

SERFF Tracking Number: EWLE-126900860 State: Arkansas  
Filing Company: Family Life Insurance Company State Tracking Number: 47296  
Company Tracking Number:  
TOI: H14I Individual Health - Hospital Indemnity Sub-TOI: H14I.000 Health - Hospital Indemnity  
Product Name: Hospital Confinement and Surgical Fixed Indemnity Policy  
Project Name/Number: /

## Filing at a Glance

Company: Family Life Insurance Company

Product Name: Hospital Confinement and Surgical Fixed Indemnity Policy SERFF Tr Num: EWLE-126900860 State: Arkansas

TOI: H14I Individual Health - Hospital Indemnity SERFF Status: Closed-Approved- Closed State Tr Num: 47296

Sub-TOI: H14I.000 Health - Hospital Indemnity Co Tr Num: State Status: Approved-Closed  
Filing Type: Form Reviewer(s): Rosalind Minor

Author: Vicki Rowe Disposition Date: 11/19/2010

Date Submitted: 11/11/2010 Disposition Status: Approved-Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

## General Information

Project Name:

Status of Filing in Domicile:

Project Number:

Date Approved in Domicile:

Requested Filing Mode:

Domicile Status Comments:

Explanation for Combination/Other:

Market Type:

Submission Type:

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 11/19/2010

Explanation for Other Group Market Type:

State Status Changed: 11/19/2010

Deemer Date:

Created By: Vicki Rowe

Submitted By: Vicki Rowe

Corresponding Filing Tracking Number:

Filing Description:

This filing is being submitted on behalf of Family Life Insurance Company. The referenced forms are submitted for your review and approval. These forms are new and are not intended to replace any previously approved forms.

Form FHCS10-AR is a Hospital Confinement and Surgical Fixed Indemnity Policy. Form FHCS10-PS is the policy schedule and form FHCS10-SS is the surgical schedule. Form FHCSAPP10-AR is the corresponding application and form FHCS10-OC-AR is the corresponding outline of coverage.

These forms provide fixed indemnity benefits for hospital confinement and specified medical and surgical events. These

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fixed indemnity benefits are paid in stated amounts without regard to the cost of services rendered and do not provide expense reimbursement for charges based on the health care provider's statement.

## Company and Contact

### Filing Contact Information

Vicki Rowe, Compliance vrowe@lewisellis.com  
 9441 LBJ Freeway 972-664-0163 [Phone]  
 Suite 102  
 Dallas, TX 75243

### Filing Company Information

(This filing was made by a third party - lewisandellisincorporated3)

Family Life Insurance Company CoCode: 63053 State of Domicile: Texas  
 10700 Northwest Freeway Group Code: 1117 Company Type: L&H  
 Houston, TX 77092 Group Name: Harris Ins. Holdings State ID Number:  
 Grp.  
 (713) 529-0045 ext. [Phone] FEIN Number: 91-0550883  
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## Filing Fees

Fee Required? Yes  
 Fee Amount: \$300.00  
 Retaliatory? No  
 Fee Explanation: 5 forms and 1 rate at \$50 each  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Family Life Insurance Company	\$300.00	11/11/2010	41793243

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	11/19/2010	11/19/2010

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## Disposition

Disposition Date: 11/19/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Authorization to File	Approved-Closed	Yes
Form	Hospital Confinement and Surgical Fixed Indemnity Policy	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Form	Policy Schedule	Approved-Closed	Yes
Form	Surgical Schedule	Approved-Closed	Yes
Form	Outline of Coverage	Approved-Closed	Yes
Rate	Hospital Confinement and Surgical Fixed Indemnity Policy	Approved-Closed	Yes

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## Form Schedule

### Lead Form Number: FHCS10-AR

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved- Closed 11/19/2010	FHCS10- AR	Policy/Cont ract/Fratern al	Hospital Confinement and Surgical Fixed Indemnity Policy Certificate	Initial			FHCS10P.pdf
Approved- Closed 11/19/2010	FHCSAPP1 0-AR	Application/ Enrollment Form	Application	Initial			FHCSAPP10.pdf
Approved- Closed 11/19/2010	FHCS10- PS	Policy/Cont ract/Fratern al	Policy Schedule Certificate	Initial			FHCS10PS.pdf
Approved- Closed 11/19/2010	FHCS10- SS	Schedule Pages	Surgical Schedule	Initial			FHCS10SS.pdf
Approved- Closed 11/19/2010	FHCS10- OC-AR	Outline of Coverage	Outline of Coverage	Initial			FHCS10OC.pdf

# FAMILY LIFE INSURANCE COMPANY

Home Office: [Houston, TX]

Administrative Office:[ 10700 Northwest Freeway, Houston, TX 77092] [800-877-7705]

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The premium may be increased upon renewal.

## HOSPITAL CONFINEMENT AND SURGICAL FIXED INDEMNITY INSURANCE POLICY

Limited Hospital Confinement and Other Fixed Indemnity Benefits

**NOTICE: This is not a major medical insurance policy. This plan provides fixed indemnity benefits for hospital confinement and specified medical and surgical Events. Fixed indemnity benefits are paid in the amount stated on the Benefit Schedule for the Covered Event without regard to the cost of services rendered. This plan does not provide expense reimbursement for charges based on Your health care provider's Statement. THIS IS NOT A MEDICARE SUPPLEMENT POLICY.**

This Policy is issued and delivered in the State of: Arkansas

The insurance described in this Policy is effective on the date shown in the Benefit Schedule only if You are eligible for the insurance, become insured, and remain insured subject to the terms, limits and conditions of this plan. This Policy is evidence of Your coverage. Please read Your Policy carefully and become familiar with its terms, limits and conditions.

This Policy is issued based on the statements and agreements in the application and information obtained during the application process; any exam that may be required; any other amendments or supplements; and payment of the required premium.

**CONDITIONALLY RENEWABLE:** You have the right to renew this Policy until the Policy anniversary on or after Your 65<sup>th</sup> birthday if You pay the correct premium when due or within the Grace Period. We retain the right to change the premium rates on this Policy. See the Premium Provisions section of this Policy.

### RIGHT TO EXAMINE POLICY FOR 10 DAYS

If You are not satisfied, return the Policy to Us or Our agent within 10 days after You have received it. All premiums will be refunded and Your coverage will be void from the Effective Date.

### IMPORTANT NOTICE CONCERNING STATEMENTS IN YOUR APPLICATION FORM FOR INSURANCE

Please read the copy of the application included with this Policy. We issued this coverage in reliance upon the accuracy and completeness of the information provided in the application and during the application process. If a material or fraudulent omission or misstatement is made in the application form, We have the right to deny any claim, rescind the coverage and/or modify the terms of the coverage or the premium amount. Carefully check the application form and, if any information shown in the application is not correct and complete, write to the address above within 10 days.



[Mary Lou Rainey  
Secretary]



[Dan George  
President]

Executed by Family Life Insurance Company on the Effective Date. Insurance will begin and end at 12:01 a.m., local time, at the Policyholder's residence on the Effective Date.

This Policy provides limited fixed indemnity benefits only. Read Your Policy and Benefit Schedule carefully to understand the coverage limitations and benefits provided.

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## DEFINITIONS

When reading this Policy, terms with a defined meaning will have the first letter of each word capitalized for easy identification. The capitalized terms used in this Policy are defined below. Just because a term is defined does not mean benefits are available for such term. Please read this Policy carefully.

### **Accident or Accidental:**

Accidental bodily Injury that is the direct cause of a loss, independent of disease, bodily infirmity or any other cause, and occurs while this Policy is in force.

If an Accident occurs as a result of a Sickness, benefits for treatment of any Injuries are considered under the applicable Accident benefit and benefits for treatment of the Sickness are considered under the applicable Sickness benefit. Accident shall include pregnancy following an act of rape of a Covered Person that was reported to the Police within seven days following its occurrence. The seven day requirement for notification to the police shall be extended to 180 days in the case of an act of rape or incest of a female under 13 years of age.

### **Behavioral Health or Substance Abuse:**

A neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

### **[Brand Name Drug:**

A Prescription Drug for which a pharmaceutical company has received a patent or trade name.]

### **Calendar Year:**

The period beginning on January 1 of any year and ending on December 31 of the same year.

### **Complications of Pregnancy:**

Complications of Pregnancy include the following:

1. Conditions requiring Hospital confinement (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, but shall not include false labor, occasional spotting, Health Care Practitioner-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting distinct complication of pregnancy; and
2. Non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

### **[Compounded Medication:**

A drug product made up of two or more active parts or ingredients which must be specially prepared by a licensed pharmacist pursuant to a Prescription Order.]

### **Confinement Period:**

A continuous and uninterrupted period of at least 24 hours during which a Covered Person is admitted to a Hospital to obtain Medically Necessary inpatient treatment of a Sickness or Injury while under the regular care and attendance of a Health Care Practitioner.

### **Cosmetic Services:**

A surgery, procedure, injection, medication or treatment primarily designed to improve appearance, self-esteem or body image and/or to relieve or prevent social, emotional or psychological distress.

### **Covered Dependent:**

A person who meets the definition of a Dependent and is eligible to receive benefits under this Policy.

### **Covered Event:**

A medical Event for which this Policy provides a Scheduled Benefit and that meets all of the following requirements:

1. The treatment, services or supplies provided in connection with the Event are provided by a Health Care Practitioner, facility or supplier.
2. It is incurred by a Covered Person while coverage is in force under this Policy as the result of a Sickness or an Injury or for preventive medicine services as specified in the Hospital Confinement and Other Fixed Indemnity Benefits section and on the Benefit Schedule.
3. It is incurred for Events shown in the Hospital Confinement and Other Fixed Indemnity Benefits section and on the Benefit Schedule.
4. The occurrence includes treatment, services or supplies which are Medically Necessary.

**Covered Person:**

A person who is eligible to receive benefits under this Policy.

**Custodial Care:**

Care, regardless of setting, that can be performed by persons without professional medical training and that is primarily for the purpose of meeting the personal needs of the patient. Custodial Care:

1. Does not contribute substantially to the improvement of a medical condition according to accepted medical standards; or
2. Is provided primarily to assist in the activities of daily living including, but not limited to, help in walking or getting in or out of bed; assistance with bathing, dressing, feeding, homemaking, or preparation of special diets; or supervision of medication which can usually be self-administered and does not entail or require the continuing services of licensed medical personnel; or
3. Is supportive in nature or primarily for the purpose of providing companionship or ensuring safety.

**Dental Injury:**

Dental care or treatment due to accidental injury to natural teeth.

**Dependent:**

A Dependent is:

1. The Policyholder's lawful spouse [including the Policyholder's Domestic Partner if recognized under applicable law]; or
2. The Policyholder's naturally born child, legally adopted child, a child whom the Policyholder has filed a petition to adopt, a stepchild, a grandchild dependent upon the Policyholder for federal income tax purposes at the time of the child's application for coverage, a child for whom the Policyholder is the legal guardian, or a child for whom the Policyholder is required to provide medical support by court or administrative order:
  - a. Who is unmarried; and
  - b. Who is under age 26.

If Your unmarried child is age 26 or older, the child will be considered a Dependent if You give Us proof that the child is not capable of self-sustaining employment because of mental incapacity or physical handicap and is chiefly dependent on You for support and maintenance. You must give Us proof that the child meets these requirements at the same time that You first enroll for coverage under this Policy. Additional proof may be requested periodically but not more often than annually after the initial 2-year period following the date the child reaches the normal age for termination.

A child will no longer be a Dependent on the earliest of the date that he or she:

1. Attains age 26 (except for a mentally incapacitated or physically handicapped child as described above; or
2. Marries; or
3. Is over age 26 and is capable of self-sustaining employment because he or she is no longer mentally incapacitated or physically handicapped.

**[Domestic Partner:**

A person of the same or opposite gender who resides with the Policyholder in a long-term relationship of indefinite duration. The partners have an exclusive mutual commitment to be jointly responsible for each other's common welfare and to share financial obligations. The Domestic Partner must meet all of the following requirements:

1. Be at least 18 years of age; and
2. Be competent to enter into a contract.

Proof that the Domestic Partner relationship continues to exist may be requested by Us periodically.]

**Durable Medical Equipment:**

Equipment, such as a Hospital bed, wheelchair or crutches, that is customarily used to serve a medical purpose and is designed for and able to withstand repeated use and is intended for use by successive patients.

**Effective Date:**

The date coverage under this Policy begins for a Covered Person. The Covered Person's coverage begins at 12:01 a.m. local time.

**Emergency Room:**

A place affiliated with and physically connected to a Hospital and used primarily for short-term Emergency Treatment.

**Emergency Treatment:**

Bonafide emergency services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:

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

**Event:**

An observable and distinct occurrence in which medical treatment, services or supplies are provided.

**Experimental or Investigational Services:**

Treatment, services or supplies which are:

1. Not given to be of benefit for diagnosis or treatment of a Sickness or an Injury; or
2. Not generally used or recognized by the medical community as safe, effective and appropriate for diagnosis or treatment of a Sickness or an Injury; or
3. In the research or investigational stage, provided or performed in a special setting for research purposes or under a controlled environment or clinical protocol; or
4. Obsolete or ineffective for the treatment of a Sickness or an Injury; or
5. Medications used for non-FDA approved indications and/or dosage regimens, except for Off-Label Drugs.

For any device, drug or biological product, final approval must have been received by the Food and Drug Administration (FDA) to market it for the particular Sickness or Injury. Any approval granted as an interim step in the FDA regulatory process, such as an investigational device exemption or an investigational new drug exemption, is not sufficient.

Only We can make the determination as to whether treatment is for Experimental or Investigational Services based on the following criteria:

1. Once final FDA approval has been granted, the usage of a device for the particular Sickness or Injury for which the device was approved will be recognized as appropriate if:
  - a. It is supported by conclusive evidence that exists in clinical studies that are published in generally accepted peer-reviewed medical literature or review articles; and
  - b. The FDA has not determined the medical device to be contraindicated for the particular Sickness or Injury for which the device has been prescribed.
2. Once final FDA approval has been granted, the usage of a drug or biological product will be recognized as appropriate for a particular Sickness or Injury if the FDA has not determined the drug or biological product to be contraindicated for the particular Sickness or Injury for which the drug or biological product has been prescribed and the prescribed usage is recognized as appropriate medical treatment by:
  - a. The American Medical Association Drug Evaluation; or
  - b. The American Hospital Formulary Service Drug Information; or
  - c. Conclusive evidence in clinical studies that are published in generally accepted peer-reviewed medical literature or review articles.
3. For any other treatment, services or supplies, conclusive evidence from generally accepted peer-reviewed literature must exist that shows or indicates:
  - a. The treatment, services or supplies have a definite positive effect on health outcomes. Such evidence must include well-designed investigations that have been reproduced by non-affiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale; and
  - b. Over time, the treatment, services or supplies lead to improvement in health outcomes which show that the beneficial effects outweigh any harmful effects; and
  - c. The treatment, services or supplies are at least as effective in improving health outcomes as established technology, or are useable in appropriate clinical contexts in which established technology is not employable.

**Family Plan:**

A plan of insurance covering the Policyholder and one or more of the Policyholder's Dependents, as shown on the Benefit Schedule.

**Free-Standing Facility:**

A facility that provides interventional services, on an Outpatient basis, which require hands-on care by a Health Care Practitioner and includes the administration of general or regional anesthesia or conscious sedation to patients. This type of facility may also be referred to as an ambulatory surgical center, an interventional diagnostic testing facility, a facility that exclusively performs endoscopic procedures or a dialysis unit. A designated area within a Health Care Practitioner's office or clinic that is used exclusively to provide interventional services and administer anesthesia or conscious sedation is also considered to be a Free-Standing Facility. Room and board and overnight services are not covered. These facilities must meet all of the following requirements:

1. Be licensed by the state in accordance with the laws for the specific services being provided in that facility; and
2. Not primarily provide care for Behavioral Health or Substance Abuse or be an Urgent Care Facility.

**[Generic Drug:**

A Prescription Drug that:

1. Has the same active ingredients as an equivalent Brand Name Drug or that can be used to treat the same condition as a Brand Name Drug; and
2. Does not carry any drug manufacturer's brand name on the label; and
3. Is not protected by a patent.

It must be listed as a Generic Drug by Our national drug data bank on the date it is purchased and it must be approved by Us. Compounded Medications are not Generic Drugs. Medications that are commercially manufactured together and/or packaged together are not considered to be Generic Drugs, unless the entire combination product is specifically listed as a Generic Drug product by Our national drug data bank on the date it is purchased and it must be approved by Us.]

**Health Care Practitioner:**

A person licensed by the state or other geographic area in which the treatment or services are rendered to treat the kind of Sickness or Injury for which a claim is made. The Health Care Practitioner must be practicing within the limits of his or her license and in the geographic area in which he or she is licensed.

**Home Health Care:**

Treatment, services or supplies provided as part of a program for care and treatment in a Covered Person's home.

**Hospice:**

An organization that provides medical services in an Inpatient, Outpatient or home setting to support and care for persons who are terminally ill.

