

SERFF Tracking Number: CEUL-127130886 State: Arkansas  
 Filing Company: Family Life Insurance Company State Tracking Number: 48523  
 Company Tracking Number:  
 TOI: H14I Individual Health - Hospital Indemnity Sub-TOI: H14I.000 Health - Hospital Indemnity  
 Product Name: Secure Care  
 Project Name/Number: /

## Filing at a Glance

Company: Family Life Insurance Company

Product Name: Secure Care

SERFF Tr Num: CEUL-127130886 State: Arkansas

TOI: H14I Individual Health - Hospital Indemnity SERFF Status: Closed-Approved-  
 Closed State Tr Num: 48523

Sub-TOI: H14I.000 Health - Hospital Indemnity Co Tr Num: State Status: Approved-Closed

Filing Type: Form/Rate

Reviewer(s): Rosalind Minor

Authors: Leigh Floyd, Rebecca  
 Podowski

Disposition Date: 04/25/2011

Date Submitted: 04/18/2011

Disposition Status: Approved-  
 Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name:

Status of Filing in Domicile: Authorized

Project Number:

Date Approved in Domicile: 02/22/2011

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type:

Overall Rate Impact:

Filing Status Changed: 04/25/2011

State Status Changed: 04/25/2011

Deemer Date:

Created By: Rebecca Podowski

Submitted By: Rebecca Podowski

Corresponding Filing Tracking Number:

Filing Description:

We are requesting the Department's review and approval of our Hospital Confinement and Surgical Fixed Indemnity policy. These forms provide indemnity benefits for hospital confinement and specified medical and surgical events. These fixed indemnity benefits are paid in stated amounts without regard to the cost of services rendered and do not provide expense reimbursement for charges based on the health care providers statement.

There are five riders to be marketed with this policy. The First Occurrence Benefit rider pays a specified benefit, as specified on the Policy Schedule, when an insured experiences a specific health event listed in the rider for the first time. The Intensive Care Unit rider pays a daily benefit amount, as specified on the Policy Schedule, when an insured is confined in a hospital's ICU or Cardiac Care Unit. The Internal Cancer Rider pays a set monthly benefit, as specified on

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the Policy Schedule, when an insured is diagnosed with internal cancer. The Outpatient Sickness and Injury Rider pays the scheduled benefit amount, as specified on the Policy Schedule, when an insured receives services in an outpatient care setting. The Prescription Drug Rider pays scheduled benefits when an insured fills a prescription drug order through an outpatient pharmacy.

This product complies with the standards set forth by the NAIC.

Agents licensed in your state will sell this plan to individual consumers. The application and outline of coverage will be used to market the policy.

We appreciate the Department's time and consideration in the review of this filing.

## Company and Contact

### Filing Contact Information

Rebecca Podowski, rpodowsk@manhattanlife.com  
 10700 Northwest Freeway 713-529-0045 [Phone]  
 Houston, TX 77092

### Filing Company Information

Family Life Insurance Company CoCode: 63053 State of Domicile: Texas  
 10700 Northwest Freeway Group Code: 1117 Company Type:  
 Houston, TX 77092 Group Name: Manhattan Insurance State ID Number:  
 Group  
 (800) 877-7705 ext. [Phone] FEIN Number: 91-0550883  
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## Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Family Life Insurance Company	\$100.00	04/18/2011	46700259
Family Life Insurance Company	\$350.00	04/19/2011	46733023

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	04/25/2011	04/25/2011

### Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	04/21/2011	04/21/2011	Rebecca Podowski	04/25/2011	04/25/2011
Pending Industry Response	Rosalind Minor	04/20/2011	04/20/2011	Rebecca Podowski	04/21/2011	04/21/2011
Pending Industry Response	Rosalind Minor	04/19/2011	04/19/2011	Rebecca Podowski	04/19/2011	04/19/2011

### Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Objection letter on handicapped dependents.	Note To Filer	Rosalind Minor	04/22/2011	04/22/2011
Second objection	Note To Reviewer	Rebecca Podowski	04/21/2011	04/21/2011

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 Product Name: Secure Care  
 Project Name/Number: /

## Disposition

Disposition Date: 04/25/2011

Implementation Date:

Status: Approved-Closed

Comment:

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
Family Life Insurance Company	%	%	\$		\$	%	%

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Variability	Approved-Closed	Yes
Form (revised)	Secure Care policy	Approved-Closed	Yes
Form	Secure Care policy	Replaced	Yes
Form	Secure Care policy	Replaced	Yes
Form	Policy Schedule	Approved-Closed	Yes
Form	Surgical Schedule (1 unit)	Approved-Closed	Yes
Form	Surgical Schedule (1.5 unit)	Approved-Closed	Yes
Form	Internal Cancer Rider	Approved-Closed	Yes
Form	Prescription Rider	Approved-Closed	Yes
Form	First Occurrence Benefit Rider	Approved-Closed	Yes
Form	ICU Rider	Approved-Closed	Yes
Form	Outpatient Rider	Approved-Closed	Yes
Rate	FHCS11 Rate	Approved-Closed	Yes

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Product Name: Secure Care  
Project Name/Number: /

## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 04/21/2011  
Submitted Date 04/21/2011  
Respond By Date

Dear Rebecca Podowski,

This will acknowledge receipt of the captioned filing.

### Objection 1

- Secure Care policy, FHCS11 (Form)

Comment:

with respect to handicapped dependents, the contract states that you have 31 days to send in proof of incapacity. Please remove the 31 day period. This is not in compliance with ACA 23-86-108(4) and Bulletin 14-81.

