

SERFF Tracking Number: MCHX-126596491 State: Arkansas
 Filing Company: Time Insurance Company State Tracking Number: 45485
 Company Tracking Number: 292.CER.AR
 TOI: H14G Group Health - Hospital Indemnity Sub-TOI: H14G.000 Health - Hospital Indemnity
 Product Name: 292.CER.XX Group Hospital-Medical Indemnity Time
 Project Name/Number: 292.CER.XX Group Hospital-Medical Indemnity Time Insurance Company /292.CER.XX Group Hospital-Medical Indemnity Time Insurance Company

Filing at a Glance

Company: Time Insurance Company

Product Name: 292.CER.XX Group Hospital-Medical Indemnity Time SERFF Tr Num: MCHX-126596491 State: Arkansas

TOI: H14G Group Health - Hospital Indemnity SERFF Status: Closed-Approved-Closed State Tr Num: 45485

Sub-TOI: H14G.000 Health - Hospital Indemnity Co Tr Num: 292.CER.AR State Status: Approved-Closed
 Filing Type: Form Reviewer(s): Rosalind Minor

Author: SPI McHughConsulting Disposition Date: 04/29/2010
 Date Submitted: 04/22/2010 Disposition Status: Approved-Closed

Implementation Date Requested: 05/22/2010

Implementation Date:

State Filing Description:

General Information

Project Name: 292.CER.XX Group Hospital-Medical Indemnity Time Insurance Company Status of Filing in Domicile: Not Filed

Project Number: 292.CER.XX Group Hospital-Medical Indemnity Time Insurance Company Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: The state of Wisconsin does not require the filing of forms that are being marketed for out-of-state use with their office.

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Large

Overall Rate Impact:

Group Market Type: Association

Filing Status Changed: 04/29/2010

Explanation for Other Group Market Type:

State Status Changed: 04/29/2010

Deemer Date:

Created By: SPI McHughConsulting

Submitted By: SPI McHughConsulting

Corresponding Filing Tracking Number:

Filing Description:

TIME INSURANCE COMPANY (NAIC #69477; FEIN 39-0658730)

Hospital Confinement and Other Fixed Indemnity Insurance form:292.CER.AR et al.

SERFF Tracking Number: MCHX-126596491 State: Arkansas
Filing Company: Time Insurance Company State Tracking Number: 45485
Company Tracking Number: 292.CER.AR
TOI: H14G Group Health - Hospital Indemnity Sub-TOI: H14G.000 Health - Hospital Indemnity
Product Name: 292.CER.XX Group Hospital-Medical Indemnity Time
Project Name/Number: 292.CER.XX Group Hospital-Medical Indemnity Time Insurance Company /292.CER.XX Group Hospital-Medical Indemnity Time Insurance Company

McHugh Consulting Resources, Inc. has been requested to file the attached forms on behalf of Time Insurance Company. We have provided an authorization letter for your files.

The enclosed forms are hereby submitted for your review seeking approval. These forms are new and do not replace any forms currently on file with your office. These forms will be used to issue limited benefit insurance providing fixed indemnity benefits for hospital confinement and other specified medical and surgical events on an underwritten basis in the individual market. This plan does not provide expense reimbursement for billed charges by a health care provider or coverage for health care services or supplies. This plan is designed as a non-coordinated, limited hospital confinement and other fixed indemnity plan, defined in federal code (42 U.S.C. s. 300gg-91) as an "excepted benefit" plan and is therefore exempt from the HIPAA reform requirements of federal code Title 42 pursuant to the exemption provided at 42 U.S.C. s. 300gg-63.

This coverage is offered for benefit of individuals who are members of a non-employer sponsored association, and coverage will be offered by independent agents licensed in your state. The master group policy is issued and delivered to the association group policyholder in the state of Illinois.

Coverage may be offered with supplemental term life insurance rider, form 4797, previously approved by your office on 07/15/2008 enclosed herewith for review.

For your ease in reference, a listing of all submitted forms is enclosed. Please note that the form is numbered using a matrix format, where each section of the document has a unique form number. For example, the face page is numbered 292.CER.AR, while the Exclusions section of the same document is numbered 292.EXC.XX. The Company employs this form numbering style for administrative and tracking purposes. The form will always be issued in it's entirety with all sections and form numbers included.

All forms are subject to minor modifications in paper size, stock, layout, format, company logo and printing specifications of the document upon issue. As mentioned above, some of the provisions/sections are bracketed to provide flexibility as well as to afford future flexibility to adjust to changing regulatory and market needs. Please see the enclosed Statement of Variability for additional information on form adaptability.

Please note that Wisconsin is the state domicile for Time Insurance Company. The state of Wisconsin does not require the filing of forms that are being marketed for out-of-state use with their office.

Thank you in advance for your time and attention to this filing. Should you have any questions, or require additional information, please contact me at any of the numbers listed below.

SERFF Tracking Number: MCHX-126596491 State: Arkansas
 Filing Company: Time Insurance Company State Tracking Number: 45485
 Company Tracking Number: 292.CER.AR
 TOI: H14G Group Health - Hospital Indemnity Sub-TOI: H14G.000 Health - Hospital Indemnity
 Product Name: 292.CER.XX Group Hospital-Medical Indemnity Time
 Project Name/Number: 292.CER.XX Group Hospital-Medical Indemnity Time Insurance Company /292.CER.XX Group Hospital-Medical Indemnity Time Insurance Company

Sincerely,

Jane Neal
 Compliance Project Specialist

Company and Contact

Filing Contact Information

Jane Neal, Compliance Project Specialist mcr@mchughconsulting.com
 McHugh Consulting Resources, Inc. 215-230-7960 [Phone]
 2005 South Easton Road, Suite 207 215-230-7961 [FAX]
 Doylestown, PA 18901

Filing Company Information

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

Time Insurance Company	CoCode: 69477	State of Domicile: Wisconsin
501 West Michigan Avenue	Group Code: 19	Company Type:
Milwaukee, WI 53201-0624	Group Name:	State ID Number:
(414) 299-1140 ext. [Phone]	FEIN Number: 39-0658730	

Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Time Insurance Company	\$50.00	04/22/2010	35888680
Time Insurance Company	\$100.00	04/23/2010	35923499

SERFF Tracking Number: MCHX-126596491 State: Arkansas
 Filing Company: Time Insurance Company State Tracking Number: 45485
 Company Tracking Number: 292.CER.AR
 TOI: H14G Group Health - Hospital Indemnity Sub-TOI: H14G.000 Health - Hospital Indemnity
 Product Name: 292.CER.XX Group Hospital-Medical Indemnity Time
 Project Name/Number: 292.CER.XX Group Hospital-Medical Indemnity Time Insurance Company /292.CER.XX Group Hospital-Medical Indemnity Time Insurance Company

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	04/29/2010	04/29/2010

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	04/29/2010	04/29/2010	SPI McHughConsulting	04/29/2010	04/29/2010
Pending Industry Response	Rosalind Minor	04/23/2010	04/23/2010	SPI McHughConsulting	04/23/2010	04/23/2010

SERFF Tracking Number: MCHX-126596491 *State:* Arkansas
Filing Company: Time Insurance Company *State Tracking Number:* 45485
Company Tracking Number: 292.CER.AR
TOI: H14G Group Health - Hospital Indemnity *Sub-TOI:* H14G.000 Health - Hospital Indemnity
Product Name: 292.CER.XX Group Hospital-Medical Indemnity Time
Project Name/Number: 292.CER.XX Group Hospital-Medical Indemnity Time Insurance Company /292.CER.XX Group Hospital-Medical Indemnity Time Insurance Company

Disposition

Disposition Date: 04/29/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: MCHX-126596491 State: Arkansas
 Filing Company: Time Insurance Company State Tracking Number: 45485
 Company Tracking Number: 292.CER.AR
 TOI: H14G Group Health - Hospital Indemnity Sub-TOI: H14G.000 Health - Hospital Indemnity
 Product Name: 292.CER.XX Group Hospital-Medical Indemnity Time
 Project Name/Number: 292.CER.XX Group Hospital-Medical Indemnity Time Insurance Company /292.CER.XX Group Hospital-Medical Indemnity Time Insurance Company

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Forms Listing	Approved-Closed	Yes
Supporting Document	Statement of Variability	Approved-Closed	Yes
Supporting Document	Authorization Letter	Approved-Closed	Yes
Supporting Document	HAA Articles of Incorporation and Bylaws	Approved-Closed	Yes
Supporting Document	04/22/10 Submission Letter	Approved-Closed	Yes
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	04.29.10 Objection Response	Approved-Closed	Yes
Form	Hospital Confinement and Surgical Fixed Indemnity Certificate-Table of Contents	Approved-Closed	Yes
Form	Hospital Confinement and Surgical Fixed Indemnity Certificate-Definitions	Approved-Closed	Yes
Form	Hospital Confinement and Surgical Fixed Indemnity Certificate-Effective Date and Termination Date	Approved-Closed	Yes
Form	Hospital Confinement and Surgical Fixed Indemnity Certificate- Hospital Confinement and Other Fixed Indemnity Benefits	Approved-Closed	Yes
Form	Hospital Confinement and Surgical Fixed Indemnity Certificate-Exclusions	Approved-Closed	Yes
Form	Hospital Confinement and Surgical Fixed Indemnity Certificate-Claim Provisions	Approved-Closed	Yes
Form	Hospital Confinement and Surgical Fixed Indemnity Certificate- Premium Provisions	Approved-Closed	Yes
Form	Hospital Confinement and Surgical Fixed Indemnity Certificate- Other Provisions	Approved-Closed	Yes
Form (revised)	Hospital Confinement and Surgical Fixed Indemnity Certificate-Cover Page	Approved-Closed	Yes
Form	Hospital Confinement and Surgical Fixed Indemnity Certificate-Cover Page	Replaced	Yes
Form	Benefit Schedule	Approved-Closed	Yes
Form	Application Form for Hospital-Medical Fixed Indemnity Insurance Plan	Approved-Closed	Yes

SERFF Tracking Number: MCHX-126596491 State: Arkansas
Filing Company: Time Insurance Company State Tracking Number: 45485
Company Tracking Number: 292.CER.AR
TOI: H14G Group Health - Hospital Indemnity Sub-TOI: H14G.000 Health - Hospital Indemnity
Product Name: 292.CER.XX Group Hospital-Medical Indemnity Time
Project Name/Number: 292.CER.XX Group Hospital-Medical Indemnity Time Insurance Company /292.CER.XX Group Hospital-Medical Indemnity Time Insurance Company

Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 04/29/2010

Submitted Date 04/29/2010

Respond By Date

Dear Jane Neal,

This will acknowledge receipt of the captioned filing.

Objection 1

- Hospital Confinement and Surgical Fixed Indemnity Certificate-Cover Page, 292.CER.AR (Form)

Comment:

With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-86-108(4) and Bulletin 14-81.

Objection 2

- Hospital Confinement and Surgical Fixed Indemnity Certificate-Cover Page, 292.CER.AR (Form)

Comment:

Coverage for newborn infants must be for at least 90 days as outlined under ACA 23-79-129.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

Response Letter

Response Letter Status Submitted to State

Response Letter Date 04/29/2010

Submitted Date 04/29/2010

Dear Rosalind Minor,

Comments:

Please find attached a response to your objection letter dated today.

SERFF Tracking Number: MCHX-126596491 State: Arkansas
 Filing Company: Time Insurance Company State Tracking Number: 45485
 Company Tracking Number: 292.CER.AR
 TOI: H14G Group Health - Hospital Indemnity Sub-TOI: H14G.000 Health - Hospital Indemnity
 Product Name: 292.CER.XX Group Hospital-Medical Indemnity Time
 Project Name/Number: 292.CER.XX Group Hospital-Medical Indemnity Time Insurance Company /292.CER.XX Group Hospital-Medical Indemnity Time Insurance Company

Response 1

Comments: Please find attached:

Related Objection 1

Applies To:

- Hospital Confinement and Surgical Fixed Indemnity Certificate-Cover Page, 292.CER.AR (Form)

Comment:

With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-86-108(4) and Bulletin 14-81.

Related Objection 2

Applies To:

- Hospital Confinement and Surgical Fixed Indemnity Certificate-Cover Page, 292.CER.AR (Form)

Comment:

Coverage for newborn infants must be for at least 90 days as outlined under ACA 23-79-129.

Changed Items:

Supporting Document Schedule Item Changes

Satisfied -Name: 04.29.10 Objection Response

Comment:

Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Hospital Confinement and Surgical Fixed Indemnity Certificate-Cover Page	292.CER.AR		Certificate	Revised		50.000	TIC IM Association 292 Certificate-AR Clean.PDF

SERFF Tracking Number: MCHX-126596491 State: Arkansas
Filing Company: Time Insurance Company State Tracking Number: 45485
Company Tracking Number: 292.CER.AR
TOI: H14G Group Health - Hospital Indemnity Sub-TOI: H14G.000 Health - Hospital Indemnity
Product Name: 292.CER.XX Group Hospital-Medical Indemnity Time
Project Name/Number: 292.CER.XX Group Hospital-Medical Indemnity Time Insurance Company /292.CER.XX Group Hospital-Medical Indemnity Time Insurance Company

Previous Version

Hospital Confinement and Surgical Fixed Indemnity Certificate- Cover Page	292.CER. AR	Certificate	Initial	50.000	292_CER _AR.PDF
--	----------------	-------------	---------	--------	--------------------

No Rate/Rule Schedule items changed.

Thank you for your assistance with this filing.

Sincerely,
SPI McHughConsulting

SERFF Tracking Number: MCHX-126596491 State: Arkansas
Filing Company: Time Insurance Company State Tracking Number: 45485
Company Tracking Number: 292.CER.AR
TOI: H14G Group Health - Hospital Indemnity Sub-TOI: H14G.000 Health - Hospital Indemnity
Product Name: 292.CER.XX Group Hospital-Medical Indemnity Time
Project Name/Number: 292.CER.XX Group Hospital-Medical Indemnity Time Insurance Company /292.CER.XX Group Hospital-Medical Indemnity Time Insurance Company

Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 04/23/2010
Submitted Date 04/23/2010
Respond By Date
Dear Jane Neal,

This will acknowledge receipt of the captioned filing.

Objection 1

- Hospital Confinement and Surgical Fixed Indemnity Certificate-Cover Page, 292.CER.AR (Form)

Comment:

As discussed in our telephone conversation on this date, our filing fees under Rule 57 has been updated. Please review the General Instructions for ArkansasLH.

The new fee for this submission is \$50.00 per form for a total of \$150.00. Please submit an additional \$100.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee.

Please feel free to contact me if you have questions.

Sincerely,
Rosalind Minor

Response Letter

Response Letter Status Submitted to State
Response Letter Date 04/23/2010
Submitted Date 04/23/2010

Dear Rosalind Minor,

Comments:

Thank you for your letter and phone call of today.

SERFF Tracking Number: MCHX-126596491 State: Arkansas
Filing Company: Time Insurance Company State Tracking Number: 45485
Company Tracking Number: 292.CER.AR
TOI: H14G Group Health - Hospital Indemnity Sub-TOI: H14G.000 Health - Hospital Indemnity
Product Name: 292.CER.XX Group Hospital-Medical Indemnity Time
Project Name/Number: 292.CER.XX Group Hospital-Medical Indemnity Time Insurance Company /292.CER.XX Group Hospital-Medical Indemnity Time Insurance Company

Response 1

Comments: The added fees will be submitted by EFT.

Related Objection 1

Applies To:

- Hospital Confinement and Surgical Fixed Indemnity Certificate-Cover Page, 292.CER.AR (Form)

Comment:

As discussed in our telephone conversation on this date, our filing fees under Rule 57 has been updated. Please review the General Instructions for ArkansasLH.

The new fee for this submission is \$50.00 per form for a total of \$150.00. Please submit an additional \$100.00 for this submission.

We will begin our review of this submission upon receipt of the additional filing fee.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Please contact our office at 215-230-7960 if there are any questions.

Thank you.

Jane Neal
Compliance Project Specialist
McHugh Consulting Resources, Inc.

Sincerely,
SPI McHughConsulting

SERFF Tracking Number: MCHX-126596491 State: Arkansas
 Filing Company: Time Insurance Company State Tracking Number: 45485
 Company Tracking Number: 292.CER.AR
 TOI: H14G Group Health - Hospital Indemnity Sub-TOI: H14G.000 Health - Hospital Indemnity
 Product Name: 292.CER.XX Group Hospital-Medical Indemnity Time
 Project Name/Number: 292.CER.XX Group Hospital-Medical Indemnity Time Insurance Company /292.CER.XX Group Hospital-Medical Indemnity Time Insurance Company

Form Schedule

Lead Form Number: 292.CER.AR

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 04/29/2010	292.TOC.X X	Matrix	Hospital Confinement and Surgical Indemnity Certificate- Table of Contents	Initial Fixed		50.000	
Approved-Closed 04/29/2010	292.DEF.X X	Matrix	Hospital Confinement and Surgical Indemnity Certificate- Definitions	Initial Fixed		50.000	
Approved-Closed 04/29/2010	292.EFF.A R	Matrix	Hospital Confinement and Surgical Indemnity Certificate- Effective Date and Termination Date	Initial Fixed		50.000	
Approved-Closed 04/29/2010	292.BEN.A R	Matrix	Hospital Confinement and Surgical Indemnity Certificate- Hospital Confinement and Other Fixed Indemnity Benefits	Initial Fixed		50.000	
Approved-Closed 04/29/2010	292.EXC.X X	Matrix	Hospital Confinement and Surgical Indemnity Certificate- Exclusions	Initial Fixed		50.000	
Approved-Closed 04/29/2010	292.CLM.X X	Matrix	Hospital Confinement and Surgical Indemnity Certificate- Claim Provisions	Initial Fixed		50.000	
Approved-Closed 04/29/2010	292.PRM.A R	Matrix	Hospital Confinement and Surgical Indemnity Certificate-	Initial Fixed		50.000	

SERFF Tracking Number: MCHX-126596491 State: Arkansas
 Filing Company: Time Insurance Company State Tracking Number: 45485
 Company Tracking Number: 292.CER.AR
 TOI: H14G Group Health - Hospital Indemnity Sub-TOI: H14G.000 Health - Hospital Indemnity
 Product Name: 292.CER.XX Group Hospital-Medical Indemnity Time
 Project Name/Number: 292.CER.XX Group Hospital-Medical Indemnity Time Insurance Company /292.CER.XX Group Hospital-Medical Indemnity Time Insurance Company

Approval Status	Tracking Number	Description	Initial	Revised	Replaced Form #:	Previous Filing #:	Amount	File Name
Approved- Closed 04/29/2010	292.OTH.X	Matrix Hospital Confinement and Surgical Indemnity Certificate- Other Provisions	Initial				50.000	
Approved- Closed 04/29/2010	292.CER.A	Certificate Hospital Confinement and Surgical Fixed Indemnity Certificate- Cover Page	Revised				50.000	TIC IM Association 292 Certificate-AR Clean.PDF
Approved- Closed 04/29/2010	292.BNS.X	Schedule Pages	Initial				64.000	292_BNS_XX .PDF
Approved- Closed 04/29/2010	Form 49800-AR	Application/ Enrollment Form	Application Form for Hospital-Medical Fixed Indemnity Insurance Plan	Initial			51.000	Form 49800- AR.PDF

Time Insurance Company
[501 West Michigan
Milwaukee, WI 53203]

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

NOTICE: This is not a major medical insurance plan. 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 bill. THIS IS NOT A MEDICARE SUPPLEMENT PLAN.

This Certificate is evidence of Your coverage under the Policy of hospital confinement and other fixed indemnity insurance issued to a[n] [association/trust]. This Certificate describes the benefits and provisions which affect Covered Persons. The final interpretation of any specific provision is based on the terms of the Policy. The Policy is issued in the State of [Illinois] and is governed by applicable laws of that State and federal laws, except as otherwise provided by this Certificate or the Policy. The Policy may be examined at Our Home Office or the main office of the Policyholder. This Certificate provides hospital confinement and other fixed indemnity benefits that, at a minimum, meet the requirements for such plans under applicable [Illinois law][or][law of the state in which the Certificate is issued]. Please read Your Certificate carefully and become familiar with its terms, limits and conditions.

This Certificate is issued based on the statements and agreements in the enrollment form and during the enrollment process, [any exam that may be required,] any other amendments or supplements and payment of the required premium. This Certificate may be changed. If that happens, You will be notified of any such changes.

RIGHT TO EXAMINE CERTIFICATE FOR [10-30] DAYS

If You are not satisfied, return the Certificate to Us or Our agent within [10-30] 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 ENROLLMENT FORM FOR INSURANCE**

Please read the copy of the enrollment form included with this Certificate. We issued this coverage in reliance upon the accuracy and completeness of the information provided in the enrollment form and during the enrollment process. If a [material] [or] [fraudulent] omission or misstatement is made in the enrollment 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 enrollment form and, if any information shown in the enrollment form is not correct and complete, write to Us at the address above, within [10-30] days.

[insert signature]
Secretary

[insert signature]
President

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

Conditionally Renewable: Read the Effective Date and Termination Date provision carefully. We reserve the right to change premiums by class upon any renewal date after the initial 12 months coverage is in force.

II. GUIDE TO YOUR COVERAGE

The sections of the Certificate appear in the following order:

- I. Signature Page
- II. Guide To Your Coverage
- III. Definitions
- IV. Effective Date and Termination Date
- V. Hospital Confinement and Other Fixed Indemnity Benefits
- [VI. Pre-Existing Conditions Limitation]
- [VII.] Exclusions
- [VIII.] Claim Provisions
- [IX.] Premium Provisions
- [X.] Other Provisions

III. DEFINITIONS

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

Accident or Accidental

Any event that meets all of the following requirements:

1. It causes harm to the physical structure of the body.
2. It is the direct cause of a loss, independent of disease, bodily infirmity or any other cause.
3. It is definite as to time and place.
4. It happens involuntarily or entails unforeseen consequences if it is the result of an intentional act.

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

Any condition classified as a mental disorder or abuse of, addiction to, or dependence on drugs, chemicals or alcohol as defined in the edition of the International Classification of Diseases (ICD) in use at the time a claim is received by Us.

[Benefit Waiting Period

The period of consecutive days that must pass after the Effective Date before a Covered Person is eligible for Scheduled Benefits under the terms of this plan.

A Benefit Waiting Period only applies if it is shown in the Benefit Schedule. The Benefit Schedule will identify what any applicable Benefit Waiting Periods are along with the Scheduled Benefits to which they apply.]

[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.

Certificate

This certificate issued to the Certificate Holder as evidence of coverage under the master group Policy.

Certificate Holder

The person listed on the Benefit Schedule as the Certificate Holder.

[Complications of Pregnancy

Complications of Pregnancy include the following:

1. Conditions (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, physician-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 a nosologically distinct complication of pregnancy; and

2. Non-elective cesarean section, ectopic pregnancy which is terminated, 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 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 a Sickness or an Injury or for preventive medicine services as specified in the Hospital Confinement and Other Fixed Indemnity Benefits section and the Benefit Schedule[, and does not occur during a Benefit Waiting Period].
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 plan.