**Hospital:**

A facility that provides acute care of a Sickness or an Injury on an Inpatient basis. This type of facility must meet all of the following requirements:

1. Be licensed as a hospital and operational pursuant to law;
2. Be primarily engaged in providing or operating either on its premises or in facilities available to the hospital on a contractual prearranged basis and under the supervision of a staff of one or more duly licensed Health Care Practitioners, medical, diagnostic, and major surgery facilities for the medical care and treatment of sick or injured persons on an Inpatient basis for which a charge is made;
3. Provide 24-hour nursing service by or under the supervision of a registered graduate professional nurse (RN);
4. Maintain and operate a minimum of five (5) beds;
5. Maintain permanent medical records that document all services provided to each patient;
6. Provide access to laboratory and imaging services at appropriate in-house facilities or offsite facilities on a prearranged contractual basis; and
7. Not primarily provide care for Behavioral Health or Substance Abuse although these services may be provided in a distinct section of the same physical facility.

A Hospital does not include convalescent, nursing, rest or extended care facilities or facilities operated exclusively for treatment of the aged, whether such facilities are operated as a separate institution or as a section of an institution operated as a Hospital. A Hospital does not include a facility primarily providing Custodial Care or educational services.

**Immediate Family Member:**

An Immediate Family Member is:

1. You or Your spouse [or Domestic Partner];
2. The children, brothers, sisters and parents of either You or Your spouse [or Domestic Partner];
3. The spouses of the children, brothers and sisters of You and Your spouse [or Domestic Partner]; or
4. Anyone with whom a Covered Person has a relationship based on a legal guardianship.

**Individual Plan:**

A plan of insurance covering only the Policyholder.

**Injury:**

Accidental bodily damage, independent of all other causes, occurring unexpectedly.

**Inpatient:**

Admitted to a Hospital for a stay of at least 24 hours for Medically Necessary room and board.

**Inpatient Day:**

A continuous and uninterrupted period of at least 24 hours during which a Covered Person is admitted to a Hospital to obtain Medically Necessary Inpatient treatment of a Sickness or Injury while under the regular care and attendance of a Health Care Practitioner.

**Laboratory Services:**

Testing of bodily fluids or tissues for purposes of determining the cause and severity of a condition for preventive and screening purposes.

**Maximum Benefit:**

A Maximum Benefit is the amount of benefits, as shown in the Benefits Schedule, that We will pay for each Covered Person under this plan. This plan has varying types of Maximum Benefit limitations. Each Maximum Benefit limitation is stated on the Benefit Schedule corresponding to the applicable benefit provision. A particular Maximum Benefit only applies if it is shown on the Benefit Schedule.

**Maximum Lifetime Benefit:**

The maximum amount of all benefits combined that We will pay for each Covered Person under this plan over the lifetime of that Covered Person. This maximum will apply even if coverage with Us is interrupted. When the Maximum Lifetime Benefit has been paid by Us, no further benefits are payable for that Covered Person.

**Maximum Benefit for Inpatient Hospital Confinement:**

The maximum amount of Inpatient Hospital Confinement Benefits that We will pay for each Covered Person under this plan.

**Maximum Benefit for Emergency Room and Urgent Care Facility Visit:**

The maximum amount of Emergency Room and Urgent Care Facility Visit Benefits that We will pay for each Covered Person under this plan.

**Maximum Benefit for Outpatient Medical Events:**

The Maximum amount of Outpatient Medical Events Benefits that We will pay for each Covered Person under this plan.

**Maximum Benefit for Office Visit:**

The maximum amount of Office Visit Benefits that We will pay for each Covered Person under this plan.

**Maximum Benefit for Allergy Immunotherapy Injection, and Immunization:**

The maximum amount of Allergy Immunotherapy Injection, and Immunization Benefits that We will pay for each Covered Person under this plan.

**[Maximum Benefit for Outpatient Prescription:**

The maximum amount of Outpatient Prescription Benefits that We will pay for each Covered Person under this plan.]

**Maximum Benefit for Professional Ground or Air Ambulance Services:**

The maximum amount of Professional Ground or Air Ambulance Services Benefits that We will pay for each Covered Person under this plan.

**Maximum Benefit for Anesthesia:**

The maximum amount of Anesthesia Benefits that We will pay for each Covered Person under this plan.

**Maximum Benefit for Surgical Services:**

The maximum amount of Surgical Services Benefits that We will pay for each Covered Person under this plan.

**Medical Supply Provider:**

Agencies, facilities or wholesale or retail outlets that make disposable medical products available for use.

**Medically Necessary or Medical Necessity:**

Treatment, services or supplies that are rendered to diagnose or treat a Sickness or an Injury as part of a Covered Event. Medical Necessity does not include care that is prescribed or provided on the recommendation of a Covered Person's Immediate Family Member. We must determine that such care:

1. Is appropriate and consistent with the diagnosis and does not exceed in scope, duration or intensity that level of care which is needed to provide safe, adequate and appropriate diagnosis and treatment of the Sickness or Injury;
2. Is commonly accepted as proper care or treatment of the condition in accordance with United States medical practice and federal government guidelines; and
3. Is provided in the most conservative manner or in the least intensive setting without adversely affecting the condition or the quality of medical care provided.

The fact that a Health Care Practitioner may prescribe, order, recommend or approve a treatment, service or supply, does not, in itself, make the treatment, service or supply Medically Necessary.

**Medicare:**

Any portion of Title XVIII of the United States Social Security Act of 1965, as amended.

**Occupational Therapy:**

The treatment of Sickness or Injury, by a Health Care Practitioner who is an occupational therapist, using purposeful activities or assistive devices that focus on all of the following:

1. Developing daily living skills;
2. Strengthening and enhancing function;
3. Coordination of fine motor skills; and
4. Muscle and sensory stimulation.

**Office Visits:**

An in-person, face-to-face meeting or consultation between a Covered Person and a Health Care Practitioner in the Health Care Practitioner's office or a Retail Health Clinic. During this meeting, the Health Care Practitioner evaluates and manages the Covered Person's Sickness or Injury or provides preventive medicine services. For the purpose of this Policy, an Office Visit does not include services received in a Hospital's Outpatient department, an Emergency Room, a Free-Standing Facility or an Urgent Care Facility.

**[Off-Label Drug:**

Prescription Drugs approved by the FDA for at least one indication but prescribed for the treatment of a type of cancer of chronic fatigue syndrome for which indication the drug has not been approved.]

**Outpatient:**

Treatment, services or supplies received at a licensed medical facility, Health Care Practitioner's office or dispensary on other than an Inpatient basis for a stay of less than 24 hours. For purposes of determining benefits under this Policy, Outpatient does not include Office Visits, Emergency Room visits, [Telehealth Services, Telemedicine Services,] Urgent Care visits or Retail Health Clinic visits.

**Outpatient Facility:**

A Hospital's Outpatient department or a Free-Standing Facility.

**Personal Medical Equipment:**

Equipment, such as a prosthesis, that is customarily used to serve a medical purpose, is designed for and able to withstand repeated use and is not intended for use by successive patients.

**[Pharmacy:**

A licensed establishment where Prescription Drugs are dispensed by a licensed pharmacist in accordance with all applicable state and federal laws.]

**[Prescription Drug:**

Any medication that:

1. Has been fully approved by the Food and Drug Administration (FDA) for marketing in the United States;
2. Can be legally dispensed only with the written Prescription Order of a Health Care Practitioner in accordance with applicable state and federal laws; and
3. Contains the legend wording: "Caution: Federal Law Prohibits Dispensing Without Prescription" or "RX Only" on the manufacturer's label, or similar wording as designated by the FDA.]

**[Prescription Order:**

The request by a Health Care Practitioner for:

1. Each separate Prescription Drug and each authorized refill;
2. Insulin or insulin derivatives only by prescription; or
3. Any one of the following supplies used in the self-management of diabetes and purchased during the same transaction only by prescription:
  - a. Disposable insulin syringes and needles; or
  - b. Disposable blood/urine/glucose/acetone testing agents or lancets.]

**Physician or Doctor:**

Physician means a Health Care Practitioner who is duly qualified, legally licensed to practice medicine, whose permanent practice is in the United States and who is legally authorized to and does use the designation M.D.; who is a duly licensed Physician of osteopathy who uses the designation D.O.; or any Physician who is legally practicing within the scope of his or her license. The term includes surgeons and other specialists who meet the preceding definition. "Physician" does not include any Covered Person or member of the family by blood, marriage, or adoption.

Benefits will be paid only if the services provided are covered under this Policy and are within the scope and limitation of the license of the Physician performing the service.

**Physical Medicine:**

Treatment of physical conditions relating to bone, muscle or neuromuscular pathology, including but not limited to Occupational Therapy, Physical Therapy and Speech Therapy. This treatment focuses on restoring function using mechanical or other physical methods.

**Physical Therapy:**

The treatment of a Sickness or an Injury, by a Health Care Practitioner who is a physical therapist, using therapeutic exercise and other services that focus on improving posture, locomotion, strength, endurance, balance, coordination, joint mobility, flexibility, functional activities of daily living and alleviating pain.

**Policy:**

The contract issued by Us to the Policyholder providing benefits for Covered Persons.

**Policyholder:**

The person to whom the Policy is issued as shown in the Benefit Schedule.

**Pre-Existing Condition:**

A Sickness or an Injury and related complications:

1. For which medical advice, diagnosis, care or treatment was sought, received or recommended from a provider or Prescription Drugs were prescribed during the 12-month period immediately prior to the Covered Person's Effective Date, regardless of whether the condition was diagnosed, misdiagnosed or not diagnosed; or
2. That produced symptoms during the 12-month period immediately prior to the Covered Person's Effective Date which reasonably should have caused or would have caused an ordinarily prudent person to seek diagnosis or treatment.

**Radiology Services:**

Diagnostic imaging procedures and testing including, but not limited to, X-rays, Positron Emission Tomography (PET) scans, Magnetic Resonance Imaging (MRI) and Computerized Axial Tomography (CT), that are performed to diagnose a condition, determine the nature of a condition, or provide preventative screening.

**Rehabilitation Unit:**

An Inpatient facility providing specialized treatment for a Sickness or an Injury that meets all of the following requirements:

1. Is a program of services provided by one or more members of a multidisciplinary team;
2. Is designed to improve the patient's function and independence;
3. Is under the direction of a qualified Health Care Practitioner; and
4. Includes a formal written treatment plan with specific attainable and measurable goals and objectives.

**Retail Health Clinic:**

A facility that meets all of the following requirements:

1. Is licensed by the state in accordance with the laws for the specific services being provided in that facility;
2. Is staffed by a Health Care Practitioner in accordance with the laws of that state;
3. Is attached to or is part of a store or retail facility;
4. Is separate from a Hospital, Emergency Room, acute medical rehabilitation facility, Free-Standing Facility, Skilled Nursing Facility, sub acute rehabilitation facility, or Urgent Care Facility, and any Health Care Practitioner's office located therein even when services are performed after normal business hours;
5. Provides general medical treatment of services for a Sickness or Injury, or provides preventive medical services; [and]
6. Does not provide room and board or overnight services [; and].
- [7. Does not include Telehealth Services or Telemedicine Services.]

**Scheduled Benefit:**

The fixed benefit amount payable upon occurrence of a Covered Event under the terms of this plan. The Scheduled Benefit for a Covered Event is shown on the Benefit Schedule.

**Sickness:**

A disease or an illness of a Covered Person that first manifested itself after the Covered Person's Effective Date and while this Policy is in force. Sickness does not include a family history of a disease or illness or a genetic predisposition for the development of a future disease or illness. For the purpose of this Policy, bug bites, stings or infestations by microorganisms and poisoning by plants, such as poison ivy, are considered to be a Sickness, not an Injury. Sickness includes Complications of Pregnancy, but not the pregnancy itself.

**Skilled Nursing Facility:**

A facility that provides continuous skilled nursing services on an Inpatient basis for persons recovering from a Sickness or an Injury. The facility may also provide extended care or Custodial Care.

**Speech Therapy:**

The treatment of a Sickness or an Injury, by a Health Care Practitioner who is a speech therapist, using rehabilitative techniques to improve function for voice, speech, language and swallowing disorders.

**Telehealth Services:**

The use of modern telecommunication and information technologies by a Health Care Practitioner in the treatment of his or her patient.

**Telemedicine Services:**

A medical inquiry initiated by a Health Care Practitioner for the purpose of assistance with a patient's assessment, diagnosis, consultation, treatment or the transfer of medical data that requires the use of modern telecommunications technology.

**Temporomandibular Joint (TMJ) Dysfunction and Craniomandibular Joint (CMJ) Dysfunction:**

1. Clicking and/or difficulties in opening and closing the mouth;
2. Pain or swelling; and
3. Complications including arthritis, dislocation and bite problems of the jaw.

**Urgent Care:**

Treatment, services or supplies provided for a Sickness or an Injury that:

1. Develops suddenly and unexpectedly outside of a Health Care Practitioner's normal business hours;
2. Are not provided on an overnight room and board basis; and
3. Requires immediate treatment, but is not of sufficient severity to be considered Emergency Treatment.

**Urgent Care Facility:**

A facility that is attached to a Hospital, but separate from the Emergency Room, or a separate facility that provides Urgent Care on an Outpatient basis. A Health Care Practitioner's office is not considered to be an Urgent Care Facility even if services are provided after normal business hours. This type of facility must meet all of the following requirements:

1. Be licensed by the state in accordance with the laws for the specific services being provided in that facility;
2. Be staffed by an on-duty Health Care Practitioner during operating hours;
3. Provide services to stabilize patients who need Emergency Treatment and arrange immediate transportation to an Emergency Room; and
4. Provide immediate access to appropriate in-house laboratory and imaging services.

**We, Us, Our, Our Company:**

Family Life Insurance Company.

**You, Your, Yours:**

The person listed on the Benefit Schedule as the Policyholder.

## EFFECTIVE DATE AND TERMINATION DATE

### Eligibility and Effective Date of Policyholder:

A person who is eligible may elect to be covered under this plan by completing the Application process and submitting any required premium. You must be a resident of the state where this Policy is issued. Evidence of insurability according to Our underwriting and eligibility criteria must also be provided. Your coverage will take effect at 12:01a.m. local time at the Policyholder's state of residence on Your Effective Date as shown on the Benefit Schedule.

If the Policyholder moves out of the state where this Policy is issued, We will replace this Policy with a similar fixed indemnity plan with the form number this is issued in the Policyholder's new state of residence. The new plan will be effective on the date the Policyholder becomes a resident of the new state. If the Policyholder moves to a state where We do not provide insurance under a fixed indemnity plan with the same plan design as this Policy, We reserve the right to terminate this plan for You and any Covered Dependents.

### Eligibility and Effective Date of Dependents:

The following information explains how You can obtain coverage for any Dependents that You want to add to Your plan:

1. **Individual Plan:** If the Policyholder has an Individual Plan, as shown in the Benefit Schedule a Dependent **cannot** be added after the Policyholder's Effective Date.

If you have an Individual Plan and want to add any Dependents after Your Effective Date, You may apply for a new policy by completing an application and submitting any required premium. Evidence of insurability will not be required for You but it must be provided for any Dependents. Coverage under the new policy will take effect at 12:01 a.m. local time at the Policyholder's state of residence on the Effective Date for that Covered Person shown on the Benefit Schedule. The time during which a Pre-Existing Condition Limitation applies to You under the new policy will be reduced by the total number of consecutive days that You were covered under this Policy immediately prior to termination. Benefits paid under the new policy cannot exceed the Maximum Lifetime Benefit or any other applicable Maximum Benefit that would have otherwise been paid under the terms of this Policy if coverage under this Policy would have remained in force.

2. **Family Plan:** If the Policyholder has a Family Plan, as shown in the Benefit Schedule a Dependent **can** be added after the Policyholder's Effective Date. To be covered under this plan, a person must meet the Dependent definition in this plan and is subject to the additional requirements below:
  - a. **Adding a Newborn Child:** A newborn child can be added on the date the child was born. You must send Us written notice of the birth of the child and We must receive any required additional premium within 90 days of birth. The Effective Date of coverage will be 12:01a.m. local time at the Policyholder's state of residence on the date the child is born. If these requirements are not met, Your newborn child will be covered for Sickness or Injury, including Events related to the necessary care and treatment of medically diagnosed congenital defects only for the first 90 days from birth.
  - b. **Adding an Adopted Child:** A newly adopted child can be added on the date the child is adopted or the date You file a petition for adoption whichever is earlier. You must send Us written notice of the adoption or petition for adoption of the child and We must receive any required additional premium within 60 days of the adoption or petition for adoption of the child, whichever is earlier. The Effective Date of coverage will be 12:01a.m. local time at the Policyholder's state of residence on the earlier of the date the child is adopted or the date You file a petition for adoption. If these requirements are not met, Your newly adopted child will be covered for Sickness or Injury only for the first 60 days from the date of adoption or petition for adoption. A child is no longer considered adopted if, prior to legal adoption, You relinquish legal obligation for support of the child or when You are no longer petitioning for adoption of the child.
  - c. **Adding a Child For Whom a Court Order Requires You to Provide Insurance:** A child for whom a court order requires the Policyholder or Covered Dependent spouse to provide this insurance will be covered for the first 31 days from the time We receive a medical support order or notice of a medical support order. Any required additional premium must be received within 31 days from Our notice or receipt of the court order. If these requirements are not met, the child will only be covered for the first 31 days from the date We receive the medical support order or notice of the medical support order.