### Objection 2

- Secure Care policy, FHCS11 (Form)

Comment:

Under Covered Dependent, the handicapped dependent language is not in compliance with ACA 23-86-108(4) and Bulletin 14-81. Please remove the language on "31 day period" to send in proof.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

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 Product Name: Secure Care  
 Project Name/Number: /

## Response Letter

Response Letter Status Submitted to State  
 Response Letter Date 04/25/2011  
 Submitted Date 04/25/2011

Dear Rosalind Minor,

### Comments:

Thank you for your patience and your objection clarification. The objection has been addressed below.

### Response 1

Comments: I have removed all time period references from this provision.

### Related Objection 1

Applies To:

- Secure Care policy, FHCS11 (Form)

Comment:

with respect to handicapped dependents, the contract states that you have 31 days to send in proof of incapacity. Please remove the 31 day period. This is not in compliance with ACA 23-86-108(4) and Bulletin 14-81.

### Changed Items:

No Supporting Documents changed.

### Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Secure Care policy	FHCS11		Policy/Contract/Fraternal Certificate	Initial			FHCS11-AR REDLINE D pt 2.pdf,FHC S11-AR

SERFF Tracking Number: CEUL-127130886 State: Arkansas  
 Filing Company: Family Life Insurance Company State Tracking Number: 48523  
 Company Tracking Number:  
 TOI: H14I Individual Health - Hospital Indemnity Sub-TOI: H14I.000 Health - Hospital Indemnity  
 Product Name: Secure Care  
 Project Name/Number: /

0411.pdf

**Previous Version**

Secure Care policy	FHCS11	Policy/Contract/Fraternal Initial Certificate	FHCS11-AR.pdf, FHCS11-AR REDLINE D.pdf
Secure Care policy	FHCS11	Policy/Contract/Fraternal Initial Certificate	FHCS11.pdf

No Rate/Rule Schedule items changed.

**Response 2**

Comments: N/A

**Related Objection 1**

Applies To:

- Secure Care policy, FHCS11 (Form)

Comment:

Under Covered Dependent, the handicapped dependent language is not in compliance with ACA 23-86-108(4) and Bulletin 14-81. Please remove the language on "31 day period" to send in proof.

**Changed Items:**

No Supporting Documents changed.

**Form Schedule Item Changes**

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Secure Care policy	FHCS11		Policy/Contract/Fraternal Initial Certificate				FHCS11-AR REDLINE D pt

SERFF Tracking Number: CEUL-127130886 State: Arkansas  
Filing Company: Family Life Insurance Company State Tracking Number: 48523  
Company Tracking Number:  
TOI: H14I Individual Health - Hospital Indemnity Sub-TOI: H14I.000 Health - Hospital Indemnity  
Product Name: Secure Care  
Project Name/Number: /

2.pdf,FHC  
S11-AR  
0411.pdf

**Previous Version**

Secure Care policy FHCS11 Policy/Contract/Fraternal Initial Certificate

FHCS11-  
AR.pdf,FH  
CS11-AR  
REDLINE  
D.pdf

Secure Care policy FHCS11 Policy/Contract/Fraternal Initial Certificate

FHCS11.p  
df

No Rate/Rule Schedule items changed.

Please let me know if you require any additional changes.

Sincerely,  
Leigh Floyd, Rebecca Podowski

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Company Tracking Number:  
TOI: H14I Individual Health - Hospital Indemnity Sub-TOI: H14I.000 Health - Hospital Indemnity  
Product Name: Secure Care  
Project Name/Number: /

## Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 04/20/2011

Submitted Date 04/20/2011

Respond By Date

Dear Rebecca Podowski,

This will acknowledge receipt of the captioned filing.

Objection 1

- Secure Care policy, FHCS11 (Form)

Comment:

With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-85-131(b) and Bulletin 14-81.

Objection 2

- Secure Care policy, FHCS11 (Form)

Comment:

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

Objection 3

- Secure Care policy, FHCS11 (Form)

Comment:

With respect to coverage for minors for whom the insured has filed a petition to adopt, please refer to the 60-day period outlined under ACA 23-79-137.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

SERFF Tracking Number: CEUL-127130886 State: Arkansas  
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 TOI: H14I Individual Health - Hospital Indemnity Sub-TOI: H14I.000 Health - Hospital Indemnity  
 Product Name: Secure Care  
 Project Name/Number: /

## Response Letter

Response Letter Status Submitted to State  
 Response Letter Date 04/21/2011  
 Submitted Date 04/21/2011

Dear Rosalind Minor,

### Comments:

Thank you for your prompt review of our product. Your objections have been addressed below.

### Response 1

Comments: We have revised our provision to comply.

### Related Objection 1

Applies To:

- Secure Care policy, FHCS11 (Form)

Comment:

With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-85-131(b) and Bulletin 14-81.

### Changed Items:

No Supporting Documents changed.

### Form Schedule Item Changes

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Secure Care policy	FHCS11		Policy/Contract/Fraternal Certificate	Initial			FHCS11-AR.pdf, FHCS11-AR REDLINE D.pdf

### Previous Version

SERFF Tracking Number: CEUL-127130886 State: Arkansas  
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 Company Tracking Number:  
 TOI: H14I Individual Health - Hospital Indemnity Sub-TOI: H14I.000 Health - Hospital Indemnity  
 Product Name: Secure Care  
 Project Name/Number: /  
 Secure Care policy FHCS11 Policy/Contract/Fraternal Initial Certificate FHCS11.pdf

No Rate/Rule Schedule items changed.

**Response 2**

Comments: We have revised the coverage date for newborns.

**Related Objection 1**

Applies To:

- Secure Care policy, FHCS11 (Form)

Comment:

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

**Changed Items:**

No Supporting Documents changed.

