive Care does not include charges (i) by **Providers** for any spinal manipulations, physical therapy, occupational therapy, or other **Outpatient** therapy or treatment, or any form of medical or surgical treatment of an **Injury** or **Sickness**.

3. [CHILDHOOD IMMUNIZATIONS]

Services **Provided** for the following routine childhood immunizations **Provided** to each **Insured** under the age of 19: poliomyelitis, rubella, rubeola, mumps, tetanus, pertussis, diphtheria, hepatitis B, Haemophilus influenza type b (Hib) and varicella. Childhood immunizations are not subject to any deductibles, coinsurance or [**Co-Pays.]**

[4]. [VISITS TO PARTICIPATING PROVIDERS OFFICE

a. Doctor Office Visits Co-Pay

Subject to the **Doctor Office Visit Co-Pay** for **Outpatient** visits to the professional offices of a physician who is a **Participating Provider**, **We** will pay the remaining amount of **Covered Expenses** incurred for professional services **Provided** by the **Participating Provider** during each visit for **Medically Necessary** physical examinations, diagnosis [,][and] development of a treatment plan, [laboratory, x-ray or other diagnostic tests] [performed during such visit at such professional offices] for **Sickness** and **Injury**. [**Covered Expenses** incurred for all services under this section are limited to [$1,200] per **Calendar Year** per **Insured**.]

[b. X-Ray Laboratory and Diagnostic Testing Co-Pay

After satisfaction of the **Doctor Office Visit Co-Pay** and the satisfaction of the **X-Ray, Laboratory and Diagnostic Testing Co-Pay We** will pay the remaining amount of **Covered Expenses** incurred during [the first [two (2)]] [an] **Outpatient** office visit at a **Participating Provider** per **Insured** per **Calendar Year** for laboratory, x-ray or other diagnostic tests performed during any such visit at such professional offices.[up to a maximum **Benefit** of [$50-$2,000][per **Insured** per **Calendar Year**.]]

However, the following limitations apply to this VISIT TO PARTICIPATING PROVIDER OFFICE coverage:

[a.] [Covered Expenses incurred by an **Insured** for any **Outpatient** therapy or treatment **Provided** for any **Injury** or **Sickness** during any visit to the professional offices of such **Participating Provider** are subject to satisfaction of (i) the **Calendar Year Deductible**, and (ii) the **Insured Coinsurance Percentage**;]

[b.] [Covered Expenses incurred by an **Insured** for any **Outpatient** diagnostic testing and laboratory services **Provided** at a location other than the professional offices of such **Participating Provider** are subject to satisfaction of (i) **Laboratory and Diagnostic Testing Access Fee**, and (ii) the **Calendar Year Deductible**, and(iii) the **Insured Coinsurance Percentage**;]

[c.] [Covered Expenses incurred by an **Insured** for any **Outpatient** surgery **Provided** during any visit to the professional offices of such **Participating Provider** are subject to satisfaction of (i) the **Calendar Year Deductible**, (ii) the **Insured Coinsurance Percentage**;]

[d.] [Covered Expenses incurred by an **Insured** for professional services **Provided** during any **Outpatient** office visit to the professional offices of a **Participating Provider** in excess of [$0 - $1,200] [two (2) visits] per **Calendar Year** are subject to satisfaction of (i) the **Calendar Year Deductible**, and (ii) the **Insured Coinsurance Percentage**;]

[e.] [Covered Expenses incurred by an **Insured** for any type of service provided during any visit to the professional offices of such **Non-Participating Provider** are subject to satisfaction of (i) the **Calendar Year Deductible**, (ii) the **Separate Deductible for Non-Participating Providers**, and (iii) the applicable **Insured Coinsurance Percentage** for **Non-Participating Providers**; and]

[f.] [Covered Expenses incurred by an **Insured** under any other provision or limitation such as [ADULT WELLNESS, [CHILDHOOD WELLNESS,] [CHILDHOOD IMMUNIZATIONS,] [TREATMENT FOR ALLERGIES,] [SPINAL MANIPULATION,] [OCCUPATION,] [SPEECH] [OR PHYSICAL THERAPY,] [COLORECTAL CANCER SCREENING,] [PROSTATE CANCER SCREENING,] [MAMMOGRAPHY SCREENING,] [and] [or] [PAP SMEAR SCREENING] are not considered **Covered Expenses** under this section.]

[5. [OUTPATIENT PRESCRIPTIONS

[Subject to the applicable] [**Calendar Year Deductible**][**Insured Coinsurance Percentage]**] [**Prescription Drug Co-Pay**][**Prescription Drug Calendar Year Deductible Per Insured**][**Prescription Drug Insured Coinsurance Percentage**] **We** will pay **Covered Expenses** incurred by an **Insured** for **Prescription**

Drugs filled at a **Participating Pharmacy. [We** will pay, to or on behalf of the **Insured**, the **Covered Expenses** but not to exceed the **Calendar Year Maximum Per Insured For Prescription Drugs** as shown on the **Certificate Schedule**.] [If the charge for the **Prescription Drug** is less than the **Prescription Drug Co-pay** and/or [**Prescription Drug Insured Coinsurance Percentage]** [**Insured Coinsurance Percentage]**] shown on the **Certificate Schedule**, the **Insured** will be responsible for the full cost of the medication.] [If the **Insured's Provider** has not specified that a **Brand Name Drug** be used rather than a **Generic Drug,** but the **Insured** selects a **Brand Name Drug**, the **Insured** will pay the applicable [**Prescription Drug Co-pay]** [and/or] [**Prescription Drug Insured Coinsurance Percentage]** [**Insured Coinsurance Percentage]**], plus the difference in price between the **Generic Drug** and **Brand Name Drug.]** [**Covered Expenses** for such **Prescriptions** shall not exceed, the amount of the cost of the least expensive drug, medicine or **Prescription Drug** that may be used to treat the **Insured's Sickness** or **Injury**, all in accordance with the following schedule:

a. If a **Generic Drug** is available at the **Participating Pharmacy** selected by the **Insured** that may be taken by such **Insured** in substitute for either a **Brand Name Drug** or a **Preferred Brand Drug** that was prescribed for the **Insured**, the amount of **Covered Expenses** for such **Prescription** shall be limited to the cost of such **Generic Drug** at such pharmacy;
b. If a **Preferred Brand Drug** is available at the **Participating Pharmacy** selected by the **Insured** that may be taken by such **Insured** in substitute for a **Brand Name Drug** that was prescribed for the **Insured**, the amount of **Covered Expenses** for such **Prescription** shall be limited to the cost of the **Preferred Brand Drug** at such pharmacy; and
c. If both a **Generic Drug** and a **Preferred Brand Drug** are available at the **Participating Pharmacy** selected by the **Insured** that may be taken by such **Insured** in substitute for a **Brand Name Drug** that was prescribed for the **Insured**, the amount of **Covered Expenses** for such **Prescription** shall be limited to the cost of such **Generic Drug** at the pharmacy.]

[The **Prescription Drug Co-Pay** made to **Participating Pharmacies** may not be used to satisfy the [**Prescription Drug Calendar Year Deductible** per **Insured]**, [**Prescription Drug Insured Coinsurance Percentage],** [**Calendar Year Deductible]**, [the **Insured Coinsurance Percentage]**, the **Separate Deductible for Non-Participating Providers**, [the **Access Fees**] and the [**Failure to Pre-certify Treatment Deductible**.]

If **Prescription Drugs** are purchased by an **Insured** from a **Non-Participating Pharmacy**, then the amount of **Covered Expenses** for the purposes of calculating a benefit payment hereunder shall be limited to the amount of **Covered Expenses** that would have been incurred by such **Insured** if the **Prescription Drugs** had been purchased at a **Participating Pharmacy** instead of the **Non-Participating Pharmacy**.**]**

D. PRE-CERTIFICATION OF TREATMENT

If an **Insured** notifies and obtains from **Us** a certification that **Covered Expenses** are to be incurred due to a **Medically Necessary Hospital Confinement** or surgery, **We** will provide the **Sickness and Injury Benefits** for **Covered Expenses** as specified under the terms and provisions of this **Certificate** and any riders, amendments, or endorsements attached hereto.

Certification must be obtained prior to all **Inpatient** admissions, except in the case of an **Emergency** admission. In the event of an **Emergency Inpatient** admission, the **Insured** or his or her **Provider** must notify **Us** within seventy-two (72) hours of **Confinement**, or as soon thereafter as reasonably possible.

At the time notification of surgery is made, **We** will inform the **Insured** and his or her **Provider** if a second surgical opinion is required, at the expense of the **Company**, before certification will be given and will assign a length of stay if it is determined that **Inpatient Hospital** care is **Medically Necessary**. **We** may extend the length of stay upon the request of the **Insured** or **Provider** if **We** determine an extension is **Medically Necessary**. No **Sickness and Injury Benefits** will be provided under this **Certificate** for expenses that are determined not **Medically Necessary**.

Treatment provided at any time after initial certification that differs from the specific plan of care and treatment previously authorized requires re-certification by **Us**.

Pre-Certification of Treatment, services, and/or a length of stay is not a guarantee of **Sickness and Injury Benefits** under this **Certificate** or the **Group Policy**. All claims for **Sickness and Injury Benefits** under this **Certificate**, including claims for services and treatment that were pre-certified by **Us**, are subject to all terms, definitions, limitations, exclusions and restrictions contained in this **Certificate** and any riders, endorsements, or amendments attached hereto.

E. CLAIM PROCEDURES, INVESTIGATION AND PAYMENT

1. NOTICE OF CLAIM

Written notice of claim must be received by **Us** within thirty (30) days of the date that each **Covered Expense** is incurred by an **Insured**. If it is not reasonably possible for the notice of claim to be transmitted to **Us** so that it is received within such thirty (30) day period, then written notice of claim must be received by **Us** as soon thereafter as reasonably possible. A **Provider's** billing statement that is timely received by **Us** will suffice as a written notice of the claim under this Section. **Our** current address for providing a written notice of claim is shown on Page 1. A written notice of claim should include the applicable **Insured's** name, the **Primary Insured's** name, the applicable **Provider's** name, and the **Certificate** number.

2. CLAIM FORMS AND ADDITIONAL INFORMATION TO BE PROVIDED

When **We** receive timely written notice of claim, **We** will normally send **You** a claim form to be completed, signed and returned. The general purpose of the claim form is to provide **Us** with general background information about the nature of the claim, which information may be necessary in order to complete a proper proof of loss. If this claim form is not provided to **You** within fifteen (15) days, of **Our** timely receipt of written notice of the claim, then **You** will not be required to later complete, sign and return the written claim form, but may be required to provide other information, including a written authorization for the release of medical records and information, which in each event is necessary either for **Our** investigation of the claim or otherwise as part of the completion of a proper proof of loss. **We** must receive information requested within the time limit stated in the Section V E 3, PROOFS OF LOSS.

3. PROOFS OF LOSS

Written proof of a **Covered Expense** must be provided to **Us** within ninety (90) days after such **Covered Expense** is incurred by an **Insured**. If it was not reasonably possible for **You** to give **Us** proof in the time required, **We** will not reduce or deny the claim for this reason if the proof is filed as soon as possible. In any event, the proof of loss required must be provided no later than one (1) year from the date the **Covered Expense** was incurred by the **Insured** unless **You** are legally incompetent or otherwise physically unable to act.

4. CLAIMS REVIEW, INVESTIGATION, ADJUSTMENT AND ADJUDICATION

As written notice of claims, completed claim forms, signed authorizations for release of medical authorizations, medical records, and other written information from **Insureds** and **Providers** are received and reviewed additional investigation, requests for information and other matters may occur in connection with the completion of a proper proof of loss, adjustment and adjudication of the claim. At **Our** expense, **We** have the right to have the **Insured** examined by a **Provider** of **Our** choice as often as is reasonably necessary while a claim or other benefit determination is pending. Information received during the review and investigation of a claim will be considered, as applicable, in connection of whether a timely and proper proof of loss has been completed. After **Our** investigation has been completed, claims will be adjusted and adjudicated in accordance with the coverage under this **Certificate** that was in force on the date the applicable expense was incurred. Part of the adjustment and adjudication process includes a determination of the amount of **Covered Expense** incurred by the **Insured** for the applicable services rendered. This determination will normally require communication with the network with whom the applicable **Provider** was contracted at the time the service was rendered, as well as other matters. Once a decision has been made on a claim and this decision has been processed, an explanation of benefits form will be transmitted to the **Primary Insured** and each applicable **Provider**.

5. PAYMENT OF CLAIMS

The applicable portion of **Covered Expenses** incurred by an **Insured**, which are owed by the **Company** under this **Certificate**, will be paid to the **Primary Insured**, unless the right to such payment was previously assigned to a **Provider** for direct payment. Upon the death of the **Primary Insured**, the unpaid amount of any applicable **Covered Expenses** incurred by an **Insured**, which are owed by the **Company** under this **Certificate** will be paid to the **Beneficiary**, unless the right to such payment was previously assigned to a **Provider** for direct payment. Any claim payment made by **Us** in good faith will fully discharge **Our** liability under this **Certificate** for such claim to the extent of the amount of such good faith payment.

6. TIME OF PAYMENT OF CLAIMS

We will make payments due promptly once a decision has been made on a claim and this decision has been processed.

Payment shall be treated as being made on the date a draft or valid instrument was placed in the United States mail to the last known address of the applicable **Primary Insured**, **Provider**, or **Beneficiary** in a properly addressed, postpaid envelope, or, if not so posted, on the date of delivery.

A **Benefit** payment owed by **Us** under this **Certificate**, but not paid within thirty (30) days after the date of **Our** receipt of a proper proof of loss and the completion of **Our** investigation of the claim, will be considered past due. **We** will pay interest on any past due benefit payment amount at the rate of one and one-half percent per month commencing on the thirty first (31st) day after the completion and **Our** receipt of a proper proof of loss and the completion of **Our** investigation of the claim until the date such payment is tendered by **Us**.

VI. DEDUCTIBLES

A. CALENDAR YEAR DEDUCTIBLE

No **Sickness and Injury Benefits** or **Wellness and Screening Benefits** are payable under this **Certificate** for any **Covered Expenses** incurred by an **Insured**, until after the **Calendar Year Deductible** is satisfied and fully payable each **Calendar Year** by such **Insured**. In addition to the **Calendar Year Deductible**, the **Separate Deductible For Non-Participating Providers** will apply to services rendered by **Non-Participating Providers**.

Neither (i) the amount of the **Separate Deductible For Non-Participating Providers**, nor (ii) the amount of the **Failure to Pre-Certify Treatment Deductible** may be used to satisfy the **Calendar Year Deductible**.

B. SEPARATE DEDUCTIBLE FOR NON-PARTICIPATING PROVIDERS

No **Sickness and Injury Benefits** or **Wellness and Screening Benefits** are payable under this **Certificate** for services rendered by **Non-Participating Providers** until after the amount of the **Separate Deductible For Non-Participating Providers** is satisfied and fully payable. The amount of the **Separate Deductible For Non-Participating Providers** is shown on the **Certificate Schedule** and applies per **Calendar Year** separately to each **Insured**.

Neither (i) the amount of the **Calendar Year Deductible** nor (ii) the amount of the **Failure to Pre-Certify Treatment Deductible** may be used to satisfy the **Separate Deductible For Non-Participating Providers**.

C. SEPARATE DEDUCTIBLE FOR FAILURE TO PRE-CERTIFY TREATMENT

An additional deductible in the amount of [$1,000], the **Failure to Pre-Certify Treatment Deductible**, will be applied to **Covered Expenses** before the **Company Insurance Percentage** is payable under this **Certificate** for each (i) **Inpatient Hospital Confinement**, and (ii) surgery, if **Pre-Certification of Treatment** is not obtained. No **Sickness and Injury Benefits** are payable under this **Certificate** for any **Covered Expenses**

that are subject to the **Failure to Pre-Certify Treatment Deductible** until after the amount of any such **Failure to Pre-Certify Treatment Deductible** is satisfied and fully payable by either **You** or such **Insured.**

[D. FAMILY CALENDAR YEAR DEDUCTIBLE MAXIMUM

Once a combined total of [three (3)] **Calendar Year Deductibles** or **Separate Deductible for Non-Participating Providers** have been satisfied in any **Calendar Year** by any [three (3)] **Insureds**, no additional **Calendar Year Deductible** or **Separate Deductible for Non-Participating Provider** will be assessed by **Us** in connection with medical treatment and services rendered to any other **Insured** during the remainder of such **Calendar Year**.]

[E.COMMON ACCIDENT CALENDAR YEAR DEDUCTIBLE MAXIMUM

If [two (2)] or more **Insureds** incur **Covered Expenses** for **Injuries** sustained in the same accident, only one (1) **Calendar Year Deductible** or **Separate Deductible for Non-Participating Providers** will be applied that **Calendar Year** to the combined **Covered Expenses** resulting from the **Injuries** sustained in such common accident by all **Insureds**.]

VII. LIMITATIONS, EXCLUSIONS AND NON-WAIVER

A. LIMITATIONS-WAITING PERIODS

Coverage under this **Certificate** is limited as provided by the definitions, limitations, exclusions, and terms contained in each and every Section of this **Certificate**, as well as the following limitations and waiting periods:

[1]. Any loss or expense incurred as a result of an **Insured's Pre-existing Condition [**not disclosed on the application] is not covered under this **Certificate** unless such loss or expense constitutes **Covered Expenses** incurred by such **Insured** more than [twelve (12)] [twenty-four (24)] months after the **Issue Date**, and are not otherwise limited or excluded by this **Certificate** or any riders, endorsements, or amendments attached to this **Certificate**;

[2]. Any loss or expense which results from the diagnosis, care or treatment of hernia, disease or disorders of the reproductive organs, hemorrhoids, varicose veins, tonsils and/or adenoids, or otitis media shall be covered under this **Certificate** only if (i) such loss or expense constitutes **Covered Expenses** incurred by an **Insured** after this **Certificate** has been in force for a period of six (6) months from the **Issue Date**, (ii) such **Sicknesses** are not otherwise limited or excluded by this **Certificate** or any riders, endorsements, or amendments attached to this Certificate, [(iii) care for such **Sicknesses** is **Provided** on an **Emergency** basis], and [(iv)] such **Sicknesses** are not **Pre-existing Conditions**;

[3]. **[Insureds** have the right to obtain **Prescriptions** from the pharmacy of their choice. However, if an **Insured**: (i) uses a **Non-Participating Pharmacy** to fill a **Prescription**; or (ii) does not present his/her correct ID card when the **Prescription** is filled at a **Participating Pharmacy**, then such **Insured** must pay the applicable pharmacy in full and file a claim form with the **Company** for reimbursement. In either event, the **Insured** will be reimbursed by the **Company** at the discounted or negotiated rate for such **Prescription** that would have been paid to a **Participating Pharmacy** by the **Company** under this **Certificate** if the **Insured** had used a **Participating Pharmacy** and properly presented the correct ID card at the time the **Prescription** was filled;]

[4]. [Pre-authorization may be required by the **Company** prior to the time that **Prescriptions** for certain **Prescription Drugs** are filled;]

[5.] If as the result of an **Emergency Sickness** or an **Emergency Injury** services are rendered for an **Insured** by a **Non-Participating Provider** when a **Participating Provider** was not reasonably available in connection with either (i) on an **Outpatient** basis in the emergency room of a **Hospital** or (ii) an **Emergency Inpatient** admission to a **Hospital**, then the **Covered Expenses** incurred will be reimbursed by **Us** as if such **Non-Participating Provider** were a **Participating Provider** up to the point when the **Insured** can be safely transferred to a **Participating Provider**. If the **Insured** refuses or is unwilling to be transferred to the care of a **Participating Provider** after such **Insured** can be safely transferred, then reimbursement shall thereafter be reduced to the **Company's Insurance Percentage for Non-Participating Providers**;

[6.] [Because the [**Calendar Year Deductible]** under this **Certificate** is calculated on the basis of **Covered Expenses**, it is possible that every dollar an **Insured** pays for **Prescription Drugs** at a **Participating Pharmacy** may not apply toward meeting the **[**applicable **Calendar Year Deductible]**;]

[7.] **Sickness and Injury Benefits** and **Wellness and Screening Benefits** under this **Certificate** for any **Insured** who is eligible for or has coverage under **Medicare**, and/or amendments thereto, regardless of whether such **Insured** is enrolled in **Medicare** shall be limited to only the **Usual and Customary** charges for services, supplies, care or treatment covered under this **Certificate** that are not or would not have been payable or reimbursable by **Medicare** and/or its amendments (assuming such enrollment), subject to all provisions, limitations, exclusions, reductions and maximum benefits set forth in this **Certificate**;

[8.] [[Two-Five million dollars ($2,000,000-$5,000,000)] is the maximum total amount of all applicable annual increases in the **Lifetime Certificate Maximum Per Insured** that can be conditionally received after the **Issue Date** pursuant to SectionVIII. INCREASE IN THE LIFETIME CERTIFICATE MAXIMUM of this **Certificate**;] and

[9.] Except as contained and specifically set forth in the INCREASE IN THE LIFETIME CERTIFICATE MAXIMUM Section of this **Certificate**, there shall be no increase in the amount of the **Lifetime Certificate Maximum Per Insured**.

B. EXCLUSIONS

Coverage under this **Certificate** is limited as provided by the definitions, limitations, exclusions, and terms contained in each and every Section of this **Certificate**. In addition, this **Certificate** does not provide coverage for expenses charged to an **Insured** or any payment obligation for **Us** under this **Certificate** for any of the following, all of which are excluded from coverage:

[1]. the amount of any professional fees or other medical expenses or charges for treatments, care, procedures, services or supplies which do not constitute **Covered Expenses**;

[2]. **Covered Expenses** incurred before the **Certificate Issue Date**;

[3]. **Covered Expenses** incurred after this **Certificate** terminates, regardless of when the condition originated, except as **Provided** in the EXTENSION OF BENEFITS provision;

[4]. **Covered Expenses** which exceed the **Lifetime Certificate Maximum Per Insured**;

[5]. **Covered Expenses** which exceed the **[Lifetime] Transplant Maximum [Per Organ] Per Insured** for all **Solid Organ Transplants**, **Bone Marrow Transplants**, and **Stem Cell Transplants** received by each **Insured** including any applicable **Covered Expenses** for professional fees and facility fee incurred in connection with harvesting the applicable donor organ or donor bone marrow for the purposes of such transplantation;

[6]. **[[Prescription Drugs]** [that are immunosuppressants;]]

[7]. the amount of any professional fees or other medical expenses contained on a billing statement to a **Insured** which exceed the amount of the **Maximum Allowable Charge**;

[8]. any professional fees or other medical expenses for treatments, care, procedures, services or supplies which are not specifically enumerated in the SICKNESS AND INJURY BENEFITS,[or] WELLNESS AND SCREENING BENEFITS, [or] [MISCELLANEOUS BENEFITS] Sections of this **Certificate** and any optional coverage rider attached hereto;

[9]. **Covered Expenses You** or **Your** covered **Family** members are not required to pay, which are covered by other insurance, or that would not have been billed if no insurance existed;

[10]. any professional fees or expenses for which the **Insured** and/or any covered **Family** member are not legally liable for payment;

[11]. any professional fees or expenses for which the **Insured** and/or any covered **Family** member were once legally liable for payment, but from which liability the **Insured** and/or **Family** member were released;

[12]. treatment of the teeth, the surrounding tissue or structure, including the gums and tooth sockets. This exclusion does not apply to treatment: (a) due to **Injury** to natural teeth (treatment must be **Provided** within ninety (90) days of the date of the **Injury**); or (b) for malignant tumors;

[13]. **Injury** or **Sickness** due to any act of war (whether declared or undeclared);

[14]. services provided by any state or Federal government agency, including the Veterans Administration unless, by law, an **Insured** must pay for such services;

[15]. **Covered Expenses** that are payable under any motor vehicle no fault law insurance policy or certificate;

[16]. charges that are payable or reimbursable by either:

a) a plan or program of any governmental agency (except Medicaid), or

b) **Medicare** Part A, Part B and/or Part D (If the applicable **Insured** does not enroll in **Medicare**, **We** will estimate the charges that would have be paid if such enrollment had occurred);

[17]. [drugs or medication not used for an Food and Drug Administration (FDA) approved use or indication;]

[18]. [administration of experimental drugs or substances or investigational use or experimental use of **Prescription Drugs** except for any **Prescription Drug** prescribed to treat a covered chronic, disabling, life-threatening **Sickness** or **Injury,** but only if the investigational or experimental drug in question:

a) has been approved by the FDA for at least one indication; and

b) is recognized for treatment of the indication for which the drug is prescribed in:

1) a standard drug reference compendia; or

2) substantially accepted peer-reviewed medical literature.

c) drugs labeled "Caution –limited by Federal law to investigational use";]

[19]. experimental procedures or treatment methods not approved by the American Medical Association or other appropriate medical society;

[20]. any **Injury** or **Sickness** covered by any Workers' Compensation insurance coverage, or similar coverage underwritten in connection with any Occupational Disease Law, or Employer's Liability Law, regardless of whether you file a claim for benefits thereunder;

[21]. eyeglasses, contact lenses, radial keratotomy, lasik surgery, hearing aids and exams for their prescription or fitting;

[22]. Cochlear implants;

[23]. any professional fees or other medical expenses incurred by an **Insured** which were caused or contributed to by such **Insured's** being intoxicated or under the influence of any drug, narcotic or hallucinogens unless administered on the advice of a **Provider**, and taken in accordance with the limits of such advice;

[24]. intentionally self-inflicted **Injury**, suicide or any suicide attempt while sane or insane;

[25]. serving in one of the branches of the armed forces of any foreign country or any international authority;

[26]. voluntary abortions, abortificants or any other drug or device that terminates a pregnancy;

[27]. services **Provided** by **You** or a **Provider** who is a member of an **Insured's Family**;

[28]. any medical condition excluded by name or specific description by either this **Certificate** or any riders, endorsements, or amendments attached to this **Certificate**;

[29]. any loss to which a contributing cause was the **Insured's** being engaged in or attempting to engage in an illegal occupation or illegal activity;

[30]. [participation in aviation, except as fare-paying passenger traveling on a regular scheduled commercial airline flight;]

[31]. cosmetic surgery or reconstructive procedures, except for **Medically Necessary** cosmetic surgery or reconstructive procedures performed under the following circumstances: (i) where such cosmetic surgery is incidental to or following surgery resulting from trauma or infection; (ii) to correct a normal bodily function; or (iii) such cosmetic surgery constitutes **Breast Reconstruction** that is incident to a **Mastectomy**; provided any of the above occurred while the **Insured** was covered under this **Certificate**.

[32]. Charges for breast reduction or augmentation or complications arising from these procedures;

[33]. **[Prescription Drugs** or other medicines and products used for cosmetic purposes or indications;]

[34]. [voluntary sterilization [except as **Provided** in the **Benefit** entitled Sterilization in the SICKNESS AND INJURY BENEFIT section of this **Certificate**], reversal or attempted reversal of a previous elective attempt to induce or facilitate sterilization;]

[35]. fertility hormone therapy and/or fertility devices for any type fertility therapy, artificial insemination or any other direct conception;

[36]. any operation or treatment performed, **Prescription** or medication prescribed in connection with sex transformations or any type of sexual or erectile dysfunction, including complications arising from any such operation or treatment;

[37]. appetite suppressants, including but not limited to, anorectics or any other drugs used for the purpose of weight control, or services, treatments, or surgical procedures rendered or performed in connection with an overweight condition or a condition of obesity or related conditions;

[38]. **[Prescriptions**, treatment or services for behavioral or learning disorders, Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD);]

[39]. any professional fees or other medical expenses incurred as the result of an **Injury** which was caused or contributed by an **Insured** racing any land or water vehicle;

[40]. any professional fees or other medical expenses incurred for the diagnosis, care or treatment of **Mental and Emotional Disorders**, **Alcoholism**, and drug addiction/abuse;

[41]. **[Prescription Drugs** that are classified as psychotherapeutic drugs, including antidepressants;]

[42]. Except for **Complications of Pregnancy**, routine maternity or any other expenses related to childbirth, including routine nursery charges and well baby care; [unless the optional MATERNITY BENEFIT RIDER was purchased and in force on the date said expenses related to childbirth, routine nursery charges, well baby care or maternity were incurred];

[43]. contraceptives, oral or otherwise, whether medication or device, regardless of intended use;

[44]. **[Outpatient Prescription Drugs** that are dispensed by a **Provider**, **Hospital** or other state-licensed facility;]

[45]. **[Prescription Drugs** produced from blood, blood plasma and blood products, derivatives, Hemofil M, Factor VIII, and synthetic blood products, or immunization agents, biological or allergy sera, hematinics, blood or blood products administered on an **Outpatient** basis;]

[46]. [level one controlled substances;]

[47]. **[Prescription Drugs** used to treat or cure hair loss or baldness;]

[48]. **[Prescription Drugs** that are classified as anabolic steroids or growth hormones [except as **Provided** in the **Benefit** entitled Growth Disorders in the SICKNESS AND INJURY BENEFIT section or this **Certificate**];]

[49]. [compounded **Prescription Drugs**;]

[50]. fluoride products;

[51]. [allergy kits intended for future emergency treatment of possible future allergic reactions;]

[52]. [replacement of a prior filled prescription for **Prescription Drugs** that was covered and is replaced because the original prescription was lost, stolen or damaged;]

[53]. **[Prescription Drugs**, which have an over the counter equivalent that may be obtained without a **Prescription**, even though such **Prescription Drugs** were prescribed by a **Provider**;]

[54]. [any intentional misuse or abuse of **Prescription Drugs**, including **Prescription Drugs** purchased by an **Insured** for consumption by someone other than such **Insured**;]

[55]. **[Prescription Drugs** that are classified as anti-fungal medication used for treatment of onychomycosis;]

[56]. [fees or expenses charged for spinal manipulations [except as **Provided** in the **Benefit** entitled Spinal Manipulation in the SICKNESS AND INJURY BENEFIT section of this **Certificate**];

[57]. Programs, treatment or procedures for tobacco use cessation;

[58]. **[Prescription Drugs** that are classified as tobacco cessation products;]

[59]. [drugs prescribed for the treatment of any disease, illness or condition that has been excluded from coverage under the **Certificate** by exclusionary rider, limitation or exclusion;]

[60]. [charges for blood, blood plasma, or derivatives that has been replaced;]

[61]. [treatment of autism;]

[62]. Temporomandibular Joint Disorder (TMJ) and Craniomandibular Disorder (CMD); and

[63]. treatment received outside of the United States, [except as provided for in the **Benefit** entitled Foreign Travel Benefit in the SICKNESS AND INJURY BENEFITS section of this **Certificate**;]

[64]. Services or supplies for personal convenience, including custodial care or homemaker services, except as provided for in this **Certificate**;

[65]. expenses for a cane, a crutch, a corset, a dental appliance, an elastic hose, an elastic support, a fabric support, a generic arch support, a low-temperature plastic splint, a soft cervical collar, a truss, or other similar device except as stated in the PROSTHETIC AND ORTHODIC DEVICE BENEFIT section of Your **Certificate** that: (i) is carried in stock and sold without therapeutic modification by a corset shop, department store, drug store, surgical supply facility, or similar retail entity; and (ii) has no significant impact on the neuromuscular, musculoskeletal, or neuromusculoskeletal functions of the body; and

[66]. expenses for artificial eyes, ears, dental appliances, a cosmetic device such as artificial eyelashes or wigs, a device used exclusively for athletic purposes, an artificial facial device, or other device except as stated in the PROSTHETIC AND ORTHODIC DEVICE BENEFIT section of **Your Certificate** that does not have significant impact on the neuromuscular, musculoskeletal, or neuromusculoskeletal functions of the body.

C. NON-WAIVER

1. Billed charges for medical care and treatment received by all **Insureds** during a **Calendar Year** that are considered and applied by **Us** under Section VIII. INCREASE IN LIFETIME CERTIFICATE MAXIMUM, does not mean **We** have any liability for coverage or the payment of any **Sickness and Injury Benefits** under the **Certificate** for the illness, injury or condition that resulted in such expenses, and any such mistake and error by **Us** shall not constitute a waiver of or modification to any of the conditions, terms,

definitions, limitations or exclusions contained in either the **Certificate** or any exclusionary rider attached to the **Certificate**.

[2. Expenses that are mistakenly applied by **Us** to the **Calendar Year Deductible** or erroneously paid by **Us** under any Section or provision of this **Certificate [**including **Prescription Drugs]** shall not:

a) constitute a waiver of or modification to any conditions, terms, definitions or limitations contained in the **Certificate**, specifically including, but not by way of limitation, the definitions of **Sickness** and **Injury**, the limitation of coverage under the **Certificate** for **Pre-existing Conditions**, as well as any exclusion, limitation and/or exclusionary riders which may be attached to the **Certificate**, or otherwise operate to alter, amend, affect, abridge or modify the **Certificate** to which it is attached;

b) create or establish coverage of any medical condition illness, disease or injury under the **Certificate** or under any exclusion, limitation and/or exclusionary riders which may be attached to the **Certificate**; or

c) affect, alter, amend, abridge, constitute or act as a waiver of the **Company's** ability to rely upon, assert and apply such terms, definitions, limitations or exclusions of the **Certificate** or any amendments thereto.]

VIII. INCREASE IN LIFETIME CERTIFICATE MAXIMUM

A. CONDITIONAL ANNUAL INCREASE

Notwithstanding the amount of the **Lifetime Certificate Maximum Per Insured** stated on the **Certificate Schedule**, but subject to all applicable definitions, exclusions, limitations, non-waiver, and provisions contained in the **Certificate**, as well as all riders, endorsements, and amendments attached to the **Certificate**, **We** will automatically increase the amount of the **Lifetime Certificate Maximum Per Insured** on each anniversary of the **Issue Date** while coverage under the **Certificate** has remained in full force and effect on the following terms and conditions:

1. $125,000 FIRST ANNIVERSARY OF ISSUE DATE

$125,000 shall be added to the amount shown on the **Certificate Schedule** for the **Lifetime Certificate Maximum Per Insured** on the first anniversary of the **Issue Date**, if the total amount of all billed charges for medical care and treatment received by all **Insureds** and submitted to **Us** for consideration during the **First Certificate Year**, is greater than the amount of the **Calendar Year Deductible** applicable to such **Insureds** as shown on the **Certificate Schedule**, but the amount of such billed medical charges is less than twice the amount of such **Calendar Year Deductible** applicable to such **Insureds**.

2. $250,000 FIRST ANNIVERSARY OF ISSUE DATE

$250,000 shall be added to the amount shown on the **Certificate Schedule** for the **Lifetime Certificate Maximum Per Insured** on the first anniversary of the **Issue Date**, if the total amount of all billed charges for medical care and treatment received by all **Insureds** and submitted to **Us** for consideration during the **First Certificate Year** is less than the amount of the **Calendar Year Deductible** applicable to such **Insureds** as shown on the **Certificate Schedule**.

3. $125,000 SUBSEQUENT CERTIFCATE YEARS

$125,000 shall be added to the then current amount of the **Lifetime Certificate Maximum Per Insured** on each subsequent anniversary of the **Issue Date**, if the total amount of all billed charges for medical care and treatment received by all **Insureds** and submitted to **Us** for consideration during the **Subsequent Certificate Year** that immediately precedes such anniversary of the **Issue Date** is greater than the amount of the **Calendar Year Deductible** shown on the **Certificate Schedule**, but the amount of such billed medical charges is less than twice the amount of such **Calendar Year Deductible** applicable to such **Insureds**.

4. $250,000 SUBSEQUENT CERTIFCATE YEARS

$250,000 shall be added to the then current amount of the **Lifetime Certificate Maximum Per Insured** on each subsequent anniversary of the **Issue Date**, if the total amount of all billed medical charges received by

all **Insureds** and submitted to **Us** for consideration during the **Subsequent Certificate Year** that immediately precedes such anniversary of the **Issue Date** is less than the amount of the **Calendar Year Deductible** applicable to such **Insureds** as shown on the **Certificate Schedule**.

However, the maximum total amount of all applicable annual increases in the **Lifetime Certificate Maximum Per Insured** pursuant to this Section shall not exceed the sum of two million dollars.

IX. GRIEVANCE PROCEDURES

The Arkansas External Review Regulation requires **Us** to provide **You** with the opportunity for an independent review of any **Adverse Determination** or **Final Adverse Determination**. **You** have the right to request an **External Review** once **Your Internal Grievance Procedures** have been exhausted, unless otherwise stated. The criteria for the Grievance Procedures, including the **External Review** process by an **Independent Review Organization** to examine any **Adverse Determinations**, is outlined below.

INTERNAL GRIEVANCE PROCEDURES

You have the right to appeal any denial of a claim for **Benefits** by submitting a written request, via facsimile or mail, for reconsideration.

Requests for reconsideration must be filed within sixty (60) days of receipt of the written notification of denial. Within ten (10) days from receipt of the request for reconsideration, **We** will acknowledge receipt. Within thirty (30) days from receipt of the request for reconsideration, **We** will review **Your** request and provide a written response describing the final determination. If **You** are not satisfied with the **Final Adverse Determination**, **You** may request an **External Review**.

EXTERNAL GRIEVANCE PROCEDURES

I. Notice of Right to External Review -

Adverse Determinations: **You** may file a request for an expedited **External Review** to be conducted at the same time **You** file a request for a review of an appeal as set forth in the **Internal Grievance Procedure**, if:

(A) **You** have a medical condition where the timeframe for completion of an expedited review of an appeal in **Our Internal Grievance Procedures** would seriously jeopardize **Your** life or health or would jeopardize **Your** ability to regain maximum function; or

(B) The **Adverse Determination** involves a denial of coverage based on a determination that the recommended or requested **Health Care Service** or treatment is “experimental” or “investigational” and **Your Provider** certifies in writing and supports such certification with reasoning, rationale, or evidence that the recommended or requested **Health Care Service** or treatment would be significantly less effective if not promptly initiated.

The **Independent Review Organization** conducting the **External Review** will determine whether **You** will be required to complete the **Internal Grievance Procedures** prior to the expedited External Grievance Procedures. **You** may file an appeal under **Our Internal Grievance Procedures**, if **We** have not issued a written decision to **You** within thirty (30) days following the date **You** filed the appeal with **Us** for a pre-service claim or within sixty (60) days following the date **You** filed the appeal with **Us** for a post-service claim and **You** have not requested or agreed to a delay, **You** may file a request for **External Review** and shall be considered to have exhausted **Our Internal Grievance Procedures**.

Final Adverse Determinations: **You** may file a request for an expedited **External Review** to be conducted at the same time **You** file a request for a review of an appeal as set forth in the **Internal Grievance Procedure**, if:

(A) **You** have a medical condition where the timeframe for completion of an expedited review of an appeal in **Our Internal Grievance Procedures** would seriously jeopardize **Your** life or health or would jeopardize **Your** ability to regain maximum function.

(B) If the **Final Adverse Determination** concerns:

(i) an admission, availability of care, continued stay or **Health Care Service** for which **You** received **Emergency** services, but has not been discharged from a facility; or

(ii) a denial of coverage based on a determination that the recommended or requested **Health Care Service** or treatment is "experimental" or "investigational" and **Your Provider** certifies in writing and supports such certification with reasoning, rationale, or evidence that the recommended or requested **Health Care Service** or treatment would be significantly less effective if not promptly initiated.

You have the right to seek assistance from the Arkansas Department of Insurance at any time.

Commissioner [Jay Bradford]
Arkansas Dept. of Insurance
1200 West 3rd Street
Little Rock, Arkansas 72201

E-mail: insurance.Consumers@mail.state.ar.us
Phone: 501-371-2640 or 800-852-5494
Fax: 501-371-2749

All requests for **External Reviews** shall be made in writing or via electronic media to **Us** at the mailing address and facsimile telephone number identified below:

Freedom Life Insurance Company of America
Attn.: Vice President of Claims
Claims and Communications Dept.
3100 Burnett, 801 Cherry Street, Unit 33
Fort Worth, Texas 76102

Phone: 800-387-9027
Fax: 817-878-3440

Please be advised when filing a request for an **External Review**, **You** will be required to authorize the release of any of **Your** medical records that may be required to be reviewed for the purpose of reaching a decision on the **External Review**. This authorization will allow **Us** to disclose **Your** protected health information, including medical records, that are pertinent to the **External Review**.

II. Standard External Review -

Within sixty (60) days after the date of receipt of a notice of an **Adverse Determination** or **Final Adverse Determination**, **You** may file a request for an **External Review** with **Us**, as specified below:

(A) At the time **We** receive a request for an **External Review**, **We** shall assign an **Independent Review Organization** (from the list of approved **Independent Review Organizations** compiled and maintained by the Arkansas Insurance Commissioner) to conduct a preliminary review of the request to determine if:

- the request for the **External Review** meets the applicability standards as set out above;
- **You** have exhausted **Our Internal Grievance Procedures**; and
- **You** have provided all the information and forms required to process an **External Review**, including the authorization to release medical records.

(B) Within five (5) business days after receipt of the request for **External Review**, the **Independent Review Organization** assigned shall complete the preliminary review and notify **You**, **Your Provider** and Freedom Life Insurance Company of America in writing as to whether:

- the request is complete; and
- the request has been accepted for **External Review**.

The **Independent Review Organization** shall include in the notice provided a statement that **You**, **Your Provider** and Freedom Life Insurance Company of America may submit in writing to the **Independent Review Organization** within seven (7) business days following the date of receipt of the notice additional information and supporting documentation that the **Independent Review Organization** shall consider when conducting the **External Review**.

If the request:

- is not complete, the assigned **Independent Review Organization** shall, within five (5) business days, inform **You**, **Your Provider** and Freedom Life Insurance Company of America what information or materials are needed to make the request complete; or
- is not accepted for **External Review**, the assigned **Independent Review Organization** shall
- inform **You**, **Your Provider** and Freedom Life Insurance Company of America in writing within five (5) business days of the reasons for non-acceptance.

Upon receipt of any information submitted by **You**, the assigned **Independent Review Organization** shall forward copies of the information to **Us**.

(C) In reaching a decision to accept or reject a matter for **External Review**, the assigned **Independent Review Organization** is not bound by any decisions or conclusions reached during **Our Internal Grievance Procedures**.

(D) Within seven (7) business days after the receipt of the notice provided in part (B) above, **We** shall provide to the assigned **Independent Review Organization**, **You** and **Your Provider** the documents and any information considered in making the **Adverse Determination** or **Final Adverse Determination**, together with any additional information **We** deem necessary. If **We** fail to provide the documents or information, this will not delay the **External Review**; instead, the **Independent Review Organization** may terminate the **External Review** and make a decision to reverse any **Adverse Determination** or **Final Adverse Determination**. Immediately upon making such a decision, the **Independent Review Organization** shall notify **You**, **Your Provider** and Freedom Life Insurance Company of America.

(E) Upon receipt of the information, if any, required to be forwarded to **Us** as stated in (B) above, **We** may reconsider any prior **Adverse Determination** or **Final Adverse Determination** for the **External Review**. This reconsideration by **Us** shall not delay or terminate the **External Review**. The **External Review** may only be terminated if **We** decide, upon completion of our reconsideration, to reverse **Our Adverse Determination** or **Final Adverse Determination** and provide coverage or payment for the **Health Care Services** that is the subject of the **Adverse Determination** or **Final Adverse Determination**.

Immediately upon making the decision to reverse **Our Adverse Determination** or **Final Adverse Determination**, **We** shall notify **You** and **Your Provider**, as well as the assigned **Independent Review Organization**, in writing of **Our** decision. The assigned **Independent Review Organization** shall terminate the **External Review** upon receipt of this notice from **Us**.

(F) In exercising its independent medical judgment in reviewing an **Adverse Determination**, in addition to the documents and information provided, the assigned **Independent Review Organization**, to the extent the information or documents are available, shall consider the following in reaching a decision:

- the **Insured's** medical records;
- the **Provider's** professional recommendation;
- consulting reports from appropriate health care professionals and other documents submitted by **Us**, **You** or **Your Provider**;
- the applicable terms of coverage under **Your** contract of insurance to ensure that the **Independent Review Organization's** decision is not contrary to the terms of the coverage;
- the most appropriate practice guidelines, which may include generally accepted practice guidelines, evidence-based practice guidelines or any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;
- any applicable written screening procedures, decision abstracts, clinical protocols and practice guidelines used by **Us** to determine the necessity and appropriateness of **Health Care Services**; and
- if the **Adverse Determination** involves a denial of coverage based on a determination that the recommended or requested **Health Care Service** is "experimental" or "investigational" , the **Independent Review Organization** shall also consider whether: (a) the recommended or requested **Health Care Service** or treatment has been approved by the federal Food and Drug Administration for the condition, while realizing that treatments or services are often legitimately used for purposes other than those listed in the FDA approval; or (b) medical or scientific evidence demonstrates that the expected benefits of the recommended or requested **Health Care Service** or treatment is more likely than not to be more beneficial to **You** than any available standard **Health Care Service** or treatment and the adverse risks of the recommended or requested **Health Care Service** or treatment would not be substantially increased over those of available standard **Health Care Services** or treatments.

(G) Within forty-five (45) calendar days after the date of receipt of the request for an **External Review**, the assigned **Independent Review Organization** shall provide written notice of its decision to uphold, reverse, or partially uphold or reverse the **Adverse Determination** or **Final Adverse Determination** to **You**, **Your Provider** and Freedom Life Insurance Company of America.

III. Expedited External Review -

(A) Except as provided under item (E) below, **You** may make a request for an expedited **External Review** with **Us** at the time **You** receive an **Adverse Determination** or **Final Adverse Determination**. At the time **You** elect to make a request for an expedited **External Review**, **You** and **Your Provider** shall submit additional information and supporting documentation that the **Independent Review Organization** shall consider when conducting the expedited **External Review**.

(B) An expedited **External Review** may NOT be provided for an **Adverse Determination** or **Final Adverse Determination** involving a **Retrospective Review**.

(C) At the time **We** receive a request for an expedited **External Review**, **We** immediately shall assign an **Independent Review Organization** (from the list compiled and maintained by the Arkansas Insurance Commissioner) to determine whether the request meets the reviewability requirements, and then initiate the expedited **External Review** if all the requirements are met.

(D) At the time **We** assign an **Independent Review Organization** to conduct the expedited **External Review**, **We** shall immediately provide or transmit all pertinent documentation and information to the assigned **Independent Review Organization**.

(E) As expeditiously as **Your** medical condition or circumstances require, but in no event more than seventy-two (72) hours after the date of receipt of the request for an expedited **External Review** that meets the reviewability requirements, the assigned **Independent Review Organization** shall:

- Make a decision to uphold or reverse the **Adverse Determination** or **Final Adverse Determination**; and
- Notify **You**, **Your Provider** and Freedom Life Insurance Company of America of the decision.

IV. Binding Nature of External Review Decision -

All **External Reviews** conducted will be fair and impartial, and in compliance with the standards approved by the Arkansas Insurance Commissioner.

An **External Review** decision is binding on **Us**, except to the extent that **We** have other remedies available under applicable federal or state law. An **External Review** decision is binding on the **Covered Insured**, except to the extent that **You** have other remedies available under applicable federal or state law. A **Covered Insured** may NOT file a subsequent request for an **External Review** involving the same **Adverse Determination** or **Final Adverse Determination** for which **You** have already received an **External Review** decision.

V. Filing Fees and Funding –

(A) Except in the case of a request for an expedited **External Review**, at the time of filing a request for **External Review**, the **Covered Insured** shall submit to the **Independent Review Organization** a filing fee of [$25.00], along with the information and documentation to be used by the **Independent Review Organization** in conducting the **External Review**. However, upon application by the **Covered Insured**, the Arkansas Insurance Commissioner may waive the filing fee upon a showing of undue financial hardship.

(B) The filing fee shall be refunded to the **Insured** who paid the fee if the **External Review** results in the reversal, in whole or part, of **Our Adverse Determination** or **Final Adverse Determination** that was subject of the **External Review**.

We shall pay the cost of the **Independent Review Organization** for conducting the **External Review** or expedited **External Review**, and shall not charge back the cost of any **External Review** to the **Covered Insured's Provider**.

X. COORDINATION OF BENEFITS

This Section regarding coordination of benefits applies when an **Insured** has health care coverage under more than one **Plan**. The ORDER OF BENEFIT DETERMINATION RULES below determine whether this **Certificate** is a **Primary Plan** or a **Secondary Plan** when compared to another **Plan** covering the **Insured**. If coverage for **Sickness and Injury Benefits**,[or] **Wellness and Screening Benefits**, [or] [**Miscellaneous Benefits]** under this **Certificate** is primary when considered in connection with other **Plans,** then such benefits are determined before the determination of benefits under any other **Plan** and without considering any other **Plan's** benefits. If coverage for **Sickness and Injury Benefits**, [or] **Wellness and Screening Benefits**, or [**Miscellaneous Benefits]** under this **Certificate** is secondary, when considered in connection with other **Plans**, then such benefits are determined after the determination of benefits under the other **Plan** and any such benefits under this **Certificate that** would have otherwise been payable in the absence of such other **Plan** may be reduced because of the **Primary Plan's** benefits.

A. ORDER OF BENEFIT DETERMINATION RULES

When a claim under a **Plan** with a coordination of benefits provision involves another **Plan**, which also has a coordination of benefits provision, the order of benefit determination shall be made as follows:

1. The benefits of a **Plan** that covers the person claiming benefits other than as a dependent shall be determined before those of the **Plan** which covers the person as a dependent.

2. The benefits of a **Plan** of a parent whose birthday occurs earlier in a **Calendar Year** shall cover a dependent child before the benefits of a **Plan** of a parent whose birthday occurs later in a **Calendar Year.** The word "birthday" as used in this paragraph refers only to the month and day in the **Calendar Year**, not the year in which the person was born.

3. If two or more **Plans** cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

a) First, the **Plan** of the parent with custody of the child;
b) Then, the **Plan** of the spouse of the parent with custody of the child; and
c) Finally, the **Plan** of the parent not having custody of the child.

However, notwithstanding the above, if the specific terms of a court decree state that one (1) 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.

4. The benefits of a **Plan** which covers a person as an employee (or as an employee's dependent) are determined before those of a **Plan** that covers that person as a laid off or retired employee (or as that employee's dependent). If the other **Plan** does not have this provision and if, as a result, the **Plans** do not agree on the order of benefits, this paragraph shall not apply.

5. If none of the provisions above determine the order of benefits, the benefits of the **Plan** which covered the claimant longer are determined before those of the **Plan** that covered the person for the shorter time.

6. If one of the **Plans** is issued out of this state and determines the order of benefits based upon the gender of a parent and, as a result, the **Plans** do not agree on the order of benefits, the **Plan** with the gender rule shall determine the order of benefits.

7. A **Complying Plan** may coordinate its benefits with a **Plan** which is "excess" or "always secondary" or with a **Non-Complying Plan** on the following basis:

a) If the **Complying Plan** is the **Primary Plan**, it shall pay or provide its benefits on a primary basis.
b) If the **Complying Plan** is the **Secondary Plan**, it shall, nevertheless, pay or provide its benefits first, as the **Secondary Plan**. In such a situation, such payment shall be the limit of the complying **Plan's** liability, except as provided in subparagraph (d).
c) If the **Non-Complying Plan** does not provide the information needed by the **Complying Plan** to determine its benefits within a reasonable time after it is requested to do so, the **Complying Plan** shall assume that the benefits of the **Non-Complying Plan** are identical to its own, and shall pay its benefits

accordingly. However, the **Complying Plan** must adjust any payments it makes based on such assumption whether information becomes available as the actual benefits of the **Non-Complying Plan**.

d) If the **Non-Complying Plan** pays benefits so that the claimant receives less in benefits than he or she would have received had the **Non-Complying Plan** paid or provided its benefits as the **Primary Plan** then the complying **Plan** shall advance to or on behalf of the claimant an amount equal to such difference which advance shall not include a right to reimbursement from the claimant.

B. EFFECT ON THE BENEFITS OF THIS PLAN

When this **Certificate** is a **Secondary Plan**, it may reduce its **Sickness and Injury Benefits**, [and] **Wellness and Screening Benefits**, [and] [**Miscellaneous Benefits]** so that the total amount paid or provided by all **Plans** during a **Claim Determination Period** is not more than 100% of total **Allowable Expenses**. The difference between the covered benefit payments that this **Certificate** would have paid had it been the **Primary Plan**, and the payments that it actually paid or provided shall be recorded as a benefit reserve for the **Insured** and used by this **Certificate** to pay any **Allowable Expenses**, not otherwise paid during the **Claim Determination Period**. As each claim is submitted, this **Certificate** will:

1. Determine its obligation to pay or provide covered benefits under the **Group Policy**;
2. Determine whether a benefit reserve has been recorded for the **Insured**; and
3. Determine whether there are any unpaid **Allowable Expenses** during that **Claims Determination Period**.

If there is a benefit reserve, the **Secondary Plan** will use the **Insured's** benefit reserve to pay up to 100% of total **Allowable Expenses** incurred during the **Claim Determination Period**. At the end of the **Claims Determination Period**, the benefit reserve returns to zero. A new benefit reserve must be created for each new **Claim Determination Period**.

C. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these coordination of benefit rules and to determine benefits payable under this **Certificate** and other **Plans**. **We** may get the facts **We** need from or give them to other organizations or persons for the purpose of applying these rules and determining **Sickness and Injury Benefits**, [and] **Wellness and Screening Benefits**, [and] [**Miscellaneous Benefits]** payable under this **Certificate** and other **Plans** covering the **Insured** claiming coverage for a claim. **We** need not tell, or get the consent of, any **Insured** to do this. Each **Insured** claiming **Sickness and Injury Benefits**, [and] **Wellness and Screening Benefits**, [and] [**Miscellaneous Benefits]** under this **Certificate** must give **Us** any facts **We** need to apply those rules and determine any amounts payable.

D. FACILITY OF PAYMENT

A payment made under another **Plan** may include an amount that should have been paid under this **Certificate**. If it does, **We** may pay that amount to the organization that made that payment. That amount will then be treated as though it was a **Sickness and Injury Benefit**, [or] **Wellness and Screening Benefit**, [or] [**Miscellaneous Benefit]** paid under this **Certificate**. **We** will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

E. RIGHT OF RECOVERY

If the amount of the payments made by **Us** is more than **We** should have paid under the coordination of benefits provision, **We** may recover the excess from one or more of the persons **We** have paid or for whom **We** have paid; or any other person or organization that may be responsible for the benefits or services provided for the **Insured**. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

XI. UNIFORM PROVISIONS

A. ENTIRE CONTRACT- CHANGES

The entire contract between **You** and the **Company** consists of the **Group Policy**, this **Certificate**, including **Your** application, which is attached hereto, and any amendments, riders, or endorsements attached to this **Certificate**. All statements made by **You** will, in the absence of fraud, be deemed representations and not warranties. No statement made by an applicant for insurance will be used to contest the insurance or reduce the **Sickness and Injury Benefits** or **Wellness and Screening Benefits**, unless contained in a written application, which is signed by the applicant. No agent may:

1. change, alter or modify the **Group Policy**, this **Certificate**, or any amendments, riders, or endorsements attached to this **Certificate**;
2. waive any provisions of the **Group Policy**, this **Certificate**, or any amendments, riders, or endorsements attached to this **Certificate**;
3. extend the time period for payment of premiums under this **Certificate**; or
4. waive any of the **Company's** rights or requirements.

No change in the **Group Policy** or this **Certificate** will be valid unless it is:

1. noted on or attached to the **Group Policy** or this **Certificate**;
2. signed by one of **Our** officers; and
3. delivered to the **Primary Insured**, as shown on the **Certificate Schedule**.

B. TIME LIMIT ON CERTAIN DEFENSES

After two (2) years from the effective date of coverage, only fraudulent misstatements in the enrollment application may be used to void this **Certificate** or deny any claim for a loss occurring after the two (2) year period.

No claim for a **Covered Expense** charged after two (2) years from the **Insured's** effective date of coverage will be reduced or denied because a medical condition, not excluded by name or specific description, existed before the effective date of coverage.