- d. **Adding Any other Dependent:** To add any other Dependents, an application must be completed and sent to Us along with any required premium. Evidence of insurability must also be provided. The Effective Date of coverage will be 12:01 a.m. local time at the Policyholder's state of residence on the Effective Date for that Covered Person shown on the Benefit Schedule.

**Termination Date:**

The Policyholder may cancel this Policy at any time by sending Us written notice. Upon cancellation, We will return the unearned portion of any premium paid, in accordance with the laws in the Policyholder's state of residence, minus any claims that were incurred after the termination date and paid by Us.

This Policy will terminate at 12:01 a.m. local time at the Policyholder's state of residence on the earliest of the following date:

1. The date We receive a request in writing or by telephone to terminate this Policy on or on a later date that is requested by the Policyholder for termination;
2. The date We receive a request in writing or by telephone to terminate coverage for a Covered Dependent or on a later date that is requested by the Policyholder for termination of a Covered Dependent;
3. The date this Policy lapses for nonpayment of premium subject to the Grace Period provision in the Premium Provision section;
4. The date there is fraud or material misrepresentation made by or with the knowledge of any Covered Person applying for this coverage or filing a claim for benefits;
5. The date all plans the same as this one are non-renewed in the state in which this Policy was issued or the state in which the Policyholder presently resides;
6. The date We terminate or nonrenew all individual market hospital-indemnity insurance plans in the state in which this Policy was issue or the state in which You presently reside. We will give You advance notice, as required by state law, of the termination of Your coverage;
7. The date the Policyholder moves to a state where We do not provide insurance under a plan with the same plan design as this Policy, We reserve the right to terminate this coverage; or
8. For a Dependent, the date a Covered Dependent no longer meets the Dependent definition in this Policy. We will pay benefits to the end of the time for which We have accepted premiums.

If coverage terminates due to the death of the Policyholder, the spouse [or Domestic Partner] of the Policyholder will become the named Policyholder provided the spouse [or Domestic Partner] is a Covered Person under this Policy on the date of death.

Delay or failure to report termination of any insurance will not continue the insurance in force beyond the date it would have terminated according to this Policy.

## HOSPITAL CONFINEMENT AND OTHER FIXED INDEMNITY BENEFITS

**WE WILL PAY SCHEDULED BENEFITS ONLY FOR THE COVERED EVENTS LISTED IN THIS SECTION OF THE PLAN. THE SCHEDULED BENEFIT AMOUNT AND THE MAXIMUM BENEFIT FOR ELIGIBLE COVERED EVENTS LISTED IN THIS SECTION ARE SHOWN IN THE BENEFIT SCHEDULE. REFER TO THE EXCLUSIONS SECTION FOR EVENTS FOR WHICH BENEFITS ARE NOT PROVIDED UNDER THIS PLAN.**

All benefits paid will be applied to the Maximum Lifetime Benefit and are also subject to any other applicable Maximum Benefit limitations provided under this plan. Benefits are subject to all the terms, limits and conditions in this plan.

We will pay the corresponding Scheduled Benefit amount shown on the Benefit Schedule when a Covered Event described below is rendered to a Covered Person and is Medically Necessary. A Covered Event may involve more than one service component (such as involving both technical and professional services). Regardless of the number of components involved in the Covered Event, only one Scheduled Benefit will be paid for the Covered Event.

### **Inpatient Hospital Confinement Benefits:**

We will pay the corresponding Scheduled Benefit amount for each day of Inpatient room and board during a Confinement Period under the orders of a Health Care Practitioner for care of a Sickness or an Injury. Room and board may be provided in any appropriate Inpatient setting including in an intensive care setting, such as an Intensive Care Unit (ICU), a Neonatal Intensive Care Unit (NICU), a Coronary Intensive Care Unit (CICU) or a step-down unit. Benefits under this provision are not payable when the confinement is for rehabilitation due to Sickness or Injury.

When an Inpatient Hospital Confinement Benefit is payable, no other benefits are payable for the Covered Person under this plan for Events that occur during the same Confinement Period, except for eligible Surgical Services Benefits and/or Anesthesia Benefits.

Benefits are limited to the Calendar Year Maximum Benefit shown on the Benefit Schedule. The benefit payable when confined for treatment of a Sickness differs from the benefit payable when confined for treatment of an Injury as shown on the Benefit Schedule.

### **Hospital Admission Benefits:**

We will pay the corresponding Scheduled Benefit amount if a Covered Person is confined for the first time as a resident Inpatient during the Calendar Year. Confinement as a resident Inpatient means assigned to a Hospital bed for an overnight stay for Medically Necessary reasons resulting from Injury or Sickness on the advice of a Physician.

### **Emergency Room Benefits:**

We will pay the corresponding Scheduled Benefit amount upon the occurrence of a visit to an Emergency Room during which a Covered Person received Emergency Treatment.

When an Emergency Room Visit Benefit is payable, no other benefits are payable for the Covered Person under this plan for Events that occur during the same visit, except for eligible Surgical Services Benefits and/or Anesthesia Benefits. Benefits are limited to the Calendar Year Maximum Benefit shown on the Benefit Schedule.

### **Urgent Care Facility Visit Benefits:**

We will pay the corresponding Scheduled Benefit amount upon the occurrence of a visit to an Urgent Care Facility during which a Covered Person received Urgent Treatment.

When an Urgent Care Facility Benefit is payable, no other benefits are payable for the Covered Person under this plan for Events that occur during the same visit, except for eligible Surgical Services Benefits and/or Anesthesia Benefits. Benefits are limited to the Calendar Year Maximum Benefit shown on the Benefit Schedule.

### **Outpatient Medical Event Benefits:**

We will pay the corresponding Scheduled Benefit amount upon occurrence of an Event wherein the Covered Person receives one of the following for treatment of a Sickness or Injury or preventive medical services as recommended by the United States Preventive Services Task Force:

1. Covered Events involving Laboratory Services as shown on the Benefit Schedule that are incurred on an Outpatient basis.
2. Covered Events involving Radiology Services as shown on the Benefit Schedule that are incurred on an Outpatient basis.
3. Covered Events involving Physical Medical services as shown on the Benefit Schedule that are incurred on an Outpatient basis.

4. **Other Outpatient Event Benefit:** This benefit consists of all other Medically Necessary Covered Events that are incurred on an Outpatient basis and for which benefits are not provided in another provision under this plan. Receipt of breast prostheses by a Covered Person following a Medically Necessary mastectomy, is considered a Covered Event.

Those Covered Events for which benefits are considered under any other provision of this plan are not considered for benefits under this provision. Benefits are limited to the Calendar Year Maximum Benefit shown on the Benefit Schedule.

**Office Visit Benefits:**

We will pay the corresponding Scheduled Benefit amount upon the occurrence of an Office Visit for a Covered Person during which any of the following are rendered in a Health Care Practitioner's Office:

1. Professional services that are provided by or under the direction of a Health Care Practitioner for a Sickness or an Injury for:
  - a. Measuring height, weight and blood pressure;
  - b. Obtaining a health history;
  - c. Performing a physical examination;
  - d. Making a medical decision;
  - e. Explaining treatment options;
  - f. Developing a treatment plan; or
  - g. Instructions for management of the condition.
2. Professional services that are provided by or under the direction of a Health Care Practitioner for preventive medicine services for:
  - a. Measuring height, weight and blood pressure;
  - b. Obtaining a health history;
  - c. Performing a routine physical examination;
  - d. Explaining risk reduction behavior; or
  - e. Preventive medicine services as recommended by the United States Preventive Services Task Force.

Benefits are limited to the Calendar Year Maximum Benefit shown on the Benefit Schedule.

**Allergy Immunotherapy Injection Benefits:**

We will pay the corresponding Scheduled Benefit amount upon an occurrence of an allergy immunotherapy injection for a Covered Person. Benefits are limited to the Calendar Year Maximum Benefit shown on the Benefit Schedule.

**Immunization Benefits:**

We will pay the corresponding Scheduled Benefit amount for each immunization received by a Covered Person as recommended by the United States Preventive Service Task Force or the Advisory Committee on Immunization Practices on the date the immunization is rendered. Benefits are limited to the Calendar Year Maximum Benefit shown on the Benefit Schedule.

**[Outpatient Prescription Order Benefits:**

We will pay the corresponding Scheduled Benefit amount when a Covered Person fills a Prescription Order through an outpatient pharmacy. Refer to the Exclusions section for a description of what Prescription Order fill or re-fill Events are not eligible for benefits under this plan.

This plan provides benefits only for Prescription Orders received on an Outpatient basis and comprised of:

1. Prescription Drugs that are fully approved by the U.S. Food and Drug Administration (FDA) for marketing in the United States and can be obtained only with a Prescription Order from a Health Care Practitioner;
2. Prescription Drugs in dosages, dosage forms, dosage regimens and durations of treatment that are Medically Necessary for the treatment of Sickness or Injury; and
3. Prescription Drugs that are within the quantity, supply, or other limits that We determine is appropriate for a Prescription Drug.

If a Generic Prescription Drug is available and You receive a Brand Name Prescription Drug, only the Scheduled Benefit for the Generic Prescription Drug will be paid. We will not pay benefits for Prescription Order refills in excess of the number specified on the Health Care Practitioner's Prescription Order or prescriptions refilled more frequently than the prescribed dosage indicates.

In addition to those drugs and supplies identified in the Exclusions section, Prescription Orders are not eligible for benefits under this plan when consisting of the following:

1. Compounded Medication that contains one or more active ingredients that is/are not covered under this plan;
2. A combination product wherein two or more Prescription Drug products are packaged and/or manufactured together and one or more of the active ingredients in the products are not covered under this plan; or
3. Any Prescription Drug which is a metabolite, isomer, extended release or other dosage form, unique salt or other formulation, or other direct or indirect derivative of a Prescription Drug approved by the FDA if the original drug would not be covered.

A Prescription Order fill or re-fill Event for maintenance drugs needed on an ongoing basis for a period of more than 30-days are eligible only for one Scheduled Benefit per month. No benefits are payable for any Prescription Order filled for a Covered Person on or after the date his or her coverage terminates under this plan.]

**Professional Ground or Air Ambulance Services Benefits:**

We will pay the corresponding Scheduled Benefit when professional ground or air transportation in an ambulance is obtained by a Covered Person who needs Emergency Treatment, for a Sickness or an Injury. The ambulance service must meet all applicable state licensing requirements. Benefits are limited to the Calendar Year Maximum Benefit shown on the Benefit Schedule.

**Anesthesia Benefits:**

We will pay the Anesthesia Benefit corresponding to the Scheduled Benefit when a Covered Person is administered anesthesia as part of a Covered Event. Benefits are limited to the Calendar Year Maximum Benefit shown on the Benefit Schedule.

**Surgical Services Benefits:**

We will pay the corresponding Scheduled Benefit when the Covered Person obtains surgical treatment as shown on the Surgical Schedule.

When a Surgical Services Benefit is payable, no other benefits are payable for the Covered Person under this plan for Events that occur during the same surgical Event, except for Hospital Confinement Benefits and eligible Anesthesia Benefits.

Two or more surgical procedures performed during the same operative session are considered one operation and benefits will be based on the procedure with the highest Scheduled Benefit shown in the Surgical Schedule. If a surgical procedure is performed that is not specifically named in the Surgical Schedule, a benefit will be paid for the procedure identified in the Surgical Schedule that is the most similar (in terms of technique and location on the body) to the procedure undergone by the Covered Person. Benefits are limited to the Calendar Year Maximum Benefit shown on the Benefit Schedule.

**Assisting Surgeon Benefit:**

If an Assistant Surgeon is required to assist the Surgeon during the operation, We will pay a benefit equal to [20%] of the benefit shown in the Surgical Schedule for the operation.

**PRE-EXISTING CONDITIONS LIMITATION**

**Pre-Existing Conditions Limitation:**

We will not pay benefits for Events that result from or are related to a Pre-Existing Condition, or its complications, until the Covered Person has been continuously insured under this plan for 12 months. After this period, benefits will be available for Events resulting from or related to a Pre-Existing Condition, or its complications, provided that the Covered Event occurs while this plan is in force. Pregnancy that exists on the Covered Person's Effective Date will be considered a Pre-Existing Condition under this plan.

## EXCLUSIONS

This plan provides benefits only for Covered Events identified in the Hospital Confinement and Other Fixed Indemnity Benefits section.

We will not pay benefits for claims resulting, whether directly or indirectly, from Events or loss related to or resulting from any of the following:

1. A Sickness or Injury that is the result of a work-related condition that is eligible for benefits under Worker's Compensation, Employers' Liability or similar laws even when the Covered Person does not file a claim for benefits. This exclusion will not apply to a Covered Person who is not required to have coverage under any Worker's Compensation, Employers' Liability or similar law and does not have such coverage. However, the Covered Person must receive services in accordance with the Hospital Confinement and Other Fixed Indemnity Benefits section.
2. War or any act of war, whether declared or undeclared.
3. Participation in the military service of any country or international organization.
4. Treatment, services or supplies that:
  - a. Are not part of a specifically listed Covered Event shown on the Benefit Schedule;
  - b. Are due to complications of a non-covered service;
  - c. Are incurred before the Covered Person's Effective Date or after the termination date of coverage, except as provided under the Extension of Benefits provision in the Other Provisions section; or
  - d. Are provided in a student health center or by or through a school system.
5. Glasses, contact lenses, vision therapy, exercise or training, surgery including any complications arising therefrom to correct visual acuity including, but not limited to, lasik and other laser surgery, radial keratotomy services or surgery to correct astigmatism, nearsightedness (myopia) and/or farsightedness (presbyopia); vision care that is routine.
6. Hearing care that is routine; any artificial hearing device, cochlear implant, auditory prostheses or other electrical, digital, mechanical or surgical means of enhancing, creating or restoring auditory comprehension.
7. Treatment for foot conditions including, but not limited to:
  - a. Flat foot conditions;
  - b. Foot supportive devices, including orthotics and corrective shoes;
  - c. Foot subluxation treatment;
  - d. Corns, bunions, calluses, toenails, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet; or
  - e. Hygienic foot care that is routine.
8. Dental treatment, dental care that is routine, bridges, crowns, caps, dentures, dental implants or other dental prostheses, dental braces or dental appliances, extraction of teeth, orthodontic treatment, odontogenic cysts, any other treatment or complication of teeth and gum tissue, except as otherwise covered for a Dental Injury.
9. Treatment of Temporomandibular Joint Dysfunction and Craniomandibular Joint Dysfunction; any appliance, medical or surgical treatment for malocclusion (teeth that do not fit together properly which creates a bite problem), protrusion or recession of the mandible (a large chin which causes an underbite or a small chin which causes an overbite), maxillary or mandibular hyperplasia (excess growth of the upper or lower jaw) or maxillary or mandibular hypoplasia (undergrowth of the upper or lower jaw).
10. Treatment of Behavioral Health or Substance Abuse, whether organic or non-organic, chemical or non-chemical, biological or non-biological in origin and irrespective of cause, basis or inducement, including, but not limited to, drugs and medicines for Inpatient or Outpatient treatment of Behavioral Health or Substance Abuse.
11. Any treatment, services, supplies, diagnosis, drugs, medications or regimen, whether medical or surgical, for purposes of controlling the Covered Person's weight or related to obesity or morbid obesity, whether or not weight reduction is Medically Necessary or appropriate or regardless of potential benefits for co-morbid conditions, weight reduction or weight control surgery, treatment or programs, any type of gastric bypass surgery, suction lipectomy, physical fitness programs, exercise equipment or exercise therapy, including health club membership visits or services; nutritional counseling.