**Form Schedule Item Changes**

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Secure Care policy	FHCS11		Policy/Contract/Fraternal Initial Certificate				FHCS11-AR.pdf, FHCS11-AR REDLINE D.pdf
<b>Previous Version</b>							
Secure Care policy	FHCS11		Policy/Contract/Fraternal Initial Certificate				FHCS11.pdf

No Rate/Rule Schedule items changed.

SERFF Tracking Number: CEUL-127130886 State: Arkansas  
 Filing Company: Family Life Insurance Company State Tracking Number: 48523  
 Company Tracking Number:  
 TOI: H141 Individual Health - Hospital Indemnity Sub-TOI: H141.000 Health - Hospital Indemnity  
 Product Name: Secure Care  
 Project Name/Number: /

**Response 3**

Comments: We have revised the coverage date for adopted minors.

**Related Objection 1**

Applies To:

- Secure Care policy, FHCS11 (Form)

Comment:

With respect to coverage for minors for whom the insured has filed a petition to adopt, please refer to the 60-day period outlined under ACA 23-79-137.

**Changed Items:**

No Supporting Documents changed.

**Form Schedule Item Changes**

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Secure Care policy	FHCS11		Policy/Contract/Fraternal Certificate	Initial			FHCS11-AR.pdf, FHCS11-AR REDLINE D.pdf
<b>Previous Version</b>							
Secure Care policy	FHCS11		Policy/Contract/Fraternal Certificate	Initial			FHCS11.pdf

No Rate/Rule Schedule items changed.

Thank you for your patience as we revised our product. Please let me know if you have any additional questions or concerns.

Sincerely,  
 Leigh Floyd, Rebecca Podowski

SERFF Tracking Number: CEUL-127130886 State: Arkansas  
Filing Company: Family Life Insurance Company State Tracking Number: 48523  
Company Tracking Number:  
TOI: H14I Individual Health - Hospital Indemnity Sub-TOI: H14I.000 Health - Hospital Indemnity  
Product Name: Secure Care  
Project Name/Number: /

## Objection Letter

Objection Letter Status Pending Industry Response  
Objection Letter Date 04/19/2011  
Submitted Date 04/19/2011  
Respond By Date

Dear Rebecca Podowski,

This will acknowledge receipt of the captioned filing.

### Objection 1

- Secure Care policy, FHCS11 (Form)
- Policy Schedule, FHCS11-PS (Form)
- Surgical Schedule (1 unit), FHCS11-SS (Form)
- Surgical Schedule (1.5 unit), FHCS11-SS-2 (Form)
- Internal Cancer Rider, FHCS11-CX (Form)
- Prescription Rider, FHCS11-RX (Form)
- First Occurrence Benefit Rider, FHCS11-FOB (Form)
- ICU Rider, FHCS11-ICU (Form)
- Outpatient Rider, FHCS11-OPSI (Form)

### Comment:

Our filing fees under Rule and Regulation 57 have been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is \$50.00 per form for a total of \$450.00. Please submit an additional \$350.00 for this submission.

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

Please feel free to contact me if you have questions.

Sincerely,  
Rosalind Minor

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TOI: H14I Individual Health - Hospital Indemnity Sub-TOI: H14I.000 Health - Hospital Indemnity  
Product Name: Secure Care  
Project Name/Number: /

## Response Letter

Response Letter Status Submitted to State  
Response Letter Date 04/19/2011  
Submitted Date 04/19/2011

Dear Rosalind Minor,

### Comments:

Thank you for your response to our filing. Your objection has been addressed below.

### Response 1

Comments: Additional fees have been submitted.

### Related Objection 1

Applies To:

- Secure Care policy, FHCS11 (Form)
- Policy Schedule, FHCS11-PS (Form)
- Surgical Schedule (1 unit), FHCS11-SS (Form)
- Surgical Schedule (1.5 unit), FHCS11-SS-2 (Form)
- Internal Cancer Rider, FHCS11-CX (Form)
- Prescription Rider, FHCS11-RX (Form)
- First Occurrence Benefit Rider, FHCS11-FOB (Form)
- ICU Rider, FHCS11-ICU (Form)
- Outpatient Rider, FHCS11-OPSI (Form)

Comment:

Our filing fees under Rule and Regulation 57 have been updated. Please review the General Instructions for ArkansasLH or Rule and Regulation 57.

The fee for this submission is \$50.00 per form for a total of \$450.00. Please submit an additional \$350.00 for this submission.

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

### Changed Items:

*SERFF Tracking Number:* CEUL-127130886      *State:* Arkansas  
*Filing Company:* Family Life Insurance Company      *State Tracking Number:* 48523  
*Company Tracking Number:*  
*TOI:* H14I Individual Health - Hospital Indemnity      *Sub-TOI:* H14I.000 Health - Hospital Indemnity  
*Product Name:* Secure Care  
*Project Name/Number:* /

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Sincerely,  
Leigh Floyd, Rebecca Podowski

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Product Name: Secure Care  
Project Name/Number: /

**Note To Filer**

**Created By:**

Rosalind Minor on 04/22/2011 09:03 AM

**Last Edited By:**

Rosalind Minor

**Submitted On:**

04/25/2011 09:09 AM

**Subject:**

Objection letter on handicapped dependents.

**Comments:**

By substituting "immediately" for 31 days it is still setting a time limit for providing proof of notice. ACA 23-85-131(b) states that when the dependent reaches the age limit where the dependent would normally be terminated because he has reached a certain age, the coverage for the handicapped shall continue so long as the contract remains in force and so long as the dependent remains in such condition. As further outlined under our Bulletin 14-81 (A), you may request the insured to submit notice of such incapacity, but you cannot establish a time limit for providing this notice.

With respect to your questions on the second objection, I was having computer problems and should have only sent that one objection.

If you have any further questions, you may call me at (501)371-2767.