C. OTHER INSURANCE WITH US

You may have only one policy or certificate providing major medical or medical and surgical coverage with **Us**. If through error, **We** issue more than one like policy or certificate to **You**, only one policy or certificate chosen by **You** or **Your** estate, as the case may be, will stay in force. **We** will return the money **You** paid for the other policy(ies) or certificate(s).

D. CONFORMITY WITH STATE STATUTES

Any provision of this **Certificate** or the **Group Policy** which, on its effective date, is in conflict with the laws of the state in which **You** live on that date, is amended to conform to the minimum requirements of such laws.

E. MISSTATEMENT OF AGE

If the age of an **Insured** has not been stated correctly, his or her correct age will be used to determine (i) the amount of insurance for which he or she is entitled, (ii) the effective date of termination of insurance, and (iii) any other rights or **Sickness and Injury Benefits** under this **Certificate** or the **Group Policy**.

Premiums will be adjusted if too much or too little was paid due to the misstatement.

F. NONDISCLOSED MEDICAL HISTORY, MEDICAL CONDITIONS AND RELATED INFORMATION

During the first two (2) years coverage under this **Certificate** is in force it may be modified as provided below if, within that time, **We** discover that a medical condition or other material information was mistakenly not disclosed to **Us**:

1. The coverage under this **Certificate** will stay in force with no change in **Sickness and Injury Benefits, Wellness and Screening Benefits, [Miscellaneous Benefits**,] or premiums if the disclosure of such condition would not have affected the way the **Certificate** was issued.
2. If the disclosure would have resulted in coverage not being issued to an **Insured**, **We** will return all premium paid, less any **Benefits** paid for that person during the time the coverage was in force in error. The coverage for that person shall be void from the **Issue Date**.
3. If the disclosure would have resulted in coverage under this **Certificate** being issued either: (a) at an increased premium, or (b) with an endorsement eliminating that condition from coverage, **We** will either (i) have **You** pay the increased rate beginning with the **Issue Date** (if **You** do not pay the increased premium within thirty (30) days after receiving **Our** notice, **We** will refund all premium paid less any **Benefits** paid, and the coverage under this **Certificate** will be void from the **Issue Date**); or (ii) add an endorsement to the **Certificate** to exclude that condition from coverage. The endorsement must be signed by **You** to put this change in effect. If **You** do not return a signed copy of the endorsement within thirty (30) days after receiving it, **We** will refund all premiums paid less any **Benefits** paid, and the **Certificate** will be void from the **Issue Date**.

This Section does not apply to any fraudulent misrepresentations that are made, which in all events can result in rescission of any coverage issued as a result of such fraudulent misrepresentations.

[G. LEGAL ACTION

No action at law or in equity will be brought to recover on this **Certificate** prior to the expiration of sixty (60) days after proof of loss has been filed as required by this **Certificate**; nor will any action be brought after three (3) years from the expiration of the time within which proof of loss is required by this **Certificate**.]

[H. SUBROGATION

We shall be subrogated to all rights of recovery which any **Insured** may acquire against any party for ordinary negligence, gross negligence, strict liability in tort or any willful or intentional act or omissions resulting in **Injury** or **Sickness** for which **We** pay **Sickness and Injury Benefits, [and] Wellness and Screening Benefits [**and] **[Miscellaneous Benefits]** but only to the extent of the **Benefits** provided. Any **Insured**, by receiving **Benefits** under this **Certificate**, in such case, shall be deemed to have assigned such rights of recovery to **Us** and have agreed to do whatever may be necessary to secure the recovery, including, but not limited to, the execution of any and all appropriate documents or papers. The **Insured** also agrees to execute and deliver all necessary instruments, to furnish such information and assistance, and to take any action **We** may require to facilitate enforcement of **Our** rights.**]**

[I. EXTRATERRITORIAL MEDICAL EXPENSES

Covered Expenses charged in any jurisdiction outside the United States of America (U.S.) or its territories or possessions shall be reimbursed under the terms and conditions of this **Certificate** in U.S. currency at the rate of exchange between the U.S. dollar and the benchmark currency of the foreign jurisdiction on the date such **Covered Expenses** were incurred.]

THIS CONCLUDES THIS CERTIFICATE

FREEDOM LIFE INSURANCE COMPANY OF AMERICA

[3100 Burnett Plaza • 801 Cherry Street, Unit 33 • Fort Worth, Texas 76102 • 1-800-387-9027]

CERTIFICATE OF COVERAGE
ASSOCIATION GROUP MEDICAL-SURGICAL EXPENSE PLAN

This is **Your Certificate** of coverage under an association **Group Policy** issued to the **Group Policyholder**. The coverage of all **Insureds** is governed and determined by the terms, conditions, definitions, limitations and exclusions contained in this **Certificate.** This **Certificate** is a legal contract between **You** and the **Company.** Please read it carefully!

Your Certificate is guaranteed renewable, subject to the **Company's** right to adjust **Renewal Premiums** in accordance with Section IV.B. RENEWAL PREMIUM, and otherwise discontinue or terminate the **Certificate** as provided in Section III.C. TERMINATION OF COVERAGE. The **Initial Premium** for coverage of all **Insureds** under this **Certificate** is due and payable on or before the **Issue Date**. **Renewal Premiums** are due and payable in accordance with the Section IV.B. RENEWAL PREMIUM. You may renew coverage under this **Certificate**, as applicable, by timely payment of the proper amount of **Renewal Premium** when due.

Certain phrases and words have the first letter of each word capitalized and the entire word or phrase printed in bold face type. These are generally defined phrases and words, and as such have the express meaning set forth in Section II. DEFINITIONS.

IMPORTANT NOTICE ABOUT STATEMENTS IN THE APPLICATION: Please read the copy of **Your** application for coverage, which is attached to and part of this **Certificate**, to see if any medical history or other information inquired about or contained in the application is incorrect, incomplete or missing. Contact **Us** immediately if any information contained in the application is incorrect, incomplete or missing. Any incorrect or incomplete statements or answers, as well as any missing information could cause a claim to be denied or the coverage under this **Certificate** to be reformed or voided.

This **Certificate** was issued in consideration of (i) the payment of the **Initial Premium**, (ii) upon **Our** reliance upon **Your** representation that the answers to all questions in the application are correct and complete, and (iii) upon **Our** reliance upon the representation from **You** and any other applicable **Insureds**, that the content of any supplemental information provided to **Us** in the underwriting process, including information provided during any telephone verification of the application or by, e-mails, facsimiles and correspondence is in each instance correct and complete.

YOUR [10][30] DAY RIGHT TO RETURN THIS CERTIFICATE

If **You** are not satisfied with this **Certificate**, **You** may return it to **Us** within [ten (10)] [thirty (30)] days after **You** receive it. **You** may return it to **Us** by mail or to the agent who sold it. This **Certificate** will be voided as of the **Issue Date**, and We will refund any premium **We** have received prior to **Our** receipt of the returned **Certificate**.

SECRETARY

PRESIDENT

NEITHER THE GROUP POLICY NOR THIS CERTIFICATE IS A POLICY OF WORKERS' COMPENSATION INSURANCE.

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I. Certificate Schedule

A. GENERAL INFORMATION

Coverage is pursuant to a **Group Policy** form: [GRP-P-06-FLIC]

Issued to **Group Policyholder**: [ABC Association]

Certificate form: [USHG-2009-C-AR-FLIC]

Primary Insured: [ ]

Age at Issue: [ ]

Certificate Number: [ ]

Issue Date: [ ]

Other Insureds on **Issue Date**:
[ ]
[ ]

Beneficiary: [ ]

Initial Premium: **[ ]**

Amount	**Mode Of Premium Payment**	Method
$[ ]	[Monthly], [Quarterly], [Semi-Annual], [Annual]	[Credit Card], [Check]

First Renewal Date: **[**]

First Renewal Premium	**Mode Of Premium Payment**	Method
$[ ]	[Monthly], [Quarterly], [Semi-Annual], [Annual]	[Bank Draft]

Premium Rate Guarantee Period: **[**12] [24] [36] [48] months

B. COVERAGE SCHEDULES

1. **Lifetime Certificate Maximum Per Insured :** [$1,000,000 to $7,000,000]
2. **[Lifetime]Transplant Maximum [Per Organ] Per Insured:** [$100,000 to $1,000,000]

[3.] **Calendar Year Maximum Benefit Per Insured**:] [$100,000 to Lifetime Certificate Maximum Per Insured]

[4]. **Calendar Year Maximum Per Insured for Outpatient Treatment**] [$1,000 - $100,000]

[5.] **Calendar Year Maximum Per Insured for Prescription Drugs]** [$1,000 to $5,000] [or] [**Calendar Year Maximum Per Insured for Outpatient Treatment**] [or] [**Lifetime Maximum Per Insured]**

[6]. **DEDUCTIBLE SCHEDULES:**

The following deductibles are to be paid by the **Insured** in addition to the **Insured Coinsurance Percentage** before any **Sickness and Injury Benefits** or **Wellness and Screening Benefits** are payable by **Us** for **Covered Expenses**:

A. **Calendar Year Deductible** per **Insured**: [$1,000 to $50,000]
[Effective [Certificate Effective Date] [$1,000 to $50,000;]
[[Effective [Second Calendar Year]] [$1,000 to $50,000;]
[[Effective [Third Calendar Year]] [$1,000 to $50,000;]
[[Effective [Fourth Calendar Year]] [$1,000 to $50,000;]

[B.] [**Failure to Pre-Certify Treatment Deductible**:] **[**$1,000]; and

C. **Separate Deductible For Non-Participating Providers**: [$1,000 to $100,000]

[Effective [Certificate Effective Date] [$1,000 to $100,000;]
[[Effective [Second Calendar Year]] [$1,000 to $100,000;]
[[Effective [Third Calendar Year]] [$1,000 to $100,000;]
[[Effective [Fourth Calendar Year]] [$1,000 to $100,000;]

[7]. **COINSURANCE PAYMENT SCHEDULES – PARTICIPATING PROVIDERS [AND PARTICIPATING PHARMACIES]:**

For **Participating Providers [**and **Participating Pharmacies]**, after satisfaction of all applicable deductibles, the following **Company Insurance Percentage**, **Insured Coinsurance Percentage**, and **Insured Maximum Participating Provider Coinsurance Payment**, apply to all **Covered Expenses** in a **Calendar Year**:

A. **Company Insurance Percentage**: [50% to 100%]
(**Sickness and Injury Benefits** and **Wellness and Screening Benefits**)

[B. [**Company Insurance Percentage:**
(**Miscellaneous Benefits**)] [50% to 100%]]

C. **Insured Coinsurance Percentage**: [0% to 50%]; and
(**Sickness and Injury Benefits** and **Wellness and Screening Benefits**)

[D. [**Insured Coinsurance Percentage**:
(**Miscellaneous Benefits**)] [0% to 50%]]

E. **Insured Maximum Participating Provider Coinsurance Payment:** [$1,000 to $10,000]

[8]**. COINSURANCE PAYMENT SCHEDULES – NON-PARTICIPATING PROVIDERS [AND NON-PARTICIPATING PHARMACIES]:**

For **Non-Participating Providers [**and **Non-Participating Pharmacies]**, after satisfaction of all applicable deductibles, the following **Company Insurance Percentage**, **Insured Coinsurance Percentage**, **Insured Maximum Non-Participating Provider Coinsurance Payment**, and **Separate Deductible For Non-Participating Providers** apply to all **Covered Expenses** in a **Calendar Year**:

A. **Company Insurance Percentage** (**Sickness and Injury Benefits** and **Wellness and Screening Benefits**) [50% to 90%]

B. **Insured Coinsurance Percentage** (**Sickness and Injury Benefits** and **Wellness and Screening Benefits**) [10% to 50%]; and

C. **Insured Maximum Non-Participating Provider Coinsurance Payment** [$1,000 to $20,000]

[9]**. [PRESCRIPTION DRUGS]**

[A.] **[Prescription Drug Co-Pay** **[Generic Drug** **[**$0.00 to $35.00]
[Preferred Brand Drug **[**$25.00 to $40.00]]

[COVERED EXPENSES REMAINING AFTER SATISFACTION OF THE CALENDAR YEAR DEDUCTIBLES ARE SUBJECT TO COPAY]

[COVERED EXPENSES REMAINING AFTER SATISFACTION OF THE PRESCRIPTION DRUG CALENDAR YEAR DEDUCTIBLE PER INSURED ARE SUBJECT TO COPAY]

[COVERED EXPENSES REMAINING AFTER CO-PAY SUBJECT TO CALENDAR YEAR DEDUCTIBLES AND INSURED COINSURANCE PERCENTAGE]

[COVERED EXPENSES REMAINING AFTER CO-PAY SUBJECT TO PRESCRIPTION DRUG CALENDAR YEAR DEDUCTIBLE AND PRESCRIPTION DRUG COINSURANCE PERCENTAGE]

[COVERED EXPENSES FOR [GENERIC DRUG] [BRAND NAME DRUG] [AND] [PREFERRED BRAND DRUG] ARE SUBJECT TO CALENDAR YEAR DEDUCTIBLE AND INSURED COINSURANCE PERCENTAGE]

[B.] **[Prescription Drug Calendar Year Deductible Per Insured:**

[Generic Drug]	**[**$0 to $500]
[Preferred Brand Drug]	**] [**$0 to $500]
[Brand Name Drug]	**[**$0 to $500]

[C.] **[**Coinsurance Payments Schedules For **Participating Pharmacies:**

For **Participating Pharmacies** after satisfaction of all applicable deductibles, the following **Prescription Drug Company Insurance Percentage**, and the **Prescription Drug Insured Coinsurance Percentage**, applies to all **Covered Expenses** in a **Calendar Year**:

1**. Prescription Drug Company Insurance Percentage**: [0% to 100%]

2. **Prescription Drug Insured Coinsurance Percentage**: [0% to 100%]; [and]]

[D.] **[**Coinsurance Payments Schedules **Non-Participating Pharmacies:**

For **Non-Participating Pharmacies** after satisfaction of all applicable deductibles, the following **Prescription Drug Company Insurance Percentage**, applies to all **Covered Expenses** in a **Calendar Year**:

1. **Prescription Drug Company Insurance Percentage** [0% to 100%]

2. **Prescription Drug Insured Coinsurance Percentage** [0% to 100%]]

[10] **[DOCTOR OFFICE VISIT]**

[A.] **[Doctor Office Visit Co-Pay]**	[$25.00 to $50.00] [per visit] [per **Participating Provider**]
[B.] [**X-Ray, Laboratory And Diagnostic Testing Co-Pay]**	[25.00 to $50.00] [per service] [per type][per visit][per **Participating Provider**]

(If received during a Doctor Office Visit at a **Participating Provider)**

[This **Benefit** does not apply to **Covered Expenses** under any other **Benefit** provision or limitation such as ALLERGIES; SPINAL MANIPULATION; occupational, speech or physical therapy; and mental nervous disorders, if applicable. The **Doctor Office Visit Co-Pay** applies only to the actual office visit. The **X-Ray, Laboratory and Diagnostic Testing Co-Pay** is in addition to the **Doctor Office Visit Co-Pay**. **[Benefit** Payments by **Us** for the actual doctor office visit are limited to [$0 - $1,200] per **Insured** per **Calendar Year.]** Any services for the doctor office visit in excess of the [$0 - $1,200] limit or any other services, such as office surgeries, processing or reading charges, are subject to the **Calendar Year Deductible** and **Insured Coinsurance Percentage**.]

[All services received during the office visit are limited to [$0 - $1,000] per **Insured** per **Calendar Year]**

[Non-Participating Providers doctor office visits are subject to the [**Calendar Year Deductible]** [and] [or] [**Separate Deductible For Non-Participating Providers**] [[and] the **Insured Coinsurance Percentage**]]

[11] **[ACCESS FEES]**

[A. **Emergency Room Access Fee**] [(waived if **Insured** is **Confined** in a **Hospital** within twenty-four (24) hours following the **Emergency** room visit)]	[[$0 to $500] per **Insured** per visit to either a **Participating Provider** or a **Non-Participating Provider]**
[B. **[Laboratory and Diagnostic Testing Access Fee]**	[[$0 to $500] [per test] [per day] for either **Participating Provider** or **Non**- **Participating Provider** for each of the following **Inpatient** or **Outpatient** diagnostic tests: [MRI], [CAT Scan], [PET], [Myleogram] and [Nuclear Imaging Service] [(including Myocardial Perfusion Imaging - Thallium 201 Scintigraphy/Thallium Stress Tests)]**]**
[C. **Outpatient Therapy Access Fee]**	[[$0 to $500] per **Insured** per visit to a **Participating Provider** facility] [[$0 to $500] per **Insured** per visit to a **Non-Participating Provider** facility]
[12] [**Calendar Year Adult Wellness Maximum**	[$50 to $2,000]

[C. OPTIONAL RIDERS

[1]. **[MATERNITY AND IN VITRO FERTILIZATION BENEFIT RIDER***

Covered Expenses for services performed within [13-24] months from the effective date of coverage for such female **Insured**: [$1,500 to $3,000]

Covered Expenses for services performed [25] or more months from the effective date of coverage for such female **Insured**: [$1,000 to $5,000]

***** Note: Conception must begin [12] months after the effective date of coverage under this **Certificate**.]

In Vitro Fertilization **Benefits** are subject to a **Lifetime Certificate Maximum** of $15,000.

[2]**. [WAIVER OF RENEWAL PREMIUM DURING FIRST RENEWAL PREMIUM RATE GUARANTEE PERIOD UPON DEATH OR TOTAL DISABILITY OF PRIMARY INSURED]**

[Elimination Period:] [90 days]**]**

II. DEFINITIONS

The following terms or words that have the first letter of each word (including the plural form of such word) capitalized and the entire word or phrase printed in bold face type as used within any phrase, sentence, paragraph, provision or schedule in this **Certificate** shall have the express meaning set forth below:

["**Access Fee(s)**" means the [**Emergency Room Access Fee**,] [and] [the **Laboratory and Diagnostic Testing Access Fee**,] [and the **Outpatient Therapy Access Fee]**.

The remaining amount of **Covered Expenses** after the application and satisfaction of the designated **Access Fee** for applicable **Sickness and Injury Benefits** is subject to the **Calendar Year Deductible** and the **Insured Coinsurance Percentage.**

The amount of each applicable **Access Fee** is shown on the **Certificate Schedule**.]

"**Accident**", "**Accidentally**" means an event or occurrence that was unplanned and unintended by the **Insured** that was the sole cause of **Injuries** sustained or suffered by such **Insured** and that takes place on or after the **Issue Date**.

["**Adult Wellness Preventive Care**" means routine physicals, screenings and immunizations that are appropriate for the age and sex of the **Insured** and based on generally accepted standards of medical practice. **Adult Wellness Preventive Care** does not include: COLORECTAL CANCER SCREENING, PROSTATE CANCER SCREENING, MAMMOGRAPHY SCREENING, and PAP SMEAR SCREENING contained in the WELLNESS and SCREENING BENEFITS Section of this **Certificate.]**

"**Adverse Determination**" means a determination by **Us** that an admission, availability of care, continued stay or other **Health Care Service** has been reviewed and, based upon the information provided, the requested payment for the service is denied, reduced or terminated, because:

- the requested **Health Care Service** does not meet **Our Certificate** requirements for **Medical Necessity**; or
- the requested **Health Care Service** has been found to be "experimental/investigational".

To be considered as an **Adverse Determination**, the **Adverse Determination** must be a **Final Adverse Determination**, except as provided herein. The **Adverse Determination** must involve treatment, services, equipment, supplies or drugs that would require **Your Certificate** to expend five hundred dollars [$500] or more of expenditures.

Adverse Determination does NOT include a determination by **Us** to deny a **Health Care Service** or **Benefit** based upon:

- an express exclusion within the **Certificate**, other than a general exclusion for "**Medical Necessity**" or "experimental/investigational";
- an express limitation within the **Certificate** with respect to the number of visits, treatments, supplies or services for a covered **Benefit** in a given **Calendar Year** or due to the **Lifetime Certificate Maximum** for an Insured;
- an express limitation within the **Certificate** with respect to a maximum dollar limitation with respect to a covered **Benefit** in a given **Calendar Year** period or due to the **Lifetime Certificate Maximum** for an Insured;
- a determination by **Us** that an individual is not eligible to be an Insured;
- a determination by **Us** that treatment, service or supplies were requested or obtained by a **Covered Insured** through fraud or material misrepresentation;
- the procedure for determining the **Insured's** access to a **Provider**, including but not limited to any primary care gatekeeper, referral or network access provision;
- Illegality of services or the means or methods of administering them;
- FDA or other government agency determinations, reports or statements; or
- Licensure, permit or accreditation status of a **Provider**.

"**Alcoholism**" means the chronic and habitual use of alcoholic beverages by any person to the extent that such person has lost the power of self-control with respect to the use of such beverages.

"**Allowable Expense**" means, in connection with Section IX. COORDINATION OF BENEFITS, any necessary, reasonable and customary item of expense, at least a portion of which is covered under one or more of the **Plans** covering the applicable **Insured** for whom medical service was rendered and provided, and for which a **Benefit** claim was made. When a **Plan** provides benefits in the form of services, (for example an HMO) the reasonable cash value of each service rendered shall be deemed to be both an allowable expense and a benefit paid. A **Plan**, which takes **Medicare** or similar government benefits into consideration when determining the application of its coordination of benefits provision, does not expand the definition of an **Allowable Expense**.

"Ambulatory Surgical Center" means a state licensed public or private establishment with an organized medical staff of **Providers** with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures and continuous **Provider** services and registered professional nursing services whenever an **Insured** is in the center that does not provide services or other accommodations for the overnight stay of patients.

Ambulatory Surgical Center does not include a facility that primarily terminates pregnancies, a **Provider's** office maintained for the practice of medicine, or an office maintained for the practice of dentistry.

"Beneficiary" means the individual or organization listed on the **Certificate Schedule** as the **Beneficiary**.

"**Benefit(s)**" means **Sickness and Injury Benefits**, [and] **Wellness and Screening Benefits** [and] [**Miscellaneous Benefits]**.

"Bone Marrow Transplants" means the **Medically Necessary** transplantation, combined transplantation, and sequential transplantation procedures, sometimes referred to as "Bone Marrow Reconstitution or Support" in which Medically Necessary human blood precursor cells are administered following mylesuppressive or ablative therapy are received by an **Insured** while coverage for such **Insured** under this **Certificate** is in full force and effect. Such cells may be derived from such **Insured** in an autologous harvest, or from a matched donor for an allogenic transplant.

[**"Brand Name Drug"** means a **Prescription Drug** for which a pharmaceutical company possesses either (i) an active and valid registered patent or (ii) an active and valid registered trade name after expiration of such patent.]

"Breast Reconstruction" means reconstruction of a breast incident to a **Mastectomy** to restore or achieve breast symmetry. **Breast Reconstruction** includes surgical reconstruction of a breast on which **Mastectomy** surgery has been performed in order to establish symmetry, as well as prostheses and services and other supplies that are **Medically Necessary** for any physical complication, including lymphedemas, at all stages of the reconstruction incident to a **Mastectomy**.

"Calendar Year" means the period beginning on the **Issue Date** and ending on December 31 of that year. In subsequent years, it is the period from January 1 through December 31 of the same year.

"Calendar Year Deductible" means the amount of **Covered Expenses** each **Insured** must incur within a **Calendar Year** before any **Sickness and Injury Benefits** or **Wellness and Screening Benefits** are payable by **Us** for such **Insured**. No **Sickness and Injury Benefits** or **Wellness and Screening Benefits** are payable by **Us** for any **Covered Expenses** incurred by an **Insured**, until after all applicable [**Co-Pays** and] **Access Fees**, the **Failure to Pre-Certify Treatment Deductible**, if applicable, the **Separate Deductible for Non-Participating Providers**, if applicable, and the **Calendar Year Deductible** are each satisfied and fully payable by either **You** or such **Insured**.

None of the following expenses may be used to satisfy the **Calendar Year Deductible**: (i) the amount of any applicable [**Co-Pay** or] **Access Fee**; (ii) the amount of the **Separate Deductible For Non-Participating Providers**, (iii) [**Covered Expenses** that constitute **Miscellaneous Benefits** for which payment is made by **Us**,] and (iv) the amount of the **Failure to Pre-Certify Treatment Deductible**.

[When [three (3)] **Insureds** satisfy this **Calendar Year Deductible**, no additional **Calendar Year Deductible** per **Insured** will be required for the remainder of the **Calendar Year**.]

[If [two (2)] or more **Insureds** incur **Covered Expenses** for **Injuries** sustained in the same accident, only one (1) **Calendar Year Deductible** will be applied that **Calendar Year** to the combined **Covered Expenses** resulting from the **Injuries** sustained in such common accident by all **Insureds**.]

The amount of the **Calendar Year Deductible** is shown on the **Certificate Schedule**.

[**"Calendar Year Maximum Benefit Per Insured"** means the maximum dollar amount of **Covered Expenses** per **Calendar Year** per **Insured** that **We** are required to pay, after satisfaction of all applicable deductibles, [**Co-Pays**,] [**Access Fees]** and the amount of any **Insured Coinsurance Percentage**. The amount of the **Calendar Year Maximum Benefit Per Insured** is shown on the **Certificate Schedule**.]

[**"Calendar Year Maximum Per Insured For Prescription Drugs"** means the maximum dollar amount of **Covered Expenses** incurred per **Insured** per **Calendar Year** that **We** are required to pay for **Prescription Drugs** ,after the satisfaction by each applicable **Insured** of (i) [the amount of any applicable **Co-pays**;] **[ii)] [**the **Prescription Drug Calendar Year Deductible;]** and [(iii)] [the amount of the **Prescription Drug Insured Coinsurance Percentage]**. The amount of the **Calendar Year Maximum Per Insured for Prescription Drugs** is shown on the **Certificate Schedule**.]

["Calendar Year Maximum Per Insured For Outpatient Treatment" means the maximum dollar amount of **Covered Expenses** incurred per **Insured** per **Calendar Year** that **We** are required to pay, after the satisfaction by each applicable **Insured** of (i) the amount of all applicable deductibles and **Access Fees** (ii) the amount of the **Insured Coinsurance Percentage** for the **Outpatient** coverages listed in Section V. A. EMERGENCY ROOM AND OTHER OUTPATIENT BENEFITS. The amount of the **Calendar Year Maximum Per Insured** for **Outpatient Treatment** is shown on the **Certificate Schedule**.**]**

["Calendar Year Adult Wellness Maximum" means the maximum dollar amount of **Covered Expenses** per **Calendar Year** per **Insured** that **We** are required to pay, after satisfaction of all applicable deductibles, [**Co-Pays**,] [**Access Fees]** and the amount of any **Insured Coinsurance Percentage**. The amount of the **Calendar Year Maximum Adult Wellness Maximum** is shown on the **Certificate Schedule**.]

["Center of Excellence" means a **Participating Provider** who has agreed to provide organ transplants.]

"Certificate" means this contract of coverage between all **Insureds** and the **Company** that was issued under the **Group Policy**. This contract of coverage consists solely of (i) this written CERTIFICATE OF COVERAGE, (ii) the application for coverage of each **Insured**, which application is attached hereto and by this reference incorporated for all purposes, and (iii) any riders, endorsements or amendments attached hereto.

"Certificate Of Conversion Coverage" means the documents prepared by **Us** in accordance with the provisions of Section III.E. CONTINUATION OF COVERAGE AND CERTIFICATE OF CONVERSION, which on their effective date will replace this **Certificate** as the contract of coverage between the applicable **Insured** and the **Company**, consisting of (i) an endorsement removing each applicable **Insured** from this **Certificate**, and (ii) a new certificate of coverage for each applicable **Insured** with the same applicable provisions as this **Certificate**, including any riders or amendments attached hereto, but bearing a new certificate number.

"Certificate Schedule" means the schedule of **Certificate** information that commences on page 3 of this **Certificate**.

["Childhood Wellness Preventive Care" means a routine annual **Outpatient** physical examination of each **Insured** under the age of [19, or to age 24] if **Full-Time Student** performed by a **Participating Provider**, not in connection with any **Sickness** or **Injury**, but instead as an evaluation of the annual health status of such individual, including any necessary laboratory blood tests, urinalysis, and x-rays performed in connection with each routine annual **Outpatient** physical examination and at the order of such **Participating Provider**. Provided, however, that such ordered medical laboratory and diagnostic tests, services and supplies are:

1. reasonably designed to permit early diagnoses of certain **Sicknesses**;
2. appropriate and performed according to and within generally accepted standards for medical practice;
3. in the most cost effective setting and manner available;
4. not primarily for the convenience of an **Insured**, a **Family**, or a **Provider**; and

5. the costs incurred do not exceed the **Maximum Allowable Charge** for such services.]

"Claim Determination Period" means, in connection with Section IX. COORDINATION OF BENEFITS, a **Calendar Year**. However, it does not include any part of a year during which an **Insured** has no coverage under this **Certificate**, or before the date that Section IX. COORDINATION OF BENEFITS or a similar provision takes effect.

"Class" means the classification by **Us** of (i) individuals to whom **We** have issued new coverage for the purposes of the calculation of their **Initial Premium** rates, and (ii) individuals to whom **We** have previously issued coverage for purposes of the calculation of their **Renewal Premium** rates.

"Company" means Freedom Life Insurance Company of America.

"Company Insurance Percentage" means the portion of the **Covered Expenses We** must pay to or on behalf of an **Insured** for **Benefits** under this **Certificate**, after satisfaction by the **Insured** of (i) all applicable [**Co-Pays** and] **Access Fees**, (ii) all applicable deductibles and (iii) the amount of the applicable **Insured Coinsurance Percentage**. The **Company Insurance Percentage** is shown on the **Certificate Schedule** for **Covered Expenses** for **Sickness and Injury Benefits**, [and] **Wellness and Screening Benefits** [and] [**Miscellaneous Benefits]** at (i) **Participating Providers**; and (ii) **Non-Participating Providers**.

"Complications of Pregnancy" means:

1. Conditions (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy, including but not limited to, acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity; and
2. Non-elective **Emergency** cesarean sections, termination of ectopic pregnancy, and spontaneous termination of pregnancy occurring during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy does not include false labor, occasional spotting, **Provider** prescribed rest during the period of pregnancy, morning sickness, and hyperemesis gravidarum. Nor does it include pre-eclampsia and similar conditions associated with the management of a difficult pregnancy unless such condition constitutes a nosologically distinct complication.

"Complying Plan" means, in connection with Section IX. COORDINATION OF BENEFITS, a **Plan** with an order of benefit determination provision which complies with the ORDER OF BENEFIT DETERMINATION RULES contained is Section IX. A.

"Confinement or **Confined"** means **Inpatient** services received as a resident bed patient for not less than eight (8) hours in a **Hospital**. A period of **Confinement** begins on the date of admission to the **Hospital** as an **Inpatient** and ends on the date of discharge.

["Co-Pays" means the amount of each first dollar co-payment of **Covered Expenses** incurred by an **Insured** for the applicable service and care that is required to be applied to and satisfied by the **Insured** before the remaining portion of such **Covered Expenses** are eligible for payment consideration by **Us. Co-Pays** may not be used to satisfy the **Calendar Year Deductible**, the **Insured Coinsurance Percentage**, the **Separate Deductible for Non-Participating Providers**, [any applicable **Access Fees**,] the amount of **Covered Expenses** for which benefit payments are received by **You** under any optional rider issued with this **Certificate**, or the amount of any applicable **Failure to Pre-Certify Treatment Deductible**.

[The remaining amount of **Covered Expenses** after the application and satisfaction of the designated **Co-Pay** is subject to the **Calendar Year Deductible** [the **Separate Deductible for Non-Participating Providers**,] [any applicable **Access Fees**,] and the **Insured Coinsurance Percentage.]**

The amount of each **Co-Pay** is shown on the **Certificate Schedule**.]

"Covered Expenses" means for the covered items and services listed in the **Sickness and Injury Benefits**, [and] **Wellness and Screening Benefits [**and the] [**Miscellaneous Benefits]** Sections of this **Certificate** the amount of expenses actually incurred by an **Insured**, after the **Issue Date** of this **Certificate** and before **Termination of Coverage**, as a result of being **Provided** applicable medical, surgical, or diagnostic services, supplies, care,

Prescription Drugs and other applicable treatment, which in each event is **Medically Necessary**, up to but not exceeding the amount of each of the following:

1. the **Maximum Allowable Charge** for each applicable medical, surgical or diagnostic service, supply, care [**Prescription Drugs]** or other applicable treatment;
2. the **Lifetime Certificate Maximum Per Insured**;
3. the **[Lifetime] Transplant Maximum [Per Organ] Per Insured**; [and]
4. the amount of any other applicable coverage limit or excluded amount set forth in any limitation, exclusion or waiting period that is contained in any Section in this **Certificate** and**/**or in any exclusionary or limiting rider, amendment or endorsement attached hereto.
5. **[**the **Calendar Year Maximum Benefit Per Insured**; [and]]
6. **[**the **Calendar Year Maximum Per Insured For Prescription Drugs**;] [and]]
7. [the **Calendar Year Maximum Per Insured For Outpatient Treatment**.**]**

"CPT Code" means the applicable numeric code assigned to a particular medical procedure **Provided** consistent with the most current version of the *Physicians' Current Procedural Terminology,* published by the American Medical Association on the date charges for such procedure are incurred by an **Insured**.

"Custodial Care" means care given mainly to meet personal needs. It may be provided by persons without professional skills or training. "**Custodial Care**" includes, but is not limited to, help in walking, getting in and out of bed, bathing, dressing, eating and taking medicine.

"Diabetes Equipment" means blood glucose monitors, insulin pumps and associated appurtenances, insulin infusion devices, and podiatric appliances for the prevention of complications associated with diabetes.

"Diabetes Self-Management Training" means training provided by a health care practitioner or **Provider** who is licensed, registered or certified in this state to provide appropriate health care services for the treatment of diabetes.

Diabetes Self-Management Training includes:

1. training provided after the initial diagnosis of diabetes, including nutritional counseling and proper use of **Diabetes Equipment** and **Diabetes Supplies**;
2. training authorized on the diagnosis of a **Provider** or other health care practitioner due to a significant change in the **Insured's** symptoms or condition which necessitates changes in the self-management regime; and
3. periodic or episodic continuing education training when prescribed by an appropriate health care practitioner as warranted by the development of new techniques and treatments for diabetes.

"Diabetes Supplies" means (a) test strips for blood glucose monitors; (b) visual reading and urine test strips; (c) lancets and lancet devices; (d) insulin and insulin analogs; (e) injection aids; (f) syringes; (g) prescriptive oral agents for controlling blood sugar levels; and (h) glucagon emergency kits.

"Disability Period" means the period of time that the **Primary Insured** is continuously **Totally Disabled** while coverage under the **Certificate** for such **Primary Insured** is in full force and effect.

["Doctor Office Visit Co-Pay" means the **Co-Pay** payment that is required [per visit] [per **Insured]** [per type of service] toward the applicable amount of **Covered Expenses** incurred by an **Insured** for **Outpatient** visits per **Calendar Year** per **Insured** to the professional offices of a physician who is a **Participating Provider** as defined in the **Certificate. Co-Pays** may not be used to satisfy the **Calendar Year Deductible**, the **Insured Coinsurance Percentage**, the **Separate Deductible for Non-Participating Providers**, [any applicable **Access Fees**,] the amount of **Covered Expenses** for which benefit payments are received by **You** under any optional rider issued with this **Certificate**, or the amount of any applicable **Failure to Pre-Certify Treatment Deductible**.]

[The remaining amount of **Covered Expenses** after the application and satisfaction of the **Doctor Office Visit Co-Pay** is subject to the **Calendar Year Deductible** [the **Separate Deductible for Non-Participating Providers**,] [any applicable **Access Fees**,] and the **Insured Coinsurance Percentage.]**

[The amount of the **Doctor Office Visit Co-Pay** is shown on the **Certificate Schedule**.]

"Emergency" means the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:

1. placing the patient's health in severe jeopardy;
2. serious impairment to bodily functions; or
3. serious dysfunction of any bodily organ or part.

"Emergency Care Facility" means a state licensed public or private establishment with an organized medical staff of **Providers** with permanent facilities that are equipped and operated primarily for the purpose of rendering **Outpatient Emergency** medical services for **Sicknesses** and **Injuries**, and which facility does not render **Inpatient** services. **Emergency Care Facility** does not include the emergency room of a **Hospital**, an **Ambulatory Surgical Center**, a facility that primarily terminates pregnancies, a **Providers** office maintained for the practice of medicine, or an office maintained for the practice of dentistry.

["Emergency Room Access Fee" means the amount of **Covered Expenses** under Section V.A. EMERGENCY ROOM SERVICES, an **Insured** must incur before any **Benefits** are payable under this **Certificate** if such **Insured** receives and is charged for services rendered in the emergency room of a **Hospital**. No **Benefits** are payable under this **Certificate** for any **Covered Expenses** for such an emergency room visit, until after the amount of any applicable **Emergency Room Access Fee**, the amount of the **Calendar Year Deductible**, **Insured Coinsurance Percentage,** as well as the amount of all other applicable **Access Fees** are satisfied and fully payable either by **You** or such **Insured**. In addition to the **Emergency Room Access Fee**, the **Separate Deductible for Non-Participating Providers** may apply to services rendered by **Non-Participating Providers**. However, the **Emergency Room Access Fee** shall be waived by **Us** if such **Insured** is **Confined** in any **Hospital** within twenty-four (24) hours of such emergency room visit.

None of the following expenses may be used to satisfy the **Emergency Room Access Fee**: (i) [the amount of the **Laboratory and Diagnostic Testing Access Fee**,] [(ii)][the amount of the **Outpatient Therapy Access Fee**,][(iii)] t[he amount of the **Separate Deductible for Non-Participating Providers**,][(iv)] t[he amount of **Covered Expenses** for which benefit payments are received by **You** under any optional rider issued with this **Certificate**,] [(v)[]the amount of any applicable **Failure to Pre-Certify Treatment Deductible**,] [(vi)] [the amount of the **Calendar Year Deductible,][** and] [vii] the **Insured Coinsurance Percentage]**.

[The amount of the **Emergency Room Access Fee** is shown on the **Certificate Schedule**.]

"External Review" means a process, independent of all affected parties, to determine if a **Health Care Service** is **Medically Necessary** or experimental/investigational.

"Failure to Pre-Certify Treatment Deductible" means the additional amount of **Covered Expenses** an **Insured** must incur before any **Sickness and Injury Benefits** are payable under this **Certificate** if such **Insured** fails to properly obtain **Pre-Certification of Treatment** as required under Section V.D. PRE-CERTIFICATION OF TREATMENT. No **Sickness and Injury Benefits** are payable under this **Certificate** for any **Covered Expenses** until after the amount of any applicable **Failure to Pre-Certify Treatment Deductible**, and the amount of the **Calendar Year Deductible** are satisfied and fully payable either by **You** or such **Insured**. In addition to the **Failure to Pre-Certify Treatment Deductible**, the **Separate Deductible For Non-Participating Providers** will apply to services rendered by **Non-Participating Providers**.

The amount of the **Failure to Pre-Certify Treatment Deductible** is shown on the **Certificate Schedule**.

None of the following expenses may be used to satisfy the **Failure to Pre-Certify Treatment Deductible**: (i) the amount of the **Separate Deductible For Non-Participating Providers**, (ii) the amount of **Covered Expenses** that constitute **Wellness and Screening Benefits** for which payment is made by **Us**, and (iii) the amount of the **Calendar Year Deductible** , and (iv) the amount of any applicable [**Co-Pay][** or][and][**Access Fee]**.

"Family" means the spouse, son or daughter, brother or sister, parent, grandparent or grandchild of an **Insured**.

"Final Adverse Determination" means an **Adverse Determination** involving a covered **Benefit** that has been upheld by **Us** at the completion of **Our Internal Grievance Procedure**. "**First Certificate Year**" means for the

period beginning on the **Issue Date** and ending on the last day immediately preceding the first anniversary of the **Issue Date**.

"First Certificate Year" means for the period beginning on the **Issue Date** and ending on the last day immediately preceding the first anniversary of the **Issue Date**.

"First Renewal Date" means the first premium due date following payment of the **Initial Premium** which is shown on the **Certificate Schedule**.

"First Renewal Premium" means the amount of **Renewal Premium** due on the **First Renewal Date**. The amount of **First Renewal Premium**, if known on the **Issue Date**, is shown on the **Certificate Schedule**.

"Full-Time Student" means an individual, under the age of [24], who is enrolled in at least twelve (12) credit hours per semester at an accredited college or university.

[**"Generic Drug"** means a **Prescription Drug** that contains the same active ingredients as an equivalent former **Brand Name Drug** that is no longer protected by a patent, and the trade name, if any, associated with such former **Brand Name Drug** is not listed on the label of such **Prescription Drug**.]

"Group Policy" means the association group insurance contract issued to the **Group Policyholder** under which this **Certificate** is issued to the **Primary Insured**.

"Group Policyholder" means the association shown on the **Certificate Schedule** to whom the **Group Policy** was issued.

"Health Care Services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, **Sickness, Injury** or disease, as used within the Grievance Procedures section.

"Home Health Care Plan" means a **Medically Necessary** program of care, established by an **Insured's Provider**, taking place in a residential setting.

"Hospice" means an agency licensed by the appropriate licensing agency to provide **Hospice Care**, under an administered program for a terminally ill **Insured** and his or her **Family**, with the following services available twenty-four (24) hours a day, seven (7) days a week: (a) **Inpatient** services, (b) home services, and (c) follow-up bereavement services.

"Hospice Care" means a **Medically Necessary**, coordinated, interdisciplinary **Hospice**-provided program for meeting the physical, psychological, spiritual, and social needs of dying individuals and his or her **Family**. **Hospice Care** provides **Medically Necessary** nursing, medical, and other health services to relieve pain and provide support through home and **Inpatient** care during the **Sickness** and bereavement of an **Insured** and his or her **Family**.

"Hospital" means a place which:

1. is legally operated for the care and treatment of sick and injured persons at their expense;
2. is primarily engaged in providing medical, diagnostic and surgical facilities (either on its premises or in facilities available to it on a formal pre-arranged basis);
3. has continuous twenty-four (24) hour nursing services by or under the supervision of a registered nurse (R.N.); and
4. has a staff of one or more **Providers** available at all times.

It also means a place that may not meet the above requirements, but is accredited as a hospital by the Joint Commission on Accreditation of Healthcare Organizations, the American Osteopathic Association or the Commission on the Accreditation of Rehabilitation Facilities.

Hospital does not mean:

1. a convalescent home, nursing home, rest home or **Skilled Nursing Home**;

2. a place primarily operated for treatment of **Mental and Emotional Disorders**, drug addicts, alcoholics, or the aged;
3. a special unit or wing of a **Hospital** used by or for any of the above;
4. a long-term mental care facility; or
5. a facility primarily providing **Custodial Care**.

"Independent Review Organization" means an entity that conducts independent **External Reviews** of **Adverse Determinations** and **Final Adverse Determinations**.

"Inherited Metabolic Disorder" means a disease caused by an inherited abnormality of body chemistry and includes a disease tested under a newborn screening program.

"Initial Premium" means the amount charged for coverage under this **Certificate** for **You** and all **Other Insureds** for the period of time from the **Issue Date** through the day before the **First Renewal Date**. The amount of the **Initial Premium** is shown on the **Certificate Schedule**, and is payable in advance of the **Issue Date**.

"Injury" means damage or harm **Accidentally** sustained to the physical structure of the body of an **Insured** that is the direct cause of the loss independent of disease, bodily infirmity, or any other cause, which occurs while this **Certificate** is in force and effect for such **Insured**. A specific **Injury** from which disability continues or recurs shall be considered one and the same **Injury** or "any one **Injury**", unless periods of **Confinement** to a **Hospital** or service, treatment, or **Covered Expenses** incurred resulting from such **Injury** are separated by an interval of at least ninety (90) consecutive days between the end of one such period and the beginning of a subsequent such period.

"Inpatient" means an **Insured** who receives **Medically Necessary** services from a **Provider** in a **Hospital** when such **Insured** is **Confined** and receives room and board from such **Hospital** for not less than eight (8) hours. Treatment or services rendered or **Provided** in a **Hospital** emergency room is not an **Inpatient Confinement** for the purposes of this **Certificate**. A period of **Inpatient Confinement** begins on the date of admission to the **Hospital** as an **Inpatient** and ends on the date of discharge.

"Insured" means the following:

1. the **Primary Insured** whose coverage under this **Certificate** is still in force and effect,
2. any other individuals named as **Other Insureds** on the **Certificate Schedule** whose coverage under this **Certificate** is still in force and effect, and
3. any individual who is added to this **Certificate** after the **Issue Date** by proper endorsement after proper application and payment of any additional premium whose coverage under this **Certificate** is still in force and effect.

"Insured Coinsurance Percentage" means the portion of the **Covered Expenses** that **You** must pay after satisfaction of all applicable deductibles[,] [**Co-pays**] and **Access Fees**. The different **Insured Coinsurance Percentages** are shown on the **Certificate Schedule** at [(i]) **Participating Providers [.]** [(i]i) [**Participating Pharmacies][**,][and] [(iii)] **Non-Participating Providers**, and (iv) **Non-Participating Pharmacies]**. (

"Insured Maximum Participating Provider Coinsurance Payment" means the maximum amount, after the satisfaction of all applicable **Certificate** deductibles, **Access Fees** [and **Co-Pays]**, that an **Insured** is required to pay in a **Calendar Year** under the **Insured Coinsurance Percentage** for services rendered at **Participating Providers [**and **Participating Pharmacies]. Covered Expenses** incurred for services rendered at **Participating Providers [**and **Participating Pharmacies]** that are covered under the **Sickness and Injury Benefits** and the **Wellness and Screening Benefits** sections and applied by the **Company** toward satisfaction of the **Calendar Year Deductible**, the **Separate Deductible For Non-Participating Providers**, the **Failure to Pre-Certify Treatment Deductible** and/or any other deductible contained in this **Certificate** or any rider attached to this **Certificate**, shall not be credited or applied toward satisfaction of the **Insured Maximum Participating Provider Coinsurance Payment**. The amount of the **Insured Maximum Participating Provider Coinsurance Payment** is shown on the **Certificate Schedule**.

"Insured Maximum Non-Participating Provider Coinsurance Payment" means the maximum amount, after the satisfaction of all applicable **Certificate** deductibles and **Access Fees**, that an **Insured** is required to pay in a

Calendar Year under the **Insured Coinsurance Percentage** for services rendered at **Non-Participating Providers [**and **Non-Participating Pharmacies]**. **Covered Expenses** incurred for services rendered at **Non-Participating Providers [**and **Non-Participating Pharmacies]** that are covered under the **Sickness and Injury Benefits** and the **Wellness and Screening Benefits** Sections and applied by the **Company** toward satisfaction of the **Calendar Year Deductible**, the **Failure to Pre-Certify Treatment Deductible**, and/or any other deductible contained in this **Certificate** or any rider attached to this **Certificate** shall not be credited or applied toward satisfaction of the **Insured Maximum Non-Participating Provider Coinsurance Payment**. The amount of the **Insured Maximum Non-Participating Provider Coinsurance Payment** is shown on the **Certificate Schedule**.

"Intensive Care Unit" means only the specifically designed facility of a **Hospital** which provides the highest level of medical care and restricts admission to only patients who are physically critically ill or injured, and which is separate and distinct from the rooms, beds and wards of such **Hospital** customarily used for patients who are not critically ill. To be considered an **Intensive Care Unit** under this **Certificate**, such facility must be permanently equipped with special life-saving equipment for the care of the physically critically ill or injured, and patients in such unit must be under constant and continuous observation by nursing staffs assigned on a full-time basis, exclusively to such facility of the **Hospital**. A coronary care facility and a specialized burn unit of a **Hospital** shall be considered an **Intensive Care Unit** if it meets these requirements and is restricted to persons receiving critical coronary or specialized burn care. However, the following are not considered an **Intensive Care Unit** under this **Certificate**:

1. a **Hospital** emergency room, regardless of the services or supplies rendered in such emergency room,
2. a surgical recovery room,
3. a sub-acute intensive care unit,
4. a progressive care unit,
5. an intermediate care unit,
6. a private monitored room,
7. any other observation unit or other facilities in a **Hospital** that are step downs from the unit in such **Hospital** that provides the highest level of medical care to critically ill patients.

"Internal Grievance Procedure" means the procedure by which **We** handle and resolve grievances, and provide **Insureds** with prompt and meaningful review on the issue of denial, in whole or part, of **Health Care Services**.

"Issue Date" means the date on which coverage under this **Certificate** commences for **You** and **Other Insureds**. This date is shown on the **Certificate Schedule**.

["Laboratory and Diagnostic Testing Access Fee" means the amount of **Covered Expenses** an **Insured** must incur [either per test per day, (as set forth in the **Certificate Schedule** by test and service)], before any **Benefits** are payable by **Us** under this **Certificate** for [MRI], [CAT Scan], [PET], [Myleogram] and [Nuclear Imaging Service (including Myocardial Perfusion Imaging - Thallium 201 Scintigraphy/Thallium Stress Tests)]. No **Benefits** are payable under this **Certificate** for any **Covered Expenses** for [MRI], [CAT Scan], [PET], [Myleogram] and [Nuclear Imaging Service (including Myocardial Perfusion Imaging - Thallium 201 Scintigraphy/Thallium Stress Tests)] performed on or for such **Insured** until after the amount of the **Laboratory and Diagnostic Testing Access Fee,** the amount of the **Calendar Year Deductible**, the **Insured Coinsurance Percentage**, as well as the amount of all other applicable **Access Fees** are satisfied and fully payable by either **You** or such **Insured**. In addition to the **Laboratory and Diagnostic Testing Access Fee**, the **Separate Deductible for Non-Participating Providers** will apply to services rendered by **Non-Participating Providers**.]

[None of the following expenses may be used to satisfy the **Laboratory and Diagnostic Testing Access** Fee, (i) **Emergency Room Access Fee**, [(ii) the amount of the **Outpatient Therapy Access Fee**,][(iii)] the amount of the **Separate Deductible for Non-Participating Providers**,[(iv)] the amount of **Covered Expenses** for which benefit payments are received by **You** under any optional rider issued with this **Certificate**,[(v)]the amount of any applicable **Failure to Pre-Certify Treatment Deductible**, [(vi)] the amount of the **Calendar Year Deductible,** and [vii] the **Insured Coinsurance Percentage**.]

[The amount of the **Laboratory and Diagnostic Testing Access Fee** is shown on the **Certificate Schedule**.]

"Lifetime Certificate Maximum Per Insured" means the total dollar amount of **Covered Expenses** payable on behalf of an **Insured** under this **Certificate** for **Benefits**. The minimum amount of the **Lifetime Certificate**

Maximum Per Insured is shown on the **Certificate Schedule**. The amount of the **Lifetime Certificate Maximum Per Insured** may increase on an annual basis in accordance with the terms, limitations and exclusions of Section VIII. INCREASE IN LIFETIME CERTIFICATE MAXIMUM.

["[Lifetime] Transplant Maximum [Per Organ] Per Insured" means the total dollar amount of **Covered Expenses** payable by **Us** under the terms of this **Certificate** for services **Provided** to an **Insured** in connection with or attributable to all **Solid Organ Transplants**, **Bone Marrow Transplants**, and **Stem Cell Transplants** received by the **Insured**. This [lifetime] [per organ] maximum **Benefit** includes all related **Covered Expenses** incurred from 14 days before each applicable transplant surgery or procedure to 365 days after each such transplant surgery or procedure. The amount of the **[Lifetime] Transplant Maximum [Per Organ] Per Insured** is shown on the **Certificate Schedule** and shall not exceed the **Lifetime Certificate Maximum Per Insured**.]

"Mammogram" means the X-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression device, screens, and films and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast.

"Manifests" or **"Manifested"** means either the presentation of symptoms or the presence of a medical condition, whether physical or mental, and regardless of the cause:

1. for which medical advice, diagnosis, care or treatment was recommended or received; and/ or
2. which would have caused a reasonably prudent person to seek medical advice, diagnosis, care or treatment, and which condition would have been medically diagnosable after the receipt of the results of medical diagnostic and laboratory tests that would have been reasonably indicated and ordered by a reasonably prudent **Provider** under the same or similar circumstances.

"Mastectomy" means the surgical removal of all or part of the breast as a result of breast cancer. **Mastectomy** does not include biopsies or other exploratory or diagnostic procedures used to detect the presence of cancer.

"Maximum Allowable Charge" means the following:

1. For **Providers**, **Maximum Allowable Charge** is the actual expense incurred by an **Insured** for the applicable service, supplies, care, or treatment **Provided**, after any reduction, adjustment, and/or discount pursuant to any **Participating Provider** agreements or other network agreements, negotiated rates, fee schedules or arrangements that determine or prescribe the actual amount of charges or fees that the **Provider**:

   a) agreed to accept as payment in full for such services, supplies, care or treatment, and
   b) ultimately charged such **Insured**, regardless of any higher amount that may have been placed on the **Provider's** billing statement of charges.

2. For **Hospitals**, **Ambulatory Surgical Centers**, **Emergency Care Facility**, **Skilled Nursing Homes**, laboratories, pharmacies or other medical, diagnostic or treatment facilities, "**Maximum Allowable Charge**" is the actual amount charged by such entity for the applicable service or treatment **Provided** to an **Insured**, after a reduction, adjustment, and/or network discount pursuant to any **Participating Provider** agreements, [**Participating Pharmacy** agreements] or other network agreements, negotiated rates, fee schedules or other arrangements that determine or prescribe the actual amount of charges or fees that such entity:

   a) agreed to accept as payment in full for such applicable services, supplies, care, treatment[or **Prescription Drugs]**, and
   b) ultimately charged such **Insured** for such applicable services, supplies, care, treatment [or **Prescription Drugs]**, regardless of any higher amount that may have been placed on the entity's billing statement of charges.

However, the amount of the **Maximum Allowable Charge** under (1) and (2) above shall never exceed (i) the amount for which the applicable **Insured** has a legal liability and payment obligation for the receipt of such applicable services, supplies, care, treatment [or **Prescription Drugs]**, (ii) the amount of the **Medicare** allowable or approved charge for the receipt of such applicable services, supplies, care, treatment [or **Prescription Drugs]** with

respect to any **Insured** who is **Medicare** eligible, or (iii) the amount of **Usual and Customary Expense** for the receipt of such applicable services, supplies, care, treatment [or **Prescription Drugs]**.

"Medical Foods" means modified low protein foods and metabolic formulas. Metabolic formulas are foods that are all of the following: (i) formulated to be consumed or administered enterally under the supervision of a **Provider**; (ii) processed or formulated to be deficient in one or more of the nutrients present in typical foodstuffs; (iii) administered for the medical and nutritional management of a person who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrient requirements as established by medical evaluation; and (iv) essential to a person's optimal growth, health and metabolic homeostasis.

Modified low protein foods are foods that are all of the following: (i) formulated to be consumed or administered enterally under the supervision of a **Provider** (ii) processed or formulated to contain less than one gram of protein per unit of serving, but does not include a natural food that is naturally low in protein; (iii) administered for the medical and nutritional management of a person who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrient requirements as established by medical evaluation; and (iv) essential to a person's optimal growth, health and metabolic homeostasis.

"Medical Necessity" and **"Medically Necessary"** means:

1. For the covered items and services listed in the **Sickness and Injury Benefits** Section of this **Certificate**, **Medical Necessity** and **Medically Necessary** is any applicable **Confinement** of an **Insured**, as well as any other diagnostic test, laboratory test, examination, surgery, medical treatment, service or supply listed therein that is **Provided** to an **Insured**:

   a) by or at the appropriate order, or upon the approval of a **Provider**;
   b) for the medically recognized diagnosis or care and treatment of an **Injury** or **Sickness**;
   c) in a manner appropriate and necessary for the symptoms, diagnosis or treatment of such **Injury** or **Sickness**;
   d) according to and within generally accepted standards for medical practice;
   e) in the most cost effective setting and manner available to treat the **Injury** or **Sickness**;
   f) not primarily for the convenience of an **Insured**, **Family**, or a **Provider**; and
   g) not investigational or experimental in nature.

