

SERFF Tracking Number: USHG-127046186 State: Arkansas
Filing Company: Freedom Life Insurance Company of America State Tracking Number: 48040
Company Tracking Number: ACCPYD-2011-C-FLIC
TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only
Product Name: ACCPYD-2011-C-FLIC
Project Name/Number: ACCPYD-2011-C-FLIC/

Filing at a Glance

Company: Freedom Life Insurance Company of America

Product Name: ACCPYD-2011-C-FLIC

TOI: H02G Group Health - Accident Only

Sub-TOI: H02G.000 Health - Accident Only

Filing Type: Form

SERFF Tr Num: USHG-127046186 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num: 48040

Co Tr Num: ACCPYD-2011-C-FLIC State Status: Approved-Closed

Reviewer(s): Rosalind Minor

Authors: Shelley Rooker, Shannon
Morgan Cubby

Date Submitted: 02/21/2011

Disposition Status: Approved-

Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

General Information

Project Name: ACCPYD-2011-C-FLIC

Project Number:

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Group Market Type: Association

Filing Status Changed: 03/01/2011

State Status Changed: 03/01/2011

Created By: Shelley Rooker

Corresponding Filing Tracking Number: ACCPYD-2011-C-FLIC

Filing Description:

Please see attached cover letter.

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Overall Rate Impact:

Deemer Date:

Submitted By: Shelley Rooker

Company and Contact

Filing Contact Information

Shannon M. Morgan, Product Analyst

3100 Burnett Plaza

801 Cherry Street, Unit 33

morgans@ushealthgroup.com

817-878-3748 [Phone]

817-878-3310 [FAX]

SERFF Tracking Number: USHG-127046186 State: Arkansas
Filing Company: Freedom Life Insurance Company of America State Tracking Number: 48040
Company Tracking Number: ACCPYD-2011-C-FLIC
TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only
Product Name: ACCPYD-2011-C-FLIC
Project Name/Number: ACCPYD-2011-C-FLIC/

Fort Worth, TX 76102

Filing Company Information

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

Filing Fees

Fee Required? Yes
Fee Amount: \$100.00
Retaliatory? Yes
Fee Explanation: \$100.00 per filing
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Freedom Life Insurance Company of America	\$100.00	02/21/2011	44909366

SERFF Tracking Number: USHG-127046186 State: Arkansas
 Filing Company: Freedom Life Insurance Company of America State Tracking Number: 48040
 Company Tracking Number: ACCPYD-2011-C-FLIC
 TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only
 Product Name: ACCPYD-2011-C-FLIC
 Project Name/Number: ACCPYD-2011-C-FLIC/

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	03/01/2011	03/01/2011

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Supporting Document	Cover Letter	Shelley Rooker	02/21/2011	02/21/2011

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Change to General Information	Note To Reviewer	Shelley Rooker	02/22/2011	02/22/2011

SERFF Tracking Number: USHG-127046186 State: Arkansas
Filing Company: Freedom Life Insurance Company of America State Tracking Number: 48040
Company Tracking Number: ACCPYD-2011-C-FLIC
TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only
Product Name: ACCPYD-2011-C-FLIC
Project Name/Number: ACCPYD-2011-C-FLIC/

Disposition

Disposition Date: 03/01/2011

Implementation Date:

Status: Approved-Closed

Comment:

This submission is being approved with the understanding that all associations must have our Department's prior approval before this product is marketed through the association group.

Rate data does NOT apply to filing.

SERFF Tracking Number: USHG-127046186 State: Arkansas
 Filing Company: Freedom Life Insurance Company of America State Tracking Number: 48040
 Company Tracking Number: ACCPYD-2011-C-FLIC
 TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only
 Product Name: ACCPYD-2011-C-FLIC
 Project Name/Number: ACCPYD-2011-C-FLIC/

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document (revised)	Cover Letter	Approved-Closed	Yes
Supporting Document	Cover Letter	Replaced	Yes
Form	Accidental Bodily Injury Expense Certificate	Approved-Closed	Yes
Form	Accidental Bodily Injury Expense Certificate	Approved-Closed	Yes

SERFF Tracking Number: USHG-127046186 State: Arkansas
Filing Company: Freedom Life Insurance Company of America State Tracking Number: 48040
Company Tracking Number: ACCPYD-2011-C-FLIC
TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only
Product Name: ACCPYD-2011-C-FLIC
Project Name/Number: ACCPYD-2011-C-FLIC/

Note To Reviewer

Created By:

Shelley Rooker on 02/22/2011 02:27 PM

Last Edited By:

Rosalind Minor

Submitted On:

03/01/2011 01:12 PM

Subject:

Change to General Information

Comments:

The Group Market Size says small and large but it should be large only.

SERFF Tracking Number: USHG-127046186 State: Arkansas
Filing Company: Freedom Life Insurance Company of America State Tracking Number: 48040
Company Tracking Number: ACCPYD-2011-C-FLIC
TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only
Product Name: ACCPYD-2011-C-FLIC
Project Name/Number: ACCPYD-2011-C-FLIC/

Amendment Letter

Submitted Date: 02/21/2011

Comments:

I have attached a corrected cover letter.

Changed Items:

Supporting Document Schedule Item Changes:

User Added -Name: Cover Letter

Comment: See attached cover letter.

FLIC cover letter .pdf

SERFF Tracking Number: USHG-127046186 State: Arkansas
 Filing Company: Freedom Life Insurance Company of America State Tracking Number: 48040
 Company Tracking Number: ACCPYD-2011-C-FLIC
 TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only
 Product Name: ACCPYD-2011-C-FLIC
 Project Name/Number: ACCPYD-2011-C-FLIC/

Form Schedule

Lead Form Number: ACCPYD-2011-C-FLIC

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved- Closed 03/01/2011	ACCPYD- 2011-C- FLIC	Certificate	Accidental Bodily Injury Expense Certificate	Initial			ACCPYD- 2011-ACC- AR-FLIC.pdf
Approved- Closed 03/01/2011	ACCCYD- 2011-C- FLIC	Certificate	Accidental Bodily Injury Expense Certificate	Initial			ACCCYD- 2011-ACC- AR-FLIC.pdf

FREEDOM LIFE INSURANCE COMPANY OF AMERICA

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

CERTIFICATE OF COVERAGE ASSOCIATION GROUP ACCIDENTAL BODILY INJURY INSURANCE PLAN

This is **Your Certificate** of coverage under the **Group Accidental Bodily Injury Insurance Policy** issued to the association that is the **Group Accidental Bodily Injury Insurance Policyholder** and in which association each **Insured** is an enrolled member. The coverage of all **Insureds** is independent and non-coordinated insurance coverage for **Bodily Injuries** sustained in an **Accident**, which coverage is governed and determined by the terms, conditions, definitions, limitations and exclusions contained in this **Certificate**. Certain phrases and words contained in this **Certificate** have the first letter of each word capitalized and the entire word or phrase printed in bold face type. These are generally defined phrases and words, and as such have the express meaning set forth in Section II. DEFINITIONS. This **Certificate** is a legal contract between **You** and the **Company**. Please read it carefully!

Your Certificate is guaranteed renewable to age 65 or in the event an **Insured** otherwise becomes a **Medicare Enrollee**, subject to the **Company's** right to adjust **Renewal Premiums** in accordance with Section IV.B. RENEWAL PREMIUM, and otherwise discontinue or terminate the **Certificate** as provided in Section III.C. TERMINATION OF COVERAGE. The **Initial Premium** for coverage of all **Insureds** under this **Certificate** is due and payable on or before the **Issue Date**. **Renewal Premiums** are due and payable in accordance with the Section IV.B. RENEWAL PREMIUM. You may renew coverage under this **Certificate**, as applicable, by timely payment of the proper amount of **Renewal Premium** when due.

IMPORTANT NOTICE ABOUT STATEMENTS IN THE APPLICATION: Please read the copy of **Your** application for coverage, which is attached to and part of this **Certificate**, to verify that no medical history or other information inquired about or contained in the application is incorrect, incomplete or missing. Contact **Us** immediately if any information contained in the application is incorrect, incomplete or missing. Any incorrect or incomplete statements or answers, as well as any missing information could cause a claim to be denied or the coverage under this **Certificate** to be reformed or voided.

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

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

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



SECRETARY



PRESIDENT

THE COVERAGE UNDER THIS CERTIFICATE PROVIDES ONLY ASSOCIATION GROUP ACCIDENTAL BODILY INJURY INSURANCE COVERAGE. IT DOES NOT PROVIDE EITHER WORKERS' COMPENSATION COVERAGE OR COMPREHENSIVE MAJOR MEDICAL INSURANCE COVERAGE.

TABLE OF CONTENTS

Provision	Page
I. CERTIFICATE SCHEDULE.....	3A-3C
II. DEFINITIONS.....	4-17
III. WHEN COVERAGE BEGINS AND ENDS.....	17-21
A. EFFECTIVE DATE.....	17
B. ELIGIBILITY AND ADDITIONS.....	18
C. TERMINATION OF COVERAGE.....	18-19
D. EXTENSION OF BENEFITS.....	19-20
E. CONTINUATION OF COVERAGE AND CERTIFICATE OF CONVERSION.....	20-21
IV. PREMIUM.....	21-24
A. INITIAL PREMIUM.....	21
B. RENEWAL PREMIUM.....	21-23
V. ACCIDENTAL BODILY INJURY BENEFITS AND CLAIM PROCEDURES.....	23-31
A. ACCIDENTAL BODILY INJURY BENEFITS.....	31
B. PRE-CERTIFICATION OF TREATMENT.....	31-32
C. CLAIM PROCEDURES, INVESTIGATION AND PAYMENT.....	33
VI. DEDUCTIBLES.....	33
A. POLICY YEAR DEDUCTIBLE.....	33
B. SEPARATE DEDUCTIBLE FOR NON-PARTICIPATING PROVIDERS.....	34
C. SEPARATE DEDUCTIBLE FOR FAILURE TO PRE-CERTIFY TREATMENT.....	33-36
VII. LIMITATIONS, EXCLUSIONS AND NON-WAIVER.....	33-34
A. LIMITATIONS-WAITING PERIODS.....	34-36
B. EXCLUSIONS.....	36
C. NON-WAIVER.....	36-37
VIII. INCREASE IN LIFETIME CERTIFICATE MAXIMUM.....	39-45
IX. UNIFORM PROVISIONS.....	39-40
A. ENTIRE CONTRACT-CHANGES.....	40
B. TIME LIMIT ON CERTAIN DEFENSES.....	44
C. OTHER INSURANCE WITH US.....	44
D. CONFORMITY WITH STATE STATUTES.....	44
E. MISSTATEMENT OF AGE.....	45
F. NONDISCLOSED MEDICAL HISTORY, MEDICAL CONDITIONS AND RELATED INFORMATION.....	45
G. LEGAL ACTION.....	45
H. SUBROGATION.....	45
I. EXTRATERRITORIAL MEDICAL EXPENSES.....	45

I. Certificate Schedule

A. GENERAL INFORMATION

Coverage is pursuant to a **Group Accidental Bodily Injury Insurance Policy** form: [GRP-ACC-11-FLIC]

Issued to **Group Accidental Bodily Injury Insurance Policyholder**:

Certificate form: [ACCPYD-2011-C-AR-FLIC]

Primary Insured: []

Age at Issue: []

Certificate Number: []

Issue Date: []

Other Insureds on Issue Date:
[]
[]

Beneficiary: []

Initial Premium: []

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

First Renewal Date: []

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

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

B. COVERAGE SCHEDULES

- Lifetime Certificate Maximum Per Insured:** [\$2,000,000 or \$5,000,000].
- Lifetime Transplant Maximum Per Insured:** [\$500,000 or \$1,000,000].

3. **Policy Year Maximum Benefit Per Insured:** [\$100,000, \$200,000, \$300,000, \$400,000, \$500,000, \$1,000,000 or Lifetime Certificate Maximum Per Insured].

4. **DEDUCTIBLE SCHEDULES:**

The following deductibles are to be paid by the **Insured** in addition to the **Insured Coinsurance Percentage** before any **Accidental Bodily Injury Benefits** are payable by **Us** for **Covered Expenses**:

A. **Policy Year Deductible per Insured:** [\$2,500, \$3,000, \$3,500, \$4,000, \$4,500, \$5,000, \$5,500, \$6,000, \$6,500, \$7,000, \$7,500, \$8,000, \$8,500, \$9,000, \$9,500, \$10,000, \$11,000, \$12,000, \$13,000, \$14,000, \$15,000, \$20,000, \$25,000, \$30,000, \$35,000, \$40,000, \$45,000, \$50,000].

B. **Failure to Pre-Certify Treatment Deductible:** [\$1,000, \$2,000, \$3,000].

C. **Separate Deductible For Non-Participating Providers:** [\$2,500, \$3,000, \$3,500, \$4,000, \$4,500, \$5,000, \$5,500, \$6,000, \$6,500, \$7,000, \$7,500, \$8,000, \$8,500, \$9,000, \$9,500, \$10,000, \$11,000, \$12,000, \$13,000, \$14,000, \$15,000, \$20,000, \$25,000, \$30,000, \$35,000, \$40,000, \$45,000, \$50,000].

5. **COINSURANCE PAYMENT SCHEDULES – PARTICIPATING PROVIDERS:**

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

A. **Company Insurance Percentage:** [50%, 70%, 80%, \$100%]

B. **Insured Coinsurance Percentage:** [50%, 30%, 20%, 0%]

C. **Insured Maximum Participating Provider Coinsurance Payment:** [\$10,000, \$6,000, \$4,000, \$3,000, \$0]

6. **COINSURANCE PAYMENT SCHEDULES – NON-PARTICIPATING PROVIDERS:**

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

A. **Company Insurance Percentage** [50%, 60%, 80%]

B. **Insured Coinsurance Percentage** [50%, 40%, 20%]

C. **Insured Maximum Non-Participating Provider Coinsurance Payment** [\$20,000, \$12,000, \$8,000, \$6,000]

7. ACCESS FEES

- A. **Emergency Room Access Fee** in the amount of \$250 per **Insured** per **Emergency Room** visit to either a (waived for any **Emergency Room** visit if the **Insured** is **Confined** in a **Hospital** on the order of a **Participating Provider** or a **Non-Participating** within twenty-four (24) hours following such **Emergency Room** visit)
- B. **Laboratory and Diagnostic Testing Access Fee** in the amount of \$250 per test for each of the following **Inpatient** and/or **Outpatient** diagnostic tests:

MRI,
CAT Scan,
Myleogram, and
Nuclear Imaging Service (including Myocardial Perfusion Imaging - Thallium
01Scintigraphy/Thallium Stress Tests)

II. DEFINITIONS

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

“**Access Fee(s)**” means the **Emergency Room Access Fee**, and the **Laboratory and Diagnostic Testing Access Fee**. The remaining amount of **Covered Expenses** after the application and satisfaction of the designated **Access Fee** for applicable **Accidental Bodily Injury Benefits** is subject to the **Policy Year Deductible** and the **Insured Coinsurance Percentage**. The amount of each applicable **Access Fee** is shown on the **Certificate Schedule**.

“**Accident,**” “**Accidental,**” and “**Accidentally**” means an event, circumstance, or occurrence involving an **Insured** that (i) is not excluded from coverage under this **Certificate**, (ii) takes place on or after the **Issue Date** and while coverage under this **Certificate** for such **Insured** is in force and effect, (iii) was unplanned and unintended by such **Insured**, and (iv) was the sole cause of **Bodily Injuries** sustained or suffered by such **Insured** during such event or occurrence.

“**Accidental Bodily Injury Benefits**” means only **Medically Necessary** treatments, procedures, services, and supplies received by an **Insured** for **Bodily Injuries** while coverage under this **Certificate** for such **Insured** is in full force and effect, and which are specifically enumerated in Section V. A. entitled ACCIDENTAL BODILY INJURY BENEFITS. If a treatment, procedure, service, or supply is not specifically enumerated in the ACCIDENTAL BODILY INJURY BENEFITS Section, then fees charged or expenses associated with such items are not covered under this **Certificate** as an **Accidental Bodily Injury Benefit**. Payments by **Us** for **Accidental Bodily Injury Benefits** are subject to all definitions, exclusions, limitations and provisions contained herein, including but not limited to the satisfaction and payability by **You** or the applicable **Insured** of all applicable deductibles, as well as the limitation of the **Company Insurance Percentage**.

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

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

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

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

“**Bodily Injury**” and “**Bodily Injuries**” means damage or harm to the physical structure of the body of an **Insured** sustained in an **Accident**, which (i) is separate and independent from the adverse effects upon the **Insured** caused by any illness, sickness or disease, (ii) is not excluded from coverage under this **Certificate**, and (ii) occurs on or after the **Issue Date** and while coverage under this **Certificate** for such **Insured** is in force and effect on or after the **Issue Date**.

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

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

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

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

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

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

“**Company**” means Freedom Life Insurance Company of America.

“**Company Insurance Percentage**” means the portion of the **Covered Expenses We** must pay to or on behalf of an **Insured** for **Accidental Bodily Injury Benefit** under this **Certificate**, after satisfaction by the **Insured** of (i) all applicable **Access Fees**, (ii) all applicable deductibles and (iii) the amount of the applicable **Insured Coinsurance Percentage**. The **Company Insurance Percentage** is shown on the **Certificate Schedule** for **Covered Expenses** for **Accidental Bodily Injury Benefits** at (i) **Participating Providers**; and (ii) **Non-Participating Providers**.

“**Confinement or Confined**” means **Inpatient** services received as a resident bed patient for not less than eight (8) hours in a **Hospital**. A period of **Confinement** begins on the date of admission to the **Hospital** as an **Inpatient** and ends on the date of discharge. “**Covered Expenses**” means for the covered items and services listed in the ACCIDENTAL BODILY INJURY BENEFITS Section of this **Certificate** the amount of expenses actually incurred by an **Insured**, after the **Issue Date** of this **Certificate** and before **Termination of Coverage**, as a result of being **Provided** applicable medical, surgical, or diagnostic services, supplies, care, and other applicable treatment for a **Bodily Injury**, which in each event is **Medically Necessary**, up to but not exceeding the amount of each of the following:

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

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

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

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

“Emergency” means the sudden occurrence of a **Bodily Injury** manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:

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

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

“Emergency Room” means the designated **Outpatient** area of a **Hospital** that is open twenty four (24) hours a day and intended by the **Hospital** as its location to receive acutely ill or injured patients, and which provides **Medically Necessary** diagnosis and treatment on an **Emergency** basis prior to either the resolution of patient's **Emergency** and discharge from such **Emergency Room** of the **Hospital** or the transfer of such patient to another designated area of the **Hospital** where the patient is then **Confined** as an **Inpatient**.

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

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

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

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

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

None of the following expenses may be used to satisfy the **Failure to Pre-Certify Treatment Deductible**: (i) the amount of the **Separate Deductible For Non-Participating Providers**, and (ii) the amount of the **Policy Year Deductible**, and (iv) the amount of any applicable **Access Fee**.

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

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

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

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

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

“**Group Accidental Bodily Injury Insurance Policy**” means the association group insurance contract issued to the **Group Accidental Bodily Injury Insurance Policyholder** under which this **Certificate** is issued to the **Primary Insured**.

“**Group Accidental Bodily Injury Insurance Policyholder**” means the association shown on the **Certificate Schedule** to whom the **Group Accidental Bodily Injury Insurance Policy** was issued.