12. Organ, tissue or cellular material donation by a Covered Person, including administrative visits for registry, computer search for donor matches, preliminary donor typing, donor counseling, donor identification and donor activation.
13. Chemical peels, reconstructive or plastic surgery that does not alleviate a functional impairment and other confinement or treatment visits that are primarily for a Cosmetic Service as determined by Us.
14. Capsular contraction, augmentation or reduction mammoplasty, except for all stages and revisions of reconstruction of the breast following a Medically Necessary mastectomy for treatment of cancer, including reconstruction of the other breast to produce a symmetrical appearance and treatment of lymphedemas.
15. Removal or replacement of a prosthesis, Durable Medical Equipment or Personal Medical Equipment, except for internal breast prostheses following a Medically Necessary mastectomy for treatment of cancer and services are received in accordance with the Hospital Confinement and Other Fixed Indemnity Benefits section.
16. Prophylactic treatment, services or surgery including, but not limited to, prophylactic mastectomy or any other treatment, services or surgery to prevent a disease process from becoming evident in the organ or tissue at a later date.
17. Treatment, services, and supplies for:
  - a. Home Health Care;
  - b. Hospice Care;
  - c. Skilled Nursing Facility care, Inpatient rehabilitation services;
  - d. Custodial Care, respite care, rest care, supportive care, homemaker services;
  - e. Phone, facsimile, internet or e-mail consultation, compressed digital interactive video, audio or clinical data transmission using computer imaging by way of still-image capture and store forward; [except for] [including] Telemedicine Services or Telehealth Services or technology that facilitates access to a Health Care Practitioner;
  - f. Treatment, services or supplies that are furnished primarily for the personal comfort or convenience of the Covered Person, Covered Person's family, a Health Care Practitioner or provider;
  - g. Treatment or services provided by a standby Health Care Practitioner; or
  - h. Treatment or services provided by a masseur, masseuse or massage therapist, massage therapy, a rolfer.
18. Treatment, services, and supplies for growth hormone therapy, including growth hormone medication and its derivatives or other drugs used to stimulate, promote or delay growth or to delay puberty to allow for increased growth.
19. Treatment, services and supplies related to the following conditions, regardless of underlying causes: sex transformation, gender dysphoric disorder, gender reassignment, and treatment of sexual function, dysfunction or inadequacy, treatment to enhance, restore or improve sexual energy, performance or desire.
20. Treatment, services and supplies related to: maternity, pregnancy (except Complications of pregnancy), routine well newborn care at birth including nursery care, abortion.
21. Contraceptive procedures, contraceptive drugs or devices, not dispensed from a pharmacy, including, but not limited to, contraceptive patches, contraceptive vaginal rings, diaphragms, injectable contraceptives and contraceptive implants.
22. Treatment for or treatment use of:
  - a. Genetic testing or counseling, genetic services and related procedures for screening purposes including, but not limited to, amniocentesis and chronic villi testing;
  - b. Services, drugs or medicines used to treat males or females for an infertility diagnosis regardless of intended use including, but not limited to: artificial insemination, in vitro fertilization, reversal of reproductive sterilization, any treatment to promote conception;
  - c. Sterilization;
  - d. Cryopreservation of sperm or eggs;
  - e. Surrogate pregnancy;
  - f. Fetal surgery, treatment or services;
  - g. Umbilical cord stem cell or other blood component harvest and storage in the absence of a Sickness or an Injury; or
  - h. Circumcision;

23. Spinal and other adjustments, manipulations, subluxation treatment and/or services.
24. Treatment for: behavior modification or behavioral (conduct) problems; learning disabilities, developmental delays, attention deficit disorders, hyperactivity, educational testing, training or materials, except for Outpatient diabetes self-management training and education for treatment of a Covered Person with diabetes, memory improvement, cognitive enhancement or training, vocational or work hardening programs, transitional living.
25. Treatment for or through use of:
  - a. Non-medical items, self-care or self-help programs;
  - b. Aroma therapy;
  - c. Meditation or relaxation therapy;
  - d. Naturopathic medicine;
  - e. Treatment of hyperhidrosis (excessive sweating);
  - f. Acupuncture, biofeedback, neurotherapy, electrical stimulation;
  - g. Inpatient treatment of chronic pain disorders;
  - h. Treatment of spider veins;
  - i. Family or marriage counseling;
  - j. Applied behavior therapy treatment for autistic spectrum disorders;
  - k. Smoking deterrence or cessation;
  - l. Snoring or sleep disorders;
  - m. Change in skin coloring or pigmentation; or
  - n. Stress Management.
26. A Sickness or Injury resulting from abuse or overdoes of any illegal or controlled substance, except when administered in accordance with the advice of the Covered Person's Health Care Practitioner.
27. Treatment of Sickness or an Injury when a contributing cause of the condition was the Covered Person's voluntary attempt to commit or participation in or commission of a felony, whether or not charged, or as a consequence of the Covered Person being under the influence of any illegal or non-prescribed controlled substance while committing a felony.
28. Services ordered, directed or performed by a Health Care Practitioner or supplies purchased from a Medical Supply Provider who is a Covered Person, an Immediate Family Member, employer of a Covered Person or a person who ordinarily resides with a Covered Person.
29. Any amount in excess of the Maximum Lifetime Benefit or any other Maximum Benefit limitation for covered Scheduled Benefits.
30. Treatment that does not meet the definition of a Covered Event in this Policy including, but not limited to, treatment that is not Medically Necessary.
31. Treatment, services and supplies for Experimental or Investigational Services.
32. Treatment incurred outside of the United States, including drugs or medicines obtained from pharmacy provider sources outside the United States.
33. Sickness or Injury caused or aggravated by suicide, attempted suicide or self-inflicted Sickness or Injury.
34. Vitamins and/or vitamin combinations even if they are prescribed by a Health Care Practitioner.
35. Any over-the-counter or prescription products, drugs or medicines in the following categories, whether or not prescribed by a Health Care Practitioner:
  - a. Herbal or homeopathic medicines or products;
  - b. Minerals;
  - c. Health and beauty aids;
  - d. Batteries;
  - e. Appetite suppressants;
  - f. Dietary or nutritional substances or dietary supplements;
  - g. Nutraceuticals;
  - h. Tube feeding formulas and infant formulas;
  - i. Medical Foods; or

- j. Devices or supplies including, but not limited to, support garments, bandages and non-medical items regardless of intended use, except for injectable insulin and blood/urine/glucose/acetone testing devices, needles and syringes as described under a Prescription Order for treatment of a Covered Person with diabetes who receives these drugs, medicines or supplies in accordance with the Hospital Confinement and Other Fixed Indemnity Benefits section.
- 36. Drugs or medicines that have an over-the-counter equivalent or contain the same or therapeutically equivalent active ingredient(s) as over-the-counter medication, as determined by Us.
  - 37. Drugs or medicines: administered or dispensed at or by the rest home, sanitarium, extended care facility, convalescent care facility, Skilled Nursing Facility or similar institution, dispensed at or by a Hospital, an Emergency Room, a Free-Standing Facility, an Urgent Care Facility, a Health Care Practitioner's office or other Inpatient or Outpatient setting for take home by the Covered Person.
  - 38. Drugs or medicines used to treat, impact or influence: athletic performance; body conditioning, strengthening, or energy; social phobias, slowing the normal processes of aging, daytime drowsiness, overactive bladder, dry mouth, excessive salivation, genetic make-up or genetic predisposition, prevention or treatment of hair loss, excessive hair growth or abnormal hair patterns.
  - 39. Unit-dose drugs, drugs or medicines used to treat onychomycosis (nail fungus), botulinum toxin and its derivatives.
  - 40. Drugs or medicines prescribed for treatment of a condition that is specifically excluded under this Policy.
  - 41. Drugs, medicines or supplies that are illegal under federal law, such as marijuana, even if they are prescribed for medical use in a state.
  - 42. Duplicate prescriptions, replacement of lost, stolen, destroyed, spilled or damaged prescriptions; Prescription Order refills in excess of the number specified on the Health Care Practitioner's Prescription Order; prescriptions refilled more frequently than the prescribed dosage indicates, prescriptions refilled after one year from the Health Care Practitioner's original Prescription Order, any administration for drug injections or any other drugs or medicines obtained other than through a pharmacy.

## **CLAIM PROVISIONS**

### **Notice of Claim:**

You must notify Us at Our Home Office of the claim within 60 calendar days after the date the Covered Event occurs, or as soon as reasonably possible. When providing notice of claim, You must include Your name, address and policy number.

### **Claim Forms:**

The Company, upon receipt of a Notice of Claim, will furnish to the claimant such forms as are usually furnished by it for filing proof of loss. If such forms are not furnished within 15 days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of this Policy as to proof of loss upon submitting, within the time fixed in this Policy for filing proof of loss, written proof covering the occurrence, the character and the extent of the loss for which claim is made.

### **Proof of Loss:**

We must receive written or electronic proof of loss for which the claim is made. Proof of loss must be provided to Us within 90 calendar days after a covered loss occurs or as soon as reasonably possible, but in no event later than 12 months from the date proof of loss is otherwise required, unless You are declared incompetent by a court of law.

### **The proof of loss must include all of the following:**

1. Your name and Policy number.
2. The name of the Covered Person who incurred the claim.
3. The name and address of the provider of the services involved with the Covered Event.
4. An itemized Statement from the provider of the services involved with the Covered Event that includes all of the following as appropriate:
  - a. International Classification of Disease (ICD) diagnosis codes.
  - b. International Classification of Disease (ICD) procedures.
  - c. Current Procedural Terminology (CPT) code(s).
  - d. Healthcare Common Procedure coding System (HCPCS) level II codes.
  - e. National Drug Codes (NDC).

When We receive written or electronic proof of loss, We may require additional information. You must furnish all items We decide are necessary to determine Our liability in accordance with the Right to Collect Information provision in this section. We will not pay benefits if the required information or authorization for its release is not furnished to Us. For a Covered Event under the Surgical Services Benefits provision, valid proof of loss must include a statement from the surgeon. A statement from the facility where the surgery took place will not constitute valid proof of loss for Surgical Services Benefits.

**Assignment Not Prohibited:**

You may assign benefits under this Policy. We will pay any claimant who produces evidence of assignment by You, payable in the order in which We receive such evidence of assignment and pursuant to proof of loss. If You assign benefits to a provider involved in the Covered Event, the assigned amount paid will not be in excess of the amount shown on the provider's statement submitted at proof of loss. Any Scheduled Benefit amount in excess of the billed amount will be paid directly to You, unless otherwise expressly assigned by You.

**Right to Collect Information:**

To determine Our liability, We may request additional information from a Covered Person, Health Care Practitioner, facility or other individual or entity. A Covered Person must cooperate with Us, and assist Us by obtaining the following information within 30 days of Our request. Claims will be denied if We are unable to determine Our liability because a Covered Person, Health Care Practitioner, facility or other individual or entity failed to:

1. Authorize the release of all medical records to Us and other information We requested.
2. Provide Us with information We requested about pending claims.
3. Provide Us with information that is accurate and complete.
4. Have any examination completed as requested by Us.
5. Provide reasonable cooperation to any requests made by Us.

Such Events may be considered for benefits upon receipt of the requested information, provided all necessary information is received prior to expiration of the time allowed for submission of claim information as set forth in this Claim Provisions section.

**Physical Examination and Autopsy:**

We have the right to have a Health Care Practitioner of Our choice examine a Covered Person at any time regarding a claim for benefits. These exams will be paid by Us. We also have the right, in case of death, to have an autopsy, at Our expense, where it is not prohibited by law.

**Payment of Benefits:**

Benefits will be paid immediately when We receive due written proof of loss, subject to any time period requirements under state law. Benefits for Covered Events will be paid to the Policyholder unless they have been assigned to a provider. Benefit payments may be assigned to another person in whole or in part. Any benefits unpaid at Your death will be paid at Our option to Your designated beneficiary or to Your estate. If benefits are payable to Your estate or to a beneficiary, who is a minor or is otherwise not competent to give a valid release, We may pay benefits, up to an amount not exceeding \$1,000 to any relative by blood or marriage to You or Your designated beneficiary who is considered by Us to be equitably entitled to the benefits.

We will base claim determinations according to the latest editions of the Current Procedural Terminology (CPT) manual or International Classification of Diseases (ICD) manual. When a Covered Event involves both a professional and technical component, We will pay benefits only for the technical component. We will not pay benefits for claims for Events that are not eligible for benefits under this plan, or duplicates of previously received or processed claims.

Any amount We pay in good faith will release Us from further liability for that amount. Payment by Us does not constitute any assumption of liability for further benefits under this plan.

**Overpayment:**

If a benefit is paid under this plan and it is later shown that a lesser amount should have been paid, We will be entitled to recover the excess amount from You or the person or entity receiving the incorrect payment. We may offset any overpayment to You or a provider against future benefit payments.

**Rights of Administration:**

We maintain Our ability to determine Our rights and obligations under this plan including, without limitation, the eligibility for an amount of any benefits payable, subject to applicable provisions of state and federal law.

**Claims Involving Misrepresentation or Fraud:**

Claims will be denied in whole or in part in the event of misrepresentation or fraud by a Covered Person or a Covered Person’s representative. If benefits are paid under this plan and it is later shown the claims for these benefits involved misrepresentation or fraud, We will be entitled to a refund from You or the person or entity receiving the payment.

A claim will not be honored if the Covered Person or the provider of the services will not, or cannot provide adequate documentation to substantiate that treatment constituting a Covered Event was rendered for the claim submitted. If the Covered Person, or anyone acting on the Covered Person’s behalf, knowingly files a fraudulent claim, claims may be denied in whole or in part, coverage may be terminated or rescinded, and the Covered Person may be subject to civil and/or criminal penalties.

**Worker’s Compensation Not Affected:**

Insurance under this plan does not replace or affect any requirements for coverage by Worker’s Compensation insurance. If state law allows, We may participate in a Worker’s Compensation dispute arising from a claim for which We paid benefits.

**Claim Appeal:**

You have the right to request a review of all adverse claim decisions. A review must be requested in writing within 180 days following Your receipt of the notice that the claim was denied or reduced.

**PREMIUM PROVISIONS**

**Consideration:**

This Policy is issued based on the statements and agreements in the Covered Person’s application form and during the application process, any exam of a Covered Person that is required, any other amendments or supplements to the application form and payment of the required premium. Each renewal premium is payable on the due date subject to the Grace Period provision in this section.

**Premium Payment:**

The initial premium must be paid on or before the due date for this coverage to be in-force. Subsequent premiums are due as billed by Us. Each renewal premium must be received by Us on its due date subject to the Grace Period provision in this section. Premiums must be received in cash or check at Our office on the date due. We may agree to accept premium payment in alternative forms, such as credit card or automatic charge to a bank account. If we tried to obtain payment for the amount due but were unsuccessful, We reserve the right to require an alternative form of payment during the Grace Period.

**Changes in Premiums:**

We have the right to change premiums at any renewal date. When this occurs, the new rate will be guaranteed for a period of 12 months. If We change premiums, We will do so only:

1. If We change the premiums for all policies of this form and issue age in Your state of issue;
2. If such change is in accordance with the laws and regulations of Your state of issue; and
3. If We give You 60 days notice before such change becomes effective.

**Refund of Unearned Premiums:**

Within 30 days of proof of death or termination of this Policy, We will refund any unearned premium. Unearned premium is any premium paid for any period beyond the end of the month in which death or termination occurred.

**Grace Period:**

There is a grace period of 31 days for the payment of each premium due after the initial premium during which period coverage will continue in-force. If the full premium due is not received at Our Home Office by the end of the Grace Period, the coverage will lapse. If the full premium is received during or by the end of the Grace Period, coverage will continue without interruption unless You give Us written notice to cancel the coverage. If a benefit is payable for an Event that occurs during the Grace Period, any unpaid premiums due will be deducted from the benefit payment.

**Reinstatement:**

If any premium is not paid before the expiration of the Grace Period, coverage for You and any Covered Dependents will lapse. The coverage will be reinstated if all of the following requirements are met:

1. You submit a supplemental application form for reinstatement to Us and remit the required premium payment. Submission of premium to Your agent is not submission of premium to Us.
2. We approve Your application form for reinstatement.

The coverage will be reinstated on the date We approve Your application form for reinstatement. If We have not responded to Your application form for reinstatement by the 45th day after We receive the application form, the coverage will be reinstated on that date.

Any premium accepted in connection with a reinstatement will be applied to a period for which premium has not been previously paid, but not to any period more than 60 days before the date of reinstatement.

If the coverage is reinstated, loss resulting from an Injury is sustained on or after the date of reinstatement. Loss due to a Sickness will be covered only if the Sickness begins more than 10 days after the date of reinstatement.

In all other respects, You and Our Company will have the same rights as existed under this Policy before this Policy lapsed, subject to any provisions included with or attached to this Policy in connection with the reinstatement.

**Covered Dependent Conversion:**

A Covered Dependent may be eligible to convert to another similar fixed indemnity plan that We issue in the Covered Dependent's state of residence at the time coverage terminates under this Policy if:

1. The Covered Dependent's insurance terminated due to a valid decree of divorce [termination of domestic partnership] between the Policyholder and the Covered Dependent. The Covered Dependent will be issued a policy, which We are currently issuing, that most nearly approximates the coverage of this Policy, without evidence of insurability and with the same effective date as the Covered Dependent's coverage under this Policy; or
2. The Covered Dependent's insurance terminates due to the death of the Policyholder; or
3. A Covered Dependent child's insurance terminates because the child no longer meets the eligibility requirements for a Dependent.

To obtain conversion coverage, the Covered Dependent must submit a written application form and the required premium to Us within 31 days after coverage under this Policy terminates. Evidence of insurability will not be required. The conversion plan will be provided on the limited hospital confinement and other fixed indemnity insurance plan that We select for providing conversion coverage at that time. However, the conversion plan may provide different benefit levels, covered services and premium rates.

If written Application is not made within 31 days following the termination of insurance under this Policy, conversion coverage may not be available.