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

Injury resulting from an Accidental blow to the mouth causing trauma to teeth, the mouth, gums or supporting structures of the teeth.

[Dependent

A Dependent is:

1. The Certificate Holder's lawful spouse[, including the Certificate Holder's Domestic Partner [if recognized under applicable law]]; or
2. The Certificate Holder's naturally born child, legally adopted child, a child that is placed for adoption with the Certificate Holder, a stepchild or a child for whom the Certificate Holder is the legal guardian, or a child for whom the Certificate Holder is required to provide medical support by court or administrative order:
 - a. Who is unmarried; and
 - b. Who is age [18-30] or younger[; and
 - c. Who is claimed as an exemption on Your most recent federal income tax return, except for a Dependent child who is a full-time student][; and
 - d. Whose legal address is the same as the Certificate Holder's legal address.

If the child's legal address is different than the Certificate Holder, the child will be considered a Dependent if You submit proof that:

- a. You are required by a qualified medical child support order to provide medical insurance; or
- b. The child was claimed as an exemption on Your most recent federal income tax return.]

If Your unmarried child is age [19-31] or older, the child will be considered a Dependent if You give Us proof that:

- [a.] The child is a full-time student at an accredited educational institution, college or university. A student will be considered full-time if the student meets the standards for full-time status at the school the student is attending. A student will be considered full-time during regular vacation periods that interrupt, but do not terminate, the continuous full-time course of study; or]
- [b.] The child is not capable of self-sustaining employment or engaging in the normal and customary activities of a person of the same age because of mental incapacity or physical handicap and is chiefly dependent on the Certificate Holder for financial support.

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

- [a.] [Is no longer a full-time student; or]
- [b.] [Graduates; or]
- [c.] [Ceases to be claimed as an exemption on the Certificate Holder's federal income tax return, except for a Dependent child who is a full-time student; or]
- [d.] Attains age [19-31]; or
- [e.] Marries; or
- [f.] Is over age [21-30] and is capable of self-sustaining employment because he or she is no longer mentally incapacitated or physically handicapped.

[If only Dependent children are covered under this plan, the youngest child will be considered the Certificate Holder. All siblings of the Certificate Holder will be considered Covered Dependents if they meet the requirements above.]]

[Domestic Partner

A person of the same or opposite gender who resides with the Certificate Holder in a long-term relationship of indefinite duration. The partners have an exclusive mutual commitment to be jointly responsible for each

others common welfare and share financial obligations. The Domestic Partner must meet all of the following requirements:

1. Be at least [18] years of age.
2. Be competent to enter into a contract.
3. Not be related by blood to a degree of closeness that would prohibit legal marriage in the state in which he or she legally resides.

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

[Drug List

A list of Prescription Drugs that We designate as eligible for benefits. A Drug List is subject to change at any time without notice.]

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 plan begins for a Covered Person. The Covered Person's coverage begins at 12:01 a.m. local time at the Certificate Holder's state of residence.

[Emergency Room

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

[Emergency Treatment

Treatment, services or supplies for a Sickness or an Injury that develops suddenly and unexpectedly and, if not treated immediately, would:

1. Endanger the Covered Person's life; or
2. Cause serious bodily impairment to 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 proven 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 to market it by the Food and Drug Administration (FDA) for the particular Sickness or Injury. However, final approval by the FDA is not sufficient to prove that the treatment, services or supplies are of proven benefit or appropriate or effective for diagnosis or treatment of a Sickness or an 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 Evaluations; 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:
 - 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 Certificate Holder and one or more of the Certificate Holder'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 physician 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.
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.]

Home Office

Our office in [Milwaukee, Wisconsin] or other administrative offices as indicated by Us.

[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 by the state in which the services are rendered and accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or Medicare to provide acute care.
2. Be staffed by an on duty physician 24 hours per day.
3. Provide nursing services supervised by an on duty registered nurse 24 hours per day.
4. Maintain daily medical records that document all services provided for each patient.
5. Provide immediate access to appropriate in-house laboratory and imaging services.
6. Not primarily provide care for Behavioral Health or Substance Abuse or Inpatient rehabilitation services although these services may be provided in a distinct section of the same physical facility.

Immediate Family Member

An Immediate Family Member is:

1. You or Your spouse [or Domestic Partner]; or
2. The children, brothers, sisters and parents of either You or Your spouse [or Domestic Partner]; or
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.

Injury

Accidental bodily damage, independent of all other causes, occurring unexpectedly [and unintentionally].

Inpatient

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

[Laboratory Services

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

- [1.] [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.]
- [2.] [Maximum Benefit for Inpatient Hospital Confinement Benefits:
The maximum amount of Inpatient Hospital Confinement Benefits that We will pay for each Covered Person under this plan.]
- [3.] [Maximum Benefit for Rehabilitation Unit Confinement Benefits:
The maximum amount of Rehabilitation Unit Confinement Benefits that We will pay for each Covered Person under this plan.]
- [4.] [Maximum Benefit for Initial Hospitalization Benefits:
The maximum amount of Inpatient Hospitalization Benefits that We will pay for each Covered Person under this plan.]
- [5.] [Maximum Benefit for Emergency Room [and Urgent Care Facility] Visit Benefits:
The maximum amount of Emergency Room [and Urgent Care Facility] Visit Benefits that We will pay for each Covered Person under this plan.]
- [6.] [Maximum Benefit for Urgent Care Facility Visit Benefits:
The maximum amount of Urgent Care Facility Visit Benefits that We will pay for each Covered Person under this plan.]
- [7.] [Maximum Benefit for Outpatient Medical Event Benefits:
The maximum amount of Outpatient Medical Event Benefits that We will pay for each Covered Person under this plan.]
- [8.] [Maximum Benefit for Office Visit Benefits:
The maximum amount of Office Visit Benefits that We will pay for each Covered Person under this plan.]
- [9.] [Maximum Benefit for Allergy Immunotherapy Injection [and Immunization] Benefits:
The maximum amount of Allergy Immunotherapy Injection [and Immunization] Benefits that We will pay for each Covered Person under this plan.]

- [10.] [Maximum Benefit for Immunization Benefits:

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

[11.] [Maximum Benefit for Telehealth [and Telemedicine] Services Benefits:
The maximum amount of Telehealth [and Telemedicine] Services Benefits that We will pay for each Covered Person under this plan.]

[12.] [Maximum Benefit for Telemedicine Services Benefits:
The maximum amount of Telemedicine Services Benefits that We will pay for each Covered Person under this plan.]

[13.] [Maximum Benefit for Outpatient Prescription Order Benefits:
The maximum amount of Outpatient Prescription Order Benefits that We will pay for each Covered Person under this plan.]

[14.] [Maximum Benefit for Professional Ground [or Air] Ambulance Services Benefits:
The maximum amount of Professional Ground [or Air] Ambulance Services Benefits that We will pay for each Covered Person under this plan.]

[15.] [Maximum Benefit for Anesthesia Benefits:
The maximum amount of Anesthesia Benefits that We will pay for each Covered Person under this plan.]

[16.] [Maximum Benefit for Surgical Services Benefits:
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; and
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. Can reasonably be expected to result in or contribute substantially to the improvement of a condition resulting from a Sickness or an Injury; and
4. 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, of 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.

[Non-Preferred Brand Name Drug

A Brand Name Drug that is not listed as preferred in a Drug List.]

[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.
4. Muscle and sensory stimulation.]

[Office Visit

An in-person, face-to-face meeting [or a Telehealth [or Telemedicine] consultation] between a Covered Person and a Health Care Practitioner in [or from] 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 plan, 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 [or 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 plan, Outpatient does not include Office Visits, Emergency Room visits, [Telehealth Services, Telemedicine Services,]Urgent Care visits or Retail Health Clinic visits.]

[Outpatient Facility

Any of the following: a Hospital's Outpatient department[,] [or] a Free-Standing Facility[or an Urgent Care 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.]

[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 group master contract issued by Us to the Policyholder providing benefits for Covered Persons.

Policyholder

The [person,] [organization] [or] [entity] to [which] [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, consultation, diagnosis, care or treatment was sought, received or recommended from a provider or Prescription Drugs were prescribed during the [12-24]-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 signs or symptoms during the [12-24] -month period immediately prior to the Covered Person's Effective Date.

The signs or symptoms were significant enough to establish manifestation or onset by one of the following tests:

- a. The signs or symptoms reasonably should have allowed or would have allowed one learned in medicine to diagnose the condition; or
- b. The signs or symptoms reasonably should have caused or would have caused an ordinarily prudent person to seek diagnosis or treatment.

[A pregnancy that exists on the day before the Covered Person's Effective Date will be considered a Pre-Existing Condition.]]

[Preferred Brand Name Drug

A Brand Name Drug that is listed as preferred in a Drug List. This list is subject to change at any time without notice.]

[Prescription Drug

Any medication [or contraceptive drug or device including oral contraceptives, contraceptive patches, contraceptive vaginal rings, and diaphragms] that:

1. Has been fully approved by the Food and Drug Administration (FDA) for marketing in the United States; and
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.

[For purposes of this plan Prescription Drug does not include injectable contraceptives (depo provera injections) and contraceptive implants (IUDs).]]

[Prescription Order

The request by a Health Care Practitioner for:

1. Each separate Prescription Drug and each authorized refill; or
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]

[Primary Care Practitioner

A Health Care Practitioner who is a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) whose practice predominantly includes pediatrics, internal medicine, family practice, general practice or obstetrics/gynecology. [A [licensed nurse practitioner,] [podiatrist,] [chiropractor] [and] [dentist] would also qualify as a Primary Care Practitioner if he or she meets the definition of a Health Care Practitioner and the services rendered would be Covered Charges if performed by a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who is also a Primary Care Practitioner.]]

[Radiology Services

Diagnostic imaging procedures and tests including, but not limited to, x-rays, positron emission tomography (PET) scan, magnetic resonance imaging (MRI) and computerized axial tomography (CT), that are performed to diagnose a condition, determine the nature of a condition, or provide preventive 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 multi-disciplinary team.
2. Is designed to improve the patient's function and independence.
3. Is under the direction of a qualified Health Care Practitioner.
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 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, subacute 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 or services for a Sickness or Injury, or provides preventive medicine services, [on a non-seasonal basis]; and
6. Does not provide room and board or overnight services.
- [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. 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 plan, 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.]

[Single Plan

A plan of insurance covering only the Certificate Holder.]

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.

[Specialist Practitioner

A Health Care Practitioner who is classified as a specialist by the American Boards of Medical Specialties. [A Specialist Practitioner, for purposes of this plan, [is not][and][cannot be] a Primary Care Practitioner.]

[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 [established] 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

TMJ Dysfunction and CMJ Dysfunction is any joint disorder of the jaw causing any of the following:

1. Clicking and/or difficulties in opening and closing the mouth.
2. Pain or swelling.
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
2. 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 physician during operating hours.

3. Provide services to stabilize patients who need Emergency Treatment and arrange immediate transportation to an Emergency Room.
4. Provide immediate access to appropriate in-house laboratory and imaging services.]

We, Us, Our, Our Company

Time Insurance Company or its administrator.

You, Your, Yours

The person listed on the Benefit Schedule as the Certificate Holder.

IV. EFFECTIVE DATE AND TERMINATION DATE

Eligibility and Effective Date of Certificate Holder

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

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

[This is a Single Plan. Dependents may not be added.]

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.] **Single Plan:** If the Certificate Holder has a Single Plan, as shown in the Benefit Schedule, on the Effective Date of his or her plan, a Dependent cannot be added after the Certificate Holder's Effective Date.

If You have a Single Plan and want to add any Dependents after Your Effective Date, You may apply for a new certificate by completing an enrollment form 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 certificate will take effect at 12:01 a.m. local time at the Certificate Holder'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 [and a Benefit Waiting Period apply][applies] to You under the new certificate will be reduced by the total number of consecutive days that You were covered under this Certificate immediately prior to termination. Benefits paid under the new certificate cannot exceed the [Maximum Lifetime Benefit or any other] applicable Maximum Benefit that would have otherwise been paid under the terms of this Certificate if coverage under this Certificate would have remained in force.]

- [[2.] **Family Plan:** If the Certificate Holder has a Family Plan, as shown in the Benefit Schedule, on the Effective Date of his or her plan, a Dependent can be added after the Certificate Holder'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 call Our office or 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 12:01 a.m. local time at the Certificate Holder'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 and premature birth 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 placed with the Certificate Holder in anticipation of legal adoption and the Certificate Holder assumes a legal obligation for support of the child or the date of legal adoption, whichever is earlier. You must call Our office or send Us written notice of the adoption or placement for adoption of the child and We must receive any required additional premium within [31-60] days of the adoption or placement for adoption, whichever is earlier. The Effective Date of coverage will be 12:01 a.m. local time at the Certificate Holder's state of residence on the earlier of the date the child is adopted or placed for adoption. If these requirements are not met, Your newly adopted child will be covered for Sickness or Injury only for the first [31-60] days from placement for adoption. A child is no longer considered adopted if, prior to legal adoption, You relinquish legal obligation for support of the child and the child is removed from placement.
- c. **Adding a Child for Whom a Court Order Requires You to Provide Insurance:** A child for whom a court order requires the Certificate Holder or Covered Dependent spouse to provide this insurance can be added as of the date required by the order. You must call Our office or send Us written notice of the court order, provide a copy of the court order to Us, and We must receive any required additional premium within [31-60] days of the effective date of the order. The Effective Date of coverage for the child will be 12:01 a.m. local time at the Certificate Holder's state of residence on:
 - I. the date the court order becomes effective, when the notice and premium payment requirements above are met; or
 - II. the date You provide notice, including a copy of the court order, and any required premium to Us if received after the first [31-60] days following the date of the court order.
- d. **Adding Any Other Dependent:** To add any other Dependents, an enrollment form 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 Certificate Holder's state of residence on the Effective Date for that Covered Person shown on the Benefit Schedule.]]

Termination Date

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

This Certificate, and coverage hereunder, will terminate at 12:01 a.m. local time at the Certificate Holder's state of residence on the earliest of the following dates:

1. The date We receive a request in writing or by telephone to terminate this plan or on a later date that is requested by the Certificate Holder 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 Certificate Holder for termination of a Covered Dependent.]

- [3.] The date this plan lapses for nonpayment of premium per the Grace Period provision in the Premium Provisions 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 Certificate was issued or the state in which the Certificate Holder presently resides.
- [6.] [The date We terminate or nonrenew all individual market hospital-indemnity insurance plans in the state in which this Certificate was issued 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.] [On] [T][t]he date the Certificate Holder moves to a state where We do not provide insurance under a plan with the same plan design as this Certificate[, We reserve the right to terminate this coverage].
- [8.] [On the date the master group Policy terminates or is non-renewed.]
- [9.] [For a Dependent, the date a Covered Dependent no longer meets the Dependent definition in this plan.]

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 Certificate.

[V]. 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 limitation provided under this plan. Benefits are subject to all the terms, limits and conditions in this plan.

[We will not pay benefits for Events that occur during a Covered Person's Benefit Waiting Period. A Benefit Waiting Period only applies if it is shown in the Benefit Schedule.]

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.

[Initial Hospitalization Benefit [for] [Sickness] [or] [Injury]

We will pay the corresponding Scheduled Benefit amount when the Covered Person is initially admitted to a Hospital for at least 24 hours for treatment of [Sickness] [or] [Injury]. [In cases of Injury, this benefit is not payable unless You [or Your Covered Dependent] [is][are] admitted to a Hospital within [2-90] days of the Accident event that caused the Injury.] [This benefit is payable only once per Calendar Year, per Covered Person.] Benefits are limited to the Calendar Year Maximum Benefit shown on the Benefit Schedule.]

[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 physician 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[; see the Rehabilitation Unit Confinement Benefit for such benefits].

The Scheduled Benefit for Sickness under this Inpatient Hospital Confinement Benefits provision will be paid for each day of confinement for routine nursery care and pediatric care of a newborn child for up to five (5) full days in a hospital nursery or until the mother, who is a Covered Person under this plan, is discharged from the hospital following the birth of the child, whichever is the lesser period of time.

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.]

[Rehabilitation Unit Confinement Benefit

We will pay the corresponding Scheduled Benefit amount for each day of room and board during a Confinement Period under the orders of a physician for rehabilitative care of a Sickness or an Injury in a Rehabilitation Unit.

When a Rehabilitation Unit 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.]

[Emergency Room Visit Benefits

We will pay the corresponding Scheduled Benefit amount upon the occurrence of a visit to an Emergency Room during which a Covered Person receives Emergency Treatment. [An Emergency Room visit that is not for Emergency Treatment will not be considered for benefits under this plan.]

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. [An Urgent Care Facility visit that is not for Urgent Care will not be considered for benefits under this plan.]

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 one of the following for treatment of a Sickness or Injury or preventive medicine 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. Laboratory Services includes, but is not limited to, newborn infant tests for hypothyroidism, phenylketonuria, galactosemia, sickle-cell anemia, and all other disorders of metabolism for which screening is performed by or for the State of Arkansas.
2. Covered Events involving Radiology Services as shown on the Benefit Schedule that are incurred on an Outpatient basis.
3. Covered Events involving Physical Medicine services as shown on the Benefit Schedule that are incurred on an Outpatient basis.

4. All other Medically Necessary Covered Events that are incurred on an Outpatient basis and for which benefit is 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 and eligible for the Other Outpatient Event benefit.

Those Covered Events for which benefit is 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.
 - 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.
 - [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 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.]

[Telehealth Services Benefits

We will pay the corresponding Scheduled Benefit amount upon an occurrence during which a Covered Person obtains Telehealth Services. Benefits are limited to the Calendar Year Maximum Benefit shown on the Benefit Schedule.]

[Telemedicine Services Benefits

We will pay the corresponding Scheduled Benefit shown on the Benefit Schedule upon an occurrence during which a Covered Person obtains Telemedicine Services. 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.
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. Benefits are limited to the Calendar Year Maximum Benefit shown on the Benefit Schedule.]

[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 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 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 eligible Anesthesia Benefits.]

Two or more surgical procedures performed during the same operative session are considered one operation and benefits will be considered 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, benefits will be considered under the benefit level for Surgical Event – Not Otherwise Listed. Benefits are limited to the Calendar Year Maximum Benefit shown on the Benefit Schedule.]

[[VI]. 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 [6-12] 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.]

[VII]. 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 arises out of, or is the result of, any work for wage or profit; 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 workers' 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, including non-military units supporting such forces.]
- [4.] [Foreign [or domestic] acts of terrorism that result in a nationwide epidemic.]
- [5.] [Treatment, services or supplies that:
 - a. Is not part of a specifically listed Covered Event shown on the Benefit Schedule.
 - b. Is due to complications of a non-covered service.
 - c. Is 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.
 - d. Is provided in a student health center or by or through a school system.]]
- [6.] [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.]
- [7.] [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.]
- [8.] [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.
- e. Hygienic foot care that is routine.]

- [9.] [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 complications of the teeth and gum tissue, except as otherwise covered for a Dental Injury.]
- [10.] [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).]
- [11.] [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.]
- [12.] [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.]
- [13.] [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.]
- [14.] [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.]
- [15.] [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.]
- [16.] [Removal or replacement of a prosthesis; Durable Medical Equipment or Personal Medical Equipment, except for external 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.]

- [17.] [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.]
- [18.] [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.
 - f. [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; other [Telemedicine Services] [or] [Telehealth Services] [technology] that facilitates access to a Health Care Practitioner[, except for Telehealth Services [or Telemedicine Services] [provided as part of the Office Visit Benefits]].]
 - k. 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.
 - l. Treatment or services provided by a standby Health Care Practitioner.
 - m. Treatment or services provided by a masseur, masseuse or massage therapist; massage therapy; a rolfer.
 - n. Treatment or services provided by a chiropractor.]
- [19.] [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.]
- [20.] [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.]
- [21.] [Treatment, services, and supplies related to: maternity; pregnancy (except Complications of Pregnancy); ; abortion.]
- [22.] [Contraceptive procedures;] [contraceptive drugs] [or] [devices including, but not limited to,] [oral contraceptives,] [contraceptive patches,] [contraceptive vaginal rings,] [diaphragms,] [injectable contraceptives] [and] [contraceptive implants].]
- [23.] [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 chorionic 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.
- h. Circumcision.]

[24.] [Spinal [and other] adjustments, manipulations, subluxation treatment and/or services.]

[25.] [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.]

[26.] [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 [or varicose 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][, such as obstructive sleep apnea].
- m. Change in skin coloring or pigmentation.
- n. Stress management.]

[27.] [Treatment of an Injury sustained in operating a motor vehicle while the Covered Person's blood alcohol level, as defined by law, exceeded the blood alcohol level otherwise permitted by law or violated legal standards for a person operating a motor vehicle in the state where the Injury occurred. This exclusion applies whether or not the Covered Person is charged with any violation in connection with the Accident.]

[28.] [A condition 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.]

[29.] [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].]

[30.] [Treatment or services required due to Injury received while engaging in any hazardous [occupation or other] activity including, but not limited to: Participating, instructing, demonstrating, guiding or accompanying others in [parachute jumping,] [hang-gliding,] [bungee jumping,] [flight in an aircraft other than a regularly scheduled flight by an airline,] [racing any motorized [or non-motorized] vehicle,] [rock or mountain climbing,] [hunting,] [parkour,] [free running] [and] [extreme sports]. [Also excluded are treatment and services required due to Injury received while practicing, exercising, undergoing conditioning or physical preparation for any such activity.]]

- [31.] [[Treatment or services required due to Injury received while engaging in any hazardous [occupation or other] activity [for which compensation is received in any form, including sponsorship,] such as, but not limited to: Participating, instructing, demonstrating, guiding or accompanying others in [skiing,] [horse riding,] [rodeo activities,] [professional [or semi-professional] [contact] sports,] [adult sporting competition at a national or international level] [and] [extreme sports]. [Also excluded are treatment and services required due to Injury received while practicing, exercising, undergoing conditioning or physical preparation for any such compensated activity.]]
- [32.] [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.]
- [33.] [Any amount in excess of [the Maximum Lifetime Benefit or] any [other] Maximum Benefit limitation for covered Scheduled Benefits.]
- [34.] [Treatment that does not meet the definition of a Covered Event in this plan including, but not limited to, treatment that is not Medically Necessary.]
- [35.] [Treatment, services and supplies for Experimental or Investigational Services.]
- [36.] [Treatment incurred outside of the United States, including drugs or medicines obtained from pharmacy provider sources outside the United States.]
- [37.] [Sickness or Injury caused or aggravated by suicide, attempted suicide or self-inflicted Sickness or Injury, even if the Covered Person did not intend to cause the harm which resulted from the action which led to the self-inflicted Sickness or Injury.]
- [38.] [Vitamins and/or vitamin combinations even if they are prescribed by a Health Care Practitioner.]
- [39.] [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.
 - 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.]
- [40.] [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.]