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

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

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

“**Hospital**” means a place which:

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

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

Hospital does not mean:

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

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

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

“Insured” means the following:

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

“Insured Coinsurance Percentage” means the portion of the **Covered Expenses** that **You** must pay after satisfaction of all applicable deductibles and **Access Fees**. The different **Insured Coinsurance Percentages** are shown on the **Certificate Schedule** at (i) **Participating Providers**, and (ii) **Non-Participating Providers**.

“Insured Maximum Participating Provider Coinsurance Payment” means the maximum amount, after the satisfaction of all applicable **Certificate** deductibles, and **Access Fees**, that an **Insured** is required to pay in a **Policy Year** under the **Insured Coinsurance Percentage** for services rendered at **Participating Providers**. **Covered Expenses** incurred for services rendered at **Participating Providers** that are covered under the ACCIDENTAL BODILY INJURY BENEFITS section and applied by the **Company** toward satisfaction of the **Policy Year Deductible**, the **Separate Deductible For Non-Participating Providers**, the **Failure to Pre-Certify Treatment Deductible** and/or any other deductible contained in this **Certificate** or any rider attached to this **Certificate**, shall not be credited or applied toward satisfaction of the **Insured Maximum Participating Provider Coinsurance Payment**. The amount of the **Insured Maximum Participating Provider Coinsurance Payment** is shown on the **Certificate Schedule**.

“Insured Maximum Non-Participating Provider Coinsurance Payment” means the maximum amount, after the satisfaction of all applicable **Certificate** deductibles and **Access Fees** that an **Insured** is required to pay in a **Policy Year** under the **Insured Coinsurance Percentage** for services rendered at **Non-Participating Providers**. **Covered Expenses** incurred for services rendered at **Non-Participating Providers** that are covered under the ACCIDENTAL BODILY INJURY BENEFITS Section and applied by the **Company** toward satisfaction of the **Policy Year Deductible**, the **Failure to Pre-Certify Treatment Deductible**, and/or any other deductible contained in this **Certificate** or any rider attached to this **Certificate** shall not be credited or applied toward satisfaction of the **Insured Maximum Non-Participating Provider Coinsurance Payment**. The amount of the **Insured Maximum Non-Participating Provider Coinsurance Payment** is shown on the **Certificate Schedule**.

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

1. a **Hospital** emergency room, regardless of the services or supplies rendered in such emergency room,
2. a surgical recovery room,
3. a sub-acute intensive care unit,

4. a progressive care unit,
5. an intermediate care unit,
6. a private monitored room,
7. any other observation unit or other facilities in a **Hospital** that are step downs from the unit in such **Hospital** that provides the highest level of medical care to critically ill patients.

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

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

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

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

“**Lifetime Certificate Maximum Per Insured**” means the total dollar amount of **Covered Expenses** payable on behalf of an **Insured** under this **Certificate** for **Accidental Bodily Injury Benefit**. The minimum amount of the **Lifetime Certificate Maximum Per Insured** is shown on the **Certificate Schedule**. The amount of the **Lifetime Certificate Maximum Per Insured** may increase on an annual basis in accordance with the terms, limitations and exclusions of Section VIII. INCREASE IN LIFETIME CERTIFICATE MAXIMUM.

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

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

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

[“**Mastectomy**” means the surgical removal of all or part of the breast as a result of an **Accidental bodily Injury**.]

“Maximum Allowable Charge” means the following:

1. For **Providers**, **Maximum Allowable Charge** is the actual expense incurred by an **Insured** for the applicable service, supplies, care, or treatment **Provided**, after any reduction, adjustment, and/or discount pursuant to any **Participating Provider** agreements or other network agreements, negotiated rates, fee schedules or arrangements that determine or prescribe the actual amount of charges or fees that the **Provider**:
 - a) agreed to accept as payment in full for such services, supplies, care or treatment, and
 - b) ultimately charged such **Insured**, regardless of any higher amount that may have been placed on the **Provider’s** billing statement of charges.
2. For **Hospitals, Ambulatory Surgical Centers, Emergency Care Facility, Skilled Nursing Homes**, laboratories, pharmacies or other medical, diagnostic or treatment facilities, **“Maximum Allowable Charge”** is the actual amount charged by such entity for the applicable service or treatment **Provided** to an **Insured**, after a reduction, adjustment, and/or network discount pursuant to any **Participating Provider** agreements, or other network agreements, negotiated rates, fee schedules or other arrangements that determine or prescribe the actual amount of charges or fees that such entity:
 - a) agreed to accept as payment in full for such applicable services, supplies, care, treatment, and
 - b) ultimately charged such **Insured** for such applicable services, supplies, care, treatment, regardless of any higher amount that may have been placed on the entity’s billing statement of charges.

However, the amount of the **Maximum Allowable Charge** under (1) and (2) above shall never exceed (i) the amount for which the applicable **Insured** has a legal liability and payment obligation for the receipt of such applicable services, supplies, care, or treatment, (ii) the amount of the **Medicare** allowable or approved charge for the receipt of such applicable services, supplies, care, or treatment with respect to any **Insured** who is **Medicare** eligible, or (iii) the amount of **Usual and Customary Expense** for the receipt of such applicable services, supplies, care, or treatment.

“Medical Necessity” and **“Medically Necessary”** means:

1. For the covered items and services listed in the ACCIDENTAL BODILY INJURY BENEFITS Section of this **Certificate**, **Medical Necessity** and **Medically Necessary** is any applicable **Confinement** of an **Insured**, as well as any other diagnostic test, laboratory test, examination, surgery, medical treatment, service or supply listed therein that is **Provided** to an **Insured**:
 - a) by or at the appropriate order, or upon the approval of a **Provider**;
 - b) for the medically recognized diagnosis or care and treatment of a **Bodily Injury**;
 - c) in a manner appropriate and necessary for the symptoms, diagnosis or treatment of such **Bodily Injury**;
 - d) according to and within generally accepted standards for medical practice;
 - e) in the most cost effective setting and manner available to treat the **Bodily Injury**;
 - f) not primarily for the convenience of an **Insured**, family, or a **Provider**; and
 - g) not investigational or experimental in nature.

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

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

“Mental, Nervous and Emotional Disorders” means any neurosis, psychoneurosis, psychopathy, psychosis, or other mental or emotional disease or disorder of any kind, including, but not limited to anxiety, generalized anxiety disorder, panic disorder, panic attacks, agoraphobia, acrophobia, social phobia, simple phobias (irrational fears and avoidance of specific objects or situations), obsessive-compulsive disorder, posttraumatic stress syndrome, posttraumatic stress disorder, depression, depression disorder, dysthymic disorder (dysthymia) manic depression, manic episodes, hypo-manic episodes, bi-polar disorder, bi-polar syndrome, bi-polar disease, delusions,

hallucinations, disorganized thought and behavior, schizophrenia, anorexia, anorexia nervosa, bulimia, bulimia nervosa, hyperorexia, and all complications thereof.

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

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

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

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

“Our” means Freedom Life Insurance Company of America.

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

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

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

“Policy Year” means the period beginning on the calendar day and month of the **Issue Date** and ending on the calendar day and month 12 months after the **Issue Date**.

“Policy Year Deductible” means the amount of **Covered Expenses** each **Insured** must incur within a **Policy Year** before any **Accidental Bodily Injury Benefits** are payable by **Us** for such **Insured**. No **Accidental Bodily Injury Benefits** are payable by **Us** for any **Covered Expenses** incurred by an **Insured**, until after the **Failure to Pre-Certify Treatment Deductible**, if applicable, the **Separate Deductible for Non-Participating Providers**, if applicable, and the **Policy Year Deductible** are each satisfied and fully payable by either **You** or such **Insured**.

Neither of the following expenses may be used to satisfy the **Policy Year Deductible**: (i) the amount of the **Separate Deductible For Non-Participating Providers**, and (ii) the amount of the **Failure to Pre-Certify Treatment Deductible**.

When [one, two three] [(1) (2) (3)] **Insured[s]** satisfy this **Policy Year Deductible**, no additional **Policy Year Deductible** per **Insured** will be required for the remainder of the **Policy Year**.

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

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

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

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

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

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

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

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

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

“Premium Rate Guarantee Period” means the number of months immediately following the **Issue Date** that must expire before the amount of **Renewal Premium** charged by **Us** (with the same **Mode of Premium Payment** as the **Mode of Premium Payment** selected for payment of the **Initial Premium**) can be higher than the amount of the **Initial Premium** because of (i) a change by **Us** in the table of premium rates used to calculate the **Initial Premium**, or (ii) an increase in the attained age after the **Issue Date** of any **Insured** listed on the **Certificate Schedule**. However, the amount of **Renewal Premium** required for this **Certificate** may be increased by **Us**, even during the **Premium Rate Guarantee Period**, if after the **Issue Date**:

- 1) **You add Insureds** to this **Certificate**;
- 2) **You change** the amount of the **Policy Year Deductible** shown on the **Certificate Schedule**;
- 3) **You change** the **Insured Coinsurance Percentage** shown on the **Certificate Schedule**;
- 4) **You change** any other coverage option;
- 5) **You change** residence to a different zip code;
- 6) **You change** the **Mode Of Premium Payment**;
- 7) **You add** optional coverage riders, if any;
- 8) **You change** after the **Issue Date** to a different optional **Participating Provider** network available in **Your** state, if any;
- 9) a change occurs in the relationship between **Your Participating Provider** network and the **Company**;
- 10) the **Participating Provider** network availability changes for **Your** state;
- 11) the **Participating Provider** negotiated discounts change;
- 12) a change occurs in **Group Accidental Bodily Injury Insurance Policy** coverage, benefits, limitations, exclusions, premium or other material matter;
- 13) any change in coverage, **Accidental Bodily Injury Benefits**, limitations, exclusions, or premium is required pursuant to any federal or state law or regulation; and/or

- 14) any other change in federal or state law affecting the definitions, **Accidental Bodily Injury Benefits**, limitations, exclusions, and/or premium of this **Certificate** or the **Group Accidental Bodily Injury Insurance Policy**.

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

“**Prescription**” means the **Medically Necessary** authorization for a **Prescription Drug** to be dispensed to an **Insured** on an **Outpatient** basis pursuant to the order of a **Provider** who is acting within the scope of his or her license to treat a **Bodily Injury**.

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

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

“**Provide**”, “**Provided**” or “**Providing**” means each medical, diagnostic and surgical test, service, care, treatment, or supply, which is:

1. prescribed or ordered by a **Provider**;
2. rendered to and received by an **Insured** while coverage under this **Certificate** for such **Insured** is in full force and effect;
3. listed as a covered item, type of service and/or supply in the ACCIDENTAL BODILY INJURY BENEFITS Section; and
4. not otherwise limited or excluded by any provision in this **Certificate** or rider, endorsement or amendment attached hereto.

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

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

“**Separate Deductible For Non-Participating Providers**” means, in addition to the **Policy Year Deductible**, the amount of **Covered Expenses** an **Insured** must incur in a **Policy Year** for services rendered by **Non-Participating Providers** before any applicable **Accidental Bodily Injury Benefits** are payable under this **Certificate**.

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

None of the following expenses may be used to satisfy the **Separate Deductible For Non-Participating Providers**: (i) the amount of the **Policy Year Deductible**; (ii) the amount of any applicable **Access Fees**; and (iii) the amount of the **Failure to Pre-certify Treatment Deductible**.

“**Skilled Nursing Home**” means a place which:

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

6. keeps complete medical records on each patient.

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

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

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

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

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

“Total Disability” or **“Totally Disabled”** means that, due to a **Bodily Injury**, an **Insured** is:

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

“Us” means Freedom Life Insurance Company of America.

“Usual and Customary Expense” means the following:

1. For **Providers Usual and Customary Expense** is the seventieth (70th) percentile of the prevailing charges by all **Providers** in the same geographic area as such **Provider**, as determined by one of the current prevailing health care charges information systems in the insurance industry utilizing the applicable **CPT Code** for such services or treatment and the applicable zip code (first 3 or 5 digits) of such **Provider**.
2. For services or treatments **Provided** by **Hospitals, Ambulatory Surgical Centers, Emergency Care Facilities, Skilled Nursing Homes**, pharmacies or other applicable facilities, **Usual and Customary Expense** is average charge made for similar services or supplies in the locality where the service or supply is furnished, taking into consideration the nature and the severity of the **Bodily Injury** suffered by the **Insured**.

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

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

“We” means Freedom Life Insurance Company of America.

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

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

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

III. WHEN COVERAGE BEGINS AND ENDS

A. EFFECTIVE DATE

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

B. ELIGIBILITY AND ADDITIONS

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

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

Newborn children born after the **Issue Date** and immediately placed for adoption after birth with **You**, or **Your Spouse**, while this **Certificate** is in full force and effect (a newborn adoptee) will be automatically insured under this **Certificate** from and after the date of the adoption placement of such newborn adoptee for a period of sixty (60) days. If **You** wish to continue such automatic coverage under this **Certificate** for any such newborn adoptee past the initial sixty (60) day period, **You** must notify **Us** of such birth, adoption placement and **Your** desire for continued coverage under this **Certificate** within sixty (60) days after the date of the adoption placement of such newborn adoptee. **You** must also pay any additional premium required for such additional

coverage within such sixty (60) day period. If **You** do not notify **Us** within such sixty (60) day period of the birth, adoption placement and Your desire for continued coverage under this **Certificate** for such newborn adoptee and timely pay any additional premium that may be due, then the automatic coverage under this **Certificate** for such newborn adoptee will end after the expiration of day from the date of such adoption placement of such newborn adoptee. **We** will notify **You** if more premium is needed.

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

C. TERMINATION OF COVERAGE

1. TERMINATIONS SUBJECT TO RIGHT OF CONVERSION

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

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

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

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

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

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

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

- a. **We** are required by the order of an appropriate regulatory authority to non-renew or cancel the **Certificate** or **Group Accidental Bodily Injury Insurance Policy**;
- b. **We** cease offering and renewing coverage of the same form of coverage as this **Certificate** in **Your** state upon a minimum of thirty (30) days prior written notice mailed to **Your** last known address Take out conversion

- c. the date **We** receive due proof that fraud or intentional misrepresentation of material fact existed in applying for this **Certificate** or in filing a claim for **Accidental Bodily Injury Benefit** under this **Certificate**; or
- d. the **Primary Insured** terminates membership in the association which is the **Group Accidental Bodily Injury Insurance Policyholder**.

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

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

- a. the total amount of any **Accidental Bodily Injury Benefit** payments made by **Us** are equal to the **Lifetime Certificate Maximum Per Insured**;
- b. with respect to **You** and **Your Spouse**, the premium due date in the month following the attainment of age 65 or eligibility for **Medicare**;
- c. An **Insured** ceases to be a member of the association which is the **Group Accidental Bodily Injury Insurance Policyholder**; or
- d. the date **We** receive due proof that fraud or intentional misrepresentation of material fact existed in applying for this **Certificate** or in filing a claim for **Accidental Bodily Injury Benefit** under this **Certificate**.

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

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

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

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

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

E. CONTINUATION OF COVERAGE AND CERTIFICATE OF CONVERSION

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

1. for **Your Spouse** who is covered under this **Certificate**, if his or her coverage ceases due to divorce, annulment or court approved separation; or
2. for **Your** unmarried child(ren) who is covered under this **Certificate**, if his or her coverage ceases due to his or her reaching the limiting age of 19 (24 if enrolled as a **Full-Time Student**).

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

1. an **Insured's** coverage under the **Group Accidental Bodily Injury Insurance Policy** ceases because the **Group Accidental Bodily Injury Insurance Policy** was terminated;
2. an **Insured's** coverage under this **Certificate** ceases because of failure to pay the required premiums in the time allowed;
3. **We** were required by the order of an appropriate regulatory authority to non-renew or cancel the **Certificate** or **Group Accidental Bodily Injury Insurance Policy**;
4. The total amount of **Accidental Bodily Injury Benefit** payments made by **Us** are equal to the **Lifetime Certificate Maximum Per Insured**;
5. **You** voluntarily terminated coverage under this **Certificate** for any **Insured** by notifying **Us** of the date **You** desired such coverage to terminate;
6. **We** received due proof that fraud or intentional misrepresentation of material fact existed in applying for this **Certificate** or in filing a claim for **Accidental Bodily Injury Benefit** under this **Certificate**;
7. The **Insured** is or could be covered by **Medicare**; or
8. **We** ceased offering and renewing coverage of the same form of coverage as this **Certificate** in **Your** state upon a minimum of thirty (30) days prior written notice mailed to **Your** last known address with an opportunity for **You** to convert to any similar medical expense policy or certificate that **We** are then actively marketing and offering to new applicants in **Your** state.

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

IV. PREMIUM

A. INITIAL PREMIUM

The **Initial Premium** specified on the **Certificate Schedule** is due and payable {*Option 1* [by **You**]} {*Option 2* by the **Group Accidental Bodily Injury Insurance Policyholder** on **Your** behalf from the amount of the member dues timely and properly paid by **You** to the **Group Accidental Bodily Injury Insurance Policyholder** for each **Insured's** membership in the **Group Accidental Bodily Injury Insurance Policyholder**] to the **Company** at its home office on or before the **Issue Date**. This **Initial Premium** payment will keep this **Certificate** in force until the **First Renewal Date**. The amount of the **Initial Premium** and the **First Renewal Date** are shown on the **Certificate Schedule**. **Initial Premium** has been determined by **Us** for this **Certificate** on a **Class** basis. **Your Class** for **Initial Premium** was determined by **Us** based upon several factors, including, among other things, a combination of the following: (i) **Your** zip code (either first 3 or first 5 digits); (ii) **Your** county of residence; (iii) **Your** state of residence; (iv) the number, age, sex and tobacco use of each **Insured** listed on the **Certificate Schedule**; (v) the plan of coverage contained in this **Certificate** on the **Issue Date**, including its deductibles, **Accidental Bodily Injury Benefits**, limitations, and exclusions; (vi) the health status of each applicant, including the results of any required physical examination and laboratory test results; (vii) **Participating Provider** network selected on the application, (viii) the underwriting risk assessment of each **Insured**; (ix) the discounted or preferred premium rate status of any **Insured**; (x) premium rate ups, if any, for any **Insured**; (xi) **Mode Of Premium Payment** selected on the application; (xii) distribution channels; (xiii) administrative costs; (xiv) taxes; (xv) other economic factors; and/or (xvi) other certificates of coverage issued and to be issued by **Us** covering individuals in **Your** current state of residence with the same or similar factors described above.

B. RENEWAL PREMIUM

1. CALCULATION - PAYMENT

The current **Mode Of Premium Payment** is shown on the **Certificate Schedule**. **Renewal Premium** is payable {*Option 1* [by **You**]} {*Option 2* by the **Group Accidental Bodily Injury Insurance Policyholder** on **Your** behalf from the amount of the member dues timely and properly paid by **You** to the **Group Accidental Bodily Injury Insurance Policyholder** for each **Insured's** membership in the **Group Accidental Bodily Injury Insurance Policyholder**} on or before its due date, and must be paid to the **Company** at its home office. Any **Renewal Premium** not paid {*Option 1* [by **You**]} {*Option 2* by the **Group Accidental Bodily Injury Insurance Policyholder** on **Your** behalf from the amount of the member dues timely and properly paid by **You** to the **Group Accidental Bodily Injury Insurance Policyholder** for each **Insured's** membership in the **Group Accidental Bodily Injury Insurance Policyholder**} on or before its due date is a premium in default. If a **Renewal Premium** payment default is not corrected and properly paid before the end of the grace period, coverage under this **Certificate** will terminate.