The conversion plan will take effect at 12:01 a.m. local time at the Covered Person's residence on the day after coverage under this Policy terminates. The time during which a Pre-Existing Condition Limitation applies under the new plan will be reduced by the total number of consecutive days that You were covered under this Policy immediately prior to termination. Benefits paid under the new plan cannot exceed the Maximum Lifetime Benefit or any other applicable Maximum Benefit that would have otherwise been paid under the terms of this Policy if coverage under this Policy would have remained in force.

**OTHER PROVISIONS**

**Policy Changes:**

No change in this Policy will be valid unless approved by one of Our executive officers and included with this Policy. No agent or other employee of Our Company has authority to waive or change any plan provision or waive any other applicable application or application requirements.

**Clerical Error:**

If a clerical error is made by Us, it will not affect the insurance to which a Covered Person is entitled.

The premium charges will be adjusted as required, but not for more than two years prior to the date the error was found. If the premium was overpaid, We will refund the difference. If the premium was underpaid, the difference must be paid to Us within 60 days of Our notifying You of the error.

**Conformity with State Statutes:**

If this plan, on its Effective Date, is in conflict with any applicable federal laws or laws of the state where it is issued, it is changed to meet the minimum requirements of those laws. In the event that new or applicable state or federal laws are enacted which conflict with current provisions of this plan, the provisions that are affected will be administered in accordance with the new applicable laws, despite anything in the plan to the contrary. If the payment of the benefits under this Policy would violate any U.S. economic or trade sanctions, such coverage will be null and void.

**Enforcement of Plan Provisions:**

Failure by Us to enforce or require compliance with any provision within this plan will not waive, modify or render any provision unenforceable at any other time, whether the circumstances are the same or not.

**Entire Contract:**

This Policy is issued to the Policyholder. The entire contract of insurance includes the Policy, Policy Benefit Schedule, Surgical Schedule, a Covered Person's application form or any riders and endorsements.

**Representations Made on Application Form:**

All statements made on the application form will be deemed representations and not warranties. No statement made in the application form will be used in any suit or action at law or equity unless a copy of the application form is furnished to the Policyholder, or in the event of death or incapacity of the Policyholder, a copy will be furnished to the Policyholder's beneficiary or personal representative.

**Extension of Benefits:**

On the date this coverage terminates, We may extend benefits during a Confinement Period that is a result of a Sickness that commenced or an Injury sustained while this Policy was in force. Benefits are payable only for Covered Events relating to the Sickness or Injury that directly caused the confinement. Newly diagnosed conditions and complications of the condition that caused the initial confinement are not eligible for benefits during the Extension of Benefits. The Covered Person must be under the care of a Health Care Practitioner for the Inpatient stay. Medical documentation verifying the Hospital stay must be sent to Us within 90 days after termination. Benefits are subject to all the terms, limits and conditions in this Policy. Premium payment will not be required during the extension of benefits period.

**The extension will end on the earliest of:**

1. The date on which the Covered Person is no longer continuously confined in a Hospital;
2. Payment of any applicable Maximum Benefit under this plan;
3. 90 days from the date coverage would have terminated under this plan if there was no extension of benefit;
4. The date the Covered Person is eligible for Medicare; or
5. The earliest date otherwise permitted by law.

**Misstatements:**

If a Covered Person's material information has been misstated and the premium amount would have been different had the correct information been disclosed, an adjustment in premiums may be made based on the corrected information. In addition to adjusting future premiums, We may require payment of past premiums at the adjusted rate to continue coverage. If the Covered Person's age is misstated and coverage would not have been issued based on the Covered Person's true age, Our sole liability will be to refund all of the premiums paid for that Covered Person's coverage, minus the amount of any benefits paid by Us.

**Rescission of Insurance and/or Denial of Claim:**

Within the first two years after the Effective Date of coverage, We have the right to rescind or modify Your insurance Policy and/or deny a claim for a Covered Person if the application form contains an omission or misrepresentation, whether intended or not, which We determine to be material. We also reserve the right to rescind an insurance Policy and/or deny a claim for a fraudulent misstatement or omission at any time during the coverage period.

**Legal Action:**

No suit or action at law or equity may be brought to recover benefits under this Policy prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Policy. No suit or action at law or equity can be brought later than 3 years after the time written proof of loss is required to be furnished. You agree that You will not file a suit or legal action against Us for any breach of this agreement or denial of benefits without first submitting the dispute through Our claims review process and exhaustion of administrative remedies.

The right to change a beneficiary is reserved for the Policyholder, and the consent of the beneficiary or beneficiaries is not required for the surrender or assignment of this Policy, for any change of beneficiary or beneficiaries, or for any other changes in this Policy.

**Modification of Your Coverage:**

This Policy may be changed at any time. We will give You 30 days notice prior to any change.

We may modify the insurance plan for You and any Covered Dependents. This modification will be consistent with state law and will apply uniformly to all policies with Your plan of coverage. You will be notified of any change.

**HOSPITAL CONFINEMENT AND SURGICAL FIXED INDEMNITY INSURANCE POLICY**  
Limited Hospital Confinement and Other Fixed Indemnity Benefits

**CONDITIONALLY RENEWABLE. SUBJECT TO OUR RIGHT TO CHANGE PREMIUMS**

**FAMILY LIFE INSURANCE COMPANY**

[10700 Northwest Freeway  
Houston, Texas 77092]

<b>HOME OFFICE USE ONLY</b>	
Pol. No.	_____
Pol. Date	_____
No. Units	_____

**HOSPITAL INDEMNITY APPLICATION**

1. Print name of applicant and each member of the family

FIRST	MI	LAST	Relationship	Sex	DOB	Age	Ht.	Wt. Now	Wt. 1 Yr Ago
			Primary						

2. (a) Requested Coverage Effective Date \_\_\_\_\_  Individual  Individual and Spouse  One Parent Family  Two Parent Family (b) Hospital Indemnity Benefit \_\_\_\_\_ (c)  [Classic]  [Elite]

3. Insured SS# \_\_\_\_\_ Spouse SS# \_\_\_\_\_

4. (a) Method of Payment:  Bank Draft  Direct Bill  Credit Card  List Bill (b) Group # \_\_\_\_\_

(c) Premium Mode:  Annual  Quarterly  Semi-Annual  Monthly  \_\_\_\_\_ Mode Premium \$ \_\_\_\_\_

5. Applicant's Home Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

6. Business: Name (Applicant) \_\_\_\_\_ Occupation: \_\_\_\_\_

7. Business: Name (Spouse) \_\_\_\_\_ Occupation: \_\_\_\_\_

8. MAILING ADDRESS:  Business  Home \_\_\_\_\_

9. Do all the members to be insured reside in the home of the applicant?  YES  NO If "No" which member? \_\_\_\_\_ Explain: \_\_\_\_\_

10. Has any person proposed for insurance been declined for insurance due to health reasons?  YES  NO If yes, provide details and dates: \_\_\_\_\_

11. Has any person proposed for insurance had surgery within the last 5 years?  YES  NO If yes, provide details (date, reasons, results): \_\_\_\_\_

12. Has any person had surgery advised but not yet performed?  YES  NO If yes, provide details \_\_\_\_\_

13. Has any person proposed for insurance been treated, within the last twelve months, by a physician for elevated blood pressure?  YES  NO If yes, please list the name(s) of the person (s), types on treatment including medication, date last seen by a physician, last blood pressure reading, and how long blood pressure has been under control and date diagnosed \_\_\_\_\_

14. Have you or any person proposed for insurance within the past 5 years been diagnosed as having or been told by a doctor that they had any of the following conditions?  YES  NO If yes to any conditions, state the name of the person and details. The answers to these questions may exclude You or Your dependents from coverage.

- |   |  |  |
|---|--|--|
| a. Addison's Disease  | i. Diabetes (except cases treated by diet alone              | s. Lung Disorder (Chronic)   |
| b. AIDS, or tested positive for antibodies to the AIDS virus or HIV virus                 | j. Functionally limiting musculoskeletal disease or disorder | t. Mental or Nervous Disorder or disease or disorder of the Central Nervous System |
| c. Alcohol & Substance Abuse  | k. Grand Mal Epilepsy  | u. Multiple Sclerosis  |
| d. Cataracts uncorrected  | l. Heart Attack  | v. Paralysis   |
| e. Cerebral Palsy   | m. Hemophilia  | w. Ulcerative Colitis  |
| f. Cirrhosis of the Liver   | n. Hernia uncorrected  |  |
| g. Coronary Bypass  | o. Hepatitis (other than Virus A)                            |  |
| h. Currently (or within 3 months) Hospitalized or confined to any health care institution | p. Internal Cancer within 5 years                            |  |
|   | r. Leukemia  |  |

(Please continue on next page)





		To obtain further information, contact
Notice of Information Practices		Family Life Insurance Company
Including Fair Credit Reporting Act Notice and MIB, Inc. Notice		[10700 Northwest Freeway, Houston, TX 77092]

Thank you for your application. It is the major source of information about you which we use in evaluating your application and reviewing your policy. However, we wish to inform you that an investigative consumer report may be ordered as to your insurability. If an investigative consumer report is prepared in connection with this application, you may request to be interviewed in connection with the preparation of this report. This report may include, if applicable, information as to your character, general reputation, personal characteristics and mode of living as may be obtained through interviews with family members, friends, neighbors and associates. If you would like to know whether such a report was ordered and, if so, receive additional information as to its nature and scope, including the name, address and phone number of the reporting agency, we will be pleased to furnish this information upon your written request to our Home Office at the above address. You may receive a copy of such report by contacting the reporting agency.

Our experience shows that information from investigative reports usually does not have any adverse effect on our underwriting decision. However, if it should, we will notify you in writing of this fact as well as provide you the identity by name and address of the reporting agency. You may then wish to discuss the matter with that agency. We will not disclose information about you without your prior written authorization except as permitted by law. In certain situations we may disclose, as allowed by law, all types of nonpublic personal information as is necessary in order to conduct our business.

This could include disclosures to persons or organizations that will use the information for sales purposes, unless you indicate to us that you do not want the information disclosed for this purpose. You have the right to obtain access to certain items of information we have collected about you, and you have the further right to request correction of information if you feel it is inaccurate. If you wish to have a more detailed description of our information practices, we will be pleased to furnish this information upon your written request to our Home Office at the address on the front of this Notice..

**MIB, Inc. Notice**

While the information regarding your insurability is treated as confidential, Family Life Insurance Company or its reinsurers may make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. Should you apply for life or health insurance, or submit a claim for benefits to another member company, the Medical Information Bureau, upon request from that member company, will supply the information in its file. Upon written request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's Information Office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, telephone number (781) 751-6000. We or our reinsurers may also release information in our file to other life insurance companies to whom you apply for life or health insurance or to whom a claim for benefits may be submitted.

**FAMILY LIFE INSURANCE COMPANY**  
**[10700 Northwest Freeway**  
**Houston, TX 77092]**

**POLICY BENEFIT SCHEDULE**

**Limited Hospital Confinement and Other Fixed Indemnity Benefits**

For questions or information on premiums or claims, call [1-800-877-7705].

<b>Policyholder:</b>		[Name]	Effective Date: [XX/XX/XXXX] Renewal Date:[xx/xx/xxxx]
[Covered Dependents:]		[Spouse's Name] [Dependent Child's Name] [Dependent Child's Name]	
<b>Policy Number:</b>		[XXXXXXXX]	
<b>Initial Payment Option Mode:</b>	[Monthly]	<b>Initial Modal Premium:</b>	[\$XXX.XX]
<b>HOSPITAL CONFINEMENT AND OTHER FIXED INDEMNITY BENEFITS</b>			
<b>Maximum Lifetime Benefit:</b>		[\$25,000-5,000,000] – All benefit payments apply to the Maximum Lifetime Benefit unless otherwise indicated.	
<b>Inpatient Hospital Confinement Benefits:</b>		<ul style="list-style-type: none"> <li>• Scheduled Benefit per Inpatient Day of a Confinement Period due to Sickness: \$[100-10,000].</li> <li>• Scheduled Benefit per Inpatient Day of a Confinement Period due to Injury: \$[100-10,000].</li> <li>• If treated for both a Sickness and an Injury during a Confinement Period, only the Injury benefit above will be paid.</li> <li>• All Inpatient Hospital Confinement Benefits are limited to a Maximum Benefit of \$[10,000-300,000] per Calendar Year, per Covered Person.</li> </ul>	
<b>Hospital Admission Benefits:</b>		<ul style="list-style-type: none"> <li>• Scheduled Benefit per Hospital Admission Event: \$[10-10,000].</li> </ul>	
<b>Emergency Room and Urgent Care Facility Visit Benefits:</b>		<ul style="list-style-type: none"> <li>• Scheduled Benefit per Emergency Room visit: \$[10-500].</li> <li>• Scheduled Benefit per Urgent Care visit: \$[10-500].</li> <li>• All Emergency Room Visit Benefits and Urgent Care Visit Benefits combined are limited to a Maximum Benefit of [1-5] visit[s] per Calendar Year, per Covered Person.</li> </ul>	

<b>Outpatient Medical Event Benefits:</b>	<p>All Outpatient Medical Event Benefits combined are limited to a Maximum Benefit of \$[250-10,000] per Calendar Year, per Covered Person. Scheduled Benefits:</p> <table border="1" data-bbox="592 220 1502 812"> <thead> <tr> <th data-bbox="597 226 1258 289">Outpatient Medical Event</th> <th data-bbox="1263 226 1497 289">Scheduled Benefit</th> </tr> </thead> <tbody> <tr> <td colspan="2" data-bbox="597 296 1497 327"><b>Laboratory Service</b></td> </tr> <tr> <td data-bbox="597 333 1258 365">Surgical Pathology</td> <td data-bbox="1263 333 1497 365">\$[10-1,000]</td> </tr> <tr> <td data-bbox="597 371 1258 403">All other laboratory services</td> <td data-bbox="1263 371 1497 403">\$[5-500]</td> </tr> <tr> <td colspan="2" data-bbox="597 409 1497 441"><b>Radiology Services</b></td> </tr> <tr> <td data-bbox="597 447 1258 478">Mammogram</td> <td data-bbox="1263 447 1497 478">\$[10-2,500]</td> </tr> <tr> <td data-bbox="597 485 1258 516">Computerized Tomography Scan (CT)</td> <td data-bbox="1263 485 1497 516">\$[10-2,500]</td> </tr> <tr> <td data-bbox="597 522 1258 554">Magnetic Resonance Imaging (MRI)</td> <td data-bbox="1263 522 1497 554">\$[10-2,500]</td> </tr> <tr> <td data-bbox="597 560 1258 592">Positron Emission Tomography Scan (PET)</td> <td data-bbox="1263 560 1497 592">\$[10-2,500]</td> </tr> <tr> <td data-bbox="597 598 1258 630">All other radiology services</td> <td data-bbox="1263 598 1497 630">\$[10-1,000]</td> </tr> <tr> <td colspan="2" data-bbox="597 636 1497 667"><b>Physical Medicine</b></td> </tr> <tr> <td data-bbox="597 674 1258 705">Physical Therapy (PT)</td> <td data-bbox="1263 674 1497 705">\$[10-1,000]</td> </tr> <tr> <td data-bbox="597 711 1258 743">Occupational Therapy (OT)</td> <td data-bbox="1263 711 1497 743">\$[10-1,000]</td> </tr> <tr> <td data-bbox="597 749 1258 781">Speech Therapy (ST)</td> <td data-bbox="1263 749 1497 781">\$[10-1,000]</td> </tr> <tr> <td data-bbox="597 787 1258 812"><b>All Other Outpatient Events</b>, not otherwise Shown on this Benefit Schedule</td> <td data-bbox="1263 787 1497 812">\$[10-1,000]</td> </tr> </tbody> </table>	Outpatient Medical Event	Scheduled Benefit	<b>Laboratory Service</b>		Surgical Pathology	\$[10-1,000]	All other laboratory services	\$[5-500]	<b>Radiology Services</b>		Mammogram	\$[10-2,500]	Computerized Tomography Scan (CT)	\$[10-2,500]	Magnetic Resonance Imaging (MRI)	\$[10-2,500]	Positron Emission Tomography Scan (PET)	\$[10-2,500]	All other radiology services	\$[10-1,000]	<b>Physical Medicine</b>		Physical Therapy (PT)	\$[10-1,000]	Occupational Therapy (OT)	\$[10-1,000]	Speech Therapy (ST)	\$[10-1,000]	<b>All Other Outpatient Events</b> , not otherwise Shown on this Benefit Schedule	\$[10-1,000]
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<b>Office Visit Benefits:</b>	<ul style="list-style-type: none"> <li>• Scheduled Benefit: \$[25-500] per Office Visit in a Health Care Practitioner's office.</li> <li>• Office Visit Benefits are limited to a Maximum Benefit of [1-12] visit[s] per Calendar Year, per Covered Person.</li> </ul>																														
<b>Immunization and Allergy Immunotherapy Injection Benefits:</b>	<ul style="list-style-type: none"> <li>• Scheduled Benefit per Immunization: \$[5-250].</li> <li>• Scheduled Benefit per Allergy Immunotherapy Injection: \$[5-250].</li> <li>• All Immunization and Allergy Immunotherapy Injection Benefits combined are limited to a Maximum Benefit of \$[50-1,000] per Calendar Year, per Covered Person.</li> </ul>																														
<b>[Outpatient Prescription Order Benefits:</b>	<ul style="list-style-type: none"> <li>• Scheduled Benefit per Generic Prescription Drug: \$[5-25].</li> <li>• Scheduled Benefit per Brand Name Prescription Drug: \$[10-100].</li> <li>• If a Generic Prescription Drug is available and You receive a Brand Name Prescription Drug, only the Scheduled Benefit for the Generic Prescription Drug will be paid.</li> <li>• All Outpatient Prescription Order Benefits are limited a Maximum Benefit of \$[100-2,500] per Calendar Year, per Covered Person.]</li> </ul>																														
<b>Professional Ground or Air Ambulance Service Benefits:</b>	<ul style="list-style-type: none"> <li>• Scheduled Benefit per trip by ground ambulance: \$[10-1,000].</li> <li>• Scheduled Benefit per trip by air ambulance: \$[500-10,000].</li> <li>• All Professional Ground or Air Ambulance Service Benefits combined are limited to a Maximum Benefit of [1-5] one-way trip[s] per Calendar Year, per Covered Person.</li> </ul>																														
<b>Anesthesia Benefits:</b>	<ul style="list-style-type: none"> <li>• 20% of the Surgical Benefit Amount listed on the Schedule per Anesthesia event: \$[10-5,000].</li> <li>• All Anesthesia Benefits are limited to a Maximum Benefit of [1-5] Covered Event[s] per Calendar Year, per Covered Person.</li> </ul>																														