- [41.] [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.]
- [42.] [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.]
- [43.] [Unit-dose drugs; drugs or medicines used to treat onychomycosis (nail fungus); botulinum toxin and its derivatives.]
- [44.] [Drugs or medicines prescribed for treatment of a condition that is specifically excluded under this plan.]
- [45.] [Drugs, medicines or supplies that are illegal under federal law, such as marijuana, even if they are prescribed for a medical use in a state.]
- [46.] [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.]

[VIII]. CLAIM PROVISIONS

Notice of Claim

You must notify Us of the claim within [20-90] calendar days after the date the Covered Event occurs, or as soon as reasonably possible[, by calling Our Home Office]. When providing notice of claim, You must include Your name, address, and Certificate number.

Claim Forms

Within [15-30] calendar days after We receive Your notice of claim, We will provide claim forms to be used when submitting Proof of Loss. The forms must be completed and sent to Us or Our designee. If You do not receive the claim forms within [15-30] [calendar][business] days or if We do not require Proof of Loss to be submitted on a specified claim form, We will accept a written description of the exact nature and extent of the loss as Proof of Loss provided it meets the requirements, including timeframes, for submitting Proof of Loss stated below.

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 [60-180] calendar days after a covered loss occurs or as soon as reasonably possible, but in no event later than 12 months from the date the 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 Certificate 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 bill from the provider of the services involved with the Covered Event that includes all of the following as appropriate:
 - a. International Classification of Diseases (ICD) diagnosis codes.
 - b. International Classification of Diseases (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 bill from the surgeon. A bill 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 plan. 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 bill submitted as 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 [30-90] 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 done, at Our expense, where it is not prohibited by law.

Payment of Benefits

Benefits will be paid 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 Certificate Holder 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 spouse, [Your Domestic Partner,] [or]Your estate[or the providers of the services].

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, [except when the professional component occurs as a fully separate and distinct Covered Event under this plan.] 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 and 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.

[Workers' Compensation Not Affected

Insurance under this plan does not replace or affect any requirements for coverage by workers' compensation insurance. If state law allows, We may participate in a workers' 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.

[IX]. PREMIUM PROVISIONS

Consideration

This plan is issued based on the statements and agreements in the Covered Person's enrollment form and during the enrollment process, any exam of a Covered Person that is required, any other amendments or supplements to the enrollment 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.]

Your premium may be adjusted from time to time based on different factors including, but not limited to, Your [geographic area,] [gender,] age[,] [payment method] [and] [plan design.] All premium adjustments will be made to individuals on the basis of shared characteristics. The premium may also change if You [add or delete Covered Dependents,] [change the payment method,] [move to another zip code] [or otherwise] change the coverage. [The mode of payment (monthly, quarterly or other) is subject to change at Our discretion.]

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 end on the [date that the unpaid premium was due and no loss incurred during the grace period will be considered for benefits][date the grace period expires]. If the premium is received during or by the end of the grace period, coverage will continue without interruption unless You call Our office or give Us written notice to cancel the coverage. [If a claim is payable during the grace period, any unpaid premiums due will be deducted from the claim payment.]

Reinstatement

If any premium is not paid within the required time period, coverage for You [and any Covered Dependents] will lapse. The coverage will be reinstated if all of the following requirements are met:

1. The lapse was not more than [30-180] days.
2. You submit a supplemental enrollment form for reinstatement to Us and remit the required premium payment. Submission of premium to Your agent is not submission of premium to Us.
3. We approve Your enrollment form for reinstatement.

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

If the coverage is reinstated, loss resulting from an Injury will be covered only if the 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 plan before the plan lapsed, subject to any provisions included with or attached to this plan in connection with the reinstatement.

Continuation

A Covered Dependent may be eligible to continue coverage under this plan after coverage would otherwise terminate due to loss of dependency status or change in marital status. The benefits will be the same as those in effect on the date of termination. You must furnish written request for continuation to Us within 10 days after ceasing to be eligible for coverage. The continued coverage will end on the earliest of:

1. Full coverage under any other group accident and health policy or contract. This includes being covered for conditions deemed to be pre-existing conditions under that plan;
2. The end of the period for which premiums are paid;
3. The period ending 120 days from the date continuation began;
4. The premium due date following the date the dependent becomes eligible for Medicare;
5. The date coverage under the plan would have otherwise terminated;
6. The date the Life Time Maximum Benefit amount is reached; or
7. The date the master group Policy ends.

The Covered Dependent will be eligible for conversion after exhaustion of continuation of coverage.

[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 plan if:

1. The Covered Dependent's insurance terminates due to a valid decree of divorce between the Certificate Holder and the Covered Dependent; or
2. The Covered Dependent's insurance terminates due to the death of the Certificate Holder; 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 enrollment form and the required premium to Us within 31 days after coverage under this plan 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 enrollment is not made within [31 days] following the termination of insurance under this plan, 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 plan terminates. The time during which a Pre-Existing Condition Limitation [and a Benefit Waiting Period apply][applies] under the new plan will be reduced by the total number of consecutive days that You were covered under this Certificate 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 Certificate if coverage under this Certificate would have remained in force.]

[X]. OTHER PROVISIONS

Modification of Coverage

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

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

The group master Policy may be changed at any time. We will give the Policyholder [30 days] notice prior to any change.

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 payment of the benefits under this Certificate 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 Certificate is issued to the Certificate Holder. The entire contract of insurance includes the group master Policy, a Covered Person's Certificate, Benefit Schedule, [application][enrollment] form and any riders and endorsements.

Representations Made on [Application][Enrollment Form]

All statements made on the [application][enrollment] form will be deemed representations and not warranties. No statement made in the [application][enrollment] form will be used in any suit or action at law or equity unless a copy of the [application][enrollment] form is furnished to the Certificate Holder, or in the event of death or incapacity of the Certificate Holder, a copy will be furnished to the Certificate Holder'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 plan 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 [60-90] days after termination. Benefits are subject to all the terms, limits and conditions in this plan. [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. [90-180] days from the date coverage would have terminated under this plan if there was no extension of benefits.
4. The date the Covered Person is eligible for Medicare.
5. The earliest date otherwise permitted by law.

[Incentives, Rebates and Contributions

We may elect to furnish or participate in programs with other organizations that furnish [group applicants for coverage] [members of groups applying for coverage] [individual applicants for coverage] [Covered Persons] [individuals] [that meet common criteria or requirements determined by Us][, not to include health or claims history,] [with “premium holidays” or programs where premiums, fees or plan benefit limits will be discounted, credited, refunded, waived or otherwise adjusted] [or] [where other gifts or items of value may be offered or provided to You at no charge or at a discount] [at a time or times] [for a period of time] determined by Us.]

Discounted or Free Non-Insurance Programs We may elect to furnish or participate in programs with other organizations that furnish Certificate Holders that meet common criteria or requirements determined by Us with discount cards, vouchers, coupons, or other programs that may be offered or provided to Covered Persons at no charge or a reduced charge for a period of time determined by Us. We may provide You with access to discounts with certain health care providers and suppliers negotiated by Us.

[Provider Access

We may provide Covered Persons with access to providers with whom We have a contracted rate for services or supplies. Our fixed-indemnity benefit payment for a Covered Event does not change regardless of whether or not We have a contracted rate with the provider from whom You obtain hospital, medical, surgical or prescription services or supplies or the cost of treatment occurring as part of the Covered Event. By using such providers to obtain Your medical services or supplies, You may obtain a lower cost of services or supplies. You must show Your plan ID card at the time services are rendered to obtain these contracted rates, if available.]

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 (Time Limit on Certain Defenses)

Within the first two years after the Effective Date of coverage, We have the right to rescind or modify Your Certificate of insurance coverage and/or deny a claim for a Covered Person if the [application][enrollment] form contains an omission or misrepresentation, whether intended or not, which We determine to be material. We

also reserve the right to rescind a Certificate of insurance 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 in equity may be brought to recover benefits under this plan prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Certificate. No suit or action at law or in 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.]

Forum

Any lawsuits or disputes arising under the terms of the Certificate or Policy must be brought in the United States District Court for the Eastern District of Wisconsin.

BENEFIT SCHEDULE
 Limited Hospital Confinement and Other Fixed Indemnity Benefits

Date of this Benefit Schedule: [XX/XX/XXXX]

THIS BENEFIT SCHEDULE CONTAINS LIMITED INFORMATION ABOUT YOUR PLAN. IN ADDITION, THE PLAN HAS LIMITED BENEFITS AND ANNUAL MAXIMUMS. PLEASE READ YOUR CERTIFICATE CAREFULLY TO UNDERSTAND PLAN LIMITATIONS. REVIEW THIS BENEFIT SCHEDULE FOR INFORMATION ON WHAT BENEFITS ARE PROVIDED.

Benefits will be paid for hospital confinement and medical Covered Events Incurred while this plan is in force. Payment of benefits is subject to all the terms, limits and conditions in the plan.

Policyholder, Certificate Holder and Plan Information	
Policyholder:	[ABC Association]
Certificate Holder:	[Name] Effective Date: [XX/XX/XXXX] [Address/City/State/Zip]
Covered Dependents:	[Spouse's Name] [Effective Date: [XX/XX/XXXX]] [Dependent Child's Name] [Effective Date: [XX/XX/XXXX]] [Dependent Child's Name] [Effective Date: [XX/XX/XXXX]]
Certificate Number:	[XXXXXXXX]
Initial Annual Premium:	[\$XXX.XX]
Initial Payment Option Mode:	[Monthly]
Initial Modal Premium:	[\$XXX.XX]
Hospital Confinement and Other Fixed Indemnity Benefits We will pay the Scheduled Benefit shown below only for the Covered Events listed in the Hospital Confinement and Other Fixed Indemnity Benefits section of the plan.	
[[Maximum Lifetime Benefit:]]	[\$XXX,XXX] – All benefit payments apply to the Maximum Lifetime Benefit unless otherwise indicated.]
[Benefit Waiting Period for Sickness:	Events caused by or related to Sickness are eligible for benefits under this plan only if the hospital confinement or medical event occurs after the first [2-180] calendar days from the Effective Date. There is no waiting period on events due to Injury.]
[Initial Hospitalization Benefit	<ul style="list-style-type: none"> • [Benefit Waiting Period for Sickness: [2-180] days from the Effective Date.] • Scheduled Benefit per Confinement Period[for Sickness]: \$[XX] • [Scheduled Benefit per Confinement Period for Injury: \$[XX]] • The Maximum Benefit is one (1) Initial Hospitalization Benefit per Calendar Year, per Covered Person.]
[Inpatient Hospital Confinement	<ul style="list-style-type: none"> • [Benefit Waiting Period for Sickness: [2-180] days from the

Benefits:	<p>Effective Date.]</p> <ul style="list-style-type: none"> • Scheduled Benefit per day of a Confinement Period due to Sickness: \$[XXXX] • Scheduled Benefit per day of a Confinement Period due to Injury: \$[XXXX] • If treated for both a Sickness and an Injury during a Confinement Period, only the Injury benefit above will be paid. • All Inpatient Hospital Confinement Benefits are limited to a Maximum Benefit of \$[XXX,XXX][[X] days] per Calendar Year, per Covered Person.] 														
[Rehabilitation Unit Confinement Benefits	<ul style="list-style-type: none"> • [Benefit Waiting Period for Sickness: [2-180] days from the Effective Date.] • Scheduled Benefit per day of a Confinement Period due to rehabilitation for Sickness: \$[XXXX] • Scheduled Benefit per day of a Confinement Period due to rehabilitation for Injury: \$[XXXX] • If rehabilitation is provided for both a Sickness and an Injury during a Confinement Period, only the Injury benefit above will be paid. • All Rehabilitation Unit Confinement Benefits are limited to a Maximum Benefit of \$[XXXX][[X] days] per Calendar Year, per Covered Person.] 														
[Emergency Room [and Urgent Care Facility] Visit Benefits	<ul style="list-style-type: none"> • [Benefit Waiting Period for Sickness: [2-180] days from the Effective Date.] • Scheduled Benefit per Emergency Room visit: \$[XX] • [Scheduled Benefit per Urgent Care visit: \$[XX]] • All Emergency Room Visits Benefits [and Urgent Care Visit Benefits combined] are limited to a Maximum Benefit of \$[XXXX] [[X] visit[s]] [per Calendar Year, per Covered Person.] 														
[Urgent Care Facility Visit Benefits	<ul style="list-style-type: none"> • [Benefit Waiting Period for Sickness: [2-180] days from the Effective Date.] • Scheduled Benefit per Urgent Care visit: \$[XX] • All Urgent Care Visit Benefits are limited to a Maximum Benefit of \$[XXXX] [[X] visit[s]] [per Calendar Year, per Covered Person.] 														
[Outpatient Medical Event Benefits:	<p>All Outpatient Medical Event Benefits combined are limited to a Maximum Benefit of \$[XX][[X] Covered Events] per Calendar Year, per Covered Person.</p> <ul style="list-style-type: none"> • [Benefit Waiting Period for Sickness: [2-180] days from the Effective Date.] • Scheduled Benefits: <table border="1" data-bbox="618 1661 1430 1917"> <thead> <tr> <th data-bbox="618 1661 1149 1696">Outpatient Medical Event</th> <th data-bbox="1149 1661 1430 1696">Scheduled Benefit</th> </tr> </thead> <tbody> <tr> <td data-bbox="618 1696 1149 1732">[Laboratory Service</td> <td data-bbox="1149 1696 1430 1732"></td> </tr> <tr> <td data-bbox="618 1732 1149 1768">[Surgical Pathology</td> <td data-bbox="1149 1732 1430 1768">\$[XX]</td> </tr> <tr> <td data-bbox="618 1768 1149 1803">[All other laboratory services</td> <td data-bbox="1149 1768 1430 1803">\$[XX]</td> </tr> <tr> <td data-bbox="618 1803 1149 1839"></td> <td data-bbox="1149 1803 1430 1839"></td> </tr> <tr> <td data-bbox="618 1839 1149 1875">[Radiology Services</td> <td data-bbox="1149 1839 1430 1875"></td> </tr> <tr> <td data-bbox="618 1875 1149 1917">[Mammogram</td> <td data-bbox="1149 1875 1430 1917">\$[XX]</td> </tr> </tbody> </table>	Outpatient Medical Event	Scheduled Benefit	[Laboratory Service		[Surgical Pathology	\$[XX]	[All other laboratory services	\$[XX]			[Radiology Services		[Mammogram	\$[XX]
Outpatient Medical Event	Scheduled Benefit														
[Laboratory Service															
[Surgical Pathology	\$[XX]														
[All other laboratory services	\$[XX]														
[Radiology Services															
[Mammogram	\$[XX]														

	<table border="1"> <tr> <td>[Computerized Tomography (CT) Scan</td> <td>[\$XX]</td> </tr> <tr> <td>[Magnetic Resonance Imaging (MRI)</td> <td>[\$XX]</td> </tr> <tr> <td>[Positron Emission Tomography (PET) Scan</td> <td>[\$XX]</td> </tr> <tr> <td>[All other radiology services</td> <td>[\$XX]</td> </tr> <tr> <td></td> <td></td> </tr> <tr> <td>[Physical Medicine</td> <td></td> </tr> <tr> <td>[Physical Therapy (PT)</td> <td>[\$XX]</td> </tr> <tr> <td>[Occupational Therapy (OT)</td> <td>[\$XX]</td> </tr> <tr> <td>[Speech Therapy (ST)</td> <td>[\$XX]</td> </tr> <tr> <td></td> <td></td> </tr> <tr> <td>[All Other Outpatient Events, not otherwise shown on this Benefit Schedule:</td> <td>[\$XX]]</td> </tr> <tr> <td></td> <td></td> </tr> </table>	[Computerized Tomography (CT) Scan	[\$XX]	[Magnetic Resonance Imaging (MRI)	[\$XX]	[Positron Emission Tomography (PET) Scan	[\$XX]	[All other radiology services	[\$XX]			[Physical Medicine		[Physical Therapy (PT)	[\$XX]	[Occupational Therapy (OT)	[\$XX]	[Speech Therapy (ST)	[\$XX]			[All Other Outpatient Events, not otherwise shown on this Benefit Schedule:	[\$XX]]		
[Computerized Tomography (CT) Scan	[\$XX]																								
[Magnetic Resonance Imaging (MRI)	[\$XX]																								
[Positron Emission Tomography (PET) Scan	[\$XX]																								
[All other radiology services	[\$XX]																								
[Physical Medicine																									
[Physical Therapy (PT)	[\$XX]																								
[Occupational Therapy (OT)	[\$XX]																								
[Speech Therapy (ST)	[\$XX]																								
[All Other Outpatient Events, not otherwise shown on this Benefit Schedule:	[\$XX]]																								
[Office Visit Benefits:	<ul style="list-style-type: none"> • [Benefit Waiting Period for Sickness: [2-180] days from the Effective Date.] • Scheduled Benefit: [\$XX] per Office Visit in a Retail Health Clinic.] <ul style="list-style-type: none"> • \$[XX] per Office Visit in a [Primary Care][Health Care] Practitioner's office. • \$[XX] per Office Visit in a Specialist Practitioner's office.] • [Office Visit Benefits [in a Retail Health Clinic] are limited to a Maximum Benefit of [\$XX]][[X] visit[s]] [per month][per Calendar Year], per Covered Person.] • [Office Visit Benefits [in a Primary Care][Health Care][Practitioner' office] are limited to a Maximum Benefit of [\$XX]][[X] visit[s]] [per month][per Calendar Year], per Covered Person.] • [Office Visit Benefits Specialist Practitioner's office are limited to a Maximum Benefit of [\$XX]][[X] visit[s]] [per month][per Calendar Year], per Covered Person.] • Office Visit Benefits [combined] are limited to a Maximum Benefit of [\$XX]][[X] visit[s]] per Calendar Year, per Covered Person.] 																								
[[Immunization][and][or][Allergy Immunotherapy Injection] Benefits]	<ul style="list-style-type: none"> • [Benefit Waiting Period for Sickness: [2-180] days from the Effective Date.] • Scheduled Benefit per immunization: \$[X] • Scheduled Benefit per allergy immunotherapy injection: \$[X] • [[All] [Immunization][and][Allergy Immunotherapy Injection] Benefits [combined]are limited to a Maximum Benefit of [\$XX]][[X] Covered Events] per Calendar Year, per Covered Person.]] 																								
[Telehealth Benefits	<ul style="list-style-type: none"> • [Benefit Waiting Period for Sickness: [2-180] days from the Effective Date.] • [Scheduled Benefit per Telehealth Services event: \$[X]] • [All Telehealth Benefits combined are limited to a Maximum Benefit of [\$XX]][[X] Covered Events] per Calendar Year, per Covered Person.] 																								

<p>[[Telehealth] [and] [Telemedicine] Benefits</p>	<ul style="list-style-type: none"> • [Benefit Waiting Period for Sickness: [2-180] days from the Effective Date.] • [Scheduled Benefit per Telehealth Services event: \$[X]] • [Scheduled Benefit per Telemedicine Services event: \$[X]] • [[All] [Telehealth] [and] [Telemedicine] Benefits [combined] are limited to a Maximum Benefit of [\$[XX]][[X] Covered Events] per Calendar Year, per Covered Person.]]
<p>[Outpatient Prescription Order Benefits:</p>	<ul style="list-style-type: none"> • [Benefit Waiting Period for Sickness: 2-180] days from the Effective Date.] • Scheduled Benefit per [Generic] Prescription Drug: \$[XX]. • [Scheduled Benefit per [Preferred] Brand Name Prescription Drug: \$[XX]. • [Scheduled Benefit per [Non-Preferred] Brand Name Prescription Drug: \$[XX]] • [If a Generic Prescription Drug is available and You receive a [Non-Preferred] Brand Name Prescription Drug, only the Scheduled Benefit for the Generic Prescription Drug will be paid.] • [Outpatient Prescription Order Benefits are limited to a Maximum Benefit of [\$[XX]][[X] Covered Events] per month, per Covered Person.] • All Outpatient Prescription Order Benefits are limited a Maximum Benefit of [\$[XX]][[X] Covered Events] per Calendar Year, per Covered Person.]
<p>[Professional Ground [or Air] Ambulance Services Benefits:</p>	<ul style="list-style-type: none"> • [Benefit Waiting Period for Sickness: [2-180] days from the Effective Date.] • Scheduled Benefit per trip by ground ambulance: \$[XX]. • [Scheduled Benefit per trip by air ambulance: \$[XX].] • [All Professional Ground [or Air] Ambulance Services Benefits combined are limited to a Maximum Benefit of [\$[XX]][[X] one-way trip[s]] per Calendar Year, per Covered Person.] • [All Professional [Ground] [or] [Air] Ambulance Services Benefits combined are limited to a Maximum Benefit of [\$[XX]][[X] one-way trip[s]] per Calendar Year, per Covered Person.]]
<p>[Anesthesia Benefit</p>	<ul style="list-style-type: none"> • [Benefit Waiting Period for Sickness: [2-180] days from the Effective Date.] • Scheduled Benefit per anesthesia Event: \$[XX] • All Anesthesia Benefits are limited to a Maximum Benefit of [\$[XX]][[X] Covered Events] per Calendar Year, per Covered Person.]
<p>[Surgical Services Benefits:</p>	<ul style="list-style-type: none"> • [Benefit Waiting Period for Sickness: [2-180] days from the Effective Date.] • The Scheduled Benefit for surgical Covered Events is the amount shown in the Surgical Schedule below for the corresponding Surgical Event. • Two or more Surgical Events performed during the same operative session are considered one operation and the Surgical Services Benefit will be considered based on the event with the highest Scheduled Benefit shown in the Surgical Schedule.