2. For the covered items and services listed in the **Wellness and Screening Benefits [**and the] [**Miscellaneous Benefits]** Section[s] of this **Certificate**, **Medical Necessity** and **Medically Necessary** is any applicable diagnostic test, laboratory test, examination, or medical treatment, service or supply listed therein that is **Provided** to an **Insured**:

   a) reasonably designed to either prevent certain future **Sickness** or permit early diagnoses of certain **Sickness**;
   b) prescribed, performed and/or ordered by a **Provider**;
   c) appropriate and performed according to and within generally accepted standards for medical practice;
   d) rendered in the most cost effective setting and manner available, and
   e) not primarily for the convenience of an **Insured**, a **Family**, or a **Provider**.

The fact that a **Provider** prescribed, ordered, recommended or approved a service, supply, treatment or **Confinement** does not in and of itself make it **Medically Necessary** or a **Medical Necessity**.

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

"Mental and Emotional Disorders" means a neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

[“Miscellaneous Benefits” means only treatments, procedures, services, and supplies that are specifically enumerated in Section V.C. MISCELLANEOUS BENEFITS. If a treatment, procedure, service, or supply is not specifically enumerated in the MISCELLANEOUS BENEFITS Section, then fees charged or expenses associated with such items are not covered under this **Certificate** as a **Miscellaneous Benefit.]**

“Mode Of Premium Payment” means the interval of time (monthly, quarterly, semi-annual or annual) that you have selected for payment of the **Initial Premium** and **Renewal Premium**. The premium payment interval selected by **You** as the **Mode Of Premium Payment** is shown on the **Certificate Schedule**. This **Mode Of Premium Payment** is subject to change at **Our** discretion.

“Non-Complying Plan” means, in connection with Section IX. COORDINATION OF BENEFITS, a **Plan** with an order of benefit determination provision which does not comply with Section IX. A. ORDER OF BENEFIT DETERMINATION RULES.

[“Non-Participating Pharmacy” means a pharmacy that at the time **Covered Expenses** are incurred, has not entered into or has terminated a prior agreement to provide services to **Insureds** under this **Certificate**.]

“Non-Participating Provider” means a **Hospital**, **Provider**, **Ambulatory Surgical Center, Skilled Nursing Home**, or other licensed practitioner of the healing arts for which **Sickness and Injury Benefits** or **Wellness and Screening Benefits** are payable under this **Certificate** that, at the time **Covered Expenses** are incurred, has not entered into or has terminated a prior agreement to provide health care services to **Insureds** under this **Certificate** form at discounted rates.

“**Orthotic Device**” means an external device that is (i) intended to restore physiological function or cosmesis to a patient; and (ii) custom-designed, fabricated, assembled, fitted or adjusted for the patient using the device prior to or concurrent with the delivery of the device to the patient.

“**Orthotic Service**” means the evaluation and treatment of a condition that requires the use of an orthotic device.

“Other Insureds” means those members of **Your Family** that are listed on the **Certificate Schedule** on the **Issue Date.**

“Our” means Freedom Life Insurance Company of America.

“Outpatient” means **Medically Necessary** medical care, treatment, services or supplies from a **Provider** at (i) a clinic, (ii) an emergency room of a **Hospital**, (iii) an **Ambulatory Surgical Center**, (iv) an **Emergency Care Facility**, or (v) the surgical facility of a **Hospital** which does not result in an **Inpatient Confinement** at such **Hospital** following such surgery.

[“Outpatient Therapy Access Fee” means the amount of **Covered Expenses** an **Insured** must incur **[**per **Outpatient** visit] [per service] [per type of service] to any medical facility for any **Outpatient** non-surgical medical therapy or treatment under Section V.A. OUTPATIENT THERAPY before any **Benefits** are payable by **Us** under this **Certificate** for any **Outpatient** non-surgical medical therapy or treatment received by such **Insured** during each such visit. No **Benefits** are payable under this **Certificate** for any **Covered Expenses** for any non-surgical medical therapy or treatment received by such **Insured** on an **Outpatient** basis after the amount of the **Outpatient Therapy Access Fee** , the amount of the **Calendar Year Deductible**, the **Insured Coinsurance Percentage**, as well as the amount of all other applicable **Access Fees** are satisfied and fully payable by either **You** or such **Insured**. In addition to the **Outpatient Therapy Access Fee**, the **Separate Deductible for Non-Participating Providers** will apply to services rendered by **Non-Participating Providers**.

None of the following expenses may be used to satisfy the Outpatient Therapy Access Fee (i) **Laboratory and Diagnostic Testing Access Fee**, (ii) **Emergency Room Access Fee**, [(iii)] the amount of the **Separate Deductible for Non-Participating Providers**,[(iv)] the amount of **Covered Expenses** for which benefit payments are received by **You** under any optional rider issued with this **Certificate**,[(v)]the amount of any applicable **Failure to Pre-Certify Treatment Deductible**, [(vi)] the amount of the **Calendar Year Deductible,** [(vii)] [the amount of any applicable **Co-Pay**,] and [(viii)] the **Insured Coinsurance Percentage**.

The amount of the **Outpatient Therapy Access Fee** is shown on the **Certificate Schedule**.]

[**"Participating Pharmacy"** means a pharmacy that has entered into, and not terminated by the date the **Covered Expenses** are incurred, an agreement to dispense **Prescriptions** to **Insureds** under this **Certificate**. A **Participating Pharmacy** can be either a retail store or mail order for home delivery.]

"Participating Provider" means a **Hospital**, **Provider**, **Ambulatory Surgical Center**, **Skilled Nursing Home,** or other licensed practitioner of the healing arts for which **Sickness and Injury Benefits**, [and/or] **Wellness and Screening Benefits** [and/or] [**Miscellaneous Benefits]** are payable under this **Certificate** that has entered into, and not terminated by the date the **Covered Expenses** are incurred, an agreement to provide health care services to **Insureds** under this **Certificate** at discounted rates.

"Periodic Preventive Care Visits" means the routine tests and procedures for the purpose of detection of abnormalities or malfunctions of bodily systems and parts according to accepted medical practice.

"Plan(s)" means, in connection with Section IX. COORDINATION OF BENEFITS, this **Certificate** and other types of coverage that **We** may consider in determining whether over insurance exists with respect to a specific claim. The ORDER OF BENEFIT DETERMINATION RULES determines whether this **Certificate** is a **Primary Plan** or **Secondary Plan** when compared to another **Plan** covering the applicable **Insured**.

"Pre-Certification of Treatment" means the process of obtaining prior verbal or written authorization from **Us** for **Medically Necessary Inpatient Confinement** or surgery. **Pre-Certification of Treatment** is not required for **Emergency Inpatient** admission.

"Pre-existing Condition" means a condition, whether physical or mental, and regardless of the cause:

1. for which medical advice, diagnosis, care or treatment was recommended or received during the [twelve (12)] [twenty-four (24)] month period immediately preceding the effective date of coverage under this **Certificate** for the **Insured** incurring the expense; or
2. which **Manifested** during the [twelve (12)] [twenty-four (24)] month period immediately preceding the effective date of coverage under the **Certificate** for the **Insured** incurring the expense.

This **Certificate** provides coverage as of the **Issue Date** for **Pre-existing Conditions**, disclosed on the application, provided they are not otherwise limited or excluded by this **Certificate** or any riders, amendments, or endorsements attached hereto.

This **Certificate** does not cover expenses for **Pre-existing Conditions**, that are not disclosed on the application, unless the expenses are incurred more than [twelve (12)] [twenty-four (24)] months after the **Insured's** coverage has been in effect, and are not otherwise limited or excluded by this **Certificate** or any riders, amendments, or endorsements attached hereto.

[**"Preferred Brand Drugs"** means each **Brand Name Drug** that is identified and listed upon the **Preferred Drug List**. In certain circumstances, a **Preferred Brand Drug** maybe a medically acceptable alternative medication to a **Brand Name Drug** that is not listed on the **Preferred Drug List** such that an **Insured** may want to consult with his/her **Provider** and the pharmacist of the **Participating Pharmacy** regarding whether such **Preferred Brand Drug** would be appropriate and proper in the treatment of such **Insured's** condition.]

[**"Preferred Drug List"** means a list either created or sponsored by **Us**, which identifies certain **Brand Name Drugs** that may be preferred. The **Preferred Drug List** is updated from time to time and may be found on the Internet at www.ushealthgroup.com in the prescription services location of the website. **You** may also call the toll free Rx Help Desk number on your ID card.]

"Premium Rate Guarantee Period" means the number of months [(that **We** guarantee **Your** premium will not increase more than [five-twenty percent][5%-20%] annually on **Your** anniversary)] immediately following the **Issue Date] [**that must expire before the amount of **Renewal Premium** charged by **Us]** (with the same **Mode of Premium Payment** as the **Mode of Premium Payment** selected for payment of the **Initial Premium**) [can be higher than the amount of the **Initial Premium] [**because of (i) a change by **Us** in the table of premium rates used to calculate the **Initial Premium**, or (ii) an increase in the attained age after the **Issue Date** of any **Insured** listed on the **Certificate Schedule**.] However, the amount of **Renewal Premium** required for this

Certificate may be increased by **Us**, even during the **Premium Rate Guarantee Period**, if after the **Issue Date**:

1. **You** add **Insureds** to this **Certificate**;
2. **You** change the amount of the **Calendar Year Deductible** shown on the **Certificate Schedule**;
3. **You** change the **Insured Coinsurance Percentage** shown on the **Certificate Schedule**;
4. **You** change any other coverage option;
5. **You** change residence to a different zip code;
6. **You** change the **Mode Of Premium Payment**;
7. **You** add optional coverage riders, if any;
8. **You** change to a different optional **Participating Provider** network available in **Your** state, if any;
9. a **change occurs in the relationship between US** and **Your Participating Provider** network;
10. the **Participating Provider** network availability changes for **Your** state;
11. the **Participating Provider** negotiated discounts change; and/ or
12. a change occurs in **Sickness and Injury Benefits**, [and/or] **Wellness and Screening Benefits**, [and/or the] [**Miscellaneous Benefits]** by amendatory endorsement pursuant to any federal or state law or regulation.

The length of the **Premium Rate Guarantee Period** is shown on the **Certificate Schedule**.

"Prescription" means the **Medically Necessary** authorization for a **Prescription Drug** to be dispensed to an **Insured** on an **Outpatient** basis pursuant to the order of a **Provider** who is acting within the scope of his or her license to treat an **Injury** or **Sickness**. [Retail store filled **Prescriptions** for which **Sickness and Injury Benefits** are payable under this **Certificate** will be limited to a single thirty (30) day supply for each new or refilled **Prescription Drug**, unless adjusted based on the drug manufacturer's packaging size or based on supply limits. Mail order for home delivery filled **Prescriptions** for which **Sickness and Injury Benefits** are payable under this **Certificate** will be limited to a single ninety (90) day supply for each new or refilled **Prescription Drug**.]

"Prescription Drug" means legend drugs and medications that by Federal law may only be legally obtained on an **Outpatient** basis with a **Prescription**.

["Prescription Drug Calendar Year Deductible Per Insured" means the amount of **Covered Expenses** an **Insured** must incur, [after satisfaction of any applicable **Co-Pay**,] within a **Calendar Year** before any **Outpatient Prescription Drug Benefit** is payable.]

["Prescription Drug Company Insurance Percentage" means the portion of the **Covered Expenses We** must pay to or on behalf of an **Insured** for **Prescription Drug Benefits** under this **Certificate**, after satisfaction by the **Insured** of (i) all applicable **Co-Pays**, (ii) all applicable deductibles and (iii) the amount of the applicable **Prescription Drug Insured Coinsurance Percentage**. The **Prescription Drug Company Insurance Percentage** is shown on the **Certificate Schedule** for **Covered Expenses** for **Prescription Drug Benefits** at (i) **Participating Pharmacies** ; and (ii) **Non-Participating Pharmacies**.]

["Prescription Drug Co-Pay" means the **Co-Pay** payment that is required toward the total amount of **Covered Expenses** per **Prescription** per **Insured** under Section V. A. OUTPATIENT PRESCRIPTIONS. **Co-Pays** may not be used to satisfy the **Calendar Year Deductible**, [**Prescription Drug Calendar Year Deductible Per Insured]**, the **Insured Coinsurance Percentage**, [**Prescription Drug Insured Coinsurance Percentage**] the **Separate Deductible for Non-Participating Providers**, any applicable **Access Fees**, the amount of **Covered Expenses** for which benefit payments are received by **You** under any optional rider issued with this **Certificate**, or the amount of any applicable **Failure to Pre-Certify Treatment Deductible**.**]**

[The remaining amount of **Covered Expenses** after the application and satisfaction of the designated **Prescription Drug Co-Pay** is subject to the **Calendar Year Deductible** [the **Separate Deductible for Non-Participating Providers**,] and the **Insured Coinsurance Percentage.]**

The amount of the **Prescription Drug Co-Pay** is shown on the **Certificate Schedule**]

["Prescription Drug Insured Coinsurance Percentage" means the portion of the **Covered Expenses** that **You** must pay after satisfaction of all applicable **Co-Pays** and deductibles. The different **Prescription Drug Insured**

Coinsurance Percentages are shown on the **Certificate Schedule** at (i) **Participating Pharmacies**, and (ii) **Non-Participating Pharmacies**.]

"Primary Insured" means the individual whose name is printed on the **Certificate Schedule** as the **Primary Insured** and whose coverage under this **Certificate** has not ended.

"Primary Plan" means, in connection with Section IX. COORDINATION OF BENEFITS, of this **Certificate** the **Plan** that pays first pursuant to the order of benefit determination rules contained in such Section without regard to the possibility that another **Plan** may cover some expenses of the applicable **Insured**.

"**Prosthetic Device**" means an external device that is (i) intended to replace an absent external body part for the purpose of restoring physiological function or cosmesis to a patient; and (ii) custom-designed, fabricated, assembled, fitted, or adjusted for the patient using the device prior to or concurrent with being delivered to the patient.

"**Prosthetic Service**" means the evaluation and treatment of a condition that requires the use of a prosthetic device.

"Provide", "Provided" or **"Providing"** means each medical, diagnostic and surgical test, service, care, treatment, supply, [including **Prescriptions**,] which is:

1. prescribed or ordered by a **Provider;**
2. rendered to and received by an **Insured** while coverage under this **Certificate** for such **Insured** is in full force and effect;
3. listed as a covered item, type of service and/or supply in the **Sickness and Injury Benefits**, [and/or] **Wellness and Screening Benefits**, and/or [**Miscellaneous Benefits]** Sections; and
4. not otherwise limited or excluded by any provision in this **Certificate** or rider, endorsement or amendment attached hereto.

"Provider" means a person who has successfully completed the prescribed course of studies in medicine at a medical school officially recognized and accredited in the country in which it is located, and which person has been licensed by the state in which the medical services are rendered to practice medicine. The **Provider** must be acting within the scope of such license while rendering **Medically Necessary** professional service to an **Insured**, and cannot be a member of the **Insured's Family**.

"Renewal Premium" means the amount charged for coverage of all **Insureds** under this **Certificate** for the period of time from the **First Renewal Date** through the day before each subsequent renewal coverage renewal date. **Renewal Premium** for each renewal period is payable in advance for each applicable renewal period.

"Retrospective Review" means a review of **Medical Necessity** conducted after services have been **Provided** to a **Covered Insured**, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment.

"Secondary Plan(s)" means, in connection with Section IX. COORDINATION OF BENEFITS, the **Plan** that pays after the **Primary Plan** pursuant to the order of benefit determination rules contained in such Section, and such **Secondary Plan** may reduce its benefit payments that the benefit payments from all **Plans** do not exceed 100% of the total **Allowable Expense**.

"Separate Deductible For Non-Participating Providers" meansthe amount of **Covered Expenses** an **Insured** must incur in a **Calendar Year** for services rendered by **Non-Participating Providers** before any applicable **Sickness and Injury Benefits** or **Wellness and Screening Benefits** are payable under this **Certificate**.

No **Sickness and Injury Benefits** or **Wellness and Screening Benefits** are payable under this **Certificate** for services rendered by **Non-Participating Providers** until after the **Separate Deductible For Non-Participating Providers** is satisfied and fully payable by either **You** or such **Insured**. The amount of the **Separate Deductible For Non-Participating Providers** is shown on the **Certificate Schedule** and applies per **Calendar Year** separately to each **Insured**.

None of the following expenses may be used to satisfy the **Separate Deductible For Non-Participating Providers**: (i) the amount of the **Calendar Year Deductible**; (ii) the amount of any applicable [**Co-Pays** and] **Access Fees**; (iii) [the amount of Covered **Expenses** that constitute **Miscellaneous Benefits** for which payment is made by **Us**;] and (iv) the amount of the **Failure to Pre-certify Treatment Deductible**.

[When [three (3)] **Insureds** satisfy this **Separate Deductible For Non-Participating Providers**, no additional **Separate Deductible For Non-Participating Providers** per **Insured** will be required for the remainder of the **Calendar Year**.]

[If [two (2)] or more **Insureds** incur **Covered Expenses** for **Injuries** sustained in the same accident, only one (1) **Separate Deductible For Non-Participating Providers** will be applied that **Calendar Year** to the combined **Covered Expenses** resulting from the **Injuries** sustained in such common accident by all **Insureds**.]

"Sickness" means illness or disease afflicting an **Insured**, including **Complications of Pregnancy**, which first **Manifests** itself on or after the **Issue Date** shown on the **Certificate Schedule** and while this **Certificate** is in force and effect for such **Insured**.

Provided, however, any expenses incurred by an **Insured** (from a condition which is not otherwise excluded by a rider, endorsement, or amendment attached to this **Certificate**), which results from hernia, disease or disorders of the reproductive organs, hemorrhoids, varicose veins, tonsils and/or adenoids, or otitis media, shall be eligible for consideration as **Covered Expenses** only if such expenses are incurred after the expiration of six (6) months from the **Issue Date** shown on the **Certificate Schedule** or are **Provided** on an **Emergency** basis.

"Sickness and Injury Benefit(s)" mean only treatments, procedures, services, and supplies that are specifically enumerated in Section V.A. SICKNESS AND INJURY BENEFITS. If a treatment, procedure, service, or supply is not specifically enumerated in the SICKNESS AND INJURY BENEFITS Section**,** then fees charged or expenses associated with such items are not covered under this **Certificate** as a **Sickness and Injury Benefit**. Payments by **Us** for **Sickness and Injury Benefits** are subject to all definitions, exclusions, limitations and provisions contained herein, including but not limited to the satisfaction and payability by **You** or the applicable **Insured** of all applicable deductibles, as well as the limitation of the **Company Insurance Percentage**.

"Skilled Nursing Home" means a place which:

1. charges patients for their services;
2. is legally operated in the state (or similar jurisdiction) in which it is located;
3. has beds for patients who need medical and skilled care;
4. operates under a doctor's supervision;
5. has continuous twenty-four (24) hour nursing service supervised by a registered nurse (R.N.); and
6. keeps complete medical records on each patient.

Skilled Nursing Home also means a wing, area or floor of a **Hospital** specifically set aside to provide care similar to that of a **Skilled Nursing Home**, but it does not mean a **Hospital**.

"Solid Organ Transplant(s)" means the **Medically Necessary** surgical transplantation, combined transplantation, sequential transplantation, (including grafts) of the following **Medically Necessary** organs received by an **Insured** while coverage for such **Insured** under this **Certificate** is in full force and effect:

1. heart;
2. lung;
3. kidney;
4. pancreas;
5. combined heart/lung;
6. combined kidney/pancreas;
7. skin;
8. eye or parts thereof (including lens and cornea); and
9. liver (**Insureds** who are candidates for liver transplantation must have abstained from the use of alcohol for one year immediately prior to such transplantation surgery in order for the planned liver transplantation to constitute a **Solid Organ Transplant**).

"Stem Cell Transplants" means the **Medically Necessary** insertion or transplantation, combined insertion or transplantation, sequential insertion or transplantation procedures, in which any **Medically Necessary** form of stem cells are received by an **Insured** while coverage for such **Insured** under this **Certificate** is in full force and effect.

"Subsequent Certificate Year(s)" means each twelve (12) month period ending on each anniversary of the **Issue Date** following the **First Certificate Year**.

"Termination of Coverage" means Section III.C. TERMINATION OF COVERAGE, that governs the conditions and circumstances under which the coverage provided by this **Certificate** may be terminated for any or all **Insureds**.

"Total Disability" or **"Totally Disabled"** means that, due to an **Injury** or **Sickness**, an **Insured** is:

1. under a **Provider's** continuous care; and
2. not able to perform the normal activities of a person of like age or sex who is in good health; and
3. unable to engage in any activity, occupation, or business for income or profit, for which such **Insured** is qualified by reason of training, education, or experience.

"Us" means Freedom Life Insurance Company of America.

"Usual and Customary Expense" means the following:

1. For **Providers Usual and Customary Expense** is the seventieth (70th) percentile of the prevailing charges by all **Providers** in the same geographic area as such **Provider**, as determined by one of the current prevailing health care charges information systems in the insurance industry utilizing the applicable **CPT Code** for such services or treatment and the applicable zip code (first 3 or 5 digits) of such **Provider**.

2. For services or treatments **Provided** by **Hospitals**, **Ambulatory Surgical Centers**, **Emergency Care Facilities**, **Skilled Nursing Homes**, pharmacies or other applicable facilities, **Usual and Customary Expense** is average charge made for similar services or supplies in the locality where the service or supply is furnished, taking into consideration the nature and the severity of the **Injury** or **Sickness** suffered by the **Insured**.

Provided, however, that **Usual and Customary Expense** shall never exceed the **Medicare** allowable or approved charge with respect to **Insureds** who are **Medicare** eligible.

"Utilization Review" means a system for prospective or concurrent review of the **Medical Necessity** and appropriateness of health care services being **Provided,** or proposed to be **Provided,** to an **Insured** within this state. **Utilization Review** does not include elective requests for clarification of coverage.

"We" means Freedom Life Insurance Company of America.

"Wellness and Screening Benefit(s)" means only treatments, procedures, services, and supplies that are specifically enumerated in the Section V.B. WELLNESS AND SCREENING BENEFITS. If a treatment, procedure, service, or supply is not specifically enumerated in the WELLNESS AND SCREENING BENEFITS Section, then fees charged or expenses associated with such items are not covered under this **Certificate** as a **Wellness and Screening Benefit**.

["X-Ray, Laboratory and Diagnostic Testing Co-Pay" means the **Co-Pay** payment that is required [per visit per **Insured]** [per type of service] toward the applicable amount of **Covered Expenses** incurred by an **Insured** for **Outpatient** testing, per **Calendar Year** per **Insured,** at the professional offices of a physician who is a **Participating Provider** as defined in the **Certificate. Co-Pays** may not be used to satisfy the **Calendar Year Deductible**, the **Insured Coinsurance Percentage**, the **Separate Deductible for Non-Participating Providers**, [any applicable **Access Fees**,] the amount of **Covered Expenses** for which benefit payments are received by **You** under any optional rider issued with this **Certificate**, or the amount of any applicable **Failure to Pre-Certify Treatment Deductible**.]

[The remaining amount of **Covered Expenses** after the application and satisfaction of the **X-Ray, Laboratory and Diagnostic Testing Co-Pay** is subject to the **Calendar Year Deductible** [the **Separate Deductible for Non-Participating Providers**,] [any applicable **Access Fees**,] and the **Insured Coinsurance Percentage.]**

[The amount of the **X-Ray, Laboratory and Diagnostic Testing Co-Pay** is shown on the **Certificate Schedule**.]

"You", "Your" and **"Yours"** means the individual listed on the **Certificate Schedule** as the **Primary Insured**.

"Your Renewal Premium Class" means the **Class** in which this **Certificate** is placed for **Renewal Premium** purposes. **Your Renewal Premium Class** will be determined by **Us** based upon several factors, including, among other things, a combination of one or more of the following: (i) **Your** zip code (either first 3 or first 5 digits) at the commencement of such renewal period, (ii) **Your** county of residence at the commencement of such renewal period, (iii) **Your** state of residence at the commencement of such renewal period, (iv) the **Issue Date**, (v) **Your** state of residence on the **Issue Date**, (vi) the number, sex, attained age, and tobacco use of each **Insured** on each applicable renewal date, (vii) **Your** plan of coverage under this **Certificate** on each applicable renewal date, including its deductibles, **Benefits**, limits, exclusions, limitations, optional riders, and exclusionary endorsements (viii) the underwriting risk assessment of each **Insured**, (ix) discounted or preferred premium rate status of any **Insured**, (x) premium rate ups, if any, for any **Insured**, (xi) the amount of the **Initial Premium**, (xii) the amount of the **Renewal Premium** charged in the preceding renewal period, (xiii) **Mode of Premium Payment** for the renewal period and (xiv) the number and type other certificates of coverage issued by **Us** covering individuals in **Your** current state of residence with the same or similar factors described above.

"Your Spouse" means the spouse of the **Primary Insured** who (i) is either listed as an **Other Insured** on the **Certificate Schedule** or later added to this **Certificate,** and (ii) is an **Insured** whose coverage has not ended by the date of such spouse's death.

III. WHEN COVERAGE BEGINS AND ENDS

A. EFFECTIVE DATE

This **Certificate** is effective at 12:01 A.M. local time where **You** live on the **Issue Date** shown on the **Certificate Schedule**.

B. ELIGIBILITY AND ADDITIONS

Your spouse; **Your** unmarried, dependent children who are under the age of [19 (24 if a **Full-Time Student**]; and grandchildren who are considered **Your** dependents for federal income tax purposes and who are under age [19 (24 if a **Full-Time Student**]; any children which an **Insured** is required to insure under a medical support order; any child whom **You**, or **Your Spouse** (if listed as an **Other Insured** on the **Certificate Schedule**), intends to adopt and has become a party to a suit for that purpose; and any child who is in the custody of an **Insured** under a temporary court order that grants the **Insured** conservatorship of the child, are eligible for this coverage. Any eligible dependent (other than a newborn or adoptee) will be added to this **Certificate** when **We** approve the written application for such coverage, and accept payment of any necessary premium.

Newborn children born after the **Issue Date** to **You**, or **Your Spouse**, while this **Certificate** is in full force and effect (a newborn child) will be automatically insured under this **Certificate** from and after the moment of birth for a period of ninety (90) days or before the next premium due date, whichever is later. If **You** wish to continue such automatic coverage under this **Certificate** for any such newborn child past the initial ninety (90) day period or beyond the next premium due date, **You** must notify **Us** of such birth and **Your** desire for such continued coverage under this **Certificate** within ninety (90) days or before the next premium due date after the date of such newborn child's birth. **You** must also pay any additional premium required for such additional coverage within such ninety (90) day period or before the next premium due date. If **You** do not notify **Us** of such birth and **Your** desire for continued coverage under this **Certificate** within such ninety (90) day period or before the next premium due date, and timely pay any additional premium that may be due, then the automatic coverage under this **Certificate** for such newborn child will end after the expiration of ninety (90) days or the next premium due date, whichever is later, from the date of such newborn child's birth. **We** will notify **You** if more premium is needed.

Newborn children born after the **Issue Date** and immediately placed for adoption after birth with **You**, or **Your Spouse**, while this **Certificate** is in full force and effect (a newborn adoptee) will be automatically insured under this **Certificate** from and after the date of the adoption placement of such newborn adoptee for a period of sixty (60) days. If **You** wish to continue such automatic coverage under this **Certificate** for any such newborn adoptee past the initial sixty (60) day period, **You** must notify **Us** of such birth, adoption placement and **Your** desire for continued coverage under this **Certificate** within sixty (60) days after the date of the adoption placement of such newborn adoptee. **You** must also pay any additional premium required for such additional coverage within such sixty (60) day period. If **You** do not notify **Us** within such sixty (60) day period of the birth, adoption placement and Your desire for continued coverage under this **Certificate** for such newborn adoptee and timely pay any additional premium that may be due, then the automatic coverage under this **Certificate** for such newborn adoptee will end after the expiration of day from the date of such adoption placement of such newborn adoptee. **We** will notify **You** if more premium is needed.

If **You** wish to have automatic coverage under this **Certificate** after the **Issue Date** for any child not listed as an **Other Insured** on the **Certificate Schedule**, but for which adoption or custody of such child is sought by **You** or **Your Spouse** in a civil suit or other judicial custody proceeding filed or initiated after the **Issue Date**, **You** must notify **Us** within thirty-one (31) days after **You** or **Your Spouse**, as applicable: (i) become a party in such civil suit in which such adoption of the child is sought; or (ii) obtain custody of the child under the first court order (including temporary orders) that grants conservatorship and/or custody of the child. **You** must also pay any additional premium required for such additional coverage within such thirty-one (31) day period. If **You** do not notify **Us** within such applicable thirty-one (31) day period of **Your** desire for automatic coverage under this **Certificate** in the future for such child and timely pay any additional premium that may thereafter become due, then no automatic coverage will be afforded under this **Certificate** for such child. **We** will notify **You** if more premium is needed.

C. TERMINATION OF COVERAGE

1. TERMINATIONS SUBJECT TO RIGHT OF CONVERSION

Subject to the Section III. E. CONTINUATION OF COVERAGE AND CERTIFICATE OF CONVERSION below, an applicable **Insured's** coverage under this **Certificate** ends on the earlier of the following:

a. the premium due date in the month following the date the **Group Policy** is terminated by the **Group Policyholder**, in which case **You** will be given thirty (30) days prior written notice of the termination, mailed to **Your** last known address;
b. with respect to **Your** spouse who is covered under this **Certificate**, the premium due date in the month following the effective date of **Your** divorce decree, annulment or court approved separation;
c. with respect to **Your** child(ren) who are covered under this **Certificate**, the premium due date in the month following such **Insured's** 19th birthday (24th if a **Full-Time Student**).

2. TERMINATIONS BY PRIMARY INSURED NOT SUBJECT TO RIGHT OF CONVERSION

Section III.E. CONTINUATION OF COVERAGE AND CERTIFICATE OF CONVERSION notwithstanding, the following described actions by either the **Primary Insured** or other applicable **Insured** will result in a termination of each applicable **Insured's** coverage under this **Certificate** with no right of conversion, in which event the coverage ends on the earlier of the following:

a. the due date of any unpaid **Renewal Premium**, subject to the grace period; or
b. the date **You** terminate coverage by notifying **Us** of the date **You** desire coverage to terminate and specify the **Insured** whose coverage is to terminate.

3. TERMINATION OF THE CERTIFICATE BY THE COMPANY NOT SUBJECT TO RIGHT OF CONVERSION

Section III.E. CONTINUATION OF COVERAGE AND CERTIFICATE OF CONVERSION notwithstanding, **We** may refuse to renew and cancel coverage for all **Insureds** under this **Certificate** with no right of conversion for the following reasons:

a. **We** are required by the order of an appropriate regulatory authority to non-renew or cancel the **Certificate** or **Group Policy**;
b. **We** cease offering and renewing coverage of the same form of coverage as this **Certificate** in **Your** state upon a minimum of ninety (90) days prior written notice mailed to **Your** last known address with an opportunity for **You** to convert to any similar medical expense policy or certificate that **We** are then actively marketing and offering to new applicants in **Your** state;
c. **We** elect to discontinue offering all similar types of coverage under any association group or individual medical-surgical expense policy forms in **Your** state and to terminate all such certificates of coverage and individual policies in **Your** state, including **Your** form of coverage, in which case the commissioner of insurance for **Your** state, the **Group Policyholder** and **You** will be given a minimum of one hundred eighty (180) days prior written notice of the termination, mailed to **Your** last known address; or
d. the date **We** receive due proof that fraud or intentional misrepresentation of material fact existed in applying for this **Certificate** or in filing a claim for **Benefits** under this **Certificate**.

4. TERMINATION OF AN INSURED BY THE COMPANY NOT SUBJECT TO RIGHT OF CONVERSION

Section III.E. CONTINUATION OF COVERAGE AND CERTIFICATE OF CONVERSION notwithstanding, **We** may refuse to renew and cancel coverage for each **Insured** under this **Certificate** with no right of conversion for the following reasons:

a. the total amount of any **Benefit** payments made by **Us** are equal to the **Lifetime Certificate Maximum Per Insured**; or
b. the date **We** receive due proof that fraud or intentional misrepresentation of material fact existed in applying for this **Certificate** or in filing a claim for **Benefits** under this **Certificate**.

As long as this **Certificate** is in force for **You**, the coverage of **Your** child who is an **Insured** will not end if he or she is dependent upon **You** for support and maintenance and incapable of self-support because of a mental handicap or physical disability. Such dependent **Insured's** coverage under this **Certificate** will continue regardless of the dependent **Insured's** age, as long as **Renewal Premium** is timely and properly paid for **You** and the dependent **Insured** and such dependent **Insured** remains dependent upon **You** and incapable of self support because of such mental handicap or physical disability. Proof of such handicap or disability must be furnished to **Us** as soon as reasonably possible prior to the dependent **Insured** reaching the limiting age, and thereafter upon **Our** request, but not more frequently than annually after the two (2) year period following the attainment of the limiting age.

Any termination of coverage or of this **Certificate** will be effective at 11:59 P.M. local time where **You** live on the date(s) specified above.

If **You** die, **Your Spouse**, if then an **Insured** under this **Certificate**, will become the **Primary Insured**. If **You** and **Your** spouse (if any) are not covered under this **Certificate**, the oldest **Insured** will become the **Primary Insured**.

We will not accept premium for any **Insured** whose coverage has terminated. Premiums, which are sent to **Us** and include an amount to cover the **Insured** whose coverage has terminated, will be returned. **We** will only accept the correct premium to cover those **Insureds** who are eligible for coverage. If premiums are accepted in error, **Our** liability is limited to coverage for the period of time for which premiums were accepted in error.

Except for claims involving fraud or intentional misrepresentation of material fact, any termination will be without prejudice to any **Covered Expenses** incurred by an **Insured** for **Sickness and Injury Benefits**, [or] **Wellness and Screening Benefits** [or] [**Miscellaneous Benefits]** prior to the date of termination. If coverage is terminated, unearned premium will be computed pro-rata and any unearned premium will be refunded to **You**.

D. EXTENSION OF BENEFITS

If the **Group Policy** terminates while an **Insured** is **Totally Disabled**, **Sickness and Injury Benefits** will be extended for **Covered Expenses** incurred by such **Insured** after the date of termination of coverage under this **Certificate**. These extended **Sickness and Injury Benefits** are subject to the same terms that would have applied if the **Group Policy** had remained in force.

Extended **Sickness and Injury Benefits** are payable only (i) for **Covered Expenses** incurred for treatment of the specified **Injury** or **Sickness** that caused **Total Disability** of an **Insured** and while coverage under this **Certificate** for such **Insured** was in full force and effect and (ii) while the **Insured** remains **Totally Disabled** until the earlier of:

1. the day the **Total Disability** ends;
2. the date twelve (12) months after the date the **Group Policy** terminated; or
3. the day the person becomes covered under a replacement policy providing substantially equal or greater benefits which replaces coverage under the **Group Policy**.

Subject to the terms and conditions otherwise contained herein, Benefits shall be payable for Covered Expenses incurred by an **Insured** who is **Hospital Confined** on the date of termination, if the **Group Policy** is terminated and replaced by a group health insurance policy or contract issued by another insurer. **Benefits** are payable until the **Hospital Confinement** ends or **Hospital Benefits** under this contract have been exhausted, whichever is earlier.

E. CONTINUATION OF COVERAGE AND CERTIFICATE OF CONVERSION

A **Certificate Of Conversion Coverage**, whereby the coverage then afforded by this **Certificate** for an applicable **Insured** will continue without a requirement of any additional evidence of the insurability of such **Insured**, is available only:

1. for **Your** spouse who is covered under this **Certificate**, if his or her coverage ceases due to divorce, annulment or court approved separation;
2. for **Your** unmarried child(ren) who is covered under this **Certificate**, if his or her coverage ceases due to his or her reaching the limiting age of 19 (24 if enrolled as a **Full-Time Student**), or
3. for each applicable **Insured**, if coverage under this **Certificate** terminates because the **Group Policyholder** has terminated coverage under the **Group Policy**, and does not replace coverage with another group policy, in which case **You** will be given thirty (30) days prior written notice of the termination, mailed to **Your** last known address. Upon termination of the **Group Policy**, **You** may apply on behalf of all **Insureds** for a **Certificate Of Conversion Coverage**. The **Certificate Of Conversion Coverage** must be applied for and the first premium received by **Us** within thirty-one (31) days after the date that coverage under the **Group Policy** terminates. If a **Certificate Of Conversion Coverage** is issued, it will take effect on the day after coverage under the **Group Policy** terminates.

A **Certificate Of Conversion Coverage** is not available and will not be provided if:

1. an **Insured** has full coverage under any other group accident and health certificate or contract.
   a. to be full coverage the plan must provide benefits for all pre-existing conditions,
   b. an **Insured** may continue his or her previous group coverage until all pre-existing conditions are or would be covered under another group policy or contract or until termination;
2. an **Insured's** coverage under the **Group Policy** ceases because the **Group Policy** was terminated and was replaced by similar group coverage within thirty-one (31) days;
3. an **Insured's** coverage under this **Certificate** ceases because of failure to pay the required premiums in the time allowed;
5. an **Insured** is covered by similar benefits furnished by any:
   a. medical expense plan;
   b. medical service subscriber contract;
   c. medical pre-payment plan; or
   d. medical plan provided in accordance with the requirements of any state or federal law;
6. an **Insured** is eligible to be covered by any group plan, insured or uninsured:
   a. medical expense plan;
   b. medical service subscriber contract;

c. medical pre-payment plan; or
d. medical plan provided in accordance with the requirements of any state or federal law;

7. **We** were required by the order of an appropriate regulatory authority to non-renew or cancel the **Certificate** or **Group Policy**;
8. The total amount of **Benefit** payments made by **Us** are equal to the **Lifetime Certificate Maximum Per Insured**;
9. **We** cease offering and renewing coverage under the same form of coverage as this **Certificate** in **Your** state upon a minimum of ninety (90) days prior written notice mailed to **Your** last known address with an opportunity for **You** to convert to any similar medical expense policy or certificate that **We** are then actively marketing and offering to new applicants in **Your** state;
10. **We** elect to discontinue offering all similar types of coverage under any association group or individual medical-surgical expense policy forms in **Your** state and to terminate all such certificates of coverage and individual policies in **Your** state, including **Your** form of coverage, in which case the commissioner of insurance for **Your** state, the **Group Policyholder** and **You** will be given a minimum of one hundred eighty (180) days prior written notice of the termination, mailed to **Your** last known address;
11. **You** voluntarily terminated coverage under this **Certificate** for any **Insured** by notifying **Us** of the date **You** desired such coverage to terminate;
12. **We** received due proof that fraud or intentional misrepresentation of material fact existed in applying for this **Certificate** or in filing a claim for **Benefits** under this **Certificate**; or
13. The **Insured** is or could be covered by **Medicare**.

In order to be eligible for a **Certificate Of Conversion Coverage**, a written election of continuation of coverage via conversion must be made by the applicable **Insured**, on a form furnished by **Us**, and the first premium must be paid, in advance, to **Us** on or before the date on which the applicable coverage under this **Certificate** for such **Insured** would otherwise terminate. The amount of first premium required from the effective date through the end of the first renewal period of the **Certificate Of Conversion Coverage** shall not be more than **Our** full group premium rate then applicable for the applicable **Insured** under the **Certificate** with the same mode of payment. Applicable **Insureds** shall not be required to pay the **Renewal Premium** for a **Certificate Of Conversion Coverage** less often than monthly.

IV. PREMIUM

A. INITIAL PREMIUM

The **Initial Premium** specified on the **Certificate Schedule** is due and payable to the **Company** at its home office on or before the **Issue Date**. This **Initial Premium** payment will keep this **Certificate** in force until the **First Renewal Date**. The amount of the **Initial Premium** and the **First Renewal Date** are shown on the **Certificate Schedule**. **Initial Premium** has been determined by **Us** for this **Certificate** on a **Class** basis. **Your Class** for **Initial Premium** was determined by **Us** based upon several factors, including, among other things, a combination of the following: (i) **Your** zip code (either first 3 or first 5 digits); (ii) **Your** county of residence; (iii) **Your** state of residence; (iv) the number, age, sex and tobacco use of each **Insured** listed on the **Certificate Schedule**; (v) the plan of coverage contained in this **Certificate** on the **Issue Date**, including its deductibles, **Benefits**, limitations, and exclusions; (vi) the health status of each applicant, including the results of any required physical examination and laboratory test results; (vii) **Participating Provider** network selected on the application, (viii) the underwriting risk assessment of each **Insured**; (ix) the discounted or preferred premium rate status of any **Insured;** (x) premium rate ups, if any, for any **Insured**; (xi) **Mode Of Premium Payment** selected on the application; (xii) distribution channels; (xiii) administrative costs; (xiv) taxes; (xv) other economic factors; and/or (xvi) other certificates of coverage issued and to be issued by **Us** covering individuals in **Your** current state of residence with the same or similar factors described above.

B. RENEWAL PREMIUM

1. CALCULATION - PAYMENT

The current **Mode Of Premium Payment** is shown on the **Certificate Schedule**. **Renewal Premium** is payable on or before its due date, and must be paid to the **Company** at its home office. Any **Renewal Premium** not paid on or before its due date is a premium in default. If a **Renewal Premium** payment

default is not corrected and properly paid before the end of the grace period, coverage under this **Certificate** will terminate.

Renewal Premium rates for this **Certificate** may be increased by **Us** for any renewal period after the **Issue Date**, including during the **Premium Rate Guarantee Period**, if after the **Issue Date**:

a. **You** add **Insureds** to this **Certificate**;
b. **You** change the amount of the **Calendar Year Deductible** shown on the **Certificate Schedule**;
c. **You** change the **Insured Coinsurance Percentage** shown on the **Certificate Schedule**;
d. **You** change any other coverage option;
e. **You** change residence to a different zip code;
f. **You** change the **Mode Of Premium Payment**;
g. **You** add optional coverage riders, if any;
h. **You** change after the **Issue Date** to a different optional **Participating Provider** network available in **Your** state, if any;
i. a change occurs in the relationship between **Us** and **Your Participating Provider** network:
j. the **Participating Provider** network availability changes for Your state;
k. the **Participating Provider** negotiated discounts change; and/or
l. a change occurs in **Sickness and Injury Benefits**, [and/or] **Wellness and Screening Benefits**, [and/or the] [**Miscellaneous Benefits]** by amendatory endorsement pursuant to any federal or state law or regulation.

The current table of premium rates upon which the **Initial Premium** and the **First Renewal Premium** were calculated for this **Certificate** may include scheduled increases in the amount of **Renewal Premium** based upon the future attained age of each **Insured**. To be eligible for a discounted or preferred premium rate each **Insured** may be required to complete a preferred health risk assessment upon enrollment and at renewal. Additionally, the current table of premium rates upon which the **Initial Premium** and **First Renewal Premium** were calculated and any subsequent table of premium rates upon which the **Renewal Premium** for any renewal period is to be calculated may be changed from time to time by **Us**. Accordingly, after expiration of the **Premium Rate Guarantee Period**, the amount of **Renewal Premium** may be increased for any renewal period based upon items a. through i. above as well as the following:

a. a new attained age of any **Insured** reached prior to the first day of any renewal period,
b. change by **Us** in the table of premium rates used to calculate the **First Renewal Premium,** and
c. change by **Us** in the table of premium rates used to calculate **Renewal Premium** for any prior renewal period.

Any changes in the table of premium rates establishing the amount of required **Renewal Premium** during any renewal period will be implemented on a **Class** basis for all members of **Your Renewal Premium Class**. Factors that may be involved and considered by **Us** in determining the amount of **Renewal Premium** to be charged to **Your Renewal Premium Class** during any renewal period include, among other things, a combination of one or more of the following: (i) past claims experience of **Your Renewal Premium Class**; (ii) anticipated inflationary trends in the cost of future medical services; (iii) historical experience in the inflationary cost of medical services; (iv) anticipated inflationary trends in the cost of **Prescription Drugs**; (v) historical experience in the past inflationary cost of **Prescription Drugs**; (vi) anticipated future claims experience of **Your Renewal Premium Class**; (vii) other economic factors; (viii) anticipated advances in the medical diagnosis capabilities of injuries and illnesses, including the anticipated cost thereof; (ix) anticipated advances in the manner, method and delivery of medical care and treatment, including the anticipated cost thereof; and (x) any other reason permitted by applicable state law. **We** will tell **You** at least thirty (30) days in advance of the effective date of any **Renewal Premium** increase that occurs due to a change in the table of premium rates for **Renewal Premium**.

2. RENEWAL PREMIUM CHECK OR DRAFT NOT HONORED

Any premium payment made by a check or draft which is not honored at the bank upon which it is drawn shall be of no effect toward coverage under this **Certificate** unless and until valid restitution is made to **Us** within the time provided herein for making such premium payment.

3. GRACE PERIOD

Unless at least thirty-one (31) days prior to a **Renewal Premium** due date **We** have mailed to **You** written notice of **Our** intention not to renew this **Certificate** pursuant to the provisions of Section III. C. TERMINATION OF COVERAGE, a grace period of thirty-one (31) days from such due date is given for the late payment of the **Renewal Premium** due. If **You** make payment of the required **Renewal Premium** during such grace period, then this **Certificate** will remain in force for **Benefit** claims arising during such grace period. However, if the **Company** has received notification of **Your** intention to cancel any **Insured's** coverage under this **Certificate**, there is no grace period for the late payment of any **Renewal Premium** that would otherwise have been due for such **Insured** but for such cancellation.

4. REINSTATEMENT

If the **Renewal Premium** is not paid before the grace period ends, later acceptance of premium by **Us** (or by an agent authorized to accept payment) without requiring an application for reinstatement will reinstate this **Certificate** as of the date of acceptance of the late premium. If **We** require an application that will be fully underwritten by **Us**, **You** will be given a conditional receipt for the premium. If the application is approved after underwriting, this **Certificate** will be reinstated as of the approval date together with all back or past due premium permitted by applicable state law. Lacking such approval, this **Certificate** will be reinstated on the forty-fifth (45th) day after the date of the conditional receipt, unless **We** have previously notified **You**, in writing, of **Our** disapproval of the reinstatement.

The reinstated **Certificate** will cover only **Covered Expenses** that result from an **Injury** sustained after the date of reinstatement or from **Sickness** that begins more than ten (10) days after the date of reinstatement.

In all other respects **Your** rights and **Our** rights will remain the same subject to any provisions noted on or attached to the reinstated **Certificate**.

5. PREMIUM RATE GUARANTEE PERIOD

The amount of **Renewal Premium** with the same **Mode of Premium Payment** as the **Mode of Premium Payment** of the **Initial Premium** is guaranteed not to exceed [5%-20% annually][the amount of the **Initial Premium]** for each renewal period commencing prior to the expiration of the **Premium Rate Guarantee Period** as a result of any: (i) change in the table of premium rates used to calculate the **Initial Premium**; or (ii) increase in the attained age after the **Issue Date** of any **Insured** listed on the **Certificate Schedule**. The length of the **Premium Rate Guarantee Period** is shown on the **Certificate Schedule**. However, **Renewal Premium** rates may be increased by **Us** for any renewal period after the **Issue Date**, including during the **Premium Rate Guarantee Period**, if after the **Issue Date** (i) **You** either add or change coverage under this Certificate as provided in paragraphs a. through i. of the Calculation – Payment provision, or (ii) an amendatory endorsement is issued that changes any of the **Benefits** pursuant to any federal or state law or regulation

V. BENEFITS AND CLAIM PROCEDURES

Insureds have the right to obtain medical care from the **Provider** and **Hospital** of their choice[, as well as **Prescription Drugs** from a pharmacy of their choice]; however, all applicable **Benefit** payments by **Us** under this BENEFITS AND CLAIMS PROCEDURES Section of the **Certificate** are limited to the applicable **Company Insurance Percentage** of **Covered Expenses** incurred by an **Insured**. Coverage under this Section of the **Certificate** will be reduced for medical services, supplies, care or treatment obtained from a **Non-Participating Provider[**, as well as **Prescription Drugs** from a **Non-Participating Pharmacy]**. The difference between both the **Company Insurance Percentages** and the **Insured Coinsurance Percentages** for: (i) **Participating Providers** and **Non-Participating Providers**; [and (ii) **Participating Pharmacies** and **Non-Participating Pharmacies]** are shown in the **Certificate Schedule**. In addition, **We** shall never be required to make a payment for **Covered Expenses** incurred in excess of the amount of the **[Lifetime] Transplant Maximum [Per Organ] Per Insured** or the **Lifetime Certificate Maximum Per Insured**.

Covered Expenses incurred by an **Insured** for **Sickness and Injury Benefits** and **Wellness and Screening Benefits** are subject to the **Calendar Year Deductible,** the **Insured Coinsurance Percentage** and any applicable [**Co-Pays** and] **Access Fees,** unless otherwise specified.

A. SICKNESS AND INJURY BENEFITS

Subject to all applicable definitions, exclusions, limitations, non-waiver, waiting periods, and other provisions contained in this **Certificate**, as well as any riders, endorsements, or amendments attached to hereto, **We** promise to pay to or on behalf of each **Insured** the **Company Insurance Percentage** of the amount of professional fees and other applicable medical diagnostic or treatment expenses and charges that constitute **Covered Expenses** incurred by each **Insured** for the following described **Inpatient** and **Outpatient** services that are **Provided** as a result of **Sickness** or **Injuries**, but only after: (i) each applicable [**Co-Pay] [**and] **Access Fee** amount in this Section has been first satisfied and deducted from such **Covered Expenses** and applied to the applicable **Insured** for payment; (ii) each of the applicable deductibles has been first satisfied by deduction from such **Covered Expenses** and applied to the applicable **Insured** for payment; and (iii) the applicable **Insured Coinsurance Percentage** of the **Covered Expenses** remaining after satisfaction of all applicable deductibles is, likewise, satisfied by deduction from the remaining **Covered Expenses** and applied to the applicable **Insured** for payment:

1. INPATIENT HOSPITAL CONFINEMENT BENEFITS:

a. INPATIENT HOSPITAL CARE

The following services **Provided** by a **Hospital** or a **Provider** in connection with admission and **Confinement** of an **Insured** at the **Hospital** due to **Injuries** or **Sickness**:

1) **Hospital** - semi-private daily room and board [(if a semi-private room is not available, benefit will be limited to ninety (90) percent of the **Usual and Customary** private room rate)];

2) **Intensive Care Unit** of the **Hospital** - daily room and board (Note, daily room and board will be at the semi-private rate for admission to units or areas of the applicable **Hospital** which are step-down units from the **Intensive Care Unit**, including, sub-acute intensive care units, progressive care units, intermediate care units, private monitored rooms, observation units or other facilities not meeting the standards set forth in the definition of an **Intensive Care Unit**). [**Covered Expenses** incurred at a **Non-Participating Provider** will not exceed three times the **Usual and Customary** semi-private room charge of the **Hospital** and are limited to 30 continuous days of such **Confinement** for each type of **Confinement** during any one period of **Hospital Confinement**.;]

3) **Hospital** miscellaneous medications, **Prescription Drugs**, services and supplies - (Note, miscellaneous charges by a **Hospital** for personal convenience items, including but not limited to television, telephone, internet and radio are not considered **Covered Expenses**); and

4) **Provider** Visits – [(Note: limited [one (1)] **Provider** visit per treating **Provider** per day while the **Insured** is an **Inpatient** at a **Hospital**, and a maximum of [sixty (60)] **Provider** visits per **Hospital Confinement**.] **Sickness and Injury Benefits** are not payable for professional fees for visits at the **Hospital** following surgery by a Surgeon, Anesthesiologist or Nurse Anesthetist whose professional fees in connection with the surgery constitute **Covered Expenses**, unless the visit is to evaluate or treat an **Injury** or **Sickness** other than that which resulted in the **Insured's** covered surgery).

b. INPATIENT SURGERY

The following services **Provided** by a **Hospital** and **Providers** received by an **Insured** in connection with **Inpatient** surgery performed at the **Hospital** due to **Injuries** or **Sickness**:

1) Primary Surgeon;

2) Assistant Surgeon – (professional fees that constitute **Covered Expenses** will be considered for a **Sickness and Injury Benefit** payment for one assistant surgeon in connection with surgery for which **Sickness and Injury Benefits** are payable hereunder for the professional fees of the primary surgeon);

3) Anesthesiologist or Nurse Anesthetist – (professional fees that constitute **Covered Expenses** will be considered for a **Sickness and Injury Benefit** payment for either an anesthesiologist's or a nurse anesthetist's administration and monitoring of anesthesia administered during surgery for which **Sickness and Injury Benefits** are payable hereunder for the professional fees of the primary surgeon);

4) Pathologist Fees – (professional fees that constitute **Covered Expenses** will be considered for a **Sickness and Injury Benefit** payment for a pathologist's evaluation and/or interpretation of any tissue specimen removed during or in connection with such surgery); and

5) Second Surgical Opinion - Up to [$250] of professional fees for a second surgical opinion if:

a) the **Insured's Provider** determines that surgery is needed;

b) the surgery is not excluded from this **Certificate** or any riders, amendments or endorsements attached hereto;

c) the **Insured** is examined in person by another qualified **Provider** for the purpose of obtaining a second surgical opinion; and

d) the **Provider** issuing the second surgical opinion sends **Us** a written report.

However, **We** will not pay for the second surgical opinion if the **Provider** issuing the second surgical opinion performs or assists in the surgery.

c. BREAST RECONSTRUCTION

Services **Provided** by a **Hospital** and a **Provider** received by an **Insured** in connection with **Breast Reconstruction** performed at a **Hospital**.

d. INPATIENT THERAPY

Services **Provided** by a **Hospital** or a **Provider** in connection with the following types of therapy received by an **Insured** as an **Inpatient** at the **Hospital** due to **Injuries** or **Sickness**:

1) Radiation therapy;
2) Chemotherapy;
3) Occupational therapy;
4) Physical therapy and
5) Speech therapy.

[[Occupational,] [Physical] and [Speech] Therapy [are/is] limited to [[$50] per visit] [25] [visits] up to [$2,000] maximum per type of therapy per **Calendar Year** per **Insured**`] [This **Inpatient** therapy coverage does not include fees or expenses charged for spinal manipulations.]

e. INPATIENT LABORATORY AND DIAGNOSTIC TESTS

[Subject to **Laboratory and Diagnostic Testing Access Fee,** if applicable,**] [S][**s]ervices **Provided** by a **Hospital** or a **Provider** in connection with the performance and interpretation of laboratory and diagnostic tests received by an **Insured** as an **Inpatient** at the **Hospital** due to **Injuries** or **Sickness**

f. TRANSPLANTS

When generally accepted medical indications and standards for transplantation (including grafts) have been met and all assessments required by the treating institution are successfully completed, then services **Provided** by a **Hospital** and **Providers** in connection with the performance of **Solid Organ Transplants**, **Bone Marrow Transplants**, and/or **Stem Cell Transplants** that are received by an **Insured** are covered.

The maximum amount of **Covered Expenses** allowed for professional fees of a **Provider** and facility fees for the harvesting of applicable donor organs or donor bone marrow is [$5,000 to $50,000] per transplant, to the extent that any benefits hereunder remain and are available under the **Certificate** for the applicable **Insured** recipient. Any payment of donor expenses hereunder will be applied toward the satisfaction of the **[Lifetime] Transplant Maximum [Per Organ] Per Insured**.

[An **Insured** requiring a **Solid Organ Transplant**, **Bone Marrow Transplant**, and/or **Stem Cell Transplant** may elect to request participation in the **Centers of Excellence** program. To be considered for a **Centers of Excellence** transplant, an **Insured** must agree, in writing, to use **Centers of Excellence Providers** for all **Covered Expenses** related to a **Solid Organ Transplants**, **Bone Marrow Transplants**, and/or **Stem Cell Transplants**.