<b>Assisting Surgeon Benefits:</b>	<ul style="list-style-type: none"> <li>• If an Assistant Surgeon is required to assist the Surgeon during the operation, we will pay a maximum of [20%] of the surgical benefit amount payable for the operation listed on the Surgical Schedule.</li> </ul>
<b>Surgical Services Benefits:</b>	<ul style="list-style-type: none"> <li>• The Scheduled Benefit for surgical Covered Events is the amount shown in the Surgical Schedule for the corresponding Surgical Event.</li> <li>• Two or more Surgical Events performed during the same operative session are considered one operation and the Surgical Services Benefit will be paid based on the event with the highest Scheduled Benefit shown in the Surgical Schedule.</li> <li>• All Surgical Services Benefits are limited to a Maximum Benefit of \$[5,000-250,000] per Calendar Year, per Covered Person.</li> </ul>

For questions or information on premiums or claims, call [1-800-877-7705].

## Family Life Insurance Company

[10700 Northwest Freeway, Houston, TX 77092]

## Surgical Schedule for Limited-Benefit Plans

We will pay the Scheduled Benefit shown below when the corresponding surgical covered Event occurs as shown below and subject to the conditions and limitations of the Surgical Services Benefits provision.

### SURGICAL EVENT ON CARDIOVASCULAR SYSTEM

Insertion of electrode leads and pulse generator .....	\$960
Upgrade of implanted pacemaker system, including conversion of a single chamber system to a dual chamber system .....	\$520
Valvotomy, mitral valve; closed heart .....	\$1,600
Valvotomy, pulmonary valve, closed heart transventricular .....	\$1,370
Valvuloplasty, mitral valve, with cardiopulmonary bypass .....	\$3,090
Valvuloplasty, open, with cardiopulmonary bypass.....	\$2,570
Valvuloplasty, open, with inflow occlusion .....	\$1,550
Repair atrial septal defect, secundum, with cardiopulmonary bypass, with or without patch .....	\$1,860
Ligation, division, and stripping, short or long saphenous vein .....	\$520
Ligation, division, and stripping, of short and long saphenous vein, bilateral .....	\$520
Catheterization – left heart.....	\$980

### SURGICAL EVENT ON DIGESTIVE SYSTEM

Biopsy of salivary gland, needle .....	\$110
Biopsy of salivary gland, incisional .....	\$320
Tonsillectomy, with or without adenoidectomy, under 12 years of age .....	\$310
Tonsillectomy, with or without adenoidectomy, 12 and over years of age .....	\$310
Excision, local; ulcer or benign tumor of stomach .....	\$1,070
Gastrectomy, total .....	\$2,150
Colectomy, total, with proctectomy; with ileostomy .....	\$2,160
Incision and drainage of appendicular abscess, open .....	\$840
Appendectomy open.....	\$700
Appendectomy laparoscopic.....	\$650
Proctectomy; complete, combined abdominoperineal, with colostomy .....	\$2,080
Colonoscopy, diagnostic or preventive screening .....	\$400
Colonoscopy with biopsy .....	\$470
Colonoscopy with removal of tumor, polyp or other lesions .....	\$540
Upper Gastro-Intestinal (GI) Endoscopy with biopsy.....	\$340
Upper Gastro-Intestinal (GI) Endoscopy – diagnostic.....	\$290
Incision of rectal fistula, superficial .....	\$500
Fissurectomy, with or without sphincterotomy .....	\$450
Hemorrhoidectomy, external, complete .....	\$470
Hemorrhoidectomy, internal and external, complete .....	\$520
Cholecystectomy (removal of gall bladder) – open without exploration of common duct .....	\$1,180
Cholecystectomy – open with exploration of common duct .....	\$1,370
Cholecystectomy – laparoscopic, with or without Exploration of common duct .....	\$810
Cholecystectomy – laparoscopic, with graph .....	\$820

Pancreatectomy, total .....	\$1,960
Exploratory laparotomy; exploratory celiotomy .....	\$840
Repair inguinal hernia; sliding; any age .....	\$620
Repair initial femoral hernia .....	\$620

### SURGICAL EVENT ON EAR

Tympanostomy .....	\$200
Stapes mobilization .....	\$870
Fenestration of semicircular canal .....	\$930

### SURGICAL EVENT ON EYE

Removal of foreign body, conjunctival, superficial.....	\$60
Removal of foreign body, corneal, with or without slit lamp .....	\$70
Excision or transposition of pterygium; without graft .....	\$250
Cataract removal, intra capsular, extracapsular, with insertion of intraocular lens .....	\$810
Repair of retinal detachment; scleral buckling, with or without implant .....	\$1,330
Muscle operation involving one or more muscles in one or both eyes .....	\$760

### SURGICAL EVENT RELATED TO GYNECOLOGY

Incision and drainage of Bartholin's gland abscess .....	\$130
Excision of Bartholin's gland or cyst .....	\$330
Anterior colporrhaphy, repair of cystocele, with or without repair of urethrocele .....	\$730
Posterior colporrhaphy, repair of rectocele with or without perineorrhaphy.....	\$740
Combined anteroposterior colporrhaphy .....	\$920
Cautery of cervix; electro or thermal .....	\$140
Dilation and curettage, diagnostic and/or therapeutic (non-obstetrical) .....	\$270
Total abdominal hysterectomy (corpus and cervix), with or without removal of tube (s), with or without removal of ovary (s) .....	\$1,100
Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube (s), with or without removal of ovary (s) ....	\$1,060
Radical abdominal hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with or without removal of tube (s), with or without removal of ovary (s) .....	\$1,940
Salpingectomy, complete or partial, unilateral or bilateral (separate procedure) .....	\$850
Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure) .....	\$790
Hysteroscopy – biopsy.....	\$410
Hysteroscopy – ablation .....	\$1,600

### SURGICAL EVENT MUSCULOSKELETAL SYSTEM

Muscle biopsy, superficial .....	\$200
Muscle biopsy, deep.....	\$290
Arthrocentesis, large joint.....	\$80
Removal of implant; superficial, (e.g., buried wire, pin or rod) (separate procedure) .....	\$380

**SURGICAL EVENT ON****MUSCULOSKELETAL SYSTEM (cont.)**

Closed treatment of mandibular fracture with interdental fixation .....	\$920
Arthrodesis, including laminectomy and/or diskectomy .....	\$1,650
Closed treatment of clavicular fracture; without manipulation .....	\$220
Open treatment of clavicular fracture, with or without internal or external fixation .....	\$770
Closed treatment of proximal humeral (surgical or anatomical neck) fracture, with or without manipulation.....	\$330
Open treatment of proximal humeral (surgical or anatomical neck) fracture, with or without internal or external fixation, with or without repair of tuberosity (s).....	\$940
Closed treatment of shoulder dislocation, with manipulation; without anesthesia .....	\$310
Closed treatment of shoulder dislocation, with manipulation; requiring anesthesia .....	\$410
Open treatment of acute shoulder dislocation .....	\$620
Arthroscopy – shoulder .....	\$710
Arthrotomy, elbow, including exploration, drainage, or removal of foreign body .....	\$500
Treatment of closed elbow dislocation; without anesthesia .....	\$370
Treatment of closed elbow dislocation; requiring anesthesia .....	\$390
Open treatment of acute or chronic elbow dislocation .....	\$760
Closed treatment of ulnar shaft fracture; without manipulation .....	\$260
Open treatment of ulnar shaft fracture .....	\$660
Closed treatment of radial and ulnar shaft fractures .....	\$280
Open treatment; fixation of radius or ulna .....	\$710
Open treatment; fixation of radius AND ulna .....	\$960
Closed treatment of distal radial fracture (e.g., Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid; without manipulation .....	\$300
Open treatment of distal radial fracture or epiphyseal separation, with internal fixation .....	\$780
Arthrotomy, with exploration, drainage, or removal of loose or foreign body; interphalangeal joint, each .....	\$400
Excision of lesion of tendon sheath or joint capsule (e.g., cyst, mucous cyst, or ganglion), hand or finger .....	\$570
Closed treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb; without manipulation, each .....	\$200
Open treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb; without manipulation, each .....	\$630
Amputation, finger or thumb, primary or secondary, any joint or phalanx, single including neurectomies; with direct closure .....	\$660
Arthrotomy, hip, including exploration or removal of loose or foreign body .....	\$1,040

Closed treatment of femoral fracture, proximal end, neck; without manipulation .....	\$500
Closed treatment of femoral fracture, proximal end, neck; with manipulation .....	\$820
Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement .....	\$1,290
Arthroplasty, hip .....	\$1,560
Arthroscopy, knee .....	\$790
Arthrotomy, knee, with exploration, drainage, or removal of foreign body .....	\$780
Amputation, thigh, through femur, any level .....	\$910
Amputation, thigh, through femur, any level; open, circular (guillotine) .....	\$760
Closed reduction of fracture of tibia, shaft .....	\$350
Closed treatment of tibial shaft fracture (with or without fibular fracture); with manipulation .....	\$560
Open treatment of fracture of tibia, shaft .....	\$950
Closed treatment of proximal fibula or shaft fracture; without manipulation .....	\$310
Open treatment of proximal fibula or shaft fracture, with or without internal or external fixation .....	\$760
Closed treatment of distal fibular fracture (lateral malleolus); without manipulation .....	\$320
Open treatment of distal fibular fracture (lateral malleolus) .....	\$760
Closed treatment of bimalleolar ankle fracture, (including Potts); without manipulation .....	\$340
Closed treatment of bimalleolar ankle fracture, (including Potts); with manipulation .....	\$490
Open treatment of bimalleolar ankle fracture, with or without internal or external fixation .....	\$830
Excision of lesion, tendon, tendon sheath, or capsule (including synovectomy) (e.g., cyst or ganglion); toes, wrist, forearm, foot, ankle .....	\$460
Carpal Tunnel surgery .....	\$450
Closed treatment of fracture great toe .....	\$150
Open treatment of fracture great toe .....	\$700
Closed treatment of fracture of toes, other than great toes, without manipulation, each .....	\$130
Open treatment of fracture of toes, other than great toes, without manipulation, each .....	\$590
Amputation, toe; interphalangeal joint .....	\$610

**SURGICAL EVENT ON NERVOUS SYSTEM**

Burr hole (s) with evacuation and/or drainage of hematoma, extradural or subdural .....	\$1,340
Burr holes, intracerebral .....	\$1,320
Craniectomy or craniotomy for evacuation of hematoma, supratentorial; extradural or subdural.....	\$2,220
Craniectomy or craniotomy for evacuation of hematoma, infratentorial; extradural or subdural.....	\$1,940
Craniectomy, trephination, bone flap craniotomy; for excision of brain tumor, supratentorial, except meningioma .....	\$2,320
Spinal puncture, lumbar, diagnostic .....	\$160
Injection procedure for myelography and/or computed tomography, spinal (other than C1-C2 and posterior fossa) .....	\$210
Injection procedure for diskography .....	\$340

**SURGICAL EVENT ON NERVOUS SYSTEM (cont)**

Laminectomy with decompression of spinal cord and discectomy, cervical .....	\$1,580
Laminotomy and/or excision of herniated intervertebral disk, single interspace .....	\$1,510
Sympathectomy, cervical.....	\$720
Sympathectomy, lumbar .....	\$720

**SURGICAL EVENT ON RESPIRATORY SYSTEM**

Excision of nasal polyp(s), simple .....	\$240
Excision of nasal polyp(s), extensive requiring hospitalization .....	\$460
Submucous resection, classic, nasal septum .....	\$670
Laryngectomy; total, without radical neck dissection .....	\$2,280
Laryngectomy; total, with radical neck dissection .....	\$2,840
Bronchoscopy, diagnostic without biopsy .....	\$320
Bronchoscopy with bronchial or endobronchial biopsy .....	\$340
Bronchoscopy with removal of foreign body .....	\$350
Bronchoscopy with excision of tumor .....	\$280
Thoracotomy, exploratory, including biopsy .....	\$1,060
Lobectomy, total, subtotal, or segmentation, single lobe .....	\$1,880
Bilobectomy .....	\$1,770
Pulmonary resection with concomitant thoracoplasty .....	\$2,290

**SURGICAL EVENT RELATED TO SKIN LESIONS, CYSTS AND MASTECTOMY**

Incision and drainage of abscess; simple or single.....	\$120
Incision and drainage of pilonidal cyst .....	\$170
Biopsy of skin, subcutaneous tissue and/or mucous membrane, single lesion .....	\$100
Biopsy of each additional lesion in addition to primary procedure .....	\$50
Excision, benign lesions including margins, except skin tag, 2cm or less .....	\$160
Excision, benign lesions including margins, except skin tag, over 2 cm .....	\$310
Excision of pilonidal cyst or sinus, simple .....	\$280
Excision of pilonidal cyst or sinus, extensive .....	\$590
Excision of pilonidal cyst or sinus, complicated .....	\$710
Destruction of benign or premalignant lesions; one lesion .....	\$80
Destruction of benign or premalignant lesions, second thru 14 lesions, each .....	\$50
Wart destruction, up to 14 .....	\$110
Wart destruction 15 or more .....	\$130
Excision of cyst, fibroadenoma, or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple or areolar lesion, open, male or female, one or more lesions .....	\$510
Mastectomy, simple, complete .....	\$1,090
Radical mastectomy, including breast, pectoral muscles and axillary lymph nodes .....	\$1,210
Immediate insertion of breast prosthesis following mastopexy, Mastectomy or in reconstruction .....	\$1,050
Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion .....	\$1,690
Breast reconstruction with latissimus dorsi flap, without prosthetic implant .....	\$1,860
Breast reconstruction with free flap .....	\$3,040

Breast reconstruction with other technique .....	\$1,510
Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM) .....	\$2,270

**SURGICAL EVENT RELATED TO THYROID**

Excision of cyst or adenoma of thyroid .....	\$720
Partial thyroidectomy unilateral .....	\$770
Thyroidectomy, total or complete .....	\$1,070
Total or subtotal for malignancy with limited neck dissection .....	\$1,460
Total or subtotal for malignancy with radical neck dissection .....	\$1,860
Thyroidectomy, removal of all remaining thyroid tissue following previous removal of a portion of thyroid .....	\$1,210

**SURGICAL EVENT RELATED TO URINARY SYSTEM**

Cystoscopy .....	\$210
Nephrectomy .....	\$1,140
Kidney lithotripsy .....	\$930
Excision or fulguration of Skene's glands .....	\$230

**SURGICAL EVENT FOR TRANSPLANTS**

Heart Transplant .....	\$5,460
Lung Transplant .....	\$3,680
Heart/Lung Transplant .....	\$3,880
Liver Transplant .....	\$5,330
Kidney Transplant .....	\$2,770
Pancreas Transplant .....	\$2,740
Bone Marrow/Stem Cell Transplant .....	\$140
Cornea Transplant .....	\$1,280
Skin Transplant .....	\$640

# **Family Life Insurance Company**

[10700 Northwest Freeway

Houston, TX 77092]

[800-877-7705]

## **OUTLINE OF COVERAGE FOR FORM FHCS10-AR HOSPITAL CONFINEMENT AND OTHER FIXED INDEMNITY INSURANCE REQUIRED OUTLINE OF COVERAGE**

**“READ YOUR POLICY CAREFULLY”** This outline of coverage provides a very brief description of the important features of Your Policy. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth, in detail, the rights and obligations of both You and Your insurance company. It is, therefore, important that You **READ YOUR POLICY CAREFULLY!** **The capitalized terms used in this Outline of Coverage are defined in your Policy.**

Hospital confinement and other fixed indemnity coverage are designed to provide You with a fixed daily benefit during periods of Hospital confinement, and specified medical and surgical Events from a covered Injury or Sickness. Coverage is provided for the benefits outlined in Section 2. The benefits described in Section 2 may be limited by Section 3.