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

- 1) **You** add **Insureds** to this **Certificate**;
- 2) **You** change the amount of the **Policy Year Deductible** shown on the **Certificate Schedule**;
- 3) **You** change the **Insured Coinsurance Percentage** shown on the **Certificate Schedule**;
- 4) **You** change any other coverage option;
- 5) **You** change residence to a different zip code;
- 6) **You** change the **Mode Of Premium Payment**;
- 7) **You** add optional coverage riders, if any;
- 8) **You** change after the **Issue Date** to a different optional **Participating Provider** network available in **Your** state, if any;
- 9) a change occurs in the relationship between **Your Participating Provider** network and the **Company**;
- 10) the **Participating Provider** network availability changes for **Your** state;
- 11) the **Participating Provider** negotiated discounts change;
- 12) a change occurs in **Group Accidental Bodily Injury Insurance Policy** coverage, benefits, limitations, exclusions, premium or other material matter;
- 13) any change in coverage, **Accidental Bodily Injury Benefits**, limitations, exclusions, or premium is required pursuant to any federal or state law or regulation; and/or
- 14) any other change in federal or state law affecting the definitions, **Accidental Bodily Injury Benefits**, limitations, exclusions, and/or premium of this **Certificate** or the **Group Accidental Bodily Injury Insurance Policy**.

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

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

Any changes in the table of premium rates establishing the amount of required **Renewal Premium** during any renewal period will be implemented on a **Class** basis for all members of **Your Renewal Premium Class**. Factors that may be involved and considered by **Us** in determining the amount of **Renewal**

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

2. RENEWAL PREMIUM CHECK OR DRAFT NOT HONORED

Any [premium payment made {*Option 1* [by **You** to **Us**]} {*Option 2* by the **Group Accidental Bodily Injury Insurance Policyholder** to **Us** on **Your** behalf from the amount of the member dues timely and properly paid by **You** to the **Group Accidental Bodily Injury Insurance Policyholder** for each **Insured's** membership in the **Group Accidental Bodily Injury Insurance Policyholder**}] by a check or draft which is not honored at the bank upon which it is drawn shall be of no effect toward coverage under this **Certificate** unless and until valid restitution is made to **Us** within the time provided herein for making such premium payment.

3. GRACE PERIOD

Unless at least thirty-one (31) days prior to a **Renewal Premium** due date **We** have mailed to **You** written notice of **Our** intention not to renew this **Certificate** a grace period of thirty-one (31) days from such due date is given for the late payment [{*Option 1* [by **You** to **Us**]} {*Option 2* by the **Group Accidental Bodily Injury Insurance Policyholder** to **Us** on **Your** behalf from the amount of the member dues timely and properly paid by **You** to the **Group Accidental Bodily Injury Insurance Policyholder** for each **Insured's** membership in the **Group Accidental Bodily Injury Insurance Policyholder**}] of the **Renewal Premium** due. If {*Option 1* [**You**]} {*Option 2* the **Group Accidental Bodily Injury Insurance Policyholder** on **Your** behalf}] make[s] payment to **Us** of the required **Renewal Premium** during such grace period {*Option 2* [from the amount of the member dues timely and properly paid by **You** to the **Group Accidental Bodily Injury Insurance Policyholder** for each **Insured's** membership in the **Group Accidental Bodily Injury Insurance Policyholder**]}, then this **Certificate** will remain in force for **Benefit** claims arising during such grace period. However, if the **Company** has received notification of **Your** intention to cancel any **Insured's** coverage under this **Certificate**, there is no grace period for the late payment of any **Renewal Premium** that would otherwise have been due for such **Insured** but for such cancellation.

4. REINSTATEMENT

If the **Renewal Premium** is not paid {*Option 1* [by **You**]} {*Option 2* [by the **Group Accidental Bodily Injury Insurance Policyholder** on **Your** behalf from the amount of the member dues timely and properly paid by **You** to the **Group Accidental Bodily Injury Insurance Policyholder** for each **Insured's** membership in the **Group Accidental Bodily Injury Insurance Policyholder**}] before the grace period ends, later acceptance of premium by **Us** without requiring an application for reinstatement will reinstate this **Certificate** as of the date of acceptance of the late premium, together with all applicable administration and policy fees, as well as all applicable state and federal taxes. If **We** require an application that will be fully underwritten by **Us**, {*Option 1* [**You**]} {*Option 2* [**You** and the **Group Accidental Bodily Injury Insurance Policyholder**]} will be given a conditional receipt for the premium. If the application is approved after underwriting, this **Certificate** will be reinstated as of the approval date together with payment {*Option 1* [by **You**]} {*Option 2* by the **Group Accidental Bodily Injury Insurance Policyholder** on **Your** behalf on **Your** behalf from the amount of the member dues timely and properly paid by **You** to the **Group Accidental Bodily Injury Insurance Policyholder** for each **Insured's** membership in the **Group Accidental Bodily Injury Insurance Policyholder**}] all back or past due premium and all applicable administration and policy fees, as well as all applicable state and federal taxes permitted by applicable state law. Lacking such approval, this **Certificate** will be reinstated on the forty-fifth (45th) day after the date of the conditional

receipt, unless **We** have previously notified {*Option 1 [You]*} {*Option 2 [You and the Group Accidental Bodily Injury Insurance Policyholder]*}, in writing, of **Our** disapproval of the reinstatement.

The reinstated **Certificate** will cover only **Covered Expenses** that result from a **Bodily Injury** that occurs more than ten (10) days after the date of reinstatement.

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

5. INITIAL PREMIUM RATE GUARANTEE PERIOD

The amount of **Renewal Premium** with the same **Mode of Premium Payment** as the **Mode of Premium Payment** of the **Initial Premium** is guaranteed not to exceed the amount of the **Initial Premium** for each renewal period commencing prior to the expiration of the **Premium Rate Guarantee Period** as a result of any: (i) change in the table of premium rates used to calculate the **Initial Premium**; or (ii) increase in the attained age after the **Issue Date** of any **Insured** listed on the **Certificate Schedule**. The length of the **Premium Rate Guarantee Period** is shown on the **Certificate Schedule**. However, **Renewal Premium** rates may be increased by **Us** during the **Premium Rate Guarantee Period** upon any one or more of the following:

- a. **You** add **Insureds** to this **Certificate**;
- b. **You** change the amount of the **Policy Year Deductible** shown on the **Certificate Schedule**;
- c. **You** change the **Insured Coinsurance Percentage** shown on the **Certificate Schedule**;
- d. **You** change any other coverage option;
- e. **You** change residence to a different zip code;
- f. **You** change the **Mode Of Premium Payment**;
- g. **You** add optional coverage riders, if any;
- h. **You** change after the **Issue Date** to a different optional **Participating Provider** network available in **Your** state, if any;
- i. a change occurs in the relationship between **Your Participating Provider** network and the **Company**;
- j. the **Participating Provider** network availability changes for **Your** state;
- k. the **Participating Provider** negotiated discounts change;
- l. a change occurs in **Group Accidental Bodily Injury Insurance Policy** coverage, benefits, limitations, exclusions, premium or other material matter;
- m. any change in coverage, **Accidental Bodily Injury Benefits**, limitations, exclusions, or premium is required pursuant to any federal or state law or regulation; and/or
- n. any other change in federal or state law affecting the definitions, **Accidental Bodily Injury Benefits**, limitations, exclusions, and/or premium of this **Certificate** or the **Group Accidental Bodily Injury Insurance Policy**.

V. ACCIDENTAL BODILY INJURY BENEFITS AND CLAIM PROCEDURES

Insureds have the right to obtain medical care from the **Provider** and **Hospital** of their choice, however, all applicable **Accidental Bodily Injury Benefit** payments by **Us** under this ACCIDENTAL BODILY INJURY BENEFITS AND CLAIMS PROCEDURES Section of the **Certificate** are limited to the applicable **Company Insurance Percentage** of **Covered Expenses** incurred by an **Insured**. Coverage under this Section of the **Certificate** will be reduced for medical services, supplies, care or treatment obtained from a **Non-Participating Provider**. The difference between both the **Company Insurance Percentages** and the **Insured Coinsurance Percentages** for: (i) **Participating Providers** and (ii) **Non-Participating Providers** are shown in the **Certificate Schedule**. In addition, **We** shall never be required to make a payment for **Covered Expenses** incurred in excess of the amount of (i) the **Policy Year Maximum Benefit Per Insured** during any **Policy Year**, (ii) the amount of the **Lifetime Transplant Maximum Per Insured** during an **Insured's** lifetime, or (iii) the amount of the **Lifetime Certificate Maximum Per Insured** during an **Insured's** lifetime.

Covered Expenses incurred by an **Insured** for **Accidental Bodily Injury Benefits** are subject to the **Policy Year Deductible**, the **Insured Coinsurance Percentage** and any applicable **Access Fees**, unless otherwise specified.

A. ACCIDENTAL BODILY INJURY BENEFITS

Subject to and expressly limited by all applicable definitions, exclusions, limitations, non-waiver provisions, waiting periods, and other provisions contained in this **Certificate**, as well as any exclusionary coverage riders, endorsements, or amendments attached to hereto, **We** promise to pay to or on behalf of each **Insured** on an independent and non-coordinated basis the **Company Insurance Percentage** of the amount of professional fees and other applicable medical diagnostic or treatment expenses and charges that constitute **Covered Expenses** incurred by each **Insured** for the following described **Inpatient** and **Outpatient** services that are **Provided** as a result of a **Bodily Injury**, but only after: (i) each applicable **Access Fee** amount in this Section has been first satisfied and deducted from such **Covered Expenses** and applied to the applicable **Insured** for payment; (ii) the amount of the **Policy Year Deductible** has been first satisfied by deduction from such **Covered Expenses** and applied to the applicable **Insured** for payment; (iii) the amount of any applicable **Separate Deductible For Non-Participating Providers** and **Failure to Pre-Certify Treatment Deductible** has been first satisfied by deduction from such **Covered Expenses** and applied to the applicable **Insured** for payment; and (iv) the applicable **Insured Coinsurance Percentage** of the **Covered Expenses** remaining after satisfaction of all applicable deductibles and **Access Fees** is, likewise, satisfied by deduction from the remaining **Covered Expenses** and applied to the applicable **Insured** for payment:

1. INPATIENT HOSPITAL CONFINEMENT FOR BODILY INJURIES:

a. INPATIENT HOSPITAL CARE FOR BODILY INJURIES

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

- 1) **Hospital** - semi-private daily room and board;
- 2) **Intensive Care Unit** of the **Hospital** - daily room and board (Note, daily room and board will be at the semi-private rate for admission to units or areas of the applicable **Hospital** which are step-down units from the **Intensive Care Unit**, including, sub-acute intensive care units, progressive care units, intermediate care units, private monitored rooms, observation units or other facilities not meeting the standards set forth in the definition of an **Intensive Care Unit**);
- 3) **Hospital** miscellaneous medications, prescription drugs, services and supplies - (Note, miscellaneous charges by a **Hospital** for personal convenience items, including but not limited to television, telephone, internet and radio are not considered **Covered Expenses**); and
- 4) **Provider** Visits – (Note: limited one (1) **Provider** visit per treating **Provider** per day while the **Insured** is an **Inpatient** at a **Hospital**, and a maximum of sixty (60) **Provider** visits per **Hospital Confinement**. **Accidental Bodily Injury Benefits** are not payable for professional fees for visits at the **Hospital** following surgery by a Surgeon, Anesthesiologist or Nurse Anesthetist whose professional fees in connection with the surgery constitute **Covered Expenses**, unless the visit is to evaluate or treat a **Bodily Injury** other than that which resulted in the **Insured's** covered surgery).

b. INPATIENT SURGERY FOR BODILY INJURIES

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

- 1) Primary Surgeon;
- 2) Assistant Surgeon – (professional fees that constitute **Covered Expenses** will be considered for an **Accidental Bodily Injury Benefit** payment for one assistant surgeon in connection with surgery for which **Accidental Bodily Injury Benefits** are payable hereunder for the professional fees of the primary surgeon);
- 3) Anesthesiologist or Nurse Anesthetist – (professional fees that constitute **Covered Expenses** will be considered for an **Accidental Bodily Injury Benefit** payment for either an anesthesiologist's or a nurse anesthetist's administration and monitoring of anesthesia administered during surgery)

for which **Accidental Bodily Injury Benefits** are payable hereunder for the professional fees of the primary surgeon); and

- 4) Second Surgical Opinion - Up to \$250 of professional fees for a second surgical opinion if:
 - a) the **Insured's Provider** determines that surgery is needed;
 - b) the surgery is not excluded from this **Certificate** or any riders, amendments or endorsements attached hereto;
 - c) the **Insured** is examined in person by another qualified **Provider** for the purpose of obtaining a second surgical opinion; and
 - d) the **Provider** issuing the second surgical opinion sends **Us** a written report.

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

[c. **BREAST RECONSTRUCTION FOR BODILY INJURIES**

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

d. **INPATIENT THERAPY FOR BODILY INJURIES**

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

- 1) Occupational therapy;
- 2) Physical therapy (not to exceed 25 treatments or a maximum physical therapy **Accidental Bodily Injury Benefit** payment of \$2,000 per **Policy Year**, per **Insured**);
- 3) Rehabilitation therapy; and
- 4) Speech therapy.

This **Inpatient** therapy coverage does not include fees or expenses charged for spinal manipulations.

e. **INPATIENT LABORATORY AND DIAGNOSTIC TESTS FOR BODILY INJURIES**

Services **Provided** by a **Hospital** or a **Provider** in connection with the performance and interpretation of laboratory and diagnostic tests received by an **Insured** as an **Inpatient** at the **Hospital** due to **Bodily Injuries**.

f. **TRANSPLANTS FOR BODILY INJURIES**

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

The maximum amount of **Covered Expenses** allowed for professional fees of a **Provider** and facility fees for the harvesting of applicable donor organs or donor bone marrow is \$10,000 per transplant, to the extent that any **Accidental Bodily Injury Benefit** hereunder remain and are available under the **Certificate** for the applicable **Insured** recipient. Any payment of donor expenses hereunder will be applied toward the satisfaction of the **Lifetime Transplant Maximum Per Insured**.

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

- 1) any non-human (including animal or mechanical) **Solid Organ Transplant**;
- 2) transplants approved for a specific medical condition, but applied to another condition;

- 3) the purchase price of any organ, tissue, blood, bone marrow, cells, or stem cells that are sold and not donated;
- 4) any donor charge or donor expense incurred that does not constitute **Covered Expenses** allowed for professional fees and facility fees incurred in connection with the harvesting of applicable donor organs or donor bone marrow; and
- 5) any transplantation (including grafts) that does not constitute **Solid Organ Transplants, Bone Marrow Transplants, and/or Stem Cell Transplants**.

2. EMERGENCY ROOM AND OTHER OUTPATIENT COVERAGE FOR BODILY INJURIES:

a. EMERGENCY ROOM SERVICES FOR BODILY INJURIES

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

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

The **Emergency Room Access Fee** shall be waived by **Us** if such **Insured** is **Confined** in any **Hospital** within twenty-four (24) hours of such **Emergency Room** visit.

b. OUTPATIENT TREATMENT OF BODILY INJURIES

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

c. EMERGENCY TRANSPORTATION TO HOSPITAL BY AMBULANCE FOR BODILY INJURIES

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

d. OUTPATIENT SURGERY FOR BODILY INJURIES

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

- 1) **Hospital** or **Ambulatory Surgical Center** – (expenses that constitute **Covered Expenses** will be considered for **Accidental Bodily Injury Benefit** payment for the pre-operation, operation and recovery rooms, as well as for medications, **Prescription Drugs**, and other miscellaneous items, services and supplies; provided that miscellaneous charges for any personal convenience items, including but not limited to television, telephone, and radio are not considered **Covered Expenses**);
- 2) Primary Surgeon;

- 3) Assistant Surgeon – (professional fees that constitute **Covered Expenses** will be considered for an **Accidental Bodily Injury Benefit** payment for one assistant surgeon in connection with surgery for which **Accidental Bodily Injury Benefits** are payable hereunder for the professional fees of the primary surgeon);
- 4) Anesthesiologist or Nurse Anesthetist – (professional fees that constitute **Covered Expenses** will be considered for an **Accidental Bodily Injury Benefit** payment for either an anesthesiologist or a nurse anesthetist administration and monitoring of anesthesia, during surgery for which **Accidental Bodily Injury Benefits** are payable hereunder for the professional fees of the primary surgeon);
- 5) Pathologist – (professional Fees that constitute **Covered Expenses** will be considered for an **Accidental Bodily Injury Benefit** payment for a pathologist’s evaluation and/or interpretation of any tissue specimen removed during or in connection with such surgery); and
- 6) Second Surgical Opinion - Up to \$250 of professional fees for a second surgical opinion if:
 - a) the **Insured's Provider** determines that surgery is needed;
 - b) the surgery is not excluded from this **Certificate** or any riders, amendments or endorsements attached hereto;
 - c) the **Insured** is examined in person by another qualified **Provider** for the purpose of obtaining a second surgical opinion; and
 - d) the **Provider** issuing the second surgical opinion sends **Us** a written report.

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

e. [OUTPATIENT LABORATORY AND DIAGNOSTIC TESTS FOR BODILY INJURIES

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

f. [OUTPATIENT THERAPY FOR BODILY INJURIES

Services **Provided** by a **Hospital**, or other medical facility in connection with the following types of therapy received on an **Outpatient** basis by an **Insured** due to **Bodily Injuries**:

- 1) Occupational therapy;
- 2) Physical therapy (not to exceed 25 treatments or a maximum **Accidental Bodily Injury Benefit** payment of \$2,000 per **Policy Year** per **Insured**);
- 3) Rehabilitation therapy; and
- 4) Speech therapy.

This **Outpatient** therapy **Accidental Bodily Injury Benefit** does not include fees or expenses charged for spinal manipulations.]

g. [DOCTOR OFFICE VISITS FOR BODILY INJURIES

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

h. [OUTPATIENT PRESCRIPTIONS FOR BODILY INJURIES

Prescriptions filled by a **Participating Pharmacy**, but **Covered Expenses** for such **Prescriptions** shall not exceed, the amount of the cost of the least expensive drug, medicine or **Prescription Drug** that may be used to treat the **Insured’s Bodily Injury**, all in accordance with the following schedule:

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

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

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

i. **[HOME HEALTH CARE FOR BODILY INJURIES**

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

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

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

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

j. **[HOSPICE CARE FOR BODILY INJURIES**

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

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

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

k. **[MEDICAL EQUIPMENT AND SUPPLIES FOR BODILY INJURIES**

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

- 1) Blood, plasma, and derivatives, if not replaced;
- 2) Initial replacement of natural limbs and eyes when loss occurs while this **Certificate** is in force;
- 3) Casts, non-dental splints, trusses, crutches and braces (except dental or orthodontic braces);

- 5) Rental (not to exceed the purchase price) of a wheelchair, hospital bed, or other durable portable medical equipment **Provided** to an **Insured** in each event required for therapeutic treatment of **Bodily Injury** on an **Outpatient** basis; and
- 6) Oxygen and its administration.]

I. [SKILLED NURSING HOME FOR BODILY INJURIES

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

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

B. PRE-CERTIFICATION OF TREATMENT

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

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

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

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

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

C. CLAIM PROCEDURES, INVESTIGATION AND PAYMENT

1. NOTICE OF CLAIM

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

2. CLAIM FORMS AND ADDITIONAL INFORMATION TO BE PROVIDED

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

3. PROOFS OF LOSS

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

4. CLAIMS REVIEW, INVESTIGATION, ADJUSTMENT AND ADJUDICATION

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

5. PAYMENT OF CLAIMS

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

6. TIME OF PAYMENT OF CLAIMS

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

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

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

VI. DEDUCTIBLES

A. POLICY YEAR DEDUCTIBLE

No **Accidental Bodily Injury Benefits** are payable under this **Certificate** for any **Covered Expenses** incurred by an **Insured**, until after the **Policy Year Deductible** is satisfied and fully payable each **Policy Year** by such **Insured**. The amount of the **Policy Year Deductible** is shown on the **Certificate Schedule** and applies per **Policy Year** separately to each **Insured**.