If a **Medically Necessary** transplant is performed in a designated **Center of Excellence**, **We** will **Provide Covered Expenses** for; (i) travel, (ii) food, and (iii) lodging, for a live donor, if applicable; and the **Insured** and one companion, or if the **Insured** is a dependent child, two parents. The maximum **Covered Expenses** allowed for (i) travel, (ii) food and (iii) lodging is [$5,000] per covered transplant.

If an **Insured** elects to use a **Center of Excellence**, approved by **Us**, for the transplant services, the **[Lifetime] Transplant Maximum [Per Organ] Per Insured** is increased to [$500,000 - $1,000,000].] [If the **Insured** elects to use a **Provider** that is not a **Center Of Excellence** the **[Lifetime] Transplant Maximum [Per Organ] Per Insured** is reduced to [$100,000 - $500,000]]

However, the amount of **Benefits** hereunder will be reduced by fifty (50%) percent for any **Solid Organ Transplants**, **Bone Marrow Transplants**, and **Stem Cell Transplants** received that were not reviewed by **Us** prior to transplantation evaluation, testing or donor search. In addition, the following items/procedures are not covered under this **Certificate**:

1) any non-human (including animal or mechanical) **Solid Organ Transplant**,
2) transplants approved for a specific medical condition, but applied to another condition,
3) the purchase price of any organ, tissue, blood, bone marrow, cells, or stem cells that are sold and not donated,
4) any donor charge or donor expense incurred that does not constitute **Covered Expenses** allowed for professional fees and facility fees incurred in connection with the harvesting of applicable donor organs or donor bone marrow, and
5) any transplantation (including grafts) that does not constitute **Solid Organ Transplants**, **Bone Marrow Transplants**, and/or **Stem Cell Transplants**.

[2. FOREIGN TRAVEL BENEFIT

Services for **Covered Expenses** incurred for **Medically Necessary Emergency Hospital**, **Provider** and medical care that an **Insured** receives outside the United States during the first [60] consecutive days of each trip up to a lifetime maximum **Benefit** of [$50,000 to $250,000].]

[3.] EMERGENCY ROOM AND OTHER OUTPATIENT BENEFITS:

a. EMERGENCY ROOM SERVICES

[Subject to the **Emergency Room Access Fee]**, [S][s]ervices **Provided** by a **Hospital** or a **Provider** in the emergency room of the **Hospital** for the following items received by an **Insured** on an **Emergency** basis:

1) Emergency room services and supplies;
2) **Provider** services for surgery in the emergency room of the **Hospital**, if **We** are notified of such surgery within seventy-two (72) hours after such surgical procedure has been performed, or as soon thereafter as reasonably possible;
3) X-ray and laboratory examinations;
4) **Prescription Drugs** administered prior to discharge from the emergency room;
5) [[Surgical dressings], [casts,] [splints,] [trusses,] [braces] [and] [crutches] received prior to discharge from the emergency room]; [and]
6) Services of a registered nurse (R.N.) in the emergency room of a **Hospital**.

The **Emergency Room Access Fee** will be waived if an Insured [is confined in a Hospital within [twenty-four (24) hours of the Emergency Room visit].[admitted directly from the emergency room into the Hospital as an Inpatient] .]

b. OUTPATIENT TREATMENT OF ACCIDENTAL INJURIES

Services **Provided** by a **Hospital**, [or] an **Emergency Care Facility** [or a **Provider]** in connection with the **Outpatient** treatment of **Injuries** received by an **Insured**. Services **Provided** by a **Hospital** or a **Provider** in the emergency room of the **Hospital** are subject to the **Emergency Room Access Fee**.

c. EMERGENCY TRANSPORTATION TO HOSPITAL BY AMBULANCE

Services **Provided** in connection with transportation of an **Insured** by either local ground ambulance or local air ambulance [(air ambulance is limited to [$1,000 to $10 ,000] per occurrence)] to the nearest **Hospital** that is appropriately staffed, equipped, available and suitable for the **Emergency** diagnosis, care and treatment of an **Insured's Injury** or **Sickness**. However, expenses charged for transportation to a **Hospital** by air ambulance are not payable or otherwise considered a **Sickness and Injury Benefit**, if such **Insured's** medical condition was not sufficiently acute or severe upon arrival at the **Hospital** to result in an **Inpatient** admission and **Confinement** in the **Hospital** immediately following the **Insured's** evaluation and treatment in the emergency room of such **Hospital.**

d. OUTPATIENT SURGERY AT A HOSPITAL OR AN AMBULATORY SURGICAL CENTER

The following services **Provided** by a **Hospital** or **Ambulatory Surgical Center** and **Providers** in connection with surgery performed on an **Insured** on an **Outpatient** basis:

1) **Hospital** or **Ambulatory Surgical Center** – (expenses that constitute **Covered Expenses** will be considered for **Sickness and Injury Benefit** payment for the pre-operation, operation and recovery rooms, as well as for medications, **Prescription Drugs**, and other miscellaneous items, services and supplies; provided that miscellaneous charges for any personal convenience items, including but not limited to television, telephone, and radio are not considered **Covered Expenses**);
2) Primary Surgeon;
3) Assistant Surgeon – (professional fees that constitute **Covered Expenses** will be considered for a **Sickness and Injury Benefit** payment for one assistant surgeon in connection with surgery for which **Sickness and Injury Benefits** are payable hereunder for the professional fees of the primary surgeon);
4) Anesthesiologist or Nurse Anesthetist – (professional fees that constitute **Covered Expenses** will be considered for a **Sickness and Injury Benefit** payment for either an anesthesiologist or a nurse anesthetist administration and monitoring of anesthesia, during surgery for which **Sickness and Injury Benefits** are payable hereunder for the professional fees of the primary surgeon);
5) Pathologist – (professional Fees that constitute **Covered Expenses** will be considered for a **Sickness and Injury Benefit** payment for a pathologist's evaluation and/or interpretation of any tissue specimen removed during or in connection with such surgery); and
6) Second Surgical Opinion - Up to [$250] of professional fees for a second surgical opinion if:
   a) the **Insured's Provider** determines that surgery is needed;
   b) the surgery is not excluded from this **Certificate** or any riders, amendments or endorsements attached hereto;
   c) the **Insured** is examined in person by another qualified **Provider** for the purpose of obtaining a second surgical opinion; and
   d) the **Provider** issuing the second surgical opinion sends **Us** a written report.

However, **We** will not pay for the second surgical opinion if the **Provider** issuing the second surgical opinion performs or assists in the surgery.

[e. OUTPATIENT PROVIDER OFFICE VISITS

Professional services **Provided** by a **Provider** during a **Medically Necessary** visit to the professional offices of such **Provider** for the purposes of evaluation, diagnosis and treatment of **Injuries** or **Sickness**. **]**

[f. [OUTPATIENT PRESCRIPTIONS

[Subject to the applicable] [**Calendar Year Deductible**][**Insured Coinsurance Percentage]**] [**Prescription Drug Co-Pay**][**Prescription Drug Calendar Year Deductible Per Insured**][**Prescription Drug Insured Coinsurance Percentage**] **We** will pay **Covered Expenses** incurred by an **Insured** for **Prescription Drugs** filled at a **Participating Pharmacy. [We** will pay, to or on behalf of the **Insured**, the **Covered Expenses** but not to exceed the **Calendar Year Maximum Per Insured For Prescription Drugs** as shown on the **Certificate Schedule**.] [If the charge for the **Prescription Drug** is less than the **Prescription Drug Co-pay** and/or [**Prescription Drug Insured Coinsurance Percentage]** [**Insured Coinsurance Percentage]**] shown on the **Certificate Schedule**, the **Insured** will be responsible for the full cost of the medication.] [If the **Insured's Provider** has not specified that a **Preferred Brand Drug** be used rather than a **Generic Drug,** but the **Insured** selects a **Preferred Brand Drug**, the **Insured** will pay the applicable [**Prescription Drug Co-pay]** [and/or] [**Prescription Drug Insured Coinsurance Percentage]** [**Insured Coinsurance Percentage]**], plus the difference in price between the **Generic Drug** and **Preferred Brand Drug.]** [**Covered Expenses** for such **Prescriptions** shall not exceed, the amount of the cost of the least expensive drug, medicine or **Prescription Drug** that may be used to treat the **Insured's Sickness** or **Injury**, all in accordance with the following schedule:

a. If a **Generic Drug** is available at the **Participating Pharmacy** selected by the **Insured** that may be taken by such **Insured** in substitute for either a **Brand Name Drug** or a **Preferred Brand Drug** that was prescribed for the **Insured**, the amount of **Covered Expenses** for such **Prescription** shall be limited to the cost of such **Generic Drug** at such pharmacy;

b. If a **Preferred Brand Drug** is available at the **Participating Pharmacy** selected by the **Insured** that may be taken by such **Insured** in substitute for a **Brand Name Drug** that was prescribed for the **Insured**, the amount of **Covered Expenses** for such **Prescription** shall be limited to the cost of the **Preferred Brand Drug** at such pharmacy; and

c. If both a **Generic Drug** and a **Preferred Brand Drug** are available at the **Participating Pharmacy** selected by the **Insured** that may be taken by such **Insured** in substitute for a **Brand Name Drug** that was prescribed for the **Insured**, the amount of **Covered Expenses** for such **Prescription** shall be limited to the cost of such **Generic Drug** at the pharmacy.]

[The **Prescription Drug Co-Pay** made to **Participating Pharmacies** may not be used to satisfy the [**Prescription Drug Calendar Year Deductible per Insured]**, [**Prescription Drug Insured Coinsurance Percentage],** [C**alendar Year Deductible]**, [the **Insured Coinsurance Percentage]**, the **Separate Deductible for Non-Participating Providers**, [the **Access Fees**] and the [**Failure to Pre-certify Treatment Deductible**.]

If **Prescription Drugs** are purchased by an **Insured** from a **Non-Participating Pharmacy**, then the amount of **Covered Expenses** for the purposes of calculating a benefit payment hereunder shall be limited to the amount of **Covered Expenses** that would have been incurred by such **Insured** if the **Prescription Drugs** had been purchased at a **Participating Pharmacy** instead of the **Non-Participating Pharmacy**.**]**

[g.] OUTPATIENT LABORATORY AND DIAGNOSTIC TESTS

[Subject to **Laboratory and Diagnostic Testing Access Fee**, if applicable,][S][s]ervices **Provided** by a **[Provider]**, **Hospital**, or other medical facility in connection with the performance and interpretation of laboratory and diagnostic tests received on an **Outpatient** basis by an **Insured** due to **Injuries** or **Sickness**.

[h.] OUTPATIENT THERAPY

[Subject to the **Outpatient Therapy Access Fee**] [S][s]ervices **Provided** by [**Providers**,] a **Hospital**, or other medical facility in connection with the following types of therapy received on an **Outpatient** basis by an **Insured** due to **Injuries** or **Sickness**:

1. Radiation therapy;

2. Chemotherapy;
3. Occupational therapy;
4. Physical therapy;
5. Rehabilitation therapy; and
6. Speech therapy.

[[Occupational,] [Physical] [and] [Speech] Therapy [are/is] limited to [[$50] per visit] [25] [visits] up to [$2,000] maximum [per type of therapy] per **Calendar Year** per **Insured**`] [This **Outpatient** therapy **Benefit** does not include fees or expenses charged for spinal manipulations.]

[i.] HOME HEALTH CARE

Services **Provided** to an **Insured** due to **Injuries** or **Sickness** for the care specified in a **Home Health Care Plan**, up to a **Covered Expense** maximum per day of 50% of the amount of the semi-private room rate of either (i) the **Hospital** where such **Insured** was **Confined** prior to the development of the **Home Health Care Plan**, or (ii) the **Skilled Nursing Home** where such **Insured** was a resident immediately prior to the development of the **Home Health Care Plan**. Such expenses incurred by an **Insured** as the result of a **Home Health Care Plan** are payable for an **Insured**, if:

1) The **Insured** had first been **Confined** in a **Hospital** or was a resident at a **Skilled Nursing Home** due to an **Injury** or **Sickness**;
2) The **Home Health Care Plan** of the **Insured** begins no later than thirty (30) days after discharge from the **Hospital** or **Skilled Nursing Home**; and
3) The **Home Health Care Plan** is for the same or related **Injury** or **Sickness** as the **Hospital** or **Skilled Nursing Home Confinement**.

A **Provider** must certify that the **Insured** would have to be in a **Hospital** or **Skilled Nursing Home** (and receive a level of care greater than **Custodial Care**) if **Home Health Care Plan** services had not been available.

Payment under this coverage is limited to a period of a maximum of [40-120] days during a twelve (12) consecutive month period.

[j.] HOSPICE CARE

Services **Provided** to an **Insured** for **Hospice Care** due to **Injuries** or **Sickness**, if:

1) such **Hospice Care** is provided as the result of **Injury** or **Sickness** for which **Covered Expenses** were incurred by such **Insured** for **Hospital Confinement**;
2) the **Insured's Provider** certifies the life expectancy of the **Insured** is six (6) months or less; and
3) the **Insured's Provider** recommends a **Hospice Care** program.

Payment under this coverage is limited to a period of a maximum of six (6) consecutive months.

[k.] MEDICAL EQUIPMENT AND SUPPLIES

Medical Equipment and supplies **Provided** to an **Insured** as a result of **Injury** or **Sickness** which are **Covered Expenses** includes:

1) Blood, plasma, and derivatives, if not replaced;
2) Initial replacement of natural limbs and eyes when loss occurs while this **Certificate** is in force;
3) Initial permanent lens immediately following cataract surgery, except the replacements will not be covered;
4) [Casts,] [non-dental splints,] [trusses,] [crutches] [and] [braces (except dental or orthodontic braces);]
5) Rental (not to exceed the purchase price) of a wheelchair, hospital bed, or other durable portable medical equipment **Provided** to an **Insured** in each event required for therapeutic treatment of **Injuries** or **Sickness** on an **Outpatient** basis; and
6) oxygen and its administration.

[l.] SKILLED NURSING HOME

Daily room and board and miscellaneous charges for other services **Provided** to an **Insured** due to **Injuries** or **Sickness** for residential care received in a **Skilled Nursing Home** for up to a maximum of [60-120] days in a twelve (12) month period, if:

1) the **Insured** has first been **Confined** in a **Hospital** for three (3) or more consecutive days;
2) the **Skilled Nursing Home** stay begins within thirty (30) days after discharge from the **Hospital**;
3) the **Skilled Nursing Home** stay is for the same or related **Injury** or **Sickness** as the **Hospital Confinement**; and
4) the **Insured's Provider** certifies the need for **Skilled Nursing Home Confinement**.

[m.] SUPPLIES AND SERVICES ASSOCIATED WITH THE TREATMENT OF DIABETES

The following **Outpatient** services **Provided** to an **Insured** for care received during for the treatment of diabetes and associated conditions:

1) **Diabetes Equipment**;
2) **Diabetes Supplies**; and
3) **Diabetes Self-Management Training**.

[n.] INHERITED METABOLIC DISORDERS

Benefits include **Covered Expenses** for **Medical Foods** prescribed or ordered under the supervision of a **Provider**, as **Medically Necessary** for the therapeutic treatment of an **Inherited Metabolic Disorder**. This **Benefit** is limited to a maximum of [$5,000] in a twelve (12) month period.

[o.] PROSTHETIC AND ORTHOTIC DEVICE BENEFIT

Benefits include **Covered Expenses** for **Medically Necessary** services and supplies for the effective use of a **Prosthetic** or **Orthotic Device**, including formulating its design, fabrication, material and component selection, measurements, fittings, static and dynamic alignments, and instructing the patient in the use of the device. The repair and replacement of a **Prosthetic** or **Orthotic Device** will be considered a covered **Benefit** unless necessitated by misuse or loss.

[p]. NEWBORN CARE

Benefits include, **Covered Expenses** for the care and treatment of **Your**, or **Your Spouse's** newborn child or newborn adoptee including care for **Injury**, **Sickness**, congenital defects, birth abnormalities, premature birth, tests for hypothyroidism, phenylketonuria, galactosemia, and in the case of non-Caucasian newborn infants, tests for sickle-cell anemia. Additionally, **Benefits** include **Covered Expenses** for well-baby care up to five (5) 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.

[p]. IMPAIRMENT OF SPEECH OR HEARING

Benefits include **Covered Expenses** for the care and treatment of loss or impairment of speech or hearing. Loss or impairment of speech or hearing shall include those communicative disorders generally treated by a licensed pathologist or audiologists. **Benefits** for the care and treatment of loss or impairment of speech or hearing shall not include hearing instruments or devices.

[q]. GENERAL ANESTHESIA FOR DENTAL PROCEDURES

Benefits include **Covered Expenses** incurred for general anesthesia and related hospitalization services for dental care if the **Provider** treating the **Insured** certifies that because of **the Insured's** age or condition or problem, hospitalization or general anesthesia is required to safely and effectively perform the procedures and the **Insured**:

1. is 6 years of age or younger, and is determined by two (2) dentists, licensed under the Arkansas Dental Practices Act §§ 17-82-101 et seq, to require **Medically Necessary** dental treatment in a **Hospital** or **Ambulatory Surgical Center** due to a significantly complex dental condition,
2. is a person with a diagnosed serious mental or physical condition; or
3. is a person with a significant behavioral problem as determined by the **Insured's** Provider as licensed under the Arkansas Medical Practices Act, §§17-95-201 et seq., and 17-95-401 et seq.

Covered Expenses do not include dental care benefits which may require general anesthesia in a **Hospital** or **Ambulatory Surgical Center**.

[r. STERILIZATION

[Commencing after the first anniversary of the **Issue Date]**, **Benefits** will be paid for **Covered Expenses** incurred for sterilization not to exceed a maximum lifetime **Benefit** of [$500 to $2,000] per **Insured**.]

[**s. ALLERGIES**

Benefits will be paid for **Covered Expenses** incurred for allergy testing and allergy injections, including, but not limit to, injectable antigens, and extracts, not to exceed a maximum of [$250 to $1,000] of **Covered Expense** per **Insured** per **Calendar Year.]**

[t. TREATMENT OF SLEEP APNEA

Benefits will be paid for **Covered Expenses** incurred for the treatment of sleep apnea, including, but not limited to: sleep study, durable medical equipment (CPAP or BiPAP), and surgery not to exceed a lifetime maximum of [$1,000 to $5,000] per **Insured**.]

[u. GROWTH DISORDERS

Benefits will be paid for **Covered Expenses** incurred for the treatment of a growth disorder or abnormally short stature, including, but not limited to, growth hormone deficiency therapy (GHDT) not to exceed a maximum lifetime **Benefit** of [$10,000 to $25,000] of **Covered Expenses** for each **Insured** child.]

[**v. SPINAL MANIPULATION**

Benefits will be paid for **Covered Expenses** incurred for spinal manipulation, including, but not limited to, manipulation for spinal subluxation and any associated treatment or services not to exceed a covered expense maximum of : (i) [$25 to $100] per day of treatment (does not include x-rays); and (ii) [$250 to $1,000] of **Covered Expense** per **Calendar Year** per **Insured,** for all treatments and x-rays**.]**

[w. BREAST IMPLANT REMOVAL

Benefits will be paid for **Covered Expenses** incurred for breast implant removal for the **Medically Necessary** treatment of a covered **Sickness** or **Injury**.]

B. [WELLNESS][AND][SCREENING BENEFITS]

[Subject to all applicable definitions, exclusions, limitations, waiting periods, and other provisions contained in this **Certificate**, as well as any riders, endorsements, or amendments attached to hereto, **We** promise to pay to or on behalf of each **Insured** the **Company Insurance Percentage** of the amount of professional fees and other applicable medical diagnostic or treatment expenses and charges that constitute **Covered Expenses** incurred by each **Insured** for the following described **[Wellness and Screening Benefit]** services, but only after (i) each of the applicable deductible has been first satisfied by deduction from such **Covered Expenses** and applied to the applicable **Insured** for payment, and (ii) the applicable **Insured Coinsurance Percentage** of

the **Covered Expenses** remaining after satisfaction of all applicable deductibles is, likewise, satisfied by deduction from the remaining **Covered Expenses** and applied to the applicable **Insured** for payment:]

[ANNUAL PHYSICAL EXAM][AND] SCREENING TESTS]:

[[a].ADULT WELLNESS AND PREVENTIVE CARE

[Commencing [twelve (12)] to [twenty-four (24)] months after the **Issue Date]** [S][s]ervices **Provided** to **You** and **Your Spouse** (if such spouse is listed as an **Other Insured**) for necessary **Adult Wellness Preventive Care** by a **Participating Provider** no more than [once] every [twelve (12) months][.] [up to] [the] [a] [[**Calendar Year]** [**Adult Wellness Maximum]]** [payment] [stated on the Certificate Schedule] [by **Us]** [of $50 to $250] [per adult **Insured** per **Calendar Year]**.

Adult Wellness Preventive Care does not include charges[(i)] by **Participating Providers** for COLORECTAL CANCER SCREENING, PROSTATE CANCER SCREENING, MAMMOGRAPHY SCREENING, PAP SMEAR SCREENING**,** any spinal manipulations, physical therapy, occupational therapy, or other **Outpatient** therapy or treatment, or any form of medical or surgical treatment of an **Injury** or **Sickness**[; or (ii) any service, care, test or treatment by a **Non-Participating Provider**.]]

[[b]. COLORECTAL CANCER SCREENING

[Commencing [twelve (12)] to [twenty-four (24)] months after the **Issue Date**] **[B][b]enefits** include **Covered Expenses** incurred by an **Insured** for colorectal cancer screening for a **Insured** who is fifty (50) years of age or older and at normal risk for developing colon cancer or has attained at least 30 years of age and has a history of, or a first degree family member with colorectal cancer, as follows:

1) a fecal occult blood test performed annually; and
2) a flexible sigmoidoscopy performed every five (5) years or a colonoscopy performed every ten (10) years.]

[d]. MAMMOGRAPHY SCREENING

[Commencing [twelve (12)] to [twenty-four (24)] [S][s]ervices **Provided** for screening by low dose **Mammogram** to detect the presence of occult breast cancer, as follows:

1) A single baseline **Mammogram** for female **Insureds** 35 to 39 years of age;
2) One **Mammogram** every two (2) years for female **Insureds** 40 to 49 years of age; and
3) An annual **Mammogram** for each female **Insured** 50 years of age or older.

[e.] PAP SMEAR SCREENING

[Commencing [twelve (12)] to [twenty-four (24)] months after the **Issue Date]** [S][s]ervices **Provided** for an annual Pap Smear **Provided** to female **Insureds**, including the examination by a **Provider**, the laboratory fee, and the **Provider**'**s** interpretation of the laboratory results.

[C. MISCELLANEOUS BENEFITS

Miscellaneous Benefits are [not] subject to [either] [the [**Calendar Year Deductible]** [or] [and] [the **Insured Coinsurance Percentage**,] [but are subject to any applicable **Co-Pays**.] Therefore, subject to all applicable definitions, exclusions, limitations, waiting periods, and other provisions contained in this **Certificate**, as well as any riders, endorsements, or amendments attached to hereto, [including applicable **Co-Pays**,] **We** promise to pay to or on behalf of each **Insured** the **Company Insurance Percentage** of the amount of professional fees and other applicable medical diagnostic or treatment expenses and charges that constitute **Covered Expenses** incurred by each applicable **Insured** for the following described **Miscellaneous Benefits**:

[1]. [ADULT WELLNESS AND PREVENTIVE CARE

[Commencing [twelve (12)] to [twenty-four (24)] months after the **Issue Date]** [S][s]ervices **Provided** to **You** and **Your Spouse** (if such spouse is listed as an **Other Insured**) for necessary **Adult Wellness Preventive Care** by a **Participating Provider** no more than [once] every [twelve (12) months][.] [up to]

[the] [a] [[**Calendar Year]** [**Adult Wellness Maximum]]** [payment] [stated on the Certificate Schedule] [by **Us]** [of $50 to $250] [per adult **Insured** per **Calendar Year]**.

Adult Wellness Preventive Care does not include charges [(i)] by **Participating Providers** for COLORECTAL CANCER SCREENING, PROSTATE CANCER SCREENING, MAMMOGRAPHY SCREENING, PAP SMEAR SCREENING**,** any spinal manipulations, physical therapy, occupational therapy, or other **Outpatient** therapy or treatment, or any form of medical or surgical treatment of an **Injury** or **Sickness** [; or (ii) any service, care, test or treatment by a **Non-Participating Provider**.]]

[2]. [PROSTATE CANCER SCREENING BENEFIT

Benefits include the following **Covered Expenses** incurred by male **Insureds** during a medically recognized diagnostic examination for the detection of prostate cancer. This **Benefit** shall include an annual physical examination for the detection of prostate cancer, and an prostate-specific antigen test used for the detection of prostate cancer for each male **Insured** who is at least forty (40) years of age or older.

The prostate cancer screening must be performed by a **Provider**, and shall consist of a prostate specific antigen blood test and a digital rectal examination.

The prostate cancer screening is not subject to any plan deductibles and shall not exceed the actual cost of the prostate cancer screening.] [Will appear after 1/1/2010.]

[2]. [CHILDHOOD WELLNESS AND PREVENTIVE CARE

Services **Provided** to each **Insured** under the age of [19 (or 24 if a **Full-Time Student**)] for necessary **Childhood Wellness Preventive Care** up to a **Calendar Year** maximum payment by **Us** of [$100 to $500] per person per **Calendar Year**.]

Benefits include **Covered Expenses** for a child **Insured** for **Periodic Preventive Care Visits** to include twenty (20) visits at approximately the following age intervals: birth, 2 weeks, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years, 5 years, 6 years, 8 years, 10 years, 12 years, 14 years, 16 years, and 18 years. Services rendered during a periodic review shall only be covered to the extent that those services are **Provided** by or under the supervision of a single **Provider** during the course of one visit.

[Childhood Wellness Preventive Care does not include charges (i) by **Providers** for any spinal manipulations, physical therapy, occupational therapy, or other **Outpatient** therapy or treatment, or any form of medical or surgical treatment of an **Injury** or **Sickness**.

3. [CHILDHOOD IMMUNIZATIONS]

Services **Provided** for the following routine childhood immunizations **Provided** to each **Insured** under the age of 19: poliomyelitis, rubella, rubeola, mumps, tetanus, pertussis, diphtheria, hepatitis B, Haemophilus influenza type b (Hib) and varicella. Childhood immunizations are not subject to any deductibles, coinsurance or [**Co-Pays.]**

[4]. [VISITS TO PARTICIPATING PROVIDERS OFFICE

a. Doctor Office Visits Co-Pay

Subject to the **Doctor Office Visit Co-Pay** for **Outpatient** visits to the professional offices of a physician who is a **Participating Provider**, **We** will pay the remaining amount of **Covered Expenses** incurred for professional services **Provided** by the **Participating Provider** during each visit for **Medically Necessary** physical examinations, diagnosis [,][and] development of a treatment plan, [laboratory, x-ray or other diagnostic tests] [performed during such visit at such professional offices] for **Sickness** and **Injury**. [**Covered Expenses** incurred for all services under this section are limited to [$1,200] per **Calendar Year** per **Insured**.]

[b. X-Ray Laboratory and Diagnostic Testing Co-Pay

After satisfaction of the **Doctor Office Visit Co-Pay** and the satisfaction of the **X-Ray, Laboratory and Diagnostic Testing Co-Pay We** will pay the remaining amount of **Covered Expenses** incurred during [the first [two (2)]] [an] **Outpatient** office visit at a **Participating Provider** per **Insured** per **Calendar Year** for laboratory, x-ray or other diagnostic tests performed during any such visit at such professional offices.[up to a maximum **Benefit** of [$50-$2,000][per **Insured** per **Calendar Year**.]]

However, the following limitations apply to this VISIT TO PARTICIPATING PROVIDER OFFICE coverage:

[a.] [Covered Expenses incurred by an **Insured** for any **Outpatient** therapy or treatment **Provided** for any **Injury** or **Sickness** during any visit to the professional offices of such **Participating Provider** are subject to satisfaction of (i) the **Calendar Year Deductible**, and (ii) the **Insured Coinsurance Percentage**;]

[b.] [Covered Expenses incurred by an **Insured** for any **Outpatient** diagnostic testing and laboratory services **Provided** at a location other than the professional offices of such **Participating Provider** are subject to satisfaction of (i) **Laboratory and Diagnostic Testing Access Fee**, and (ii) the **Calendar Year Deductible**, and(iii) the **Insured Coinsurance Percentage**;]

[c.] [Covered Expenses incurred by an **Insured** for any **Outpatient** surgery **Provided** during any visit to the professional offices of such **Participating Provider** are subject to satisfaction of (i) the **Calendar Year Deductible**, (ii) the **Insured Coinsurance Percentage**;]

[d.] [Covered Expenses incurred by an **Insured** for professional services **Provided** during any **Outpatient** office visit to the professional offices of a **Participating Provider** in excess of [$0 - $1,200] [two (2) visits] per **Calendar Year** are subject to satisfaction of (i) the **Calendar Year Deductible**, and (ii) the **Insured Coinsurance Percentage**;]

[e.] [Covered Expenses incurred by an **Insured** for any type of service provided during any visit to the professional offices of such **Non-Participating Provider** are subject to satisfaction of (i) the **Calendar Year Deductible**, (ii) the **Separate Deductible for Non-Participating Providers**, and (iii) the applicable **Insured Coinsurance Percentage** for **Non-Participating Providers**; and]

[f.] [Covered Expenses incurred by an **Insured** under any other provision or limitation such as [ADULT WELLNESS, [CHILDHOOD WELLNESS,] [CHILDHOOD IMMUNIZATIONS,] [TREATMENT FOR ALLERGIES,] [SPINAL MANIPULATION,] [OCCUPATION,] [SPEECH] [OR PHYSICAL THERAPY,] [COLORECTAL CANCER SCREENING,] [PROSTATE CANCER SCREENING,] [MAMMOGRAPHY SCREENING,] [and] [or] [PAP SMEAR SCREENING] are not considered **Covered Expenses** under this section.]

[5. [OUTPATIENT PRESCRIPTIONS

[Subject to the applicable] [**Calendar Year Deductible**][**Insured Coinsurance Percentage]**] [**Prescription Drug Co-Pay**][**Prescription Drug Calendar Year Deductible Per Insured**][**Prescription Drug Insured Coinsurance Percentage**] **We** will pay **Covered Expenses** incurred by an **Insured** for **Prescription Drugs** filled at a **Participating Pharmacy. [We** will pay, to or on behalf of the **Insured**, the **Covered Expenses** but not to exceed the **Calendar Year Maximum Per Insured For Prescription Drugs** as shown on the **Certificate Schedule**.] [If the charge for the **Prescription Drug** is less than the **Prescription Drug Co-pay** and/or [**Prescription Drug Insured Coinsurance Percentage]** [**Insured Coinsurance Percentage]]** shown on the **Certificate Schedule**, the **Insured** will be responsible for the full cost of the medication.] [If the **Insured's Provider** has not specified that a **Brand Name Drug** be used rather than a **Generic Drug,** but the **Insured** selects a **Brand Name Drug**, the **Insured** will pay the applicable [**Prescription Drug Co-pay]** [and/or] [**Prescription Drug Insured Coinsurance Percentage]** [**Insured Coinsurance Percentage]]**, plus the difference in price between the **Generic Drug** and **Brand Name Drug.]** [**Covered Expenses** for such **Prescriptions** shall not exceed, the amount of the cost of the least expensive drug, medicine or **Prescription Drug** that may be used to treat the **Insured's Sickness** or **Injury**, all in accordance with the following schedule:

a. If a **Generic Drug** is available at the **Participating Pharmacy** selected by the **Insured** that may be taken by such **Insured** in substitute for either a **Brand Name Drug** or a **Preferred Brand Drug** that was prescribed for the **Insured**, the amount of **Covered Expenses** for such **Prescription** shall be limited to the cost of such **Generic Drug** at such pharmacy;

b. If a **Preferred Brand Drug** is available at the **Participating Pharmacy** selected by the **Insured** that may be taken by such **Insured** in substitute for a **Brand Name Drug** that was prescribed for the **Insured**, the amount of **Covered Expenses** for such **Prescription** shall be limited to the cost of the **Preferred Brand Drug** at such pharmacy; and
c. If both a **Generic Drug** and a **Preferred Brand Drug** are available at the **Participating Pharmacy** selected by the **Insured** that may be taken by such **Insured** in substitute for a **Brand Name Drug** that was prescribed for the **Insured**, the amount of **Covered Expenses** for such **Prescription** shall be limited to the cost of such **Generic Drug** at the pharmacy.]

[The **Prescription Drug Co-Pay** made to **Participating Pharmacies** may not be used to satisfy the [**Prescription Drug Calendar Year Deductible** per **Insured]**, [**Prescription Drug Insured Coinsurance Percentage],** [**Calendar Year Deductible]**, [the **Insured Coinsurance Percentage]**, the **Separate Deductible for Non-Participating Providers**, [the **Access Fees**] and the [**Failure to Pre-certify Treatment Deductible**.]

If **Prescription Drugs** are purchased by an **Insured** from a **Non-Participating Pharmacy**, then the amount of **Covered Expenses** for the purposes of calculating a benefit payment hereunder shall be limited to the amount of **Covered Expenses** that would have been incurred by such **Insured** if the **Prescription Drugs** had been purchased at a **Participating Pharmacy** instead of the **Non-Participating Pharmacy**.**]**

D. PRE-CERTIFICATION OF TREATMENT

If an **Insured** notifies and obtains from **Us** a certification that **Covered Expenses** are to be incurred due to a **Medically Necessary Hospital Confinement** or surgery, **We** will provide the **Sickness and Injury Benefits** for **Covered Expenses** as specified under the terms and provisions of this **Certificate** and any riders, amendments, or endorsements attached hereto.

Certification must be obtained prior to all **Inpatient** admissions, except in the case of an **Emergency** admission. In the event of an **Emergency Inpatient** admission, the **Insured** or his or her **Provider** must notify **Us** within seventy-two (72) hours of **Confinement**, or as soon thereafter as reasonably possible.

At the time notification of surgery is made, **We** will inform the **Insured** and his or her **Provider** if a second surgical opinion is required, at the expense of the **Company**, before certification will be given and will assign a length of stay if it is determined that **Inpatient Hospital** care is **Medically Necessary**. **We** may extend the length of stay upon the request of the **Insured** or **Provider** if **We** determine an extension is **Medically Necessary**. No **Sickness and Injury Benefits** will be provided under this **Certificate** for expenses that are determined not **Medically Necessary**.

Treatment provided at any time after initial certification that differs from the specific plan of care and treatment previously authorized requires re-certification by **Us**.

Pre-Certification of Treatment, services, and/or a length of stay is not a guarantee of **Sickness and Injury Benefits** under this **Certificate** or the **Group Policy**. All claims for **Sickness and Injury Benefits** under this **Certificate**, including claims for services and treatment that were pre-certified by **Us**, are subject to all terms, definitions, limitations, exclusions and restrictions contained in this **Certificate** and any riders, endorsements, or amendments attached hereto.

E. CLAIM PROCEDURES, INVESTIGATION AND PAYMENT

1. NOTICE OF CLAIM

Written notice of claim must be received by **Us** within thirty (30) days of the date that each **Covered Expense** is incurred by an **Insured**. If it is not reasonably possible for the notice of claim to be transmitted to **Us** so that it is received within such thirty (30) day period, then written notice of claim must be received by **Us** as soon thereafter as reasonably possible. A **Provider's** billing statement that is timely received by **Us** will suffice as a written notice of the claim under this Section. **Our** current address for

providing a written notice of claim is shown on Page 1. A written notice of claim should include the applicable **Insured's** name, the **Primary Insured's** name, the applicable **Provider's** name, and the **Certificate** number.

2. CLAIM FORMS AND ADDITIONAL INFORMATION TO BE PROVIDED

When **We** receive timely written notice of claim, **We** will normally send **You** a claim form to be completed, signed and returned. The general purpose of the claim form is to provide **Us** with general background information about the nature of the claim, which information may be necessary in order to complete a proper proof of loss. If this claim form is not provided to **You** within fifteen (15) days, of **Our** timely receipt of written notice of the claim, then **You** will not be required to later complete, sign and return the written claim form, but may be required to provide other information, including a written authorization for the release of medical records and information, which in each event is necessary either for **Our** investigation of the claim or otherwise as part of the completion of a proper proof of loss. **We** must receive information requested within the time limit stated in the Section V E 3, PROOFS OF LOSS.

3. PROOFS OF LOSS

Written proof of a **Covered Expense** must be provided to **Us** within ninety (90) days after such **Covered Expense** is incurred by an **Insured**. If it was not reasonably possible for **You** to give **Us** proof in the time required, **We** will not reduce or deny the claim for this reason if the proof is filed as soon as possible. In any event, the proof of loss required must be provided no later than one (1) year from the date the **Covered Expense** was incurred by the **Insured** unless **You** are legally incompetent or otherwise physically unable to act.

4. CLAIMS REVIEW, INVESTIGATION, ADJUSTMENT AND ADJUDICATION

As written notice of claims, completed claim forms, signed authorizations for release of medical authorizations, medical records, and other written information from **Insureds** and **Providers** are received and reviewed additional investigation, requests for information and other matters may occur in connection with the completion of a proper proof of loss, adjustment and adjudication of the claim. At **Our** expense, **We** have the right to have the **Insured** examined by a **Provider** of **Our** choice as often as is reasonably necessary while a claim or other benefit determination is pending. Information received during the review and investigation of a claim will be considered, as applicable, in connection of whether a timely and proper proof of loss has been completed. After **Our** investigation has been completed, claims will be adjusted and adjudicated in accordance with the coverage under this **Certificate** that was in force on the date the applicable expense was incurred. Part of the adjustment and adjudication process includes a determination of the amount of **Covered Expense** incurred by the **Insured** for the applicable services rendered. This determination will normally require communication with the network with whom the applicable **Provider** was contracted at the time the service was rendered, as well as other matters. Once a decision has been made on a claim and this decision has been processed, an explanation of benefits form will be transmitted to the **Primary Insured** and each applicable **Provider**.

5. PAYMENT OF CLAIMS

The applicable portion of **Covered Expenses** incurred by an **Insured**, which are owed by the **Company** under this **Certificate**, will be paid to the **Primary Insured**, unless the right to such payment was previously assigned to a **Provider** for direct payment. Upon the death of the **Primary Insured**, the unpaid amount of any applicable **Covered Expenses** incurred by an **Insured**, which are owed by the **Company** under this **Certificate** will be paid to the **Beneficiary**, unless the right to such payment was previously assigned to a **Provider** for direct payment. Any claim payment made by **Us** in good faith will fully discharge **Our** liability under this **Certificate** for such claim to the extent of the amount of such good faith payment.

6. TIME OF PAYMENT OF CLAIMS

We will make payments due promptly once a decision has been made on a claim and this decision has been processed.

Payment shall be treated as being made on the date a draft or valid instrument was placed in the United States mail to the last known address of the applicable **Primary Insured**, **Provider**, or **Beneficiary** in a properly addressed, postpaid envelope, or, if not so posted, on the date of delivery.

A **Benefit** payment owed by **Us** under this **Certificate**, but not paid within thirty (30) days after the date of **Our** receipt of a proper proof of loss and the completion of **Our** investigation of the claim, will be considered past due. **We** will pay interest on any past due benefit payment amount at the rate of one and one-half percent per month commencing on the thirty first (31st) day after the completion and **Our** receipt of a proper proof of loss and the completion of **Our** investigation of the claim until the date such payment is tendered by **Us**.

VI. DEDUCTIBLES

A. CALENDAR YEAR DEDUCTIBLE

No **Sickness and Injury Benefits** or **Wellness and Screening Benefits** are payable under this **Certificate** for any **Covered Expenses** incurred by an **Insured**, until after the **Calendar Year Deductible** is satisfied and fully payable each **Calendar Year** by such **Insured**. In addition to the **Calendar Year Deductible**, the **Separate Deductible For Non-Participating Providers** will apply to services rendered by **Non-Participating Providers**.

Neither (i) the amount of the **Separate Deductible For Non-Participating Providers**, nor (ii) the amount of the **Failure to Pre-Certify Treatment Deductible** may be used to satisfy the **Calendar Year Deductible**.

B. SEPARATE DEDUCTIBLE FOR NON-PARTICIPATING PROVIDERS

No **Sickness and Injury Benefits** or **Wellness and Screening Benefits** are payable under this **Certificate** for services rendered by **Non-Participating Providers** until after the amount of the **Separate Deductible For Non-Participating Providers** is satisfied and fully payable. The amount of the **Separate Deductible For Non-Participating Providers** is shown on the **Certificate Schedule** and applies per **Calendar Year** separately to each **Insured**.

Neither (i) the amount of the **Calendar Year Deductible** nor (ii) the amount of the **Failure to Pre-Certify Treatment Deductible** may be used to satisfy the **Separate Deductible For Non-Participating Providers**.

C. SEPARATE DEDUCTIBLE FOR FAILURE TO PRE-CERTIFY TREATMENT

An additional deductible in the amount of [$1,000], the **Failure to Pre-Certify Treatment Deductible**, will be applied to **Covered Expenses** before the **Company Insurance Percentage** is payable under this **Certificate** for each (i) **Inpatient Hospital Confinement**, and (ii) surgery, if **Pre-Certification of Treatment** is not obtained. No **Sickness and Injury Benefits** are payable under this **Certificate** for any **Covered Expenses** that are subject to the **Failure to Pre-Certify Treatment Deductible** until after the amount of any such **Failure to Pre-Certify Treatment Deductible** is satisfied and fully payable by either **You** or such **Insured.**

[D. FAMILY CALENDAR YEAR DEDUCTIBLE MAXIMUM

Once a combined total of [three (3)] **Calendar Year Deductibles** [or **Separate Deductible for Non-Participating Providers]** have been satisfied in any **Calendar Year** by any [three (3)] **Insureds**, no additional **Calendar Year Deductible** [or **Separate Deductible for Non-Participating Provider]** will be assessed by **Us** in connection with medical treatment and services rendered to any other **Insured** during the remainder of such **Calendar Year**.]

[E.COMMON ACCIDENT CALENDAR YEAR DEDUCTIBLE MAXIMUM

If [two (2)] or more **Insureds** incur **Covered Expenses** for **Injuries** sustained in the same accident, only one (1) **Calendar Year Deductible** [or **Separate Deductible for Non-Participating Providers]** will be applied

that **Calendar Year** to the combined **Covered Expenses** resulting from the **Injuries** sustained in such common accident by all **Insureds**.]

VII. LIMITATIONS, EXCLUSIONS AND NON-WAIVER

A. LIMITATIONS-WAITING PERIODS

Coverage under this **Certificate** is limited as provided by the definitions, limitations, exclusions, and terms contained in each and every Section of this **Certificate**, as well as the following limitations and waiting periods:

[1]. Any loss or expense incurred as a result of an **Insured's Pre-existing Condition [**not disclosed on the application] is not covered under this **Certificate** unless such loss or expense constitutes **Covered Expenses** incurred by such **Insured** more than [twelve (12)] [twenty-four (24)] months after the **Issue Date**, and are not otherwise limited or excluded by this **Certificate** or any riders, endorsements, or amendments attached to this **Certificate**;

[2]. Any loss or expense which results from the diagnosis, care or treatment of hernia, disease or disorders of the reproductive organs, hemorrhoids, varicose veins, tonsils and/or adenoids, or otitis media shall be covered under this **Certificate** only if (i) such loss or expense constitutes **Covered Expenses** incurred by an **Insured** after this **Certificate** has been in force for a period of six (6) months from the **Issue Date**, (ii) such **Sicknesses** are not otherwise limited or excluded by this **Certificate** or any riders, endorsements, or amendments attached to this Certificate, [(iii) care for such **Sicknesses** is **Provided** on an **Emergency** basis], and [(iv)] such **Sicknesses** are not **Pre-existing Conditions**;

[3]. [Insureds have the right to obtain **Prescriptions** from the pharmacy of their choice. However, if an **Insured**: (i) uses a **Non-Participating Pharmacy** to fill a **Prescription**; or (ii) does not present his/her correct ID card when the **Prescription** is filled at a **Participating Pharmacy**, then such **Insured** must pay the applicable pharmacy in full and file a claim form with the **Company** for reimbursement. In either event, the **Insured** will be reimbursed by the **Company** at the discounted or negotiated rate for such **Prescription** that would have been paid to a **Participating Pharmacy** by the **Company** under this **Certificate** if the **Insured** had used a **Participating Pharmacy** and properly presented the correct ID card at the time the **Prescription** was filled;]

[4]. [Pre-authorization may be required by the **Company** prior to the time that **Prescriptions** for certain **Prescription Drugs** are filled;]

[5.] If as the result of an **Emergency Sickness** or an **Emergency Injury** services are rendered for an **Insured** by a **Non-Participating Provider** when a **Participating Provider** was not reasonably available in connection with either (i) on an **Outpatient** basis in the emergency room of a **Hospital** or (ii) an **Emergency Inpatient** admission to a **Hospital**, then the **Covered Expenses** incurred will be reimbursed by **Us** as if such **Non-Participating Provider** were a **Participating Provider** up to the point when the **Insured** can be safely transferred to a **Participating Provider**. If the **Insured** refuses or is unwilling to be transferred to the care of a **Participating Provider** after such **Insured** can be safely transferred, then reimbursement shall thereafter be reduced to the **Company's Insurance Percentage for Non-Participating Providers**;

[6.] [Because the [**Calendar Year Deductible]** under this **Certificate** is calculated on the basis of **Covered Expenses**, it is possible that every dollar an **Insured** pays for **Prescription Drugs** at a **Participating Pharmacy** may not apply toward meeting the **[**applicable **Calendar Year Deductible]**;]

[7.] Sickness and Injury Benefits and **Wellness and Screening Benefits** under this **Certificate** for any **Insured** who is eligible for or has coverage under **Medicare**, and/or amendments thereto, regardless of whether such **Insured** is enrolled in **Medicare** shall be limited to only the **Usual and Customary** charges for services, supplies, care or treatment covered under this **Certificate** that are not or would not have been payable or reimbursable by **Medicare** and/or its amendments (assuming such enrollment), subject to all provisions, limitations, exclusions, reductions and maximum benefits set forth in this **Certificate**;

[8.] [[Two-Five million dollars ($2,000,000-$5,000,000)] is the maximum total amount of all applicable annual increases in the **Lifetime Certificate Maximum Per Insured** that can be conditionally received after the **Issue Date** pursuant to SectionVIII. INCREASE IN THE LIFETIME CERTIFICATE MAXIMUM of this **Certificate**;] and

[9.] Except as contained and specifically set forth in the INCREASE IN THE LIFETIME CERTIFICATE MAXIMUM Section of this **Certificate**, there shall be no increase in the amount of the **Lifetime Certificate Maximum Per Insured**.

B. EXCLUSIONS

Coverage under this **Certificate** is limited as provided by the definitions, limitations, exclusions, and terms contained in each and every Section of this **Certificate**. In addition, this **Certificate** does not provide coverage for expenses charged to an **Insured** or any payment obligation for **Us** under this **Certificate** for any of the following, all of which are excluded from coverage:

[1]. the amount of any professional fees or other medical expenses or charges for treatments, care, procedures, services or supplies which do not constitute **Covered Expenses**;

[2]. **Covered Expenses** incurred before the **Certificate Issue Date**;

[3]. **Covered Expenses** incurred after this **Certificate** terminates, regardless of when the condition originated, except as **Provided** in the EXTENSION OF BENEFITS provision;

[4]. **Covered Expenses** which exceed the **Lifetime Certificate Maximum Per Insured**;

[5]. **Covered Expenses** which exceed the **[Lifetime] Transplant Maximum [Per Organ] Per Insured** for all **Solid Organ Transplants**, **Bone Marrow Transplants**, and **Stem Cell Transplants** received by each **Insured** including any applicable **Covered Expenses** for professional fees and facility fee incurred in connection with harvesting the applicable donor organ or donor bone marrow for the purposes of such transplantation;

[6]. **[[Prescription Drugs]** [that are immunosuppressants;]]

[7]. the amount of any professional fees or other medical expenses contained on a billing statement to a **Insured** which exceed the amount of the **Maximum Allowable Charge**;

[8]. any professional fees or other medical expenses for treatments, care, procedures, services or supplies which are not specifically enumerated in the SICKNESS AND INJURY BENEFITS,[or] WELLNESS AND SCREENING BENEFITS, [or] [MISCELLANEOUS BENEFITS] Sections of this **Certificate** and any optional coverage rider attached hereto;

[9]. **Covered Expenses You** or **Your** covered **Family** members are not required to pay, which are covered by other insurance, or that would not have been billed if no insurance existed;

[10]. any professional fees or expenses for which the **Insured** and/or any covered **Family** member are not legally liable for payment;

[11]. any professional fees or expenses for which the **Insured** and/or any covered **Family** member were once legally liable for payment, but from which liability the **Insured** and/or **Family** member were released;

[12]. treatment of the teeth, the surrounding tissue or structure, including the gums and tooth sockets. This exclusion does not apply to treatment: (a) due to **Injury** to natural teeth (treatment must be **Provided** within ninety (90) days of the date of the **Injury**); or (b) for malignant tumors;

[13]. **Injury** or **Sickness** due to any act of war (whether declared or undeclared);

[14]. services provided by any state or Federal government agency, including the Veterans Administration unless, by law, an **Insured** must pay for such services;

[15]. **Covered Expenses** that are payable under any motor vehicle no fault law insurance policy or certificate;

[16]. charges that are payable or reimbursable by either:
- a) a plan or program of any governmental agency (except Medicaid), or
- b) **Medicare** Part A, Part B and/or Part D (If the applicable **Insured** does not enroll in **Medicare**, **We** will estimate the charges that would have be paid if such enrollment had occurred);

[17]. [drugs or medication not used for an Food and Drug Administration (FDA) approved use or indication;]

[18]. [administration of experimental drugs or substances or investigational use or experimental use of **Prescription Drugs** except for any **Prescription Drug** prescribed to treat a covered chronic, disabling, life-threatening **Sickness** or **Injury,** but only if the investigational or experimental drug in question:
- a) has been approved by the FDA for at least one indication; and
- b) is recognized for treatment of the indication for which the drug is prescribed in:
  - 1) a standard drug reference compendia; or
  - 2) substantially accepted peer-reviewed medical literature.
- c) drugs labeled “Caution –limited by Federal law to investigational use”;]

[19]. experimental procedures or treatment methods not approved by the American Medical Association or other appropriate medical society;

[20]. any **Injury** or **Sickness** covered by any Workers’ Compensation insurance coverage, or similar coverage underwritten in connection with any Occupational Disease Law, or Employer’s Liability Law, regardless of whether you file a claim for benefits thereunder;

[21]. eyeglasses, contact lenses, radial keratotomy, lasik surgery, hearing aids and exams for their prescription or fitting;
[22]. Cochlear implants;
[23]. any professional fees or other medical expenses incurred by an **Insured** which were caused or contributed to by such **Insured's** being intoxicated or under the influence of any drug, narcotic or hallucinogens unless administered on the advice of a **Provider**, and taken in accordance with the limits of such advice;
[24]. intentionally self-inflicted **Injury**, suicide or any suicide attempt while sane or insane;
[25]. serving in one of the branches of the armed forces of any foreign country or any international authority;
[26]. voluntary abortions, abortificants or any other drug or device that terminates a pregnancy;
[27]. services **Provided** by **You** or a **Provider** who is a member of an **Insured's Family**;
[28]. any medical condition excluded by name or specific description by either this **Certificate** or any riders, endorsements, or amendments attached to this **Certificate**;
[29]. any loss to which a contributing cause was the **Insured's** being engaged in or attempting to engage in an illegal occupation or illegal activity;
[30]. [participation in aviation, except as fare-paying passenger traveling on a regular scheduled commercial airline flight;]
[31]. cosmetic surgery or reconstructive procedures, except for **Medically Necessary** cosmetic surgery or reconstructive procedures performed under the following circumstances: (i) where such cosmetic surgery is incidental to or following surgery resulting from trauma or infection; (ii) to correct a normal bodily function; or (iii) such cosmetic surgery constitutes **Breast Reconstruction** that is incident to a **Mastectomy**; provided any of the above occurred while the **Insured** was covered under this **Certificate**.
[32]. Charges for breast reduction or augmentation or complications arising from these procedures;
[33]. **[Prescription Drugs** or other medicines and products used for cosmetic purposes or indications;]
[34]. [voluntary sterilization [except as **Provided** in the **Benefit** entitled Sterilization in the SICKNESS AND INJURY BENEFIT section of this **Certificate**], reversal or attempted reversal of a previous elective attempt to induce or facilitate sterilization;]
[35]. fertility hormone therapy and/or fertility devices for any type fertility therapy, artificial insemination or any other direct conception;
[36]. any operation or treatment performed, **Prescription** or medication prescribed in connection with sex transformations or any type of sexual or erectile dysfunction, including complications arising from any such operation or treatment;
[37]. appetite suppressants, including but not limited to, anorectics or any other drugs used for the purpose of weight control, or services, treatments, or surgical procedures rendered or performed in connection with an overweight condition or a condition of obesity or related conditions;
[38]. **[Prescriptions**, treatment or services for behavioral or learning disorders, Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD);]
[39]. any professional fees or other medical expenses incurred as the result of an **Injury** which was caused or contributed by an **Insured** racing any land or water vehicle;
[40]. any professional fees or other medical expenses incurred for the diagnosis, care or treatment of **Mental and Emotional Disorders**, **Alcoholism**, and drug addiction/abuse;
[41]. **[Prescription Drugs** that are classified as psychotherapeutic drugs, including antidepressants;]
[42]. Except for **Complications of Pregnancy**, routine maternity or any other expenses related to childbirth, including routine nursery charges and well baby care; [unless the optional MATERNITY BENEFIT RIDER was purchased and in force on the date said expenses related to childbirth, routine nursery charges, well baby care or maternity were incurred];
[43]. contraceptives, oral or otherwise, whether medication or device, regardless of intended use;
[44]. **[Outpatient Prescription Drugs** that are dispensed by a **Provider**, **Hospital** or other state-licensed facility;]
[45]. **[Prescription Drugs** produced from blood, blood plasma and blood products, derivatives, Hemofil M, Factor VIII, and synthetic blood products, or immunization agents, biological or allergy sera, hematinics, blood or blood products administered on an **Outpatient** basis;]
[46]. [level one controlled substances;]
[47]. **[Prescription Drugs** used to treat or cure hair loss or baldness;]
[48]. **[Prescription Drugs** that are classified as anabolic steroids or growth hormones [except as **Provided** in the **Benefit** entitled Growth Disorders in the SICKNESS AND INJURY BENEFIT section or this **Certificate**];]
[49]. [compounded **Prescription Drugs**;]
[50]. fluoride products;

[51]. [allergy kits intended for future emergency treatment of possible future allergic reactions;]

[52]. [replacement of a prior filled prescription for **Prescription Drugs** that was covered and is replaced because the original prescription was lost, stolen or damaged;]

[53]. **[Prescription Drugs**, which have an over the counter equivalent that may be obtained without a **Prescription**, even though such **Prescription Drugs** were prescribed by a **Provider**;]

[54]. [any intentional misuse or abuse of **Prescription Drugs**, including **Prescription Drugs** purchased by an **Insured** for consumption by someone other than such **Insured**;]

[55]. **[Prescription Drugs** that are classified as anti-fungal medication used for treatment of onychomycosis;]

[56]. [fees or expenses charged for spinal manipulations [except as **Provided** in the **Benefit** entitled Spinal Manipulation in the SICKNESS AND INJURY BENEFIT section of this **Certificate**];

[57]. Programs, treatment or procedures for tobacco use cessation;

[58]. **[Prescription Drugs** that are classified as tobacco cessation products;]

[59]. [drugs prescribed for the treatment of any disease, illness or condition that has been excluded from coverage under the **Certificate** by exclusionary rider, limitation or exclusion;]

[60]. [charges for blood, blood plasma, or derivatives that has been replaced;]

[61]. [treatment of autism;]

[62]. Temporomandibular Joint Disorder (TMJ) and Craniomandibular Disorder (CMD); and

[63]. treatment received outside of the United States, [except as provided for in the **Benefit** entitled Foreign Travel Benefit in the SICKNESS AND INJURY BENEFITS section of this **Certificate**;]

[64]. Services or supplies for personal convenience, including custodial care or homemaker services, except as provided for in this **Certificate**;

[65]. expenses for a cane, a crutch, a corset, a dental appliance, an elastic hose, an elastic support, a fabric support, a generic arch support, a low-temperature plastic splint, a soft cervical collar, a truss, or other similar device except as stated in the PROSTHETIC AND ORTHODIC DEVICE BENEFIT section of Your **Certificate** that: (i) is carried in stock and sold without therapeutic modification by a corset shop, department store, drug store, surgical supply facility, or similar retail entity; and (ii) has no significant impact on the neuromuscular, musculoskeletal, or neuromusculoskeletal functions of the body; and

[66]. expenses for artificial eyes, ears, dental appliances, a cosmetic device such as artificial eyelashes or wigs, a device used exclusively for athletic purposes, an artificial facial device, or other device except as stated in the PROSTHETIC AND ORTHODIC DEVICE BENEFIT section of **Your Certificate** that does not have significant impact on the neuromuscular, musculoskeletal, or neuromusculoskeletal functions of the body.