	All Surgical Services Benefits are limited to a Maximum Benefit of [XX][X Covered Events] [per Calendar Year][,] [per Covered Person][over the lifetime of each Covered Person].]
--	--

[Surgical Schedule

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	Scheduled Benefit
[Insertion of electrode leads and pulse generator	\$[XX]
[Upgrade of implanted pacemaker system, including conversion of a single chamber system to a dual chamber system	\$[XX]
[Valvotomy, mitral valve; closed heart	\$[XX]
[Valvuloplasty, mitral valve, with cardiopulmonary bypass	\$[XX]
[Valvotomy, pulmonary valve, closed heart; transventricular	\$[XX]
[Repair atrial septal defect, secundum, with cardiopulmonary bypass, with or without patch	\$[XX]
[Ligation, division, and stripping, short or long saphenous vein	\$[XX]
[Ligation, division, and stripping, of short and long saphenous vein, bilateral	\$[XX]
[Catheterization – left heart	\$[XX]
Surgical Event on Digestive System	Scheduled Benefit
[Biopsy of salivary gland, needle	\$[XX]
[Biopsy of salivary gland, incisional	\$[XX]
[Tonsillectomy, with or without adenoidectomy, under 12 years of age	\$[XX]
[Tonsillectomy, with or without adenoidectomy, 12 and over years of age	\$[XX]
[Excision, local; ulcer or benign tumor of stomach	\$[XX]
[Gastrectomy, total	\$[XX]
[Colectomy, total, with proctectomy; with ileostomy	\$[XXX]
[Incision and drainage of appendicular abscess, open	\$[XX]
[Appendectomy – open	\$[XX]
[Appendectomy – laparoscopic	\$[XX]
[Proctectomy; complete, combined abdominoperineal, with colostomy	\$[XX]
[Colonoscopy – diagnostic [or preventive screening]	\$[XX]
[Colonoscopy with biopsy	\$[XX]
[Colonoscopy with removal of tumor, polyp or other lesions	\$[XX]
[Upper Gastro-Intestinal (GI) Endoscopy with biopsy	\$[XX]
[Upper Gastro-Intestinal (GI) Endoscopy - diagnostic	\$[XX]
[Incision of rectal fistula, superficial	\$[XX]
[Fissurectomy, with or without sphincterotomy	\$[XX]
[Hemorrhoidectomy, external, complete	\$[XX]
[Hemorrhoidectomy, internal and external, complete	\$[XX]
[Cholecystectomy (removal of gall bladder) – open without exploration of common	\$[XX]

duct	
[Cholecystectomy – open with exploration of common duct	[\$XX]
[Cholecystectomy – laparoscopic, with or without exploration of common duct	[\$XX]
[Cholecystectomy – laparoscopic, with graph	[\$XX]
[Pancreatectomy, total	[\$XX]
[Exploratory laparotomy; exploratory celiotomy	[\$XX]
[Repair inguinal hernia; sliding; any age	[\$XX]
[Repair initial femoral hernia	[\$XX]
Surgical Event on Ear	Scheduled Benefit
[Tympanostomy	[\$XX]
[Stapes mobilization	[\$XX]
[Fenestration of semicircular canal	[\$XX]
Surgical Event on Eye	Scheduled Benefit
[Removal of foreign body, conjunctival, superficial	[\$XX]
[Removal of foreign body, corneal, with or without slit lamp	[\$XX]
[Excision or transposition of pterygium; without graft	[\$XX]
[Cataract removal, intra capsular, extracapsular, with insertion of intraocular lens	[\$XX]
[Repair of retinal detachment; scleral buckling, with or without implant	[\$XX]
[Muscle operation involving one or more muscles in one or both eyes	[\$XX]
Surgical Event Related to Gynecology	Scheduled Benefit
[Incision and drainage of Bartholin's gland abscess	[\$XX]
[Excision of Bartholin's gland or cyst	[\$XX]
[Anterior colporrhaphy, repair of cystocele, with or without repair of urethrocele	[\$XX]
[Posterior colporrhaphy, repair of rectocele with or without perineorrhaphy	[\$XX]
[Combined anteroposterior colporrhaphy	[\$XX]
[Cautery of cervix; electro or thermal	[\$XX]
[Dilation and curettage, diagnostic and/or therapeutic (non-obstetrical)	[\$XX]
[Total abdominal hysterectomy (corpus and cervix), with or without removal of tube(s), with or without removal of ovary(s)	[\$XX]
[Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary(s)	[\$XX]
[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)	[\$XX]
[Salpingectomy, complete or partial, unilateral or bilateral (separate procedure)	[\$XX]
[Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)	[\$XX]
[Hysteroscopy - biopsy	[\$XX]
[Hysteroscopy - ablation	[\$XX]
Surgical Event on Musculoskeletal System	Scheduled Benefit
[Muscle biopsy, superficial	[\$XX]
[Muscle biopsy, deep	[\$XX]
[Arthrocentesis, large joint	[\$XX]

[Removal of implant; superficial, (e.g., buried wire, pin or rod) (separate procedure)	\$\$[XX]
[Closed treatment of mandibular fracture with interdental fixation	\$\$[XX]
[Arthrodesis, including laminectomy and/or diskectomy	\$\$[XX]
[Closed treatment of clavicular fracture; without manipulation	\$\$[XX]
[Open treatment of clavicular fracture, with or without internal or external fixation	\$\$[XX]
[Closed treatment of proximal humeral (surgical or anatomical neck) fracture; without manipulation	\$\$[XX]
[Open treatment of proximal humeral (surgical or anatomical neck) fracture, with or without internal or external fixation, with or without repair of tuberosity(s)	\$\$[XX]
[Closed treatment of shoulder dislocation, with manipulation; without anesthesia	\$\$[XX]
[Closed treatment of shoulder dislocation, with manipulation; requiring anesthesia	\$\$[XX]
[Open treatment of acute shoulder dislocation	\$\$[XX]
[Arthroscopy - shoulder	\$\$[XX]
[Arthrotomy, elbow, including exploration, drainage, or removal of foreign body	\$\$[XX]
[Treatment of closed elbow dislocation; without anesthesia	\$\$[XX]
[Treatment of closed elbow dislocation; requiring anesthesia	\$\$[XX]
[Open Treatment of acute or chronic elbow dislocation	\$\$[XX]
[Closed treatment of ulnar shaft fracture; without manipulation	\$\$[XX]
[Open treatment of ulnar shaft fracture	\$\$[XX]
[Closed treatment of radial and ulnar shaft fractures	\$\$[XX]
[Open treatment; fixation of radius or ulna	\$\$[XX]
[Open treatment; fixation of radius AND ulna	\$\$[XX]
[Closed treatment of distal radial fracture (e.g., Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid; without manipulation	\$\$[XX]
[Open treatment of distal radial fracture or epiphyseal separation, with internal fixation	\$\$[XX]
[Arthrotomy, with exploration, drainage, or removal of loose or foreign body; interphalangeal joint, each	\$\$[XX]
[Excision of lesion of tendon sheath or joint capsule (e.g., cyst, mucous cyst, or ganglion), hand or finger	\$\$[XX]
[Closed treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb; without manipulation, each	\$\$[XX]
[Open treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb; without manipulation, each	\$\$[XX]
[Amputation, finger or thumb, primary or secondary, any joint or phalanx, single, including neurectomies; with direct closure	\$\$[XX]
[Arthrotomy, hip, including exploration or removal of loose or foreign body	\$\$[XX]
[Closed treatment of femoral fracture, proximal end, neck; without manipulation	\$\$[XX]
[Closed treatment of femoral fracture, proximal end, neck; with manipulation	\$\$[XX]
[Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement	\$\$[XX]
[Arthroplasty, hip	\$\$[XX]
[Arthroscopy, knee	\$\$[XX]
[Arthrotomy, knee, with exploration, drainage, or removal of foreign body	\$\$[XX]
[Amputation, thigh, through femur, any level	\$\$[XX]
[Amputation, thigh, through femur, any level; open, circular (guillotine)	\$\$[XX]
[Closed reduction of fracture of tibia, shaft	\$\$[XX]
[Closed treatment of tibial shaft fracture (with or without fibular fracture); with	\$\$[XX]

manipulation	
[Open treatment of fracture of tibia, shaft	[\$XX]
[Closed treatment of proximal fibula or shaft fracture; without manipulation	[\$XX]
[Open treatment of proximal fibula or shaft fracture, with or without internal or external fixation	[\$XX]
[Closed treatment of distal fibular fracture (lateral malleolus); without manipulation	[\$XX]
[Open treatment of distal fibular fracture (lateral malleolus)	[\$XX]
[Closed treatment of bimalleolar ankle fracture, (including Potts); without manipulation	[\$XX]
[Closed treatment of bimalleolar ankle fracture, (including Potts); with manipulation	[\$XX]
[Open treatment of bimalleolar ankle fracture, with or without internal or external fixation	[\$XX]
[Excision of lesion, tendon, tendon sheath, or capsule (including synovectomy) (e.g., cyst or ganglion); toes, wrist, forearm, foot, ankle	[\$XX]
[Carpal Tunnel surgery	[\$XX]
[Closed treatment of fracture great toe	[\$XX]
[Open treatment of fracture great toe	[\$XX]
[Closed treatment of fracture of toes, other than great toes, without manipulation, each	[\$XX]
[Open treatment of fracture of toes, other than great toes, without manipulation, each	[\$XX]
[Amputation, toe; interphalangeal joint	[\$XX]
Surgical Event on Nervous System	Scheduled Benefit
[Burr hole(s) with evacuation and/or drainage of hematoma, extradural or subdural	[\$XX]
[Burr holes , intracerebral	[\$XX]
[Craniectomy or craniotomy for evacuation of hematoma, supratentorial; extradural or subdural	[\$XX]
[Craniectomy or craniotomy for evacuation of hematoma, infratentorial; extradural or subdural	[\$XX]
[Craniectomy, trephination, bone flap craniotomy; for excision of brain tumor, supratentorial, except meningioma	[\$XX]
[Spinal puncture, lumbar, diagnostic	[\$XX]
[Injection procedure for myelography and/or computed tomography, spinal (other than C1-C2 and posterior fossa)	[\$XX]
[Injection procedure for diskography	[\$XX]
[Laminectomy with decompression of spinal cord and discectomy, cervical	[\$XX]
[Laminotomy and/or excision of herniated intervertebral disk, single interspace	[\$XX]
[Sympathectomy, cervical	[\$XX]
[Sympathectomy, lumbar	[\$XX]
Surgical Event on Respiratory System	Scheduled Benefit
[Excision of nasal polyp(s), simple	[\$XX]
[Excision of nasal polyp(s), extensive requiring hospitalization	[\$XX]
[Submucous resection, classic, nasal septum	[\$XX]
[Laryngectomy; total, without radical neck dissection	[\$XX]
[Laryngectomy; total, with radical neck dissection	[\$XX]

[Bronchoscopy, diagnostic without biopsy	[\$XX]
[Bronchoscopy with bronchial or endobronchial biopsy	[\$XX]
[Bronchoscopy with removal of foreign body	[\$XX]
[Bronchoscopy with excision of tumor	[\$XX]
[Thoracotomy, exploratory, including biopsy	[\$XX]
[Lobectomy, total, subtotal, or segmentation, single lobe	[\$XX]
[Bilobectomy	[\$XX]
[Pulmonary resection with concomitant thoracoplasty	[\$XX]
Surgical Event Related to Skin Lesions, Cysts and Mastectomy	Scheduled Benefit
[Incision and drainage of abscess; simple or single	[\$XX]
[Incision and drainage of pilonidal cyst	[\$XX]
[Biopsy of skin, subcutaneous tissue and/or mucous membrane, single lesion	[\$XX]
[Biopsy of each additional lesion in addition to primary procedure	[\$XX]
[Excision, benign lesions including margins, except skin tag, 2cm or less	[\$XX]
[Excision, benign lesions including margins, except skin tag, over 2 cm	[\$XX]
[Excision of pilonidal cyst or sinus, simple	[\$XX]
[Excision of pilonidal cyst or sinus, extensive	[\$XX]
[Excision of pilonidal cyst or sinus, complicated	[\$XX]
[Destruction of benign or premalignant lesions; one lesion	[\$XX]
[Destruction of benign or premalignant lesions, second thru 14 lesions, each	[\$XX]
[Wart destruction, up to 14	[\$XX]
[Wart destruction 15 or more	[\$XX]
[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	[\$XX]
[Mastectomy, simple, complete	[\$XX]
[Radical mastectomy, including breast, pectoral muscles and axillary lymph nodes	[\$XX]
Surgical Event Related to Thyroid	Scheduled Benefit
[Excision of cyst or adenoma of thyroid	[\$XX]
[Partial thyroidectomy unilateral	[\$XX]
[Thyroidectomy, total or complete	[\$XX]
[Total or subtotal for malignancy with limited neck dissection	[\$XX]
[Total or subtotal for malignancy with radical neck dissection	[\$XX]
[Thyroidectomy, removal of all remaining thyroid tissue following previous removal of a portion of thyroid	[\$XX]
Surgical Event Related to Urinary System	Scheduled Benefit
[Cystoscopy	[\$XX]
[Nephrectomy	[\$XX]
[Kidney lithotripsy	[\$XX]
[Excision or fulguration of Skene's glands	[\$XX]
Surgical Event for Transplants	Scheduled Benefit
[Heart Transplant	[\$XX]
[Lung Transplant	[\$XX]
[Heart/Lung Transplant	[\$XX]
[Liver Transplant	[\$XX]

[Kidney Transplant	[\$XX]
[Pancreas Transplant	[\$XX]
[Bone Marrow/Stem Cell Transplant	[\$XX]
[Cornea Transplant	[\$XX]
[Skin Transplant	[\$XX]
[Surgical Event – Not Otherwise Listed	Scheduled Benefit
[For all other surgical Events not listed above:	[\$XX]]

PERSON(S) TO BE INSURED

[Attach a separate sheet, signed and dated, if additional space is needed below. Label additional dependents starting with the letter "E" and after.]

[Only complete the [spouse] [/domestic partner] [/civil union] [and] [dependent] information if it applies.]

	Last	Name First	MI	Sex	Birthdate (MM/DD/YY)	State of Birth	Social Security Number
1. Primary							
[2.] Spouse [/Domestic Partner] [/Civil Union]							
[3.] [Dependents (list relationship below)]	Last	Name First	MI	Sex	Birthdate (MM/DD/YY)	Full-time student?	Social Security Number
[A.]							
[B.]							
[C.]							
[D.]							

[Examples of types of coverage are individual medical insurance, group insurance, and supplemental coverage for specific conditions, like cancer.]

[4.] [Resident Address: _____]
 (NO P.O. BOXES) (Street) (City) (State) (ZIP)

[5.] [Phone Number: (____) _____] [6.] [E-mail Address: _____]

[7]a. [[Are] [Is] [any of] the proposed insured[s] covered by, or has application been made for any type of medical insurance?..... Yes No]
 [If "Yes," complete the section below.]

Proposed Insured's Name	Insurance Company Name	Group or Individual	Type of Coverage	Effective Date (MM/DD/YY)	Termination Date (MM/DD/YY)	Is this coverage being replaced by proposed coverage?

[7]b. [Primary Insured Occupation: _____]

[Company Name: _____] [Work Number: (____) _____]

[Duties: _____]

[Is the Primary Insured [self-employed] [or] a [sole proprietor]?..... Yes No]

[Is the Primary Insured covered by Workers' Compensation?..... Yes No]

[7]c. [Spouse [/Domestic Partner] [/Civil Union] Occupation: _____]

[Company Name: _____] [Work Number: (____) _____]

[Duties: _____]

[Is the Spouse [/Domestic Partner] [/Civil Union] [self-employed]

[or] a [sole proprietor]?..... Yes No]

[Is the Spouse [/Domestic Partner] [/Civil Union] covered by

Workers' Compensation?..... Yes No]

REQUESTED EFFECTIVE DATE

[8.] [Requested effective date: _____]

[Your effective date is based on the date [you sign] [we receive] your enrollment form.] [If [you sign] [we receive] it on the [1st] through the [15th] of the month, your effective date will be the [1st] of the [following] month. If [you sign] [we receive] the enrollment form on the [16th] through the [31st] of the month, your effective date will be the [15th] of the [following] month.] [Check with your agent for more details.]

[FAX ALL PAGES EXCEPT "IMPORTANT NOTICES" TO [414-299-6020]

[HEALTH STATEMENT

[To determine if you're eligible for this [hospital] [confinement] [and] [surgical] [fixed indemnity] [insurance] [plan][,] you need to answer a few medical questions [for you and anyone else applying for this plan.]

[Attach a separate sheet if additional information is needed. Date and sign any additional sheets.]

[Note: The plan cannot be issued to any person who answers YES to any of the following questions.]

[Primary] [Spouse] [A.] [B.] [C.] [D.]
 [Enter dependent information in same order as page 1.]

[9.] [[Are you] [or] [,] [your spouse] [,] [or any person to be insured] now pregnant, an expectant parent, in the process of adopting a child or undergoing infertility treatment? Yes No

[10.] [[Are you] [or] [,] [your spouse] [,] [or any person to be insured] totally and permanently disabled and/or receiving long-term disability benefits? Yes No

[11.] [For any of the following conditions within the last [5] years, have you [or any person to be insured] received any abnormal test results or medical or surgical treatment, or consulted a health care professional, or taken medication for:

- [Heart disorder][, excluding] [Mitral Valve Prolapse (MVP)] [or] [surgically corrected or closed] [Atrial Septal Defect (ASD)][/][Ventricular Septal Defect (VSD)]
- [Stroke] [or] [,] [Brain Aneurysm]
- [Peripheral Vascular Disease (PVD)] [or] [,] [Peripheral Arterial Disease (PAD)]
- [Crohn's Disease] [or] [Ulcerative Colitis]
- [Liver disorders][, excluding fully recovered Hepatitis A]
- [Kidney disorders [, excluding kidney stones]
- [Emphysema] [or] [,] [Chronic Obstructive Pulmonary Disease (COPD)] [or] [,] [Fibrotic Lung Disease] [or] [,] [Primary Pulmonary Hypertension]
- [Diabetes][, excluding Gestational Diabetes]
- [Basal Cell Carcinoma with recommended surgery that has not been completed]
- [Cancer] [or] [Tumor]
- [Alcoholism] [or] [,] [Alcohol or Chemical Dependency][,] [or] [Drug or Alcohol Abuse]
- [Acquired Immune Deficiency Syndrome (AIDS)] [or] [tested positive for Human Immunodeficiency Virus (HIV)]
- [Multiple Sclerosis (MS)]
- [Tuberculosis (TB)]
- [Any condition that resulted in a surgery or procedure whose purpose is to promote weight-loss]
- [Autism Spectrum Disorders] [or] [,] [Autism] [or] [,] [Asperger's Disorder] [or] [,] [Rett's Syndrome] [or] [,] [Pervasive Developmental Disorders] [or] [,] [Pervasive Developmental Delay]]

[FAX ALL PAGES EXCEPT "IMPORTANT NOTICES" TO [414-299-6020]

BILLING

[You have [four] choices for billing. It's important to note we'll request funds as soon as we issue your policy.]

[You have [four] billing methods to choose from:]

[[1.][Monthly payroll deduction [(list bill)]]

→ Assigned [list bill] number, if known: _____
[Note to agent: This option requires the employer have a list bill agreement on file.]

[[2.][Monthly [Electronic Funds Transfer] [(EFT)][/Check-O-Matic] [/Automatic Bank Draft]

→ To begin withdrawals:
Select a desired withdrawal date [1-28]: _____

Bank name: _____

City: _____ State: _____

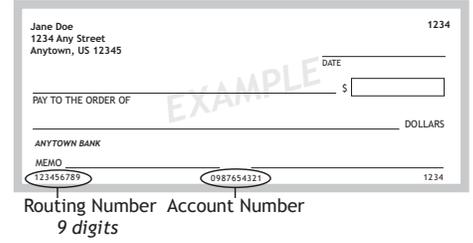
Routing number: _____

Account number: _____

→ To add this policy to an existing [Electronic Funds Transfer] [(EFT)] [/Check-O-Matic] [/Automatic Bank Draft]
Existing [Electronic Funds Transfer] [(EFT)] [/Check-O-Matic] [/Automatic Bank Draft]

number: _____

Associated policy number: _____]



[We recommend you pick [a] [an] [Electronic Funds Transfer] [(EFT)] [/Check-O-Matic] [/Automatic Bank Draft] draft date that is the same as your effective date.]

[The accountholder's signature is needed here if requesting [Electronic Funds Transfer] [(EFT)] [/Check-O-Matic] [/Automatic Bank Draft].]

Authorization for [Electronic Funds Transfer] [(EFT)] [/Check-O-Matic] [/Automatic Bank Draft] – please sign below

I (we) hereby authorize Time Insurance Company, hereinafter called COMPANY, to initiate debit entries to the account and depository, hereinafter called DEPOSITORY, to debit the same to such account. This authority is to remain in full force and effect until COMPANY and DEPOSITORY have received written notification from me (or either of us) of its termination in such time and in such manner as to afford COMPANY and DEPOSITORY a reasonable opportunity to act on it.

Accountholder signature: _____ Date: _____

[You have [two] options if choosing to pay by credit card [– recurring or 1st payment only].]

[[3.][Credit card] → Choose how often: Monthly] Quarterly] Semi-Annual] Annual]
[or
→ Charge first payment only*]

[*You must also select a secondary billing method other than payroll deduction [(list bill)] for subsequent payments. Once you choose below, go to that section and complete.]

Choose method: Payroll deduction] [(list bill)]
 [Monthly [Electronic Funds Transfer] [(EFT)] [/Check-O-Matic] [/Automatic Bank Draft]]] Bill me directly]]

[The cardholder's signature is needed here if requesting to pay by credit card.]

Authorization for credit card payments – please sign below

I authorize Time Insurance Company to charge my account for the [hospital] [confinement] [and] [surgical] [fixed indemnity] [insurance] [plan]. I understand there will be no refund of premium after the [10-30]-day free look in the contract.

Card number: _____ - _____ - _____ - _____

Card type: MasterCard VISA

Expiration date: ____/____ [Security code number ([3] digits on back of card): ____ ____ ____]

Name as it appears on card: _____

Address of cardholder, if different: _____

Cardholder signature: _____ Date: _____]

[Please complete this if your billing address is different than your home address.]

[[4.][Bill me directly: → Choose how often: Monthly] Quarterly] Semi-Annual] Annual]]

If your billing address is different than your home address, please enter it here:

Billing Address: _____
(Street) (City) (State) (ZIP)

Name of person paying, if different: _____]

[FAX ALL PAGES EXCEPT "IMPORTANT NOTICES" TO [414-299-6020]

[LIFE INSURANCE

[Complete this section to designate a beneficiary for life insurance.]

Beneficiary for Primary Insured: _____
(Full Name) (Relationship)
Contingent Beneficiary: _____]
(Full Name) (Relationship)

[HEALTH ADVOCATES ALLIANCE MEMBERSHIP APPLICATION

[Membership in Health Advocates Alliance (HAA) is required to apply for this plan. Your signature is needed here to complete HAA enrollment.]

Health Advocates Alliance is a membership organization that promotes good health among its members and their communities. Membership in the Alliance is required in order to be eligible for [the] insurance [plan]. Membership privileges include the opportunity to participate in all [programs] [benefits] offered or sponsored by the Association. For additional information and benefits provided by the Association please see the Health Advocates Alliance Brochure - Fixed Indemnity Plan [(Form 30235)].

I hereby request enrollment in the Health Advocates Alliance. I understand that nominal dues are required for membership in the Association; if participating in a sponsored insurance program, then my annual dues may be collected in installments along with my insurance premiums. I also understand that membership dues are non-refundable, and my failure to remit membership dues will result in loss of eligibility to participate in any of the Association sponsored [programs] [or] [benefits].

Member Signature Date]

[EMPLOYER SPONSORED BUSINESS (ESB) STATEMENT

[By checking "yes" here, you agree that the insurance you're applying for will not be paid for by an employer.]

You understand and agree that you are applying for a [hospital] [confinement] [and] [surgical] [fixed indemnity] [insurance] [plan] [for you (and your family)]. [You further understand that this enrollment form [will] [may] [be] [fully] [medically] [underwritten][,] [and] [that eligibility for this plan is not guaranteed].] You are personally paying the entire premium for this plan. Your employer is not contributing in any way to the payment of premium, either directly or indirectly.