In addition to the **Policy Year Deductible**, the **Separate Deductible For Non-Participating Providers** will apply to services rendered by **Non-Participating Providers**.

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

B. SEPARATE DEDUCTIBLE FOR NON-PARTICIPATING PROVIDERS

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

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

C. SEPARATE DEDUCTIBLE FOR FAILURE TO PRE-CERTIFY TREATMENT

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

D. FAMILY POLICY YEAR DEDUCTIBLE MAXIMUM

Once a [combined] total of [one, two or three] [(1), (2), or (3)] **Policy Year Deductible[s]** [have/has] been satisfied in any **Policy Year** by any [three (3)] **Insured[s]**, no additional **Policy Year Deductible** will be assessed by **Us** in connection with medical treatment and services rendered to any other **Insured** during the remainder of such **Policy Year**.

VII. LIMITATIONS, EXCLUSIONS AND NON-WAIVER

A. LIMITATIONS-WAITING PERIODS

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

1. Any treatment, medical service, surgery, medication, equipment, claim, loss or expense received, purchased, leased or otherwise incurred as a result of an **Insured's Pre-existing Condition** is not covered under this **Certificate** unless such treatment, medical service, surgery, medication, equipment, claim, loss or expense constitutes **Covered Expenses** incurred by such **Insured** more than twelve (12) months after the **Issue Date**, and such treatment, medical service, surgery, medication, equipment, claim, loss or expense are not otherwise limited or excluded by this **Certificate** or any riders, endorsements, or amendments attached to this **Certificate**;
2. If as the result of an **Emergency** treatment of an **Accidental Bodily Injury** services are rendered for an **Insured** by a **Non-Participating Provider** when a **Participating Provider** was not reasonably available in connection with either (i) on an **Outpatient** basis in the emergency room of a **Hospital** or (ii) an **Emergency Inpatient** admission to a **Hospital**, then the **Covered Expenses** incurred will be reimbursed by **Us** as if such **Non-Participating Provider** were a **Participating Provider** up to the point when the **Insured** can be safely transferred to a **Participating Provider**. If the **Insured** refuses or is unwilling to be transferred to the care of a **Participating Provider** after such **Insured** can be safely transferred, then reimbursement shall thereafter be reduced to the **Company's Insurance Percentage for Non-Participating Providers**;
3. **Accidental Bodily Injury Benefits** under this **Certificate** for any **Insured** who is eligible for or has coverage under **Medicare**, and/or amendments thereto, regardless of whether such **Insured** is enrolled in **Medicare** shall be limited to only the **Usual and Customary** charges for services, supplies, care or treatment covered under this **Certificate** that are not or would not have been payable or reimbursable by **Medicare** and/or its amendments (assuming such enrollment), subject to all provisions, limitations, exclusions, reductions and maximum benefits set forth in this **Certificate**;
4. Two-Five million dollars (\$2,000,000- \$5,000,000) is the maximum total amount of all applicable annual increases in the **Lifetime Certificate Maximum Per Insured** that can be conditionally received after the **Issue Date** pursuant to Section VIII. INCREASE IN THE LIFETIME CERTIFICATE MAXIMUM of this **Certificate**; and
5. Except as contained and specifically set forth in the INCREASE IN THE LIFETIME CERTIFICATE MAXIMUM Section of this **Certificate**, there shall be no increase in the amount of the **Lifetime Certificate Maximum Per Insured**.

B. EXCLUSIONS

Coverage under this **Certificate** is limited as provided by the definitions, limitations, exclusions, and terms contained in each and every Section of this **Certificate**. In addition, this **Certificate** does not provide coverage the amount of any professional fees or other medical expenses or charges for treatments, care, procedures, services or supplies incurred for the diagnosis, care or treatment charged to an **Insured** or any payment obligation for **Us** under this **Certificate** for any of the following, all of which are excluded from coverage:

1. any damage or harm to the physical structure of the body of an **Insured** received as a result of any act of war (whether declared or undeclared);
2. any damage or harm to the physical structure of the body of an **Insured** that was intentionally self-inflicted;
3. any damage or harm to the physical structure of the body of an **Insured** caused by suicide or any suicide attempt while sane or insane;
4. any damage or harm to the physical structure of the body of an **Insured** occurring while the **Insured** is serving on active duty in the armed forces of the United States (including the active Reserves) or the National Guard;
5. any medical care, service, treatments, procedures, or supplies received, provided to, or incurred by an **Insured** from any state or Federal government agency, including the Veterans Administration for a **Bodily Injury**, unless the **Insured** must pay for such services by law;

6. any damage or harm to the physical structure of the body of an **Insured** occurring while the Insured is serving on active duty in one of the branches of the armed forces of any foreign country or any international authority;
7. any damage or harm to the physical structure of the body of an **Insured** occurring while the **Insured** is engaged in an illegal occupation or attempting to commit assault or illegal activity;
8. any damage or harm to the physical structure of the body of an **Insured** occurring while the **Insured** is resisting arrest by a law enforcement officer, or otherwise resisting incarceration by a municipality, or other political subdivision of a state, a state or the federal government;
9. any damage or harm to the physical structure of the body of an **Insured** occurring while the **Insured** is incarcerated in a city or county jail or a state or federal penal institution;
10. any damage or harm to the physical structure of the body of an **Insured** occurring while the **Insured** is engaged in hang gliding, paragliding, hot air ballooning or any other form of aviation, except as a fare paying passenger traveling on a regularly scheduled commercial airline flight;
11. any damage or harm to the physical structure of the body of an **Insured** occurring while the **Insured** is engaged in the sport of avocation of bungee jumping, parachuting, rock climbing, para-sailing, para-kiting, or mountain climbing;
12. any damage or harm to the physical structure of the body of an **Insured** occurring while the **Insured** is engaged in raising, caring for, handling or working with knowingly dangerous animals;
13. any damage or harm to the physical structure of the body of an **Insured** occurring while the **Insured** is engaged, as a contestant (professional or amateur), in any rodeo event or participating at a rodeo as a rodeo clown;
14. any damage or harm to the physical structure of the body of an **Insured** occurring while the **Insured** is participating, as a professional contestant, in any boxing, marital arts or mixed martial arts event, including the sanctioned practice thereof;
15. any damage or harm to the physical structure of the body of an **Insured** occurring while the **Insured** is participating, as a professional or semi-professional contestant, in any sanctioned equestrian event;
16. any damage or harm to the physical structure of the body of an **Insured** while the **Insured** is participating, as driver or passenger contestant (professional or amateur), in any race competition, race, or speed contest, including sanctioned practice thereof, involving any land vehicle or water craft;
17. any damage or harm to the physical structure of the body of an **Insured** occurring while the **Insured** is participating, as a professional contestant, in any race competition, race or speed contest, including sanctioned practice thereof, on snow skis or a snowboard;
18. any damage or harm to the physical structure of the body of an **Insured** occurring while the **Insured** is participating on a wager in any knowingly hazardous activity;
19. any damage or harm to the physical structure of the body of an **Insured** occurring while the **Insured** is intoxicated or under the influence of alcohol or any drug, narcotic or hallucinogens unless administered via a prescription and on the advice of a **Provider**, and taken in accordance with the limits of such advice. An **Insured** is conclusively determined to be intoxicated by drug or alcohol if (ii) a chemical test administered in the jurisdiction where either the **Accident** occurred or the **Insured** was medically treated is at or above the legal limit set by that jurisdiction or (ii) the level of alcohol was such that a person's coordination, ability to reason, was impaired, regardless of the legal limit set by that jurisdiction;
20. any damage or harm to the physical structure of the body of an **Insured** occurring during any surgical procedure or operation performed in the treatment of any disease, illness, sickness or ailment;
21. any damage or harm to the physical structure of the body of an **Insured** occurring as a result of the intentional inhalation or ingestion of any poison, gas or fumes;
22. any damage or harm to the physical structure of the body of an **Insured** occurring as a result of the operation by an **Insured** of any motor vehicle without the permission/consent of the owner of such vehicle;
23. any damage or harm to the physical structure of the body of an **Insured** occurring as a result of the operation by an **Insured** of any motor vehicle without a valid operator's license/permit;
24. any damage or harm to the physical structure of the body of an **Insured** occurring as a result of an **Insured's** knowing and intentional participation in a riot, act of civil disobedience or insurrection;
25. any cost item, charge or expense which does not constitute **Covered Expenses**;
26. any damage or harm to the physical structure of the body of an **Insured** that did not occur **Accidentally**;
27. any disease, illness, ailment or sickness of any type or character suffered or sustained by an **Insured**;
28. any medical care, service, treatments, procedures, or supplies received, provided to, or incurred by an **Insured** before the **Certificate Issue Date**;
29. any medical care, service, treatments, procedures, or supplies received, provided to, or incurred by an **Insured** after an **Insured's** coverage under this **Certificate** terminates, regardless of when the **Bodily Injury** occurred, except as **Provided** in the EXTENSION OF BENEFITS provision;

30. any medical care, service, treatments, procedures, or supplies received, provided to, or incurred by an **Insured**, which exceed the **Lifetime Certificate Maximum Per Insured**;
31. any medical care, service, treatments, procedures, or supplies received, provided to, or incurred by an **Insured** which exceed the **Lifetime Transplant Maximum Per Insured** for all **Solid Organ Transplants**, **Bone Marrow Transplants**, and **Stem Cell Transplants** received by each **Insured** including any applicable expense for professional fees and facility fee incurred in connection with harvesting the applicable donor organ or donor bone marrow for the purposes of such transplantation;
32. [any **Prescription Drugs**];
33. any medical care, service, treatments, procedures, or supplies received, provided to, or incurred by an **Insured** and contained on a billing statement to the **Insured** which exceeds the amount of the **Maximum Allowable Charge**;
34. any medical care, service, treatments, procedures, or supplies received, provided to, or incurred by an **Insured**, which **You** or **Your** covered family members are not required to pay;
35. any medical care, service, treatments, procedures, or supplies received, provided to, or incurred by an **Insured** for which the **Insured** and/or any covered family members are not legally liable for payment;
36. any medical care, service, treatments, procedures, or supplies received, provided to, or incurred by an **Insured** for which the **Insured** and/or any covered family members were once legally liable for payment, but from which liability the **Insured** and/or family members were forgiven and released by the applicable **Provider** without payment or promise of payment;
37. any medical care, service, treatments, procedures, or supplies received, provided to, or incurred by an **Insured** from any state or federal government agency, including the Veterans Administration unless, by law, an **Insured** must pay for such services;
38. any medical care, service, treatments, procedures, or supplies received, provided to, or incurred by an **Insured** as a result of experimental procedures or treatment methods not approved by the American Medical Association or other appropriate medical society;
39. any eyeglasses, contact lenses, radial keratotomy, lasik surgery, hearing aids and exams for their prescription or fitting;
40. any Cochlear implants;
41. any damage or harm to the physical structure of the body of an **Insured** received as a result of any voluntary abortions, abortifacients or any other drug or device that terminates a pregnancy;
42. any damage or harm to the physical structure of the body of an **Insured** received as a result of any services **Provided** by **You** or a **Provider** who is a member of an **Insured's** family;
43. any medical condition excluded by name or specific description by either this **Certificate** or any riders, endorsements, or amendments attached to this **Certificate**;
44. cosmetic surgery or reconstructive procedures, except for **Medically Necessary** cosmetic surgery or reconstructive procedures performed under the following circumstances: (i) where such cosmetic surgery is incidental to or following surgery in treatment of a **Bodily Injury**, (ii) to correct a normal bodily function in connection with the treatment of a covered **Bodily Injury**; or (iii) such cosmetic surgery constitutes **Breast Reconstruction** that is incident to a **Mastectomy** performed in treatment of a **Bodily Injury**; provided any of the above occurred while the **Insured** was covered under this **Certificate**.
45. any damage or harm to the physical structure of the body of an **Insured** received as a result of any voluntary or elective surgical procedure, including breast reduction or augmentation or other cosmetic procedure;
46. any damage or harm to the physical structure of the body of an **Insured** received as a result of any voluntary sterilization procedure or sterilization reversal procedure;
47. any damage or harm to the physical structure of the body of an **Insured** received as a result of any treatment of infertility, including fertility hormone therapy and/or fertility devices for any type fertility therapy, artificial insemination or any other direct conception;
48. any damage or harm to the physical structure of the body of an **Insured** received as a result of any for any operation or treatment performed, **Prescription** or medication prescribed in connection with sex transformations or any type of sexual or erectile dysfunction, including complications arising from any such operation or treatment;
49. any diagnosis, care or treatment of Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD);
50. any diagnosis, care or treatment of **Mental, Nervous and Emotional Disorders**;
51. any diagnosis, care or treatment of autism;
52. any diagnosis, care or treatment of **Alcoholism**, addiction to illegal drugs or substances, and/or abuse or illegal drugs or substances;
53. any diagnosis, care or treatment of cirrhosis of the liver;

54. any fluoride products;
55. any intentional misuse or abuse of **Prescription Drugs**, including **Prescription Drugs** purchased by an **Insured** for consumption by someone other than such **Insured**;
56. any spinal manipulations;
57. charges for blood, blood plasma, or derivatives that has been replaced;
58. any Temporomandibular Joint Disorder (TMJ) and Craniomandibular Disorder (CMD);
59. any treatment received outside of the United States, except as provided for in the EXTRATERRITORIAL MEDICAL EXPENSES provision; and
60. any services or supplies for personal convenience, including custodial care or homemaker services, except as provided for in this **Certificate**.

C. NON-WAIVER

1. Billed charges for medical care and treatment received by all **Insureds** during a **Policy Year** that are considered and applied by **Us** under Section VIII. INCREASE IN LIFETIME CERTIFICATE MAXIMUM, does not mean **We** have any liability for coverage or the payment of any **Accidental Bodily Injury Benefits** under the **Certificate** for the illness that resulted in such expenses, and any such mistake and error by **Us** shall not constitute a waiver of or modification to any of the conditions, terms, definitions, limitations or exclusions contained in either the **Certificate** or any exclusionary rider attached to the **Certificate**.
2. Expenses that are mistakenly applied by **Us** to the **Policy Year Deductible** or erroneously paid by **Us** under any Section or provision of this **Certificate** shall not:
 - a) constitute a waiver of or modification to any conditions, terms, definitions or limitations contained in the **Certificate**, specifically including, but not by way of limitation, the definition of **Bodily Injury, Medical Necessity** or **Covered Expenses**, the limitation of coverage under the **Certificate** for **Pre-existing Conditions**, as well as any exclusion, limitation and/or exclusionary riders which may be attached to the **Certificate**, or otherwise operate to alter, amend, affect, abridge or modify the **Certificate** to which it is attached;
 - b) create or establish coverage of any medical condition, illness, or disease under the **Certificate** or under any exclusion, limitation and/or exclusionary riders which may be attached to the **Certificate**; or
 - c) affect, alter, amend, abridge, constitute or act as a waiver of the **Company's** ability to rely upon, assert and apply such terms, definitions, limitations or exclusions of the **Certificate** or any amendments thereto.

VIII. INCREASE IN LIFETIME CERTIFICATE MAXIMUM

A. CONDITIONAL ANNUAL INCREASE

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

1. \$125,000 FIRST ANNIVERSARY OF ISSUE DATE

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

2. \$250,000 FIRST ANNIVERSARY OF ISSUE DATE

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

3. \$125,000 SUBSEQUENT POLICY YEARS

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

4. \$250,000 SUBSEQUENT POLICY YEARS

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

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

IX. UNIFORM PROVISIONS

A. ENTIRE CONTRACT- CHANGES

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

1. change, alter or modify the **Group Accidental Bodily Injury Insurance Policy**, this **Certificate**, or any amendments, riders, or endorsements attached to this **Certificate**;
2. waive any provisions of the **Group Accidental Bodily Injury Insurance Policy**, this **Certificate**, or any amendments, riders, or endorsements attached to this **Certificate**;
3. extend the time period for payment of premiums under this **Certificate**; or
1. waive any of the **Company's** rights or requirements.

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

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

B. TIME LIMIT ON CERTAIN DEFENSES

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

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

C. CONFORMITY WITH STATE STATUTES

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

D. MISSTATEMENT OF AGE

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

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

E. NONDISCLOSED MEDICAL HISTORY, MEDICAL CONDITIONS AND RELATED INFORMATION

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

1. The coverage under this **Certificate** will stay in force with no change in **Accidental Bodily Injury Benefits**, or premiums if the disclosure of such condition would not have affected the way the **Certificate** was issued.
2. If the disclosure would have resulted in coverage not being issued to an **Insured**, **We** will return all premium paid, less any **Accidental Bodily Injury Benefit** paid for that person during the time the coverage was in force in error. The coverage for that person shall be void from the **Issue Date**.
3. If the disclosure would have resulted in coverage under this **Certificate** being issued either: (a) at an increased premium, or (b) with an endorsement eliminating that condition from coverage, **We** will either (i) have **You** pay the increased rate beginning with the **Issue Date** (if **You** do not pay the increased premium within thirty (30) days after receiving **Our** notice, **We** will refund all premium paid less any **Accidental Bodily Injury Benefit** paid, and the coverage under this **Certificate** will be void from the **Issue Date**); or (ii) add an endorsement to the **Certificate** to exclude that condition from coverage. The endorsement must be signed by **You** to put this change in effect. If **You** do not return a signed copy of the endorsement within thirty (30) days after receiving it, **We** will refund all premiums paid less any **Accidental Bodily Injury Benefit** paid, and the **Certificate** will be void from the **Issue Date**.

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

F. LEGAL ACTION

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

G. EXTRATERRITORIAL MEDICAL EXPENSES

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

THIS CONCLUDES THIS CERTIFICATE

FREEDOM LIFE INSURANCE COMPANY OF AMERICA

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

CERTIFICATE OF COVERAGE ASSOCIATION GROUP ACCIDENTAL BODILY INJURY INSURANCE PLAN

This is **Your Certificate** of coverage under the **Group Accidental Bodily Injury Insurance Policy** issued to the association that is the **Group Accidental Bodily Injury Insurance Policyholder** and in which association each **Insured** is an enrolled member. The coverage of all **Insureds** is independent and non-coordinated insurance coverage for **Bodily Injuries** sustained in an **Accident**, which coverage is governed and determined by the terms, conditions, definitions, limitations and exclusions contained in this **Certificate**. Certain phrases and words contained in this **Certificate** have the first letter of each word capitalized and the entire word or phrase printed in bold face type. These are generally defined phrases and words, and as such have the express meaning set forth in Section II. DEFINITIONS. This **Certificate** is a legal contract between **You** and the **Company**. Please read it carefully!

Your Certificate is guaranteed renewable to age 65 or in the event an **Insured** otherwise becomes a **Medicare Enrollee**, subject to the **Company's** right to adjust **Renewal Premiums** in accordance with Section IV.B. RENEWAL PREMIUM, and otherwise discontinue or terminate the **Certificate** as provided in Section III.C. TERMINATION OF COVERAGE. The **Initial Premium** for coverage of all **Insureds** under this **Certificate** is due and payable on or before the **Issue Date**. **Renewal Premiums** are due and payable in accordance with the Section IV.B. RENEWAL PREMIUM. You may renew coverage under this **Certificate**, as applicable, by timely payment of the proper amount of **Renewal Premium** when due.