C. NON-WAIVER

1. Billed charges for medical care and treatment received by all **Insureds** during a **Calendar Year** that are considered and applied by **Us** under Section VIII. INCREASE IN LIFETIME CERTIFICATE MAXIMUM, does not mean **We** have any liability for coverage or the payment of any **Sickness and Injury Benefits** under the **Certificate** for the illness, injury or condition that resulted in such expenses, and any such mistake and error by **Us** shall not constitute a waiver of or modification to any of the conditions, terms, definitions, limitations or exclusions contained in either the **Certificate** or any exclusionary rider attached to the **Certificate**.

[2. Expenses that are mistakenly applied by **Us** to the **Calendar Year Deductible** or erroneously paid by **Us** under any Section or provision of this **Certificate [**including **Prescription Drugs]** shall not:

a) constitute a waiver of or modification to any conditions, terms, definitions or limitations contained in the **Certificate**, specifically including, but not by way of limitation, the definitions of **Sickness** and **Injury**, the limitation of coverage under the **Certificate** for **Pre-existing Conditions**, as well as any exclusion, limitation and/or exclusionary riders which may be attached to the **Certificate**, or otherwise operate to alter, amend, affect, abridge or modify the **Certificate** to which it is attached;

b) create or establish coverage of any medical condition illness, disease or injury under the **Certificate** or under any exclusion, limitation and/or exclusionary riders which may be attached to the **Certificate**; or

c) affect, alter, amend, abridge, constitute or act as a waiver of the **Company's** ability to rely upon, assert and apply such terms, definitions, limitations or exclusions of the **Certificate** or any amendments thereto.]

VIII. INCREASE IN LIFETIME CERTIFICATE MAXIMUM

A. CONDITIONAL ANNUAL INCREASE

Notwithstanding the amount of the **Lifetime Certificate Maximum Per Insured** stated on the **Certificate Schedule**, but subject to all applicable definitions, exclusions, limitations, non-waiver, and provisions contained in the **Certificate**, as well as all riders, endorsements, and amendments attached to the **Certificate**, **We** will automatically increase the amount of the **Lifetime Certificate Maximum Per Insured** on each anniversary of the **Issue Date** while coverage under the **Certificate** has remained in full force and effect on the following terms and conditions:

1. $125,000 FIRST ANNIVERSARY OF ISSUE DATE

$125,000 shall be added to the amount shown on the **Certificate Schedule** for the **Lifetime Certificate Maximum Per Insured** on the first anniversary of the **Issue Date**, if the total amount of all billed charges for medical care and treatment received by all **Insureds** and submitted to **Us** for consideration during the **First Certificate Year**, is greater than the amount of the **Calendar Year Deductible** applicable to such **Insureds** as shown on the **Certificate Schedule**, but the amount of such billed medical charges is less than twice the amount of such **Calendar Year Deductible** applicable to such **Insureds**.

2. $250,000 FIRST ANNIVERSARY OF ISSUE DATE

$250,000 shall be added to the amount shown on the **Certificate Schedule** for the **Lifetime Certificate Maximum Per Insured** on the first anniversary of the **Issue Date**, if the total amount of all billed charges for medical care and treatment received by all **Insureds** and submitted to **Us** for consideration during the **First Certificate Year** is less than the amount of the **Calendar Year Deductible** applicable to such **Insureds** as shown on the **Certificate Schedule**.

3. $125,000 SUBSEQUENT CERTIFCATE YEARS

$125,000 shall be added to the then current amount of the **Lifetime Certificate Maximum Per Insured** on each subsequent anniversary of the **Issue Date**, if the total amount of all billed charges for medical care and treatment received by all **Insureds** and submitted to **Us** for consideration during the **Subsequent Certificate Year** that immediately precedes such anniversary of the **Issue Date** is greater than the amount of the **Calendar Year Deductible** shown on the **Certificate Schedule**, but the amount of such billed medical charges is less than twice the amount of such **Calendar Year Deductible** applicable to such **Insureds**.

4. $250,000 SUBSEQUENT CERTIFCATE YEARS

$250,000 shall be added to the then current amount of the **Lifetime Certificate Maximum Per Insured** on each subsequent anniversary of the **Issue Date**, if the total amount of all billed medical charges received by all **Insureds** and submitted to **Us** for consideration during the **Subsequent Certificate Year** that immediately precedes such anniversary of the **Issue Date** is less than the amount of the **Calendar Year Deductible** applicable to such **Insureds** as shown on the **Certificate Schedule**.

However, the maximum total amount of all applicable annual increases in the **Lifetime Certificate Maximum Per Insured** pursuant to this Section shall not exceed the sum of two million dollars.

IX. GRIEVANCE PROCEDURES

The Arkansas External Review Regulation requires **Us** to provide **You** with the opportunity for an independent review of any **Adverse Determination** or **Final Adverse Determination**. **You** have the right to request an **External Review** once **Your Internal Grievance Procedures** have been exhausted, unless otherwise stated. The criteria for the Grievance Procedures, including the **External Review** process by an **Independent Review Organization** to examine any **Adverse Determinations**, is outlined below.

INTERNAL GRIEVANCE PROCEDURES

You have the right to appeal any denial of a claim for **Benefits** by submitting a written request, via facsimile or mail, for reconsideration.

Requests for reconsideration must be filed within sixty (60) days of receipt of the written notification of denial. Within ten (10) days from receipt of the request for reconsideration, **We** will acknowledge receipt. Within thirty (30) days from receipt of the request for reconsideration, **We** will review **Your** request and provide a written response describing the final determination. If **You** are not satisfied with the **Final Adverse Determination**, **You** may request an **External Review**.

EXTERNAL GRIEVANCE PROCEDURES

I. Notice of Right to External Review -

Adverse Determinations: **You** may file a request for an expedited **External Review** to be conducted at the same time **You** file a request for a review of an appeal as set forth in the **Internal Grievance Procedure**, if:

(A) **You** have a medical condition where the timeframe for completion of an expedited review of an appeal in **Our Internal Grievance Procedures** would seriously jeopardize **Your** life or health or would jeopardize **Your** ability to regain maximum function; or

(B) The **Adverse Determination** involves a denial of coverage based on a determination that the recommended or requested **Health Care Service** or treatment is "experimental" or "investigational" and **Your Provider** certifies in writing and supports such certification with reasoning, rationale, or evidence that the recommended or requested **Health Care Service** or treatment would be significantly less effective if not promptly initiated.

The **Independent Review Organization** conducting the **External Review** will determine whether **You** will be required to complete the **Internal Grievance Procedures** prior to the expedited External Grievance Procedures. **You** may file an appeal under **Our Internal Grievance Procedures**, if **We** have not issued a written decision to **You** within thirty (30) days following the date **You** filed the appeal with **Us** for a pre-service claim or within sixty (60) days following the date **You** filed the appeal with **Us** for a post-service claim and **You** have not requested or agreed to a delay, **You** may file a request for **External Review** and shall be considered to have exhausted **Our Internal Grievance Procedures**.

Final Adverse Determinations: **You** may file a request for an expedited **External Review** to be conducted at the same time **You** file a request for a review of an appeal as set forth in the **Internal Grievance Procedure**, if:

(A) **You** have a medical condition where the timeframe for completion of an expedited review of an appeal in **Our Internal Grievance Procedures** would seriously jeopardize **Your** life or health or would jeopardize **Your** ability to regain maximum function.

(B) If the **Final Adverse Determination** concerns:

(i) an admission, availability of care, continued stay or **Health Care Service** for which **You** received **Emergency** services, but has not been discharged from a facility; or

(ii) a denial of coverage based on a determination that the recommended or requested **Health Care Service** or treatment is "experimental" or "investigational" and **Your Provider** certifies in writing and supports such certification with reasoning, rationale, or evidence that the recommended or requested **Health Care Service** or treatment would be significantly less effective if not promptly initiated.

You have the right to seek assistance from the Arkansas Department of Insurance at any time.

Commissioner [Jay Bradford]
Arkansas Dept. of Insurance
1200 West 3rd Street
Little Rock, Arkansas 72201

E-mail: insurance.Consumers@mail.state.ar.us
Phone: 501-371-2640 or 800-852-5494
Fax: 501-371-2749

All requests for **External Reviews** shall be made in writing or via electronic media to **Us** at the mailing address and facsimile telephone number identified below:

Freedom Life Insurance Company of America
Attn.: Vice President of Claims
Claims and Communications Dept.
3100 Burnett, 801 Cherry Street, Unit 33
Fort Worth, Texas 76102

Phone: 800-387-9027
Fax: 817-878-3440

Please be advised when filing a request for an **External Review**, **You** will be required to authorize the release of any of **Your** medical records that may be required to be reviewed for the purpose of reaching a decision on the **External Review**. This authorization will allow **Us** to disclose **Your** protected health information, including medical records, that are pertinent to the **External Review**.

II. Standard External Review -

Within sixty (60) days after the date of receipt of a notice of an **Adverse Determination** or **Final Adverse Determination**, **You** may file a request for an **External Review** with **Us**, as specified below:

(A) At the time **We** receive a request for an **External Review**, **We** shall assign an **Independent Review Organization** (from the list of approved **Independent Review Organizations** compiled and maintained by the Arkansas Insurance Commissioner) to conduct a preliminary review of the request to determine if:

- the request for the **External Review** meets the applicability standards as set out above;
- **You** have exhausted **Our Internal Grievance Procedures**; and
- **You** have provided all the information and forms required to process an **External Review**, including the authorization to release medical records.

(B) Within five (5) business days after receipt of the request for **External Review**, the **Independent Review Organization** assigned shall complete the preliminary review and notify **You**, **Your Provider** and Freedom Life Insurance Company of America in writing as to whether:

- the request is complete; and
- the request has been accepted for **External Review**.

The **Independent Review Organization** shall include in the notice provided a statement that **You**, **Your Provider** and Freedom Life Insurance Company of America may submit in writing to the **Independent Review Organization** within seven (7) business days following the date of receipt of the notice additional information and supporting documentation that the **Independent Review Organization** shall consider when conducting the **External Review**.

If the request:

- is not complete, the assigned **Independent Review Organization** shall, within five (5) business days, inform **You**, **Your Provider** and Freedom Life Insurance Company of America what information or materials are needed to make the request complete; or
- is not accepted for **External Review**, the assigned **Independent Review Organization** shall
- inform **You**, **Your Provider** and Freedom Life Insurance Company of America in writing within five (5) business days of the reasons for non-acceptance.

Upon receipt of any information submitted by **You**, the assigned **Independent Review Organization** shall forward copies of the information to **Us**.

(C) In reaching a decision to accept or reject a matter for **External Review**, the assigned **Independent Review Organization** is not bound by any decisions or conclusions reached during **Our Internal Grievance Procedures**.

(D) Within seven (7) business days after the receipt of the notice provided in part (B) above, **We** shall provide to the assigned **Independent Review Organization**, **You** and **Your Provider** the documents and any information considered in making the **Adverse Determination** or **Final Adverse Determination**, together with any additional information **We** deem necessary. If **We** fail to provide the documents or information, this will not delay the **External Review**; instead, the **Independent Review Organization** may terminate the **External Review** and make a decision to reverse any **Adverse Determination** or **Final Adverse Determination**. Immediately upon making such a decision, the **Independent Review Organization** shall notify **You**, **Your Provider** and Freedom Life Insurance Company of America.

(E) Upon receipt of the information, if any, required to be forwarded to **Us** as stated in (B) above, **We** may reconsider any prior **Adverse Determination** or **Final Adverse Determination** for the **External Review**. This reconsideration by **Us** shall not delay or terminate the **External Review**. The **External Review** may

only be terminated if **We** decide, upon completion of our reconsideration, to reverse **Our Adverse Determination** or **Final Adverse Determination** and provide coverage or payment for the **Health Care Services** that is the subject of the **Adverse Determination** or **Final Adverse Determination**.

Immediately upon making the decision to reverse **Our Adverse Determination** or **Final Adverse Determination**, **We** shall notify **You** and **Your Provider**, as well as the assigned **Independent Review Organization**, in writing of **Our** decision. The assigned **Independent Review Organization** shall terminate the **External Review** upon receipt of this notice from **Us**.

(F) In exercising its independent medical judgment in reviewing an **Adverse Determination**, in addition to the documents and information provided, the assigned **Independent Review Organization**, to the extent the information or documents are available, shall consider the following in reaching a decision:

- the **Insured's** medical records;
- the **Provider's** professional recommendation;
- consulting reports from appropriate health care professionals and other documents submitted by **Us**, **You** or **Your Provider**;
- the applicable terms of coverage under **Your** contract of insurance to ensure that the **Independent Review Organization's** decision is not contrary to the terms of the coverage;
- the most appropriate practice guidelines, which may include generally accepted practice guidelines, evidence-based practice guidelines or any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;
- any applicable written screening procedures, decision abstracts, clinical protocols and practice guidelines used by **Us** to determine the necessity and appropriateness of **Health Care Services**; and
- if the **Adverse Determination** involves a denial of coverage based on a determination that the recommended or requested **Health Care Service** is "experimental" or "investigational" , the **Independent Review Organization** shall also consider whether: (a) the recommended or requested **Health Care Service** or treatment has been approved by the federal Food and Drug Administration for the condition, while realizing that treatments or services are often legitimately used for purposes other than those listed in the FDA approval; or (b) medical or scientific evidence demonstrates that the expected benefits of the recommended or requested **Health Care Service** or treatment is more likely than not to be more beneficial to **You** than any available standard **Health Care Service** or treatment and the adverse risks of the recommended or requested **Health Care Service** or treatment would not be substantially increased over those of available standard **Health Care Services** or treatments.

(G) Within forty-five (45) calendar days after the date of receipt of the request for an **External Review**, the assigned **Independent Review Organization** shall provide written notice of its decision to uphold, reverse, or partially uphold or reverse the **Adverse Determination** or **Final Adverse Determination** to **You**, **Your Provider** and Freedom Life Insurance Company of America.

III. Expedited External Review -

(A) Except as provided under item (E) below, **You** may make a request for an expedited **External Review** with **Us** at the time **You** receive an **Adverse Determination** or **Final Adverse Determination**. At the time **You** elect to make a request for an expedited **External Review**, **You** and **Your Provider** shall submit additional information and supporting documentation that the **Independent Review Organization** shall consider when conducting the expedited **External Review**.

(B) An expedited **External Review** may NOT be provided for an **Adverse Determination** or **Final Adverse Determination** involving a **Retrospective Review**.

(C) At the time **We** receive a request for an expedited **External Review**, **We** immediately shall assign an **Independent Review Organization** (from the list compiled and maintained by the Arkansas Insurance Commissioner) to determine whether the request meets the reviewability requirements, and then initiate the expedited **External Review** if all the requirements are met.

(D) At the time **We** assign an **Independent Review Organization** to conduct the expedited **External Review**, **We** shall immediately provide or transmit all pertinent documentation and information to the assigned **Independent Review Organization**.

(E) As expeditiously as **Your** medical condition or circumstances require, but in no event more than seventy-two (72) hours after the date of receipt of the request for an expedited **External Review** that meets the reviewability requirements, the assigned **Independent Review Organization** shall:

- Make a decision to uphold or reverse the **Adverse Determination** or **Final Adverse Determination**; and
- Notify **You**, **Your Provider** and Freedom Life Insurance Company of America of the decision.

IV. Binding Nature of External Review Decision -

All **External Reviews** conducted will be fair and impartial, and in compliance with the standards approved by the Arkansas Insurance Commissioner.

An **External Review** decision is binding on **Us**, except to the extent that **We** have other remedies available under applicable federal or state law. An **External Review** decision is binding on the **Covered Insured**, except to the extent that **You** have other remedies available under applicable federal or state law. A **Covered Insured** may NOT file a subsequent request for an **External Review** involving the same **Adverse Determination** or **Final Adverse Determination** for which **You** have already received an **External Review** decision.

V. Filing Fees and Funding –

(A) Except in the case of a request for an expedited **External Review**, at the time of filing a request for **External Review**, the **Covered Insured** shall submit to the **Independent Review Organization** a filing fee of [$25.00], along with the information and documentation to be used by the **Independent Review Organization** in conducting the **External Review**. However, upon application by the **Covered Insured**, the Arkansas Insurance Commissioner may waive the filing fee upon a showing of undue financial hardship.

(B) The filing fee shall be refunded to the **Insured** who paid the fee if the **External Review** results in the reversal, in whole or part, of **Our Adverse Determination** or **Final Adverse Determination** that was subject of the **External Review**.

We shall pay the cost of the **Independent Review Organization** for conducting the **External Review** or expedited **External Review**, and shall not charge back the cost of any **External Review** to the **Covered Insured's Provider**.

X. COORDINATION OF BENEFITS

This Section regarding coordination of benefits applies when an **Insured** has health care coverage under more than one **Plan**. The ORDER OF BENEFIT DETERMINATION RULES below determine whether this **Certificate** is a **Primary Plan** or a **Secondary Plan** when compared to another **Plan** covering the **Insured**. If coverage for **Sickness and Injury Benefits**,[or] **Wellness and Screening Benefits**, [or] [**Miscellaneous Benefits]** under this **Certificate** is primary when considered in connection with other **Plans,** then such benefits are determined before the determination of benefits under any other **Plan** and without considering any other **Plan's** benefits. If coverage for **Sickness and Injury Benefits**, [or] **Wellness and Screening Benefits**, or [**Miscellaneous Benefits]** under this **Certificate** is secondary, when considered in connection with other **Plans**, then such benefits are determined after the determination of benefits under the other **Plan** and any such benefits under this **Certificate that** would have otherwise been payable in the absence of such other **Plan** may be reduced because of the **Primary Plan's** benefits.

A. ORDER OF BENEFIT DETERMINATION RULES

When a claim under a **Plan** with a coordination of benefits provision involves another **Plan**, which also has a coordination of benefits provision, the order of benefit determination shall be made as follows:

1. The benefits of a **Plan** that covers the person claiming benefits other than as a dependent shall be determined before those of the **Plan** which covers the person as a dependent.

2. The benefits of a **Plan** of a parent whose birthday occurs earlier in a **Calendar Year** shall cover a dependent child before the benefits of a **Plan** of a parent whose birthday occurs later in a **Calendar Year.** The word "birthday" as used in this paragraph refers only to the month and day in the **Calendar Year**, not the year in which the person was born.

3. If two or more **Plans** cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:
- **a)** First, the **Plan** of the parent with custody of the child;
- **b)** Then, the **Plan** of the spouse of the parent with custody of the child; and
- **c)** Finally, the **Plan** of the parent not having custody of the child.

However, notwithstanding the above, if the specific terms of a court decree state that one (1) 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.

4. The benefits of a **Plan** which covers a person as an employee (or as an employee's dependent) are determined before those of a **Plan** that covers that person as a laid off or retired employee (or as that employee's dependent). If the other **Plan** does not have this provision and if, as a result, the **Plans** do not agree on the order of benefits, this paragraph shall not apply.

5. If none of the provisions above determine the order of benefits, the benefits of the **Plan** which covered the claimant longer are determined before those of the **Plan** that covered the person for the shorter time.

6. If one of the **Plans** is issued out of this state and determines the order of benefits based upon the gender of a parent and, as a result, the **Plans** do not agree on the order of benefits, the **Plan** with the gender rule shall determine the order of benefits.

7. A **Complying Plan** may coordinate its benefits with a **Plan** which is "excess" or "always secondary" or with a **Non-Complying Plan** on the following basis:

- **a)** If the **Complying Plan** is the **Primary Plan**, it shall pay or provide its benefits on a primary basis.
- **b)** If the **Complying Plan** is the **Secondary Plan**, it shall, nevertheless, pay or provide its benefits first, as the **Secondary Plan**. In such a situation, such payment shall be the limit of the complying **Plan's** liability, except as provided in subparagraph (d).
- **c)** If the **Non-Complying Plan** does not provide the information needed by the **Complying Plan** to determine its benefits within a reasonable time after it is requested to do so, the **Complying Plan** shall assume that the benefits of the **Non-Complying Plan** are identical to its own, and shall pay its benefits accordingly. However, the **Complying Plan** must adjust any payments it makes based on such assumption whether information becomes available as the actual benefits of the **Non-Complying Plan**.
- **d)** If the **Non-Complying Plan** pays benefits so that the claimant receives less in benefits than he or she would have received had the **Non-Complying Plan** paid or provided its benefits as the **Primary Plan** then the complying **Plan** shall advance to or on behalf of the claimant an amount equal to such difference which advance shall not include a right to reimbursement from the claimant.

B. EFFECT ON THE BENEFITS OF THIS PLAN

When this **Certificate** is a **Secondary Plan**, it may reduce its **Sickness and Injury Benefits**, [and] **Wellness and Screening Benefits**, [and] [**Miscellaneous Benefits]** so that the total amount paid or provided by all **Plans** during a **Claim Determination Period** is not more than 100% of total **Allowable Expenses**. The difference between the covered benefit payments that this **Certificate** would have paid had it been the **Primary Plan**, and the payments that it actually paid or provided shall be recorded as a benefit reserve for the **Insured** and used by this **Certificate** to pay any **Allowable Expenses**, not otherwise paid during the **Claim Determination Period**. As each claim is submitted, this **Certificate** will:

1. Determine its obligation to pay or provide covered benefits under the **Group Policy**;
2. Determine whether a benefit reserve has been recorded for the **Insured**; and
3. Determine whether there are any unpaid **Allowable Expenses** during that **Claims Determination Period**.

If there is a benefit reserve, the **Secondary Plan** will use the **Insured's** benefit reserve to pay up to 100% of total **Allowable Expenses** incurred during the **Claim Determination Period**. At the end of the **Claims Determination Period**, the benefit reserve returns to zero. A new benefit reserve must be created for each new **Claim Determination Period**.

C. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these coordination of benefit rules and to determine benefits payable under this **Certificate** and other **Plans**. **We** may get the facts **We** need from or give them to other organizations or persons for the purpose of applying these rules and determining **Sickness and Injury Benefits**, [and] **Wellness and Screening Benefits**, [and] [**Miscellaneous Benefits]** payable under this **Certificate** and other **Plans** covering the **Insured** claiming coverage for a claim. **We** need not tell, or get the consent of, any **Insured** to do this. Each **Insured** claiming **Sickness and Injury Benefits**, [and] **Wellness and Screening Benefits**, [and] [**Miscellaneous Benefits]** under this **Certificate** must give **Us** any facts **We** need to apply those rules and determine any amounts payable.

D. FACILITY OF PAYMENT

A payment made under another **Plan** may include an amount that should have been paid under this **Certificate**. If it does, **We** may pay that amount to the organization that made that payment. That amount will then be treated as though it was a **Sickness and Injury Benefit**, [or] **Wellness and Screening Benefit**, [or] [**Miscellaneous Benefit]** paid under this **Certificate**. **We** will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

E. RIGHT OF RECOVERY

If the amount of the payments made by **Us** is more than **We** should have paid under the coordination of benefits provision, **We** may recover the excess from one or more of the persons **We** have paid or for whom **We** have paid; or any other person or organization that may be responsible for the benefits or services provided for the **Insured**. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

XI. UNIFORM PROVISIONS

A. ENTIRE CONTRACT- CHANGES

The entire contract between **You** and the **Company** consists of the **Group Policy**, this **Certificate**, including **Your** application, which is attached hereto, and any amendments, riders, or endorsements attached to this **Certificate**. All statements made by **You** will, in the absence of fraud, be deemed representations and not warranties. No statement made by an applicant for insurance will be used to contest the insurance or reduce the **Sickness and Injury Benefits** or **Wellness and Screening Benefits**, unless contained in a written application, which is signed by the applicant. No agent may:

1. change, alter or modify the **Group Policy**, this **Certificate**, or any amendments, riders, or endorsements attached to this **Certificate**;
2. waive any provisions of the **Group Policy**, this **Certificate**, or any amendments, riders, or endorsements attached to this **Certificate**;
3. extend the time period for payment of premiums under this **Certificate**; or
4. waive any of the **Company's** rights or requirements.

No change in the **Group Policy** or this **Certificate** will be valid unless it is:

1. noted on or attached to the **Group Policy** or this **Certificate**;
2. signed by one of **Our** officers; and

3. delivered to the **Primary Insured**, as shown on the **Certificate Schedule**.

B. TIME LIMIT ON CERTAIN DEFENSES

After two (2) years from the effective date of coverage, only fraudulent misstatements in the enrollment application may be used to void this **Certificate** or deny any claim for a loss occurring after the two (2) year period.

No claim for a **Covered Expense** charged after two (2) years from the **Insured's** effective date of coverage will be reduced or denied because a medical condition, not excluded by name or specific description, existed before the effective date of coverage.

C. OTHER INSURANCE WITH US

You may have only one policy or certificate providing major medical or medical and surgical coverage with **Us**. If through error, **We** issue more than one like policy or certificate to **You**, only one policy or certificate chosen by **You** or **Your** estate, as the case may be, will stay in force. **We** will return the money **You** paid for the other policy(ies) or certificate(s).

D. CONFORMITY WITH STATE STATUTES

Any provision of this **Certificate** or the **Group Policy** which, on its effective date, is in conflict with the laws of the state in which **You** live on that date, is amended to conform to the minimum requirements of such laws.

E. MISSTATEMENT OF AGE

If the age of an **Insured** has not been stated correctly, his or her correct age will be used to determine (i) the amount of insurance for which he or she is entitled, (ii) the effective date of termination of insurance, and (iii) any other rights or **Sickness and Injury Benefits** under this **Certificate** or the **Group Policy**.

Premiums will be adjusted if too much or too little was paid due to the misstatement.

F. NONDISCLOSED MEDICAL HISTORY, MEDICAL CONDITIONS AND RELATED INFORMATION

During the first two (2) years coverage under this **Certificate** is in force it may be modified as provided below if, within that time, **We** discover that a medical condition or other material information was mistakenly not disclosed to **Us**:

1. The coverage under this **Certificate** will stay in force with no change in **Sickness and Injury Benefits, Wellness and Screening Benefits, [Miscellaneous Benefits**,] or premiums if the disclosure of such condition would not have affected the way the **Certificate** was issued.
2. If the disclosure would have resulted in coverage not being issued to an **Insured**, **We** will return all premium paid, less any **Benefits** paid for that person during the time the coverage was in force in error. The coverage for that person shall be void from the **Issue Date**.
3. If the disclosure would have resulted in coverage under this **Certificate** being issued either: (a) at an increased premium, or (b) with an endorsement eliminating that condition from coverage, **We** will either (i) have **You** pay the increased rate beginning with the **Issue Date** (if **You** do not pay the increased premium within thirty (30) days after receiving **Our** notice, **We** will refund all premium paid less any **Benefits** paid, and the coverage under this **Certificate** will be void from the **Issue Date**); or (ii) add an endorsement to the **Certificate** to exclude that condition from coverage. The endorsement must be signed by **You** to put this change in effect. If **You** do not return a signed copy of the endorsement within thirty (30) days after receiving it, **We** will refund all premiums paid less any **Benefits** paid, and the **Certificate** will be void from the **Issue Date**.

This Section does not apply to any fraudulent misrepresentations that are made, which in all events can result in rescission of any coverage issued as a result of such fraudulent misrepresentations.

[G. LEGAL ACTION

No action at law or in equity will be brought to recover on this **Certificate** prior to the expiration of sixty (60) days after proof of loss has been filed as required by this **Certificate**; nor will any action be brought after three (3) years from the expiration of the time within which proof of loss is required by this **Certificate**.]

[H. SUBROGATION

We shall be subrogated to all rights of recovery which any **Insured** may acquire against any party for ordinary negligence, gross negligence, strict liability in tort or any willful or intentional act or omissions resulting in **Injury** or **Sickness** for which **We** pay **Sickness and Injury Benefits, [and] Wellness and Screening Benefits [**and] **[Miscellaneous Benefits]** but only to the extent of the **Benefits** provided. Any **Insured**, by receiving **Benefits** under this **Certificate**, in such case, shall be deemed to have assigned such rights of recovery to **Us** and have agreed to do whatever may be necessary to secure the recovery, including, but not limited to, the execution of any and all appropriate documents or papers. The **Insured** also agrees to execute and deliver all necessary instruments, to furnish such information and assistance, and to take any action **We** may require to facilitate enforcement of **Our** rights.**]**

[I. EXTRATERRITORIAL MEDICAL EXPENSES

Covered Expenses charged in any jurisdiction outside the United States of America (U.S.) or its territories or possessions shall be reimbursed under the terms and conditions of this **Certificate** in U.S. currency at the rate of exchange between the U.S. dollar and the benchmark currency of the foreign jurisdiction on the date such **Covered Expenses** were incurred.]

THIS CONCLUDES THIS CERTIFICATE

FREEDOM LIFE INSURANCE COMPANY OF AMERICA

[3100 Burnett Plaza • 801 Cherry Street, Unit 33 • Fort Worth, Texas 76102 • 1-800-387-9027]

CERTIFICATE OF COVERAGE
ASSOCIATION GROUP MEDICAL-SURGICAL EXPENSE PLAN

This is **Your Certificate** of coverage under an association **Group Policy** issued to the **Group Policyholder**. The coverage of all **Insureds** is governed and determined by the terms, conditions, definitions, limitations and exclusions contained in this **Certificate.** This **Certificate** is a legal contract between **You** and the **Company.** Please read it carefully!

Your Certificate is guaranteed renewable, subject to the **Company's** right to adjust **Renewal Premiums** in accordance with Section IV.B. RENEWAL PREMIUM, and otherwise discontinue or terminate the **Certificate** as provided in Section III.C. TERMINATION OF COVERAGE. The **Initial Premium** for coverage of all **Insureds** under this **Certificate** is due and payable on or before the **Issue Date**. **Renewal Premiums** are due and payable in accordance with the Section IV.B. RENEWAL PREMIUM. You may renew coverage under this **Certificate**, as applicable, by timely payment of the proper amount of **Renewal Premium** when due.

Certain phrases and words have the first letter of each word capitalized and the entire word or phrase printed in bold face type. These are generally defined phrases and words, and as such have the express meaning set forth in Section II. DEFINITIONS.

IMPORTANT NOTICE ABOUT STATEMENTS IN THE APPLICATION: Please read the copy of **Your** application for coverage, which is attached to and part of this **Certificate**, to see if any medical history or other information inquired about or contained in the application is incorrect, incomplete or missing. Contact **Us** immediately if any information contained in the application is incorrect, incomplete or missing. Any incorrect or incomplete statements or answers, as well as any missing information could cause a claim to be denied or the coverage under this **Certificate** to be reformed or voided.

This **Certificate** was issued in consideration of (i) the payment of the **Initial Premium**, (ii) upon **Our** reliance upon **Your** representation that the answers to all questions in the application are correct and complete, and (iii) upon **Our** reliance upon the representation from **You** and any other applicable **Insureds**, that the content of any supplemental information provided to **Us** in the underwriting process, including information provided during any telephone verification of the application or by, e-mails, facsimiles and correspondence is in each instance correct and complete.

YOUR [10][30] DAY RIGHT TO RETURN THIS CERTIFICATE

If **You** are not satisfied with this **Certificate**, **You** may return it to **Us** within [ten (10)] [thirty (30)] days after **You** receive it. **You** may return it to **Us** by mail or to the agent who sold it. This **Certificate** will be voided as of the **Issue Date**, and We will refund any premium **We** have received prior to **Our** receipt of the returned **Certificate**.

SECRETARY

PRESIDENT

NEITHER THE GROUP POLICY NOR THIS CERTIFICATE IS A POLICY OF WORKERS' COMPENSATION INSURANCE.

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I. Certificate Schedule

A. GENERAL INFORMATION

Coverage is pursuant to a **Group Policy** form: [GRP-P-06-FLIC]

Issued to **Group Policyholder**: [ABC Association]

Certificate form: [USHG-2009-C-AR-FLIC]

Primary Insured: [ ]

Age at Issue: [ ]

Certificate Number: [ ]

Issue Date: [ ]

Other Insureds on **Issue Date**:
[ ]
[ ]

Beneficiary: [ ]

Initial Premium: **[ ]**

Amount	**Mode Of Premium Payment**	Method
$[ ]	[Monthly], [Quarterly], [Semi-Annual], [Annual]	[Credit Card], [Check]

First Renewal Date: **[**]

First Renewal Premium	**Mode Of Premium Payment**	Method
$[ ]	[Monthly], [Quarterly], [Semi-Annual], [Annual]	[Bank Draft]

Premium Rate Guarantee Period: **[**12] [24] [36] [48] months

B. COVERAGE SCHEDULES

1. **Lifetime Certificate Maximum Per Insured :** [$1,000,000 to $7,000,000]
2. **[Lifetime]Transplant Maximum [Per Organ] Per Insured:** [$100,000 to $1,000,000]

[3.] **Calendar Year Maximum Benefit Per Insured**:] [$100,000 to Lifetime Certificate Maximum Per Insured]

[4]. **Calendar Year Maximum Per Insured for Outpatient Treatment**] [$1,000 - $100,000]

[5.] **Calendar Year Maximum Per Insured for Prescription Drugs]** [$1,000 to $5,000] [or] [**Calendar Year Maximum Per Insured for Outpatient Treatment**] [or] [**Lifetime Maximum Per Insured]**

[6]. **DEDUCTIBLE SCHEDULES:**

The following deductibles are to be paid by the **Insured** in addition to the **Insured Coinsurance Percentage** before any **Sickness and Injury Benefits** or **Wellness and Screening Benefits** are payable by **Us** for **Covered Expenses**:

A. **Calendar Year Deductible** per **Insured**: [$1,000 to $50,000]
[Effective [Certificate Effective Date] [$1,000 to $50,000;]
[[Effective [Second Calendar Year]] [$1,000 to $50,000;]
[[Effective [Third Calendar Year]] [$1,000 to $50,000;]
[[Effective [Fourth Calendar Year]] [$1,000 to $50,000;]

[B.] [**Failure to Pre-Certify Treatment Deductible**:] **[**$1,000]; and

C. **Separate Deductible For Non-Participating Providers**: [$1,000 to $100,000]

[Effective [Certificate Effective Date] [$1,000 to $100,000;]
[[Effective [Second Calendar Year]] [$1,000 to $100,000;]
[[Effective [Third Calendar Year]] [$1,000 to $100,000;]
[[Effective [Fourth Calendar Year]] [$1,000 to $100,000;]

[7]. **COINSURANCE PAYMENT SCHEDULES – PARTICIPATING PROVIDERS [AND PARTICIPATING PHARMACIES]:**

For **Participating Providers [**and **Participating Pharmacies]**, after satisfaction of all applicable deductibles, the following **Company Insurance Percentage**, **Insured Coinsurance Percentage**, and **Insured Maximum Participating Provider Coinsurance Payment**, apply to all **Covered Expenses** in a **Calendar Year**:

A. **Company Insurance Percentage**: [50% to 100%]
(**Sickness and Injury Benefits** and **Wellness and Screening Benefits**)

[B. [**Company Insurance Percentage:**
(**Miscellaneous Benefits**)] [50% to 100%]]

C. **Insured Coinsurance Percentage**: [0% to 50%]; and
(**Sickness and Injury Benefits** and **Wellness and Screening Benefits**)

[D. [**Insured Coinsurance Percentage**:
(**Miscellaneous Benefits**)] [0% to 50%]]

E. **Insured Maximum Participating Provider Coinsurance Payment:** [$1,000 to $10,000]

[8]**. COINSURANCE PAYMENT SCHEDULES – NON-PARTICIPATING PROVIDERS [AND NON-PARTICIPATING PHARMACIES]:**

For **Non-Participating Providers [**and **Non-Participating Pharmacies]**, after satisfaction of all applicable deductibles, the following **Company Insurance Percentage**, **Insured Coinsurance Percentage**, **Insured Maximum Non-Participating Provider Coinsurance Payment**, and **Separate Deductible For Non-Participating Providers** apply to all **Covered Expenses** in a **Calendar Year**:

A. **Company Insurance Percentage** (**Sickness and Injury Benefits** and **Wellness and Screening Benefits**) [50% to 90%]

B. **Insured Coinsurance Percentage** (**Sickness and Injury Benefits** and **Wellness and Screening Benefits**) [10% to 50%]; and

C. **Insured Maximum Non-Participating Provider Coinsurance Payment** [$1,000 to $20,000]

[9]**. [PRESCRIPTION DRUGS]**

[A.] **[Prescription Drug Co-Pay** **[Generic Drug** **[**$0.00 to $35.00]
[Preferred Brand Drug **[**$25.00 to $40.00]]

[COVERED EXPENSES REMAINING AFTER SATISFACTION OF THE CALENDAR YEAR DEDUCTIBLES ARE SUBJECT TO COPAY]

[COVERED EXPENSES REMAINING AFTER SATISFACTION OF THE PRESCRIPTION DRUG CALENDAR YEAR DEDUCTIBLE PER INSURED ARE SUBJECT TO COPAY]

[COVERED EXPENSES REMAINING AFTER CO-PAY SUBJECT TO CALENDAR YEAR DEDUCTIBLES AND INSURED COINSURANCE PERCENTAGE]

[COVERED EXPENSES REMAINING AFTER CO-PAY SUBJECT TO PRESCRIPTION DRUG CALENDAR YEAR DEDUCTIBLE AND PRESCRIPTION DRUG COINSURANCE PERCENTAGE]

[COVERED EXPENSES FOR [GENERIC DRUG] [BRAND NAME DRUG] [AND] [PREFERRED BRAND DRUG] ARE SUBJECT TO CALENDAR YEAR DEDUCTIBLE AND INSURED COINSURANCE PERCENTAGE]

[B.] **[Prescription Drug Calendar Year Deductible Per Insured:**

[Generic Drug]	**[**$0 to $500]
[Preferred Brand Drug]	**] [**$0 to $500]
[Brand Name Drug]	**[**$0 to $500]

[C.] **[**Coinsurance Payments Schedules For **Participating Pharmacies:**

For **Participating Pharmacies** after satisfaction of all applicable deductibles, the following **Prescription Drug Company Insurance Percentage**, and the **Prescription Drug Insured Coinsurance Percentage**, applies to all **Covered Expenses** in a **Calendar Year**:

1**. Prescription Drug Company Insurance Percentage**: [0% to 100%]

2. **Prescription Drug Insured Coinsurance Percentage**: [0% to 100%]; [and]]

[D.] **[**Coinsurance Payments Schedules **Non-Participating Pharmacies:**

For **Non-Participating Pharmacies** after satisfaction of all applicable deductibles, the following **Prescription Drug Company Insurance Percentage**, applies to all **Covered Expenses** in a **Calendar Year**:

1. **Prescription Drug Company Insurance Percentage** [0% to 100%]

2. **Prescription Drug Insured Coinsurance Percentage** [0% to 100%]]

[10] **[DOCTOR OFFICE VISIT]**

[A.] **[Doctor Office Visit Co-Pay]**	[$25.00 to $50.00] [per visit] [per **Participating Provider**]
[B.] [**X-Ray, Laboratory And Diagnostic Testing Co-Pay]**	[25.00 to $50.00] [per service] [per type][per visit][per **Participating Provider**]

(If received during a Doctor Office Visit at a **Participating Provider)**

[This **Benefit** does not apply to **Covered Expenses** under any other **Benefit** provision or limitation such as ALLERGIES; SPINAL MANIPULATION; occupational, speech or physical therapy; and mental nervous disorders, if applicable. The **Doctor Office Visit Co-Pay** applies only to the actual office visit. The **X-Ray, Laboratory and Diagnostic Testing Co-Pay** is in addition to the **Doctor Office Visit Co-Pay**. **[Benefit** Payments by **Us** for the actual doctor office visit are limited to [$0 - $1,200] per **Insured** per **Calendar Year.]** Any services for the doctor office visit in excess of the [$0 - $1,200] limit or any other services, such as office surgeries, processing or reading charges, are subject to the **Calendar Year Deductible** and **Insured Coinsurance Percentage**.]

[All services received during the office visit are limited to [$0 - $1,000] per **Insured** per **Calendar Year]**

[Non-Participating Providers doctor office visits are subject to the [**Calendar Year Deductible]** [and] [or] [**Separate Deductible For Non-Participating Providers**] [[and] the **Insured Coinsurance Percentage**]]

[11] **[ACCESS FEES]**

[A. **Emergency Room Access Fee**] [(waived if **Insured** is **Confined** in a **Hospital** within twenty-four (24) hours following the **Emergency** room visit)]	[[$0 to $500] per **Insured** per visit to either a **Participating Provider** or a **Non-Participating Provider]**
[B. **[Laboratory and Diagnostic Testing Access Fee]**	[[$0 to $500] [per test] [per day] for either **Participating Provider** or **Non**- **Participating Provider** for each of the following **Inpatient** or **Outpatient** diagnostic tests: [MRI], [CAT Scan], [PET], [Myleogram] and [Nuclear Imaging Service] [(including Myocardial Perfusion Imaging - Thallium 201 Scintigraphy/Thallium Stress Tests)]**]**
[C. **Outpatient Therapy Access Fee]**	[[$0 to $500] per **Insured** per visit to a **Participating Provider** facility] [[$0 to $500] per **Insured** per visit to a **Non-Participating Provider** facility]
[12] [**Calendar Year Adult Wellness Maximum**	[$50 to $2,000]

[C. OPTIONAL RIDERS

[1]. **[MATERNITY AND IN VITRO FERTILIZATION BENEFIT RIDER***

Covered Expenses for services performed within [13-24] months from the effective date of coverage for such female **Insured**: [$1,500 to $3,000]

Covered Expenses for services performed [25] or more months from the effective date of coverage for such female **Insured**: [$1,000 to $5,000]

***** Note: Conception must begin [12] months after the effective date of coverage under this **Certificate**.]

In Vitro Fertilization **Benefits** are subject to a **Lifetime Certificate Maximum** of $15,000.

[2]**. [WAIVER OF RENEWAL PREMIUM DURING FIRST RENEWAL PREMIUM RATE GUARANTEE PERIOD UPON DEATH OR TOTAL DISABILITY OF PRIMARY INSURED]**

[Elimination Period:] [90 days]**]**

II. DEFINITIONS

The following terms or words that have the first letter of each word (including the plural form of such word) capitalized and the entire word or phrase printed in bold face type as used within any phrase, sentence, paragraph, provision or schedule in this **Certificate** shall have the express meaning set forth below:

["**Access Fee(s)**" means the [**Emergency Room Access Fee**,] [and] [the **Laboratory and Diagnostic Testing Access Fee**,] [and the **Outpatient Therapy Access Fee]**.

The remaining amount of **Covered Expenses** after the application and satisfaction of the designated **Access Fee** for applicable **Sickness and Injury Benefits** is subject to the **Calendar Year Deductible** and the **Insured Coinsurance Percentage.**

The amount of each applicable **Access Fee** is shown on the **Certificate Schedule**.]

"**Accident**", "**Accidentally**" means an event or occurrence that was unplanned and unintended by the **Insured** that was the sole cause of **Injuries** sustained or suffered by such **Insured** and that takes place on or after the **Issue Date**.

["**Adult Wellness Preventive Care**" means routine physicals, screenings and immunizations that are appropriate for the age and sex of the **Insured** and based on generally accepted standards of medical practice. **Adult Wellness Preventive Care** does not include: COLORECTAL CANCER SCREENING, PROSTATE CANCER SCREENING, MAMMOGRAPHY SCREENING, and PAP SMEAR SCREENING contained in the WELLNESS and SCREENING BENEFITS Section of this **Certificate.]**

"**Adverse Determination**" means a determination by **Us** that an admission, availability of care, continued stay or other **Health Care Service** has been reviewed and, based upon the information provided, the requested payment for the service is denied, reduced or terminated, because:

- the requested **Health Care Service** does not meet **Our Certificate** requirements for **Medical Necessity**; or
- the requested **Health Care Service** has been found to be "experimental/investigational".

To be considered as an **Adverse Determination**, the **Adverse Determination** must be a **Final Adverse Determination**, except as provided herein. The **Adverse Determination** must involve treatment, services, equipment, supplies or drugs that would require **Your Certificate** to expend five hundred dollars [$500] or more of expenditures.

Adverse Determination does NOT include a determination by **Us** to deny a **Health Care Service** or **Benefit** based upon:

- an express exclusion within the **Certificate**, other than a general exclusion for "**Medical Necessity**" or "experimental/investigational";
- an express limitation within the **Certificate** with respect to the number of visits, treatments, supplies or services for a covered **Benefit** in a given **Calendar Year** or due to the **Lifetime Certificate Maximum** for an Insured;
- an express limitation within the **Certificate** with respect to a maximum dollar limitation with respect to a covered **Benefit** in a given **Calendar Year** period or due to the **Lifetime Certificate Maximum** for an Insured;
- a determination by **Us** that an individual is not eligible to be an Insured;
- a determination by **Us** that treatment, service or supplies were requested or obtained by a **Covered Insured** through fraud or material misrepresentation;
- the procedure for determining the **Insured's** access to a **Provider**, including but not limited to any primary care gatekeeper, referral or network access provision;
- Illegality of services or the means or methods of administering them;
- FDA or other government agency determinations, reports or statements; or
- Licensure, permit or accreditation status of a **Provider**.

"**Alcoholism**" means the chronic and habitual use of alcoholic beverages by any person to the extent that such person has lost the power of self-control with respect to the use of such beverages.

"**Allowable Expense**" means, in connection with Section IX. COORDINATION OF BENEFITS, any necessary, reasonable and customary item of expense, at least a portion of which is covered under one or more of the **Plans** covering the applicable **Insured** for whom medical service was rendered and provided, and for which a **Benefit** claim was made. When a **Plan** provides benefits in the form of services, (for example an HMO) the reasonable cash value of each service rendered shall be deemed to be both an allowable expense and a benefit paid. A **Plan**, which takes **Medicare** or similar government benefits into consideration when determining the application of its coordination of benefits provision, does not expand the definition of an **Allowable Expense**.

"Ambulatory Surgical Center" means a state licensed public or private establishment with an organized medical staff of **Providers** with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures and continuous **Provider** services and registered professional nursing services whenever an **Insured** is in the center that does not provide services or other accommodations for the overnight stay of patients.

Ambulatory Surgical Center does not include a facility that primarily terminates pregnancies, a **Provider's** office maintained for the practice of medicine, or an office maintained for the practice of dentistry.

"Beneficiary" means the individual or organization listed on the **Certificate Schedule** as the **Beneficiary**.

"**Benefit(s)**" means **Sickness and Injury Benefits**, [and] **Wellness and Screening Benefits** [and] [**Miscellaneous Benefits]**.

"Bone Marrow Transplants" means the **Medically Necessary** transplantation, combined transplantation, and sequential transplantation procedures, sometimes referred to as "Bone Marrow Reconstitution or Support" in which Medically Necessary human blood precursor cells are administered following mylesuppressive or ablative therapy are received by an **Insured** while coverage for such **Insured** under this **Certificate** is in full force and effect. Such cells may be derived from such **Insured** in an autologous harvest, or from a matched donor for an allogenic transplant.

["Brand Name Drug" means a **Prescription Drug** for which a pharmaceutical company possesses either (i) an active and valid registered patent or (ii) an active and valid registered trade name after expiration of such patent.]

"Breast Reconstruction" means reconstruction of a breast incident to a **Mastectomy** to restore or achieve breast symmetry. **Breast Reconstruction** includes surgical reconstruction of a breast on which **Mastectomy** surgery has been performed in order to establish symmetry, as well as prostheses and services and other supplies that are **Medically Necessary** for any physical complication, including lymphedemas, at all stages of the reconstruction incident to a **Mastectomy**.

"Calendar Year" means the period beginning on the **Issue Date** and ending on December 31 of that year. In subsequent years, it is the period from January 1 through December 31 of the same year.

"Calendar Year Deductible" means the amount of **Covered Expenses** each **Insured** must incur within a **Calendar Year** before any **Sickness and Injury Benefits** or **Wellness and Screening Benefits** are payable by **Us** for such **Insured**. No **Sickness and Injury Benefits** or **Wellness and Screening Benefits** are payable by **Us** for any **Covered Expenses** incurred by an **Insured**, until after all applicable [**Co-Pays** and] **Access Fees**, the **Failure to Pre-Certify Treatment Deductible**, if applicable, the **Separate Deductible for Non-Participating Providers**, if applicable, and the **Calendar Year Deductible** are each satisfied and fully payable by either **You** or such **Insured**.

None of the following expenses may be used to satisfy the **Calendar Year Deductible**: (i) the amount of any applicable [**Co-Pay** or] **Access Fee**; (ii) the amount of the **Separate Deductible For Non-Participating Providers**, (iii) [**Covered Expenses** that constitute **Miscellaneous Benefits** for which payment is made by **Us**,] and (iv) the amount of the **Failure to Pre-Certify Treatment Deductible**.

[When [three (3)] **Insureds** satisfy this **Calendar Year Deductible**, no additional **Calendar Year Deductible** per **Insured** will be required for the remainder of the **Calendar Year**.]

[If [two (2)] or more **Insureds** incur **Covered Expenses** for **Injuries** sustained in the same accident, only one (1) **Calendar Year Deductible** will be applied that **Calendar Year** to the combined **Covered Expenses** resulting from the **Injuries** sustained in such common accident by all **Insureds**.]

The amount of the **Calendar Year Deductible** is shown on the **Certificate Schedule**.

[**"Calendar Year Maximum Benefit Per Insured"** means the maximum dollar amount of **Covered Expenses** per **Calendar Year** per **Insured** that **We** are required to pay, after satisfaction of all applicable deductibles, [**Co-Pays**,] [**Access Fees]** and the amount of any **Insured Coinsurance Percentage**. The amount of the **Calendar Year Maximum Benefit Per Insured** is shown on the **Certificate Schedule**.]

[**"Calendar Year Maximum Per Insured For Prescription Drugs"** means the maximum dollar amount of **Covered Expenses** incurred per **Insured** per **Calendar Year** that **We** are required to pay for **Prescription Drugs** ,after the satisfaction by each applicable **Insured** of (i) [the amount of any applicable **Co-pays**;] **[ii)] [**the **Prescription Drug Calendar Year Deductible;]** and [(iii)] [the amount of the **Prescription Drug Insured Coinsurance Percentage]**. The amount of the **Calendar Year Maximum Per Insured for Prescription Drugs** is shown on the **Certificate Schedule**.]

["Calendar Year Maximum Per Insured For Outpatient Treatment" means the maximum dollar amount of **Covered Expenses** incurred per **Insured** per **Calendar Year** that **We** are required to pay, after the satisfaction by each applicable **Insured** of (i) the amount of all applicable deductibles and **Access Fees** (ii) the amount of the **Insured Coinsurance Percentage** for the **Outpatient** coverages listed in Section V. A. EMERGENCY ROOM AND OTHER OUTPATIENT BENEFITS. The amount of the **Calendar Year Maximum Per Insured** for **Outpatient Treatment** is shown on the **Certificate Schedule**.**]**

["Calendar Year Adult Wellness Maximum" means the maximum dollar amount of **Covered Expenses** per **Calendar Year** per **Insured** that **We** are required to pay, after satisfaction of all applicable deductibles, [**Co-Pays**,] [**Access Fees]** and the amount of any **Insured Coinsurance Percentage**. The amount of the **Calendar Year Maximum Adult Wellness Maximum** is shown on the **Certificate Schedule**.]

["Center of Excellence" means a **Participating Provider** who has agreed to provide organ transplants.]

"Certificate" means this contract of coverage between all **Insureds** and the **Company** that was issued under the **Group Policy**. This contract of coverage consists solely of (i) this written CERTIFICATE OF COVERAGE, (ii) the application for coverage of each **Insured**, which application is attached hereto and by this reference incorporated for all purposes, and (iii) any riders, endorsements or amendments attached hereto.

"Certificate Of Continuation / Conversion Coverage" means the documents prepared by **Us** in accordance with the provisions of Section III.E. CONTINUATION OF COVERAGE AND CERTIFICATE OF CONTINUATION / CONVERSION, which on their effective date will replace this **Certificate** as the contract of coverage between the applicable **Insured** and the **Company**, consisting of (i) an endorsement removing each applicable **Insured** from this **Certificate**, and (ii) a new certificate of coverage for each applicable **Insured** with the same applicable provisions as this **Certificate**, including any riders or amendments attached hereto, but bearing a new certificate number.

"Certificate Schedule" means the schedule of **Certificate** information that commences on page 3 of this **Certificate**.

["Childhood Wellness Preventive Care" means a routine annual **Outpatient** physical examination of each **Insured** under the age of [19, or to age 24] if **Full-Time Student** performed by a **Participating Provider**, not in connection with any **Sickness** or **Injury**, but instead as an evaluation of the annual health status of such individual, including any necessary laboratory blood tests, urinalysis, and x-rays performed in connection with each routine annual **Outpatient** physical examination and at the order of such **Participating Provider**. Provided, however, that such ordered medical laboratory and diagnostic tests, services and supplies are:

1. reasonably designed to permit early diagnoses of certain **Sicknesses**;
2. appropriate and performed according to and within generally accepted standards for medical practice;
3. in the most cost effective setting and manner available;

4. not primarily for the convenience of an **Insured**, a **Family**, or a **Provider**; and
5. the costs incurred do not exceed the **Maximum Allowable Charge** for such services.]

"Claim Determination Period" means, in connection with Section IX. COORDINATION OF BENEFITS, a **Calendar Year**. However, it does not include any part of a year during which an **Insured** has no coverage under this **Certificate**, or before the date that Section IX. COORDINATION OF BENEFITS or a similar provision takes effect.

"Class" means the classification by **Us** of (i) individuals to whom **We** have issued new coverage for the purposes of the calculation of their **Initial Premium** rates, and (ii) individuals to whom **We** have previously issued coverage for purposes of the calculation of their **Renewal Premium** rates.

"Company" means Freedom Life Insurance Company of America.

"Company Insurance Percentage" means the portion of the **Covered Expenses We** must pay to or on behalf of an **Insured** for **Benefits** under this **Certificate**, after satisfaction by the **Insured** of (i) all applicable [**Co-Pays** and] **Access Fees**, (ii) all applicable deductibles and (iii) the amount of the applicable **Insured Coinsurance Percentage**. The **Company Insurance Percentage** is shown on the **Certificate Schedule** for **Covered Expenses** for **Sickness and Injury Benefits**, [and] **Wellness and Screening Benefits** [and] [**Miscellaneous Benefits]** at (i) **Participating Providers**; and (ii) **Non-Participating Providers**.

"Complications of Pregnancy" means:

1. Conditions (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy, including but not limited to, acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity; and
2. Non-elective **Emergency** cesarean sections, termination of ectopic pregnancy, and spontaneous termination of pregnancy occurring during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy does not include false labor, occasional spotting, **Provider** prescribed rest during the period of pregnancy, morning sickness, and hyperemesis gravidarum. Nor does it include pre-eclampsia and similar conditions associated with the management of a difficult pregnancy unless such condition constitutes a nosologically distinct complication.