[[If my employer has [50] or fewer full-time employees,] I agree that I will not use funds from a Health Reimbursement Arrangement [(HRA)] [or a Cafeteria Plan] to pay the premium for my plan.]

Do you agree with these statements?..... Yes No]

[FAX ALL PAGES EXCEPT "IMPORTANT NOTICES" TO [414-299-6020]

[AUTHORIZATION]

[Signatures are needed in this section. It's important to note you are applying for a [hospital] [confinement] [and] [surgical] [fixed indemnity] [insurance] [plan]. This plan comes with a [10-30]-day free look.]

[My [enrollment form][,] [recorded Authorizations][,] [recorded personal health history] [and any amendments] shall be the basis for the contract.] [I agree that I must call Time Insurance Company and complete [the] [Authorization] [and] [personal health history] portion of the enrollment process within [10] [day[s]] of commencement of the enrollment process.]

[I understand the insurance plan is subject to underwriting.] [The insurance [, if approved by Time Insurance Company,] will be in force only when issued by Time Insurance Company.] [The effective date is assigned by Time Insurance Company.] [The first full premium must be paid.] [A change in the [eligibility] [health] of the proposed insured(s) after the completion of the enrollment form and before the delivery of the contract may affect my eligibility for insurance with the company.] [I understand and agree that any information I provide through this enrollment process may be shared with persons necessary to facilitate issuing this plan, including but not limited to my agent or broker.] [If any of these conditions are not met, Time Insurance Company has the right to rescind its offer of this plan and the full extent of its liability shall be limited to the sum received.]

[I agree that a photocopy of this authorization shall be valid for [two] [year[s]] from the date signed.]

[[In order to determine my (our) eligibility for insurance,] I hereby authorize any health care provider or medically related facility, pharmacy [, pharmacy benefit manager] or pharmacy related facility, [MIB, Inc.,] [(“MIB”)] [formerly known as the Medical Information Bureau][,] consumer reporting agency, insurance or reinsurance company or employer having information about me [or my minor children] to provide all such information [including information regarding [employment,] [other insurance coverage,] [personal information,] [medical or pharmacy care, advice, treatment, or medication use]] as may be requested to Time Insurance Company [(or any consumer reporting agency authorized by Time Insurance Company)], its legal representative or any medical records retrieval service Time Insurance Company may engage[,][.] [including, but not limited to, [Examination Management Services, Inc.] [(EMSI),] [and its agents][.]]

[This authorization includes any and all information you may have about me, including, but not limited to, information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition as well as alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy prescriptions, Human Immunodeficiency Virus (HIV) testing and treatment, sexually transmitted disease (STD) testing and treatment, sickle cell testing and treatment, prescription history, lab data and electrocardiograms (EKGs). This information may also be disclosed to [MIB, Inc.] and any medical records company engaged by Time Insurance Company, including but not limited to [EMSI] and its agents. Although federal regulations require that we inform you of the potential that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by such regulation, all information received by Time Insurance Company pursuant to this authorization will be protected by federal and state privacy laws and regulations.]

[I understand that this authorization is required in order to enable Time Insurance Company to make eligibility or enrollment determinations relating to me [and/or my minor children][.] [or for Time Insurance Company's underwriting or risk rating determinations.] If I refuse to sign or revoke this authorization, Time Insurance Company may refuse to consider my application for enrollment.]

[I understand that I may revoke this authorization at any time by notifying Time Insurance Company in writing of my desire to revoke. Such revocation must be sent by certified mail to the following address: Privacy Office, Time Insurance Company, [P.O. Box 3050][,] [501 West Michigan][,] [Milwaukee, WI 5320[1][3][]-3050]. Such revocation will not be valid if Time Insurance Company has taken action in reliance on the authorization.]

[Unless an earlier date is required by law, this authorization expires upon the earliest of the following events: [30] days after denial of my application, or declination of enrollment, or, if insured, [30] days after when I am no longer an insured of Time Insurance Company. But in no event will this authorization be in effect for longer than [24] months from the date signed.]

[FAX ALL PAGES EXCEPT “IMPORTANT NOTICES”] TO [414-299-6020]

[I acknowledge receiving the notification regarding [MIB, Inc.] [(“MIB”)] [and] [the Abbreviated Notice of Insurance Information Practices] [and] [the Outline of Coverage for this plan] [,] [if required].]

[I acknowledge that I have read the completed enrollment form.] [I attest that all statements and answers on this enrollment form are complete, true and correct.] [I understand and acknowledge that any fraudulent statement [or material misrepresentation] [or omission] on the [enrollment form] [,] [recorded] [Authorizations][,] [recorded] [personal health history] [and/or any amendments] may result in claim denial or contract rescission, subject to the time limit on certain defenses or incontestability provisions of the contract.]

[I understand that the plan I am applying for is a [fixed indemnity] [benefit] [plan] and has specific benefit limitations. This plan is not major medical insurance coverage or a Medicare Supplement Plan.]

Signature of Primary Proposed Insured

[_____]
[Signature of Spouse[/Domestic Partner] [/Civil Union]
or Other (if proposed to be insured)]

[_____]
[Signature(s) of Other Dependent(s) 18 or Over
(if proposed to be insured)]

[_____]
[Guardian's Signature]

Premium Amount Sent: \$ _____

[[One-time] [Processing] Fee Sent*: \$ _____]
[*Not applicable in all states]

Date and Time signed (including a.m./p.m.)

City and State signed in

Attention: (Agent)
I have reviewed this enrollment form to ensure that all required items have been completed.
To the best of my knowledge, there <input type="checkbox"/> IS <input type="checkbox"/> IS NOT a replacement of medical insurance involved in this transaction.
_____ Licensed Resident Agent's Signature
_____ Print Agent's Name
_____ Initial here if you witnessed the signing of this form by the proposed insured.

[FAX ALL PAGES EXCEPT "IMPORTANT NOTICES" TO [414-299-6020]

[ARE YOU AN EXISTING CUSTOMER?

[Policy # _____]

[What do you want to do?]

Add Dependent]

Policy/Benefit Change to an existing policy]

[List type of change requested: _____]

Reinstatement of this plan]

Internal Replacement]

Conversion (over-age dependent/divorce)]]

[AGENT/AGENCY INFORMATION

Agent Name: _____

Agent Number: _____

Key Agency Contact: _____

Fax Number: _____

Phone Number: _____

E-mail Address: _____

Agency Name: _____

Agency Number: _____

[Policy should be mailed to:] Agent] Agency] Policyholder]]

[You don't need to do anything here. Your agent will complete this section.]

[FAX ALL PAGES EXCEPT "IMPORTANT NOTICES" TO [414-299-6020]

[These additional notices provide you with more information on [your personal medical information,] your rights [, and] fraud and privacy. Keep this sheet for your records.]

[IMPORTANT NOTICES – LEAVE WITH CUSTOMER

[NOTIFICATION REGARDING [MIB, Inc.] [(“MIB”)] [formerly known as the Medical Information Bureau]

Information regarding your insurability will be treated as confidential. Time Insurance Company or its reinsurers may, however, make a brief report thereon to [the] [MIB, Inc.,] [formerly known as Medical Information Bureau,] a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another [MIB] member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, [MIB], upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, [MIB] will arrange disclosure of any information in your file. Please contact [MIB] at [866 692-6901] [(TTY 866 346-3642)]. If you question the accuracy of the information in [MIB’s] file, you may contact [MIB] and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of [MIB’s] information office is [50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734].

Time Insurance Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about [MIB] may be obtained on its website at [www.mib.com].]

[ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES

To issue an insurance policy or certificate, we need to obtain information about you and any other person proposed for insurance. Some of that information will be received from you, and some will be generated from other sources. That information and any subsequent information collected by us may in certain circumstances be disclosed to third parties without your specific authorization. You have the right of access and correction with respect to the information collected about you except information which relates to a claim or civil or criminal proceeding. If you wish to have a more detailed explanation of our information practices, please contact Time Insurance Company, [Underwriting Department, 501 West Michigan, Milwaukee, Wisconsin, 53203.]

[FRAUD NOTICE

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

[PRIVACY

We do not disclose any non-public personal information about our customers or former customers to anyone, except as permitted by law. We collect non-public information about you from the following sources: (1) information we receive from you on enrollment forms or other information related thereto or as part of policy administration and (2) information about your transactions with our affiliates, others or us. We restrict access to non-public personal information about you to those employees who need to know that information to provide products or services to you. We maintain physical, electronic and procedural safeguards that comply with federal standards to guard your non-public personal information. We may disclose non-public personal information about you to nonaffiliated third parties as permitted by law.]]

LEAVE THIS PAGE WITH THE CUSTOMER - DO NOT FAX

SERFF Tracking Number: MCHX-126596491 State: Arkansas
 Filing Company: Time Insurance Company State Tracking Number: 45485
 Company Tracking Number: 292.CER.AR
 TOI: H14G Group Health - Hospital Indemnity Sub-TOI: H14G.000 Health - Hospital Indemnity
 Product Name: 292.CER.XX Group Hospital-Medical Indemnity Time
 Project Name/Number: 292.CER.XX Group Hospital-Medical Indemnity Time Insurance Company /292.CER.XX Group Hospital-Medical Indemnity Time Insurance Company

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Application Comments: Please see Forms Schedule	Approved-Closed	04/29/2010

	Item Status:	Status Date:
Satisfied - Item: Forms Listing Comments: Attachment: Forms Listing.PDF	Approved-Closed	04/29/2010

	Item Status:	Status Date:
Satisfied - Item: Statement of Variability Comments: Attachment: Statement of Variability.PDF	Approved-Closed	04/29/2010

	Item Status:	Status Date:
Satisfied - Item: Authorization Letter Comments: Attachment: Authorization Letter.PDF	Approved-Closed	04/29/2010

	Item Status:	Status Date:
Satisfied - Item: HAA Articles of Incorporation and Bylaws	Approved-Closed	04/29/2010

SERFF Tracking Number: MCHX-126596491 State: Arkansas
 Filing Company: Time Insurance Company State Tracking Number: 45485
 Company Tracking Number: 292.CER.AR
 TOI: H14G Group Health - Hospital Indemnity Sub-TOI: H14G.000 Health - Hospital Indemnity
 Product Name: 292.CER.XX Group Hospital-Medical Indemnity Time
 Project Name/Number: 292.CER.XX Group Hospital-Medical Indemnity Time Insurance Company /292.CER.XX Group Hospital-Medical Indemnity Time Insurance Company

Comments:

Attachment:

HAA Articles of Incorporation and Bylaws.PDF

	Item Status:	Status Date:
Satisfied - Item: 04/22/10 Submission Letter	Approved-Closed	04/29/2010
Comments:		
Attachment:		
04_22_10 Submission Letter.PDF		

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	04/29/2010
Comments:		
Attachments:		
AR Certification of Compliance.PDF		
AR - READABILITY CERTIFICATION.PDF		

	Item Status:	Status Date:
Satisfied - Item: 04.29.10 Objection Response	Approved-Closed	04/29/2010
Comments:		
Attachment:		
04_29_10 Resubmission Letter.PDF		

HOSPITAL CONFINEMENT AND SURGICAL FIXED INDEMNITY
FORMS LIST

FORM NUMBER	FORM TITLE AND/OR DESCRIPTION
292.CER.AR	Hospital Confinement and Surgical Fixed Indemnity Certificate Cover Page
292.TOC.XX	Matrix Insert Section: Table of Contents
292.DEF.XX	Matrix Insert Section: Definitions
292.EFF.AR	Matrix Insert Section: Effective Date and Termination Date
292.BEN.AR	Matrix Insert Section: Hospital Confinement and Other Fixed Indemnity Benefits
292.EXC.XX	Matrix Insert Section: Exclusions
292.CLM.XX	Matrix Insert Section: Claim Provisions
292.PRM.AR	Matrix Insert Section: Premium Provisions
292.OTH.XX	Matrix Insert Section: Other Provisions
292.BNS.XX	Benefit Schedule
Form 49800-AR	Application Form for Hospital-Medical Fixed Indemnity Insurance Plan



ASSURANT
Health

501 West Michigan
P.O. Box 3050
Milwaukee, WI 53201-3050
T 800.800.1212

www.assurant.com

STATEMENT OF VARIABILITY

- A number of benefit options and/or items which customarily vary according to the Policyholder's specific plan of insurance, which will allow us to deliver a customized contract to our customers reflecting all benefit options selected, helping to alleviate any ambiguity on the part of the customers as to what is covered and how it is covered.
 - Flexibility in utilizing provisions when filing diverse products.
 - Future flexibility to adjust to changing regulatory and market needs.
1. All bracketed numbers (excluding form numbers) are variable, subject to the confines of state and federal law. Bracketed benefit amounts, illustrated as a range, list of amounts or otherwise, are variable and can fluctuate to provide a richer benefit to the insured than what is represented in the approved document.
 2. All bracketed text varies to the extent that such language may be:
 - a. included as shown;
 - b. omitted in its entirety;
 - c. rearranged; or
 - d. transferred to another provision, section or page.
 3. All bracketed numbers and/or text will be varied only:
 - a. within any statutory or regulatory requirements; and
 - b. under the condition that the numerical value(s) and benefit language is within the intent and framework of the actual approved provision.
 4. Bracketed addresses, locations, phone and fax numbers or other contact information may be changed to reflect the correct contact information.

We also reserve the right to amend the form(s) to correct any minor clerical or typographical errors we may have overlooked prior to approval, and to revise any phraseology to clarify the intent within the confines of the law.

Assurant Health markets products underwritten by Time Insurance Company, Union Security Insurance Company and John Alden Life Insurance Company.



ASSURANT
Health

501 West Michigan
P.O. Box 3050
Milwaukee, WI 53201-3050
T 800.800.1212

www.assurant.com

April 21, 2010

Filings Intake Desk
Department of Insurance
INSERT STREET NAME HERE
CITY, ST 00000

Re: Time Insurance Company - NAIC 69477-019; FEIN 39-0658730
Form Number Series: 292.CER et al.

Dear Sir or Madam,

This letter acts as authorization for McHugh Consulting Resources and its representative analysts to file the above-referenced forms and serve as the primary contact on behalf of the company regarding such filings while under review. Please contact McHugh Consulting Resources with questions or comments regarding the enclosed filing.

Best Regards,

Daniel Ziebell, MHP
Director of Product Compliance
daniel.ziebell@assurant.com
T 414.299.6045
F 414.299.6168

Assurant Health markets products underwritten by Time Insurance Company, Union Security Insurance Company and John Alden Life Insurance Company.

STATE OF MISSOURI



Rebecca McDowell Cook
Secretary of State

CORPORATION DIVISION
CERTIFICATE OF AMENDMENT
OF A
MISSOURI NONPROFIT CORPORATION

WHEREAS,

HEALTH ADVOCATES ALLIANCE

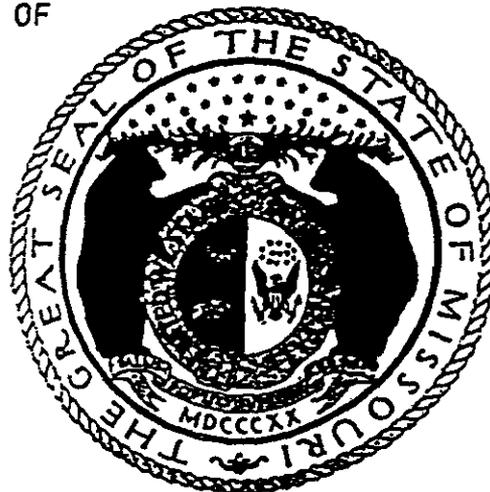
FORMERLY,

AMERICAN ASSOCIATION OF RETIRED EMPLOYEES

A CORPORATION ORGANIZED UNDER THE MISSOURI NONPROFIT CORPORATION LAW HAS DELIVERED TO ME DUPLICATE ORIGINALS OF ARTICLES OF AMENDMENT OF ITS ARTICLES OF INCORPORATION AND HAS IN ALL RESPECTS COMPLIED WITH REQUIREMENTS OF LAW GOVERNING THE AMENDMENT OF ARTICLES OF INCORPORATION UNDER THE MISSOURI NONPROFIT CORPORATION LAW, AND THAT THE ARTICLES OF INCORPORATION OF SAID CORPORATION ARE AMENDED IN ACCORDANCE THEREWITH.

IN TESTIMONY WHEREOF, I HAVE SET MY HAND AND IMPRINTED THE GREAT SEAL OF THE STATE OF MISSOURI, ON THIS, THE 20TH DAY OF NOVEMBER, 1997.

Rebecca McDowell Cook
Secretary of State



State of Missouri

Rebecca McDowell Cook, Secretary of State
P.O. Box 778, Jefferson City, Mo. 65102

Corporation Division



RECEIVED
NOV 18 3 00 PM '97
STATE OF MISSOURI
CORPORATION DIVISION

Articles of Amendment **FILED AND CERTIFICATE ISSUED**
to the

Articles of Incorporation
of a

General Not For Profit Corporation

NOV 20 1997

Rebecca McDowell Cook
SECRETARY OF STATE

(To be submitted in duplicate with a filing fee of \$10)

The undersigned corporation, for the purpose of amending its Articles of Incorporation and pursuant to the provisions of the "General Not For Profit Corporation Law" of the State of Missouri, hereby executes the following Articles of Amendment.

1. The name of the corporation is American Association of Retired Employees

2. There are No members, having voting rights with respect to amendments;

(Strike paragraphs (a), (b) or (c) when not applicable)

3. (a) At a meeting of members at which a quorum was present held on _____, 19____, same receiving at least two-thirds (2/3) of the votes cast by the members of the corporation present in person or by proxy as such receiving the following amendments were adopted.

x (b) By execution of this instrument signed by two-thirds (2/3) of all the members of the corporation as elected or appointed as directors the following amendments were adopted:

(c) At a meeting of directors (members having no voting rights with respect to amendments) held on 10/28, 1997, same receiving the votes of a majority of the directors then in office, the following amendment or amendments were adopted:

4. Article number One (1) is amended to read as follows:

The name of the corporation is:
Health Advocates Alliance

5. Article number Five (5) is amended to read as Follows:
See Attached

5. The purpose or purposes for which the corporation is organized are:

To enrich the quality of life of its members by providing educational and informational material of interest to its members; to help the members take advantage of the mass purchasing power and other benefit enhancements of other organizations through health awareness.

To exercise all the powers conferred upon corporations formed under the Missouri Not-For-Profit corporation Act.

FILED AND CERTIFICATE
ISSUED

NOV 20 1997

Rebecca McDowell Cook
SECRETARY OF STATE

IN WITNESS WHEREOF, the undersigned corporation has caused these Articles of Amendment to be executed in its name by its President or Vice President, and its Secretary or Assistant Secretary, this 28th of October, 19 97.

CORPORATE SEAL
(If no seal, state "None")
"None"

American Association of Retired Employees
(Print Corporate Title)
By [Signature]
In President or Vice President
By [Signature]
In Secretary or Assistant Secretary

State of Missouri
County of St. Louis } ss.

I, Deborah M. Vick, a Notary Public,
do hereby certify that on the 18th day of November, 19 97,
Gary Johnston personally appeared before me
(Acknowledgment of other officers is not shown)
and being first duly sworn by me, acknowledged that he signed as his free act
and deed the foregoing document in the capacity therein set forth and declared that the statements therein contained
are true, to his knowledge and belief.

IN WITNESS WHEREOF, I have hereunto set my hand and seal the day and year before written.

(Notarial Seal)



Deborah M. Vick
Notary Public

My commission expires Oct. 19, 2001

FILED AND CERTIFICATE
ISSUED

NOV 20 1997

[Signature]
SECRETARY OF STATE

DEBORAH M. VICK
Notary Public - Notary Seal
STATE OF MISSOURI
St. Louis County
My Commission Expires: Oct. 19, 2001



State of Missouri
Judith K. Moriarty, Secretary of State

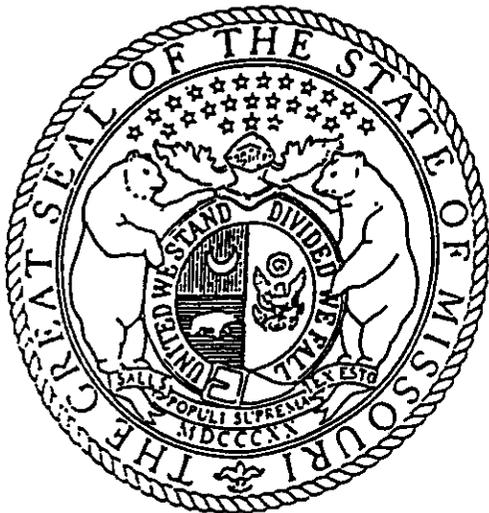
Corporation Division

**Certificate of Amendment
of a
General Not For Profit Corporation**

WHEREAS, AMERICAN ASSOCIATION OF RETIRED EMPLOYEES

a corporation organized under The General Not For Profit Corporation Law of Missouri has delivered to me duplicate originals of Articles of Amendment of its Articles of Incorporation and has in all respects complied with the requirements of law governing the amendment of Articles of Incorporation under The General Not For Profit Corporation Law of Missouri.

NOW, THEREFORE, I, JUDITH K. MORIARTY, Secretary of State of the State of Missouri, do hereby certify that I have filed said Articles of Amendment as provided by law, and that the Articles of Incorporation of said corporation are amended in accordance therewith.



IN TESTIMONY WHEREOF, I hereunto set my hand and affix the GREAT SEAL of the State of Missouri. Done at the City of Jefferson, this 30th day of July 19 93.

Judith K. Moriarty
Secretary of State



Articles of Amendment
to the
Articles of Incorporation
of a
General Not For Profit Corporation

FILED AND CERTIFIED
ISSUED

JUL 30 1993

Judith K. Dreyfus
SECRETARY OF STATE

HONORABLE ROY D. BLUNT
SECRETARY OF STATE
STATE OF MISSOURI
P.O. BOX 778
JEFFERSON CITY, MO 65102

The undersigned corporation, for the purpose of amending its Articles of Incorporation and pursuant to the provisions of the "General Not For Profit Corporation Law" of the State of Missouri, hereby executes the following Articles of Amendment:

1. The name of the corporation is AMERICAN ASSOCIATION OF RETIRED EMPLOYEES

2. There are "NO" members, having voting rights with respect to amendments;
(Insert "no" or "some")

(Strike paragraphs (a), (b) or (c) when not applicable)

3. ~~(a) By the consent of the members of the corporation, the following amendments were adopted:~~

~~(b) By the consent of the members of the corporation, the following amendments were adopted:~~

(c) At a meeting of directors (members having no voting rights with respect to amendments) held June 25, 19 93, same receiving the votes of a majority of the directors then in office, the following amendment or amendments were adopted;

4. Article number Five (5) is amended to read as follows:

The purpose or purposes for which the corporation is organized are:

To provide the opportunity for members to obtain products and services at reduced rates which are not available on an individual basis.