IMPORTANT NOTICE ABOUT STATEMENTS IN THE APPLICATION: Please read the copy of **Your** application for coverage, which is attached to and part of this **Certificate**, to verify that no medical history or other information inquired about or contained in the application is incorrect, incomplete or missing. Contact **Us** immediately if any information contained in the application is incorrect, incomplete or missing. Any incorrect or incomplete statements or answers, as well as any missing information could cause a claim to be denied or the coverage under this **Certificate** to be reformed or voided.

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

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

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



SECRETARY



PRESIDENT

THE COVERAGE UNDER THIS CERTIFICATE PROVIDES ONLY ASSOCIATION GROUP ACCIDENTAL BODILY INJURY INSURANCE COVERAGE. IT DOES NOT PROVIDE EITHER WORKERS' COMPENSATION COVERAGE OR COMPREHENSIVE MAJOR MEDICAL INSURANCE COVERAGE.

TABLE OF CONTENTS

Provision	Page
I. CERTIFICATE SCHEDULE.....	3A-3C
II. DEFINITIONS.....	4-17
III. WHEN COVERAGE BEGINS AND ENDS.....	17-21
A. EFFECTIVE DATE.....	17
B. ELIGIBILITY AND ADDITIONS.....	18
C. TERMINATION OF COVERAGE.....	18-19
D. EXTENSION OF BENEFITS.....	19-20
E. CONTINUATION OF COVERAGE AND CERTIFICATE OF CONVERSION.....	20-21
IV. PREMIUM.....	21-24
A. INITIAL PREMIUM.....	21
B. RENEWAL PREMIUM.....	21-23
V. ACCIDENTAL BODILY INJURY BENEFITS AND CLAIM PROCEDURES.....	23-31
A. ACCIDENTAL BODILY INJURY BENEFITS.....	31
B. PRE-CERTIFICATION OF TREATMENT.....	31-32
C. CLAIM PROCEDURES, INVESTIGATION AND PAYMENT.....	31-32
VI. DEDUCTIBLES.....	33
A. CALENDAR YEAR DEDUCTIBLE.....	33
B. SEPARATE DEDUCTIBLE FOR NON-PARTICIPATING PROVIDERS.....	33
C. SEPARATE DEDUCTIBLE FOR FAILURE TO PRE-CERTIFY TREATMENT.....	34
VII. LIMITATIONS, EXCLUSIONS AND NON-WAIVER.....	33-36
A. LIMITATIONS-WAITING PERIODS.....	33-34
B. EXCLUSIONS.....	34-36
C. NON-WAIVER.....	36
VIII. INCREASE IN LIFETIME CERTIFICATE MAXIMUM.....	36-37
IX. UNIFORM PROVISIONS.....	39-45
A. ENTIRE CONTRACT-CHANGES.....	39-40
B. TIME LIMIT ON CERTAIN DEFENSES.....	40
C. OTHER INSURANCE WITH US.....	44
D. CONFORMITY WITH STATE STATUTES.....	44
E. MISSTATEMENT OF AGE.....	44
F. NONDISCLOSED MEDICAL HISTORY, MEDICAL CONDITIONS AND RELATED INFORMATION.....	45
G. LEGAL ACTION.....	45
H. SUBROGATION.....	45
I. EXTRATERRITORIAL MEDICAL EXPENSES.....	45

I. Certificate Schedule

A. GENERAL INFORMATION

Coverage is pursuant to a **Group Accidental Bodily Injury Insurance Policy** form: [GRP-ACC-11-FLIC]

Issued to **Group Accidental Bodily Injury Insurance Policyholder**:

Certificate form: [ACCCYD-2011-C-AR-FLIC]

Primary Insured: []

Age at Issue: []

Certificate Number: []

Issue Date: []

Other Insureds on Issue Date:
[]
[]

Beneficiary: []

Initial Premium: []

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

First Renewal Date: []

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

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

B. COVERAGE SCHEDULES

- Lifetime Certificate Maximum Per Insured:** [\$2,000,000 or \$5,000,000].
- Lifetime Transplant Maximum Per Insured:** [\$500,000 or \$1,000,000].

3. **Calendar Year Maximum Benefit Per Insured:** [\$100,000, \$200,000, \$300,000, \$400,000, \$500,000, \$1,000,000 or Lifetime Certificate Maximum Per Insured].

4. **DEDUCTIBLE SCHEDULES:**

The following deductibles are to be paid by the **Insured** in addition to the **Insured Coinsurance Percentage** before any **Accidental Bodily Injury Benefits** are payable by **Us** for **Covered Expenses**:

A. **Calendar Year Deductible per Insured:** [\$2,500, \$3,000, \$3,500, \$4,000, \$4,500, \$5,000, \$5,500, \$6,000, \$6,500, \$7,000, \$7,500, \$8,000, \$8,500, \$9,000, \$9,500, \$10,000, \$11,000, \$12,000, \$13,000, \$14,000, \$15,000, \$20,000, \$25,000, \$30,000, \$35,000, \$40,000, \$45,000, \$50,000].

B. **Failure to Pre-Certify Treatment Deductible:** [\$1,000, \$2,000, \$3,000].

C. **Separate Deductible For Non-Participating Providers:** [\$2,500, \$3,000, \$3,500, \$4,000, \$4,500, \$5,000, \$5,500, \$6,000, \$6,500, \$7,000, \$7,500, \$8,000, \$8,500, \$9,000, \$9,500, \$10,000, \$11,000, \$12,000, \$13,000, \$14,000, \$15,000, \$20,000, \$25,000, \$30,000, \$35,000, \$40,000, \$45,000, \$50,000].

5. **COINSURANCE PAYMENT SCHEDULES – PARTICIPATING PROVIDERS:**

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

A. **Company Insurance Percentage:** [50%, 70%, 80%, \$100%]

B. **Insured Coinsurance Percentage:** [50%, 30%, 20%, 0%]

C. **Insured Maximum Participating Provider Coinsurance Payment:** [\$10,000, \$6,000, \$4,000, \$3,000, \$0]

6. **COINSURANCE PAYMENT SCHEDULES – NON-PARTICIPATING PROVIDERS:**

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

A. **Company Insurance Percentage** [50%, 60%, 80%]

B. **Insured Coinsurance Percentage** [50%, 40%, 20%]

C. **Insured Maximum Non-Participating Provider Coinsurance Payment** [\$20,000, \$12,000, \$8,000, \$6,000]

7. ACCESS FEES

- A. **Emergency Room Access Fee** in the amount of \$250 per **Insured** per **Emergency Room** visit to either a (waived for any **Emergency Room** visit if the **Insured** is **Confined** in a **Hospital** on the order of a **Participating Provider** or a **Non-Participating** within twenty-four (24) hours following such **Emergency Room** visit)
- B. **Laboratory and Diagnostic Testing Access Fee** in the amount of \$250 per test for each of the following **Inpatient** and/or **Outpatient** diagnostic tests:

MRI,
CAT Scan,
Myleogram, and
Nuclear Imaging Service (including Myocardial Perfusion Imaging - Thallium
01Scintigraphy/Thallium Stress Tests)

II. DEFINITIONS

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

“**Access Fee(s)**” means the **Emergency Room Access Fee**, and the **Laboratory and Diagnostic Testing Access Fee**. The remaining amount of **Covered Expenses** after the application and satisfaction of the designated **Access Fee** for applicable **Accidental Bodily Injury Benefits** is subject to the **Calendar Year Deductible** and the **Insured Coinsurance Percentage**. The amount of each applicable **Access Fee** is shown on the **Certificate Schedule**.

“**Accident,**” “**Accidental,**” and “**Accidentally**” means an event, circumstance, or occurrence involving an **Insured** that (i) is not excluded from coverage under this **Certificate**, (ii) takes place on or after the **Issue Date** and while coverage under this **Certificate** for such **Insured** is in force and effect, (iii) was unplanned and unintended by such **Insured**, and (iv) was the sole cause of **Bodily Injuries** sustained or suffered by such **Insured** during such event or occurrence.

“**Accidental Bodily Injury Benefits**” means only **Medically Necessary** treatments, procedures, services, and supplies received by an **Insured** for **Bodily Injuries** while coverage under this **Certificate** for such **Insured** is in full force and effect, and which are specifically enumerated in Section V. A. entitled ACCIDENTAL BODILY INJURY BENEFITS. If a treatment, procedure, service, or supply is not specifically enumerated in the ACCIDENTAL BODILY INJURY BENEFITS Section, then fees charged or expenses associated with such items are not covered under this **Certificate** as an **Accidental Bodily Injury Benefit**. Payments by **Us** for **Accidental Bodily Injury Benefits** are subject to all definitions, exclusions, limitations and provisions contained herein, including but not limited to the satisfaction and payability by **You** or the applicable **Insured** of all applicable deductibles, as well as the limitation of the **Company Insurance Percentage**.

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

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

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

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

“**Bodily Injury**” and “**Bodily Injuries**” means damage or harm to the physical structure of the body of an **Insured** sustained in an **Accident**, which (i) is separate and independent from the adverse effects upon the **Insured** caused by any illness, sickness or disease, (ii) is not excluded from coverage under this **Certificate**, and (ii) occurs on or after the **Issue Date** and while coverage under this **Certificate** for such **Insured** is in force and effect on or after the **Issue Date**.

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

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

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

“**Calendar Year Deductible**” means the amount of **Covered Expenses** each **Insured** must incur within a **Calendar Year** before any **Accidental Bodily Injury Benefits** are payable by **Us** for such **Insured**. No **Accidental Bodily Injury Benefits** are payable by **Us** for any **Covered Expenses** incurred by an **Insured**, until after the **Failure to Pre-Certify Treatment Deductible**, if applicable, the **Separate Deductible for Non-Participating Providers**, if applicable, and the **Calendar Year Deductible** are each satisfied and fully payable by either **You** or such **Insured**.

Neither of the following expenses may be used to satisfy the **Calendar Year Deductible**: (i) the amount of the **Separate Deductible For Non-Participating Providers**, and (ii) the amount of the **Failure to Pre-Certify Treatment Deductible**.

When [one, two three] [(1) (2) (3)] **Insured[s]** satisfy this **Calendar Year Deductible**, no additional **Calendar Year Deductible** per **Insured** will be required for the remainder of the **Calendar Year**.

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

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

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

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

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

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

“**Company**” means Freedom Life Insurance Company of America.

“**Company Insurance Percentage**” means the portion of the **Covered Expenses** **We** must pay to or on behalf of an **Insured** for **Accidental Bodily Injury Benefit** under this **Certificate**, after satisfaction by the **Insured** of (i) all applicable **Access Fees**, (ii) all applicable deductibles and (iii) the amount of the applicable **Insured Coinsurance Percentage**. The **Company Insurance Percentage** is shown on the **Certificate Schedule** for **Covered Expenses** for **Accidental Bodily Injury Benefits** at (i) **Participating Providers**; and (ii) **Non-Participating Providers**.

“**Confinement or Confined**” means **Inpatient** services received as a resident bed patient for not less than eight (8) hours in a **Hospital**. A period of **Confinement** begins on the date of admission to the **Hospital** as an **Inpatient** and ends on the date of discharge. “**Covered Expenses**” means for the covered items and services listed in the ACCIDENTAL BODILY INJURY BENEFITS Section of this **Certificate** the amount of expenses actually incurred by an **Insured**, after the **Issue Date** of this **Certificate** and before **Termination of Coverage**, as a result of being **Provided** applicable medical, surgical, or diagnostic services, supplies, care, and other applicable treatment for a

Bodily Injury, which in each event is **Medically Necessary**, up to but not exceeding the amount of each of the following:

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

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

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

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

“**Emergency**” means the sudden occurrence of a **Bodily Injury** manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:

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

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

“**Emergency Room**” means the designated **Outpatient** area of a **Hospital** that is open twenty four (24) hours a day and intended by the **Hospital** as its location to receive acutely ill or injured patients, and which provides **Medically Necessary** diagnosis and treatment on an **Emergency** basis prior to either the resolution of patient’s **Emergency** and discharge from such **Emergency Room** of the **Hospital** or the transfer of such patient to another designated area of the **Hospital** where the patient is then **Confined** as an **Inpatient**.

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

None of the following expenses may be used to satisfy the **Emergency Room Access Fee**: (i) the amount of the **Laboratory and Diagnostic Testing Access Fee**, (ii) the amount of the **Separate Deductible for Non-Participating Providers**, (iii) the amount of **Covered Expenses** for which benefit payments are received by **You** under any optional rider issued with this **Certificate**, (iv) the amount of any applicable **Failure to Pre-Certify**

Treatment Deductible, (v) the amount of the **Calendar Year Deductible**, and (vi) the **Insured Coinsurance Percentage**.

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

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

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

None of the following expenses may be used to satisfy the **Failure to Pre-Certify Treatment Deductible**: (i) the amount of the **Separate Deductible For Non-Participating Providers**, and (ii) the amount of the **Calendar Year Deductible**, and (iv) the amount of any applicable **Access Fee**.

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

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

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

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

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

“**Group Accidental Bodily Injury Insurance Policy**” means the association group insurance contract issued to the **Group Accidental Bodily Injury Insurance Policyholder** under which this **Certificate** is issued to the **Primary Insured**.

“**Group Accidental Bodily Injury Insurance Policyholder**” means the association shown on the **Certificate Schedule** to whom the **Group Accidental Bodily Injury Insurance Policy** was issued.

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

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

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

“**Hospital**” means a place which:

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

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

Hospital does not mean:

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

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

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

“Insured” means the following:

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

“Insured Coinsurance Percentage” means the portion of the **Covered Expenses** that **You** must pay after satisfaction of all applicable deductibles and **Access Fees**. The different **Insured Coinsurance Percentages** are shown on the **Certificate Schedule** at (i) **Participating Providers**, and (ii) **Non-Participating Providers**.

“Insured Maximum Participating Provider Coinsurance Payment” means the maximum amount, after the satisfaction of all applicable **Certificate** deductibles, and **Access Fees**, that an **Insured** is required to pay in a **Calendar Year** under the **Insured Coinsurance Percentage** for services rendered at **Participating Providers**. **Covered Expenses** incurred for services rendered at **Participating Providers** that are covered under the ACCIDENTAL BODILY INJURY BENEFITS section and applied by the **Company** toward satisfaction of the **Calendar Year Deductible**, the **Separate Deductible For Non-Participating Providers**, the **Failure to Pre-Certify Treatment Deductible** and/or any other deductible contained in this **Certificate** or any rider attached to this **Certificate**, shall not be credited or applied toward satisfaction of the **Insured Maximum Participating Provider Coinsurance Payment**. The amount of the **Insured Maximum Participating Provider Coinsurance Payment** is shown on the **Certificate Schedule**.

“Insured Maximum Non-Participating Provider Coinsurance Payment” means the maximum amount, after the satisfaction of all applicable **Certificate** deductibles and **Access Fees** that an **Insured** is required to pay in a **Calendar Year** under the **Insured Coinsurance Percentage** for services rendered at **Non-Participating Providers**. **Covered Expenses** incurred for services rendered at **Non-Participating Providers** that are covered

under the ACCIDENTAL BODILY INJURY BENEFITS Section and applied by the **Company** toward satisfaction of the **Calendar Year Deductible**, the **Failure to Pre-Certify Treatment Deductible**, and/or any other deductible contained in this **Certificate** or any rider attached to this **Certificate** shall not be credited or applied toward satisfaction of the **Insured Maximum Non-Participating Provider Coinsurance Payment**. The amount of the **Insured Maximum Non-Participating Provider Coinsurance Payment** is shown on the **Certificate Schedule**.

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

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

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

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

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

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

“Lifetime Certificate Maximum Per Insured” means the total dollar amount of **Covered Expenses** payable on behalf of an **Insured** under this **Certificate** for **Accidental Bodily Injury Benefit**. The minimum amount of the **Lifetime Certificate Maximum Per Insured** is shown on the **Certificate Schedule**. The amount of the **Lifetime Certificate Maximum Per Insured** may increase on an annual basis in accordance with the terms, limitations and exclusions of Section VIII. INCREASE IN LIFETIME CERTIFICATE MAXIMUM.

“Lifetime Transplant Maximum Per Insured” means the total dollar amount of **Covered Expenses** payable by **Us** under the terms of this **Certificate** for services **Provided** to an **Insured** in connection with or attributable to all

Solid Organ Transplants, Bone Marrow Transplants, and Stem Cell Transplants received by the **Insured** in the treatment of a **Bodily Injury**. This lifetime per organ maximum **Accidental Bodily Injury Benefit** includes all related **Covered Expenses** incurred from 14 days before each applicable transplant surgery or procedure to 365 days after each such transplant surgery or procedure. The amount of the **Lifetime Transplant Maximum Per Insured** is shown on the **Certificate Schedule** and shall not exceed the **Lifetime Certificate Maximum Per Insured**.

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

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

“Mastectomy” means the surgical removal of all or part of the breast as a result of an **Accidental** bodily **Injury**.

“Maximum Allowable Charge” means the following:

1. For **Providers**, **Maximum Allowable Charge** is the actual expense incurred by an **Insured** for the applicable service, supplies, care, or treatment **Provided**, after any reduction, adjustment, and/or discount pursuant to any **Participating Provider** agreements or other network agreements, negotiated rates, fee schedules or arrangements that determine or prescribe the actual amount of charges or fees that the **Provider**:
 - a) agreed to accept as payment in full for such services, supplies, care or treatment, and
 - b) ultimately charged such **Insured**, regardless of any higher amount that may have been placed on the **Provider’s** billing statement of charges.
2. For **Hospitals, Ambulatory Surgical Centers, Emergency Care Facility, Skilled Nursing Homes**, laboratories, pharmacies or other medical, diagnostic or treatment facilities, **“Maximum Allowable Charge”** is the actual amount charged by such entity for the applicable service or treatment **Provided** to an **Insured**, after a reduction, adjustment, and/or network discount pursuant to any **Participating Provider** agreements, or other network agreements, negotiated rates, fee schedules or other arrangements that determine or prescribe the actual amount of charges or fees that such entity:
 - a) agreed to accept as payment in full for such applicable services, supplies, care, treatment, and
 - b) ultimately charged such **Insured** for such applicable services, supplies, care, treatment, regardless of any higher amount that may have been placed on the entity’s billing statement of charges.

However, the amount of the **Maximum Allowable Charge** under (1) and (2) above shall never exceed (i) the amount for which the applicable **Insured** has a legal liability and payment obligation for the receipt of such applicable services, supplies, care, or treatment, (ii) the amount of the **Medicare** allowable or approved charge for the receipt of such applicable services, supplies, care, or treatment with respect to any **Insured** who is **Medicare** eligible, or (iii) the amount of **Usual and Customary Expense** for the receipt of such applicable services, supplies, care, or treatment.

“Medical Necessity” and **“Medically Necessary”** means:

1. For the covered items and services listed in the ACCIDENTAL BODILY INJURY BENEFITS Section of this **Certificate**, **Medical Necessity** and **Medically Necessary** is any applicable **Confinement** of an **Insured**, as well as any other diagnostic test, laboratory test, examination, surgery, medical treatment, service or supply listed therein that is **Provided** to an **Insured**:
 - a) by or at the appropriate order, or upon the approval of a **Provider**;
 - b) for the medically recognized diagnosis or care and treatment of a **Bodily Injury**;
 - c) in a manner appropriate and necessary for the symptoms, diagnosis or treatment of such **Bodily Injury**;

- d) according to and within generally accepted standards for medical practice;
- e) in the most cost effective setting and manner available to treat the **Bodily Injury**;
- f) not primarily for the convenience of an **Insured**, family, or a **Provider**; and
- g) not investigational or experimental in nature.