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Product Name: Secure Care  
Project Name/Number: /

**Note To Reviewer**

**Created By:**

Rebecca Podowski on 04/21/2011 12:52 PM

**Last Edited By:**

Rosalind Minor

**Submitted On:**

04/25/2011 09:09 AM

**Subject:**

Second objection

**Comments:**

May we use the term "immediately" to replace the stricken "31 day period"? Also, are both of the objections referring to the definition of covered dependent?

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 Product Name: Secure Care  
 Project Name/Number: /

## Form Schedule

### Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 04/25/2011	FHCS11	Policy/Cont	Secure Care policy ract/Fratern al Certificate	Initial			FHCS11-AR REDLINED pt 2.pdf FHCS11-AR 0411.pdf
Approved-Closed 04/25/2011	FHCS11-PS	Schedule Pages	Policy Schedule	Initial			FHCS11- PS.pdf
Approved-Closed 04/25/2011	FHCS11-SS	Schedule Pages	Surgical Schedule (1 unit)	Initial			FHCS11- SS.pdf
Approved-Closed 04/25/2011	FHCS11-SS-2	Schedule Pages	Surgical Schedule (1.5 unit)	Initial			FHCS11 SS - 2.pdf
Approved-Closed 04/25/2011	FHCS11-CX	Policy/Cont	Internal Cancer Rider ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial			FHCS11- CX.pdf
Approved-Closed 04/25/2011	FHCS11-RX	Policy/Cont	Prescription Rider ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme	Initial			FHCS11- RX.pdf

<i>SERFF Tracking Number:</i>	<i>CEUL-127130886</i>	<i>State:</i>	<i>Arkansas</i>
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<i>Product Name:</i>	<i>Secure Care</i>		
<i>Project Name/Number:</i>	<i>/</i>		
	<i>nt or Rider</i>		
Approved- FHCS11- Closed FOB 04/25/2011	Policy/Cont First Occurrence ract/Fratern Benefit Rider al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	FHCS11- FOB.pdf
Approved- FHCS11- Closed ICU 04/25/2011	Policy/Cont ICU Rider ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	FHCS11- ICU.pdf
Approved- FHCS11- Closed OPSI 04/25/2011	Policy/Cont Outpatient Rider ract/Fratern al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	FHCS11- OPSI.pdf

**FAMILY LIFE INSURANCE COMPANY**

*Home Office: [Houston, TX]*

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

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**HOSPITAL CONFINEMENT AND OTHER FIXED INDEMNITY INSURANCE POLICY**

Limited Hospital Confinement and Other Fixed Indemnity Benefits

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

The insurance described in this Policy is effective on the date shown in the Schedule of Benefits only if You are eligible for the insurance, become insured, subject to the terms, limits and conditions of this Policy. This Policy is evidence of Your coverage.

**PLEASE READ YOUR POLICY AND SCHEDULE OF BENEFITS CAREFULLY AND BECOME FAMILIAR WITH ITS TERMS, LIMITS, EXCLUSIONS AND BENEFIT PROVISIONS.**

**CONDITIONALLY RENEWABLE:** You have the right to renew this Policy until you attain age 65 if You pay the correct premium when due or within the Grace Period. We retain the right to change the premium rates on this Policy. See the Premium Provisions section of this Policy. Premiums are based on Your attained age and will change on your Policy anniversary date. (Your Policy anniversary date is the same month and day as the Policy Effective Date for each succeeding year this Policy remains in force). The premium may change if a new table of rates is applicable to the Policy. The change in the table of rates will apply to all Covered Persons in the same class on the date of the change. Class is defined as attained age and underwriting class.

**RIGHT TO EXAMINE POLICY FOR 10 DAYS**

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

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

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

[   ]

[Mary Lou Rainey  
Secretary]

[Dan George  
President]

Executed by Family Life Insurance Company on the Effective Date.

THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES

## TABLE OF CONTENTS

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Claim Provisions	13
Premium Provisions	15
Other Provisions	16
Schedule of Benefits	Attached
Surgical Schedule	Attached

## DEFINITIONS

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

### **Accident or Accidental:**

An unforeseen and unplanned event that occurs:

1. Unintentionally and unexpectedly;
2. independent of disease, bodily infirmity or any other cause; and
3. Resulting in injury to an Insured Person that is not due to any fault or misconduct on the part of the injured Insured Person.

Accident shall include pregnancy following an act of rape of a Covered Person that was reported to the Police within seven days following its occurrence. The seven day requirement for notification to the police shall be extended to 180 days in the case of an act of rape or incest of a female under 13 years of age.

### **Calendar Year:**

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

### **Complications of Pregnancy:**

Complications of Pregnancy include the following:

1. Conditions requiring Hospital confinement (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy including but not limited to, acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, Health Care Practitioner-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting distinct complication of pregnancy; and
2. Non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

### **Confinement Period:**

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

### **Cosmetic Services:**

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

### **Covered Dependent:**

A Covered Dependent is:

1. Your lawful spouse; or
2. Your naturally born child, legally adopted child, a child in which You are a party to a suit in which adoption is sought, a stepchild, a grandchild dependent upon You for federal income tax purposes at the time of the child's application for coverage, a child for whom You are the legal guardian, or a child for whom You are required to provide medical support by court or administrative order:
  - a. Who is unmarried; and
  - b. Who is under age 26.
3. Enrolled for coverage under the policy and eligible to receive benefits.

If Your unmarried child is age 26 or older, the child will be considered a Covered Dependent if You give Us proof that the child is not capable of self-sustaining employment because of mental incapacity or physical handicap and is chiefly dependent on You for support and maintenance. You must give Us proof that the child meets these requirements at the same time that You first enroll for coverage under this Policy ~~or within 31 days~~ after the child reaches the normal age for termination. Additional proof may be requested periodically after the date the child reaches the normal age for termination.