IN WITNESS WHEREOF, the undersigned corporation has caused these Articles of Amendment to be executed
in its name by its President ~~or Vice President~~ and its Secretary ~~or Assistant Secretary~~, this 26th
day of July, 19 93.

CORPORATE SEAL
(If no seal, state "None")
"NONE"

AMERICAN ASSOCIATION OF RETIRED EMPLOYEES
(Exact Corporate Title)

By Mark Fletcher
Its President ~~or Vice President~~

By [Signature]
Its Secretary ~~or Assistant Secretary~~

State of Missouri
County of St. Louis } ss

I, KAREN K. BOEKER, a Notary Public, do hereby certify that
on the 26th day of July, 19 93, MARK FLETCHER
(Acknowledgment by either officer is sufficient)

personally appeared before me and being first duly sworn by me, acknowledged that _____ he signed
his free act and deed the foregoing document in the capacity therein set forth and declared that the statements
therein contained are true, to his knowledge and belief.

IN WITNESS WHEREOF, I have hereunto set my hand and seal the day and year before written.

(NOTARIAL SEAL)

Karen K. Boeker
Notary Public

My commission expires 11-7-95

STATE OF MISSOURI



ROY D. BLUNT
SECRETARY OF STATE

CORPORATION DIVISION
CERTIFICATE OF INCORPORATION
GENERAL NOT FOR PROFIT

WHEREAS, DUPLICATE ORIGINALS OF ARTICLES OF INCORPORATION OF
AMERICAN ASSOCIATION OF RETIRED EMPLOYEES

HAVE BEEN RECEIVED AND FILED IN THE OFFICE OF THE SECRETARY OF
STATE, WHICH ARTICLES, IN ALL RESPECTS, COMPLY WITH THE
REQUIREMENTS OF THE GENERAL NOT FOR PROFIT CORPORATION LAW;

NOW, THEREFORE, I, ROY D. BLUNT, SECRETARY OF STATE OF THE STATE
OF MISSOURI, BY VIRTUE OF THE AUTHORITY VESTED IN ME BY LAW, DO
HEREBY CERTIFY AND DECLARE THIS ENTITY A BODY CORPORATE, DULY
ORGANIZED THIS DATE AND THAT IT IS ENTITLED TO ALL RIGHTS AND
PRIVILEGES GRANTED CORPORATIONS ORGANIZED UNDER THE GENERAL NOT
FOR PROFIT CORPORATION LAW.

IN TESTIMONY WHEREOF, I HAVE SET MY
HAND AND IMPRINTED THE GREAT SEAL OF
THE STATE OF MISSOURI, ON THIS, THE
26TH DAY OF JUNE, 1990.

Roy D. Blunt
Secretary of State



\$10.00

FILED AND CERTIFICATE OF
INCORPORATION ISSUED

JUN 26 1990

ARTICLES OF INCORPORATION
OF

Roy D. Blunt AMERICAN ASSOCIATION OF RETIRED EMPLOYEES

RECEIVED

JUN 26 1990

Roy D. Blunt
Corporation Dept. SECRETARY OF STATE

HONORABLE ROY D. BLUNT
SECRETARY OF STATE
STATE OF MISSOURI
JEFFERSON CITY, MISSOURI 65102

The undersigned being natural persons of the age of eighteen (18) years or more and citizens of the United States, for the purpose of forming a corporation under the "General Not For Profit Corporation Law" of the State of Missouri, do hereby adopt the following Articles of Incorporation.

ARTICLE ONE

The name of the Corporation is: AMERICAN ASSOCIATION OF RETIRED EMPLOYEES.

ARTICLE TWO

The period of duration of the Corporation is perpetual.

ARTICLE THREE

The address of the Corporation's initial registered office in this State is 8909 Ladue Road, St. Louis, MO 63124, and the name of its initial registered agent at such address is RONALD N. COMPTON.

ARTICLE FOUR

The first Board of Directors shall be Three (3) in number, their names and addresses being as follows:

Gary Hendricks
180 North Riverview Drive
Suite 280
Anaheim, CA 92808

Jerry Goldfarb
180 North Riverview Drive
Suite 280
Anaheim, CA 92808

Dale D. Turvey
1302 Clarkson Clayton Center
Suite 201
Ellisville, MO 63011

Thereafter, the number of Directors shall be fixed by, or in the manner provided in, the Bylaws of the Corporation. The power to make, alter, amend or repeal the Bylaws of the Corporation shall be vested in the Board of Directors; provided, however, that no such action taken pursuant hereto shall be inconsistent with the applicable laws of the State of Missouri then in force.

ARTICLE FIVE

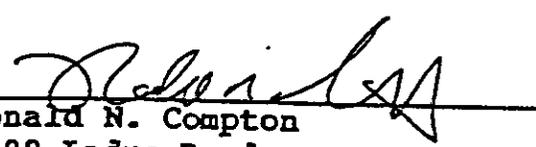
The purpose or purposes for which the corporation is organized are :

To provide the opportunity for members to obtain products and services at reduced rates which are not available on an individual basis. To establish a college scholarship program which will be made available to the dependents of association members.

ARTICLE SIX

The right of the Members, or any class or classes of members, to vote shall be limited, enlarged or denied as fixed by, or in the manner provided in, the Bylaws of the Corporation.

INCORPORATORS:



Ronald N. Compton
8909 Ladue Road
St. Louis, MO 63124

BY-LAWS
OF
HEALTH ADVOCATES ALLIANCE
INDEX

	<u>Page</u>
Article I Purposes	1
Article II Offices	1
Article III Members	1
Section 1 Classes of Members	1
Section 2 Voting Rights	1
Section 3 Termination of Membership	2
Section 4 Resignation	2
Section 5 Reinstatements	2
Section 6 Transfer of Membership	2
Article IV Meetings of Members	2
Section 1 Annual Meetings	2
Section 2 Special Meeting	2
Section 3 Place of Meeting	2
Section 4 Notice of Meetings	3
Section 5 Quorum	3
Section 6 Manner of Acting	3
Section 7 Informal Action by Members	3
Section 8 Parliamentary Procedures	3
Section 9 Voting	3
Section 10 Matters Reserved to Membership Vote	4
Article V Board of Directors	4
Section 1 General Powers	4
Section 2 Number, Tenure and Qualifications	4
Section 3 Regular Meetings	4
Section 4 Special Meetings	5
Section 5 Notice	5
Section 6 Quorum	5
Section 7 Manner of Acting	5
Section 8 Vacancies	5
Section 9 Compensation	6
Section 10 Telephonic Participation in Meetings	6
Section 11 Action by Written Consent	6

Article VI	Officers	6
Section 1	Officers	6
Section 2	Election and Term of Office	7
Section 3	Removal	7
Section 4	Vacancies	7
Section 5	President	7
Section 6	Vice President	7
Section 7	Treasurer	7
Section 8	Secretary	8
Article VII	Committees	8
Section 1	Committees of Directors	8
Section 2	Other Committees	8
Section 3	Vacancies	8
Section 4	Quorum	9
Section 5	Rules	9
Article VIII	Contracts, Checks, Deposits & Funds	9
Section 1	Contracts	9
Section 2	Checks, Drafts, Etc.	9
Section 3	Deposits	9
Section 4	Gifts	9
Section 5	Loans	10
Article IX	Certificates of Membership	10
Section 1	Certificates of Membership	10
Section 2	Issuance of Certificates	10
Article X	Books and Records	10
Article XI	Dues and Initiation Fee	11
Section 1	Annual Dues	11
Section 2	Payment of Dues	11
Section 3	Default & Termination of Membership	11
Section 4	Initiation Fee	11
Article XII	Fiscal Year	11
Article XIII	Seal	11
Article XIV	Waiver of Notice	11
Article XV	Amendment of By-Laws	12

Article XVI	Indemnification	12 ✓
Article XVII	Dissolution	12

BY-LAWS
OF
HEALTH ADVOCATES ALLIANCE

ARTICLE I
PURPOSES

The purpose of HEALTH ADVOCATES ALLIANCE ("association") shall be as that stated in the Certificate of Incorporation, as well as any powers as are now or may hereafter be granted by the General Not-For-Profit Law of the State of Missouri.

ARTICLE II
OFFICES

The Association shall have and continuously maintain in this state a registered office and a registered agent, and the registered office of the association shall be identical with that of its registered agent. The Association may have other offices within or without the State of Missouri as the Board of Directors may from time to time determine.

ARTICLE III
MEMBERS

Section 1. Classes of Members. The Association shall have three (3) classes of members. The designation of such classes and qualifications of the members of such classes shall be as follows:

1. Individual membership: The individual is entitled to participate in all benefit programs offered by the Association.

2. Family membership: The member and his spouse are entitled to participate in all benefit programs offered by the Association.

3. Limited membership: The member who is interested in only certain designated benefit programs offered by the Association.

Section 2. Voting Rights. Each member of any class shall be entitled to one vote on each matter submitted to a vote of the members by the Board of Directors. Voting may be in person or by proxy; provided that no proxy may be used for voting purposes unless the original of the proxy is filed with the Secretary of the Association at least seven (7) days before the meeting at which it is to be used.

Section 3. Termination of Membership. Any member who shall be in default in the payment of dues for the period fixed in Article XI of the By-Laws is automatically ineligible for membership and loses all privileges and rights of the Association, subject to the discretion of the Board of Directors to extend such time period for the payment of dues.

Section 4. Resignation. Any member may resign by filing a written resignation with the Secretary, but such resignation shall not entitle such member to any refund of dues and the member shall immediately lose all privileges and rights of the Association.

Section 5. Reinstatement. Upon written reapplication a former member may be reinstated to membership in the Association.

Section 6. Transfer of Membership. Membership in the Association is not transferable or assignable.

ARTICLE IV MEETINGS OF MEMBERS

Section 1. Annual Meeting. An annual meeting of the members of the Association shall be held for the purpose of electing Directors and the transaction of any other business as may come before the meeting. The date of the annual meeting shall be determined by the Board of Directors.

Section 2. Special Meeting. Special meetings of the members, for any purpose or purposes, unless otherwise prescribed by law, may be called by the President and shall be called by the

Secretary at the direction of a majority of the Board of Directors, or at the request in writing of members representing at least one hundred (100) votes entitled to be cast at such meeting.

Section 3. Place of Meeting. The Board of Directors may designate any place, within or without the State of Missouri as the place of meeting for any annual meeting. The President or the Board of Directors may designate any place within or without the State of Missouri as the place of the meeting for any special meeting. If no designation is made, the place of meeting shall be the registered office of the Association.

Section 4. Notice of Meetings. Written or printed notice stating the place, day and hour of any regular or special meeting of the Association members shall be delivered, either personally or by mail, to each member, not less than seven (7) or more than forty (40) days before the date of such meeting, by or at the direction of the President, or Secretary, or the Board of Directors or person calling the meeting. In the case of special meetings, the purpose for which the meeting is called shall be stated in the notice. If mailed, the notice of meeting shall be deemed delivered when deposited in the United States mail addressed to the member at this address as it appears on the records of the Association, with postage thereon paid. Notice of meetings may be included in any publication that is distributed to the member.

Section 5. Quorum. There shall be no minimum number of members necessary to be present at any regular meeting or special meeting, in order to constitute a quorum. Those members present shall therefore constitute a quorum.

Section 6. Manner of Acting. The act of a majority of the members present at any regular or special meeting shall constitute the act of the members.

Section 7. Informal Action by Members. Upon approval by the directors, any action required to be taken at a meeting of the members of the Association or any other action which may be taken at a meeting, may be taken without a meeting if consents in writing, setting forth the action so taken, shall be signed by a

majority of the members with respect to the subject matter thereof.

Section 8. Parliamentary Procedures. Parliamentary Procedure for all meetings of members, directors, and committees shall be conducted in accordance with the latest revised edition of Robert's Rules of Order, unless otherwise inconsistent with these By-Laws.

Section 9. Voting. At all meetings of the members, each member of records shall be entitled to one (1) vote. A vote may be cast either orally or in writing in person or by proxy. A "member of record" is a person who is a member in good standing of the Association as of the close of business on a date, selected by the Board of Directors, not less than forty (40) days nor more than fifty (50) days before the date of the meeting (the "record date"). When a quorum is present at any meeting, the vote of the holders of a majority of members present shall decide any questions brought before such meeting, unless the questions are ones upon which, by express provision of law or of the Association's Articles of Incorporation, a different vote is required, in which case such express provision shall govern and control the decision of such question.

Section 10. Matters Reserved to Membership Vote. The following matters shall be authorized only upon a vote "thereon" by the members at a meeting called to consider such matter:

1. An amendment to the Association's Articles of Incorporation;
2. The election of the Board of Directors; and
3. Any other matter which the Board of Directors, in their sole discretion, by resolution shall commit to a vote of the members.

ARTICLE V
BOARD OF DIRECTORS

Section 1. General Powers. The affairs of the Association shall be managed by its Board of Directors.

Section 2. Number, Tenure and Qualifications. The number of directors shall be no fewer than three (3) and no more than twenty-five (25) and may be changed from time to time by resolution of the Board of Directors. The Board of Directors shall appoint a committee to nominate successor directors. The directors shall be elected at an annual meeting of the members, except as provided in Section 8 of this Article, and each director elected shall hold office until his successor is elected and qualified or until his earlier death, resignation or removal. Directors shall be residents of the United States of America but need not be members.

Section 3. Regular Meetings. A regular annual meeting of the Board of Directors shall be held each year immediately after the annual meeting of the members of the Association for the purpose of electing officers and for the transaction of such other business as may come before the meeting. The regular annual meeting of directors shall be held without other notice than these By-Laws. The Board of Directors may provide by resolution the time and place, within or without the State of Missouri for the holding of additional regular meetings of the Board of Directors.

Section 4. Special Meetings. Special meetings of the Board of Directors may be called by or at the request of the President or any two (2) directors. All special meetings shall be held at the registered office of the Association unless otherwise agreed upon by a majority of the Board of Directors in attendance at the meeting.

Section 5. Notice. Notice of any special meeting of the Board of Directors and the business to be transacted shall be given at least five (5) days previously thereto by written notice delivered personally or sent by mail to each director at his address shown on the records of the Association. If notice be given by mail, such notice shall be deemed to be delivered when deposited in the United States mail addressed to the director. Any director may waive notice of any meeting. The attendance of a director at any meeting shall constitute a waiver of notice of such meeting, except where a director attends a meeting for the

express purpose of objecting to the transaction of any business because the meeting is not lawfully called or convened. The purpose of any special meeting of the Board of Directors shall be specified in the notice of such meeting.

Section 6. Quorum. A majority of the Board of Directors shall constitute a quorum for the transaction of business at any meeting of the Board of Directors provided that if less than a majority of the directors are present at said meeting, a majority of the directors present may adjourn the meeting from time to time without further notice.

Section 7. Manner of Acting. The act of a majority of the directors present at a meeting at which a quorum is present shall be the act of the Board of Directors, except where otherwise provided by law or these By-Laws.

Section 8. Vacancies. Vacancies created by the death, resignation, or removal of a director may be filled by a majority vote of the directors then in office though less than a quorum, and each director so chosen shall hold office until his successor is elected and qualified or until his earlier death, resignation or removal. A director may be removed at any time, with or without cause, by a vote of a majority of the remaining directors. If there are not directors in office, then an election of directors may be held in the manner provided by law. Newly created directorships shall be filled by election at an annual meeting or special meeting called for that purpose.

Section 9. Compensation. Directors as such shall not receive any stated salaries for their services, but by resolution of the Board of Directors, a fixed sum and expenses of attendance, if any, may be allowed for attendance at each meeting of the Board of Directors. Nothing herein contained shall be construed to preclude any director from serving the Association in any other capacity and receiving compensation therefor upon approval by the Board.

Section 10. Telephonic Participation in Meeting. The members of the Board of Directors, or of any committee designated by the Board of Directors, may participate in a meeting of the Board of Directors or committee by means of conference telephone

or similar communications equipment whereby all persons participating in the meeting can hear each other, and participation in a meeting in this manner shall constitute presence in person at the meeting.

Section 11. Action by Written Consent. Any action which is required to be or may be taken at a meeting of the directors, or of any committee of the directors, may be taken without a meeting if consents in writing, setting forth the action so taken are signed by all of the members of the Board of Directors or of the committee as the case may be. The consents shall have the same force and effect as a unanimous vote at a meeting duly held. The Secretary shall file the consents with the minutes of the meetings of the Board of Directors or of the committee as the case may be.

ARTICLE VI OFFICERS

Section 1. Officers. The Officers of the Association shall be a President, one or more Vice Presidents (the number thereof to be determined by the Board of Directors), a Treasurer, a Secretary or combination thereof, and such other officers as may be elected in accordance with the provisions of this article. The Board of Directors may elect or appoint other officers, including one or more Assistant Secretaries and one or more Assistant Treasurers, as it shall deem desirable, such officers to have the authority and perform the duties prescribed, from time to time, by the Board of Directors. Any two or more offices may be held by the same person, except the offices of President and Secretary.

Section 2. Election and Term of Office. The Officers of the Association shall be elected annually by the Board of Directors at the regular annual meeting of the Board of Directors. If the election of Officers shall not be held at such meeting, such election shall be held as soon thereafter as convenient. Vacancies may be filled or new officers created and filled at any meeting of the Board of Directors. Each Officer shall hold office until his successor shall have been duly elected and shall have qualified.

Section 3. Removal. Any Officer or Agent elected or appointed by the Board of Directors may be removed by the Board of Directors whenever in its judgment the best interests of the Association would be served thereby.

Section 4. Vacancies. A vacancy in any office because of death, resignation, removal, disqualification or otherwise, may be filled by the Board of Directors for the unexpired portion of the term.

Section 5. President. The President of the Association shall be the principal executive officer of the Association. He shall supervise and conduct the affairs of the Association in such manner as will best accomplish the purposes set forth in the Articles of Incorporation of the Association. He shall preside at all meetings of the Association members and the Board of Directors. He shall countersign all checks together with the Treasurer.

Section 6. Vice President. In the absence of the President, or in the event of his inability or refusal to act, the Vice President shall perform the duties of the President, and when so acting, shall have all the powers of and be subject to all the restrictions upon the President. The Vice President shall perform such other duties as from time to time may be assigned to him by the President or by the Board of Directors.

Section 7. Treasurer. The Treasurer or Assistant Treasurer shall have charge and custody of and be responsible for all funds and securities of the Association; receive and give receipts for monies received by the Association from any source whatsoever, and deposit all such monies in the name of the Association in such banks, trust companies or other depositories as shall be selected in accordance with the provisions of Article VIII of these By-Laws.

Section 8. Secretary. The Secretary or Assistant Secretary of the Association shall keep the minutes of the meetings of the members and of the Board of Directors in one or more books provided for that purpose; see that all notices are duly given in accordance with the provisions of these By-Laws or as required by law; be custodian of the corporate records of the Association; see

that the seal of the Association, if any, is affixed to all documents, the execution of which on behalf of the Association under its seal, if any, is duly authorized in accordance with the provisions of these By-Laws; keep a register of the post office address of each member which shall be furnished to the Secretary or Assistant Secretary by such member; and in general perform all duties incident to the office of Secretary and such other duties as from time to time may be assigned to the Secretary or Assistant Secretary by the President or by the Board of Directors.

ARTICLE VII COMMITTEES

Section 1. Committees of Directors. The Board of Directors, by resolution adopted by the majority of the directors in office, may designate one or more committees, each of which shall consist of two (2) or more directors, which committees, to the extent provided in said resolution, shall have and exercise the authority of the Board of Directors in the management of the Association; but the designation of such committees and the delegation thereto of authority shall not operate to relieve the Board of Directors, or any individual director, of any responsibility imposed upon it or him by law. The President shall be an ex-officio member of all committees of directors.

Section 2. Other Committees. Other committees not having and exercising the authority of the Board of Directors in the management of the Association may be designated by a resolution adopted by a majority of the directors present at a meeting at which a quorum is present. Except as otherwise provided in such resolution, members of each such committee shall be members of the Association, and the President of the Association shall appoint the members thereof. Any member thereof may be removed by the person or persons authorized to appoint such member whenever in their judgment the best interests of the Association will be served by such removal. One member of each committee shall be a director.

Section 3 Vacancies. Vacancies in the membership of any committee may be filled by appointments made in the same manner as provided in the case of original appointments.

Section 4. Quorum. Unless provided in the resolution of the Board of Directors designating a committee, a majority of the whole committee shall constitute a quorum and the act of a majority of the members present at a meeting at which a quorum is present shall be the act of the committee.

Section 5. Rules. Each committee may adopt rules for its own government not inconsistent with these By-Laws or with rules adopted by the Board of Directors.

ARTICLE VIII CONTRACTS, CHECKS, DEPOSITS, AND FUNDS

Section 1. Contracts. The Board of Directors may authorize the officers or agents of the Association to enter into contracts or to execute and deliver documents in the name of and on behalf of the Association. Such authority shall be confined to specific instances. Such contracts may be for any purpose deemed by the Board of Directors to be appropriate, including the contracting with a third party for any or all administrative and other services and functions necessary for the Association to achieve its purpose.

Section 2. Checks, Drafts, Etc. All checks, drafts, or other orders for payment of money, notes or other evidences of indebtedness issued in the name of the Association shall be signed by such officer or officers, agent or agents of the Association and in such manner as shall from time to time be determined by the resolution of the Board of Directors. In the absence of such determination by the Board of Directors, such instruments shall be signed by the Treasurer or an Assistant Treasurer and countersigned by the President or Vice President of the Association.

Section 3. Deposits. All funds coming into possession of the Association shall be deposited from time to time to the credit of the Association in such banks, trust companies, or other depositories as the Board of Directors may select.

Section 4. Gifts. The Board of Directors may accept on behalf of the Association any contributions, gifts, bequests, or device for the general purpose or for any special purpose of the Association.

Section 5. Loans. The Association may, upon authorization of the Board of Directors, from time to time accept or negotiate loans of financial assistance to be repaid at such time as the Association is reasonably able to repay.

ARTICLE IX CERTIFICATES OF MEMBERSHIP

Section 1. Certificates of Membership. The Board of Directors may provide for the issuance of certificates evidencing membership in the Association which shall be in such form as may be determined by the Board. Such certificates shall be signed by the President or Vice President and shall be sealed with the seal of the Association, if any. The name and address of each member and the date of issuance of the certificate shall be entered on the records of the Association. If any certificate shall become lost, mutilated or destroyed, a new certificate may be issued therefor upon such terms and conditions as the Board of Directors may determine.

Section 2. Issuance of Certificates. When a member has applied for and is eligible for membership and has paid any initiation fee and dues that may then be required, a certificate of membership shall be issued and delivered to him by the Secretary, if the Board of Directors shall have provided for the issuance of certificates of membership under the provisions of Section 1 of this article.