### **SECTION 1: GENERAL PROVISIONS:**

**NOTICE:** This is not major medical insurance coverage. This plan provides fixed indemnity benefits for Hospital confinement and specified medical and surgical Events. Fixed indemnity benefits are paid in the amount stated on the Benefit Schedule for the Covered Event without regard to the cost of services rendered. This plan does not provide expense reimbursement for charges based on the amounts shown in Your health care provider’s statement.

**THIS IS NOT MEDICARE SUPPLEMENT INSURANCE COVERAGE.**

**THE PLAN HAS LIMITED BENEFITS AND ANNUAL MAXIMUMS. PLEASE READ YOUR POLICY CAREFULLY TO UNDERSTAND PLAN LIMITATIONS.**

### **HOSPITAL CONFINEMENT AND OTHER FIXED INDEMNITY PLAN:**

The plan is designed to provide only limited fixed indemnity benefits for Hospital confinement and other specified medical Events. An Event is an observable and distinct occurrence in which medical treatment, services or supplies are provided to a Covered Person.

### **PAYMENT OF BENEFITS:**

We will pay Scheduled Benefits only for the Covered Events listed in the Hospital Confinement and Other Fixed Indemnity Benefits section of Your Policy. The Scheduled Benefit amount and the Maximum Benefit for eligible Covered Events listed in this section are shown in the Benefit Schedule. Refer to the Exclusions section for occurrences in which benefits are not provided under this plan.

**COVERED EVENT:** A medical Event for which this plan provides a Scheduled Benefit and that meets all of the following requirements:

1. The treatment, services or supplies provided in connection with the Event are provided by a Health Care Practitioner, facility or supplier.
2. It is incurred by a Covered Person while coverage is in force under this plan as the result of Sickness or an Injury or for preventive medical services as specified in the Hospital Confinement and Other Fixed Indemnity Benefits section and the Benefit Schedule.
3. It is incurred for Events shown in the Hospital Confinement and Other Fixed Indemnity Benefits section and on the Benefit Schedule.
4. The occurrence includes treatment, services or supplies which are Medically Necessary.

**SECTION 2: BENEFITS PROVIDED BY THIS PLAN:**

Only the Covered Events described in the Hospital Confinement and Other Fixed Indemnity Benefits section of Your Policy are eligible for Scheduled Benefits. The Scheduled Benefit amount and the Maximum Benefit for eligible Covered Events are shown in the Benefit Schedule.

**BENEFIT SCHEDULE**

<b>Maximum Lifetime Benefit:</b>	<p>[\$25,000-5,000,000] – All benefit payments apply to the Maximum Lifetime Benefit unless otherwise indicated.</p>
<b>Inpatient Hospital Confinement Benefits:</b>	<ul style="list-style-type: none"> <li>• Scheduled Benefit per Inpatient Day of a Confinement Period due to Sickness: \$[100-10,000].</li> <li>• Scheduled Benefit per Inpatient Day of a Confinement Period due to Injury: \$[100-10,000].</li> <li>• If treated for both a Sickness and an Injury during a Confinement Period, only the Injury benefit above will be paid.</li> <li>• All Inpatient Hospital Confinement Benefits are limited to a Maximum Benefit of \$[10,000-300,000] per Calendar Year, per Covered Person.</li> </ul>
<b>Emergency Room and Urgent Care Facility Visit Benefits:</b>	<ul style="list-style-type: none"> <li>• Scheduled Benefit per Emergency Room visit: \$[10-500].</li> <li>• Scheduled Benefit per Urgent Care visit: \$[10-500].</li> <li>• All Emergency Room Visits Benefits and Urgent Care Visit Benefits combined are limited to a Maximum Benefit of [1-5] visit[s], per Calendar Year, per Covered Person.</li> </ul>

<b>Outpatient Medical Event Benefits:</b>	<ul style="list-style-type: none"> <li>All Outpatient Medical Event Benefits combined are limited to a Maximum Benefit of \$[250-10,000] per Calendar Year, per Covered Person.</li> <li>Scheduled Benefits: <table border="1" data-bbox="492 247 1448 1171"> <thead> <tr> <th data-bbox="492 247 1128 323">Outpatient Medical Event</th> <th data-bbox="1128 247 1448 323">Scheduled Benefit</th> </tr> </thead> <tbody> <tr> <td colspan="2" data-bbox="492 323 1448 373"><b>Laboratory Service</b></td> </tr> <tr> <td data-bbox="492 373 1128 420">Surgical Pathology</td> <td data-bbox="1128 373 1448 420">\$[10-1,000]</td> </tr> <tr> <td data-bbox="492 420 1128 466">All other laboratory services</td> <td data-bbox="1128 420 1448 466">\$[5-500]</td> </tr> <tr> <td colspan="2" data-bbox="492 466 1448 516"><b>Radiology Services</b></td> </tr> <tr> <td data-bbox="492 516 1128 567">Mammogram</td> <td data-bbox="1128 516 1448 567">\$[10-2,500]</td> </tr> <tr> <td data-bbox="492 567 1128 617">Computerized Tomography Scan (CT)</td> <td data-bbox="1128 567 1448 617">\$[10-2,500]</td> </tr> <tr> <td data-bbox="492 617 1128 667">Magnetic Resonance Imaging (MRI)</td> <td data-bbox="1128 617 1448 667">\$[10-2,500]</td> </tr> <tr> <td data-bbox="492 667 1128 718">Positron Emission Tomography Scan (PET)</td> <td data-bbox="1128 667 1448 718">\$[10-2,500]</td> </tr> <tr> <td data-bbox="492 718 1128 768">All other radiology services</td> <td data-bbox="1128 718 1448 768">\$[10-1,000]</td> </tr> <tr> <td colspan="2" data-bbox="492 768 1448 819"><b>Physical Medicine</b></td> </tr> <tr> <td data-bbox="492 819 1128 869">Physical Therapy (PT)</td> <td data-bbox="1128 819 1448 869">\$[10-1,000]</td> </tr> <tr> <td data-bbox="492 869 1128 919">Occupational Therapy (OT)</td> <td data-bbox="1128 869 1448 919">\$[10-1,000]</td> </tr> <tr> <td data-bbox="492 919 1128 970">Speech Therapy (ST)</td> <td data-bbox="1128 919 1448 970">\$[10-1,000]</td> </tr> <tr> <td data-bbox="492 970 1128 1020"></td> <td data-bbox="1128 970 1448 1020"></td> </tr> <tr> <td data-bbox="492 1020 1128 1071"><b>All Other Outpatient Events</b>, not otherwise shown on the Benefit Schedule</td> <td data-bbox="1128 1020 1448 1071">\$[10-1,000]</td> </tr> </tbody> </table> </li> </ul>	Outpatient Medical Event	Scheduled Benefit	<b>Laboratory Service</b>		Surgical Pathology	\$[10-1,000]	All other laboratory services	\$[5-500]	<b>Radiology Services</b>		Mammogram	\$[10-2,500]	Computerized Tomography Scan (CT)	\$[10-2,500]	Magnetic Resonance Imaging (MRI)	\$[10-2,500]	Positron Emission Tomography Scan (PET)	\$[10-2,500]	All other radiology services	\$[10-1,000]	<b>Physical Medicine</b>		Physical Therapy (PT)	\$[10-1,000]	Occupational Therapy (OT)	\$[10-1,000]	Speech Therapy (ST)	\$[10-1,000]			<b>All Other Outpatient Events</b> , not otherwise shown on the Benefit Schedule	\$[10-1,000]
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<b>Hospital Admission Benefits:</b>	<p>Scheduled Benefit per Hospital Admission Event: \$[10-10,000].</p>																																

<b>[Outpatient Prescription Order Benefits:</b>	<ul style="list-style-type: none"> <li>• Scheduled Benefit per Generic Prescription Drug: \$[5-50].</li> <li>• Scheduled Benefit per Brand Name Prescription Drug \$[10-100].</li> <li>• If a Generic Prescription Drug is available and You receive a Brand Name Prescription Drug, only the Scheduled Benefit for the Generic Prescription Drug will be paid.</li> <li>• All Outpatient Prescription Order Benefits are limited to a Maximum Benefit of \$[100-2,500] per Calendar Year, per Covered Person.]</li> </ul>
<b>Professional Ground or Air Ambulance Services Benefits:</b>	<ul style="list-style-type: none"> <li>• Scheduled Benefit per trip by ground ambulance: \$[10-1,000].</li> <li>• Scheduled Benefit per trip by air ambulance: \$[500-10,000].</li> <li>• All Professional Ground or Air Ambulance Services Benefits combined are limited to a Maximum Benefit of [1-5] one-way trip[s] per Calendar Year, per Covered Person.</li> </ul>
<b>Anesthesia Benefits:</b>	<ul style="list-style-type: none"> <li>• 20% of the Surgical Benefit and listed in the Schedule per Anesthesia event: \$[10-5,000].</li> <li>• All Anesthesia Benefits are limited to a Maximum Benefit of [1-5] Covered Event[s] per Calendar Year, per Covered Person.</li> </ul>
<b>Assisting Surgeon Benefits:</b>	<ul style="list-style-type: none"> <li>• If an Assistant Surgeon is required to assist the Surgeon during the operation, We will pay a maximum of [20%] of the Surgical benefit amount payable as listed in the Surgical Schedule.</li> </ul>
<b>Surgical Services Benefits:</b>	<ul style="list-style-type: none"> <li>• The Scheduled Benefit for surgical Covered Events is the amount shown in the Surgical Schedule in the Policy for the corresponding Surgical Event.</li> <li>• Two or more Surgical Events performed during the same operative session are considered one operation and the Surgical Services Benefit will be paid based on the event with the highest Scheduled Benefit shown in the Surgical Schedule.</li> <li>• All Surgical Services Benefits are limited to a Maximum Benefit of \$[5,000-250,000] per Calendar Year, per Covered Person.</li> </ul>

**Inpatient Hospital Confinement Benefit:**

We will pay the corresponding Scheduled Benefit amount for each day of Inpatient room and board during a Confinement Period under the orders of a Health Care Practitioner for care of a Sickness or an Injury.

When an Inpatient Hospital Confinement Benefit is payable, no other benefits are payable for the Covered Person under this plan for Events that occur during the same Confinement Period, except for eligible Surgical Services Benefits and/or Anesthesia Benefits. Benefits are limited to the Calendar Year Maximum Benefit shown on the Benefit Schedule.

**Hospital Admission Benefits:**

We will pay the corresponding Scheduled Benefit amount if a Covered Person is confined for the first time as a resident Inpatient during the Calendar Year. Confinement as a resident Inpatient means assigned to a Hospital bed for an overnight stay for Medically Necessary reasons resulting from Injury or Sickness on the advice of a Physician.

**Emergency Room Visits Benefits:**

We will pay the corresponding Scheduled Benefit amount upon the occurrence of a visit to an Emergency Room during which a Covered Person received Emergency Treatment.

When an Emergency Room Visit Benefit is payable, no other benefits are payable for the Covered Person under this plan for Events that occur during the same visit, except for eligible Surgical Services Benefits and/or Anesthesia Benefits. Benefits are limited to the Calendar Year Maximum Benefit shown on the Benefit Schedule.

**Urgent Care Facility Visit Benefits:**

We will pay the corresponding Scheduled Benefit amount upon the occurrence of a visit to an Urgent Care Facility during which a Covered Person receives Urgent Care treatment.

When an Urgent Care Facility Visit Benefit is payable, no other benefits are payable for the Covered Person under this plan for Events that occur during the same visit, except for eligible Surgical Services Benefits and/or Anesthesia Benefits. Benefits are limited to the Calendar Year Maximum Benefit shown on the Benefit Schedule.

**Outpatient Medical Event Benefits:**

We will pay the corresponding Scheduled Benefit amount upon occurrence of an Event wherein the Covered Person receives Outpatient treatment of a Sickness or Injury or preventive medicine services as recommended by the United States Preventive Services Task Force.

Those Covered Events for which benefits are considered under any other provision of this plan are not considered for benefits under this provision. Benefits are limited to the Calendar Year Maximum Benefit shown on the Benefit Schedule.

**Office Visit Benefits:**

We will pay the corresponding Scheduled Benefit amount upon the occurrence of an Office Visit for a Covered Person during which any of the following are rendered in a Health Care Practitioner's Office:

1. Professional services that are provided by or under the direction of a Health Care Practitioner for a Sickness or an Injury for:
  - a. Measuring height, weight and blood pressure;
  - b. Obtaining a health history;
  - c. Performing a physical examination;
  - d. Making a medical decision;
  - e. Explaining treatment options;
  - f. Developing a treatment plan; or
  - g. Instructions for management of the condition.

2. Professional services that are provided by or under the direction of a Health Care Practitioner for preventive medicine services for:
  - a. Measuring height, weight and blood pressure;
  - b. Obtaining a health history;
  - c. Performing a routine physical examination;
  - d. Explaining risk reduction behavior; or
  - e. Preventative medicine services as recommended by the United States Preventive Services Task Force.

Benefits are limited to the Calendar Year Maximum Benefit shown on the Benefit Schedule.

**Allergy Immunotherapy Injection Benefits:**

We will pay the corresponding Scheduled Benefit amount upon an occurrence of an allergy immunotherapy injection for a Covered Person. Benefits are limited to the Calendar Year Maximum Benefit shown on the Benefit Schedule.

**Immunization Benefits:**

We will pay the corresponding Scheduled Benefit amount for each immunization received by a Covered Person as recommended by the United States Preventive Services Task Force or the Advisory Committee on Immunization Practices on the date the immunization is rendered. Benefits are limited to the Calendar Year Maximum Benefit shown on the Benefit Schedule.

**[Outpatient Prescription Order Benefits:**

We will pay the corresponding Scheduled Benefit amount when a Covered Person fills a Prescription Order through an outpatient pharmacy. Refer to the Exclusions section for a description of what Prescription Orders or refills are not eligible for benefits under this plan.

This plan provides benefits only for Prescription Orders received on an Outpatient basis and comprised of:

- a. Prescription Drugs that are fully approved by the U.S. Food and Drug Administration (FDA) for marketing in the United States and can be obtained only with a Prescription Order from a Health Care Practitioner;
- b. Prescription Drugs in dosages, dosage forms, dosage regimens and duration of treatment that are Medically Necessary for the treatment of Sickness or Injury; and
- c. Prescription Drugs that are within the quality, supply, or other limits that We determine is appropriate for a Prescription Drug.

If a Generic Prescription Drug is available and You receive a Brand Name Prescription Drug, only the Scheduled Benefit for the Generic Prescription Drug will be paid. We will not pay benefits for Prescription Order refills in excess of a number specified on the Health Care Practitioner's Prescription Order or prescriptions refilled more frequently than the prescribed dosage indicates.]

**Professional Ground or Air Ambulance Services Benefits:**

We will pay the corresponding Scheduled Benefit when professional ground or air transportation in an ambulance is obtained by a Covered Person who needs Emergency Treatment for a Sickness or an Injury. Benefits are limited to the Calendar Year Maximum Benefit shown on the Benefit Schedule.

**Anesthesia Benefits:**

We will pay the corresponding Scheduled Benefit when a Covered Person is administered anesthesia as part of a Covered Event. Benefits are limited to the Calendar Year Maximum Benefit shown on the Benefit Schedule.

**Surgical Services Benefits:**

We will pay the corresponding Scheduled Benefit when a Covered Person obtains surgical treatment as shown on the Surgical Schedule.

When a Surgical Services Benefit is payable, no other benefits are payable for the Covered Person under this plan for Events that occur during the same surgical Event, except for Hospital Confinement Benefits and eligible Anesthesia Benefits.

Two or more surgical procedures performed during the same operative session are considered one operation and benefits will be paid based on the procedure with the highest Scheduled Benefit shown in the Surgical Schedule. If a surgical procedure is performed that is not specifically named in the Surgical Schedule, a benefit will be paid for the procedure identified in the Surgical Schedule that is most similar (in terms of technique and location on the body) to the procedure undergone by the Covered Person. Benefits are limited to the Calendar Year Maximum Benefit shown on the Benefit Schedule.

**Assisting Surgeon Benefits:**

If an Assistant Surgeon is required to assist the Surgeon during the operation, We will pay a maximum of [20%] of the Surgical Benefit amount shown in the Surgical Schedule for the operation performed.

**SECTION 3: LIMITATIONS AND EXCLUSIONS:**

**PRE-EXISTING CONDITIONS LIMITATION:** We will not pay benefits for Events that result from or are related to a Pre-Existing Condition, or its complications, until the Covered Person has been continuously insured under this plan for 12 months. After this period, benefits will be available for Events resulting from or related to a Pre-Existing Condition, or its complications, provided that the Covered Event occurs while this plan is in force. Pregnancy that exists on the Covered Person's Effective Date will be considered a Pre-Existing Condition under this plan.