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

1. Attains age 26 (except for a mentally incapacitated or physically handicapped child as described above; or

2. Marries; or
3. Is over age 26 and is capable of self-sustaining employment because he or she is no longer mentally incapacitated or physically handicapped.

**Covered Event:**

A medical event for which this Policy and any attached Riders provides a Scheduled Benefit and that meets all of the following requirements:

1. The treatment, services or supplies provided in connection with the event are provided by a Health Care Practitioner, facility or supplier.
2. It is incurred by a Covered Person while coverage is in force under this Policy and any attached Riders as the result of a Sickness or an Injury.
3. It is incurred for events shown in the Benefits Section, any attached Riders and on the Schedule of Benefits.
4. The occurrence includes treatment, services or supplies which are Medically Necessary.

**Covered Person:**

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

**Custodial Care:**

Care, regardless of setting, that is primarily for the purpose of meeting the personal needs of the patient, including but not limited to:

1. assisting in the activities of daily living;
2. providing help in walking or getting in or out of bed;
3. assisting with bathing, dressing, feeding, homemaking, or preparation of special diets;
4. supervision of medication;
5. providing companionship; or
6. ensuring safety.

**Durable Medical Equipment:**

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

**Effective Date:**

The date coverage under this Policy begins for a Covered Person. The Covered Person's coverage begins at 12:01 a.m. local time, at Your residence. The effective date of the policy will be the date recorded by Us at our home office. It is not the date the application is signed. The policy will become effective when all underwriting requirements have been satisfied and required premium paid. The Effective Date for Covered Dependents added after the Policy Effective Date will be determined by Us.

**Emergency Room:**

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

**Emergency Treatment:**

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

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

**Experimental or Investigational Services:**

Treatment, services or supplies which are:

1. Not given to be of benefit for diagnosis or treatment of a Sickness or an Injury; or
2. Not generally used or recognized by the medical community as safe, effective and appropriate for diagnosis or treatment of a Sickness or an Injury; or
3. In the research or investigational stage, provided or performed in a special setting for research purposes or under a controlled environment or clinical protocol; or
4. Obsolete or ineffective for the treatment of a Sickness or an Injury; or

**Health Care Practitioner:**

A person licensed by the state or other geographic area in which the treatment or services are rendered to treat the kind of Sickness or Injury for which a claim is made. The Health Care Practitioner must be practicing within the limits of his or her license and in the geographic area in which he or she is licensed. The term Health Care Practitioner does not include any Covered Person or any Covered Person's Immediate Family Member. Benefits will be paid only if the services provided are covered under this Policy and any attached Riders.

**Home Health Care:**

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

**Hospice:**

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

**Hospital:**

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

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

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

**Immediate Family Member:**

An Immediate Family Member is:

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

**Injury:**

Physical damage to the structure or function of the body caused by an outside force, which may be physical or chemical, as a result of an Accident.

**Inpatient:**

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

**Maximum Benefit:**

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

**Maximum Lifetime Benefit:**

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

**Medical Supply Provider:**

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

**Medically Necessary or Medical Necessity:**

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

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

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

**Medicare:**

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

**Mental/Nervous Disorders and Substance Abuse:**

Any disorder classified as such in the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association.

**Outpatient:**

Treatments, services and/or supplies rendered on anything other than an Inpatient basis.

**Personal Medical Equipment:**

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

**Policy:**

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

**Policyholder:**

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

**Pre-Existing Condition:**

A condition and related complications:

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

**Rehabilitation Services:**

Specialized treatment received on an Inpatient basis for a Sickness or an Injury that meets all of the following requirements:

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

**Retail Health Clinic:**

A facility that meets all of the following requirements:

1. Is licensed by the state in accordance with the laws for the specific services being provided in that facility;
2. Is staffed by a Health Care Practitioner in accordance with the laws of that state;
3. Is attached to or is part of a store or retail facility;

4. Is separate from a Hospital, Emergency Room, acute medical rehabilitation facility, free-standing facility, Skilled Nursing Facility, subacute rehabilitation facility, or Urgent Care Facility, and any Health Care Practitioner's office located therein even when services are performed after normal business hours;
5. Provides general medical treatment of services for a Sickness or Injury, or provides preventive medical services;
6. Does not provide room and board or overnight services.

**Scheduled Benefit:**

The fixed benefit amount payable upon occurrence of a Covered Event under the terms of this Policy and any attached Riders. The Scheduled Benefit for a Covered Event is shown on the Schedule of Benefits.

**Sickness:**

A disease or an illness of a Covered Person that first manifested itself after the Covered Person's Effective Date under this Policy and any attached Riders and while coverage is in force. Sickness includes Complications of Pregnancy, but not the pregnancy itself.

**Skilled Nursing Facility:**

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

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

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

**Urgent Care:**

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

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

**Urgent Care Facility:**

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

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

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

Family Life Insurance Company.

**You, Your:**

The person listed on the Schedule of Benefits as the Policyholder.

**EFFECTIVE DATE AND TERMINATION DATE**

**Eligibility and Effective Date of Policyowner:**

A person who is eligible may elect to be covered under this Policy by completing the application process and submitting any required premium. You must be a resident of the state where this Policy is issued. Evidence of insurability according to Our underwriting and eligibility criteria must also be provided. Your coverage will take effect on Your Effective Date as shown on the Schedule of Benefits.