"Complying Plan" means, in connection with Section IX. COORDINATION OF BENEFITS, a **Plan** with an order of benefit determination provision which complies with the ORDER OF BENEFIT DETERMINATION RULES contained is Section IX. A.

"Confinement or **Confined"** means **Inpatient** services received as a resident bed patient for not less than eight (8) hours in a **Hospital**. A period of **Confinement** begins on the date of admission to the **Hospital** as an **Inpatient** and ends on the date of discharge.

["Co-Pays" means the amount of each first dollar co-payment of **Covered Expenses** incurred by an **Insured** for the applicable service and care that is required to be applied to and satisfied by the **Insured** before the remaining portion of such **Covered Expenses** are eligible for payment consideration by **Us. Co-Pays** may not be used to satisfy the **Calendar Year Deductible**, the **Insured Coinsurance Percentage**, the **Separate Deductible for Non-Participating Providers**, [any applicable **Access Fees**,] the amount of **Covered Expenses** for which benefit payments are received by **You** under any optional rider issued with this **Certificate**, or the amount of any applicable **Failure to Pre-Certify Treatment Deductible**.

[The remaining amount of **Covered Expenses** after the application and satisfaction of the designated **Co-Pay** is subject to the **Calendar Year Deductible** [the **Separate Deductible for Non-Participating Providers**,] [any applicable **Access Fees**,] and the **Insured Coinsurance Percentage.]**

The amount of each **Co-Pay** is shown on the **Certificate Schedule**.]

"Covered Expenses" means for the covered items and services listed in the **Sickness and Injury Benefits**, [and] **Wellness and Screening Benefits [**and the] [**Miscellaneous Benefits]** Sections of this **Certificate** the amount of expenses actually incurred by an **Insured**, after the **Issue Date** of this **Certificate** and before **Termination of**

Coverage, as a result of being **Provided** applicable medical, surgical, or diagnostic services, supplies, care, **Prescription Drugs** and other applicable treatment, which in each event is **Medically Necessary**, up to but not exceeding the amount of each of the following:

1. the **Maximum Allowable Charge** for each applicable medical, surgical or diagnostic service, supply, care [**Prescription Drugs]** or other applicable treatment;
2. the **Lifetime Certificate Maximum Per Insured**;
3. the **[Lifetime] Transplant Maximum [Per Organ] Per Insured**; [and]
4. the amount of any other applicable coverage limit or excluded amount set forth in any limitation, exclusion or waiting period that is contained in any Section in this **Certificate** and**/**or in any exclusionary or limiting rider, amendment or endorsement attached hereto.
5. **[**the **Calendar Year Maximum Benefit Per Insured**; [and]]
6. **[**the **Calendar Year Maximum Per Insured For Prescription Drugs**;] [and]]
7. [the **Calendar Year Maximum Per Insured For Outpatient Treatment**.**]**

"CPT Code" means the applicable numeric code assigned to a particular medical procedure **Provided** consistent with the most current version of the *Physicians' Current Procedural Terminology,* published by the American Medical Association on the date charges for such procedure are incurred by an **Insured**.

"Custodial Care" means care given mainly to meet personal needs. It may be provided by persons without professional skills or training. "**Custodial Care**" includes, but is not limited to, help in walking, getting in and out of bed, bathing, dressing, eating and taking medicine.

"Diabetes Equipment" means blood glucose monitors, insulin pumps and associated appurtenances, insulin infusion devices, and podiatric appliances for the prevention of complications associated with diabetes.

"Diabetes Self-Management Training" means training provided by a health care practitioner or **Provider** who is licensed, registered or certified in this state to provide appropriate health care services for the treatment of diabetes.

Diabetes Self-Management Training includes:

1. training provided after the initial diagnosis of diabetes, including nutritional counseling and proper use of **Diabetes Equipment** and **Diabetes Supplies**;
2. training authorized on the diagnosis of a **Provider** or other health care practitioner due to a significant change in the **Insured's** symptoms or condition which necessitates changes in the self-management regime; and
3. periodic or episodic continuing education training when prescribed by an appropriate health care practitioner as warranted by the development of new techniques and treatments for diabetes.

"Diabetes Supplies" means (a) test strips for blood glucose monitors; (b) visual reading and urine test strips; (c) lancets and lancet devices; (d) insulin and insulin analogs; (e) injection aids; (f) syringes; (g) prescriptive oral agents for controlling blood sugar levels; and (h) glucagon emergency kits.

"Disability Period" means the period of time that the **Primary Insured** is continuously **Totally Disabled** while coverage under the **Certificate** for such **Primary Insured** is in full force and effect.

["Doctor Office Visit Co-Pay" means the **Co-Pay** payment that is required [per visit] [per **Insured]** [per type of service] toward the applicable amount of **Covered Expenses** incurred by an **Insured** for **Outpatient** visits per **Calendar Year** per **Insured** to the professional offices of a physician who is a **Participating Provider** as defined in the **Certificate. Co-Pays** may not be used to satisfy the **Calendar Year Deductible**, the **Insured Coinsurance Percentage**, the **Separate Deductible for Non-Participating Providers**, [any applicable **Access Fees**,] the amount of **Covered Expenses** for which benefit payments are received by **You** under any optional rider issued with this **Certificate**, or the amount of any applicable **Failure to Pre-Certify Treatment Deductible**.]

[The remaining amount of **Covered Expenses** after the application and satisfaction of the **Doctor Office Visit Co-Pay** is subject to the **Calendar Year Deductible** [the **Separate Deductible for Non-Participating Providers**,] [any applicable **Access Fees**,] and the **Insured Coinsurance Percentage.]**

[The amount of the **Doctor Office Visit Co-Pay** is shown on the **Certificate Schedule**.]

"Emergency" means the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:

1. placing the patient's health in severe jeopardy;
2. serious impairment to bodily functions; or
3. serious dysfunction of any bodily organ or part.

"Emergency Care Facility" means a state licensed public or private establishment with an organized medical staff of **Providers** with permanent facilities that are equipped and operated primarily for the purpose of rendering **Outpatient Emergency** medical services for **Sicknesses** and **Injuries**, and which facility does not render **Inpatient** services. **Emergency Care Facility** does not include the emergency room of a **Hospital**, an **Ambulatory Surgical Center**, a facility that primarily terminates pregnancies, a **Providers** office maintained for the practice of medicine, or an office maintained for the practice of dentistry.

["Emergency Room Access Fee" means the amount of **Covered Expenses** under Section V.A. EMERGENCY ROOM SERVICES, an **Insured** must incur before any **Benefits** are payable under this **Certificate** if such **Insured** receives and is charged for services rendered in the emergency room of a **Hospital**. No **Benefits** are payable under this **Certificate** for any **Covered Expenses** for such an emergency room visit, until after the amount of any applicable **Emergency Room Access Fee**, the amount of the **Calendar Year Deductible**, **Insured Coinsurance Percentage,** as well as the amount of all other applicable **Access Fees** are satisfied and fully payable either by **You** or such **Insured**. In addition to the **Emergency Room Access Fee**, the **Separate Deductible for Non-Participating Providers** may apply to services rendered by **Non-Participating Providers**. However, the **Emergency Room Access Fee** shall be waived by **Us** if such **Insured** is **Confined** in any **Hospital** within twenty-four (24) hours of such emergency room visit.

None of the following expenses may be used to satisfy the **Emergency Room Access Fee**: (i) [the amount of the **Laboratory and Diagnostic Testing Access Fee**,] [(ii)][the amount of the **Outpatient Therapy Access Fee**,][(iii)] t[he amount of the **Separate Deductible for Non-Participating Providers**,][(iv)] t[he amount of **Covered Expenses** for which benefit payments are received by **You** under any optional rider issued with this **Certificate**,] [(v)[]the amount of any applicable **Failure to Pre-Certify Treatment Deductible**,] [(vi)] [the amount of the **Calendar Year Deductible,][** and] [vii] the **Insured Coinsurance Percentage]**.

[The amount of the **Emergency Room Access Fee** is shown on the **Certificate Schedule**.]

"External Review" means a process, independent of all affected parties, to determine if a **Health Care Service** is **Medically Necessary** or experimental/investigational.

"Failure to Pre-Certify Treatment Deductible" means the additional amount of **Covered Expenses** an **Insured** must incur before any **Sickness and Injury Benefits** are payable under this **Certificate** if such **Insured** fails to properly obtain **Pre-Certification of Treatment** as required under Section V.D. PRE-CERTIFICATION OF TREATMENT. No **Sickness and Injury Benefits** are payable under this **Certificate** for any **Covered Expenses** until after the amount of any applicable **Failure to Pre-Certify Treatment Deductible**, and the amount of the **Calendar Year Deductible** are satisfied and fully payable either by **You** or such **Insured**. In addition to the **Failure to Pre-Certify Treatment Deductible**, the **Separate Deductible For Non-Participating Providers** will apply to services rendered by **Non-Participating Providers**.

The amount of the **Failure to Pre-Certify Treatment Deductible** is shown on the **Certificate Schedule**.

None of the following expenses may be used to satisfy the **Failure to Pre-Certify Treatment Deductible**: (i) the amount of the **Separate Deductible For Non-Participating Providers**, (ii) the amount of **Covered Expenses** that constitute **Wellness and Screening Benefits** for which payment is made by **Us**, and (iii) the amount of the **Calendar Year Deductible** , and (iv) the amount of any applicable [**Co-Pay][** or][and][**Access Fee]**.

"Family" means the spouse, son or daughter, brother or sister, parent, grandparent or grandchild of an **Insured**.

"Final Adverse Determination" means an **Adverse Determination** involving a covered **Benefit** that has been upheld by **Us** at the completion of **Our Internal Grievance Procedure**. "**First Certificate Year**" means for the

period beginning on the **Issue Date** and ending on the last day immediately preceding the first anniversary of the **Issue Date**.

"First Certificate Year" means for the period beginning on the **Issue Date** and ending on the last day immediately preceding the first anniversary of the **Issue Date**.

"First Renewal Date" means the first premium due date following payment of the **Initial Premium** which is shown on the **Certificate Schedule**.

"First Renewal Premium" means the amount of **Renewal Premium** due on the **First Renewal Date**. The amount of **First Renewal Premium**, if known on the **Issue Date**, is shown on the **Certificate Schedule**.

"Full-Time Student" means an individual, under the age of [24], who is enrolled in at least twelve (12) credit hours per semester at an accredited college or university.

[**"Generic Drug"** means a **Prescription Drug** that contains the same active ingredients as an equivalent former **Brand Name Drug** that is no longer protected by a patent, and the trade name, if any, associated with such former **Brand Name Drug** is not listed on the label of such **Prescription Drug**.]

"Group Policy" means the association group insurance contract issued to the **Group Policyholder** under which this **Certificate** is issued to the **Primary Insured**.

"Group Policyholder" means the association shown on the **Certificate Schedule** to whom the **Group Policy** was issued.

"Health Care Services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, **Sickness, Injury** or disease, as used within the Grievance Procedures section.

"Home Health Care Plan" means a **Medically Necessary** program of care, established by an **Insured's Provider**, taking place in a residential setting.

"Hospice" means an agency licensed by the appropriate licensing agency to provide **Hospice Care**, under an administered program for a terminally ill **Insured** and his or her **Family**, with the following services available twenty-four (24) hours a day, seven (7) days a week: (a) **Inpatient** services, (b) home services, and (c) follow-up bereavement services.

"Hospice Care" means a **Medically Necessary**, coordinated, interdisciplinary **Hospice**-provided program for meeting the physical, psychological, spiritual, and social needs of dying individuals and his or her **Family**. **Hospice Care** provides **Medically Necessary** nursing, medical, and other health services to relieve pain and provide support through home and **Inpatient** care during the **Sickness** and bereavement of an **Insured** and his or her **Family**.

"Hospital" means a place which:

1. is legally operated for the care and treatment of sick and injured persons at their expense;
2. is primarily engaged in providing medical, diagnostic and surgical facilities (either on its premises or in facilities available to it on a formal pre-arranged basis);
3. has continuous twenty-four (24) hour nursing services by or under the supervision of a registered nurse (R.N.); and
4. has a staff of one or more **Providers** available at all times.

It also means a place that may not meet the above requirements, but is accredited as a hospital by the Joint Commission on Accreditation of Healthcare Organizations, the American Osteopathic Association or the Commission on the Accreditation of Rehabilitation Facilities.

Hospital does not mean:

1. a convalescent home, nursing home, rest home or **Skilled Nursing Home**;

2. a place primarily operated for treatment of **Mental and Emotional Disorders**, drug addicts, alcoholics, or the aged;
3. a special unit or wing of a **Hospital** used by or for any of the above;
4. a long-term mental care facility; or
5. a facility primarily providing **Custodial Care**.

"Independent Review Organization" means an entity that conducts independent **External Reviews** of **Adverse Determinations** and **Final Adverse Determinations**.

"Inherited Metabolic Disorder" means a disease caused by an inherited abnormality of body chemistry and includes a disease tested under a newborn screening program.

"Initial Premium" means the amount charged for coverage under this **Certificate** for **You** and all **Other Insureds** for the period of time from the **Issue Date** through the day before the **First Renewal Date**. The amount of the **Initial Premium** is shown on the **Certificate Schedule**, and is payable in advance of the **Issue Date**.

"Injury" means damage or harm **Accidentally** sustained to the physical structure of the body of an **Insured** that is the direct cause of the loss independent of disease, bodily infirmity, or any other cause, which occurs while this **Certificate** is in force and effect for such **Insured**. A specific **Injury** from which disability continues or recurs shall be considered one and the same **Injury** or "any one **Injury**", unless periods of **Confinement** to a **Hospital** or service, treatment, or **Covered Expenses** incurred resulting from such **Injury** are separated by an interval of at least ninety (90) consecutive days between the end of one such period and the beginning of a subsequent such period.

"Inpatient" means an **Insured** who receives **Medically Necessary** services from a **Provider** in a **Hospital** when such **Insured** is **Confined** and receives room and board from such **Hospital** for not less than eight (8) hours. Treatment or services rendered or **Provided** in a **Hospital** emergency room is not an **Inpatient Confinement** for the purposes of this **Certificate**. A period of **Inpatient Confinement** begins on the date of admission to the **Hospital** as an **Inpatient** and ends on the date of discharge.

"Insured" means the following:

1. the **Primary Insured** whose coverage under this **Certificate** is still in force and effect,
2. any other individuals named as **Other Insureds** on the **Certificate Schedule** whose coverage under this **Certificate** is still in force and effect, and
3. any individual who is added to this **Certificate** after the **Issue Date** by proper endorsement after proper application and payment of any additional premium whose coverage under this **Certificate** is still in force and effect.

"Insured Coinsurance Percentage" means the portion of the **Covered Expenses** that **You** must pay after satisfaction of all applicable deductibles[,] [**Co-pays**] and **Access Fees**. The different **Insured Coinsurance Percentages** are shown on the **Certificate Schedule** at [(i]) **Participating Providers [.]** [(i]i) [**Participating Pharmacies][**,][and] [(iii)] **Non-Participating Providers**, and (iv) **Non-Participating Pharmacies]**. (

"Insured Maximum Participating Provider Coinsurance Payment" means the maximum amount, after the satisfaction of all applicable **Certificate** deductibles, **Access Fees** [and **Co-Pays]**, that an **Insured** is required to pay in a **Calendar Year** under the **Insured Coinsurance Percentage** for services rendered at **Participating Providers [**and **Participating Pharmacies]. Covered Expenses** incurred for services rendered at **Participating Providers [**and **Participating Pharmacies]** that are covered under the **Sickness and Injury Benefits** and the **Wellness and Screening Benefits** sections and applied by the **Company** toward satisfaction of the **Calendar Year Deductible**, the **Separate Deductible For Non-Participating Providers**, the **Failure to Pre-Certify Treatment Deductible** and/or any other deductible contained in this **Certificate** or any rider attached to this **Certificate**, shall not be credited or applied toward satisfaction of the **Insured Maximum Participating Provider Coinsurance Payment**. The amount of the **Insured Maximum Participating Provider Coinsurance Payment** is shown on the **Certificate Schedule**.

"Insured Maximum Non-Participating Provider Coinsurance Payment" means the maximum amount, after the satisfaction of all applicable **Certificate** deductibles and **Access Fees**, that an **Insured** is required to pay in a

Calendar Year under the **Insured Coinsurance Percentage** for services rendered at **Non-Participating Providers [**and **Non-Participating Pharmacies]**. **Covered Expenses** incurred for services rendered at **Non-Participating Providers [**and **Non-Participating Pharmacies]** that are covered under the **Sickness and Injury Benefits** and the **Wellness and Screening Benefits** Sections and applied by the **Company** toward satisfaction of the **Calendar Year Deductible**, the **Failure to Pre-Certify Treatment Deductible**, and/or any other deductible contained in this **Certificate** or any rider attached to this **Certificate** shall not be credited or applied toward satisfaction of the **Insured Maximum Non-Participating Provider Coinsurance Payment**. The amount of the **Insured Maximum Non-Participating Provider Coinsurance Payment** is shown on the **Certificate Schedule**.

"Intensive Care Unit" means only the specifically designed facility of a **Hospital** which provides the highest level of medical care and restricts admission to only patients who are physically critically ill or injured, and which is separate and distinct from the rooms, beds and wards of such **Hospital** customarily used for patients who are not critically ill. To be considered an **Intensive Care Unit** under this **Certificate**, such facility must be permanently equipped with special life-saving equipment for the care of the physically critically ill or injured, and patients in such unit must be under constant and continuous observation by nursing staffs assigned on a full-time basis, exclusively to such facility of the **Hospital**. A coronary care facility and a specialized burn unit of a **Hospital** shall be considered an **Intensive Care Unit** if it meets these requirements and is restricted to persons receiving critical coronary or specialized burn care. However, the following are not considered an **Intensive Care Unit** under this **Certificate**:

1. a **Hospital** emergency room, regardless of the services or supplies rendered in such emergency room,
2. a surgical recovery room,
3. a sub-acute intensive care unit,
4. a progressive care unit,
5. an intermediate care unit,
6. a private monitored room,
7. any other observation unit or other facilities in a **Hospital** that are step downs from the unit in such **Hospital** that provides the highest level of medical care to critically ill patients.

"Internal Grievance Procedure" means the procedure by which **We** handle and resolve grievances, and provide **Insureds** with prompt and meaningful review on the issue of denial, in whole or part, of **Health Care Services**.
"Issue Date" means the date on which coverage under this **Certificate** commences for **You** and **Other Insureds**. This date is shown on the **Certificate Schedule**.

["Laboratory and Diagnostic Testing Access Fee" means the amount of **Covered Expenses** an **Insured** must incur [either per test per day, (as set forth in the **Certificate Schedule** by test and service)], before any **Benefits** are payable by **Us** under this **Certificate** for [MRI], [CAT Scan], [PET], [Myleogram] and [Nuclear Imaging Service (including Myocardial Perfusion Imaging - Thallium 201 Scintigraphy/Thallium Stress Tests)]. No **Benefits** are payable under this **Certificate** for any **Covered Expenses** for [MRI], [CAT Scan], [PET], [Myleogram] and [Nuclear Imaging Service (including Myocardial Perfusion Imaging - Thallium 201 Scintigraphy/Thallium Stress Tests)] performed on or for such **Insured** until after the amount of the **Laboratory and Diagnostic Testing Access Fee,** the amount of the **Calendar Year Deductible**, the **Insured Coinsurance Percentage**, as well as the amount of all other applicable **Access Fees** are satisfied and fully payable by either **You** or such **Insured**. In addition to the **Laboratory and Diagnostic Testing Access Fee**, the **Separate Deductible for Non-Participating Providers** will apply to services rendered by **Non-Participating Providers**.]

[None of the following expenses may be used to satisfy the **Laboratory and Diagnostic Testing Access** Fee, (i) **Emergency Room Access Fee**, [(ii) the amount of the **Outpatient Therapy Access Fee**,][(iii)] the amount of the **Separate Deductible for Non-Participating Providers**,[(iv)] the amount of **Covered Expenses** for which benefit payments are received by **You** under any optional rider issued with this **Certificate**,[(v)]the amount of any applicable **Failure to Pre-Certify Treatment Deductible**, [(vi)] the amount of the **Calendar Year Deductible,** and [vii] the **Insured Coinsurance Percentage**.]

[The amount of the **Laboratory and Diagnostic Testing Access Fee** is shown on the **Certificate Schedule**.]

"Lifetime Certificate Maximum Per Insured" means the total dollar amount of **Covered Expenses** payable on behalf of an **Insured** under this **Certificate** for **Benefits**. The minimum amount of the **Lifetime Certificate Maximum Per Insured** is shown on the **Certificate Schedule**. The amount of the **Lifetime Certificate Maximum**

Per Insured may increase on an annual basis in accordance with the terms, limitations and exclusions of Section VIII. INCREASE IN LIFETIME CERTIFICATE MAXIMUM.

["[Lifetime] Transplant Maximum [Per Organ] Per Insured" means the total dollar amount of **Covered Expenses** payable by **Us** under the terms of this **Certificate** for services **Provided** to an **Insured** in connection with or attributable to all **Solid Organ Transplants**, **Bone Marrow Transplants**, and **Stem Cell Transplants** received by the **Insured**. This [lifetime] [per organ] maximum **Benefit** includes all related **Covered Expenses** incurred from 14 days before each applicable transplant surgery or procedure to 365 days after each such transplant surgery or procedure. The amount of the **[Lifetime] Transplant Maximum [Per Organ] Per Insured** is shown on the **Certificate Schedule** and shall not exceed the **Lifetime Certificate Maximum Per Insured**.]

"Mammogram" means the X-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression device, screens, and films and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast.

"Manifests" or **"Manifested"** means either the presentation of symptoms or the presence of a medical condition, whether physical or mental, and regardless of the cause:

1. for which medical advice, diagnosis, care or treatment was recommended or received; and/ or
2. which would have caused a reasonably prudent person to seek medical advice, diagnosis, care or treatment, and which condition would have been medically diagnosable after the receipt of the results of medical diagnostic and laboratory tests that would have been reasonably indicated and ordered by a reasonably prudent **Provider** under the same or similar circumstances.

"Mastectomy" means the surgical removal of all or part of the breast as a result of breast cancer. **Mastectomy** does not include biopsies or other exploratory or diagnostic procedures used to detect the presence of cancer.

"Maximum Allowable Charge" means the following:

1. For **Providers**, **Maximum Allowable Charge** is the actual expense incurred by an **Insured** for the applicable service, supplies, care, or treatment **Provided**, after any reduction, adjustment, and/or discount pursuant to any **Participating Provider** agreements or other network agreements, negotiated rates, fee schedules or arrangements that determine or prescribe the actual amount of charges or fees that the **Provider**:

   a) agreed to accept as payment in full for such services, supplies, care or treatment, and
   b) ultimately charged such **Insured**, regardless of any higher amount that may have been placed on the **Provider's** billing statement of charges.

2. For **Hospitals**, **Ambulatory Surgical Centers**, **Emergency Care Facility**, **Skilled Nursing Homes**, laboratories, pharmacies or other medical, diagnostic or treatment facilities, "**Maximum Allowable Charge**" is the actual amount charged by such entity for the applicable service or treatment **Provided** to an **Insured**, after a reduction, adjustment, and/or network discount pursuant to any **Participating Provider** agreements, [**Participating Pharmacy** agreements] or other network agreements, negotiated rates, fee schedules or other arrangements that determine or prescribe the actual amount of charges or fees that such entity:

   a) agreed to accept as payment in full for such applicable services, supplies, care, treatment[or **Prescription Drugs]**, and
   b) ultimately charged such **Insured** for such applicable services, supplies, care, treatment [or **Prescription Drugs]**, regardless of any higher amount that may have been placed on the entity's billing statement of charges.

However, the amount of the **Maximum Allowable Charge** under (1) and (2) above shall never exceed (i) the amount for which the applicable **Insured** has a legal liability and payment obligation for the receipt of such applicable services, supplies, care, treatment [or **Prescription Drugs]**, (ii) the amount of the **Medicare** allowable or approved charge for the receipt of such applicable services, supplies, care, treatment [or **Prescription Drugs]** with

respect to any **Insured** who is **Medicare** eligible, or (iii) the amount of **Usual and Customary Expense** for the receipt of such applicable services, supplies, care, treatment [or **Prescription Drugs]**.

"Medical Foods" means modified low protein foods and metabolic formulas. Metabolic formulas are foods that are all of the following: (i) formulated to be consumed or administered enterally under the supervision of a **Provider**; (ii) processed or formulated to be deficient in one or more of the nutrients present in typical foodstuffs; (iii) administered for the medical and nutritional management of a person who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrient requirements as established by medical evaluation; and (iv) essential to a person's optimal growth, health and metabolic homeostasis.

Modified low protein foods are foods that are all of the following: (i) formulated to be consumed or administered enterally under the supervision of a **Provider** (ii) processed or formulated to contain less than one gram of protein per unit of serving, but does not include a natural food that is naturally low in protein; (iii) administered for the medical and nutritional management of a person who has limited capacity to metabolize foodstuffs or certain nutrients contained in the foodstuffs or who has other specific nutrient requirements as established by medical evaluation; and (iv) essential to a person's optimal growth, health and metabolic homeostasis.

"Medical Necessity" and **"Medically Necessary"** means:

1. For the covered items and services listed in the **Sickness and Injury Benefits** Section of this **Certificate**, **Medical Necessity** and **Medically Necessary** is any applicable **Confinement** of an **Insured**, as well as any other diagnostic test, laboratory test, examination, surgery, medical treatment, service or supply listed therein that is **Provided** to an **Insured**:

   a) by or at the appropriate order, or upon the approval of a **Provider**;
   b) for the medically recognized diagnosis or care and treatment of an **Injury** or **Sickness**;
   c) in a manner appropriate and necessary for the symptoms, diagnosis or treatment of such **Injury** or **Sickness**;
   d) according to and within generally accepted standards for medical practice;
   e) in the most cost effective setting and manner available to treat the **Injury** or **Sickness**;
   f) not primarily for the convenience of an **Insured**, **Family**, or a **Provider**; and
   g) not investigational or experimental in nature.

2. For the covered items and services listed in the **Wellness and Screening Benefits [**and the] [**Miscellaneous Benefits]** Section[s] of this **Certificate**, **Medical Necessity** and **Medically Necessary** is any applicable diagnostic test, laboratory test, examination, or medical treatment, service or supply listed therein that is **Provided** to an **Insured**:

   a) reasonably designed to either prevent certain future **Sickness** or permit early diagnoses of certain **Sickness**;
   b) prescribed, performed and/or ordered by a **Provider**;
   c) appropriate and performed according to and within generally accepted standards for medical practice;
   d) rendered in the most cost effective setting and manner available, and
   e) not primarily for the convenience of an **Insured**, a **Family**, or a **Provider**.

The fact that a **Provider** prescribed, ordered, recommended or approved a service, supply, treatment or **Confinement** does not in and of itself make it **Medically Necessary** or a **Medical Necessity**.

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

"Mental and Emotional Disorders" means a neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

[“Miscellaneous Benefits” means only treatments, procedures, services, and supplies that are specifically enumerated in Section V.C. MISCELLANEOUS BENEFITS. If a treatment, procedure, service, or supply is not specifically enumerated in the MISCELLANEOUS BENEFITS Section, then fees charged or expenses associated with such items are not covered under this **Certificate** as a **Miscellaneous Benefit.]**

“Mode Of Premium Payment” means the interval of time (monthly, quarterly, semi-annual or annual) that you have selected for payment of the **Initial Premium** and **Renewal Premium**. The premium payment interval selected by **You** as the **Mode Of Premium Payment** is shown on the **Certificate Schedule**. This **Mode Of Premium Payment** is subject to change at **Our** discretion.

“Non-Complying Plan” means, in connection with Section IX. COORDINATION OF BENEFITS, a **Plan** with an order of benefit determination provision which does not comply with Section IX. A. ORDER OF BENEFIT DETERMINATION RULES.

[“Non-Participating Pharmacy” means a pharmacy that at the time **Covered Expenses** are incurred, has not entered into or has terminated a prior agreement to provide services to **Insureds** under this **Certificate**.]

“Non-Participating Provider” means a **Hospital**, **Provider**, **Ambulatory Surgical Center, Skilled Nursing Home**, or other licensed practitioner of the healing arts for which **Sickness and Injury Benefits** or **Wellness and Screening Benefits** are payable under this **Certificate** that, at the time **Covered Expenses** are incurred, has not entered into or has terminated a prior agreement to provide health care services to **Insureds** under this **Certificate** form at discounted rates.

“**Orthotic Device**” means an external device that is (i) intended to restore physiological function or cosmesis to a patient; and (ii) custom-designed, fabricated, assembled, fitted or adjusted for the patient using the device prior to or concurrent with the delivery of the device to the patient.

“**Orthotic Service**” means the evaluation and treatment of a condition that requires the use of an orthotic device.

“Other Insureds” means those members of **Your Family** that are listed on the **Certificate Schedule** on the **Issue Date.**

“Our” means Freedom Life Insurance Company of America.

“Outpatient” means **Medically Necessary** medical care, treatment, services or supplies from a **Provider** at (i) a clinic, (ii) an emergency room of a **Hospital**, (iii) an **Ambulatory Surgical Center**, (iv) an **Emergency Care Facility**, or (v) the surgical facility of a **Hospital** which does not result in an **Inpatient Confinement** at such **Hospital** following such surgery.

[“Outpatient Therapy Access Fee” means the amount of **Covered Expenses** an **Insured** must incur **[**per **Outpatient** visit] [per service] [per type of service] to any medical facility for any **Outpatient** non-surgical medical therapy or treatment under Section V.A. OUTPATIENT THERAPY before any **Benefits** are payable by **Us** under this **Certificate** for any **Outpatient** non-surgical medical therapy or treatment received by such **Insured** during each such visit. No **Benefits** are payable under this **Certificate** for any **Covered Expenses** for any non-surgical medical therapy or treatment received by such **Insured** on an **Outpatient** basis after the amount of the **Outpatient Therapy Access Fee** , the amount of the **Calendar Year Deductible**, the **Insured Coinsurance Percentage**, as well as the amount of all other applicable **Access Fees** are satisfied and fully payable by either **You** or such **Insured**. In addition to the **Outpatient Therapy Access Fee**, the **Separate Deductible for Non-Participating Providers** will apply to services rendered by **Non-Participating Providers**.

None of the following expenses may be used to satisfy the Outpatient Therapy Access Fee (i) **Laboratory and Diagnostic Testing Access Fee**, (ii) **Emergency Room Access Fee**, [(iii)] the amount of the **Separate Deductible for Non-Participating Providers**,[(iv)] the amount of **Covered Expenses** for which benefit payments are received by **You** under any optional rider issued with this **Certificate**,[(v)]the amount of any applicable **Failure to Pre-Certify Treatment Deductible**, [(vi)] the amount of the **Calendar Year Deductible,** [(vii)] [the amount of any applicable **Co-Pay**,] and [(viii)] the **Insured Coinsurance Percentage**.

The amount of the **Outpatient Therapy Access Fee** is shown on the **Certificate Schedule**.]

[**"Participating Pharmacy"** means a pharmacy that has entered into, and not terminated by the date the **Covered Expenses** are incurred, an agreement to dispense **Prescriptions** to **Insureds** under this **Certificate**. A **Participating Pharmacy** can be either a retail store or mail order for home delivery.]

"Participating Provider" means a **Hospital**, **Provider**, **Ambulatory Surgical Center**, **Skilled Nursing Home,** or other licensed practitioner of the healing arts for which **Sickness and Injury Benefits**, [and/or] **Wellness and Screening Benefits** [and/or] [**Miscellaneous Benefits]** are payable under this **Certificate** that has entered into, and not terminated by the date the **Covered Expenses** are incurred, an agreement to provide health care services to **Insureds** under this **Certificate** at discounted rates.

"Periodic Preventive Care Visits" means the routine tests and procedures for the purpose of detection of abnormalities or malfunctions of bodily systems and parts according to accepted medical practice.

"Plan(s)" means, in connection with Section IX. COORDINATION OF BENEFITS, this **Certificate** and other types of coverage that **We** may consider in determining whether over insurance exists with respect to a specific claim. The ORDER OF BENEFIT DETERMINATION RULES determines whether this **Certificate** is a **Primary Plan** or **Secondary Plan** when compared to another **Plan** covering the applicable **Insured**.

"Pre-Certification of Treatment" means the process of obtaining prior verbal or written authorization from **Us** for **Medically Necessary Inpatient Confinement** or surgery. **Pre-Certification of Treatment** is not required for **Emergency Inpatient** admission.

"Pre-existing Condition" means a condition, whether physical or mental, and regardless of the cause:

1. for which medical advice, diagnosis, care or treatment was recommended or received during the [twelve (12)] [twenty-four (24)] month period immediately preceding the effective date of coverage under this **Certificate** for the **Insured** incurring the expense; or
2. which **Manifested** during the [twelve (12)] [twenty-four (24)] month period immediately preceding the effective date of coverage under the **Certificate** for the **Insured** incurring the expense.

This **Certificate** provides coverage as of the **Issue Date** for **Pre-existing Conditions**, disclosed on the application, provided they are not otherwise limited or excluded by this **Certificate** or any riders, amendments, or endorsements attached hereto.

This **Certificate** does not cover expenses for **Pre-existing Conditions**, that are not disclosed on the application, unless the expenses are incurred more than [twelve (12)] [twenty-four (24)] months after the **Insured's** coverage has been in effect, and are not otherwise limited or excluded by this **Certificate** or any riders, amendments, or endorsements attached hereto.

[**"Preferred Brand Drugs"** means each **Brand Name Drug** that is identified and listed upon the **Preferred Drug List**. In certain circumstances, a **Preferred Brand Drug** maybe a medically acceptable alternative medication to a **Brand Name Drug** that is not listed on the **Preferred Drug List** such that an **Insured** may want to consult with his/her **Provider** and the pharmacist of the **Participating Pharmacy** regarding whether such **Preferred Brand Drug** would be appropriate and proper in the treatment of such **Insured's** condition.]

[**"Preferred Drug List"** means a list either created or sponsored by **Us**, which identifies certain **Brand Name Drugs** that may be preferred. The **Preferred Drug List** is updated from time to time and may be found on the Internet at www.ushealthgroup.com in the prescription services location of the website. **You** may also call the toll free Rx Help Desk number on your ID card.]

"Premium Rate Guarantee Period" means the number of months [(that **We** guarantee **Your** premium will not increase more than [five-twenty percent][5%-20%] annually on **Your** anniversary)] immediately following the **Issue Date] [**that must expire before the amount of **Renewal Premium** charged by **Us]** (with the same **Mode of Premium Payment** as the **Mode of Premium Payment** selected for payment of the **Initial Premium**) [can be higher than the amount of the **Initial Premium] [**because of (i) a change by **Us** in the table of premium rates used to calculate the **Initial Premium**, or (ii) an increase in the attained age after the **Issue Date** of any **Insured** listed on the **Certificate Schedule**.] However, the amount of **Renewal Premium** required for this

Certificate may be increased by **Us**, even during the **Premium Rate Guarantee Period**, if after the **Issue Date**:

1. **You** add **Insureds** to this **Certificate**;
2. **You** change the amount of the **Calendar Year Deductible** shown on the **Certificate Schedule**;
3. **You** change the **Insured Coinsurance Percentage** shown on the **Certificate Schedule**;
4. **You** change any other coverage option;
5. **You** change residence to a different zip code;
6. **You** change the **Mode Of Premium Payment**;
7. **You** add optional coverage riders, if any;
8. **You** change to a different optional **Participating Provider** network available in **Your** state, if any;
9. a **change occurs in the relationship between US** and **Your Participating Provider** network;
10. the **Participating Provider** network availability changes for **Your** state;
11. the **Participating Provider** negotiated discounts change; and/ or
12. a change occurs in **Sickness and Injury Benefits**, [and/or] **Wellness and Screening Benefits**, [and/or the] [**Miscellaneous Benefits]** by amendatory endorsement pursuant to any federal or state law or regulation.

The length of the **Premium Rate Guarantee Period** is shown on the **Certificate Schedule**.

"Prescription" means the **Medically Necessary** authorization for a **Prescription Drug** to be dispensed to an **Insured** on an **Outpatient** basis pursuant to the order of a **Provider** who is acting within the scope of his or her license to treat an **Injury** or **Sickness**. [Retail store filled **Prescriptions** for which **Sickness and Injury Benefits** are payable under this **Certificate** will be limited to a single thirty (30) day supply for each new or refilled **Prescription Drug**, unless adjusted based on the drug manufacturer's packaging size or based on supply limits. Mail order for home delivery filled **Prescriptions** for which **Sickness and Injury Benefits** are payable under this **Certificate** will be limited to a single ninety (90) day supply for each new or refilled **Prescription Drug**.]

"Prescription Drug" means legend drugs and medications that by Federal law may only be legally obtained on an **Outpatient** basis with a **Prescription**.

["Prescription Drug Calendar Year Deductible Per Insured" means the amount of **Covered Expenses** an **Insured** must incur, [after satisfaction of any applicable **Co-Pay**,] within a **Calendar Year** before any **Outpatient Prescription Drug Benefit** is payable.]

["Prescription Drug Company Insurance Percentage" means the portion of the **Covered Expenses We** must pay to or on behalf of an **Insured** for **Prescription Drug Benefits** under this **Certificate**, after satisfaction by the **Insured** of (i) all applicable **Co-Pays**, (ii) all applicable deductibles and (iii) the amount of the applicable **Prescription Drug Insured Coinsurance Percentage**. The **Prescription Drug Company Insurance Percentage** is shown on the **Certificate Schedule** for **Covered Expenses** for **Prescription Drug Benefits** at (i) **Participating Pharmacies** ; and (ii) **Non-Participating Pharmacies**.]

["Prescription Drug Co-Pay" means the **Co-Pay** payment that is required toward the total amount of **Covered Expenses** per **Prescription** per **Insured** under Section V. A. OUTPATIENT PRESCRIPTIONS. **Co-Pays** may not be used to satisfy the **Calendar Year Deductible**, [**Prescription Drug Calendar Year Deductible Per Insured]**, the **Insured Coinsurance Percentage**, [**Prescription Drug Insured Coinsurance Percentage**] the **Separate Deductible for Non-Participating Providers**, any applicable **Access Fees**, the amount of **Covered Expenses** for which benefit payments are received by **You** under any optional rider issued with this **Certificate**, or the amount of any applicable **Failure to Pre-Certify Treatment Deductible**.**]**

[The remaining amount of **Covered Expenses** after the application and satisfaction of the designated **Prescription Drug Co-Pay** is subject to the **Calendar Year Deductible** [the **Separate Deductible for Non-Participating Providers**,] and the **Insured Coinsurance Percentage.]**

The amount of the **Prescription Drug Co-Pay** is shown on the **Certificate Schedule**]

["Prescription Drug Insured Coinsurance Percentage" means the portion of the **Covered Expenses** that **You** must pay after satisfaction of all applicable **Co-Pays** and deductibles. The different **Prescription Drug Insured**

Coinsurance Percentages are shown on the **Certificate Schedule** at (i) **Participating Pharmacies**, and (ii) **Non-Participating Pharmacies**.]

"Primary Insured" means the individual whose name is printed on the **Certificate Schedule** as the **Primary Insured** and whose coverage under this **Certificate** has not ended.

"Primary Plan" means, in connection with Section IX. COORDINATION OF BENEFITS, of this **Certificate** the **Plan** that pays first pursuant to the order of benefit determination rules contained in such Section without regard to the possibility that another **Plan** may cover some expenses of the applicable **Insured**.

"**Prosthetic Device**" means an external device that is (i) intended to replace an absent external body part for the purpose of restoring physiological function or cosmesis to a patient; and (ii) custom-designed, fabricated, assembled, fitted, or adjusted for the patient using the device prior to or concurrent with being delivered to the patient.

"**Prosthetic Service**" means the evaluation and treatment of a condition that requires the use of a prosthetic device.

"Provide", "Provided" or **"Providing"** means each medical, diagnostic and surgical test, service, care, treatment, supply, including **Prescriptions**, which is:

1. prescribed or ordered by a **Provider;**
2. rendered to and received by an **Insured** while coverage under this **Certificate** for such **Insured** is in full force and effect;
3. listed as a covered item, type of service and/or supply in the **Sickness and Injury Benefits**, [and/or] **Wellness and Screening Benefits**, and/or [**Miscellaneous Benefits]** Sections; and
4. not otherwise limited or excluded by any provision in this **Certificate** or rider, endorsement or amendment attached hereto.

"Provider" means a person who has successfully completed the prescribed course of studies in medicine at a medical school officially recognized and accredited in the country in which it is located, and which person has been licensed by the state in which the medical services are rendered to practice medicine. The **Provider** must be acting within the scope of such license while rendering **Medically Necessary** professional service to an **Insured**, and cannot be a member of the **Insured's Family**.

"Renewal Premium" means the amount charged for coverage of all **Insureds** under this **Certificate** for the period of time from the **First Renewal Date** through the day before each subsequent renewal coverage renewal date. **Renewal Premium** for each renewal period is payable in advance for each applicable renewal period.

"Retrospective Review" means a review of **Medical Necessity** conducted after services have been **Provided** to a **Covered Insured**, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment.

"Secondary Plan(s)" means, in connection with Section IX. COORDINATION OF BENEFITS, the **Plan** that pays after the **Primary Plan** pursuant to the order of benefit determination rules contained in such Section, and such **Secondary Plan** may reduce its benefit payments that the benefit payments from all **Plans** do not exceed 100% of the total **Allowable Expense**.

"Separate Deductible For Non-Participating Providers" meansthe amount of **Covered Expenses** an **Insured** must incur in a **Calendar Year** for services rendered by **Non-Participating Providers** before any applicable **Sickness and Injury Benefits** or **Wellness and Screening Benefits** are payable under this **Certificate**.

No **Sickness and Injury Benefits** or **Wellness and Screening Benefits** are payable under this **Certificate** for services rendered by **Non-Participating Providers** until after the **Separate Deductible For Non-Participating Providers** is satisfied and fully payable by either **You** or such **Insured**. The amount of the **Separate Deductible For Non-Participating Providers** is shown on the **Certificate Schedule** and applies per **Calendar Year** separately to each **Insured**.

None of the following expenses may be used to satisfy the **Separate Deductible For Non-Participating Providers**: (i) the amount of the **Calendar Year Deductible**; (ii) the amount of any applicable [**Co-Pays** and] **Access Fees**; (iii) [the amount of Covered **Expenses** that constitute **Miscellaneous Benefits** for which payment is made by **Us**;] and (iv) the amount of the **Failure to Pre-certify Treatment Deductible**.

[When [three (3)] **Insureds** satisfy this **Separate Deductible For Non-Participating Providers**, no additional **Separate Deductible For Non-Participating Providers** per **Insured** will be required for the remainder of the **Calendar Year**.]

[If [two (2)] or more **Insureds** incur **Covered Expenses** for **Injuries** sustained in the same accident, only one (1) **Separate Deductible For Non-Participating Providers** will be applied that **Calendar Year** to the combined **Covered Expenses** resulting from the **Injuries** sustained in such common accident by all **Insureds**.]

"Sickness" means illness or disease afflicting an **Insured**, including **Complications of Pregnancy**, which first **Manifests** itself on or after the **Issue Date** shown on the **Certificate Schedule** and while this **Certificate** is in force and effect for such **Insured**.

Provided, however, any expenses incurred by an **Insured** (from a condition which is not otherwise excluded by a rider, endorsement, or amendment attached to this **Certificate**), which results from hernia, disease or disorders of the reproductive organs, hemorrhoids, varicose veins, tonsils and/or adenoids, or otitis media, shall be eligible for consideration as **Covered Expenses** only if such expenses are incurred after the expiration of six (6) months from the **Issue Date** shown on the **Certificate Schedule** or are **Provided** on an **Emergency** basis.

"Sickness and Injury Benefit(s)" mean only treatments, procedures, services, and supplies that are specifically enumerated in Section V.A. SICKNESS AND INJURY BENEFITS. If a treatment, procedure, service, or supply is not specifically enumerated in the SICKNESS AND INJURY BENEFITS Section**,** then fees charged or expenses associated with such items are not covered under this **Certificate** as a **Sickness and Injury Benefit**. Payments by **Us** for **Sickness and Injury Benefits** are subject to all definitions, exclusions, limitations and provisions contained herein, including but not limited to the satisfaction and payability by **You** or the applicable **Insured** of all applicable deductibles, as well as the limitation of the **Company Insurance Percentage**.

"Skilled Nursing Home" means a place which:

1. charges patients for their services;
2. is legally operated in the state (or similar jurisdiction) in which it is located;
3. has beds for patients who need medical and skilled care;
4. operates under a doctor's supervision;
5. has continuous twenty-four (24) hour nursing service supervised by a registered nurse (R.N.); and
6. keeps complete medical records on each patient.

Skilled Nursing Home also means a wing, area or floor of a **Hospital** specifically set aside to provide care similar to that of a **Skilled Nursing Home**, but it does not mean a **Hospital**.

"Solid Organ Transplant(s)" means the **Medically Necessary** surgical transplantation, combined transplantation, sequential transplantation, (including grafts) of the following **Medically Necessary** organs received by an **Insured** while coverage for such **Insured** under this **Certificate** is in full force and effect:

1. heart;
2. lung;
3. kidney;
4. pancreas;
5. combined heart/lung;
6. combined kidney/pancreas;
7. skin;
8. eye or parts thereof (including lens and cornea); and
9. liver (**Insureds** who are candidates for liver transplantation must have abstained from the use of alcohol for one year immediately prior to such transplantation surgery in order for the planned liver transplantation to constitute a **Solid Organ Transplant**).

"Stem Cell Transplants" means the **Medically Necessary** insertion or transplantation, combined insertion or transplantation, sequential insertion or transplantation procedures, in which any **Medically Necessary** form of stem cells are received by an **Insured** while coverage for such **Insured** under this **Certificate** is in full force and effect.

"Subsequent Certificate Year(s)" means each twelve (12) month period ending on each anniversary of the **Issue Date** following the **First Certificate Year**.

"Termination of Coverage" means Section III.C. TERMINATION OF COVERAGE, that governs the conditions and circumstances under which the coverage provided by this **Certificate** may be terminated for any or all **Insureds**.

"Total Disability" or **"Totally Disabled"** means that, due to an **Injury** or **Sickness**, an **Insured** is:

1. under a **Provider's** continuous care; and
2. not able to perform the normal activities of a person of like age or sex who is in good health; and
3. unable to engage in any activity, occupation, or business for income or profit, for which such **Insured** is qualified by reason of training, education, or experience.

"Us" means Freedom Life Insurance Company of America.

"Usual and Customary Expense" means the following:

1. For **Providers Usual and Customary Expense** is the seventieth (70th) percentile of the prevailing charges by all **Providers** in the same geographic area as such **Provider**, as determined by one of the current prevailing health care charges information systems in the insurance industry utilizing the applicable **CPT Code** for such services or treatment and the applicable zip code (first 3 or 5 digits) of such **Provider**.

2. For services or treatments **Provided** by **Hospitals**, **Ambulatory Surgical Centers**, **Emergency Care Facilities**, **Skilled Nursing Homes**, pharmacies or other applicable facilities, **Usual and Customary Expense** is average charge made for similar services or supplies in the locality where the service or supply is furnished, taking into consideration the nature and the severity of the **Injury** or **Sickness** suffered by the **Insured**.

Provided, however, that **Usual and Customary Expense** shall never exceed the **Medicare** allowable or approved charge with respect to **Insureds** who are **Medicare** eligible.

"Utilization Review" means a system for prospective or concurrent review of the **Medical Necessity** and appropriateness of health care services being **Provided,** or proposed to be **Provided,** to an **Insured** within this state. **Utilization Review** does not include elective requests for clarification of coverage.

"We" means Freedom Life Insurance Company of America.

"Wellness and Screening Benefit(s)" means only treatments, procedures, services, and supplies that are specifically enumerated in the Section V.B. WELLNESS AND SCREENING BENEFITS. If a treatment, procedure, service, or supply is not specifically enumerated in the WELLNESS AND SCREENING BENEFITS Section, then fees charged or expenses associated with such items are not covered under this **Certificate** as a **Wellness and Screening Benefit**.

["X-Ray, Laboratory and Diagnostic Testing Co-Pay" means the **Co-Pay** payment that is required [per visit per **Insured]** [per type of service] toward the applicable amount of **Covered Expenses** incurred by an **Insured** for **Outpatient** testing, per **Calendar Year** per **Insured,** at the professional offices of a physician who is a **Participating Provider** as defined in the **Certificate. Co-Pays** may not be used to satisfy the **Calendar Year Deductible**, the **Insured Coinsurance Percentage**, the **Separate Deductible for Non-Participating Providers**, [any applicable **Access Fees**,] the amount of **Covered Expenses** for which benefit payments are received by **You** under any optional rider issued with this **Certificate**, or the amount of any applicable **Failure to Pre-Certify Treatment Deductible**.]

[The remaining amount of **Covered Expenses** after the application and satisfaction of the **X-Ray, Laboratory and Diagnostic Testing Co-Pay** is subject to the **Calendar Year Deductible** [the **Separate Deductible for Non-Participating Providers**,] [any applicable **Access Fees**,] and the **Insured Coinsurance Percentage.]**

[The amount of the **X-Ray, Laboratory and Diagnostic Testing Co-Pay** is shown on the **Certificate Schedule**.]

"You", "Your" and **"Yours"** means the individual listed on the **Certificate Schedule** as the **Primary Insured**.

"Your Renewal Premium Class" means the **Class** in which this **Certificate** is placed for **Renewal Premium** purposes. **Your Renewal Premium Class** will be determined by **Us** based upon several factors, including, among other things, a combination of one or more of the following: (i) **Your** zip code (either first 3 or first 5 digits) at the commencement of such renewal period, (ii) **Your** county of residence at the commencement of such renewal period, (iii) **Your** state of residence at the commencement of such renewal period, (iv) the **Issue Date**, (v) **Your** state of residence on the **Issue Date**, (vi) the number, sex, attained age, and tobacco use of each **Insured** on each applicable renewal date, (vii) **Your** plan of coverage under this **Certificate** on each applicable renewal date, including its deductibles, **Benefits**, limits, exclusions, limitations, optional riders, and exclusionary endorsements (viii) the underwriting risk assessment of each **Insured**, (ix) discounted or preferred premium rate status of any **Insured**, (x) premium rate ups, if any, for any **Insured**, (xi) the amount of the **Initial Premium**, (xii) the amount of the **Renewal Premium** charged in the preceding renewal period, (xiii) **Mode of Premium Payment** for the renewal period and (xiv) the number and type other certificates of coverage issued by **Us** covering individuals in **Your** current state of residence with the same or similar factors described above.

"Your Spouse" means the spouse of the **Primary Insured** who (i) is either listed as an **Other Insured** on the **Certificate Schedule** or later added to this **Certificate,** and (ii) is an **Insured** whose coverage has not ended by the date of such spouse's death.

III. WHEN COVERAGE BEGINS AND ENDS

A. EFFECTIVE DATE

This **Certificate** is effective at 12:01 A.M. local time where **You** live on the **Issue Date** shown on the **Certificate Schedule**.

B. ELIGIBILITY AND ADDITIONS

Your spouse; **Your** unmarried, dependent children who are under the age of [19 (24 if a **Full-Time Student**]; and grandchildren who are considered **Your** dependents for federal income tax purposes and who are under age [19 (24 if a **Full-Time Student**]; any children which an **Insured** is required to insure under a medical support order; any child whom **You**, or **Your Spouse** (if listed as an **Other Insured** on the **Certificate Schedule**), intends to adopt and has become a party to a suit for that purpose; and any child who is in the custody of an **Insured** under a temporary court order that grants the **Insured** conservatorship of the child, are eligible for this coverage. Any eligible dependent (other than a newborn or adoptee) will be added to this **Certificate** when **We** approve the written application for such coverage, and accept payment of any necessary premium.

Newborn children born after the **Issue Date** to **You**, or **Your Spouse**, while this **Certificate** is in full force and effect (a newborn child) will be automatically insured under this **Certificate** from and after the moment of birth for a period of ninety (90) days or before the next premium due date, whichever is later. If **You** wish to continue such automatic coverage under this **Certificate** for any such newborn child past the initial ninety (90) day period or beyond the next premium due date, **You** must notify **Us** of such birth and **Your** desire for such continued coverage under this **Certificate** within ninety (90) days or before the next premium due date after the date of such newborn child's birth. **You** must also pay any additional premium required for such additional coverage within such ninety (90) day period or before the next premium due date. If **You** do not notify **Us** of such birth and **Your** desire for continued coverage under this **Certificate** within such ninety (90) day period or before the next premium due date, and timely pay any additional premium that may be due, then the automatic coverage under this **Certificate** for such newborn child will end after the expiration of ninety (90) days or the next premium due date, whichever is later, from the date of such newborn child's birth. **We** will notify **You** if more premium is needed.

Newborn children born after the **Issue Date** and immediately placed for adoption after birth with **You**, or **Your Spouse**, while this **Certificate** is in full force and effect (a newborn adoptee) will be automatically insured under this **Certificate** from and after the date of the adoption placement of such newborn adoptee for a period of sixty (60) days. If **You** wish to continue such automatic coverage under this **Certificate** for any such newborn adoptee past the initial sixty (60) day period, **You** must notify **Us** of such birth, adoption placement and **Your** desire for continued coverage under this **Certificate** within sixty (60) days after the date of the adoption placement of such newborn adoptee. **You** must also pay any additional premium required for such additional coverage within such sixty (60) day period. If **You** do not notify **Us** within such sixty (60) day period of the birth, adoption placement and Your desire for continued coverage under this **Certificate** for such newborn adoptee and timely pay any additional premium that may be due, then the automatic coverage under this **Certificate** for such newborn adoptee will end after the expiration of day from the date of such adoption placement of such newborn adoptee. **We** will notify **You** if more premium is needed.

If **You** wish to have automatic coverage under this **Certificate** after the **Issue Date** for any child not listed as an **Other Insured** on the **Certificate Schedule**, but for which adoption or custody of such child is sought by **You** or **Your Spouse** in a civil suit or other judicial custody proceeding filed or initiated after the **Issue Date**, **You** must notify **Us** within thirty-one (31) days after **You** or **Your Spouse**, as applicable: (i) become a party in such civil suit in which such adoption of the child is sought; or (ii) obtain custody of the child under the first court order (including temporary orders) that grants conservatorship and/or custody of the child. **You** must also pay any additional premium required for such additional coverage within such thirty-one (31) day period. If **You** do not notify **Us** within such applicable thirty-one (31) day period of **Your** desire for automatic coverage under this **Certificate** in the future for such child and timely pay any additional premium that may thereafter become due, then no automatic coverage will be afforded under this **Certificate** for such child. **We** will notify **You** if more premium is needed.

C. TERMINATION OF COVERAGE

1. TERMINATIONS SUBJECT TO RIGHT OF CONVERSION

Subject to the Section III. E. CONTINUATION OF COVERAGE AND CERTIFICATE OF CONTINUATION / CONVERSION below, an applicable **Insured's** coverage under this **Certificate** ends on the earlier of the following:

a. the premium due date in the month following the date the **Group Policy** is terminated by the **Group Policyholder**, in which case **You** will be given thirty (30) days prior written notice of the termination, mailed to **Your** last known address;
b. with respect to **Your** spouse who is covered under this **Certificate**, the premium due date in the month following the effective date of **Your** divorce decree, annulment or court approved separation;
c. with respect to **Your** child(ren) who are covered under this **Certificate**, the premium due date in the month following such **Insured's** 19th birthday (24th if a **Full-Time Student**).