ARTICLE X
BOOKS AND RECORDS

The Association shall keep correct and complete books and records of accounts and shall also keep minutes of the proceedings of its members, Board of Directors and committees having any of the authority of the Board of Directors, and shall keep at the registered or principal office a record giving the names and addresses of the members entitled to vote. All books and records of the Association may be inspected by any member, or his agent or attorney for any purpose at any reasonable time.

ARTICLE XI
DUES AND INITIATION FEE

Section 1. Annual Dues. The Board of Directors may determine from time to time the amount of annual dues payable to the Association by members of each class.

Section 2. Payment of Dues. Dues shall be payable in advance.

Section 3. Default and Termination of Membership. When any member of any class shall be in default in the payment of dues for a period of one month from the beginning of the period from which such dues became payable, such member shall be automatically dropped from membership unless the Board of Directors, in its discretion, extends the time for payment of dues.

Section 4. Initiation Fee. Each member may be required to pay, in addition to applicable dues, the amount of any initiation fee designated by the Board of Directors as a prerequisite to membership. The Board of Directors may provide that the initiation fee is waived for members who are part of a group where

the sponsor pays a stated initiation fee on behalf of all group members.

ARTICLE XII
FISCAL YEAR

The fiscal year of the Association shall begin the first day of January and end on the last day of December in each year.

ARTICLE XIII
SEAL

The Board of Directors may provide a corporate seal which shall be in the form of a circle and shall have inscribed thereon the name of the corporation and the words "Corporate Seal".

ARTICLE XIV
WAIVER OF NOTICE

Whenever any notice is required to be given under the provisions of the General Not-For-Profit Corporation Law of Missouri under the provisions of the Articles of Incorporation or the By-Laws of the Association, a waiver thereof in writing signed by the person or persons entitled to such notice, whether before or after the time stated therein, shall be deemed equivalent to the giving of such notice.

ARTICLE XV
AMENDMENT OF BY-LAWS

These By-Laws may be altered, amended or repealed and new By-Laws may be adopted by a two-thirds (2/3) majority of the directors present at any regular meeting or any special meeting, provided that at least seven (7) days' written notice is given of intention to alter, amend or repeal or to adopt new By-Laws at such meeting.

ARTICLE XVI
INDEMNIFICATION

The Association shall provide for indemnification by the Association of any and all of its directors or officers or former directors or officers against expenses actually and necessarily incurred by them in connection with the defense of any action, suit, or proceeding, in which they or any of them are made parties, or a party, by reason of having been directors or officers of the Association, except in relation to matters as to which such director or officer or former director or officer shall be adjudged in such action, suit, or proceeding to be liable for gross negligence or misconduct in the performance of duty and to such matters as shall be settled by agreement predicated on the existence of such liability for gross negligence or misconduct.

ARTICLE XVII
DISSOLUTION

The Association shall use its funds only to accomplish the objectives and purposes specified in these By-Laws, and no part of said funds shall inure, or be distributed, to the members of the Association. On dissolution of the Association any funds remaining shall be distributed to one or more regularly organized and qualified charitable, educational, scientific, or philanthropic organizations to be selected by the Board of Directors.

Health Advocates ALLIANCE



It's Good For Your Health



Health insurance is underwritten and issued by one of the following
Fortis Health member companies: Fortis Insurance Company, John Alden
Life Insurance Company or Fortis Benefits Insurance Company

Form H-1000 (Rev. 8/2006)

What is Health Advocates Alliance?

Health Advocates Alliance promotes good health among its members and their communities. Members can improve or continue their good health by taking advantage of the offers included with the membership.

As a member of Health Advocates Alliance, you'll receive:

- A 24-hour Nurse Helpline. You'll have unlimited access to registered nurses via a toll-free number. You can ask questions and receive information about health, illness and medications.
- A membership kit and ID card, which lets you save money on the products and services from the companies listed here.
- The opportunity to apply for health insurance for individuals and their families from Fortis Health.
- An annual newsletter with informative health-oriented articles.
- A free Medical Emergency Data card.

Health Insurance from Fortis Health

Fortis Health offers affordable, comprehensive medical coverage for individuals and families – plus lower rates for people who choose healthy lifestyle habits. You can count on quality coverage from any one of our Fortis Health member companies – Fortis Insurance Company, John Alden Life Insurance Company, or Fortis Benefits Insurance Company.

Medical Emergency Data Card

This card keeps your personal medical profile handy at all times to ensure that your medical

information is available to emergency personnel. Additional cards are available for family members at a nominal cost.

Vitamins and Nutritional Supplement Discounts

Receive a 10% discount on more than 200 products in the Pro Health catalog. Satisfaction is guaranteed.

Lens Crafters Vision Club

You and your family receive a 20% discount on Lens Crafters purchases, and a 10% discount on eye exams and contact lenses at some Lens Crafters outlets.

Books to Expand Your Horizons

Receive a 40% discount off the cost on a wide selection of self-help and motivational books and tapes for your personal and professional development through special arrangements with Crisp Learning.

Odyssey Computer Discounts

Custom-built personal computers and pre-configured computers at discounted prices – up to 25% savings.

Customized Web sites

Create your own Web site and save with a 20% discount on full service Web site development and maintenance.

Internet Access Services

Discounts on unlimited dial-up access to the Internet.

For more information on Health Advocates Alliance, call 800-992-8044.

.....
McHugh Consulting Resources, Inc.

Jay Bradford
Insurance Commissioner
Arkansas Department of Insurance
Compliance - Life and Health
1200 West Third Street
Little Rock, AR 72201-1904

Submitted viaSERFF

RE: TIME INSURANCE COMPANY (NAIC #69477; FEIN 39-0658730)
Hospital Confinement and Other Fixed Indemnity Insurance form:292.CER.AR et
al.

Dear Commissioner Bradford:

McHugh Consulting Resources, Inc. has been requested to file the attached forms on behalf of Time Insurance Company. We have provided an authorization letter for your files.

The enclosed forms are hereby submitted for your review seeking approval. These forms are new and do not replace any forms currently on file with your office. These forms will be used to issue limited benefit insurance providing fixed indemnity benefits for hospital confinement and other specified medical and surgical events on an underwritten basis in the individual market. This plan does not provide expense reimbursement for billed charges by a health care provider or coverage for health care services or supplies. This plan is designed as a non-coordinated, limited hospital confinement and other fixed indemnity plan, defined in federal code (42 U.S.C. s. 300gg-91) as an "excepted benefit" plan and is therefore exempt from the HIPAA reform requirements of federal code Title 42 pursuant to the exemption provided at 42 U.S.C. s. 300gg-63.

This coverage is offered for benefit of individuals who are members of a non-employer sponsored association, and coverage will be offered by independent agents licensed in your state. The master group policy is issued and delivered to the association group policyholder in the state of Illinois.

Coverage may be offered with supplemental term life insurance rider, form 4797, previously approved by your office on 07/15/2008 enclosed herewith for review.

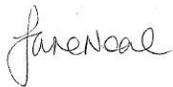
For your ease in reference, a listing of all submitted forms is enclosed. Please note that the form is numbered using a matrix format, where each section of the document has a unique form number. For example, the face page is numbered 292.CER.AR, while the Exclusions section of the same document is numbered 292.EXC.XX. The Company employs this form numbering style for administrative and tracking purposes. The form will always be issued in it's entirety with all sections and form numbers included.

All forms are subject to minor modifications in paper size, stock, layout, format, company logo and printing specifications of the document upon issue. As mentioned above, some of the provisions/sections are bracketed to provide flexibility as well as to afford future flexibility to adjust to changing regulatory and market needs. Please see the enclosed Statement of Variability for additional information on form adaptability.

Please note that Wisconsin is the state domicile for Time Insurance Company. The state of Wisconsin does not require the filing of forms that are being marketed for out-of-state use with their office.

Thank you in advance for your time and attention to this filing. Should you have any questions, or require additional information, please contact me at any of the numbers listed below.

Sincerely,

A handwritten signature in cursive script that reads "Jane Neal".

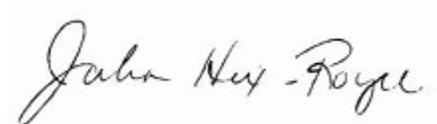
Jane Neal
Compliance Project Specialist

Certificate of Compliance with Arkansas Rule and Regulation 19

Insurer: Time Insurance Company

Form Number(s): 292.CER.AR, 292.TOC.XX, 292.DEF.XX, 292.EFF.AR, 292.BEN.AR, 292.EXC.XX,
292.CLM.XX, 292.PRM.AR, 292.OTH.XX, 292.BNS.XX, Form 49800-AR

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.



Signature of Company Officer

Julia Hix-Royer

Name

Vice President, Product Compliance

Title

April 22, 2010

Date

STATE OF ARKANSAS
READABILITY CERTIFICATION

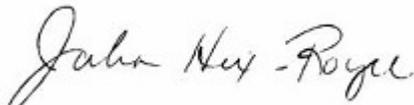
COMPANY NAME: Time Insurance Company

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
292.CER.AR	50
292.TOC.XX	50
292.DEF.XX	50
292.EFF.AR	50
292.BEN.AR	50
292.EXC.XX	50
292.CLM.XX	50
292.PRM.AR	50
292.OTH.XX	50
292.BNS.XX	64
Form 49800-AR	51

Signed: _____

Name:


Julia Hix-Royer

Title:

Vice President, Product Compliance

Date: _____

April 22, 2010

.....

McHugh Consulting Resources, Inc.

Rosalind Minor
Arkansas Department of Insurance
Compliance - Life and Health
1200 West Third Street
Little Rock, AR 72201-1904

Submitted viaSERFF

RE: TIME INSURANCE COMPANY (NAIC #69477; FEIN 39-0658730)
Hospital Confinement and Other Fixed Indemnity Insurance form:292.CER.AR et al.
SERFF Tracking No: MCHX-126596491
Objection No: 125627391

Dear Ms. Minor:

We are in receipt of your objection letter dated today with regard to the captioned filing. Time Insurance Company has provided the following response to your concerns, which we are relaying on their behalf. The responses are offered in the order in which they were presented in your letter:

Objection 1: With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-86-108(4) and Bulletin 14-81.

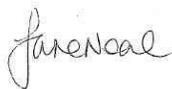
Response: We have revised the dependent definition.

Objection 2: Coverage for newborn infants must be for at least 90 days as outlined under ACA 23-79-129.

Response: We have revised the Effective Date and Termination Date

Thank you for your time and consideration of this filing. If you have any comments or questions, please feel free to contact me at the number listed below.

Sincerely,



Jane Neal
Compliance Project Specialist
McHugh Consulting Resources, Inc.
215 230 7960

SERFF Tracking Number: MCHX-126596491 State: Arkansas
 Filing Company: Time Insurance Company State Tracking Number: 45485
 Company Tracking Number: 292.CER.AR
 TOI: H14G Group Health - Hospital Indemnity Sub-TOI: H14G.000 Health - Hospital Indemnity
 Product Name: 292.CER.XX Group Hospital-Medical Indemnity Time
 Project Name/Number: 292.CER.XX Group Hospital-Medical Indemnity Time Insurance Company /292.CER.XX Group Hospital-Medical Indemnity Time Insurance Company

Superseded Schedule Items

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

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
04/22/2010	Form	Hospital Confinement and Surgical Fixed Indemnity Certificate-Cover Page	04/29/2010	292_CER_AR.PDF (Superseded)

Time Insurance Company
[501 West Michigan
Milwaukee, WI 53203]

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

NOTICE: This is not a major medical insurance plan. 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 bill. THIS IS NOT A MEDICARE SUPPLEMENT PLAN.

This Certificate is evidence of Your coverage under the Policy of hospital confinement and other fixed indemnity insurance issued to a[n] [association/trust]. This Certificate describes the benefits and provisions which affect Covered Persons. The final interpretation of any specific provision is based on the terms of the Policy. The Policy is issued in the State of [Illinois] and is governed by applicable laws of that State and federal laws, except as otherwise provided by this Certificate or the Policy. The Policy may be examined at Our Home Office or the main office of the Policyholder. This Certificate provides hospital confinement and other fixed indemnity benefits that, at a minimum, meet the requirements for such plans under applicable [Illinois law][or][law of the state in which the Certificate is issued]. Please read Your Certificate carefully and become familiar with its terms, limits and conditions.

This Certificate is issued based on the statements and agreements in the enrollment form and during the enrollment process, [any exam that may be required,] any other amendments or supplements and payment of the required premium. This Certificate may be changed. If that happens, You will be notified of any such changes.

RIGHT TO EXAMINE CERTIFICATE FOR [10-30] DAYS

If You are not satisfied, return the Certificate to Us or Our agent within [10-30] 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 ENROLLMENT FORM FOR INSURANCE

Please read the copy of the enrollment form included with this Certificate. We issued this coverage in reliance upon the accuracy and completeness of the information provided in the enrollment form and during the enrollment process. If a [material] [or] [fraudulent] omission or misstatement is made in the enrollment 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 enrollment form and, if any information shown in the enrollment form is not correct and complete, write to Us at the address above, within [10-30] days.

[insert signature]
Secretary

[insert signature]
President

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

Conditionally Renewable: Read the Effective Date and Termination Date provision carefully. We reserve the right to change premiums by class upon any renewal date after the initial 12 months coverage is in force.

II. GUIDE TO YOUR COVERAGE

The sections of the Certificate appear in the following order:

- I. Signature Page
- II. Guide To Your Coverage
- III. Definitions
- IV. Effective Date and Termination Date
- V. Hospital Confinement and Other Fixed Indemnity Benefits
- [VI. Pre-Existing Conditions Limitation]
- [VII.] Exclusions
- [VIII.] Claim Provisions
- [IX.] Premium Provisions
- [X.] Other Provisions

III. DEFINITIONS

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

Accident or Accidental

Any event that meets all of the following requirements:

1. It causes harm to the physical structure of the body.
2. It is the direct cause of a loss, independent of disease, bodily infirmity or any other cause.
3. It is definite as to time and place.
4. It happens involuntarily or entails unforeseen consequences if it is the result of an intentional act.

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

Any condition classified as a mental disorder or abuse of, addiction to, or dependence on drugs, chemicals or alcohol as defined in the edition of the International Classification of Diseases (ICD) in use at the time a claim is received by Us.

[Benefit Waiting Period

The period of consecutive days that must pass after the Effective Date before a Covered Person is eligible for Scheduled Benefits under the terms of this plan.

A Benefit Waiting Period only applies if it is shown in the Benefit Schedule. The Benefit Schedule will identify what any applicable Benefit Waiting Periods are along with the Scheduled Benefits to which they apply.]

[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.

Certificate

This certificate issued to the Certificate Holder as evidence of coverage under the master group Policy.

Certificate Holder

The person listed on the Benefit Schedule as the Certificate Holder.

[Complications of Pregnancy

Complications of Pregnancy include the following:

1. Conditions (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, physician-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 a nosologically distinct complication of pregnancy; and

2. Non-elective cesarean section, ectopic pregnancy which is terminated, 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 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 a Sickness or an Injury or for preventive medicine services as specified in the Hospital Confinement and Other Fixed Indemnity Benefits section and the Benefit Schedule[, and does not occur during a Benefit Waiting Period].
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 plan.

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

Injury resulting from an Accidental blow to the mouth causing trauma to teeth, the mouth, gums or supporting structures of the teeth.

[Dependent

A Dependent is:

1. The Certificate Holder's lawful spouse[, including the Certificate Holder's Domestic Partner [if recognized under applicable law]]; or
2. The Certificate Holder's naturally born child, legally adopted child, a child that is placed for adoption with the Certificate Holder, a stepchild or a child for whom the Certificate Holder is the legal guardian, or a child for whom the Certificate Holder is required to provide medical support by court or administrative order:
 - a. Who is unmarried; and
 - b. Who is age [18-30] or younger[; and
 - c. Who is claimed as an exemption on Your most recent federal income tax return, except for a Dependent child who is a full-time student][; and
 - d. Whose legal address is the same as the Certificate Holder's legal address.

If the child's legal address is different than the Certificate Holder, the child will be considered a Dependent if You submit proof that:

- a. You are required by a qualified medical child support order to provide medical insurance; or
- b. The child was claimed as an exemption on Your most recent federal income tax return.]

If Your unmarried child is age [19-31] or older, the child will be considered a Dependent if You give Us proof that:

- [a.] The child is a full-time student at an accredited educational institution, college or university. A student will be considered full-time if the student meets the standards for full-time status at the school the student is attending. A student will be considered full-time during regular vacation periods that interrupt, but do not terminate, the continuous full-time course of study; or]
- [b.] The child is not capable of self-sustaining employment or engaging in the normal and customary activities of a person of the same age because of mental incapacity or physical handicap and is chiefly dependent on the Certificate Holder for financial support. You must give Us proof that the child meets these requirements at the same time that You first enroll for coverage under this plan or within 31 days after the child reaches the normal age for termination. 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:

- [a.] [Is no longer a full-time student; or]
- [b.] [Graduates; or]
- [c.] [Ceases to be claimed as an exemption on the Certificate Holder's federal income tax return, except for a Dependent child who is a full-time student; or]
- [d.] Attains age [19-31]; or
- [e.] Marries; or
- [f.] Is over age [21-30] and is capable of self-sustaining employment because he or she is no longer mentally incapacitated or physically handicapped.

[If only Dependent children are covered under this plan, the youngest child will be considered the Certificate Holder. All siblings of the Certificate Holder will be considered Covered Dependents if they meet the requirements above.]

[Domestic Partner

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

1. Be at least [18] years of age.
2. Be competent to enter into a contract.
3. Not be related by blood to a degree of closeness that would prohibit legal marriage in the state in which he or she legally resides.

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

[Drug List

A list of Prescription Drugs that We designate as eligible for benefits. A Drug List is subject to change at any time without notice.]

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 plan begins for a Covered Person. The Covered Person's coverage begins at 12:01 a.m. local time at the Certificate Holder's state of residence.

[Emergency Room

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

[Emergency Treatment

Treatment, services or supplies for a Sickness or an Injury that develops suddenly and unexpectedly and, if not treated immediately, would:

1. Endanger the Covered Person's life; or
2. Cause serious bodily impairment to 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 proven 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 to market it by the Food and Drug Administration (FDA) for the particular Sickness or Injury. However, final approval by the FDA is not sufficient to prove that the treatment, services or supplies are of proven benefit or appropriate or effective for diagnosis or treatment of a Sickness or an 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 Evaluations; 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:
 - 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 Certificate Holder and one or more of the Certificate Holder'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 physician 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.
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.]

Home Office

Our office in [Milwaukee, Wisconsin] or other administrative offices as indicated by Us.

[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 by the state in which the services are rendered and accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or Medicare to provide acute care.
2. Be staffed by an on duty physician 24 hours per day.
3. Provide nursing services supervised by an on duty registered nurse 24 hours per day.
4. Maintain daily medical records that document all services provided for each patient.
5. Provide immediate access to appropriate in-house laboratory and imaging services.
6. Not primarily provide care for Behavioral Health or Substance Abuse or Inpatient rehabilitation services although these services may be provided in a distinct section of the same physical facility.

Immediate Family Member

An Immediate Family Member is:

1. You or Your spouse [or Domestic Partner]; or
2. The children, brothers, sisters and parents of either You or Your spouse [or Domestic Partner]; or
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.

Injury

Accidental bodily damage, independent of all other causes, occurring unexpectedly [and unintentionally].

Inpatient

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

[Laboratory Services

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

- [1.] [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.]
- [2.] [Maximum Benefit for Inpatient Hospital Confinement Benefits:
The maximum amount of Inpatient Hospital Confinement Benefits that We will pay for each Covered Person under this plan.]
- [3.] [Maximum Benefit for Rehabilitation Unit Confinement Benefits:
The maximum amount of Rehabilitation Unit Confinement Benefits that We will pay for each Covered Person under this plan.]
- [4.] [Maximum Benefit for Initial Hospitalization Benefits:
The maximum amount of Inpatient Hospitalization Benefits that We will pay for each Covered Person under this plan.]
- [5.] [Maximum Benefit for Emergency Room [and Urgent Care Facility] Visit Benefits:
The maximum amount of Emergency Room [and Urgent Care Facility] Visit Benefits that We will pay for each Covered Person under this plan.]
- [6.] [Maximum Benefit for Urgent Care Facility Visit Benefits:
The maximum amount of Urgent Care Facility Visit Benefits that We will pay for each Covered Person under this plan.]
- [7.] [Maximum Benefit for Outpatient Medical Event Benefits:
The maximum amount of Outpatient Medical Event Benefits that We will pay for each Covered Person under this plan.]
- [8.] [Maximum Benefit for Office Visit Benefits:
The maximum amount of Office Visit Benefits that We will pay for each Covered Person under this plan.]
- [9.] [Maximum Benefit for Allergy Immunotherapy Injection [and Immunization] Benefits:

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

- [10.] [Maximum Benefit for Immunization Benefits:
The maximum amount of Immunization Benefits that We will pay for each Covered Person under this plan.]
- [11.] [Maximum Benefit for Telehealth [and Telemedicine] Services Benefits:
The maximum amount of Telehealth [and Telemedicine] Services Benefits that We will pay for each Covered Person under this plan.]
- [12.] [Maximum Benefit for Telemedicine Services Benefits:
The maximum amount of Telemedicine Services Benefits that We will pay for each Covered Person under this plan.]
- [13.] [Maximum Benefit for Outpatient Prescription Order Benefits:
The maximum amount of Outpatient Prescription Order Benefits that We will pay for each Covered Person under this plan.]
- [14.] [Maximum Benefit for Professional Ground [or Air] Ambulance Services Benefits:
The maximum amount of Professional Ground [or Air] Ambulance Services Benefits that We will pay for each Covered Person under this plan.]
- [15.] [Maximum Benefit for Anesthesia Benefits:
The maximum amount of Anesthesia Benefits that We will pay for each Covered Person under this plan.]
- [16.] [Maximum Benefit for Surgical Services Benefits:
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; and
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. Can reasonably be expected to result in or contribute substantially to the improvement of a condition resulting from a Sickness or an Injury; and
4. 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, of 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.

[Non-Preferred Brand Name Drug

A Brand Name Drug that is not listed as preferred in a Drug List.]

[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.
4. Muscle and sensory stimulation.]

[Office Visit

An in-person, face-to-face meeting [or a Telehealth [or Telemedicine] consultation] between a Covered Person and a Health Care Practitioner in [or from] 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 plan, 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 [or 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 plan, Outpatient does not include Office Visits, Emergency Room visits, [Telehealth Services, Telemedicine Services,]Urgent Care visits or Retail Health Clinic visits.]

[Outpatient Facility

Any of the following: a Hospital's Outpatient department[,] [or] a Free-Standing Facility[or an Urgent Care 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.]

[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 group master contract issued by Us to the Policyholder providing benefits for Covered Persons.

Policyholder

The [person,] [organization] [or] [entity] to [which] [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, consultation, diagnosis, care or treatment was sought, received or recommended from a provider or Prescription Drugs were prescribed during the [12-24]-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 signs or symptoms during the [12-24] -month period immediately prior to the Covered Person's Effective Date.