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

### Eligibility and Effective Date of Dependents:

The following information explains how to apply for coverage for additional dependants:

- **Adding a Newborn Child:** A newborn child can be added on the date the child was born. You must send Us written notice of the birth of the child and We must receive any required additional premium within 90 days of birth. The Effective Date of coverage will be on the date the child is born. If these requirements are not met, Your newborn child will be covered for Sickness or Injury, including Covered Events related to the necessary care and treatment of medically diagnosed congenital defects only for the first 90 days from birth.
- **Adding an Adopted Child:** A newly adopted child can be added on the date the child is adopted or You become a party in a suit for adoption, whichever is earlier. You must send Us written notice of the adoption or suit for adoption of the child and We must receive any required additional premium within 60 days of the adoption or suit for adoption of the child, whichever is earlier. The Effective Date of coverage will be on the earlier of the date the child is adopted or You become a party in a suit for adoption. If these requirements are not met, Your newly adopted child will be covered for Sickness or Injury only for the first 60 days from the date of adoption or suit for adoption. A child is no longer considered adopted if, prior to legal adoption, You relinquish legal obligation for support of the child and the child is removed from placement or when You are no longer party to a suit for adoption of the child.
- **Adding a Child for Whom a Court Order Requires You to Provide Insurance:** A child for whom a court order requires You or your Covered Dependent spouse to provide this insurance will be covered for the first 31 days from the time We receive a medical support order or notice of a medical support order. Any required additional premium must be received within 31 days from Our notice or receipt of the court order. If these requirements are not met, the child will only be covered for the first 31 days from the date We receive the medical support order or notice of the medical support order.
- **Adding Any other Dependent:** To add any other dependents, an application must be completed and sent to Us along with any required premium. Evidence of insurability must also be provided. The Effective Date of coverage will be on the Effective Date for that Covered Person shown on the Schedule of Benefits.

### Termination Date:

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

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

1. The end of the month You attain age 65. Covered Dependents may apply for coverage without evidence of insurability. The request for coverage must be made within 30 days of You attaining age 65.
2. The date We receive a request in writing to terminate this Policy on or on a later date that is requested by You for termination;
3. The date this Policy lapses for nonpayment of premium subject to the Grace Period provision in the Premium Provision section;
4. The date all policies the same as this one are non-renewed in the state in which this Policy was issued or the state in which You presently reside;
5. The date We terminate or nonrenew all individual market hospital-indemnity insurance policies in the state in which this Policy was issue or the state in which You presently reside. We will give You advance notice, as required by state law, of the termination of Your coverage;
6. The date You move to a state where We do not provide insurance under a Policy with the same Policy design as this Policy, We reserve the right to terminate this coverage; or

Coverage of a Covered Dependent will terminate on:

1. The date We receive a request in writing to terminate coverage for a Covered Dependent or on a later date that is requested by You for termination of a Covered Dependent;
2. The date a Covered Dependent no longer meets the Covered Dependent definition in this Policy. We will pay benefits to the end of the time for which We have accepted premiums.

If coverage terminates due to Your death, your spouse will become the named Policyholder provided your spouse is a Covered Person under this Policy on the date of death.

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

**Covered Dependent Conversion:**

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

1. The Covered Dependent's insurance terminated due to a valid decree of divorce between You and the Covered Dependent. The Covered Dependent will be issued a Policy, which We are currently issuing, that most nearly approximates the coverage of this Policy, without evidence of insurability and with the same effective date as the Covered Dependent's coverage under this Policy; or
2. The Covered Dependent's insurance terminates due to Your death, or You attain age 65; or
3. A Covered Dependent child's insurance terminates because the child no longer meets the eligibility requirements for a Covered Dependent.

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

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

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

## HOSPITAL CONFINEMENT AND OTHER FIXED INDEMNITY BENEFITS

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

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

We will pay the corresponding Scheduled Benefit amount shown on the Schedule of Benefits when a Covered Event described below is rendered to a Covered Person and is Medically Necessary.

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

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

Benefits are limited to the Calendar Year Maximum Daily Hospital Confinement Benefit shown on the Schedule of Benefits.

### **Hospital Admission Benefits:**

We will pay the corresponding Scheduled Benefit amount when a Covered Person is confined for the first time as a resident Inpatient during the Calendar Year. A maximum of one benefit per Covered Person per year is payable. Confinement as a resident Inpatient means assigned to a Hospital bed for an overnight stay for Medically Necessary reasons resulting from Injury or Sickness on the advice of a Health Care Practitioner.

### **Emergency Room/Urgent Care Facility Visit Benefits:**

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

Benefits are limited to the Calendar Year Maximum Emergency Room/Urgent Care Facility Benefit shown on the Schedule of Benefits.

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

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

### **Anesthesia Benefits:**

We will pay an Anesthesia Benefit equal to 20% of the surgical benefit amount shown in the Surgical Schedule when a Covered Person is administered anesthesia as part of a surgery that is a Covered Event. Benefits are limited to the Calendar Year Maximum Benefit shown on the Schedule of Benefits.