2. TERMINATIONS BY PRIMARY INSURED NOT SUBJECT TO RIGHT OF CONVERSION

Section III.E. CONTINUATION OF COVERAGE AND CERTIFICATE OF CONTINUATION / CONVERSION notwithstanding, the following described actions by either the **Primary Insured** or other applicable **Insured** will result in a termination of each applicable **Insured's** coverage under this **Certificate** with no right of conversion, in which event the coverage ends on the earlier of the following:

a. the due date of any unpaid **Renewal Premium**, subject to the grace period; or
b. the date **You** terminate coverage by notifying **Us** of the date **You** desire coverage to terminate and specify the **Insured** whose coverage is to terminate.

3. TERMINATION OF THE CERTIFICATE BY THE COMPANY NOT SUBJECT TO RIGHT OF CONVERSION

Section III.E. CONTINUATION OF COVERAGE AND CERTIFICATE OF CONTINUATION/ CONVERSION notwithstanding, **We** may refuse to renew and cancel coverage for all **Insureds** under this **Certificate** with no right of conversion for the following reasons:

a. **We** are required by the order of an appropriate regulatory authority to non-renew or cancel the **Certificate** or **Group Policy**;
b. **We** cease offering and renewing coverage of the same form of coverage as this **Certificate** in **Your** state upon a minimum of ninety (90) days prior written notice mailed to **Your** last known address with an opportunity for **You** to convert to any similar medical expense policy or certificate that **We** are then actively marketing and offering to new applicants in **Your** state;
c. **We** elect to discontinue offering all similar types of coverage under any association group or individual medical-surgical expense policy forms in **Your** state and to terminate all such certificates of coverage and individual policies in **Your** state, including **Your** form of coverage, in which case the commissioner of insurance for **Your** state, the **Group Policyholder** and **You** will be given a minimum of one hundred eighty (180) days prior written notice of the termination, mailed to **Your** last known address; or
d. the date **We** receive due proof that fraud or intentional misrepresentation of material fact existed in applying for this **Certificate** or in filing a claim for **Benefits** under this **Certificate**.

4. TERMINATION OF AN INSURED BY THE COMPANY NOT SUBJECT TO RIGHT OF CONVERSION

Section III.E. CONTINUATION OF COVERAGE AND CERTIFICATE OF CONVERSION notwithstanding, **We** may refuse to renew and cancel coverage for each **Insured** under this **Certificate** with no right of conversion for the following reasons:

a. the total amount of any **Benefit** payments made by **Us** are equal to the **Lifetime Certificate Maximum Per Insured**; or
b. the date **We** receive due proof that fraud or intentional misrepresentation of material fact existed in applying for this **Certificate** or in filing a claim for **Benefits** under this **Certificate**.

As long as this **Certificate** is in force for **You**, the coverage of **Your** child who is an **Insured** will not end if he or she is dependent upon **You** for support and maintenance and incapable of self-support because of a mental handicap or physical disability. Such dependent **Insured's** coverage under this **Certificate** will continue regardless of the dependent **Insured's** age, as long as **Renewal Premium** is timely and properly paid for **You** and the dependent **Insured** and such dependent **Insured** remains dependent upon **You** and incapable of self support because of such mental handicap or physical disability. Proof of such handicap or disability must be furnished to **Us** within thirty-one (31) days prior to the dependent **Insured** reaching the limiting age, and thereafter upon **Our** request, but not more frequently than annually after the two (2) year period following the attainment of the limiting age.

Any termination of coverage or of this **Certificate** will be effective at 11:59 P.M. local time where **You** live on the date(s) specified above.

If **You** die, **Your Spouse**, if then an **Insured** under this **Certificate**, will become the **Primary Insured**. If **You** and **Your** spouse (if any) are not covered under this **Certificate**, the oldest **Insured** will become the **Primary Insured**.

We will not accept premium for any **Insured** whose coverage has terminated. Premiums, which are sent to **Us** and include an amount to cover the **Insured** whose coverage has terminated, will be returned. **We** will only accept the correct premium to cover those **Insureds** who are eligible for coverage. If premiums are accepted in error, **Our** liability is limited to coverage for the period of time for which premiums were accepted in error.

Except for claims involving fraud or intentional misrepresentation of material fact, any termination will be without prejudice to any **Covered Expenses** incurred by an **Insured** for **Sickness and Injury Benefits**, [or] **Wellness and Screening Benefits** [or] [**Miscellaneous Benefits]** prior to the date of termination. If coverage is terminated, unearned premium will be computed pro-rata and any unearned premium will be refunded to **You**.

D. EXTENSION OF BENEFITS

If the **Group Policy** terminates while an **Insured** is **Totally Disabled**, **Sickness and Injury Benefits** will be extended for **Covered Expenses** incurred by such **Insured** after the date of termination of coverage under this **Certificate**. These extended **Sickness and Injury Benefits** are subject to the same terms that would have applied if the **Group Policy** had remained in force.

Extended **Sickness and Injury Benefits** are payable only (i) for **Covered Expenses** incurred for treatment of the specified **Injury** or **Sickness** that caused **Total Disability** of an **Insured** and while coverage under this **Certificate** for such **Insured** was in full force and effect and (ii) while the **Insured** remains **Totally Disabled** until the earlier of:

1. the day the **Total Disability** ends;
2. the date twelve (12) months after the date the **Group Policy** terminated; or
3. the day the person becomes covered under a replacement policy providing substantially equal or greater benefits which replaces coverage under the **Group Policy**.

Subject to the terms and conditions otherwise contained herein, Benefits shall be payable for Covered Expenses incurred by an **Insured** who is **Hospital Confined** on the date of termination, if the **Group Policy** is terminated and replaced by a group health insurance policy or contract issued by another insurer. **Benefits** are payable until the **Hospital Confinement** ends or **Hospital Benefits** under this contract have been exhausted, whichever is earlier.

E. CONTINUATION OF COVERAGE AND CERTIFICATE OF CONTINUATION / CONVERSION

A **Certificate Of Continuation / Conversion Coverage**, whereby the coverage then afforded by this **Certificate** for an applicable **Insured** will continue without a requirement of any additional evidence of the insurability of such **Insured**, is available only:

1. for **Your** spouse who is covered under this **Certificate**, if his or her coverage ceases due to divorce, annulment or court approved separation;
2. for **Your** unmarried child(ren) who is covered under this **Certificate**, if his or her coverage ceases due to his or her reaching the limiting age of 19 (24 if enrolled as a **Full-Time Student**), or
3. for each applicable **Insured**, if coverage under this **Certificate** terminates because the **Group Policyholder** has terminated coverage under the **Group Policy**, and does not replace coverage with another group policy, in which case **You** will be given thirty (30) days prior written notice of the termination, mailed to **Your** last known address. Upon termination of the **Group Policy**, **You** may apply on behalf of all **Insureds** for a **Certificate Of Continuation / Conversion Coverage**. The **Certificate Of Continuation / Conversion Coverage** must be applied for and the first premium received by **Us** within thirty-one (31) days after the date that coverage under the **Group Policy** terminates. If a **Certificate Of Conversion Coverage** is issued, it will take effect on the day after coverage under the **Group Policy** terminates.

A **Certificate Of Continuation / Conversion Coverage** is not available and will not be provided if:

1. an **Insured** has full coverage under any other group accident and health certificate or contract.
   a. to be full coverage the plan must provide benefits for all pre-existing conditions,
   b. an **Insured** may continue his or her previous group coverage until all pre-existing conditions are or would be covered under another group policy or contract or until termination;
2. an **Insured's** coverage under the **Group Policy** ceases because the **Group Policy** was terminated and was replaced by similar group coverage within thirty-one (31) days;
3. an **Insured's** coverage under this **Certificate** ceases because of failure to pay the required premiums in the time allowed;
4. an **Insured** was not covered under this **Certificate** for the three (3) consecutive months immediately prior to the date the **Group Policy** terminates;
5. an **Insured** is covered by similar benefits furnished by any:

a. medical expense plan;
b. medical service subscriber contract;
c. medical pre-payment plan; or
d. medical plan provided in accordance with the requirements of any state or federal law;

6. an **Insured** is eligible to be covered by any group plan, insured or uninsured:
a. medical expense plan;
b. medical service subscriber contract;
c. medical pre-payment plan; or
d. medical plan provided in accordance with the requirements of any state or federal law;

7. **We** were required by the order of an appropriate regulatory authority to non-renew or cancel the **Certificate** or **Group Policy**;

8. The total amount of **Benefit** payments made by **Us** are equal to the **Lifetime Certificate Maximum Per Insured**;

9. **We** cease offering and renewing coverage under the same form of coverage as this **Certificate** in **Your** state upon a minimum of ninety (90) days prior written notice mailed to **Your** last known address with an opportunity for **You** to convert to any similar medical expense policy or certificate that **We** are then actively marketing and offering to new applicants in **Your** state;

10. **We** elect to discontinue offering all similar types of coverage under any association group or individual medical-surgical expense policy forms in **Your** state and to terminate all such certificates of coverage and individual policies in **Your** state, including **Your** form of coverage, in which case the commissioner of insurance for **Your** state, the **Group Policyholder** and **You** will be given a minimum of one hundred eighty (180) days prior written notice of the termination, mailed to **Your** last known address;

11. **You** voluntarily terminated coverage under this **Certificate** for any **Insured** by notifying **Us** of the date **You** desired such coverage to terminate;

12. **We** received due proof that fraud or intentional misrepresentation of material fact existed in applying for this **Certificate** or in filing a claim for **Benefits** under this **Certificate**; or

13. The **Insured** is or could be covered by **Medicare**.

In order to be eligible for a **Certificate Of Continuation / Conversion Coverage**, a written election of continuation of coverage via conversion must be made by the applicable **Insured**, on a form furnished by **Us**, and the first premium must be paid, in advance, to **Us** on or before the date on which the applicable coverage under this **Certificate** for such **Insured** would otherwise terminate. The amount of first premium required from the effective date through the end of the first renewal period of the **Certificate Of Continuation / Conversion Coverage** shall not be more than **Our** full group premium rate then applicable for the applicable **Insured** under the **Certificate** with the same mode of payment. Applicable **Insureds** shall not be required to pay the **Renewal Premium** for a **Certificate Of Continuation / Conversion Coverage** less often than monthly.

IV. PREMIUM

A. INITIAL PREMIUM

The **Initial Premium** specified on the **Certificate Schedule** is due and payable to the **Company** at its home office on or before the **Issue Date**. This **Initial Premium** payment will keep this **Certificate** in force until the **First Renewal Date**. The amount of the **Initial Premium** and the **First Renewal Date** are shown on the **Certificate Schedule**. **Initial Premium** has been determined by **Us** for this **Certificate** on a **Class** basis. **Your Class** for **Initial Premium** was determined by **Us** based upon several factors, including, among other things, a combination of the following: (i) **Your** zip code (either first 3 or first 5 digits); (ii) **Your** county of residence; (iii) **Your** state of residence; (iv) the number, age, sex and tobacco use of each **Insured** listed on the **Certificate Schedule**; (v) the plan of coverage contained in this **Certificate** on the **Issue Date**, including its deductibles, **Benefits**, limitations, and exclusions; (vi) the health status of each applicant, including the results of any required physical examination and laboratory test results; (vii) **Participating Provider** network selected on the application, (viii) the underwriting risk assessment of each **Insured**; (ix) the discounted or preferred premium rate status of any **Insured;** (x) premium rate ups, if any, for any **Insured**; (xi) **Mode Of Premium Payment** selected on the application; (xii) distribution channels; (xiii) administrative costs; (xiv) taxes; (xv) other economic factors; and/or (xvi) other certificates of coverage issued and to be issued by **Us** covering individuals in **Your** current state of residence with the same or similar factors described above.

B. RENEWAL PREMIUM

1. CALCULATION - PAYMENT

The current **Mode Of Premium Payment** is shown on the **Certificate Schedule**. **Renewal Premium** is payable on or before its due date, and must be paid to the **Company** at its home office. Any **Renewal Premium** not paid on or before its due date is a premium in default. If a **Renewal Premium** payment default is not corrected and properly paid before the end of the grace period, coverage under this **Certificate** will terminate.

Renewal Premium rates for this **Certificate** may be increased by **Us** for any renewal period after the **Issue Date**, including during the **Premium Rate Guarantee Period**, if after the **Issue Date**:

a. **You** add **Insureds** to this **Certificate**;
b. **You** change the amount of the **Calendar Year Deductible** shown on the **Certificate Schedule**;
c. **You** change the **Insured Coinsurance Percentage** shown on the **Certificate Schedule**;
d. **You** change any other coverage option;
e. **You** change residence to a different zip code;
f. **You** change the **Mode Of Premium Payment**;
g. **You** add optional coverage riders, if any;
h. **You** change after the **Issue Date** to a different optional **Participating Provider** network available in **Your** state, if any;
i. a change occurs in the relationship between **Us** and **Your Participating Provider** network:
j. the **Participating Provider** network availability changes for Your state;
k. the **Participating Provider** negotiated discounts change; and/or
l. a change occurs in **Sickness and Injury Benefits**, [and/or] **Wellness and Screening Benefits**, [and/or the] [**Miscellaneous Benefits]** by amendatory endorsement pursuant to any federal or state law or regulation.

The current table of premium rates upon which the **Initial Premium** and the **First Renewal Premium** were calculated for this **Certificate** may include scheduled increases in the amount of **Renewal Premium** based upon the future attained age of each **Insured**. To be eligible for a discounted or preferred premium rate each **Insured** may be required to complete a preferred health risk assessment upon enrollment and at renewal. Additionally, the current table of premium rates upon which the **Initial Premium** and **First Renewal Premium** were calculated and any subsequent table of premium rates upon which the **Renewal Premium** for any renewal period is to be calculated may be changed from time to time by **Us**. Accordingly, after expiration of the **Premium Rate Guarantee Period**, the amount of **Renewal Premium** may be increased for any renewal period based upon items a. through i. above as well as the following:

a. a new attained age of any **Insured** reached prior to the first day of any renewal period,
b. change by **Us** in the table of premium rates used to calculate the **First Renewal Premium,** and
c. change by **Us** in the table of premium rates used to calculate **Renewal Premium** for any prior renewal period.

Any changes in the table of premium rates establishing the amount of required **Renewal Premium** during any renewal period will be implemented on a **Class** basis for all members of **Your Renewal Premium Class**. Factors that may be involved and considered by **Us** in determining the amount of **Renewal Premium** to be charged to **Your Renewal Premium Class** during any renewal period include, among other things, a combination of one or more of the following: (i) past claims experience of **Your Renewal Premium Class**; (ii) anticipated inflationary trends in the cost of future medical services; (iii) historical experience in the inflationary cost of medical services; (iv) anticipated inflationary trends in the cost of **Prescription Drugs**; (v) historical experience in the past inflationary cost of **Prescription Drugs**; (vi) anticipated future claims experience of **Your Renewal Premium Class**; (vii) other economic factors; (viii) anticipated advances in the medical diagnosis capabilities of injuries and illnesses, including the anticipated cost thereof; (ix) anticipated advances in the manner, method and delivery of medical care and treatment, including the anticipated cost thereof; and (x) any other reason permitted by applicable state law. **We** will

tell **You** at least thirty (30) days in advance of the effective date of any **Renewal Premium** increase that occurs due to a change in the table of premium rates for **Renewal Premium**.

2. RENEWAL PREMIUM CHECK OR DRAFT NOT HONORED

Any premium payment made by a check or draft which is not honored at the bank upon which it is drawn shall be of no effect toward coverage under this **Certificate** unless and until valid restitution is made to **Us** within the time provided herein for making such premium payment.

3. GRACE PERIOD

Unless at least thirty-one (31) days prior to a **Renewal Premium** due date **We** have mailed to **You** written notice of **Our** intention not to renew this **Certificate** pursuant to the provisions of Section III. C. TERMINATION OF COVERAGE, a grace period of thirty-one (31) days from such due date is given for the late payment of the **Renewal Premium** due. If **You** make payment of the required **Renewal Premium** during such grace period, then this **Certificate** will remain in force for **Benefit** claims arising during such grace period. However, if the **Company** has received notification of **Your** intention to cancel any **Insured's** coverage under this **Certificate**, there is no grace period for the late payment of any **Renewal Premium** that would otherwise have been due for such **Insured** but for such cancellation.

4. REINSTATEMENT

If the **Renewal Premium** is not paid before the grace period ends, later acceptance of premium by **Us** (or by an agent authorized to accept payment) without requiring an application for reinstatement will reinstate this **Certificate** as of the date of acceptance of the late premium. If **We** require an application that will be fully underwritten by **Us**, **You** will be given a conditional receipt for the premium. If the application is approved after underwriting, this **Certificate** will be reinstated as of the approval date together with all back or past due premium permitted by applicable state law. Lacking such approval, this **Certificate** will be reinstated on the forty-fifth (45th) day after the date of the conditional receipt, unless **We** have previously notified **You**, in writing, of **Our** disapproval of the reinstatement.

The reinstated **Certificate** will cover only **Covered Expenses** that result from an **Injury** sustained after the date of reinstatement or from **Sickness** that begins more than ten (10) days after the date of reinstatement.

In all other respects **Your** rights and **Our** rights will remain the same subject to any provisions noted on or attached to the reinstated **Certificate**.

5. PREMIUM RATE GUARANTEE PERIOD

The amount of **Renewal Premium** with the same **Mode of Premium Payment** as the **Mode of Premium Payment** of the **Initial Premium** is guaranteed not to exceed [5%-20% annually][the amount of the **Initial Premium]** for each renewal period commencing prior to the expiration of the **Premium Rate Guarantee Period** as a result of any: (i) change in the table of premium rates used to calculate the **Initial Premium**; or (ii) increase in the attained age after the **Issue Date** of any **Insured** listed on the **Certificate Schedule**. The length of the **Premium Rate Guarantee Period** is shown on the **Certificate Schedule**. However, **Renewal Premium** rates may be increased by **Us** for any renewal period after the **Issue Date**, including during the **Premium Rate Guarantee Period**, if after the **Issue Date** (i) **You** either add or change coverage under this Certificate as provided in paragraphs a. through i. of the Calculation – Payment provision, or (ii) an amendatory endorsement is issued that changes any of the **Benefits** pursuant to any federal or state law or regulation

V. BENEFITS AND CLAIM PROCEDURES

Insureds have the right to obtain medical care from the **Provider** and **Hospital** of their choice[, as well as **Prescription Drugs** from a pharmacy of their choice]; however, all applicable **Benefit** payments by **Us** under this BENEFITS AND CLAIMS PROCEDURES Section of the **Certificate** are limited to the applicable **Company Insurance Percentage** of **Covered Expenses** incurred by an **Insured**. Coverage under this Section of the **Certificate** will be reduced for medical services, supplies, care or treatment obtained from a **Non-Participating Provider[**, as well as **Prescription Drugs** from a **Non-Participating Pharmacy]**. The difference between both the **Company Insurance Percentages** and the **Insured Coinsurance Percentages** for: (i) **Participating Providers** and **Non-Participating Providers**; [and (ii) **Participating Pharmacies** and **Non-Participating Pharmacies]** are shown in the **Certificate Schedule**. In addition, **We** shall never be required to make a payment for **Covered Expenses** incurred in excess of the amount of the **[Lifetime] Transplant Maximum [Per Organ] Per Insured** or the **Lifetime Certificate Maximum Per Insured**.

Covered Expenses incurred by an **Insured** for **Sickness and Injury Benefits** and **Wellness and Screening Benefits** are subject to the **Calendar Year Deductible,** the **Insured Coinsurance Percentage** and any applicable [**Co-Pays** and] **Access Fees,** unless otherwise specified.

A. SICKNESS AND INJURY BENEFITS

Subject to all applicable definitions, exclusions, limitations, non-waiver, waiting periods, and other provisions contained in this **Certificate**, as well as any riders, endorsements, or amendments attached to hereto, **We** promise to pay to or on behalf of each **Insured** the **Company Insurance Percentage** of the amount of professional fees and other applicable medical diagnostic or treatment expenses and charges that constitute **Covered Expenses** incurred by each **Insured** for the following described **Inpatient** and **Outpatient** services that are **Provided** as a result of **Sickness** or **Injuries**, but only after: (i) each applicable [**Co-Pay] [**and] **Access Fee** amount in this Section has been first satisfied and deducted from such **Covered Expenses** and applied to the applicable **Insured** for payment; (ii) each of the applicable deductibles has been first satisfied by deduction from such **Covered Expenses** and applied to the applicable **Insured** for payment; and (iii) the applicable **Insured Coinsurance Percentage** of the **Covered Expenses** remaining after satisfaction of all applicable deductibles is, likewise, satisfied by deduction from the remaining **Covered Expenses** and applied to the applicable **Insured** for payment:

1. INPATIENT HOSPITAL CONFINEMENT BENEFITS:

a. INPATIENT HOSPITAL CARE

The following services **Provided** by a **Hospital** or a **Provider** in connection with admission and **Confinement** of an **Insured** at the **Hospital** due to **Injuries** or **Sickness**:

1) **Hospital** - semi-private daily room and board [(if a semi-private room is not available, benefit will be limited to ninety (90) percent of the **Usual and Customary** private room rate)];
2) **Intensive Care Unit** of the **Hospital** - daily room and board (Note, daily room and board will be at the semi-private rate for admission to units or areas of the applicable **Hospital** which are step-down units from the **Intensive Care Unit**, including, sub-acute intensive care units, progressive care units, intermediate care units, private monitored rooms, observation units or other facilities not meeting the standards set forth in the definition of an **Intensive Care Unit**). [**Covered Expenses** incurred at a **Non-Participating Provider** will not exceed three times the **Usual and Customary** semi-private room charge of the **Hospital** and are limited to 30 continuous days of such **Confinement** for each type of **Confinement** during any one period of **Hospital Confinement**.;]
3) **Hospital** miscellaneous medications, **Prescription Drugs**, services and supplies - (Note, miscellaneous charges by a **Hospital** for personal convenience items, including but not limited to television, telephone, internet and radio are not considered **Covered Expenses**); and
4) **Provider** Visits – [(Note: limited [one (1)] **Provider** visit per treating **Provider** per day while the **Insured** is an **Inpatient** at a **Hospital**, and a maximum of [sixty (60)] **Provider** visits per **Hospital Confinement**.] **Sickness and Injury Benefits** are not payable for professional fees for visits at the **Hospital** following surgery by a Surgeon, Anesthesiologist or Nurse Anesthetist whose

professional fees in connection with the surgery constitute **Covered Expenses**, unless the visit is to evaluate or treat an **Injury** or **Sickness** other than that which resulted in the **Insured**'**s** covered surgery).

b. INPATIENT SURGERY

The following services **Provided** by a **Hospital** and **Providers** received by an **Insured** in connection with **Inpatient** surgery performed at the **Hospital** due to **Injuries** or **Sickness**:

1) Primary Surgeon;
2) Assistant Surgeon – (professional fees that constitute **Covered Expenses** will be considered for a **Sickness and Injury Benefit** payment for one assistant surgeon in connection with surgery for which **Sickness and Injury Benefits** are payable hereunder for the professional fees of the primary surgeon);
3) Anesthesiologist or Nurse Anesthetist – (professional fees that constitute **Covered Expenses** will be considered for a **Sickness and Injury Benefit** payment for either an anesthesiologist's or a nurse anesthetist's administration and monitoring of anesthesia administered during surgery for which **Sickness and Injury Benefits** are payable hereunder for the professional fees of the primary surgeon);
4) Pathologist Fees – (professional fees that constitute **Covered Expenses** will be considered for a **Sickness and Injury Benefit** payment for a pathologist's evaluation and/or interpretation of any tissue specimen removed during or in connection with such surgery); and
5) Second Surgical Opinion - Up to [$250] of professional fees for a second surgical opinion if:
   a) the **Insured's Provider** determines that surgery is needed;
   b) the surgery is not excluded from this **Certificate** or any riders, amendments or endorsements attached hereto;
   c) the **Insured** is examined in person by another qualified **Provider** for the purpose of obtaining a second surgical opinion; and
   d) the **Provider** issuing the second surgical opinion sends **Us** a written report.

However, **We** will not pay for the second surgical opinion if the **Provider** issuing the second surgical opinion performs or assists in the surgery.

c. BREAST RECONSTRUCTION

Services **Provided** by a **Hospital** and a **Provider** received by an **Insured** in connection with **Breast Reconstruction** performed at a **Hospital**.

d. INPATIENT THERAPY

Services **Provided** by a **Hospital** or a **Provider** in connection with the following types of therapy received by an **Insured** as an **Inpatient** at the **Hospital** due to **Injuries** or **Sickness**:

1) Radiation therapy;
2) Chemotherapy;
3) Occupational therapy;
4) Physical therapy and
5) Speech therapy.

[[Occupational,] [Physical] and [Speech] Therapy [are/is] limited to [[$50] per visit] [25] [visits] up to [$2,000] maximum per type of therapy per **Calendar Year** per **Insured**`] [This **Inpatient** therapy coverage does not include fees or expenses charged for spinal manipulations.]

e. INPATIENT LABORATORY AND DIAGNOSTIC TESTS

[Subject to **Laboratory and Diagnostic Testing Access Fee,** if applicable,**] [S][**s]ervices **Provided** by a **Hospital** or a **Provider** in connection with the performance and interpretation of laboratory and diagnostic tests received by an **Insured** as an **Inpatient** at the **Hospital** due to **Injuries** or **Sickness**

f. TRANSPLANTS

When generally accepted medical indications and standards for transplantation (including grafts) have been met and all assessments required by the treating institution are successfully completed, then services **Provided** by a **Hospital** and **Providers** in connection with the performance of **Solid Organ Transplants**, **Bone Marrow Transplants**, and/or **Stem Cell Transplants** that are received by an **Insured** are covered.

The maximum amount of **Covered Expenses** allowed for professional fees of a **Provider** and facility fees for the harvesting of applicable donor organs or donor bone marrow is [$5,000 to $50,000] per transplant, to the extent that any benefits hereunder remain and are available under the **Certificate** for the applicable **Insured** recipient. Any payment of donor expenses hereunder will be applied toward the satisfaction of the **[Lifetime] Transplant Maximum [Per Organ] Per Insured**.

[An **Insured** requiring a **Solid Organ Transplant**, **Bone Marrow Transplant**, and/or **Stem Cell Transplant** may elect to request participation in the **Centers of Excellence** program. To be considered for a **Centers of Excellence** transplant, an **Insured** must agree, in writing, to use **Centers of Excellence Providers** for all **Covered Expenses** related to a **Solid Organ Transplants**, **Bone Marrow Transplants**, and/or **Stem Cell Transplants**.

If a **Medically Necessary** transplant is performed in a designated **Center of Excellence**, **We** will **Provide Covered Expenses** for; (i) travel, (ii) food, and (iii) lodging, for a live donor, if applicable; and the **Insured** and one companion, or if the **Insured** is a dependent child, two parents. The maximum **Covered Expenses** allowed for (i) travel, (ii) food and (iii) lodging is [$5,000] per covered transplant.

If an **Insured** elects to use a **Center of Excellence**, approved by **Us**, for the transplant services, the **[Lifetime] Transplant Maximum [Per Organ] Per Insured** is increased to [$500,000 - $1,000,000].] [If the **Insured** elects to use a **Provider** that is not a **Center Of Excellence** the **[Lifetime] Transplant Maximum [Per Organ] Per Insured** is reduced to [$100,000 - $500,000]]

However, the amount of **Benefits** hereunder will be reduced by fifty (50%) percent for any **Solid Organ Transplants**, **Bone Marrow Transplants**, and **Stem Cell Transplants** received that were not reviewed by **Us** prior to transplantation evaluation, testing or donor search. In addition, the following items/procedures are not covered under this **Certificate**:

1) any non-human (including animal or mechanical) **Solid Organ Transplant**,
2) transplants approved for a specific medical condition, but applied to another condition,
3) the purchase price of any organ, tissue, blood, bone marrow, cells, or stem cells that are sold and not donated,
4) any donor charge or donor expense incurred that does not constitute **Covered Expenses** allowed for professional fees and facility fees incurred in connection with the harvesting of applicable donor organs or donor bone marrow, and
5) any transplantation (including grafts) that does not constitute **Solid Organ Transplants**, **Bone Marrow Transplants**, and/or **Stem Cell Transplants**.

[2. FOREIGN TRAVEL BENEFIT

Services for **Covered Expenses** incurred for **Medically Necessary Emergency Hospital**, **Provider** and medical care that an **Insured** receives outside the United States during the first [60] consecutive days of each trip up to a lifetime maximum **Benefit** of [$50,000 to $250,000].]

[3.] EMERGENCY ROOM AND OTHER OUTPATIENT BENEFITS:

a. EMERGENCY ROOM SERVICES

[Subject to the **Emergency Room Access Fee]**, [S][s]ervices **Provided** by a **Hospital** or a **Provider** in the emergency room of the **Hospital** for the following items received by an **Insured** on an **Emergency** basis:

1) Emergency room services and supplies;
2) **Provider** services for surgery in the emergency room of the **Hospital**, if **We** are notified of such surgery within seventy-two (72) hours after such surgical procedure has been performed, or as soon thereafter as reasonably possible;
3) X-ray and laboratory examinations;
4) **Prescription Drugs** administered prior to discharge from the emergency room;
5) [[Surgical dressings], [casts,] [splints,] [trusses,] [braces] [and] [crutches] received prior to discharge from the emergency room]; [and]
6) Services of a registered nurse (R.N.) in the emergency room of a **Hospital**.

The **Emergency Room Access Fee** will be waived if an Insured [is confined in a Hospital within [twenty-four (24) hours of the Emergency Room visit].[admitted directly from the emergency room into the Hospital as an Inpatient] .]

b. OUTPATIENT TREATMENT OF ACCIDENTAL INJURIES

Services **Provided** by a **Hospital**, an **Emergency Care Facility** or a **Provider** in connection with the **Outpatient** treatment of **Injuries** received by an **Insured**. Services **Provided** by a **Hospital** or a **Provider** in the emergency room of the **Hospital** are subject to the **Emergency Room Access Fee**.

c. EMERGENCY TRANSPORTATION TO HOSPITAL BY AMBULANCE

Services **Provided** in connection with transportation of an **Insured** by either local ground ambulance or local air ambulance [(air ambulance is limited to [$1,000 to $10 ,000] per occurrence)] to the nearest **Hospital** that is appropriately staffed, equipped, available and suitable for the **Emergency** diagnosis, care and treatment of an **Insured's Injury** or **Sickness**. However, expenses charged for transportation to a **Hospital** by air ambulance are not payable or otherwise considered a **Sickness and Injury Benefit**, if such **Insured's** medical condition was not sufficiently acute or severe upon arrival at the **Hospital** to result in an **Inpatient** admission and **Confinement** in the **Hospital** immediately following the **Insured's** evaluation and treatment in the emergency room of such **Hospital.**

d. OUTPATIENT SURGERY AT A HOSPITAL OR AN AMBULATORY SURGICAL CENTER

The following services **Provided** by a **Hospital** or **Ambulatory Surgical Center** and **Providers** in connection with surgery performed on an **Insured** on an **Outpatient** basis:

1) **Hospital** or **Ambulatory Surgical Center** – (expenses that constitute **Covered Expenses** will be considered for **Sickness and Injury Benefit** payment for the pre-operation, operation and recovery rooms, as well as for medications, **Prescription Drugs**, and other miscellaneous items, services and supplies; provided that miscellaneous charges for any personal convenience items, including but not limited to television, telephone, and radio are not considered **Covered Expenses**);
2) Primary Surgeon;
3) Assistant Surgeon – (professional fees that constitute **Covered Expenses** will be considered for a **Sickness and Injury Benefit** payment for one assistant surgeon in connection with surgery for which **Sickness and Injury Benefits** are payable hereunder for the professional fees of the primary surgeon);
4) Anesthesiologist or Nurse Anesthetist – (professional fees that constitute **Covered Expenses** will be considered for a **Sickness and Injury Benefit** payment for either an anesthesiologist or a nurse anesthetist administration and monitoring of anesthesia, during surgery for which **Sickness and Injury Benefits** are payable hereunder for the professional fees of the primary surgeon);
5) Pathologist – (professional Fees that constitute **Covered Expenses** will be considered for a **Sickness and Injury Benefit** payment for a pathologist's evaluation and/or interpretation of any tissue specimen removed during or in connection with such surgery); and
6) Second Surgical Opinion - Up to [$250] of professional fees for a second surgical opinion if:
   a) the **Insured's Provider** determines that surgery is needed;

b) the surgery is not excluded from this **Certificate** or any riders, amendments or endorsements attached hereto;
c) the **Insured** is examined in person by another qualified **Provider** for the purpose of obtaining a second surgical opinion; and
d) the **Provider** issuing the second surgical opinion sends **Us** a written report.

However, **We** will not pay for the second surgical opinion if the **Provider** issuing the second surgical opinion performs or assists in the surgery.

[e. OUTPATIENT PROVIDER OFFICE VISITS

Professional services **Provided** by a **Provider** during a **Medically Necessary** visit to the professional offices of such **Provider** for the purposes of evaluation, diagnosis and treatment of **Injuries** or **Sickness**. **]**

[f. [OUTPATIENT PRESCRIPTIONS

[Subject to the applicable] [**Calendar Year Deductible**][**Insured Coinsurance Percentage]**] [**Prescription Drug Co-Pay**][**Prescription Drug Calendar Year Deductible Per Insured**][**Prescription Drug Insured Coinsurance Percentage**] **We** will pay **Covered Expenses** incurred by an **Insured** for **Prescription Drugs** filled at a **Participating Pharmacy. [We** will pay, to or on behalf of the **Insured**, the **Covered Expenses** but not to exceed the **Calendar Year Maximum Per Insured For Prescription Drugs** as shown on the **Certificate Schedule**.] [If the charge for the **Prescription Drug** is less than the **Prescription Drug Co-pay** and/or [**Prescription Drug Insured Coinsurance Percentage]** [**Insured Coinsurance Percentage]**] shown on the **Certificate Schedule**, the **Insured** will be responsible for the full cost of the medication.] [If the **Insured's Provider** has not specified that a **Preferred Brand Drug** be used rather than a **Generic Drug,** but the **Insured** selects a **Preferred Brand Drug**, the **Insured** will pay the applicable [**Prescription Drug Co-pay]** [and/or] [**Prescription Drug Insured Coinsurance Percentage]** [**Insured Coinsurance Percentage]**], plus the difference in price between the **Generic Drug** and **Preferred Brand Drug.]** [**Covered Expenses** for such **Prescriptions** shall not exceed, the amount of the cost of the least expensive drug, medicine or **Prescription Drug** that may be used to treat the **Insured's Sickness** or **Injury**, all in accordance with the following schedule:

a. If a **Generic Drug** is available at the **Participating Pharmacy** selected by the **Insured** that may be taken by such **Insured** in substitute for either a **Brand Name Drug** or a **Preferred Brand Drug** that was prescribed for the **Insured**, the amount of **Covered Expenses** for such **Prescription** shall be limited to the cost of such **Generic Drug** at such pharmacy;
b. If a **Preferred Brand Drug** is available at the **Participating Pharmacy** selected by the **Insured** that may be taken by such **Insured** in substitute for a **Brand Name Drug** that was prescribed for the **Insured**, the amount of **Covered Expenses** for such **Prescription** shall be limited to the cost of the **Preferred Brand Drug** at such pharmacy; and
c. If both a **Generic Drug** and a **Preferred Brand Drug** are available at the **Participating Pharmacy** selected by the **Insured** that may be taken by such **Insured** in substitute for a **Brand Name Drug** that was prescribed for the **Insured**, the amount of **Covered Expenses** for such **Prescription** shall be limited to the cost of such **Generic Drug** at the pharmacy.]

[The **Prescription Drug Co-Pay** made to **Participating Pharmacies** may not be used to satisfy the [**Prescription Drug Calendar Year Deductible per Insured]**, [**Prescription Drug Insured Coinsurance Percentage],** [C**alendar Year Deductible]**, [the **Insured Coinsurance Percentage]**, the **Separate Deductible for Non-Participating Providers**, [the **Access Fees**] and the [**Failure to Pre-certify Treatment Deductible**.]

If **Prescription Drugs** are purchased by an **Insured** from a **Non-Participating Pharmacy**, then the amount of **Covered Expenses** for the purposes of calculating a benefit payment hereunder shall be limited to the amount of **Covered Expenses** that would have been incurred by such **Insured** if the **Prescription Drugs** had been purchased at a **Participating Pharmacy** instead of the **Non-Participating Pharmacy**.**]**

[g.] OUTPATIENT LABORATORY AND DIAGNOSTIC TESTS

[Subject to **Laboratory and Diagnostic Testing Access Fee**, if applicable,][S][s]ervices **Provided** by a **[Provider]**, **Hospital**, or other medical facility in connection with the performance and interpretation of laboratory and diagnostic tests received on an **Outpatient** basis by an **Insured** due to **Injuries** or **Sickness**.

[h.] OUTPATIENT THERAPY

[Subject to the **Outpatient Therapy Access Fee**] [S][s]ervices **Provided** by **Providers**, a **Hospital**, or other medical facility in connection with the following types of therapy received on an **Outpatient** basis by an **Insured** due to **Injuries** or **Sickness**:

1. Radiation therapy;
2. Chemotherapy;
3. Occupational therapy;
4. Physical therapy;
5. Rehabilitation therapy; and
6. Speech therapy.

[[Occupational,] [Physical] [and] [Speech] Therapy [are/is] limited to [[$50] per visit] [25] [visits] up to [$2,000] maximum [per type of therapy] per **Calendar Year** per **Insured**`] [This **Outpatient** therapy **Benefit** does not include fees or expenses charged for spinal manipulations.]

[i.] HOME HEALTH CARE

Services **Provided** to an **Insured** due to **Injuries** or **Sickness** for the care specified in a **Home Health Care Plan**, up to a **Covered Expense** maximum per day of 50% of the amount of the semi-private room rate of either (i) the **Hospital** where such **Insured** was **Confined** prior to the development of the **Home Health Care Plan**, or (ii) the **Skilled Nursing Home** where such **Insured** was a resident immediately prior to the development of the **Home Health Care Plan**. Such expenses incurred by an **Insured** as the result of a **Home Health Care Plan** are payable for an **Insured**, if:

1) The **Insured** had first been **Confined** in a **Hospital** or was a resident at a **Skilled Nursing Home** due to an **Injury** or **Sickness**;
2) The **Home Health Care Plan** of the **Insured** begins no later than thirty (30) days after discharge from the **Hospital** or **Skilled Nursing Home**; and
3) The **Home Health Care Plan** is for the same or related **Injury** or **Sickness** as the **Hospital** or **Skilled Nursing Home Confinement**.

A **Provider** must certify that the **Insured** would have to be in a **Hospital** or **Skilled Nursing Home** (and receive a level of care greater than **Custodial Care**) if **Home Health Care Plan** services had not been available.

Payment under this coverage is limited to a period of a maximum of [40-120] days during a twelve (12) consecutive month period.

[j.] HOSPICE CARE

Services **Provided** to an **Insured** for **Hospice Care** due to **Injuries** or **Sickness**, if:

1) such **Hospice Care** is provided as the result of **Injury** or **Sickness** for which **Covered Expenses** were incurred by such **Insured** for **Hospital Confinement**;
2) the **Insured's Provider** certifies the life expectancy of the **Insured** is six (6) months or less; and
3) the **Insured's Provider** recommends a **Hospice Care** program.

Payment under this coverage is limited to a period of a maximum of six (6) consecutive months.

[k.] MEDICAL EQUIPMENT AND SUPPLIES

Medical Equipment and supplies **Provided** to an **Insured** as a result of **Injury** or **Sickness** which are **Covered Expenses** includes:

1) Blood, plasma, and derivatives, if not replaced;
2) Initial replacement of natural limbs and eyes when loss occurs while this **Certificate** is in force;
3) Initial permanent lens immediately following cataract surgery, except the replacements will not be covered;
4) [Casts,] [non-dental splints,] [trusses,] [crutches] [and] [braces (except dental or orthodontic braces);]
5) Rental (not to exceed the purchase price) of a wheelchair, hospital bed, or other durable portable medical equipment **Provided** to an **Insured** in each event required for therapeutic treatment of **Injuries** or **Sickness** on an **Outpatient** basis; and
6) oxygen and its administration.

[l.] SKILLED NURSING HOME

Daily room and board and miscellaneous charges for other services **Provided** to an **Insured** due to **Injuries** or **Sickness** for residential care received in a **Skilled Nursing Home** for up to a maximum of [60-120] days in a twelve (12) month period, if:

1) the **Insured** has first been **Confined** in a **Hospital** for three (3) or more consecutive days;
2) the **Skilled Nursing Home** stay begins within thirty (30) days after discharge from the **Hospital**;
3) the **Skilled Nursing Home** stay is for the same or related **Injury** or **Sickness** as the **Hospital Confinement**; and
4) the **Insured's Provider** certifies the need for **Skilled Nursing Home Confinement**.

[m.] SUPPLIES AND SERVICES ASSOCIATED WITH THE TREATMENT OF DIABETES

The following **Outpatient** services **Provided** to an **Insured** for care received during for the treatment of diabetes and associated conditions:

1) Diabetes Equipment;
2) Diabetes Supplies; and
3) Diabetes Self-Management Training.

[n.] INHERITED METABOLIC DISORDERS

Benefits include **Covered Expenses** for **Medical Foods** prescribed or ordered under the supervision of a **Provider**, as **Medically Necessary** for the therapeutic treatment of an **Inherited Metabolic Disorder**. This **Benefit** is limited to a maximum of [$5,000] in a twelve (12) month period.

[o.] PROSTHETIC AND ORTHOTIC DEVICE BENEFIT

Benefits include **Covered Expenses** for **Medically Necessary** services and supplies for the effective use of a **Prosthetic** or **Orthotic Device**, including formulating its design, fabrication, material and component selection, measurements, fittings, static and dynamic alignments, and instructing the patient in the use of the device. The repair and replacement of a **Prosthetic** or **Orthotic Device** will be considered a covered **Benefit** unless necessitated by misuse or loss.

[p]. NEWBORN CARE

Benefits include, **Covered Expenses** for the care and treatment of **Your**, or **Your Spouse's** newborn child or newborn adoptee including care for **Injury**, **Sickness**, congenital defects, birth abnormalities, premature birth, tests for hypothyroidism, phenylketonuria, galactosemia, and in the case of non-Caucasian newborn infants, tests for sickle-cell anemia. Additionally, **Benefits** include **Covered**

Expenses for well-baby care up to five (5) 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.

[**p]. IMPAIRMENT OF SPEECH OR HEARING**

Benefits include **Covered Expenses** for the care and treatment of loss or impairment of speech or hearing. Loss or impairment of speech or hearing shall include those communicative disorders generally treated by a licensed pathologist or audiologists. **Benefits** for the care and treatment of loss or impairment of speech or hearing shall not include hearing instruments or devices.

[q]. GENERAL ANESTHESIA FOR DENTAL PROCEDURES

Benefits include **Covered Expenses** incurred for general anesthesia and related hospitalization services for dental care if the **Provider** treating the **Insured** certifies that because of **the Insured's** age or condition or problem, hospitalization or general anesthesia is required to safely and effectively perform the procedures and the **Insured**:

1. is 6 years of age or younger, and is determined by two (2) dentists, licensed under the Arkansas Dental Practices Act §§ 17-82-101 et seq, to require **Medically Necessary** dental treatment in a **Hospital** or **Ambulatory Surgical Center** due to a significantly complex dental condition,
2. is a person with a diagnosed serious mental or physical condition; or
3. is a person with a significant behavioral problem as determined by the **Insured's** Provider as licensed under the Arkansas Medical Practices Act, §§17-95-201 et seq., and 17-95-401 et seq.

Covered Expenses do not include dental care benefits which may require general anesthesia in a **Hospital** or **Ambulatory Surgical Facility Center**.

[r. STERILIZATION

[Commencing after the first anniversary of the **Issue Date]**, **Benefits** will be paid for **Covered Expenses** incurred for sterilization not to exceed a maximum lifetime **Benefit** of [$500 to $2,000] per **Insured**.]

[**s. ALLERGIES**

Benefits will be paid for **Covered Expenses** incurred for allergy testing and allergy injections, including, but not limit to, injectable antigens, and extracts, not to exceed a maximum of [$250 to $1,000] of **Covered Expense** per **Insured** per **Calendar Year.]**

[t. TREATMENT OF SLEEP APNEA

Benefits will be paid for **Covered Expenses** incurred for the treatment of sleep apnea, including, but not limited to: sleep study, durable medical equipment (CPAP or BiPAP), and surgery not to exceed a lifetime maximum of [$1,000 to $5,000] per **Insured**.]

[u. GROWTH DISORDERS

Benefits will be paid for **Covered Expenses** incurred for the treatment of a growth disorder or abnormally short stature, including, but not limited to, growth hormone deficiency therapy (GHDT) not to exceed a maximum lifetime **Benefit** of [$10,000 to $25,000] of **Covered Expenses** for each **Insured** child.]

[**v. SPINAL MANIPULATION**

Benefits will be paid for **Covered Expenses** incurred for spinal manipulation, including, but not limited to, manipulation for spinal subluxation and any associated treatment or services not to exceed a covered expense maximum of : (i) [$25 to $100] per day of treatment (does not include x-rays); and (ii) [$250 to $1,000] of **Covered Expense** per **Calendar Year** per **Insured,** for all treatments and x-rays**.**]

[w. BREAST IMPLANT REMOVAL

Benefits will be paid for **Covered Expenses** incurred for breast implant removal for the **Medically Necessary** treatment of a covered **Sickness** or **Injury**.]

B. [WELLNESS][AND][SCREENING BENEFITS]

[Subject to all applicable definitions, exclusions, limitations, waiting periods, and other provisions contained in this **Certificate**, as well as any riders, endorsements, or amendments attached to hereto, **We** promise to pay to or on behalf of each **Insured** the **Company Insurance Percentage** of the amount of professional fees and other applicable medical diagnostic or treatment expenses and charges that constitute **Covered Expenses** incurred by each **Insured** for the following described **[Wellness and Screening Benefit]** services, but only after (i) each of the applicable deductible has been first satisfied by deduction from such **Covered Expenses** and applied to the applicable **Insured** for payment, and (ii) the applicable **Insured Coinsurance Percentage** of the **Covered Expenses** remaining after satisfaction of all applicable deductibles is, likewise, satisfied by deduction from the remaining **Covered Expenses** and applied to the applicable **Insured** for payment:]

[ANNUAL PHYSICAL EXAM][AND] SCREENING TESTS]:

[[a].ADULT WELLNESS AND PREVENTIVE CARE

[Commencing [twelve (12)] to [twenty-four (24)] months after the **Issue Date]** [S][s]ervices **Provided** to **You** and **Your Spouse** (if such spouse is listed as an **Other Insured**) for necessary **Adult Wellness Preventive Care** by a **Participating Provider** no more than [once] every [twelve (12) months][.] [up to] [the] [a] [[**Calendar Year]** [**Adult Wellness Maximum]]** [payment] [stated on the Certificate Schedule] [by **Us]** [of $50 to $250] [per adult **Insured** per **Calendar Year]**.

Adult Wellness Preventive Care does not include charges[(i)] by **Participating Providers** for COLORECTAL CANCER SCREENING, PROSTATE CANCER SCREENING, MAMMOGRAPHY SCREENING, PAP SMEAR SCREENING**,** any spinal manipulations, physical therapy, occupational therapy, or other **Outpatient** therapy or treatment, or any form of medical or surgical treatment of an **Injury** or **Sickness**[; or (ii) any service, care, test or treatment by a **Non-Participating Provider**.]]

[[b]. COLORECTAL CANCER SCREENING

[Commencing [twelve (12)] to [twenty-four (24)] months after the **Issue Date**] **[B][b]enefits** include **Covered Expenses** incurred by an **Insured** for colorectal cancer screening for a **Insured** who is fifty (50) years of age or older and at normal risk for developing colon cancer or has attained at least 30 years of age and has a history of, or a first degree family member with colorectal cancer, as follows:

1) a fecal occult blood test performed annually; and
2) a flexible sigmoidoscopy performed every five (5) years or a colonoscopy performed every ten (10) years.]

[d]. MAMMOGRAPHY SCREENING

Services **Provided** for screening by low dose **Mammogram** to detect the presence of occult breast cancer, as follows:

1) A single baseline **Mammogram** for female **Insureds** 35 to 39 years of age;
2) One **Mammogram** every two (2) years for female **Insureds** 40 to 49 years of age; and
3) An annual **Mammogram** for each female **Insured** 50 years of age or older.

[e.] PAP SMEAR SCREENING

[Commencing [twelve (12)] to [twenty-four (24)] months after the **Issue Date]** [S][s]ervices **Provided** for an annual Pap Smear **Provided** to female **Insureds**, including the examination by a **Provider**, the laboratory fee, and the **Provider's** interpretation of the laboratory results.

[C. MISCELLANEOUS BENEFITS

Miscellaneous Benefits are [not] subject to [either] [the [**Calendar Year Deductible]** [or] [and] [the **Insured Coinsurance Percentage**,] [but are subject to any applicable **Co-Pays**.] Therefore, subject to all applicable definitions, exclusions, limitations, waiting periods, and other provisions contained in this **Certificate**, as well as any riders, endorsements, or amendments attached to hereto, [including applicable **Co-Pays**,] **We** promise to pay to or on behalf of each **Insured** the **Company Insurance Percentage** of the amount of professional fees and other applicable medical diagnostic or treatment expenses and charges that constitute **Covered Expenses** incurred by each applicable **Insured** for the following described **Miscellaneous Benefits**:

[1]. [ADULT WELLNESS AND PREVENTIVE CARE

[Commencing [twelve (12)] to [twenty-four (24)] months after the **Issue Date]** [S][s]ervices **Provided** to **You** and **Your Spouse** (if such spouse is listed as an **Other Insured**) for necessary **Adult Wellness Preventive Care** by a **Participating Provider** no more than [once] every [twelve (12) months][.] [up to] [the] [a] [[**Calendar Year]** [**Adult Wellness Maximum]]** [payment] [stated on the Certificate Schedule] [by **Us]** [of $50 to $250] [per adult **Insured** per **Calendar Year]**.

Adult Wellness Preventive Care does not include charges [(i)] by **Participating Providers** for COLORECTAL CANCER SCREENING, PROSTATE CANCER SCREENING, MAMMOGRAPHY SCREENING, PAP SMEAR SCREENING**,** any spinal manipulations, physical therapy, occupational therapy, or other **Outpatient** therapy or treatment, or any form of medical or surgical treatment of an **Injury** or **Sickness** [; or (ii) any service, care, test or treatment by a **Non-Participating Provider**.]]

[2]. PROSTATE CANCER SCREENING BENEFIT

Benefits include the following **Covered Expenses Incurred** by male **Insureds** during a medically recognized diagnostic examination for the detection of prostate cancer. This **Benefit** shall include an annual physical examination for the detection of prostate cancer, and an prostate-specific antigen test used for the detection of prostate cancer for each male **Insured** who is at least forty (40) years of age or older.

The prostate cancer screening must be performed by a **Provider**, and shall consist of a prostate specific antigen blood test and a digital rectal examination.

The prostate cancer screening is not subject to any plan deductibles and shall not exceed the actual cost of the prostate cancer screening.

[2]. [CHILDHOOD WELLNESS AND PREVENTIVE CARE

Services **Provided** to each **Insured** under the age of [19 (or 24 if a **Full-Time Student**)] for necessary **Childhood Wellness Preventive Care** up to a **Calendar Year** maximum payment by **Us** of [$100 to $500] per person per **Calendar Year**.]

Benefits include **Covered Expenses** for a child **Insured** for **Periodic Preventive Care Visits** to include twenty (20) visits at approximately the following age intervals: birth, 2 weeks, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years, 5 years, 6 years, 8 years, 10 years, 12 years, 14 years, 16 years, and 18 years. Services rendered during a periodic review shall only be covered to the extent that those services are **Provided** by or under the supervision of a single **Provider** during the course of one visit.

[Childhood Wellness Preventive Care does not include charges (i) by **Providers** for any spinal manipulations, physical therapy, occupational therapy, or other **Outpatient** therapy or treatment, or any form of medical or surgical treatment of an **Injury** or **Sickness**.

3. [CHILDHOOD IMMUNIZATIONS]

Services **Provided** for the following routine childhood immunizations **Provided** to each **Insured** under the age of 19: poliomyelitis, rubella, rubeola, mumps, tetanus, pertussis, diphtheria, hepatitis B, Haemophilus influenza type b (Hib) and varicella. Childhood immunizations are not subject to any deductibles, coinsurance or [**Co-Pays.]**

[4]. [VISITS TO PARTICIPATING PROVIDERS OFFICE

a. Doctor Office Visits Co-Pay

Subject to the **Doctor Office Visit Co-Pay** for **Outpatient** visits to the professional offices of a physician who is a **Participating Provider**, **We** will pay the remaining amount of **Covered Expenses** incurred for professional services **Provided** by the **Participating Provider** during each visit for **Medically Necessary** physical examinations, diagnosis [,][and] development of a treatment plan, [laboratory, x-ray or other diagnostic tests] [performed during such visit at such professional offices] for **Sickness** and **Injury**. [**Covered Expenses** incurred for all services under this section are limited to [$1,200] per **Calendar Year** per **Insured**.]

[b. X-Ray Laboratory and Diagnostic Testing Co-Pay

After satisfaction of the **Doctor Office Visit Co-Pay** and the satisfaction of the **X-Ray, Laboratory and Diagnostic Testing Co-Pay We** will pay the remaining amount of **Covered Expenses** incurred during [the first [two (2)]] [an] **Outpatient** office visit at a **Participating Provider** per **Insured** per **Calendar Year** for laboratory, x-ray or other diagnostic tests performed during any such visit at such professional offices.[up to a maximum **Benefit** of [$50-$2,000][per **Insured** per **Calendar Year**.]]

However, the following limitations apply to this VISIT TO PARTICIPATING PROVIDER OFFICE coverage:

[a.] [Covered Expenses incurred by an **Insured** for any **Outpatient** therapy or treatment **Provided** for any **Injury** or **Sickness** during any visit to the professional offices of such **Participating Provider** are subject to satisfaction of (i) the **Calendar Year Deductible**, and (ii) the **Insured Coinsurance Percentage**;]

[b.] [Covered Expenses incurred by an **Insured** for any **Outpatient** diagnostic testing and laboratory services **Provided** at a location other than the professional offices of such **Participating Provider** are subject to satisfaction of (i) **Laboratory and Diagnostic Testing Access Fee**, and (ii) the **Calendar Year Deductible**, and(iii) the **Insured Coinsurance Percentage**;]

[c.] [Covered Expenses incurred by an **Insured** for any **Outpatient** surgery **Provided** during any visit to the professional offices of such **Participating Provider** are subject to satisfaction of (i) the **Calendar Year Deductible**, (ii) the **Insured Coinsurance Percentage**;]

[d.] [Covered Expenses incurred by an **Insured** for professional services **Provided** during any **Outpatient** office visit to the professional offices of a **Participating Provider** in excess of [$0 - $1,200] [two (2) visits] per **Calendar Year** are subject to satisfaction of (i) the **Calendar Year Deductible**, and (ii) the **Insured Coinsurance Percentage**;]

[e.] [Covered Expenses incurred by an **Insured** for any type of service provided during any visit to the professional offices of such **Non-Participating Provider** are subject to satisfaction of (i) the **Calendar Year Deductible**, (ii) the **Separate Deductible for Non-Participating Providers**, and (iii) the applicable **Insured Coinsurance Percentage** for **Non-Participating Providers**; and]

[f.] [Covered Expenses incurred by an **Insured** under any other provision or limitation such as [ADULT WELLNESS, [CHILDHOOD WELLNESS,] [CHILDHOOD IMMUNIZATIONS,] [TREATMENT FOR ALLERGIES,] [SPINAL MANIPULATION,] [OCCUPATION,] [SPEECH] [OR PHYSICAL THERAPY,] [COLORECTAL CANCER SCREENING,] [PROSTATE CANCER SCREENING,] [MAMMOGRAPHY SCREENING,] [and] [or] [PAP SMEAR SCREENING] are not considered **Covered Expenses** under this section.]