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

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

“**Mental, Nervous and Emotional Disorders**” means any neurosis, psychoneurosis, psychopathy, psychosis, or other mental or emotional disease or disorder of any kind, including, but not limited to anxiety, generalized anxiety disorder, panic disorder, panic attacks, agoraphobia, acrophobia, social phobia, simple phobias (irrational fears and avoidance of specific objects or situations), obsessive-compulsive disorder, posttraumatic stress syndrome, posttraumatic stress disorder, depression, depression disorder, dysthymic disorder (dysthymia) manic depression, manic episodes, hypo-manic episodes, bi-polar disorder, bi-polar syndrome, bi-polar disease, delusions, hallucinations, disorganized thought and behavior, schizophrenia, anorexia, anorexia nervosa, bulimia, bulimia nervosa, hyperorexia, and all complications thereof.

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

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

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

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

“**Our**” means Freedom Life Insurance Company of America.

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

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

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

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

[“**Preferred Brand Drugs**” means each **Brand Name Drug** that is identified and listed upon the **Preferred Drug List**. In certain circumstances, a **Preferred Brand Drug** maybe a medically acceptable alternative medication to a

Brand Name Drug that is not listed on the **Preferred Brand Drug List** such that an **Insured** may want to consult with his/her **Provider** and the pharmacist of the **Participating Pharmacy** regarding whether such **Preferred Brand Drug** would be appropriate and proper in the treatment of such **Insured's** condition.]

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

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

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

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

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

"**Premium Rate Guarantee Period**" means the number of months immediately following the **Issue Date** that must expire before the amount of **Renewal Premium** charged by **Us** (with the same **Mode of Premium Payment** as the **Mode of Premium Payment** selected for payment of the **Initial Premium**) can be higher than the amount of the **Initial Premium** because of (i) a change by **Us** in the table of premium rates used to calculate the **Initial Premium**, or (ii) an increase in the attained age after the **Issue Date** of any **Insured** listed on the **Certificate Schedule**. However, the amount of **Renewal Premium** required for this **Certificate** may be increased by **Us**, even during the **Premium Rate Guarantee Period**, if after the **Issue Date**:

- 1) **You** add **Insureds** to this **Certificate**;
- 2) **You** change the amount of the **Calendar Year Deductible** shown on the **Certificate Schedule**;
- 3) **You** change the **Insured Coinsurance Percentage** shown on the **Certificate Schedule**;
- 4) **You** change any other coverage option;
- 5) **You** change residence to a different zip code;
- 6) **You** change the **Mode Of Premium Payment**;
- 7) **You** add optional coverage riders, if any;
- 8) **You** change after the **Issue Date** to a different optional **Participating Provider** network available in **Your** state, if any;
- 9) a change occurs in the relationship between **Your Participating Provider** network and the **Company**;
- 10) the **Participating Provider** network availability changes for **Your** state;
- 11) the **Participating Provider** negotiated discounts change;
- 12) a change occurs in **Group Accidental Bodily Injury Insurance Policy** coverage, benefits, limitations, exclusions, premium or other material matter;
- 13) any change in coverage, **Accidental Bodily Injury Benefits**, limitations, exclusions, or premium is required pursuant to any federal or state law or regulation; and/or
- 14) any other change in federal or state law affecting the definitions, **Accidental Bodily Injury Benefits**, limitations, exclusions, and/or premium of this **Certificate** or the **Group Accidental Bodily Injury Insurance Policy**.

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

“**Prescription**” means the **Medically Necessary** authorization for a **Prescription Drug** to be dispensed to an **Insured** on an **Outpatient** basis pursuant to the order of a **Provider** who is acting within the scope of his or her license to treat a **Bodily Injury**.

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

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

“**Provide**”, “**Provided**” or “**Providing**” means each medical, diagnostic and surgical test, service, care, treatment, or supply, which is:

1. prescribed or ordered by a **Provider**;
2. rendered to and received by an **Insured** while coverage under this **Certificate** for such **Insured** is in full force and effect;
3. listed as a covered item, type of service and/or supply in the ACCIDENTAL BODILY INJURY BENEFITS Section; and
4. not otherwise limited or excluded by any provision in this **Certificate** or rider, endorsement or amendment attached hereto.

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

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

“**Separate Deductible For Non-Participating Providers**” means, in addition to the **Calendar Year Deductible**, the amount of **Covered Expenses** an **Insured** must incur in a **Calendar Year** for services rendered by **Non-Participating Providers** before any applicable **Accidental Bodily Injury Benefits** are payable under this **Certificate**.

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

None of the following expenses may be used to satisfy the **Separate Deductible For Non-Participating Providers**: (i) the amount of the **Calendar Year Deductible**; (ii) the amount of any applicable **Access Fees**; and (iii) the amount of the **Failure to Pre-certify Treatment Deductible**.

“**Skilled Nursing Home**” means a place which:

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

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

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

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

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

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

“**Total Disability**” or “**Totally Disabled**” means that, due to a **Bodily Injury**, an **Insured** is:

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

“**Us**” means Freedom Life Insurance Company of America.

“**Usual and Customary Expense**” means the following:

1. For **Providers Usual and Customary Expense** is the seventieth (70th) percentile of the prevailing charges by all **Providers** in the same geographic area as such **Provider**, as determined by one of the current prevailing health care charges information systems in the insurance industry utilizing the applicable **CPT Code** for such services or treatment and the applicable zip code (first 3 or 5 digits) of such **Provider**.
2. For services or treatments **Provided** by **Hospitals, Ambulatory Surgical Centers, Emergency Care Facilities, Skilled Nursing Homes**, pharmacies or other applicable facilities, **Usual and Customary Expense** is average charge made for similar services or supplies in the locality where the service or supply is furnished, taking into consideration the nature and the severity of the **Bodily Injury** suffered by the **Insured**.

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

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

“**We**” means Freedom Life Insurance Company of America.

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

“**Your Renewal Premium Class**” means the **Class** in which this **Certificate** is placed for **Renewal Premium** purposes. **Your Renewal Premium Class** will be determined by **Us** based upon several factors, including, among other things, a combination of one or more of the following: (i) **Your** zip code (either first 3 or first 5 digits) at the commencement of such renewal period, (ii) **Your** county of residence at the commencement of such renewal period, (iii) **Your** state of residence at the commencement of such renewal period, (iv) the **Issue Date**, (v) **Your**

state of residence on the **Issue Date**, (vi) the number, sex, attained age, and tobacco use of each **Insured** on each applicable renewal date, (vii) **Your** plan of coverage under this **Certificate** on each applicable renewal date, including its deductibles, **Accidental Bodily Injury Benefit**, limits, exclusions, limitations, optional riders, and exclusionary endorsements (viii) the underwriting risk assessment of each **Insured**, (ix) discounted or preferred premium rate status of any **Insured**, (x) premium rate ups, if any, for any **Insured**, (xi) the amount of the **Initial Premium**, (xii) the amount of the **Renewal Premium** charged in the preceding renewal period, (xiii) **Mode of Premium Payment** for the renewal period and (xiv) the number and type other certificates of coverage issued by **Us** covering individuals in **Your** current state of residence with the same or similar factors described above.

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

III. WHEN COVERAGE BEGINS AND ENDS

A. EFFECTIVE DATE

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

B. ELIGIBILITY AND ADDITIONS

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

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

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

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

C. TERMINATION OF COVERAGE

1. TERMINATIONS SUBJECT TO RIGHT OF CONVERSION

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

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

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

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

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

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

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

- a. **We** are required by the order of an appropriate regulatory authority to non-renew or cancel the **Certificate** or **Group Accidental Bodily Injury Insurance Policy**;
- b. **We** cease offering and renewing coverage of the same form of coverage as this **Certificate** in **Your** state upon a minimum of thirty (30) days prior written notice mailed to **Your** last known address Take out conversion
- c. the date **We** receive due proof that fraud or intentional misrepresentation of material fact existed in applying for this **Certificate** or in filing a claim for **Accidental Bodily Injury Benefit** under this **Certificate**; or
- d. the **Primary Insured** terminates membership in the association which is the **Group Accidental Bodily Injury Insurance Policyholder**.

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

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

- a. the total amount of any **Accidental Bodily Injury Benefit** payments made by **Us** are equal to the **Lifetime Certificate Maximum Per Insured**;
- b. with respect to **You** and **Your Spouse**, the premium due date in the month following the attainment of age 65 or eligibility for **Medicare**;
- c. An **Insured** ceases to be a member of the association which is the **Group Accidental Bodily Injury Insurance Policyholder**; or
- d. the date **We** receive due proof that fraud or intentional misrepresentation of material fact existed in applying for this **Certificate** or in filing a claim for **Accidental Bodily Injury Benefit** under this **Certificate**.

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

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

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

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

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

E. CONTINUATION OF COVERAGE AND CERTIFICATE OF CONVERSION

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

1. for **Your Spouse** who is covered under this **Certificate**, if his or her coverage ceases due to divorce, annulment or court approved separation; or
2. for **Your** unmarried child(ren) who is covered under this **Certificate**, if his or her coverage ceases due to his or her reaching the limiting age of 19 (24 if enrolled as a **Full-Time Student**).

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

1. an **Insured's** coverage under the **Group Accidental Bodily Injury Insurance Policy** ceases because the **Group Accidental Bodily Injury Insurance Policy** was terminated;
2. an **Insured's** coverage under this **Certificate** ceases because of failure to pay the required premiums in the time allowed;
3. **We** were required by the order of an appropriate regulatory authority to non-renew or cancel the **Certificate** or **Group Accidental Bodily Injury Insurance Policy**;
4. The total amount of **Accidental Bodily Injury Benefit** payments made by **Us** are equal to the **Lifetime Certificate Maximum Per Insured**;
5. **You** voluntarily terminated coverage under this **Certificate** for any **Insured** by notifying **Us** of the date **You** desired such coverage to terminate;
6. **We** received due proof that fraud or intentional misrepresentation of material fact existed in applying for this **Certificate** or in filing a claim for **Accidental Bodily Injury Benefit** under this **Certificate**;
7. The **Insured** is or could be covered by **Medicare**; or
8. **We** ceased offering and renewing coverage of the same form of coverage as this **Certificate** in **Your** state upon a minimum of thirty (30) days prior written notice mailed to **Your** last known address with an opportunity for **You** to convert to any similar medical expense policy or certificate that **We** are then actively marketing and offering to new applicants in **Your** state.

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

IV. PREMIUM

A. INITIAL PREMIUM

The **Initial Premium** specified on the **Certificate Schedule** is due and payable {*Option 1* [by **You**]} {*Option 2* by the **Group Accidental Bodily Injury Insurance Policyholder** on **Your** behalf from the amount of the member dues timely and properly paid by **You** to the **Group Accidental Bodily Injury Insurance Policyholder**} for each **Insured's** membership in the **Group Accidental Bodily Injury Insurance Policyholder**] to the **Company** at its home office on or before the **Issue Date**. This **Initial Premium** payment will keep this **Certificate** in force until the **First Renewal Date**. The amount of the **Initial Premium** and the **First Renewal Date** are shown on the **Certificate Schedule**. **Initial Premium** has been determined by **Us** for this **Certificate** on a **Class** basis. **Your Class** for **Initial Premium** was determined by **Us** based upon several factors, including, among other things, a combination of the following: (i) **Your** zip code (either first 3 or first 5 digits); (ii) **Your** county of residence; (iii) **Your** state of residence; (iv) the number, age, sex and tobacco use of each **Insured** listed on the **Certificate Schedule**; (v) the plan of coverage contained in this **Certificate** on the **Issue Date**, including its deductibles, **Accidental Bodily Injury Benefits**, limitations, and exclusions; (vi) the health status of each applicant, including the results of any required physical examination and laboratory test results; (vii) **Participating Provider** network selected on the application, (viii) the underwriting risk assessment of each **Insured**; (ix) the discounted or preferred premium rate status of any **Insured**; (x) premium rate ups, if any, for any **Insured**; (xi) **Mode Of Premium Payment** selected on the application; (xii) distribution channels; (xiii) administrative costs; (xiv) taxes; (xv) other economic factors; and/or (xvi) other certificates of coverage issued and to be issued by **Us** covering individuals in **Your** current state of residence with the same or similar factors described above.

B. RENEWAL PREMIUM

1. CALCULATION - PAYMENT

The current **Mode Of Premium Payment** is shown on the **Certificate Schedule**. **Renewal Premium** is payable {*Option 1* [by **You**]} {*Option 2* by the **Group Accidental Bodily Injury Insurance Policyholder** on

Your behalf from the amount of the member dues timely and properly paid by You to the **Group Accidental Bodily Injury Insurance Policyholder** for each **Insured's** membership in the **Group Accidental Bodily Injury Insurance Policyholder**}] on or before its due date, and must be paid to the **Company** at its home office. Any **Renewal Premium** not paid {*Option 1* [by You]} {*Option 2* by the **Group Accidental Bodily Injury Insurance Policyholder** on Your behalf from the amount of the member dues timely and properly paid by You to the **Group Accidental Bodily Injury Insurance Policyholder** for each **Insured's** membership in the **Group Accidental Bodily Injury Insurance Policyholder**}] on or before its due date is a premium in default. If a **Renewal Premium** payment default is not corrected and properly paid before the end of the grace period, coverage under this **Certificate** will terminate.

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

- 1) You add **Insureds** to this **Certificate**;
- 2) You change the amount of the **Calendar Year Deductible** shown on the **Certificate Schedule**;
- 3) You change the **Insured Coinsurance Percentage** shown on the **Certificate Schedule**;
- 4) You change any other coverage option;
- 5) You change residence to a different zip code;
- 6) You change the **Mode Of Premium Payment**;
- 7) You add optional coverage riders, if any;
- 8) You change after the **Issue Date** to a different optional **Participating Provider** network available in Your state, if any;
- 9) a change occurs in the relationship between Your **Participating Provider** network and the **Company**;
- 10) the **Participating Provider** network availability changes for Your state;
- 11) the **Participating Provider** negotiated discounts change;
- 12) a change occurs in **Group Accidental Bodily Injury Insurance Policy** coverage, benefits, limitations, exclusions, premium or other material matter;
- 13) any change in coverage, **Accidental Bodily Injury Benefits**, limitations, exclusions, or premium is required pursuant to any federal or state law or regulation; and/or
- 14) any other change in federal or state law affecting the definitions, **Accidental Bodily Injury Benefits**, limitations, exclusions, and/or premium of this **Certificate** or the **Group Accidental Bodily Injury Insurance Policy**.

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

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

Any changes in the table of premium rates establishing the amount of required **Renewal Premium** during any renewal period will be implemented on a **Class** basis for all members of **Your Renewal Premium Class**. Factors that may be involved and considered by **Us** in determining the amount of **Renewal Premium** to be charged to **Your Renewal Premium Class** during any renewal period include, among other things, a combination of one or more of the following: (i) past claims experience of **Your Renewal Premium Class**; (ii) anticipated inflationary trends in the cost of future medical services; (iii) historical experience in the inflationary cost of medical services; [(iv) anticipated inflationary trends in the cost of **Prescription Drugs**; (v) historical experience in the past inflationary cost of **Prescription Drugs**;] (vi) anticipated future claims experience of **Your Renewal Premium Class**; (vii) other economic factors; (viii) anticipated advances in the medical diagnosis capabilities of injuries and illnesses, including the anticipated

cost thereof; (ix) anticipated advances in the manner, method and delivery of medical care and treatment, including the anticipated cost thereof; and (x) any other reason permitted by applicable state law. **We** will tell **You** [and the **Group Accidental Bodily Injury Insurance Policyholder**] at least thirty (30) days in advance of the effective date of any **Renewal Premium** increase that occurs due to a change in the table of premium rates for **Renewal Premium**.

2. RENEWAL PREMIUM CHECK OR DRAFT NOT HONORED

Any [premium payment made {*Option 1* [by **You** to **Us**]} {*Option 2* by the **Group Accidental Bodily Injury Insurance Policyholder** to **Us** on **Your** behalf from the amount of the member dues timely and properly paid by **You** to the **Group Accidental Bodily Injury Insurance Policyholder** for each **Insured's** membership in the **Group Accidental Bodily Injury Insurance Policyholder**]} by a check or draft which is not honored at the bank upon which it is drawn shall be of no effect toward coverage under this **Certificate** unless and until valid restitution is made to **Us** within the time provided herein for making such premium payment.

3. GRACE PERIOD

Unless at least thirty-one (31) days prior to a **Renewal Premium** due date **We** have mailed to **You** written notice of **Our** intention not to renew this **Certificate** a grace period of thirty-one (31) days from such due date is given for the late payment [{*Option 1* [by **You** to **Us**]} {*Option 2* by the **Group Accidental Bodily Injury Insurance Policyholder** to **Us** on **Your** behalf from the amount of the member dues timely and properly paid by **You** to the **Group Accidental Bodily Injury Insurance Policyholder** for each **Insured's** membership in the **Group Accidental Bodily Injury Insurance Policyholder**]} of the **Renewal Premium** due. If {*Option 1* [**You**]} {*Option 2* the **Group Accidental Bodily Injury Insurance Policyholder** on **Your** behalf]} make[s] payment to **Us** of the required **Renewal Premium** during such grace period {*Option 2* [from the amount of the member dues timely and properly paid by **You** to the **Group Accidental Bodily Injury Insurance Policyholder** for each **Insured's** membership in the **Group Accidental Bodily Injury Insurance Policyholder**]}, then this **Certificate** will remain in force for **Benefit** claims arising during such grace period. However, if the **Company** has received notification of **Your** intention to cancel any **Insured's** coverage under this **Certificate**, there is no grace period for the late payment of any **Renewal Premium** that would otherwise have been due for such **Insured** but for such cancellation.

4. REINSTATEMENT

If the **Renewal Premium** is not paid {*Option 1* [by **You**]} {*Option 2* [by the **Group Accidental Bodily Injury Insurance Policyholder** on **Your** behalf from the amount of the member dues timely and properly paid by **You** to the **Group Accidental Bodily Injury Insurance Policyholder** for each **Insured's** membership in the **Group Accidental Bodily Injury Insurance Policyholder**]} before the grace period ends, later acceptance of premium by **Us** without requiring an application for reinstatement will reinstate this **Certificate** as of the date of acceptance of the late premium, together with all applicable administration and policy fees, as well as all applicable state and federal taxes. If **We** require an application that will be fully underwritten by **Us**, {*Option 1* [**You**]} {*Option 2* [**You** and the **Group Accidental Bodily Injury Insurance Policyholder**]} will be given a conditional receipt for the premium. If the application is approved after underwriting, this **Certificate** will be reinstated as of the approval date together with payment {*Option 1* [by **You**]} {*Option 2* by the **Group Accidental Bodily Injury Insurance Policyholder** on **Your** behalf on **Your** behalf from the amount of the member dues timely and properly paid by **You** to the **Group Accidental Bodily Injury Insurance Policyholder** for each **Insured's** membership in the **Group Accidental Bodily Injury Insurance Policyholder**]} all back or past due premium and all applicable administration and policy fees, as well as all applicable state and federal taxes permitted by applicable state law. Lacking such approval, this **Certificate** will be reinstated on the forty-fifth (45th) day after the date of the conditional receipt, unless **We** have previously notified {*Option 1* [**You**]} {*Option 2* [**You** and the **Group Accidental Bodily Injury Insurance Policyholder**]}, in writing, of **Our** disapproval of the reinstatement.