### **Surgical Services Benefits:**

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

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

**Assistant Surgeon Benefit:**

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

**PRE-EXISTING CONDITIONS LIMITATION****Pre-Existing Conditions Limitation:**

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

**EXCLUSIONS**

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

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

- weight reduction is Medically Necessary or appropriate or regardless of potential benefits for co-morbid conditions, weight reduction or weight control surgery, treatment or programs, any type of gastric bypass surgery, suction lipectomy, physical fitness programs, exercise equipment or exercise therapy, including health club membership visits or services; nutritional counseling.
12. Organ, tissue or cellular material donation by a Covered Person, including administrative visits for registry, computer search for donor matches, preliminary donor typing, donor counseling, donor identification and donor activation.
  13. Chemical peels, reconstructive or plastic surgery that does not alleviate a functional impairment and other confinement or treatment visits that are primarily for Cosmetic Services as determined by Us.
  14. Capsular contraction, augmentation or reduction mammoplasty, except for all stages and revisions of reconstruction of the breast following a Medically Necessary mastectomy for treatment of cancer, including reconstruction of the other breast to produce a symmetrical appearance and treatment of lymphedemas.
  15. Removal or replacement of a prosthesis, Durable Medical Equipment or Personal Medical Equipment, except for internal breast prostheses following a Medically Necessary mastectomy for treatment of cancer and services are received in accordance with the Hospital Confinement and Other Fixed Indemnity Benefits Section.
  16. Prophylactic treatment, services or surgery including, but not limited to, prophylactic mastectomy or any other treatment, services or surgery to prevent a disease process from becoming evident in the organ or tissue at a later date.
  17. Treatment, services, and supplies for:
    - a. Home Health Care;
    - b. Hospice Care;
    - c. Skilled Nursing Facility care, Inpatient rehabilitation services;
    - d. Custodial Care, respite care, rest care, supportive care, homemaker services;
    - e. Phone, facsimile, internet or e-mail consultation, compressed digital interactive video, audio or clinical data transmission using computer imaging by way of still-image capture and store forward;
    - f. Treatment, services or supplies that are furnished primarily for the personal comfort or convenience of the Covered Person, Covered Person's family, a Health Care Practitioner or provider;
    - g. Treatment or services provided by a standby Health Care Practitioner; or
    - h. Treatment or services provided by a masseur, masseuse or massage therapist, massage therapy, a rolfer.
  18. Treatment, services, and supplies for growth hormone therapy, including growth hormone medication and its derivatives or other drugs used to stimulate, promote or delay growth or to delay puberty to allow for increased growth.
  19. Treatment, services and supplies related to the following conditions, regardless of underlying causes: sex transformation, gender dysphoric disorder, gender reassignment, and treatment of sexual function, dysfunction or inadequacy, treatment to enhance, restore or improve sexual energy, performance or desire.
  20. Treatment, services and supplies related to: maternity, pregnancy (except Complications of Pregnancy), routine well newborn care at birth including nursery care, abortion.
  21. Any prescription drugs whether purchased, dispensed, or received from or by a physician, pharmacy, hospital, emergency room or any other medical facility, including contraceptive drugs or devices.
  22. Treatment for or treatment use of:
    - a. Genetic testing or counseling, genetic services and related procedures for screening purposes including, but not limited to, amniocentesis and chronic villi testing;
    - b. Services, drugs or medicines used to treat males or females for an infertility diagnosis regardless of intended use including, but not limited to: artificial insemination, in vitro fertilization, reversal of reproductive sterilization, any treatment to promote conception;
    - c. Sterilization;
    - d. Cryopreservation of sperm or eggs;
    - e. Surrogate pregnancy;
    - f. Fetal surgery, treatment or services;
    - g. Umbilical cord stem cell or other blood component harvest and storage in the absence of a Sickness or an Injury; or
    - h. Circumcision;
  23. Spinal and other adjustments, manipulations, subluxation treatment and/or services.
  24. Treatment for: behavior modification or behavioral (conduct) problems; learning disabilities, developmental delays, attention deficit disorders, hyperactivity, educational testing, training or materials, memory improvement, cognitive enhancement or training, vocational or work hardening programs, transitional living.
  25. Treatment for or through use of:
    - a. Non-medical items, self-care or self-help programs;
    - b. Aroma therapy;

- c. Meditation or relaxation therapy;
  - d. Naturopathic medicine;
  - e. Treatment of hyperhidrosis (excessive sweating);
  - f. Acupuncture, biofeedback, neurotherapy, electrical stimulation;
  - g. Inpatient treatment of chronic pain disorders;
  - h. Treatment of spider veins;
  - i. Family or marriage counseling;
  - j. Applied behavior therapy treatment for autistic spectrum disorders;
  - k. Smoking deterrence or cessation;
  - l. Snoring or sleep disorders;
  - m. Change in skin coloring or pigmentation; or
  - n. Stress Management.
26. A Sickness or Injury resulting from abuse or overdose of any illegal or controlled substance, except when administered in accordance with the advice of the Covered Person's Health Care Practitioner.
  27. Treatment of Sickness or an Injury when a contributing cause of the condition was the Covered Person's voluntary attempt to commit or participation in or commission of a felony, whether or not charged, or as a consequence of the Covered Person being under the influence of any illegal or non-prescribed controlled substance while committing a felony.
  28. Services ordered, directed or performed by a Health Care Practitioner or supplies purchased from a Medical Supply Provider who is a Covered Person, an Immediate Family Member, employer of a Covered Person or a person who ordinarily resides with a Covered Person.
  29. Any amount in excess of the Maximum Lifetime Benefit or any other Maximum Benefit limitation for covered Scheduled Benefits.
  30. Treatment that does not meet the definition of a Covered Event in this Policy including, but not limited to, treatment that is not Medically Necessary.
  31. Treatment, services and supplies for Experimental or Investigational Services.
  32. Treatment incurred outside of the United States.
  33. Sickness or Injury caused or aggravated by suicide, attempted suicide or self-inflicted Sickness or Injury.

## **CLAIM PROVISIONS**

### **Notice of Claim:**

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

### **Claim Forms:**

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

### **Proof of Loss:**

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

The proof of loss must include all of the following:

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

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

**Assignment Accepted:**

You may assign benefits under this Policy. Benefit payments may be assigned to another person in whole or in part. We will not honor any assignment of this Policy unless it is in writing and filed with Us at Our home office. We are not responsible for the validity of an assignment. If You assign benefits to a provider involved in the Covered Event, the assigned amount paid will not be in excess of the amount shown on the provider's statement submitted at proof of loss. Any Scheduled Benefit amount in excess of the billed amount will be paid directly to You, unless otherwise expressly assigned by You.