[5. [OUTPATIENT PRESCRIPTIONS

[Subject to the applicable] [**Calendar Year Deductible**][**Insured Coinsurance Percentage]**] [**Prescription Drug Co-Pay**][**Prescription Drug Calendar Year Deductible Per Insured**][**Prescription Drug Insured Coinsurance Percentage**] **We** will pay **Covered Expenses** incurred by an **Insured** for **Prescription**

Drugs filled at a **Participating Pharmacy. [We** will pay, to or on behalf of the **Insured**, the **Covered Expenses** but not to exceed the **Calendar Year Maximum Per Insured For Prescription Drugs** as shown on the **Certificate Schedule**.] [If the charge for the **Prescription Drug** is less than the **Prescription Drug Co-pay** and/or [**Prescription Drug Insured Coinsurance Percentage]** [**Insured Coinsurance Percentage]**] shown on the **Certificate Schedule**, the **Insured** will be responsible for the full cost of the medication.] [If the **Insured's Provider** has not specified that a **Brand Name Drug** be used rather than a **Generic Drug,** but the **Insured** selects a **Brand Name Drug**, the **Insured** will pay the applicable [**Prescription Drug Co-pay]** [and/or] [**Prescription Drug Insured Coinsurance Percentage]** [**Insured Coinsurance Percentage]**], plus the difference in price between the **Generic Drug** and **Brand Name Drug.]** [**Covered Expenses** for such **Prescriptions** shall not exceed, the amount of the cost of the least expensive drug, medicine or **Prescription Drug** that may be used to treat the **Insured's Sickness** or **Injury**, all in accordance with the following schedule:

a. If a **Generic Drug** is available at the **Participating Pharmacy** selected by the **Insured** that may be taken by such **Insured** in substitute for either a **Brand Name Drug** or a **Preferred Brand Drug** that was prescribed for the **Insured**, the amount of **Covered Expenses** for such **Prescription** shall be limited to the cost of such **Generic Drug** at such pharmacy;
b. If a **Preferred Brand Drug** is available at the **Participating Pharmacy** selected by the **Insured** that may be taken by such **Insured** in substitute for a **Brand Name Drug** that was prescribed for the **Insured**, the amount of **Covered Expenses** for such **Prescription** shall be limited to the cost of the **Preferred Brand Drug** at such pharmacy; and
c. If both a **Generic Drug** and a **Preferred Brand Drug** are available at the **Participating Pharmacy** selected by the **Insured** that may be taken by such **Insured** in substitute for a **Brand Name Drug** that was prescribed for the **Insured**, the amount of **Covered Expenses** for such **Prescription** shall be limited to the cost of such **Generic Drug** at the pharmacy.]

[The **Prescription Drug Co-Pay** made to **Participating Pharmacies** may not be used to satisfy the [**Prescription Drug Calendar Year Deductible** per **Insured]**, [**Prescription Drug Insured Coinsurance Percentage],** [**Calendar Year Deductible]**, [the **Insured Coinsurance Percentage]**, the **Separate Deductible for Non-Participating Providers**, [the **Access Fees**] and the [**Failure to Pre-certify Treatment Deductible**.]

If **Prescription Drugs** are purchased by an **Insured** from a **Non-Participating Pharmacy**, then the amount of **Covered Expenses** for the purposes of calculating a benefit payment hereunder shall be limited to the amount of **Covered Expenses** that would have been incurred by such **Insured** if the **Prescription Drugs** had been purchased at a **Participating Pharmacy** instead of the **Non-Participating Pharmacy**.**]**

D. PRE-CERTIFICATION OF TREATMENT

If an **Insured** notifies and obtains from **Us** a certification that **Covered Expenses** are to be incurred due to a **Medically Necessary Hospital Confinement** or surgery, **We** will provide the **Sickness and Injury Benefits** for **Covered Expenses** as specified under the terms and provisions of this **Certificate** and any riders, amendments, or endorsements attached hereto.

Certification must be obtained prior to all **Inpatient** admissions, except in the case of an **Emergency** admission. In the event of an **Emergency Inpatient** admission, the **Insured** or his or her **Provider** must notify **Us** within seventy-two (72) hours of **Confinement**, or as soon thereafter as reasonably possible.

At the time notification of surgery is made, **We** will inform the **Insured** and his or her **Provider** if a second surgical opinion is required, at the expense of the **Company**, before certification will be given and will assign a length of stay if it is determined that **Inpatient Hospital** care is **Medically Necessary**. **We** may extend the length of stay upon the request of the **Insured** or **Provider** if **We** determine an extension is **Medically Necessary**. No **Sickness and Injury Benefits** will be provided under this **Certificate** for expenses that are determined not **Medically Necessary**.

Treatment provided at any time after initial certification that differs from the specific plan of care and treatment previously authorized requires re-certification by **Us**.

Pre-Certification of Treatment, services, and/or a length of stay is not a guarantee of **Sickness and Injury Benefits** under this **Certificate** or the **Group Policy**. All claims for **Sickness and Injury Benefits** under this **Certificate**, including claims for services and treatment that were pre-certified by **Us**, are subject to all terms, definitions, limitations, exclusions and restrictions contained in this **Certificate** and any riders, endorsements, or amendments attached hereto.

E. CLAIM PROCEDURES, INVESTIGATION AND PAYMENT

1. NOTICE OF CLAIM

Written notice of claim must be received by **Us** within thirty (30) days of the date that each **Covered Expense** is incurred by an **Insured**. If it is not reasonably possible for the notice of claim to be transmitted to **Us** so that it is received within such thirty (30) day period, then written notice of claim must be received by **Us** as soon thereafter as reasonably possible. A **Provider's** billing statement that is timely received by **Us** will suffice as a written notice of the claim under this Section. **Our** current address for providing a written notice of claim is shown on Page 1. A written notice of claim should include the applicable **Insured's** name, the **Primary Insured's** name, the applicable **Provider's** name, and the **Certificate** number.

2. CLAIM FORMS AND ADDITIONAL INFORMATION TO BE PROVIDED

When **We** receive timely written notice of claim, **We** will normally send **You** a claim form to be completed, signed and returned. The general purpose of the claim form is to provide **Us** with general background information about the nature of the claim, which information may be necessary in order to complete a proper proof of loss. If this claim form is not provided to **You** within fifteen (15) days, of **Our** timely receipt of written notice of the claim, then **You** will not be required to later complete, sign and return the written claim form, but may be required to provide other information, including a written authorization for the release of medical records and information, which in each event is necessary either for **Our** investigation of the claim or otherwise as part of the completion of a proper proof of loss. **We** must receive information requested within the time limit stated in the Section V E 3, PROOFS OF LOSS.

3. PROOFS OF LOSS

Written proof of a **Covered Expense** must be provided to **Us** within ninety (90) days after such **Covered Expense** is incurred by an **Insured**. If it was not reasonably possible for **You** to give **Us** proof in the time required, **We** will not reduce or deny the claim for this reason if the proof is filed as soon as possible. In any event, the proof of loss required must be provided no later than one (1) year from the date the **Covered Expense** was incurred by the **Insured** unless **You** are legally incompetent or otherwise physically unable to act.

4. CLAIMS REVIEW, INVESTIGATION, ADJUSTMENT AND ADJUDICATION

As written notice of claims, completed claim forms, signed authorizations for release of medical authorizations, medical records, and other written information from **Insureds** and **Providers** are received and reviewed additional investigation, requests for information and other matters may occur in connection with the completion of a proper proof of loss, adjustment and adjudication of the claim. At **Our** expense, **We** have the right to have the **Insured** examined by a **Provider** of **Our** choice as often as is reasonably necessary while a claim or other benefit determination is pending. Information received during the review and investigation of a claim will be considered, as applicable, in connection of whether a timely and proper proof of loss has been completed. After **Our** investigation has been completed, claims will be adjusted and adjudicated in accordance with the coverage under this **Certificate** that was in force on the date the applicable expense was incurred. Part of the adjustment and adjudication process includes a determination of the amount of **Covered Expense** incurred by the **Insured** for the applicable services rendered. This determination will normally require communication with the network with whom the applicable **Provider** was contracted at the time the service was rendered, as well as other matters. Once a decision has been made on a claim and this decision has been processed, an explanation of benefits form will be transmitted to the **Primary Insured** and each applicable **Provider**.

5. PAYMENT OF CLAIMS

The applicable portion of **Covered Expenses** incurred by an **Insured**, which are owed by the **Company** under this **Certificate**, will be paid to the **Primary Insured**, unless the right to such payment was previously assigned to a **Provider** for direct payment. Upon the death of the **Primary Insured**, the unpaid amount of any applicable **Covered Expenses** incurred by an **Insured**, which are owed by the **Company** under this **Certificate** will be paid to the **Beneficiary**, unless the right to such payment was previously assigned to a **Provider** for direct payment. Any claim payment made by **Us** in good faith will fully discharge **Our** liability under this **Certificate** for such claim to the extent of the amount of such good faith payment.

6. TIME OF PAYMENT OF CLAIMS

We will make payments due promptly once a decision has been made on a claim and this decision has been processed.

Payment shall be treated as being made on the date a draft or valid instrument was placed in the United States mail to the last known address of the applicable **Primary Insured**, **Provider**, or **Beneficiary** in a properly addressed, postpaid envelope, or, if not so posted, on the date of delivery.

A **Benefit** payment owed by **Us** under this **Certificate**, but not paid within thirty (30) days after the date of **Our** receipt of a proper proof of loss and the completion of **Our** investigation of the claim, will be considered past due. **We** will pay interest on any past due benefit payment amount at the rate of one and one-half percent per month commencing on the thirty first (31st) day after the completion and **Our** receipt of a proper proof of loss and the completion of **Our** investigation of the claim until the date such payment is tendered by **Us**.

VI. DEDUCTIBLES

A. CALENDAR YEAR DEDUCTIBLE

No **Sickness and Injury Benefits** or **Wellness and Screening Benefits** are payable under this **Certificate** for any **Covered Expenses** incurred by an **Insured**, until after the **Calendar Year Deductible** is satisfied and fully payable each **Calendar Year** by such **Insured**. In addition to the **Calendar Year Deductible**, the **Separate Deductible For Non-Participating Providers** will apply to services rendered by **Non-Participating Providers**.

Neither (i) the amount of the **Separate Deductible For Non-Participating Providers**, nor (ii) the amount of the **Failure to Pre-Certify Treatment Deductible** may be used to satisfy the **Calendar Year Deductible**.

B. SEPARATE DEDUCTIBLE FOR NON-PARTICIPATING PROVIDERS

No **Sickness and Injury Benefits** or **Wellness and Screening Benefits** are payable under this **Certificate** for services rendered by **Non-Participating Providers** until after the amount of the **Separate Deductible For Non-Participating Providers** is satisfied and fully payable. The amount of the **Separate Deductible For Non-Participating Providers** is shown on the **Certificate Schedule** and applies per **Calendar Year** separately to each **Insured**.

Neither (i) the amount of the **Calendar Year Deductible** nor (ii) the amount of the **Failure to Pre-Certify Treatment Deductible** may be used to satisfy the **Separate Deductible For Non-Participating Providers**.

C. SEPARATE DEDUCTIBLE FOR FAILURE TO PRE-CERTIFY TREATMENT

An additional deductible in the amount of [$1,000], the **Failure to Pre-Certify Treatment Deductible**, will be applied to **Covered Expenses** before the **Company Insurance Percentage** is payable under this **Certificate** for each (i) **Inpatient Hospital Confinement**, and (ii) surgery, if **Pre-Certification of Treatment** is not obtained. No **Sickness and Injury Benefits** are payable under this **Certificate** for any **Covered Expenses**

that are subject to the **Failure to Pre-Certify Treatment Deductible** until after the amount of any such **Failure to Pre-Certify Treatment Deductible** is satisfied and fully payable by either **You** or such **Insured.**

[D. FAMILY CALENDAR YEAR DEDUCTIBLE MAXIMUM

Once a combined total of [three (3)] **Calendar Year Deductibles** or **Separate Deductible for Non-Participating Providers** have been satisfied in any **Calendar Year** by any [three (3)] **Insureds**, no additional **Calendar Year Deductible** or **Separate Deductible for Non-Participating Provider** will be assessed by **Us** in connection with medical treatment and services rendered to any other **Insured** during the remainder of such **Calendar Year**.]

[E.COMMON ACCIDENT CALENDAR YEAR DEDUCTIBLE MAXIMUM

If [two (2)] or more **Insureds** incur **Covered Expenses** for **Injuries** sustained in the same accident, only one (1) **Calendar Year Deductible** or **Separate Deductible for Non-Participating Providers** will be applied that **Calendar Year** to the combined **Covered Expenses** resulting from the **Injuries** sustained in such common accident by all **Insureds**.]

VII. LIMITATIONS, EXCLUSIONS AND NON-WAIVER

A. LIMITATIONS-WAITING PERIODS

Coverage under this **Certificate** is limited as provided by the definitions, limitations, exclusions, and terms contained in each and every Section of this **Certificate**, as well as the following limitations and waiting periods:

[1]. Any loss or expense incurred as a result of an **Insured's Pre-existing Condition [**not disclosed on the application] is not covered under this **Certificate** unless such loss or expense constitutes **Covered Expenses** incurred by such **Insured** more than [twelve (12)] [twenty-four (24)] months after the **Issue Date**, and are not otherwise limited or excluded by this **Certificate** or any riders, endorsements, or amendments attached to this **Certificate**;

[2]. Any loss or expense which results from the diagnosis, care or treatment of hernia, disease or disorders of the reproductive organs, hemorrhoids, varicose veins, tonsils and/or adenoids, or otitis media shall be covered under this **Certificate** only if (i) such loss or expense constitutes **Covered Expenses** incurred by an **Insured** after this **Certificate** has been in force for a period of six (6) months from the **Issue Date**, (ii) such **Sicknesses** are not otherwise limited or excluded by this **Certificate** or any riders, endorsements, or amendments attached to this Certificate, [(iii) care for such **Sicknesses** is **Provided** on an **Emergency** basis], and [(iv)] such **Sicknesses** are not **Pre-existing Conditions**;

[3]. **[Insureds** have the right to obtain **Prescriptions** from the pharmacy of their choice. However, if an **Insured**: (i) uses a **Non-Participating Pharmacy** to fill a **Prescription**; or (ii) does not present his/her correct ID card when the **Prescription** is filled at a **Participating Pharmacy**, then such **Insured** must pay the applicable pharmacy in full and file a claim form with the **Company** for reimbursement. In either event, the **Insured** will be reimbursed by the **Company** at the discounted or negotiated rate for such **Prescription** that would have been paid to a **Participating Pharmacy** by the **Company** under this **Certificate** if the **Insured** had used a **Participating Pharmacy** and properly presented the correct ID card at the time the **Prescription** was filled;]

[4]. [Pre-authorization may be required by the **Company** prior to the time that **Prescriptions** for certain **Prescription Drugs** are filled;]

[5.] If as the result of an **Emergency Sickness** or an **Emergency Injury** services are rendered for an **Insured** by a **Non-Participating Provider** when a **Participating Provider** was not reasonably available in connection with either (i) on an **Outpatient** basis in the emergency room of a **Hospital** or (ii) an **Emergency Inpatient** admission to a **Hospital**, then the **Covered Expenses** incurred will be reimbursed by **Us** as if such **Non-Participating Provider** were a **Participating Provider** up to the point when the **Insured** can be safely transferred to a **Participating Provider**. If the **Insured** refuses or is unwilling to be transferred to the care of a **Participating Provider** after such **Insured** can be safely transferred, then reimbursement shall thereafter be reduced to the **Company's Insurance Percentage for Non-Participating Providers**;

[6.] [Because the [**Calendar Year Deductible]** under this **Certificate** is calculated on the basis of **Covered Expenses**, it is possible that every dollar an **Insured** pays for **Prescription Drugs** at a **Participating Pharmacy** may not apply toward meeting the **[**applicable **Calendar Year Deductible]**;]

[7.] **Sickness and Injury Benefits** and **Wellness and Screening Benefits** under this **Certificate** for any **Insured** who is eligible for or has coverage under **Medicare**, and/or amendments thereto, regardless of whether such **Insured** is enrolled in **Medicare** shall be limited to only the **Usual and Customary** charges for services, supplies, care or treatment covered under this **Certificate** that are not or would not have been payable or reimbursable by **Medicare** and/or its amendments (assuming such enrollment), subject to all provisions, limitations, exclusions, reductions and maximum benefits set forth in this **Certificate**;

[8.] [[Two-Five million dollars ($2,000,000-$5,000,000)] is the maximum total amount of all applicable annual increases in the **Lifetime Certificate Maximum Per Insured** that can be conditionally received after the **Issue Date** pursuant to SectionVIII. INCREASE IN THE LIFETIME CERTIFICATE MAXIMUM of this **Certificate**;] and

[9.] Except as contained and specifically set forth in the INCREASE IN THE LIFETIME CERTIFICATE MAXIMUM Section of this **Certificate**, there shall be no increase in the amount of the **Lifetime Certificate Maximum Per Insured**.

B. EXCLUSIONS

Coverage under this **Certificate** is limited as provided by the definitions, limitations, exclusions, and terms contained in each and every Section of this **Certificate**. In addition, this **Certificate** does not provide coverage for expenses charged to an **Insured** or any payment obligation for **Us** under this **Certificate** for any of the following, all of which are excluded from coverage:

[1]. the amount of any professional fees or other medical expenses or charges for treatments, care, procedures, services or supplies which do not constitute **Covered Expenses**;

[2]. **Covered Expenses** incurred before the **Certificate Issue Date**;

[3]. **Covered Expenses** incurred after this **Certificate** terminates, regardless of when the condition originated, except as **Provided** in the EXTENSION OF BENEFITS provision;

[4]. **Covered Expenses** which exceed the **Lifetime Certificate Maximum Per Insured**;

[5]. **Covered Expenses** which exceed the **[Lifetime] Transplant Maximum [Per Organ] Per Insured** for all **Solid Organ Transplants**, **Bone Marrow Transplants**, and **Stem Cell Transplants** received by each **Insured** including any applicable **Covered Expenses** for professional fees and facility fee incurred in connection with harvesting the applicable donor organ or donor bone marrow for the purposes of such transplantation;

[6]. **[[Prescription Drugs]** [that are immunosuppressants;]]

[7]. the amount of any professional fees or other medical expenses contained on a billing statement to a **Insured** which exceed the amount of the **Maximum Allowable Charge**;

[8]. any professional fees or other medical expenses for treatments, care, procedures, services or supplies which are not specifically enumerated in the SICKNESS AND INJURY BENEFITS,[or] WELLNESS AND SCREENING BENEFITS, [or] [MISCELLANEOUS BENEFITS] Sections of this **Certificate** and any optional coverage rider attached hereto;

[9]. **Covered Expenses You** or **Your** covered **Family** members are not required to pay, which are covered by other insurance, or that would not have been billed if no insurance existed;

[10]. any professional fees or expenses for which the **Insured** and/or any covered **Family** member are not legally liable for payment;

[11]. any professional fees or expenses for which the **Insured** and/or any covered **Family** member were once legally liable for payment, but from which liability the **Insured** and/or **Family** member were released;

[12]. treatment of the teeth, the surrounding tissue or structure, including the gums and tooth sockets. This exclusion does not apply to treatment: (a) due to **Injury** to natural teeth (treatment must be **Provided** within ninety (90) days of the date of the **Injury**); or (b) for malignant tumors;

[13]. **Injury** or **Sickness** due to any act of war (whether declared or undeclared);

[14]. services provided by any state or Federal government agency, including the Veterans Administration unless, by law, an **Insured** must pay for such services;

[15]. **Covered Expenses** that are payable under any motor vehicle no fault law insurance policy or certificate;

[16]. charges that are payable or reimbursable by either:

a) a plan or program of any governmental agency (except Medicaid), or

b) **Medicare** Part A, Part B and/or Part D (If the applicable **Insured** does not enroll in **Medicare**, **We** will estimate the charges that would have be paid if such enrollment had occurred);

[17]. [drugs or medication not used for an Food and Drug Administration (FDA) approved use or indication;]

[18]. [administration of experimental drugs or substances or investigational use or experimental use of **Prescription Drugs** except for any **Prescription Drug** prescribed to treat a covered chronic, disabling, life-threatening **Sickness** or **Injury,** but only if the investigational or experimental drug in question:

a) has been approved by the FDA for at least one indication; and

b) is recognized for treatment of the indication for which the drug is prescribed in:

1) a standard drug reference compendia; or

2) substantially accepted peer-reviewed medical literature.

c) drugs labeled "Caution –limited by Federal law to investigational use";]

[19]. experimental procedures or treatment methods not approved by the American Medical Association or other appropriate medical society;

[20]. any **Injury** or **Sickness** covered by any Workers' Compensation insurance coverage, or similar coverage underwritten in connection with any Occupational Disease Law, or Employer's Liability Law, regardless of whether you file a claim for benefits thereunder;

[21]. eyeglasses, contact lenses, radial keratotomy, lasik surgery, hearing aids and exams for their prescription or fitting;

[22]. Cochlear implants;

[23]. any professional fees or other medical expenses incurred by an **Insured** which were caused or contributed to by such **Insured's** being intoxicated or under the influence of any drug, narcotic or hallucinogens unless administered on the advice of a **Provider**, and taken in accordance with the limits of such advice;

[24]. intentionally self-inflicted **Injury**, suicide or any suicide attempt while sane or insane;

[25]. serving in one of the branches of the armed forces of any foreign country or any international authority;

[26]. voluntary abortions, abortificants or any other drug or device that terminates a pregnancy;

[27]. services **Provided** by **You** or a **Provider** who is a member of an **Insured's Family**;

[28]. any medical condition excluded by name or specific description by either this **Certificate** or any riders, endorsements, or amendments attached to this **Certificate**;

[29]. any loss to which a contributing cause was the **Insured's** being engaged in or attempting to engage in an illegal occupation or illegal activity;

[30]. [participation in aviation, except as fare-paying passenger traveling on a regular scheduled commercial airline flight;]

[31]. cosmetic surgery or reconstructive procedures, except for **Medically Necessary** cosmetic surgery or reconstructive procedures performed under the following circumstances: (i) where such cosmetic surgery is incidental to or following surgery resulting from trauma or infection; (ii) to correct a normal bodily function; or (iii) such cosmetic surgery constitutes **Breast Reconstruction** that is incident to a **Mastectomy**; provided any of the above occurred while the **Insured** was covered under this **Certificate**.

[32]. Charges for breast reduction or augmentation or complications arising from these procedures;

[33]. **[Prescription Drugs** or other medicines and products used for cosmetic purposes or indications;]

[34]. [voluntary sterilization [except as **Provided** in the **Benefit** entitled Sterilization in the SICKNESS AND INJURY BENEFIT section of this **Certificate**], reversal or attempted reversal of a previous elective attempt to induce or facilitate sterilization;]

[35]. fertility hormone therapy and/or fertility devices for any type fertility therapy, artificial insemination or any other direct conception;

[36]. any operation or treatment performed, **Prescription** or medication prescribed in connection with sex transformations or any type of sexual or erectile dysfunction, including complications arising from any such operation or treatment;

[37]. appetite suppressants, including but not limited to, anorectics or any other drugs used for the purpose of weight control, or services, treatments, or surgical procedures rendered or performed in connection with an overweight condition or a condition of obesity or related conditions;

[38]. **[Prescriptions**, treatment or services for behavioral or learning disorders, Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD);]

[39]. any professional fees or other medical expenses incurred as the result of an **Injury** which was caused or contributed by an **Insured** racing any land or water vehicle;

[40]. any professional fees or other medical expenses incurred for the diagnosis, care or treatment of **Mental and Emotional Disorders**, **Alcoholism**, and drug addiction/abuse;

[41]. **[Prescription Drugs** that are classified as psychotherapeutic drugs, including antidepressants;]

[42]. Except for **Complications of Pregnancy**, routine maternity or any other expenses related to childbirth, including routine nursery charges and well baby care; [unless the optional MATERNITY BENEFIT RIDER was purchased and in force on the date said expenses related to childbirth, routine nursery charges, well baby care or maternity were incurred];

[43]. contraceptives, oral or otherwise, whether medication or device, regardless of intended use;

[44]. **[Outpatient Prescription Drugs** that are dispensed by a **Provider**, **Hospital** or other state-licensed facility;]

[45]. **[Prescription Drugs** produced from blood, blood plasma and blood products, derivatives, Hemofil M, Factor VIII, and synthetic blood products, or immunization agents, biological or allergy sera, hematinics, blood or blood products administered on an **Outpatient** basis;]

[46]. [level one controlled substances;]

[47]. **[Prescription Drugs** used to treat or cure hair loss or baldness;]

[48]. **[Prescription Drugs** that are classified as anabolic steroids or growth hormones [except as **Provided** in the **Benefit** entitled Growth Disorders in the SICKNESS AND INJURY BENEFIT section or this **Certificate**];]

[49]. [compounded **Prescription Drugs**;]

[50]. fluoride products;

[51]. [allergy kits intended for future emergency treatment of possible future allergic reactions;]

[52]. [replacement of a prior filled prescription for **Prescription Drugs** that was covered and is replaced because the original prescription was lost, stolen or damaged;]

[53]. **[Prescription Drugs**, which have an over the counter equivalent that may be obtained without a **Prescription**, even though such **Prescription Drugs** were prescribed by a **Provider**;]

[54]. [any intentional misuse or abuse of **Prescription Drugs**, including **Prescription Drugs** purchased by an **Insured** for consumption by someone other than such **Insured**;]

[55]. **[Prescription Drugs** that are classified as anti-fungal medication used for treatment of onychomycosis;]

[56]. [fees or expenses charged for spinal manipulations [except as **Provided** in the **Benefit** entitled Spinal Manipulation in the SICKNESS AND INJURY BENEFIT section of this **Certificate**];

[57]. Programs, treatment or procedures for tobacco use cessation;

[58]. **[Prescription Drugs** that are classified as tobacco cessation products;]

[59]. [drugs prescribed for the treatment of any disease, illness or condition that has been excluded from coverage under the **Certificate** by exclusionary rider, limitation or exclusion;]

[60]. [charges for blood, blood plasma, or derivatives that has been replaced;]

[61]. [treatment of autism;]

[62]. Temporomandibular Joint Disorder (TMJ) and Craniomandibular Disorder (CMD); and

[63]. treatment received outside of the United States, [except as provided for in the **Benefit** entitled Foreign Travel Benefit in the SICKNESS AND INJURY BENEFITS section of this **Certificate**;]

[64]. Services or supplies for personal convenience, including custodial care or homemaker services, except as provided for in this **Certificate**;

[65]. expenses for a cane, a crutch, a corset, a dental appliance, an elastic hose, an elastic support, a fabric support, a generic arch support, a low-temperature plastic splint, a soft cervical collar, a truss, or other similar device except as stated in the PROSTHETIC AND ORTHODIC DEVICE BENEFIT section of Your **Certificate** that: (i) is carried in stock and sold without therapeutic modification by a corset shop, department store, drug store, surgical supply facility, or similar retail entity; and (ii) has no significant impact on the neuromuscular, musculoskeletal, or neuromusculoskeletal functions of the body; and

[66]. expenses for artificial eyes, ears, dental appliances, a cosmetic device such as artificial eyelashes or wigs, a device used exclusively for athletic purposes, an artificial facial device, or other device except as stated in the PROSTHETIC AND ORTHODIC DEVICE BENEFIT section of **Your Certificate** that does not have significant impact on the neuromuscular, musculoskeletal, or neuromusculoskeletal functions of the body.

C. NON-WAIVER

1. Billed charges for medical care and treatment received by all **Insureds** during a **Calendar Year** that are considered and applied by **Us** under Section VIII. INCREASE IN LIFETIME CERTIFICATE MAXIMUM, does not mean **We** have any liability for coverage or the payment of any **Sickness and Injury Benefits** under the **Certificate** for the illness, injury or condition that resulted in such expenses, and any such mistake and error by **Us** shall not constitute a waiver of or modification to any of the conditions, terms,

definitions, limitations or exclusions contained in either the **Certificate** or any exclusionary rider attached to the **Certificate**.

[2. Expenses that are mistakenly applied by **Us** to the **Calendar Year Deductible** or erroneously paid by **Us** under any Section or provision of this **Certificate [**including **Prescription Drugs]** shall not:

a) constitute a waiver of or modification to any conditions, terms, definitions or limitations contained in the **Certificate**, specifically including, but not by way of limitation, the definitions of **Sickness** and **Injury**, the limitation of coverage under the **Certificate** for **Pre-existing Conditions**, as well as any exclusion, limitation and/or exclusionary riders which may be attached to the **Certificate**, or otherwise operate to alter, amend, affect, abridge or modify the **Certificate** to which it is attached;

b) create or establish coverage of any medical condition illness, disease or injury under the **Certificate** or under any exclusion, limitation and/or exclusionary riders which may be attached to the **Certificate**; or

c) affect, alter, amend, abridge, constitute or act as a waiver of the **Company's** ability to rely upon, assert and apply such terms, definitions, limitations or exclusions of the **Certificate** or any amendments thereto.]

VIII. INCREASE IN LIFETIME CERTIFICATE MAXIMUM

A. CONDITIONAL ANNUAL INCREASE

Notwithstanding the amount of the **Lifetime Certificate Maximum Per Insured** stated on the **Certificate Schedule**, but subject to all applicable definitions, exclusions, limitations, non-waiver, and provisions contained in the **Certificate**, as well as all riders, endorsements, and amendments attached to the **Certificate**, **We** will automatically increase the amount of the **Lifetime Certificate Maximum Per Insured** on each anniversary of the **Issue Date** while coverage under the **Certificate** has remained in full force and effect on the following terms and conditions:

1. $125,000 FIRST ANNIVERSARY OF ISSUE DATE

$125,000 shall be added to the amount shown on the **Certificate Schedule** for the **Lifetime Certificate Maximum Per Insured** on the first anniversary of the **Issue Date**, if the total amount of all billed charges for medical care and treatment received by all **Insureds** and submitted to **Us** for consideration during the **First Certificate Year**, is greater than the amount of the **Calendar Year Deductible** applicable to such **Insureds** as shown on the **Certificate Schedule**, but the amount of such billed medical charges is less than twice the amount of such **Calendar Year Deductible** applicable to such **Insureds**.

2. $250,000 FIRST ANNIVERSARY OF ISSUE DATE

$250,000 shall be added to the amount shown on the **Certificate Schedule** for the **Lifetime Certificate Maximum Per Insured** on the first anniversary of the **Issue Date**, if the total amount of all billed charges for medical care and treatment received by all **Insureds** and submitted to **Us** for consideration during the **First Certificate Year** is less than the amount of the **Calendar Year Deductible** applicable to such **Insureds** as shown on the **Certificate Schedule**.

3. $125,000 SUBSEQUENT CERTIFCATE YEARS

$125,000 shall be added to the then current amount of the **Lifetime Certificate Maximum Per Insured** on each subsequent anniversary of the **Issue Date**, if the total amount of all billed charges for medical care and treatment received by all **Insureds** and submitted to **Us** for consideration during the **Subsequent Certificate Year** that immediately precedes such anniversary of the **Issue Date** is greater than the amount of the **Calendar Year Deductible** shown on the **Certificate Schedule**, but the amount of such billed medical charges is less than twice the amount of such **Calendar Year Deductible** applicable to such **Insureds**.

4. $250,000 SUBSEQUENT CERTIFCATE YEARS

$250,000 shall be added to the then current amount of the **Lifetime Certificate Maximum Per Insured** on each subsequent anniversary of the **Issue Date**, if the total amount of all billed medical charges received by

all **Insureds** and submitted to **Us** for consideration during the **Subsequent Certificate Year** that immediately precedes such anniversary of the **Issue Date** is less than the amount of the **Calendar Year Deductible** applicable to such **Insureds** as shown on the **Certificate Schedule**.

However, the maximum total amount of all applicable annual increases in the **Lifetime Certificate Maximum Per Insured** pursuant to this Section shall not exceed the sum of two million dollars.

IX. GRIEVANCE PROCEDURES

The Arkansas External Review Regulation requires **Us** to provide **You** with the opportunity for an independent review of any **Adverse Determination** or **Final Adverse Determination**. **You** have the right to request an **External Review** once **Your Internal Grievance Procedures** have been exhausted, unless otherwise stated. The criteria for the Grievance Procedures, including the **External Review** process by an **Independent Review Organization** to examine any **Adverse Determinations**, is outlined below.

INTERNAL GRIEVANCE PROCEDURES

You have the right to appeal any denial of a claim for **Benefits** by submitting a written request, via facsimile or mail, for reconsideration.

Requests for reconsideration must be filed within sixty (60) days of receipt of the written notification of denial. Within ten (10) days from receipt of the request for reconsideration, **We** will acknowledge receipt. Within thirty (30) days from receipt of the request for reconsideration, **We** will review **Your** request and provide a written response describing the final determination. If **You** are not satisfied with the **Final Adverse Determination**, **You** may request an **External Review**.

EXTERNAL GRIEVANCE PROCEDURES

I. Notice of Right to External Review -

Adverse Determinations: **You** may file a request for an expedited **External Review** to be conducted at the same time **You** file a request for a review of an appeal as set forth in the **Internal Grievance Procedure**, if:

(A) **You** have a medical condition where the timeframe for completion of an expedited review of an appeal in **Our Internal Grievance Procedures** would seriously jeopardize **Your** life or health or would jeopardize **Your** ability to regain maximum function; or

(B) The **Adverse Determination** involves a denial of coverage based on a determination that the recommended or requested **Health Care Service** or treatment is “experimental” or “investigational” and **Your Provider** certifies in writing and supports such certification with reasoning, rationale, or evidence that the recommended or requested **Health Care Service** or treatment would be significantly less effective if not promptly initiated.

The **Independent Review Organization** conducting the **External Review** will determine whether **You** will be required to complete the **Internal Grievance Procedures** prior to the expedited External Grievance Procedures. **You** may file an appeal under **Our Internal Grievance Procedures**, if **We** have not issued a written decision to **You** within thirty (30) days following the date **You** filed the appeal with **Us** for a pre-service claim or within sixty (60) days following the date **You** filed the appeal with **Us** for a post-service claim and **You** have not requested or agreed to a delay, **You** may file a request for **External Review** and shall be considered to have exhausted **Our Internal Grievance Procedures**.

Final Adverse Determinations: **You** may file a request for an expedited **External Review** to be conducted at the same time **You** file a request for a review of an appeal as set forth in the **Internal Grievance Procedure**, if:

(A) **You** have a medical condition where the timeframe for completion of an expedited review of an appeal in **Our Internal Grievance Procedures** would seriously jeopardize **Your** life or health or would jeopardize **Your** ability to regain maximum function.

(B) If the **Final Adverse Determination** concerns:

(i) an admission, availability of care, continued stay or **Health Care Service** for which **You** received **Emergency** services, but has not been discharged from a facility; or

(ii) a denial of coverage based on a determination that the recommended or requested **Health Care Service** or treatment is "experimental" or "investigational" and **Your Provider** certifies in writing and supports such certification with reasoning, rationale, or evidence that the recommended or requested **Health Care Service** or treatment would be significantly less effective if not promptly initiated.

You have the right to seek assistance from the Arkansas Department of Insurance at any time.

Commissioner [Jay Bradford]
Arkansas Dept. of Insurance
1200 West 3rd Street
Little Rock, Arkansas 72201

E-mail: insurance.Consumers@mail.state.ar.us
Phone: 501-371-2640 or 800-852-5494
Fax: 501-371-2749

All requests for **External Reviews** shall be made in writing or via electronic media to **Us** at the mailing address and facsimile telephone number identified below:

Freedom Life Insurance Company of America
Attn.: Vice President of Claims
Claims and Communications Dept.
3100 Burnett, 801 Cherry Street, Unit 33
Fort Worth, Texas 76102

Phone: 800-387-9027
Fax: 817-878-3440

Please be advised when filing a request for an **External Review**, **You** will be required to authorize the release of any of **Your** medical records that may be required to be reviewed for the purpose of reaching a decision on the **External Review**. This authorization will allow **Us** to disclose **Your** protected health information, including medical records, that are pertinent to the **External Review**.

II. Standard External Review -

Within sixty (60) days after the date of receipt of a notice of an **Adverse Determination** or **Final Adverse Determination**, **You** may file a request for an **External Review** with **Us**, as specified below:

(A) At the time **We** receive a request for an **External Review**, **We** shall assign an **Independent Review Organization** (from the list of approved **Independent Review Organizations** compiled and maintained by the Arkansas Insurance Commissioner) to conduct a preliminary review of the request to determine if:

- the request for the **External Review** meets the applicability standards as set out above;
- **You** have exhausted **Our Internal Grievance Procedures**; and
- **You** have provided all the information and forms required to process an **External Review**, including the authorization to release medical records.

(B) Within five (5) business days after receipt of the request for **External Review**, the **Independent Review Organization** assigned shall complete the preliminary review and notify **You**, **Your Provider** and Freedom Life Insurance Company of America in writing as to whether:

- the request is complete; and
- the request has been accepted for **External Review**.

The **Independent Review Organization** shall include in the notice provided a statement that **You**, **Your Provider** and Freedom Life Insurance Company of America may submit in writing to the **Independent Review Organization** within seven (7) business days following the date of receipt of the notice additional information and supporting documentation that the **Independent Review Organization** shall consider when conducting the **External Review**.

If the request:

- is not complete, the assigned **Independent Review Organization** shall, within five (5) business days, inform **You**, **Your Provider** and Freedom Life Insurance Company of America what information or materials are needed to make the request complete; or
- is not accepted for **External Review**, the assigned **Independent Review Organization** shall
- inform **You**, **Your Provider** and Freedom Life Insurance Company of America in writing within five (5) business days of the reasons for non-acceptance.

Upon receipt of any information submitted by **You**, the assigned **Independent Review Organization** shall forward copies of the information to **Us**.

(C) In reaching a decision to accept or reject a matter for **External Review**, the assigned **Independent Review Organization** is not bound by any decisions or conclusions reached during **Our Internal Grievance Procedures**.

(D) Within seven (7) business days after the receipt of the notice provided in part (B) above, **We** shall provide to the assigned **Independent Review Organization**, **You** and **Your Provider** the documents and any information considered in making the **Adverse Determination** or **Final Adverse Determination**, together with any additional information **We** deem necessary. If **We** fail to provide the documents or information, this will not delay the **External Review**; instead, the **Independent Review Organization** may terminate the **External Review** and make a decision to reverse any **Adverse Determination** or **Final Adverse Determination**. Immediately upon making such a decision, the **Independent Review Organization** shall notify **You**, **Your Provider** and Freedom Life Insurance Company of America.

(E) Upon receipt of the information, if any, required to be forwarded to **Us** as stated in (B) above, **We** may reconsider any prior **Adverse Determination** or **Final Adverse Determination** for the **External Review**. This reconsideration by **Us** shall not delay or terminate the **External Review**. The **External Review** may only be terminated if **We** decide, upon completion of our reconsideration, to reverse **Our Adverse Determination** or **Final Adverse Determination** and provide coverage or payment for the **Health Care Services** that is the subject of the **Adverse Determination** or **Final Adverse Determination**.

Immediately upon making the decision to reverse **Our Adverse Determination** or **Final Adverse Determination**, **We** shall notify **You** and **Your Provider**, as well as the assigned **Independent Review Organization**, in writing of **Our** decision. The assigned **Independent Review Organization** shall terminate the **External Review** upon receipt of this notice from **Us**.

(F) In exercising its independent medical judgment in reviewing an **Adverse Determination**, in addition to the documents and information provided, the assigned **Independent Review Organization**, to the extent the information or documents are available, shall consider the following in reaching a decision:

- the **Insured's** medical records;
- the **Provider's** professional recommendation;
- consulting reports from appropriate health care professionals and other documents submitted by **Us**, **You** or **Your Provider**;
- the applicable terms of coverage under **Your** contract of insurance to ensure that the **Independent Review Organization's** decision is not contrary to the terms of the coverage;
- the most appropriate practice guidelines, which may include generally accepted practice guidelines, evidence-based practice guidelines or any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;
- any applicable written screening procedures, decision abstracts, clinical protocols and practice guidelines used by **Us** to determine the necessity and appropriateness of **Health Care Services**; and
- if the **Adverse Determination** involves a denial of coverage based on a determination that the recommended or requested **Health Care Service** is "experimental" or "investigational" , the **Independent Review Organization** shall also consider whether: (a) the recommended or requested **Health Care Service** or treatment has been approved by the federal Food and Drug Administration for the condition, while realizing that treatments or services are often legitimately used for purposes other than those listed in the FDA approval; or (b) medical or scientific evidence demonstrates that the expected benefits of the recommended or requested **Health Care Service** or treatment is more likely than not to be more beneficial to **You** than any available standard **Health Care Service** or treatment and the adverse risks of the recommended or requested **Health Care Service** or treatment would not be substantially increased over those of available standard **Health Care Services** or treatments.

(G) Within forty-five (45) calendar days after the date of receipt of the request for an **External Review**, the assigned **Independent Review Organization** shall provide written notice of its decision to uphold, reverse, or partially uphold or reverse the **Adverse Determination** or **Final Adverse Determination** to **You**, **Your Provider** and Freedom Life Insurance Company of America.

III. Expedited External Review -

(A) Except as provided under item (E) below, **You** may make a request for an expedited **External Review** with **Us** at the time **You** receive an **Adverse Determination** or **Final Adverse Determination**. At the time **You** elect to make a request for an expedited **External Review**, **You** and **Your Provider** shall submit additional information and supporting documentation that the **Independent Review Organization** shall consider when conducting the expedited **External Review**.

(B) An expedited **External Review** may NOT be provided for an **Adverse Determination** or **Final Adverse Determination** involving a **Retrospective Review**.

(C) At the time **We** receive a request for an expedited **External Review**, **We** immediately shall assign an **Independent Review Organization** (from the list compiled and maintained by the Arkansas Insurance Commissioner) to determine whether the request meets the reviewability requirements, and then initiate the expedited **External Review** if all the requirements are met.

(D) At the time **We** assign an **Independent Review Organization** to conduct the expedited **External Review**, **We** shall immediately provide or transmit all pertinent documentation and information to the assigned **Independent Review Organization**.

(E) As expeditiously as **Your** medical condition or circumstances require, but in no event more than seventy-two (72) hours after the date of receipt of the request for an expedited **External Review** that meets the reviewability requirements, the assigned **Independent Review Organization** shall:

- Make a decision to uphold or reverse the **Adverse Determination** or **Final Adverse Determination**; and
- Notify **You**, **Your Provider** and Freedom Life Insurance Company of America of the decision.

IV. Binding Nature of External Review Decision -

All **External Reviews** conducted will be fair and impartial, and in compliance with the standards approved by the Arkansas Insurance Commissioner.

An **External Review** decision is binding on **Us**, except to the extent that **We** have other remedies available under applicable federal or state law. An **External Review** decision is binding on the **Covered Insured**, except to the extent that **You** have other remedies available under applicable federal or state law. A **Covered Insured** may NOT file a subsequent request for an **External Review** involving the same **Adverse Determination** or **Final Adverse Determination** for which **You** have already received an **External Review** decision.

V. Filing Fees and Funding –

(A) Except in the case of a request for an expedited **External Review**, at the time of filing a request for **External Review**, the **Covered Insured** shall submit to the **Independent Review Organization** a filing fee of [$25.00], along with the information and documentation to be used by the **Independent Review Organization** in conducting the **External Review**. However, upon application by the **Covered Insured**, the Arkansas Insurance Commissioner may waive the filing fee upon a showing of undue financial hardship.

(B) The filing fee shall be refunded to the **Insured** who paid the fee if the **External Review** results in the reversal, in whole or part, of **Our Adverse Determination** or **Final Adverse Determination** that was subject of the **External Review**.

We shall pay the cost of the **Independent Review Organization** for conducting the **External Review** or expedited **External Review**, and shall not charge back the cost of any **External Review** to the **Covered Insured's Provider**.

X. COORDINATION OF BENEFITS

This Section regarding coordination of benefits applies when an **Insured** has health care coverage under more than one **Plan**. The ORDER OF BENEFIT DETERMINATION RULES below determine whether this **Certificate** is a **Primary Plan** or a **Secondary Plan** when compared to another **Plan** covering the **Insured**. If coverage for **Sickness and Injury Benefits**,[or] **Wellness and Screening Benefits**, [or] [**Miscellaneous Benefits]** under this **Certificate** is primary when considered in connection with other **Plans,** then such benefits are determined before the determination of benefits under any other **Plan** and without considering any other **Plan's** benefits. If coverage for **Sickness and Injury Benefits**, [or] **Wellness and Screening Benefits**, or [**Miscellaneous Benefits]** under this **Certificate** is secondary, when considered in connection with other **Plans**, then such benefits are determined after the determination of benefits under the other **Plan** and any such benefits under this **Certificate that** would have otherwise been payable in the absence of such other **Plan** may be reduced because of the **Primary Plan's** benefits.

A. ORDER OF BENEFIT DETERMINATION RULES

When a claim under a **Plan** with a coordination of benefits provision involves another **Plan**, which also has a coordination of benefits provision, the order of benefit determination shall be made as follows:

1. The benefits of a **Plan** that covers the person claiming benefits other than as a dependent shall be determined before those of the **Plan** which covers the person as a dependent.

2. The benefits of a **Plan** of a parent whose birthday occurs earlier in a **Calendar Year** shall cover a dependent child before the benefits of a **Plan** of a parent whose birthday occurs later in a **Calendar Year.** The word "birthday" as used in this paragraph refers only to the month and day in the **Calendar Year**, not the year in which the person was born.

3. If two or more **Plans** cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

a) First, the **Plan** of the parent with custody of the child;
b) Then, the **Plan** of the spouse of the parent with custody of the child; and
c) Finally, the **Plan** of the parent not having custody of the child.

However, notwithstanding the above, if the specific terms of a court decree state that one (1) 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.

4. The benefits of a **Plan** which covers a person as an employee (or as an employee's dependent) are determined before those of a **Plan** that covers that person as a laid off or retired employee (or as that employee's dependent). If the other **Plan** does not have this provision and if, as a result, the **Plans** do not agree on the order of benefits, this paragraph shall not apply.

5. If none of the provisions above determine the order of benefits, the benefits of the **Plan** which covered the claimant longer are determined before those of the **Plan** that covered the person for the shorter time.

6. If one of the **Plans** is issued out of this state and determines the order of benefits based upon the gender of a parent and, as a result, the **Plans** do not agree on the order of benefits, the **Plan** with the gender rule shall determine the order of benefits.

7. A **Complying Plan** may coordinate its benefits with a **Plan** which is "excess" or "always secondary" or with a **Non-Complying Plan** on the following basis:

a) If the **Complying Plan** is the **Primary Plan**, it shall pay or provide its benefits on a primary basis.
b) If the **Complying Plan** is the **Secondary Plan**, it shall, nevertheless, pay or provide its benefits first, as the **Secondary Plan**. In such a situation, such payment shall be the limit of the complying **Plan's** liability, except as provided in subparagraph (d).
c) If the **Non-Complying Plan** does not provide the information needed by the **Complying Plan** to determine its benefits within a reasonable time after it is requested to do so, the **Complying Plan** shall assume that the benefits of the **Non-Complying Plan** are identical to its own, and shall pay its benefits

accordingly. However, the **Complying Plan** must adjust any payments it makes based on such assumption whether information becomes available as the actual benefits of the **Non-Complying Plan**.

d) If the **Non-Complying Plan** pays benefits so that the claimant receives less in benefits than he or she would have received had the **Non-Complying Plan** paid or provided its benefits as the **Primary Plan** then the complying **Plan** shall advance to or on behalf of the claimant an amount equal to such difference which advance shall not include a right to reimbursement from the claimant.

B. EFFECT ON THE BENEFITS OF THIS PLAN

When this **Certificate** is a **Secondary Plan**, it may reduce its **Sickness and Injury Benefits**, [and] **Wellness and Screening Benefits**, [and] [**Miscellaneous Benefits]** so that the total amount paid or provided by all **Plans** during a **Claim Determination Period** is not more than 100% of total **Allowable Expenses**. The difference between the covered benefit payments that this **Certificate** would have paid had it been the **Primary Plan**, and the payments that it actually paid or provided shall be recorded as a benefit reserve for the **Insured** and used by this **Certificate** to pay any **Allowable Expenses**, not otherwise paid during the **Claim Determination Period**. As each claim is submitted, this **Certificate** will:

1. Determine its obligation to pay or provide covered benefits under the **Group Policy**;
2. Determine whether a benefit reserve has been recorded for the **Insured**; and
3. Determine whether there are any unpaid **Allowable Expenses** during that **Claims Determination Period**.

If there is a benefit reserve, the **Secondary Plan** will use the **Insured's** benefit reserve to pay up to 100% of total **Allowable Expenses** incurred during the **Claim Determination Period**. At the end of the **Claims Determination Period**, the benefit reserve returns to zero. A new benefit reserve must be created for each new **Claim Determination Period**.

C. RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these coordination of benefit rules and to determine benefits payable under this **Certificate** and other **Plans**. **We** may get the facts **We** need from or give them to other organizations or persons for the purpose of applying these rules and determining **Sickness and Injury Benefits**, [and] **Wellness and Screening Benefits**, [and] [**Miscellaneous Benefits]** payable under this **Certificate** and other **Plans** covering the **Insured** claiming coverage for a claim. **We** need not tell, or get the consent of, any **Insured** to do this. Each **Insured** claiming **Sickness and Injury Benefits**, [and] **Wellness and Screening Benefits**, [and] [**Miscellaneous Benefits]** under this **Certificate** must give **Us** any facts **We** need to apply those rules and determine any amounts payable.

D. FACILITY OF PAYMENT

A payment made under another **Plan** may include an amount that should have been paid under this **Certificate**. If it does, **We** may pay that amount to the organization that made that payment. That amount will then be treated as though it was a **Sickness and Injury Benefit**, [or] **Wellness and Screening Benefit**, [or] [**Miscellaneous Benefit]** paid under this **Certificate**. **We** will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

E. RIGHT OF RECOVERY

If the amount of the payments made by **Us** is more than **We** should have paid under the coordination of benefits provision, **We** may recover the excess from one or more of the persons **We** have paid or for whom **We** have paid; or any other person or organization that may be responsible for the benefits or services provided for the **Insured**. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

XI. UNIFORM PROVISIONS

A. ENTIRE CONTRACT- CHANGES

The entire contract between **You** and the **Company** consists of the **Group Policy**, this **Certificate**, including **Your** application, which is attached hereto, and any amendments, riders, or endorsements attached to this **Certificate**. All statements made by **You** will, in the absence of fraud, be deemed representations and not warranties. No statement made by an applicant for insurance will be used to contest the insurance or reduce the **Sickness and Injury Benefits** or **Wellness and Screening Benefits**, unless contained in a written application, which is signed by the applicant. No agent may:

1. change, alter or modify the **Group Policy**, this **Certificate**, or any amendments, riders, or endorsements attached to this **Certificate**;
2. waive any provisions of the **Group Policy**, this **Certificate**, or any amendments, riders, or endorsements attached to this **Certificate**;
3. extend the time period for payment of premiums under this **Certificate**; or
4. waive any of the **Company's** rights or requirements.

No change in the **Group Policy** or this **Certificate** will be valid unless it is:

1. noted on or attached to the **Group Policy** or this **Certificate**;
2. signed by one of **Our** officers; and
3. delivered to the **Primary Insured**, as shown on the **Certificate Schedule**.

B. TIME LIMIT ON CERTAIN DEFENSES

After two (2) years from the effective date of coverage, only fraudulent misstatements in the enrollment application may be used to void this **Certificate** or deny any claim for a loss occurring after the two (2) year period.

No claim for a **Covered Expense** charged after two (2) years from the **Insured's** effective date of coverage will be reduced or denied because a medical condition, not excluded by name or specific description, existed before the effective date of coverage.

C. OTHER INSURANCE WITH US

You may have only one policy or certificate providing major medical or medical and surgical coverage with **Us**. If through error, **We** issue more than one like policy or certificate to **You**, only one policy or certificate chosen by **You** or **Your** estate, as the case may be, will stay in force. **We** will return the money **You** paid for the other policy(ies) or certificate(s).

D. CONFORMITY WITH STATE STATUTES

Any provision of this **Certificate** or the **Group Policy** which, on its effective date, is in conflict with the laws of the state in which **You** live on that date, is amended to conform to the minimum requirements of such laws.

E. MISSTATEMENT OF AGE

If the age of an **Insured** has not been stated correctly, his or her correct age will be used to determine (i) the amount of insurance for which he or she is entitled, (ii) the effective date of termination of insurance, and (iii) any other rights or **Sickness and Injury Benefits** under this **Certificate** or the **Group Policy**.

Premiums will be adjusted if too much or too little was paid due to the misstatement.

F. NONDISCLOSED MEDICAL HISTORY, MEDICAL CONDITIONS AND RELATED INFORMATION

During the first two (2) years coverage under this **Certificate** is in force it may be modified as provided below if, within that time, **We** discover that a medical condition or other material information was mistakenly not disclosed to **Us**:

1. The coverage under this **Certificate** will stay in force with no change in **Sickness and Injury Benefits, Wellness and Screening Benefits, [Miscellaneous Benefits**,] or premiums if the disclosure of such condition would not have affected the way the **Certificate** was issued.
2. If the disclosure would have resulted in coverage not being issued to an **Insured**, **We** will return all premium paid, less any **Benefits** paid for that person during the time the coverage was in force in error. The coverage for that person shall be void from the **Issue Date**.
3. If the disclosure would have resulted in coverage under this **Certificate** being issued either: (a) at an increased premium, or (b) with an endorsement eliminating that condition from coverage, **We** will either (i) have **You** pay the increased rate beginning with the **Issue Date** (if **You** do not pay the increased premium within thirty (30) days after receiving **Our** notice, **We** will refund all premium paid less any **Benefits** paid, and the coverage under this **Certificate** will be void from the **Issue Date**); or (ii) add an endorsement to the **Certificate** to exclude that condition from coverage. The endorsement must be signed by **You** to put this change in effect. If **You** do not return a signed copy of the endorsement within thirty (30) days after receiving it, **We** will refund all premiums paid less any **Benefits** paid, and the **Certificate** will be void from the **Issue Date**.

This Section does not apply to any fraudulent misrepresentations that are made, which in all events can result in rescission of any coverage issued as a result of such fraudulent misrepresentations.

[G. LEGAL ACTION

No action at law or in equity will be brought to recover on this **Certificate** prior to the expiration of sixty (60) days after proof of loss has been filed as required by this **Certificate**; nor will any action be brought after three (3) years from the expiration of the time within which proof of loss is required by this **Certificate**.]

[H. SUBROGATION

We shall be subrogated to all rights of recovery which any **Insured** may acquire against any party for ordinary negligence, gross negligence, strict liability in tort or any willful or intentional act or omissions resulting in **Injury** or **Sickness** for which **We** pay **Sickness and Injury Benefits, [and] Wellness and Screening Benefits [**and] **[Miscellaneous Benefits]** but only to the extent of the **Benefits** provided. Any **Insured**, by receiving **Benefits** under this **Certificate**, in such case, shall be deemed to have assigned such rights of recovery to **Us** and have agreed to do whatever may be necessary to secure the recovery, including, but not limited to, the execution of any and all appropriate documents or papers. The **Insured** also agrees to execute and deliver all necessary instruments, to furnish such information and assistance, and to take any action **We** may require to facilitate enforcement of **Our** rights.**]**

[I. EXTRATERRITORIAL MEDICAL EXPENSES

Covered Expenses charged in any jurisdiction outside the United States of America (U.S.) or its territories or possessions shall be reimbursed under the terms and conditions of this **Certificate** in U.S. currency at the rate of exchange between the U.S. dollar and the benchmark currency of the foreign jurisdiction on the date such **Covered Expenses** were incurred.]

THIS CONCLUDES THIS CERTIFICATE