The reinstated **Certificate** will cover only **Covered Expenses** that result from a **Bodily Injury** that occurs more than ten (10) days after the date of reinstatement.

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

5. INITIAL PREMIUM RATE GUARANTEE PERIOD

The amount of **Renewal Premium** with the same **Mode of Premium Payment** as the **Mode of Premium Payment** of the **Initial Premium** is guaranteed not to exceed the amount of the **Initial Premium** for each renewal period commencing prior to the expiration of the **Premium Rate Guarantee Period** as a result of any: (i) change in the table of premium rates used to calculate the **Initial Premium**; or (ii) increase in the attained age after the **Issue Date** of any **Insured** listed on the **Certificate Schedule**. The length of the **Premium Rate Guarantee Period** is shown on the **Certificate Schedule**. However, **Renewal Premium** rates may be increased by **Us** during the **Premium Rate Guarantee Period** upon any one or more of the following:

- a. **You** add **Insureds** to this **Certificate**;
- b. **You** change the amount of the **Calendar Year Deductible** shown on the **Certificate Schedule**;
- c. **You** change the **Insured Coinsurance Percentage** shown on the **Certificate Schedule**;
- d. **You** change any other coverage option;
- e. **You** change residence to a different zip code;
- f. **You** change the **Mode Of Premium Payment**;
- g. **You** add optional coverage riders, if any;
- h. **You** change after the **Issue Date** to a different optional **Participating Provider** network available in **Your** state, if any;
- i. a change occurs in the relationship between **Your Participating Provider** network and the **Company**;
- j. the **Participating Provider** network availability changes for **Your** state;
- k. the **Participating Provider** negotiated discounts change;
- l. a change occurs in **Group Accidental Bodily Injury Insurance Policy** coverage, benefits, limitations, exclusions, premium or other material matter;
- m. any change in coverage, **Accidental Bodily Injury Benefits**, limitations, exclusions, or premium is required pursuant to any federal or state law or regulation; and/or
- n. any other change in federal or state law affecting the definitions, **Accidental Bodily Injury Benefits**, limitations, exclusions, and/or premium of this **Certificate** or the **Group Accidental Bodily Injury Insurance Policy**.

V. ACCIDENTAL BODILY INJURY BENEFITS AND CLAIM PROCEDURES

Insureds have the right to obtain medical care from the **Provider** and **Hospital** of their choice, however, all applicable **Accidental Bodily Injury Benefit** payments by **Us** under this ACCIDENTAL BODILY INJURY BENEFITS AND CLAIMS PROCEDURES Section of the **Certificate** are limited to the applicable **Company Insurance Percentage** of **Covered Expenses** incurred by an **Insured**. Coverage under this Section of the **Certificate** will be reduced for medical services, supplies, care or treatment obtained from a **Non-Participating Provider**. The difference between both the **Company Insurance Percentages** and the **Insured Coinsurance Percentages** for: (i) **Participating Providers** and (ii) **Non-Participating Providers** are shown in the **Certificate Schedule**. In addition, **We** shall never be required to make a payment for **Covered Expenses** incurred in excess of the amount of (i) the **Calendar Year Maximum Benefit Per Insured** during any **Calendar Year**, (ii) the amount of the **Lifetime Transplant Maximum Per Insured** during an **Insured's** lifetime, or (iii) the amount of the **Lifetime Certificate Maximum Per Insured** during an **Insured's** lifetime.

Covered Expenses incurred by an **Insured** for **Accidental Bodily Injury Benefits** are subject to the **Calendar Year Deductible**, the **Insured Coinsurance Percentage** and any applicable **Access Fees**, unless otherwise specified.

A. ACCIDENTAL BODILY INJURY BENEFITS

Subject to and expressly limited by all applicable definitions, exclusions, limitations, non-waiver provisions, waiting periods, and other provisions contained in this **Certificate**, as well as any exclusionary coverage riders, endorsements, or amendments attached to hereto, **We** promise to pay to or on behalf of each **Insured** on an independent and non-coordinated basis the **Company Insurance Percentage** of the amount of professional fees and other applicable medical diagnostic or treatment expenses and charges that constitute **Covered Expenses** incurred by each **Insured** for the following described **Inpatient** and **Outpatient** services that are **Provided** as a result of a **Bodily Injury**, but only after: (i) each applicable **Access Fee** amount in this Section has been first satisfied and deducted from such **Covered Expenses** and applied to the applicable **Insured** for payment; (ii) the amount of the **Calendar Year Deductible** has been first satisfied by deduction from such **Covered Expenses** and applied to the applicable **Insured** for payment; (iii) the amount of any applicable **Separate Deductible For Non-Participating Providers** and **Failure to Pre-Certify Treatment Deductible** has been first satisfied by deduction from such **Covered Expenses** and applied to the applicable **Insured** for payment; and (iv) the applicable **Insured Coinsurance Percentage** of the **Covered Expenses** remaining after satisfaction of all applicable deductibles and **Access Fees** is, likewise, satisfied by deduction from the remaining **Covered Expenses** and applied to the applicable **Insured** for payment:

1. INPATIENT HOSPITAL CONFINEMENT FOR BODILY INJURIES:

a. INPATIENT HOSPITAL CARE FOR BODILY INJURIES

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

- 1) **Hospital** - semi-private daily room and board;
- 2) **Intensive Care Unit** of the **Hospital** - daily room and board (Note, daily room and board will be at the semi-private rate for admission to units or areas of the applicable **Hospital** which are step-down units from the **Intensive Care Unit**, including, sub-acute intensive care units, progressive care units, intermediate care units, private monitored rooms, observation units or other facilities not meeting the standards set forth in the definition of an **Intensive Care Unit**);
- 3) **Hospital** miscellaneous medications, prescription drugs, services and supplies - (Note, miscellaneous charges by a **Hospital** for personal convenience items, including but not limited to television, telephone, internet and radio are not considered **Covered Expenses**); and
- 4) **Provider** Visits – (Note: limited one (1) **Provider** visit per treating **Provider** per day while the **Insured** is an **Inpatient** at a **Hospital**, and a maximum of sixty (60) **Provider** visits per **Hospital Confinement**. **Accidental Bodily Injury Benefits** are not payable for professional fees for visits at the **Hospital** following surgery by a Surgeon, Anesthesiologist or Nurse Anesthetist whose professional fees in connection with the surgery constitute **Covered Expenses**, unless the visit is to evaluate or treat a **Bodily Injury** other than that which resulted in the **Insured's** covered surgery).

b. INPATIENT SURGERY FOR BODILY INJURIES

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

- 1) Primary Surgeon;
- 2) Assistant Surgeon – (professional fees that constitute **Covered Expenses** will be considered for an **Accidental Bodily Injury Benefit** payment for one assistant surgeon in connection with surgery for which **Accidental Bodily Injury Benefits** are payable hereunder for the professional fees of the primary surgeon);
- 3) Anesthesiologist or Nurse Anesthetist – (professional fees that constitute **Covered Expenses** will be considered for an **Accidental Bodily Injury Benefit** payment for either an anesthesiologist's or a nurse anesthetist's administration and monitoring of anesthesia administered during surgery for which **Accidental Bodily Injury Benefits** are payable hereunder for the professional fees of the primary surgeon); and
- 4) Second Surgical Opinion - Up to \$250 of professional fees for a second surgical opinion if:
 - a) the **Insured's Provider** determines that surgery is needed;

- b) the surgery is not excluded from this **Certificate** or any riders, amendments or endorsements attached hereto;
- c) the **Insured** is examined in person by another qualified **Provider** for the purpose of obtaining a second surgical opinion; and
- d) the **Provider** issuing the second surgical opinion sends **Us** a written report.

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

[c. BREAST RECONSTRUCTION FOR BODILY INJURIES

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

d. INPATIENT THERAPY FOR BODILY INJURIES

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

- 1) Occupational therapy;
- 2) Physical therapy (not to exceed 25 treatments or a maximum physical therapy **Accidental Bodily Injury Benefit** payment of \$2,000 per **Calendar Year**, per **Insured**);
- 3) Rehabilitation therapy; and
- 4) Speech therapy.

This **Inpatient** therapy coverage does not include fees or expenses charged for spinal manipulations.

e. INPATIENT LABORATORY AND DIAGNOSTIC TESTS FOR BODILY INJURIES

Services **Provided** by a **Hospital** or a **Provider** in connection with the performance and interpretation of laboratory and diagnostic tests received by an **Insured** as an **Inpatient** at the **Hospital** due to **Bodily Injuries**.

f. TRANSPLANTS FOR BODILY INJURIES

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

The maximum amount of **Covered Expenses** allowed for professional fees of a **Provider** and facility fees for the harvesting of applicable donor organs or donor bone marrow is \$10,000 per transplant, to the extent that any **Accidental Bodily Injury Benefit** hereunder remain and are available under the **Certificate** for the applicable **Insured** recipient. Any payment of donor expenses hereunder will be applied toward the satisfaction of the **Lifetime Transplant Maximum Per Insured**.

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

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

- 5) any transplantation (including grafts) that does not constitute **Solid Organ Transplants, Bone Marrow Transplants, and/or Stem Cell Transplants.**

2. EMERGENCY ROOM AND OTHER OUTPATIENT COVERAGE FOR BODILY INJURIES:

a. EMERGENCY ROOM SERVICES FOR BODILY INJURIES

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

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

The **Emergency Room Access Fee** shall be waived by **Us** if such **Insured** is **Confined** in any **Hospital** within twenty-four (24) hours of such **Emergency Room** visit.

b. OUTPATIENT TREATMENT OF BODILY INJURIES

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

c. EMERGENCY TRANSPORTATION TO HOSPITAL BY AMBULANCE FOR BODILY INJURIES

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

d. OUTPATIENT SURGERY FOR BODILY INJURIES

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

- 1) **Hospital** or **Ambulatory Surgical Center** – (expenses that constitute **Covered Expenses** will be considered for **Accidental Bodily Injury Benefit** payment for the pre-operation, operation and recovery rooms, as well as for medications, **Prescription Drugs**, and other miscellaneous items, services and supplies; provided that miscellaneous charges for any personal convenience items, including but not limited to television, telephone, and radio are not considered **Covered Expenses**);
- 2) Primary Surgeon;
- 3) Assistant Surgeon – (professional fees that constitute **Covered Expenses** will be considered for an **Accidental Bodily Injury Benefit** payment for one assistant surgeon in connection with surgery for which **Accidental Bodily Injury Benefits** are payable hereunder for the professional fees of the primary surgeon);
- 4) Anesthesiologist or Nurse Anesthetist – (professional fees that constitute **Covered Expenses** will be considered for an **Accidental Bodily Injury Benefit** payment for either an anesthesiologist or a

- nurse anesthetist administration and monitoring of anesthesia, during surgery for which **Accidental Bodily Injury Benefits** are payable hereunder for the professional fees of the primary surgeon);
- 5) Pathologist – (professional Fees that constitute **Covered Expenses** will be considered for an **Accidental Bodily Injury Benefit** payment for a pathologist's evaluation and/or interpretation of any tissue specimen removed during or in connection with such surgery); and
 - 6) Second Surgical Opinion - Up to \$250 of professional fees for a second surgical opinion if:
 - a) the **Insured's Provider** determines that surgery is needed;
 - b) the surgery is not excluded from this **Certificate** or any riders, amendments or endorsements attached hereto;
 - c) the **Insured** is examined in person by another qualified **Provider** for the purpose of obtaining a second surgical opinion; and
 - d) the **Provider** issuing the second surgical opinion sends **Us** a written report.

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

e. **[OUTPATIENT LABORATORY AND DIAGNOSTIC TESTS FOR BODILY INJURIES**

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

f. **[OUTPATIENT THERAPY FOR BODILY INJURIES**

Services **Provided** by a **Hospital**, or other medical facility in connection with the following types of therapy received on an **Outpatient** basis by an **Insured** due to **Bodily Injuries**:

- 1) Occupational therapy;
- 2) Physical therapy (not to exceed 25 treatments or a maximum **Accidental Bodily Injury Benefit** payment of \$2,000 per **Calendar Year per Insured**);
- 3) Rehabilitation therapy; and
- 4) Speech therapy.

This **Outpatient** therapy **Accidental Bodily Injury Benefit** does not include fees or expenses charged for spinal manipulations.]

g. **[DOCTOR OFFICE VISITS FOR BODILY INJURIES**

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

h. **[OUTPATIENT PRESCRIPTIONS FOR BODILY INJURIES**

Prescriptions filled by a **Participating Pharmacy**, but **Covered Expenses** for such **Prescriptions** shall not exceed, the amount of the cost of the least expensive drug, medicine or **Prescription Drug** that may be used to treat the **Insured's Bodily Injury**, all in accordance with the following schedule:

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

Name Drug that was prescribed for the **Insured**, the amount of **Covered Expenses** for such **Prescription** shall be limited to the cost of such **Generic Drug** at the pharmacy.

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

i. [HOME HEALTH CARE FOR BODILY INJURIES

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

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

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

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

j. [HOSPICE CARE FOR BODILY INJURIES

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

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

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

k. [MEDICAL EQUIPMENT AND SUPPLIES FOR BODILY INJURIES

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

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

l. [SKILLED NURSING HOME FOR BODILY INJURIES

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

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

B. PRE-CERTIFICATION OF TREATMENT

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

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

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

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

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

C. CLAIM PROCEDURES, INVESTIGATION AND PAYMENT

1. NOTICE OF CLAIM

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

2. CLAIM FORMS AND ADDITIONAL INFORMATION TO BE PROVIDED

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

3. PROOFS OF LOSS

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

4. CLAIMS REVIEW, INVESTIGATION, ADJUSTMENT AND ADJUDICATION

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

5. PAYMENT OF CLAIMS

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

6. TIME OF PAYMENT OF CLAIMS

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

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

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

VI. DEDUCTIBLES

A. CALENDAR YEAR DEDUCTIBLE

No **Accidental Bodily Injury Benefits** are payable under this **Certificate** for any **Covered Expenses** incurred by an **Insured**, until after the **Calendar Year Deductible** is satisfied and fully payable each **Calendar Year** by such **Insured**. The amount of the **Calendar Year Deductible** is shown on the **Certificate Schedule** and applies per **Calendar Year** separately to each **Insured**.

In addition to the **Calendar Year Deductible**, the **Separate Deductible For Non-Participating Providers** will apply to services rendered by **Non-Participating Providers**.

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

B. SEPARATE DEDUCTIBLE FOR NON-PARTICIPATING PROVIDERS

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

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

C. SEPARATE DEDUCTIBLE FOR FAILURE TO PRE-CERTIFY TREATMENT

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

D. FAMILY CALENDAR YEAR DEDUCTIBLE MAXIMUM

Once a [combined] total of [one, two or three] [(1), (2), or (3)] **Calendar Year Deductible[s]** [have/has] been satisfied in any **Calendar Year** by any [three (3)] **Insured[s]**, no additional **Calendar Year Deductible** will be assessed by **Us** in connection with medical treatment and services rendered to any other **Insured** during the remainder of such **Calendar Year**.

VII. LIMITATIONS, EXCLUSIONS AND NON-WAIVER

A. LIMITATIONS-WAITING PERIODS

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

1. Any treatment, medical service, surgery, medication, equipment, claim, loss or expense received, purchased, leased or otherwise incurred as a result of an **Insured's Pre-existing Condition** is not covered under this **Certificate** unless such treatment, medical service, surgery, medication, equipment, claim, loss or expense constitutes **Covered Expenses** incurred by such **Insured** more than twelve (12) months after the **Issue Date**, and such treatment, medical service, surgery, medication, equipment, claim, loss or expense are not otherwise limited or excluded by this **Certificate** or any riders, endorsements, or amendments attached to this **Certificate**;
2. If as the result of an **Emergency** treatment of an **Accidental Bodily Injury** services are rendered for an **Insured** by a **Non-Participating Provider** when a **Participating Provider** was not reasonably available in connection with either (i) on an **Outpatient** basis in the emergency room of a **Hospital** or (ii) an **Emergency Inpatient** admission to a **Hospital**, then the **Covered Expenses** incurred will be reimbursed by **Us** as if such **Non-Participating Provider** were a **Participating Provider** up to the point when the **Insured** can be safely transferred to a **Participating Provider**. If the **Insured** refuses or is unwilling to be transferred to the care of a **Participating Provider** after such **Insured** can be safely transferred, then reimbursement shall thereafter be reduced to the **Company's Insurance Percentage for Non-Participating Providers**;
3. **Accidental Bodily Injury Benefits** under this **Certificate** for any **Insured** who is eligible for or has coverage under **Medicare**, and/or amendments thereto, regardless of whether such **Insured** is enrolled in **Medicare** shall be limited to only the **Usual and Customary** charges for services, supplies, care or treatment covered under this **Certificate** that are not or would not have been payable or reimbursable by **Medicare** and/or its amendments (assuming such enrollment), subject to all provisions, limitations, exclusions, reductions and maximum benefits set forth in this **Certificate**;
4. Two-Five million dollars (\$2,000,000- \$5,000,000) is the maximum total amount of all applicable annual increases in the **Lifetime Certificate Maximum Per Insured** that can be conditionally received after the **Issue Date** pursuant to Section VIII. INCREASE IN THE LIFETIME CERTIFICATE MAXIMUM of this **Certificate**; and
5. Except as contained and specifically set forth in the INCREASE IN THE LIFETIME CERTIFICATE MAXIMUM Section of this **Certificate**, there shall be no increase in the amount of the **Lifetime Certificate Maximum Per Insured**.