**EXCLUSIONS:** This plan provides benefits only for Covered Events identified in the Hospital Confinement and Other Fixed Indemnity Benefits section. We will not pay benefits for claims resulting, whether directly or indirectly, from Events or loss related to or resulting from any of the following:

1. A Sickness or Injury that is the result of a work-related condition that is eligible for benefits under Worker's Compensation, Employers' Liability or similar laws even when the Covered Person does not file a claim for benefits. This exclusion will not apply to a Covered Person who is not required to have coverage under any Worker's Compensation, Employers' Liability or similar law and does not have such coverage. However, the Covered Person must receive services in accordance with the Hospital Confinement and Other Fixed Indemnity Benefits section.
2. War or any act of war, whether declared or undeclared.
3. Participation in the military service of any country or international organization.

4. Treatment, services or supplies that:
  - a. Are not parts of a specifically listed Covered Event shown on the Benefit Schedule;
  - b. Are due to complications of a non-covered service;
  - c. Are incurred before the Covered Persons' Effective Date or after the termination date of coverage, except as provided under the Extension of Benefits provision in the Other Provision section of the Policy; or
  - d. Are provided in a student health center or by or through a school system.
5. Glasses, contact lenses, vision therapy, exercise or training, surgery including any complications arising therefrom to correct visual acuity including, but not limited to, lasik and other laser surgery, radial keratotomy services or surgery to correct astigmatism, nearsightedness (myopia) and/or farsightedness (presbyopia), vision care that is routine.
6. Hearing care that is routine; any artificial hearing device, cochlear implant, auditory prostheses or other electrical, digital, mechanical or surgical means of enhancing, creating or restoring auditory comprehension.
7. Treatment for foot conditions including, but not limited to:
  - a. Flat foot conditions;
  - b. Foot supportive devices, including orthotics and corrective shoes;
  - c. Foot subluxation treatment;
  - d. Corns, bunions, calluses, toenails, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet; or
  - e. Hygienic foot care that is routine.
8. Dental treatment, dental care that is routine, bridges, crowns, caps, dentures, dental implants or other dental prostheses, dental braces or dental appliances, extraction of teeth, orthodontic treatment, odontogenic cysts, and other treatment or complication of teeth and gum tissue, except as otherwise covered for a Dental Injury.
9. Treatment of Temporomandibular Joint Dysfunction and Craniomandibular Joint Dysfunction; any appliance, medical or surgical treatment for malocclusion (teeth that do not fit together properly which creates a bite problem), protrusion or recession of the mandible (a large chin which causes an underbite or a small chin which causes an overbite), maxillary or mandibular hyperplasia (excess growth of the upper or lower jaw) or maxillary or mandibular hypoplasia (undergrowth of the upper and lower jaw).
10. Treatment of Behavioral Health or Substance Abuse, whether organic or non-organic, chemical or non-chemical, biological or non-biological in origin and irrespective of cause, basis or inducement, including, but not limited to, drugs and medicines for Inpatient or Outpatient treatment of Behavioral Health or Substance Abuse.
11. Any treatment, services, supplies, diagnosis, drugs, medications or regimen, whether medical or surgical, for purposes of controlling the Covered Person's weight or related to obesity or morbid obesity, whether or not weight reduction is Medically Necessary or appropriate or regardless of potential benefits for co-morbid conditions, weight reduction or weight control surgery, treatment or programs, any type of gastric bypass surgery, suction lipectomy, physical fitness programs, exercise equipment or exercise therapy, including health club membership visits or services, nutritional counseling.

12. Organ, tissue or cellular material donation by a Covered Person, including administrative visits for registry, computer search for donor matches, preliminary donor typing, donor counseling, donor identification and donor activation.
13. Chemical peels, reconstructive or plastic surgery that does not alleviate a functional impairment and other confinement or treatment visits that are primarily for a Cosmetic Service as determined by Us.
14. Capsular contraction, augmentation or reduction mammoplasty, except for all stages and revisions of reconstruction of the breast following a Medically Necessary mastectomy for treatment of cancer, including reconstruction of the other breast to produce a symmetrical appearance and treatment of lymphedemas.
15. Removal or replacement of a prosthesis, Durable Medical Equipment or Personal Medical Equipment, except for internal breast prostheses following a Medically Necessary mastectomy for treatment of cancer and services are received in accordance with the Hospital Confinement and Other Fixed Indemnity Benefits section.
16. Prophylactic treatment, services or surgery including, but not limited to, prophylactic mastectomy or any other treatment, services or surgery performed to prevent a disease process from becoming evident in the organ or tissue at a later date.
17. Treatment, services, and supplies for:
  - a. Home Health Care;
  - b. Hospice Care;
  - c. Skilled Nursing Facility care; Inpatient rehabilitation services;
  - d. Custodial Care, respite care, rest care, supportive care, homemaker services;
  - e. Phone, facsimile, internet or e-mail consultations, compressed digital interactive video, audio or clinical data transmission using computer imaging by way of still-image capture and store forward, [except for] [including] Telemedicine Services or Telehealth Services or technology that facilitates access to a Health Care Practitioner;
  - f. Treatment, services or supplies that are furnished primarily for the personal comfort or convenience of the Covered Person, Covered Person's family, a Health Care Practitioner or provider;
  - g. Treatment or services provided by a standby Health Care Practitioner; or
  - h. Treatment or services provided by a masseur, masseuse or massage therapist, massage therapy, a rolfer.
18. Treatment, services and supplies for growth hormone therapy, including growth hormone medication and its derivatives or other drugs used to stimulate, promote or delay growth or to delay puberty to allow for increased growth.
19. Treatment, services and supplies related to the following conditions, regardless of underlying causes: sex transformation, gender dysphoric disorder, gender reassignment, treatment of sexual function, dysfunction or inadequacy, treatment to enhance, restore or improve sexual energy, performance or desire.
20. Treatment, services and supplies related to: maternity, pregnancy (except Complications of Pregnancy), routine well newborn care at birth including nursery care, abortion.

21. Contraceptive procedures, contraceptive drugs or devices, not dispensed from a pharmacy, including, but not limited to, contraceptive patches, contraceptive vaginal rings, diaphragms, injectable contraceptives and contraceptive implants.
22. Treatment for or through use of:
  - a. Genetic testing or counseling, genetic services and related procedures for screening purposes including, but not limited to, amniocentesis and chronic villi testing;
  - b. Services, drugs or medicines used to treat males or females for an infertility diagnosis regardless of intended use including, but not limited to, artificial insemination, in vitro fertilization, reversal of reproductive sterilization, any treatment to promote conception;
  - c. Sterilization;
  - d. Cryopreservation of sperm or eggs;
  - e. Surrogate pregnancy;
  - f. Fetal surgery, treatment or services;
  - g. Umbilical cord stem cell or other blood component harvest and storage in the absence of a Sickness or an Injury; or
  - h. Circumcision.
23. Spinal and other adjustments, manipulations, subluxation treatment and/or services.
24. Treatment for: behavior modification or behavioral (conduct) problems, learning disabilities, developmental delays, attention deficit disorders, hyperactivity, educational testing, training or materials, except for Outpatient diabetes self-management training and education for treatment of a Covered Person with diabetes, memory improvement, cognitive enhancement or training, vocational or work hardening programs, transitional living.
25. Treatment for or through use of:
  - a. Non-medical items, self-care or self-help programs;
  - b. Aroma therapy;
  - c. Meditation or relaxation therapy;
  - d. Naturopathic medicine;
  - e. Treatment of hyperhidrosis (excessive sweating);
  - f. Acupuncture, biofeedback, neurotherapy, electrical stimulation;
  - g. Inpatient treatment of chronic pain disorders;
  - h. Treatment of spider veins;
  - i. Family or marriage counseling;
  - j. Applied behavior therapy treatment for autistic spectrum disorders;
  - k. Smoking deterrence or cessation;
  - l. Snoring or sleep disorders;
  - m. Change in skin coloring or pigmentation; or
  - n. Stress management.
26. A Sickness or Injury resulting from abuse or overdose of any illegal or controlled substance, except when administered in accordance with the advice of the Covered Person's Health Care Practitioner.
27. Treatment of a Sickness or an Injury when a contributing cause of the condition was the Covered Person's voluntary attempt to commit or participation in or commission of a felony, whether or not charged, or as a consequence of the Covered Person being under the influence of any illegal or non-prescribed controlled substance while committing a felony.

28. Services ordered, directed or performed by a Health Care Practitioner or supplies purchased from a Medical Supply Provider who is a Covered Person, an Immediate Family Member, employer of a Covered Person or a person who ordinarily resides with a Covered Person.
29. Any amount in excess of the Maximum Lifetime Benefit or any other Maximum Benefit limitation for covered Scheduled Benefits.
30. Treatment that does not meet the definition of a Covered Event in the Policy including, but not limited to, treatment that is not Medically Necessary.
31. Treatment, services and supplies for Experimental or Investigational Services.
32. Treatment incurred outside of the United States, including drugs or medicines obtained from pharmacy provider sources outside the United States.
33. Sickness or Injury caused or aggravated by suicide, attempted suicide or self-inflicted Sickness or Injury.
34. Vitamins and/or vitamin combinations even if they are prescribed by a Health Care Practitioner.
35. Any over-the counter or prescription products, drugs or medicines in the following categories, whether or not prescribed by a Health Care Practitioner:
  - a. Herbal or homeopathic medicines or products;
  - b. Minerals;
  - c. Health and beauty aids;
  - d. Batteries;
  - e. Appetite suppressants;
  - f. Dietary or nutritional substances or dietary supplements;
  - g. Nutraceuticals;
  - h. Tube feeding formulas and infant formulas;
  - i. Medical foods; or
  - j. Devices or supplies including, but not limited to, support garments, bandages and non-medical items regardless of intended use, except for injectable insulin and testing devices, needles and syringes as described under a Prescription Order for treatment of a Covered Person with diabetes who receives these drugs, medicines or supplies in accordance with the Hospital Confinement and Other Fixed Indemnity Benefits section.
36. Drugs or medicines that have an over-the-counter equivalent or contain the same or therapeutically equivalent active ingredient(s) as over-the-counter medication, as determined by Us.
37. Drugs or medicines: administered or dispensed at or by a rest home, sanitarium, extended care facility, convalescent care facility, Skilled Nursing Facility or similar institution, dispensed at or by a Hospital, an Emergency Room, a Free-Standing Facility, an Urgent Care Facility, a Health Care Practitioner's office or other Inpatient or Outpatient setting for take home by the Covered Person.

- 38. Drugs or medicines used to treat, impact or influence: athletic performance, body conditioning, strengthening, or energy, social phobias, slowing the normal process of aging, daytime drowsiness, overactive bladder, dry mouth, excessive salivation, genetic make-up or genetic predisposition, prevention or treatment of hair loss, excessive hair growth or abnormal hair patterns.
- 39. Unit-dose drugs; drugs or medicines used to treat onychomycosis (nail fungus); botulinum toxin and its derivatives.
- 40. Drugs or medicines prescribed for treatment of a condition that is specifically excluded under the Policy.
- 41. Drugs, medicines or supplies that are illegal under federal law, such as marijuana, even if they are prescribed for medical use in a state.
- 42. Duplicate prescriptions, replacement of lost, stolen, destroyed, spilled or damaged prescriptions; Prescription Order refills in excess of the number specified on the Health Care Practitioner's Prescription Order; Prescriptions refilled after one year from the Health Care Practitioner's original Prescription Order, any administration for drug injections or any other drugs or medicines obtained other than through a pharmacy.

**SECTION 4: RENEWABILITY PROVISIONS:**

The Policy is Conditionally Renewable. This means that You have the right to renew the Policy until the Policy anniversary on or after Your 65<sup>th</sup> birthday if You pay the correct premium when due or within the Grace Period.

**SECTION 5: PREMIUM:**

Premiums may be changed at any renewal date. The new rate will be guaranteed for 12 months. We will give 60 days notice before premiums will be changed.

The Policy provides a 31-day grace period during which period the Policy will remain in force.

<b>PREMIUM INFORMATION</b>
<b>Initial Annual Premium:</b> _____
<b>Initial Premium Payment Mode:</b> _____
<b>INITIAL MODAL PREMIUM AMOUNT: \$</b> _____

\_\_\_\_\_  
Licensed Agent's Signature

\_\_\_\_\_  
Date

SERFF Tracking Number: EWLE-126900860 State: Arkansas  
 Filing Company: Family Life Insurance Company State Tracking Number: 47296  
 Company Tracking Number:  
 TOI: H14I Individual Health - Hospital Indemnity Sub-TOI: H14I.000 Health - Hospital Indemnity  
 Product Name: Hospital Confinement and Surgical Fixed Indemnity Policy  
 Project Name/Number: /

## Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
Approved-Closed 11/19/2010	Hospital Confinement and Surgical Fixed Indemnity Policy	FHCS10-AR	New		FLIC_FHCS10_Rates_Only_Arkansas_10-12-10[1].pdf

**Hospital Confinement and Surgical Fixed Indemnity Insurance Policy  
Policy Form – FHCS10  
Premium Exhibit**

**Monthly Premiums**

	Tier	Plan A	Plan B
Ages 18-29	Individual	\$102.71	\$122.85
	Individual & Spouse	\$205.41	\$245.70
	Individual & Child(ren)	\$227.09	\$280.35
	Individual & Family	\$357.43	\$438.20
	Individual, Spouse, & 1 Child	\$274.51	\$333.20
	Child Only	\$69.10	\$87.50
Ages 30-39	Individual	\$123.59	\$147.83
	Individual & Spouse	\$247.18	\$295.65
	Individual & Child(ren)	\$247.97	\$305.33
	Individual & Family	\$399.20	\$488.16
	Individual, Spouse, & 1 Child	\$316.28	\$383.16
	Child Only	\$69.10	\$87.50
Ages 40-49	Individual	\$150.76	\$180.33
	Individual & Spouse	\$301.53	\$360.66
	Individual & Child(ren)	\$275.14	\$337.83
	Individual & Family	\$453.54	\$553.16
	Individual, Spouse, & 1 Child	\$370.62	\$448.16
	Child Only	\$69.10	\$87.50
Ages 50-64	Individual	\$193.39	\$231.32
	Individual & Spouse	\$386.79	\$462.64
	Individual & Child(ren)	\$317.77	\$388.83
	Individual & Family	\$538.81	\$655.15
	Individual, Spouse, & 1 Child	\$455.89	\$550.15
	Child Only	\$69.10	\$87.50

SERFF Tracking Number: EWLE-126900860 State: Arkansas  
 Filing Company: Family Life Insurance Company State Tracking Number: 47296  
 Company Tracking Number:  
 TOI: H14I Individual Health - Hospital Indemnity Sub-TOI: H14I.000 Health - Hospital Indemnity  
 Product Name: Hospital Confinement and Surgical Fixed Indemnity Policy  
 Project Name/Number: /

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification <b>Comments:</b> <b>Attachment:</b> ReadabilitycertificateFL.pdf	Approved-Closed	11/19/2010

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> Application <b>Bypass Reason:</b> Shown in Form Schedule <b>Comments:</b>	Approved-Closed	11/19/2010

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Bypassed - Item:</b> Outline of Coverage <b>Bypass Reason:</b> Shown in Form Schedule <b>Comments:</b>	Approved-Closed	11/19/2010

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Authorization to File <b>Comments:</b> <b>Attachment:</b> Authorization-FLIC.pdf	Approved-Closed	11/19/2010

## Readability Certification

Insurance Company: Family Life Insurance Company

<u>Form Number</u>	<u>Description of Form</u>	<u>Score</u>
FHCS10-AR	Hospital Confinement and Surgical Fixed Indemnity Policy	50.6
FHCSAPP10-AR	Application	51.7
FHCS10-PS	Policy Schedule	Scored with Policy
FHCS10-SS	Surgical Schedule	Scored with Policy
FHCS10-OC-AR	Outline of Coverage	52.9

I hereby certify that the above referenced form complies with the readability requirements of this State.

*Mary Lou Rainey*

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Authorized Signature

Mary Lou Rainey

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Name

Secretary

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Title

November 11, 2010

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Date

# FAMILY LIFE

January 1, 2010

Filing Authorization  
Lewis & Ellis, Inc.  
P.O. Box 851857  
Richardson, TX 75085-1857

**RE: Family Life Insurance Company**

To Whom it May Concern:

We hereby authorize Lewis & Ellis, Inc. to submit state filings of insurance forms/rates/products on behalf of Family Life Insurance Company.

This authorization includes the power to provide necessary assurances and certifications related to such forms, rates and or products except as prohibited by law.

This authorization is to be effective until revoked in writing by an authorized representative of Family Life Insurance Company.

Sincerely,

**FAMILY LIFE INSURANCE COMPANY**

*Mary Lou Rainey*

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Signature of Company Officer/Representative