The signs or symptoms were significant enough to establish manifestation or onset by one of the following tests:

- a. The signs or symptoms reasonably should have allowed or would have allowed one learned in medicine to diagnose the condition; or
- b. The signs or symptoms reasonably should have caused or would have caused an ordinarily prudent person to seek diagnosis or treatment.

[A pregnancy that exists on the day before the Covered Person's Effective Date will be considered a Pre-Existing Condition.]]

[Preferred Brand Name Drug

A Brand Name Drug that is listed as preferred in a Drug List. This list is subject to change at any time without notice.]

[Prescription Drug

Any medication [or contraceptive drug or device including oral contraceptives, contraceptive patches, contraceptive vaginal rings, and diaphragms] that:

1. Has been fully approved by the Food and Drug Administration (FDA) for marketing in the United States; and
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.

[For purposes of this plan Prescription Drug does not include injectable contraceptives (depo provera injections) and contraceptive implants (IUDs).]]

[Prescription Order

The request by a Health Care Practitioner for:

1. Each separate Prescription Drug and each authorized refill; or
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]

[Primary Care Practitioner

A Health Care Practitioner who is a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) whose practice predominantly includes pediatrics, internal medicine, family practice, general practice or obstetrics/gynecology. [A [licensed nurse practitioner,] [podiatrist,] [chiropractor] [and] [dentist] would also qualify as a Primary Care Practitioner if he or she meets the definition of a Health Care Practitioner and the services rendered would be Covered Charges if performed by a Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who is also a Primary Care Practitioner.]]

[Radiology Services

Diagnostic imaging procedures and tests including, but not limited to, x-rays, positron emission tomography (PET) scan, magnetic resonance imaging (MRI) and computerized axial tomography (CT), that are performed to diagnose a condition, determine the nature of a condition, or provide preventive 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 multi-disciplinary team.
2. Is designed to improve the patient's function and independence.
3. Is under the direction of a qualified Health Care Practitioner.
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 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, subacute 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 or services for a Sickness or Injury, or provides preventive medicine services, [on a non-seasonal basis]; and
6. Does not provide room and board or overnight services.
- [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. 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 plan, 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.]

[Single Plan

A plan of insurance covering only the Certificate Holder.]

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.

[Specialist Practitioner

A Health Care Practitioner who is classified as a specialist by the American Boards of Medical Specialties. [A Specialist Practitioner, for purposes of this plan, [is not][and][cannot be] a Primary Care Practitioner.]

[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 [established] 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

TMJ Dysfunction and CMJ Dysfunction is any joint disorder of the jaw causing any of the following:

1. Clicking and/or difficulties in opening and closing the mouth.
2. Pain or swelling.
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
2. 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 physician during operating hours.

3. Provide services to stabilize patients who need Emergency Treatment and arrange immediate transportation to an Emergency Room.
4. Provide immediate access to appropriate in-house laboratory and imaging services.]

We, Us, Our, Our Company

Time Insurance Company or its administrator.

You, Your, Yours

The person listed on the Benefit Schedule as the Certificate Holder.

IV. EFFECTIVE DATE AND TERMINATION DATE

Eligibility and Effective Date of Certificate Holder

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

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

[This is a Single Plan. Dependents may not be added.]

[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.] Single Plan: If the Certificate Holder has a Single Plan, as shown in the Benefit Schedule, on the Effective Date of his or her plan, a Dependent cannot be added after the Certificate Holder's Effective Date.

If You have a Single Plan and want to add any Dependents after Your Effective Date, You may apply for a new certificate by completing an enrollment form 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 certificate will take effect at 12:01 a.m. local time at the Certificate Holder'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 [and a Benefit Waiting Period apply][applies] to You under the new certificate will be reduced by the total number of consecutive days that You were covered under this Certificate immediately prior to termination. Benefits paid under the new certificate cannot exceed the [Maximum Lifetime Benefit or any other] applicable Maximum Benefit that would have otherwise been paid under the terms of this Certificate if coverage under this Certificate would have remained in force.]

- [[2.] Family Plan: If the Certificate Holder has a Family Plan, as shown in the Benefit Schedule, on the Effective Date of his or her plan, a Dependent can be added after the Certificate Holder'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 call Our office or send Us written notice of the birth of the child and We must receive any required additional premium within [31-60] days of birth. The Effective Date of coverage will be 12:01 a.m. local time at the Certificate Holder'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 and premature birth only for the first [31-60] days from birth.

- b. Adding an Adopted Child: A newly adopted child can be added on the date the child is placed with the Certificate Holder in anticipation of legal adoption and the Certificate Holder assumes a legal obligation for support of the child or the date of legal adoption, whichever is earlier. You must call Our office or send Us written notice of the adoption or placement for adoption of the child and We must receive any required additional premium within [31-60] days of the adoption or placement for adoption, whichever is earlier. The Effective Date of coverage will be 12:01 a.m. local time at the Certificate Holder's state of residence on the earlier of the date the child is adopted or placed for adoption. If these requirements are not met, Your newly adopted child will be covered for Sickness or Injury only for the first [31-60] days from placement for adoption. A child is no longer considered adopted if, prior to legal adoption, You relinquish legal obligation for support of the child and the child is removed from placement.
- c. Adding a Child for Whom a Court Order Requires You to Provide Insurance: A child for whom a court order requires the Certificate Holder or Covered Dependent spouse to provide this insurance can be added as of the date required by the order. You must call Our office or send Us written notice of the court order, provide a copy of the court order to Us, and We must receive any required additional premium within [31-60] days of the effective date of the order. The Effective Date of coverage for the child will be 12:01 a.m. local time at the Certificate Holder's state of residence on:
 - I. the date the court order becomes effective, when the notice and premium payment requirements above are met; or
 - II. the date You provide notice, including a copy of the court order, and any required premium to Us if received after the first [31-60] days following the date of the court order.
- d. Adding Any Other Dependent: To add any other Dependents, an enrollment form 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 Certificate Holder's state of residence on the Effective Date for that Covered Person shown on the Benefit Schedule.]]

Termination Date

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

This Certificate, and coverage hereunder, will terminate at 12:01 a.m. local time at the Certificate Holder's state of residence on the earliest of the following dates:

1. The date We receive a request in writing or by telephone to terminate this plan or on a later date that is requested by the Certificate Holder 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 Certificate Holder for termination of a Covered Dependent.]

- [3.] The date this plan lapses for nonpayment of premium per the Grace Period provision in the Premium Provisions 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 Certificate was issued or the state in which the Certificate Holder presently resides.
- [6.] [The date We terminate or nonrenew all individual market hospital-indemnity insurance plans in the state in which this Certificate was issued 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.] [On] [T][t]he date the Certificate Holder moves to a state where We do not provide insurance under a plan with the same plan design as this Certificate[, We reserve the right to terminate this coverage].
- [8.] [On the date the master group Policy terminates or is non-renewed.]
- [9.] [For a Dependent, the date a Covered Dependent no longer meets the Dependent definition in this plan.]

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 Certificate.

[V]. 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 limitation provided under this plan. Benefits are subject to all the terms, limits and conditions in this plan.

[We will not pay benefits for Events that occur during a Covered Person's Benefit Waiting Period. A Benefit Waiting Period only applies if it is shown in the Benefit Schedule.]

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.

[Initial Hospitalization Benefit [for] [Sickness] [or] [Injury]

We will pay the corresponding Scheduled Benefit amount when the Covered Person is initially admitted to a Hospital for at least 24 hours for treatment of [Sickness] [or] [Injury]. [In cases of Injury, this benefit is not payable unless You [or Your Covered Dependent] [is][are] admitted to a Hospital within [2-90] days of the Accident event that caused the Injury.] [This benefit is payable only once per Calendar Year, per Covered Person.] Benefits are limited to the Calendar Year Maximum Benefit shown on the Benefit Schedule.]

[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 physician 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[; see the Rehabilitation Unit Confinement Benefit for such benefits].

The Scheduled Benefit for Sickness under this Inpatient Hospital Confinement Benefits provision will be paid for each day of confinement for routine nursery care and pediatric care of a newborn child for up to five (5) full days in a hospital nursery or until the mother, who is a Covered Person under this plan, is discharged from the hospital following the birth of the child, whichever is the lesser period of time.

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.]

[Rehabilitation Unit Confinement Benefit

We will pay the corresponding Scheduled Benefit amount for each day of room and board during a Confinement Period under the orders of a physician for rehabilitative care of a Sickness or an Injury in a Rehabilitation Unit.

When a Rehabilitation Unit 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.]

[Emergency Room Visit Benefits

We will pay the corresponding Scheduled Benefit amount upon the occurrence of a visit to an Emergency Room during which a Covered Person receives Emergency Treatment. [An Emergency Room visit that is not for Emergency Treatment will not be considered for benefits under this plan.]

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. [An Urgent Care Facility visit that is not for Urgent Care will not be considered for benefits under this plan.]

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 one of the following for treatment of a Sickness or Injury or preventive medicine 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. Laboratory Services includes, but is not limited to, newborn infant tests for hypothyroidism, phenylketonuria, galactosemia, sickle-cell anemia, and all other disorders of metabolism for which screening is performed by or for the State of Arkansas.
2. Covered Events involving Radiology Services as shown on the Benefit Schedule that are incurred on an Outpatient basis.
3. Covered Events involving Physical Medicine services as shown on the Benefit Schedule that are incurred on an Outpatient basis.

4. All other Medically Necessary Covered Events that are incurred on an Outpatient basis and for which benefit is 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 and eligible for the Other Outpatient Event benefit.

Those Covered Events for which benefit is 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.
 - 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.
 - [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 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.]

[Telehealth Services Benefits

We will pay the corresponding Scheduled Benefit amount upon an occurrence during which a Covered Person obtains Telehealth Services. Benefits are limited to the Calendar Year Maximum Benefit shown on the Benefit Schedule.]

[Telemedicine Services Benefits

We will pay the corresponding Scheduled Benefit shown on the Benefit Schedule upon an occurrence during which a Covered Person obtains Telemedicine Services. 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.
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. Benefits are limited to the Calendar Year Maximum Benefit shown on the Benefit Schedule.]

[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 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 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 eligible Anesthesia Benefits.]

Two or more surgical procedures performed during the same operative session are considered one operation and benefits will be considered 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, benefits will be considered under the benefit level for Surgical Event – Not Otherwise Listed. Benefits are limited to the Calendar Year Maximum Benefit shown on the Benefit Schedule.]

[[VI]. 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 [6-12] 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.]

[VII]. 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 arises out of, or is the result of, any work for wage or profit; 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 workers' 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, including non-military units supporting such forces.]
- [4.] [Foreign [or domestic] acts of terrorism that result in a nationwide epidemic.]
- [5.] [Treatment, services or supplies that:
 - a. Is not part of a specifically listed Covered Event shown on the Benefit Schedule.
 - b. Is due to complications of a non-covered service.
 - c. Is 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.
 - d. Is provided in a student health center or by or through a school system.]]
- [6.] [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.]
- [7.] [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.]
- [8.] [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.
- e. Hygienic foot care that is routine.]

- [9.] [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 complications of the teeth and gum tissue, except as otherwise covered for a Dental Injury.]
- [10.] [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).]
- [11.] [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.]
- [12.] [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.]
- [13.] [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.]
- [14.] [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.]
- [15.] [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.]
- [16.] [Removal or replacement of a prosthesis; Durable Medical Equipment or Personal Medical Equipment, except for external 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.]

- [17.] [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.]
- [18.] [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.
 - f. [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; other [Telemedicine Services] [or] [Telehealth Services] [technology] that facilitates access to a Health Care Practitioner[, except for Telehealth Services [or Telemedicine Services] [provided as part of the Office Visit Benefits]].]
 - k. 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.
 - l. Treatment or services provided by a standby Health Care Practitioner.
 - m. Treatment or services provided by a masseur, masseuse or massage therapist; massage therapy; a rolfer.
 - n. Treatment or services provided by a chiropractor.]
- [19.] [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.]
- [20.] [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.]
- [21.] [Treatment, services, and supplies related to: maternity; pregnancy (except Complications of Pregnancy); ; abortion.]
- [22.] [Contraceptive procedures;] [contraceptive drugs] [or] [devices including, but not limited to,] [oral contraceptives,] [contraceptive patches,] [contraceptive vaginal rings,] [diaphragms,] [injectable contraceptives] [and] [contraceptive implants].]
- [23.] [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 chorionic 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.
- h. Circumcision.]

[24.] [Spinal [and other] adjustments, manipulations, subluxation treatment and/or services.]

[25.] [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.]

[26.] [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 [or varicose 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][, such as obstructive sleep apnea].
- m. Change in skin coloring or pigmentation.
- n. Stress management.]

[27.] [Treatment of an Injury sustained in operating a motor vehicle while the Covered Person's blood alcohol level, as defined by law, exceeded the blood alcohol level otherwise permitted by law or violated legal standards for a person operating a motor vehicle in the state where the Injury occurred. This exclusion applies whether or not the Covered Person is charged with any violation in connection with the Accident.]

[28.] [A condition 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.]

[29.] [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].]

[30.] [Treatment or services required due to Injury received while engaging in any hazardous [occupation or other] activity including, but not limited to: Participating, instructing, demonstrating, guiding or accompanying others in [parachute jumping,] [hang-gliding,] [bungee jumping,] [flight in an aircraft other than a regularly scheduled flight by an airline,] [racing any motorized [or non-motorized] vehicle,] [rock or mountain climbing,] [hunting,] [parkour,] [free running] [and] [extreme sports]. [Also excluded are treatment and services required due to Injury received while practicing, exercising, undergoing conditioning or physical preparation for any such activity.]]

- [31.] [[Treatment or services required due to Injury received while engaging in any hazardous [occupation or other] activity [for which compensation is received in any form, including sponsorship,] such as, but not limited to: Participating, instructing, demonstrating, guiding or accompanying others in [skiing,] [horse riding,] [rodeo activities,] [professional [or semi-professional] [contact] sports,] [adult sporting competition at a national or international level] [and] [extreme sports]. [Also excluded are treatment and services required due to Injury received while practicing, exercising, undergoing conditioning or physical preparation for any such compensated activity.]]
- [32.] [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.]
- [33.] [Any amount in excess of [the Maximum Lifetime Benefit or] any [other] Maximum Benefit limitation for covered Scheduled Benefits.]
- [34.] [Treatment that does not meet the definition of a Covered Event in this plan including, but not limited to, treatment that is not Medically Necessary.]
- [35.] [Treatment, services and supplies for Experimental or Investigational Services.]
- [36.] [Treatment incurred outside of the United States, including drugs or medicines obtained from pharmacy provider sources outside the United States.]
- [37.] [Sickness or Injury caused or aggravated by suicide, attempted suicide or self-inflicted Sickness or Injury, even if the Covered Person did not intend to cause the harm which resulted from the action which led to the self-inflicted Sickness or Injury.]
- [38.] [Vitamins and/or vitamin combinations even if they are prescribed by a Health Care Practitioner.]
- [39.] [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.
 - 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.]
- [40.] [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.]

- [41.] [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.]
- [42.] [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.]
- [43.] [Unit-dose drugs; drugs or medicines used to treat onychomycosis (nail fungus); botulinum toxin and its derivatives.]
- [44.] [Drugs or medicines prescribed for treatment of a condition that is specifically excluded under this plan.]
- [45.] [Drugs, medicines or supplies that are illegal under federal law, such as marijuana, even if they are prescribed for a medical use in a state.]
- [46.] [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.]

[VIII]. CLAIM PROVISIONS

Notice of Claim

You must notify Us of the claim within [20-90] calendar days after the date the Covered Event occurs, or as soon as reasonably possible[, by calling Our Home Office]. When providing notice of claim, You must include Your name, address, and Certificate number.

Claim Forms

Within [15-30] calendar days after We receive Your notice of claim, We will provide claim forms to be used when submitting Proof of Loss. The forms must be completed and sent to Us or Our designee. If You do not receive the claim forms within [15-30] [calendar][business] days or if We do not require Proof of Loss to be submitted on a specified claim form, We will accept a written description of the exact nature and extent of the loss as Proof of Loss provided it meets the requirements, including timeframes, for submitting Proof of Loss stated below.

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 [60-180] calendar days after a covered loss occurs or as soon as reasonably possible, but in no event later than 12 months from the date the 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 Certificate 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 bill from the provider of the services involved with the Covered Event that includes all of the following as appropriate:
 - a. International Classification of Diseases (ICD) diagnosis codes.
 - b. International Classification of Diseases (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 bill from the surgeon. A bill 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 plan. 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 bill submitted as 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 [30-90] 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 done, at Our expense, where it is not prohibited by law.

Payment of Benefits

Benefits will be paid 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 Certificate Holder 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 spouse, [Your Domestic Partner,] [or]Your estate[or the providers of the services].

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, [except when the professional component occurs as a fully separate and distinct Covered Event under this plan.] 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 and 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.

[Workers' Compensation Not Affected]

Insurance under this plan does not replace or affect any requirements for coverage by workers' compensation insurance. If state law allows, We may participate in a workers' 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.

[IX]. PREMIUM PROVISIONS

Consideration

This plan is issued based on the statements and agreements in the Covered Person's enrollment form and during the enrollment process, any exam of a Covered Person that is required, any other amendments or supplements to the enrollment 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.]

Your premium may be adjusted from time to time based on different factors including, but not limited to, Your [geographic area,] [gender,] age[,] [payment method] [and] [plan design.] All premium adjustments will be made to individuals on the basis of shared characteristics. The premium may also change if You [add or delete Covered Dependents,] [change the payment method,] [move to another zip code] [or otherwise] change the coverage. [The mode of payment (monthly, quarterly or other) is subject to change at Our discretion.]

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 end on the [date that the unpaid premium was due and no loss incurred during the grace period will be considered for benefits][date the grace period expires]. If the premium is received during or by the end of the grace period, coverage will continue without interruption unless You call Our office or give Us written notice to cancel the coverage. [If a claim is payable during the grace period, any unpaid premiums due will be deducted from the claim payment.]

Reinstatement

If any premium is not paid within the required time period, coverage for You [and any Covered Dependents] will lapse. The coverage will be reinstated if all of the following requirements are met:

1. The lapse was not more than [30-180] days.
2. You submit a supplemental enrollment form for reinstatement to Us and remit the required premium payment. Submission of premium to Your agent is not submission of premium to Us.
3. We approve Your enrollment form for reinstatement.

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

If the coverage is reinstated, loss resulting from an Injury will be covered only if the 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 plan before the plan lapsed, subject to any provisions included with or attached to this plan in connection with the reinstatement.

Continuation

A Covered Dependent may be eligible to continue coverage under this plan after coverage would otherwise terminate due to loss of dependency status or change in marital status. The benefits will be the same as those in effect on the date of termination. You must furnish written request for continuation to Us within 10 days after ceasing to be eligible for coverage. The continued coverage will end on the earliest of:

1. Full coverage under any other group accident and health policy or contract. This includes being covered for conditions deemed to be pre-existing conditions under that plan;
2. The end of the period for which premiums are paid;
3. The period ending 120 days from the date continuation began;
4. The premium due date following the date the dependent becomes eligible for Medicare;
5. The date coverage under the plan would have otherwise terminated;
6. The date the Life Time Maximum Benefit amount is reached; or
7. The date the master group Policy ends.

The Covered Dependent will be eligible for conversion after exhaustion of continuation of coverage.

[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 plan if:

1. The Covered Dependent's insurance terminates due to a valid decree of divorce between the Certificate Holder and the Covered Dependent; or
2. The Covered Dependent's insurance terminates due to the death of the Certificate Holder; 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 enrollment form and the required premium to Us within 31 days after coverage under this plan 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 enrollment is not made within [31 days] following the termination of insurance under this plan, 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 plan terminates. The time during which a Pre-Existing Condition Limitation [and a Benefit Waiting Period apply][applies] under the new plan will be reduced by the total number of consecutive days that You were covered under this Certificate 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 Certificate if coverage under this Certificate would have remained in force.]

[X]. OTHER PROVISIONS

Modification of Coverage

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

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

The group master Policy may be changed at any time. We will give the Policyholder [30 days] notice prior to any change.

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 payment of the benefits under this Certificate 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 Certificate is issued to the Certificate Holder. The entire contract of insurance includes the group master Policy, a Covered Person's Certificate, Benefit Schedule, [application][enrollment] form and any riders and endorsements.

Representations Made on [Application][Enrollment Form]

All statements made on the [application][enrollment] form will be deemed representations and not warranties. No statement made in the [application][enrollment] form will be used in any suit or action at law or equity unless a copy of the [application][enrollment] form is furnished to the Certificate Holder, or in the event of death or incapacity of the Certificate Holder, a copy will be furnished to the Certificate Holder'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 plan 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 [60-90] days after termination. Benefits are subject to all the terms, limits and conditions in this plan. [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. [90-180] days from the date coverage would have terminated under this plan if there was no extension of benefits.
4. The date the Covered Person is eligible for Medicare.
5. The earliest date otherwise permitted by law.

[Incentives, Rebates and Contributions

We may elect to furnish or participate in programs with other organizations that furnish [group applicants for coverage] [members of groups applying for coverage] [individual applicants for coverage] [Covered Persons] [individuals] [that meet common criteria or requirements determined by Us][, not to include health or claims history,] [with "premium holidays" or programs where premiums, fees or plan benefit limits will be discounted, credited, refunded, waived or otherwise adjusted] [or] [where other gifts or items of value may be offered or provided to You at no charge or at a discount] [at a time or times] [for a period of time] determined by Us.]

Discounted or Free Non-Insurance Programs We may elect to furnish or participate in programs with other organizations that furnish Certificate Holders that meet common criteria or requirements determined by Us with discount cards, vouchers, coupons, or other programs that may be offered or provided to Covered Persons at no charge or a reduced charge for a period of time determined by Us. We may provide You with access to discounts with certain health care providers and suppliers negotiated by Us.

[Provider Access

We may provide Covered Persons with access to providers with whom We have a contracted rate for services or supplies. Our fixed-indemnity benefit payment for a Covered Event does not change regardless of whether or not We have a contracted rate with the provider from whom You obtain hospital, medical, surgical or prescription services or supplies or the cost of treatment occurring as part of the Covered Event. By using such providers to obtain Your medical services or supplies, You may obtain a lower cost of services or supplies. You must show Your plan ID card at the time services are rendered to obtain these contracted rates, if available.]

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 (Time Limit on Certain Defenses)

Within the first two years after the Effective Date of coverage, We have the right to rescind or modify Your Certificate of insurance coverage and/or deny a claim for a Covered Person if the [application][enrollment] form contains an omission or misrepresentation, whether intended or not, which We determine to be material. We

also reserve the right to rescind a Certificate of insurance 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 in equity may be brought to recover benefits under this plan prior to the expiration of sixty (60) days after written proof of loss has been furnished in accordance with the requirements of this Certificate. No suit or action at law or in 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.]

Forum

Any lawsuits or disputes arising under the terms of the Certificate or Policy must be brought in the United States District Court for the Eastern District of Wisconsin.