B. EXCLUSIONS

Coverage under this **Certificate** is limited as provided by the definitions, limitations, exclusions, and terms contained in each and every Section of this **Certificate**. In addition, this **Certificate** does not provide coverage the amount of any professional fees or other medical expenses or charges for treatments, care, procedures, services or supplies incurred for the diagnosis, care or treatment charged to an **Insured** or any payment obligation for **Us** under this **Certificate** for any of the following, all of which are excluded from coverage:

1. any damage or harm to the physical structure of the body of an **Insured** received as a result of any act of war (whether declared or undeclared);
2. any damage or harm to the physical structure of the body of an **Insured** that was intentionally self-inflicted;
3. any damage or harm to the physical structure of the body of an **Insured** caused by suicide or any suicide attempt while sane or insane;
4. any damage or harm to the physical structure of the body of an **Insured** occurring while the **Insured** is serving on active duty in the armed forces of the United States (including the active Reserves) or the National Guard;
5. any medical care, service, treatments, procedures, or supplies received, provided to, or incurred by an **Insured** from any state or Federal government agency, including the Veterans Administration for a **Bodily Injury**, unless the **Insured** must pay for such services by law;

6. any damage or harm to the physical structure of the body of an **Insured** occurring while the Insured is serving on active duty in one of the branches of the armed forces of any foreign country or any international authority;
7. any damage or harm to the physical structure of the body of an **Insured** occurring while the **Insured** is engaged in an illegal occupation or attempting to commit assault or illegal activity;
8. any damage or harm to the physical structure of the body of an **Insured** occurring while the **Insured** is resisting arrest by a law enforcement officer, or otherwise resisting incarceration by a municipality, or other political subdivision of a state, a state or the federal government;
9. any damage or harm to the physical structure of the body of an **Insured** occurring while the **Insured** is incarcerated in a city or county jail or a state or federal penal institution;
10. any damage or harm to the physical structure of the body of an **Insured** occurring while the **Insured** is engaged in hang gliding, paragliding, hot air ballooning or any other form of aviation, except as a fare paying passenger traveling on a regularly scheduled commercial airline flight;
11. any damage or harm to the physical structure of the body of an **Insured** occurring while the **Insured** is engaged in the sport of avocation of bungee jumping, parachuting, rock climbing, para-sailing, para-kiting, or mountain climbing;
12. any damage or harm to the physical structure of the body of an **Insured** occurring while the **Insured** is engaged in raising, caring for, handling or working with knowingly dangerous animals;
13. any damage or harm to the physical structure of the body of an **Insured** occurring while the **Insured** is engaged, as a contestant (professional or amateur), in any rodeo event or participating at a rodeo as a rodeo clown;
14. any damage or harm to the physical structure of the body of an **Insured** occurring while the **Insured** is participating, as a professional contestant, in any boxing, marital arts or mixed martial arts event, including the sanctioned practice thereof;
15. any damage or harm to the physical structure of the body of an **Insured** occurring while the **Insured** is participating, as a professional or semi-professional contestant, in any sanctioned equestrian event;
16. any damage or harm to the physical structure of the body of an **Insured** while the **Insured** is participating, as driver or passenger contestant (professional or amateur), in any race competition, race, or speed contest, including sanctioned practice thereof, involving any land vehicle or water craft;
17. any damage or harm to the physical structure of the body of an **Insured** occurring while the **Insured** is participating, as a professional contestant, in any race competition, race or speed contest, including sanctioned practice thereof, on snow skis or a snowboard;
18. any damage or harm to the physical structure of the body of an **Insured** occurring while the **Insured** is participating on a wager in any knowingly hazardous activity;
19. any damage or harm to the physical structure of the body of an **Insured** occurring while the **Insured** is intoxicated or under the influence of alcohol or any drug, narcotic or hallucinogens unless administered via a prescription and on the advice of a **Provider**, and taken in accordance with the limits of such advice. An **Insured** is conclusively determined to be intoxicated by drug or alcohol if (ii) a chemical test administered in the jurisdiction where either the **Accident** occurred or the **Insured** was medically treated is at or above the legal limit set by that jurisdiction or (ii) the level of alcohol was such that a person's coordination, ability to reason, was impaired, regardless of the legal limit set by that jurisdiction;
20. any damage or harm to the physical structure of the body of an **Insured** occurring during any surgical procedure or operation performed in the treatment of any disease, illness, sickness or ailment;
21. any damage or harm to the physical structure of the body of an **Insured** occurring as a result of the intentional inhalation or ingestion of any poison, gas or fumes;
22. any damage or harm to the physical structure of the body of an **Insured** occurring as a result of the operation by an **Insured** of any motor vehicle without the permission/consent of the owner of such vehicle;
23. any damage or harm to the physical structure of the body of an **Insured** occurring as a result of the operation by an **Insured** of any motor vehicle without a valid operator's license/permit;
24. any damage or harm to the physical structure of the body of an **Insured** occurring as a result of an **Insured's** knowing and intentional participation in a riot, act of civil disobedience or insurrection;
25. any cost item, charge or expense which does not constitute **Covered Expenses**;
26. any damage or harm to the physical structure of the body of an **Insured** that did not occur **Accidentally**;
27. any disease, illness, ailment or sickness of any type or character suffered or sustained by an **Insured**;
28. any medical care, service, treatments, procedures, or supplies received, provided to, or incurred by an **Insured** before the **Certificate Issue Date**;
29. any medical care, service, treatments, procedures, or supplies received, provided to, or incurred by an **Insured** after an **Insured's** coverage under this **Certificate** terminates, regardless of when the **Bodily Injury** occurred, except as **Provided** in the EXTENSION OF BENEFITS provision;

30. any medical care, service, treatments, procedures, or supplies received, provided to, or incurred by an **Insured**, which exceed the **Lifetime Certificate Maximum Per Insured**;
31. any medical care, service, treatments, procedures, or supplies received, provided to, or incurred by an **Insured** which exceed the **Lifetime Transplant Maximum Per Insured** for all **Solid Organ Transplants**, **Bone Marrow Transplants**, and **Stem Cell Transplants** received by each **Insured** including any applicable expense for professional fees and facility fee incurred in connection with harvesting the applicable donor organ or donor bone marrow for the purposes of such transplantation;
32. [any **Prescription Drugs**];
33. any medical care, service, treatments, procedures, or supplies received, provided to, or incurred by an **Insured** and contained on a billing statement to the **Insured** which exceeds the amount of the **Maximum Allowable Charge**;
34. any medical care, service, treatments, procedures, or supplies received, provided to, or incurred by an **Insured**, which **You** or **Your** covered family members are not required to pay;
35. any medical care, service, treatments, procedures, or supplies received, provided to, or incurred by an **Insured** for which the **Insured** and/or any covered family members are not legally liable for payment;
36. any medical care, service, treatments, procedures, or supplies received, provided to, or incurred by an **Insured** for which the **Insured** and/or any covered family members were once legally liable for payment, but from which liability the **Insured** and/or family members were forgiven and released by the applicable **Provider** without payment or promise of payment;
37. any medical care, service, treatments, procedures, or supplies received, provided to, or incurred by an **Insured** from any state or federal government agency, including the Veterans Administration unless, by law, an **Insured** must pay for such services;
38. any medical care, service, treatments, procedures, or supplies received, provided to, or incurred by an **Insured** as a result of experimental procedures or treatment methods not approved by the American Medical Association or other appropriate medical society;
39. any eyeglasses, contact lenses, radial keratotomy, lasik surgery, hearing aids and exams for their prescription or fitting;
40. any Cochlear implants;
41. any damage or harm to the physical structure of the body of an **Insured** received as a result of any voluntary abortions, abortifacients or any other drug or device that terminates a pregnancy;
42. any damage or harm to the physical structure of the body of an **Insured** received as a result of any services **Provided** by **You** or a **Provider** who is a member of an **Insured's** family;
43. any medical condition excluded by name or specific description by either this **Certificate** or any riders, endorsements, or amendments attached to this **Certificate**;
44. cosmetic surgery or reconstructive procedures, except for **Medically Necessary** cosmetic surgery or reconstructive procedures performed under the following circumstances: (i) where such cosmetic surgery is incidental to or following surgery in treatment of a **Bodily Injury**, (ii) to correct a normal bodily function in connection with the treatment of a covered **Bodily Injury**; or (iii) such cosmetic surgery constitutes **Breast Reconstruction** that is incident to a **Mastectomy** performed in treatment of a **Bodily Injury**; provided any of the above occurred while the **Insured** was covered under this **Certificate**.
45. any damage or harm to the physical structure of the body of an **Insured** received as a result of any voluntary or elective surgical procedure, including breast reduction or augmentation or other cosmetic procedure;
46. any damage or harm to the physical structure of the body of an **Insured** received as a result of any voluntary sterilization procedure or sterilization reversal procedure;
47. any damage or harm to the physical structure of the body of an **Insured** received as a result of any treatment of infertility, including fertility hormone therapy and/or fertility devices for any type fertility therapy, artificial insemination or any other direct conception;
48. any damage or harm to the physical structure of the body of an **Insured** received as a result of any for any operation or treatment performed, **Prescription** or medication prescribed in connection with sex transformations or any type of sexual or erectile dysfunction, including complications arising from any such operation or treatment;
49. any diagnosis, care or treatment of Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD);
50. any diagnosis, care or treatment of **Mental, Nervous and Emotional Disorders**;
51. any diagnosis, care or treatment of autism;
52. any diagnosis, care or treatment of **Alcoholism**, addiction to illegal drugs or substances, and/or abuse or illegal drugs or substances;
53. any diagnosis, care or treatment of cirrhosis of the liver;

54. any fluoride products;
55. any intentional misuse or abuse of **Prescription Drugs**, including **Prescription Drugs** purchased by an **Insured** for consumption by someone other than such **Insured**;
56. any spinal manipulations;
57. charges for blood, blood plasma, or derivatives that has been replaced;
58. any Temporomandibular Joint Disorder (TMJ) and Craniomandibular Disorder (CMD);
59. any treatment received outside of the United States, except as provided for in the EXTRATERRITORIAL MEDICAL EXPENSES provision; and
60. any services or supplies for personal convenience, including custodial care or homemaker services, except as provided for in this **Certificate**.

C. NON-WAIVER

1. Billed charges for medical care and treatment received by all **Insureds** during a **Calendar Year** that are considered and applied by **Us** under Section VIII. INCREASE IN LIFETIME CERTIFICATE MAXIMUM, does not mean **We** have any liability for coverage or the payment of any **Accidental Bodily Injury Benefits** under the **Certificate** for the illness that resulted in such expenses, and any such mistake and error by **Us** shall not constitute a waiver of or modification to any of the conditions, terms, definitions, limitations or exclusions contained in either the **Certificate** or any exclusionary rider attached to the **Certificate**.
2. Expenses that are mistakenly applied by **Us** to the **Calendar Year Deductible** or erroneously paid by **Us** under any Section or provision of this **Certificate** shall not:
 - a) constitute a waiver of or modification to any conditions, terms, definitions or limitations contained in the **Certificate**, specifically including, but not by way of limitation, the definition of **Bodily Injury, Medical Necessity** or **Covered Expenses**, the limitation of coverage under the **Certificate** for **Pre-existing Conditions**, as well as any exclusion, limitation and/or exclusionary riders which may be attached to the **Certificate**, or otherwise operate to alter, amend, affect, abridge or modify the **Certificate** to which it is attached;
 - b) create or establish coverage of any medical condition, illness, or disease under the **Certificate** or under any exclusion, limitation and/or exclusionary riders which may be attached to the **Certificate**; or
 - c) affect, alter, amend, abridge, constitute or act as a waiver of the **Company's** ability to rely upon, assert and apply such terms, definitions, limitations or exclusions of the **Certificate** or any amendments thereto.

VIII. INCREASE IN LIFETIME CERTIFICATE MAXIMUM

A. CONDITIONAL ANNUAL INCREASE

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

1. \$125,000 FIRST ANNIVERSARY OF ISSUE DATE

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

2. \$250,000 FIRST ANNIVERSARY OF ISSUE DATE

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

3. \$125,000 SUBSEQUENT CERTIFICATE YEAR S

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

4. \$250,000 SUBSEQUENT CERTIFICATE YEAR S

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

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

IX. UNIFORM PROVISIONS

A. ENTIRE CONTRACT- CHANGES

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

1. change, alter or modify the **Group Accidental Bodily Injury Insurance Policy**, this **Certificate**, or any amendments, riders, or endorsements attached to this **Certificate**;
2. waive any provisions of the **Group Accidental Bodily Injury Insurance Policy**, this **Certificate**, or any amendments, riders, or endorsements attached to this **Certificate**;
3. extend the time period for payment of premiums under this **Certificate**; or
1. waive any of the **Company's** rights or requirements.

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

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

B. TIME LIMIT ON CERTAIN DEFENSES

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

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

C. CONFORMITY WITH STATE STATUTES

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

D. MISSTATEMENT OF AGE

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

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

E. NONDISCLOSED MEDICAL HISTORY, MEDICAL CONDITIONS AND RELATED INFORMATION

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

1. The coverage under this **Certificate** will stay in force with no change in **Accidental Bodily Injury Benefits**, or premiums if the disclosure of such condition would not have affected the way the **Certificate** was issued.
2. If the disclosure would have resulted in coverage not being issued to an **Insured**, **We** will return all premium paid, less any **Accidental Bodily Injury Benefit** paid for that person during the time the coverage was in force in error. The coverage for that person shall be void from the **Issue Date**.
3. If the disclosure would have resulted in coverage under this **Certificate** being issued either: (a) at an increased premium, or (b) with an endorsement eliminating that condition from coverage, **We** will either (i) have **You** pay the increased rate beginning with the **Issue Date** (if **You** do not pay the increased premium within thirty (30) days after receiving **Our** notice, **We** will refund all premium paid less any **Accidental Bodily Injury Benefit** paid, and the coverage under this **Certificate** will be void from the **Issue Date**); or (ii) add an endorsement to the **Certificate** to exclude that condition from coverage. The endorsement must be signed by **You** to put this change in effect. If **You** do not return a signed copy of the endorsement within thirty (30) days after receiving it, **We** will refund all premiums paid less any **Accidental Bodily Injury Benefit** paid, and the **Certificate** will be void from the **Issue Date**.

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

F. LEGAL ACTION

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

G. EXTRATERRITORIAL MEDICAL EXPENSES

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

THIS CONCLUDES THIS CERTIFICATE

SERFF Tracking Number: USHG-127046186 State: Arkansas
 Filing Company: Freedom Life Insurance Company of America State Tracking Number: 48040
 Company Tracking Number: ACCPYD-2011-C-FLIC
 TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only
 Product Name: ACCPYD-2011-C-FLIC
 Project Name/Number: ACCPYD-2011-C-FLIC/

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification	Approved-Closed	03/01/2011
Comments: See attached Flesch Certifications.		
Attachments: AR FLESCH ACCPYD.flic.pdf AR FLESCH ACCCYD.flic.pdf		

	Item Status:	Status Date:
Bypassed - Item: Application	Approved-Closed	03/01/2011
Bypass Reason: This form will be marketed using application form APP-FI-FLIC, et al and/or APP-09-NOARB-FLIC, previously approved by your Department on October 18, 2006 and May 18, 2009.		
Comments:		

	Item Status:	Status Date:
Satisfied - Item: Cover Letter	Approved-Closed	03/01/2011
Comments: See attached cover letter.		
Attachment: FLIC cover letter .pdf		

FREEDOM LIFE INSURANCE COMPANY OF AMERICA

3100 Burnett Plaza • 801 Cherry Street • Unit 33 • Fort Worth, Texas 76102 • (800) 387-9027

READABILITY CERTIFICATION

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

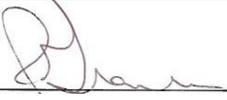
Form Number

Flesch Score

ACCPYD-2011-C-AR-FLIC

43.25

Name: Ranita Grauwiler

Signature:  _____

Title: Vice President – Product Developmen

Dated: February 21, 2011

FREEDOM LIFE INSURANCE COMPANY OF AMERICA

3100 Burnett Plaza • 801 Cherry Street • Unit 33 • Fort Worth, Texas 76102 • (800) 387-9027

READABILITY CERTIFICATION

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

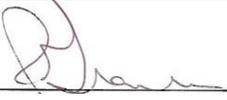
Form Number

Flesch Score

ACCCYD-2011-C-AR-FLIC

43.25

Name: Ranita Grauwiler

Signature:  _____

Title: Vice President – Product Developmen

Dated: February 21, 2011

FREEDOM LIFE INSURANCE COMPANY OF AMERICA

3100 Burnett Plaza • 801 Cherry Street • Unit 33 • Fort Worth, Texas 76102 • (800) 387-9027

February 22, 2011

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

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

ACCCYD-2011-C-AR-FLIC Association Group Accidental Bodily Injury Expense Certificate
ACCPYD-2011-C-AR-FLIC Association Group Accidental Bodily Injury Expense Certificate

Dear Director Urias:

Enclosed is the referenced form is filed for your review and approval. This form is new and is not intended to replace any forms previously filed with your Department. This form will be marketed using application form APP-FI-FLIC, et al and/or APP-09-NOARB-FLIC, previously approved by your Department on October 18, 2006 and May 18, 2009, respectively. Previously filed optional riders and amendatory endorsements may be issued with this certificate to provide additional benefits or meet regulatory requirements. These forms are basically identical except that one is a calendar year deductible and one is a policy year deductible.

The certificate is an association group accidental bodily injury that provides benefits for accidental bodily injury expenses on an inpatient and outpatient basis, subject to the provisions and limitations set forth therein. Benefits are provided for both participating and non-participating providers.

Please note that throughout the certificate, references to *{Option 1}* and *{Option 2}* denote two different options that the policyholder can choose from with regard to a specific subject. The terms *{Option 1}* and *{Option 2}* are shown for clarification only and will not show in the issued certificate. Only the bracketed language following *{Option 1}* or *{Option 2}* will show in the actual issued certificate, depending on which option is chosen by the policyholder.

This product will be issued to any associations previously filed in your state or that will be filed in the future. The group policy will be issued in Arizona. A certificate of insurance will be issued to members of the association to evidence coverage under the group policy. Please be advised this product is not employer/employee based, and we are offering it to individuals. The product is fully underwritten on an individual basis. Please note, we realize this form is exempt from filing in your state, however we require your confirmation as the situs of the association to which the group policy will be issued.

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

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

Enclosed, please find the applicable transmittals, certifications and filing fees, if any.

Your consideration of this filing is appreciated. Should you have any questions, please contact me as listed below.

Sincerely,

A handwritten signature in black ink that reads "Shannon Morgan Cubby". The signature is written in a cursive, flowing style.

Shannon Morgan Cubby
Product Analyst
Product Development
Tel. 800-387-9027 ext 748
cubbys@ushealthgroup.com

SERFF Tracking Number: USHG-127046186 State: Arkansas
 Filing Company: Freedom Life Insurance Company of America State Tracking Number: 48040
 Company Tracking Number: ACCPYD-2011-C-FLIC
 TOI: H02G Group Health - Accident Only Sub-TOI: H02G.000 Health - Accident Only
 Product Name: ACCPYD-2011-C-FLIC
 Project Name/Number: ACCPYD-2011-C-FLIC/

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)
02/21/2011		Supporting Cover Letter Document	02/21/2011	FLIC cover letter .pdf (Superseded)

FREEDOM LIFE INSURANCE COMPANY OF AMERICA

3100 Burnett Plaza • 801 Cherry Street • Unit 33 • Fort Worth, Texas 76102 • (800) 387-9027

February 22, 2011

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

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

ACCCYD-2011-C-FLIC
ACCPYD-2011-C-FLIC

Association Group Accidental Bodily Injury Expense Certificate
Association Group Accidental Bodily Injury Expense Certificate

Dear Director Urias:

Enclosed is the referenced form is filed for your review and approval. This form is new and is not intended to replace any forms previously filed with your Department. This form will be marketed using application form APP-FI-FLIC, et al and/or APP-09-NOARB-FLIC, previously approved by your Department on October 18, 2006 and May 18, 2009, respectively. Previously filed optional riders and amendatory endorsements may be issued with this certificate to provide additional benefits or meet regulatory requirements. These forms are basically identical except that one is a calendar year deductible and one is a policy year deductible.

The certificate is an association group accidental bodily injury that provides benefits for accidental bodily injury expenses on an inpatient and outpatient basis, subject to the provisions and limitations set forth therein. Benefits are provided for both participating and non-participating providers.

Please note that throughout the certificate, references to *{Option 1}* and *{Option 2}* denote two different options that the policyholder can choose from with regard to a specific subject. The terms *{Option 1}* and *{Option 2}* are shown for clarification only and will not show in the issued certificate. Only the bracketed language following *{Option 1}* or *{Option 2}* will show in the actual issued certificate, depending on which option is chosen by the policyholder.

This product will be issued to any associations previously filed in your state or that will be filed in the future. The group policy will be issued in Arizona. A certificate of insurance will be issued to members of the association to evidence coverage under the group policy. Please be advised this product is not employer/employee based, and we are offering it to individuals. The product is fully underwritten on an individual basis. Please note, we realize this form is exempt from filing in your state, however we require your confirmation as the situs of the association to which the group policy will be issued.

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

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

Enclosed, please find the applicable transmittals, certifications and filing fees, if any.

Your consideration of this filing is appreciated. Should you have any questions, please contact me as listed below.

Sincerely,

A handwritten signature in black ink that reads "Shannon Morgan Cubby". The signature is written in a cursive, flowing style.

Shannon Morgan Cubby
Product Analyst
Product Development
Tel. 800-387-9027 ext 748
cubbys@ushealthgroup.com