**Right to Collect Information:**

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

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

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

**Physical Examination and Autopsy:**

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

**Payment of Benefits:**

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

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

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

**Overpayment:**

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

**Rights of Administration:**

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

**Claims Involving Misrepresentation or Fraud:**

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

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

**Workers' Compensation Not Affected:**

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

**Claim Appeal:**

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

**PREMIUM PROVISIONS****Consideration:**

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

**Premium Payment:**

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

**Changes in Premiums:**

We have the right to change premiums on your Policy anniversary date. If We change premiums, We will do so only:

1. If We change the premiums for all policies of this form and attained age in Your state of issue;
2. If such change is in accordance with the laws and regulations of Your state of issue; and
3. If We give You 30 days notice (or longer if required by the state in which this Policy is issued) before such change becomes effective.

**Refund of Unearned Premiums:**

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

**Grace Period:**

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

**Reinstatement:**

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

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

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

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

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

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

## **OTHER PROVISIONS**

### **Policy Changes:**

This Policy may be changed at any time. We will give You 30 days notice prior to any change. No change in this Policy will be valid unless approved by one of Our executive officers and included with this Policy. No agent or other employee of Our Company has authority to waive or change any Policy provision or waive any other applicable application or application requirements.

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

### **Clerical Error:**

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

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

### **Conformity with State Statutes:**

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

### **Enforcement of Policy Provisions:**

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

### **Entire Contract:**

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

### **Representations Made on Application Form:**

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

### **Extension of Benefits:**

On the date this coverage terminates, We may extend benefits during a Confinement Period that is a result of a Sickness that commenced or an Injury sustained while this Policy was in force. Benefits are payable only for Covered Events relating to the Sickness or Injury that directly caused the confinement. Newly diagnosed conditions and complications of the condition that caused the initial confinement are not eligible for benefits during the Extension of Benefits. The Covered Person must be under the care of a Health Care Practitioner for the Inpatient stay. Medical documentation

verifying the Hospital stay must be sent to Us within 90 days after termination. Benefits are subject to all the terms, limits and conditions in this Policy. Premium payment will not be required during the extension of benefits period.

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

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

**Misstatements:**

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

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

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

**Legal Action:**

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

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

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

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

**FAMILY LIFE INSURANCE COMPANY**

*Home Office: [Houston, TX]*

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

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**HOSPITAL CONFINEMENT AND OTHER FIXED INDEMNITY INSURANCE POLICY**

Limited Hospital Confinement and Other Fixed Indemnity Benefits

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

The insurance described in this Policy is effective on the date shown in the Schedule of Benefits only if You are eligible for the insurance, become insured, subject to the terms, limits and conditions of this Policy. This Policy is evidence of Your coverage.

**PLEASE READ YOUR POLICY AND SCHEDULE OF BENEFITS CAREFULLY AND BECOME FAMILIAR WITH ITS TERMS, LIMITS, EXCLUSIONS AND BENEFIT PROVISIONS.**

**CONDITIONALLY RENEWABLE:** You have the right to renew this Policy until you attain age 65 if You pay the correct premium when due or within the Grace Period. We retain the right to change the premium rates on this Policy. See the Premium Provisions section of this Policy. Premiums are based on Your attained age and will change on your Policy anniversary date. (Your Policy anniversary date is the same month and day as the Policy Effective Date for each succeeding year this Policy remains in force). The premium may change if a new table of rates is applicable to the Policy. The change in the table of rates will apply to all Covered Persons in the same class on the date of the change. Class is defined as attained age and underwriting class.

**RIGHT TO EXAMINE POLICY FOR 10 DAYS**

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

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

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

[   ]

[Mary Lou Rainey  
Secretary]

[Dan George  
President]

Executed by Family Life Insurance Company on the Effective Date.

THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES

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## DEFINITIONS

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

### **Accident or Accidental:**

An unforeseen and unplanned event that occurs:

1. Unintentionally and unexpectedly;
2. independent of disease, bodily infirmity or any other cause; and
3. Resulting in injury to an Insured Person that is not due to any fault or misconduct on the part of the injured Insured Person.

Accident shall include pregnancy following an act of rape of a Covered Person that was reported to the Police within seven days following its occurrence. The seven day requirement for notification to the police shall be extended to 180 days in the case of an act of rape or incest of a female under 13 years of age.

### **Calendar Year:**

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

### **Complications of Pregnancy:**

Complications of Pregnancy include the following:

1. Conditions requiring Hospital confinement (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy including but not limited to, acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, Health Care Practitioner-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting distinct complication of pregnancy; and
2. Non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

### **Confinement Period:**

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

### **Cosmetic Services:**

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

### **Covered Dependent:**

A Covered Dependent is:

1. Your lawful spouse; or
2. Your naturally born child, legally adopted child, a child in which You are a party to a suit in which adoption is sought, a stepchild, a grandchild dependent upon You for federal income tax purposes at the time of the child's application for coverage, a child for whom You are the legal guardian, or a child for whom You are required to provide medical support by court or administrative order:
  - a. Who is unmarried; and
  - b. Who is under age 26.
3. Enrolled for coverage under the policy and eligible to receive benefits.

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

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

1. Attains age 26 (except for a mentally incapacitated or physically handicapped child as described above; or
2. Marries; or

3. Is over age 26 and is capable of self-sustaining employment because he or she is no longer mentally incapacitated or physically handicapped.

**Covered Event:**

A medical event for which this Policy and any attached Riders provides a Scheduled Benefit and that meets all of the following requirements:

1. The treatment, services or supplies provided in connection with the event are provided by a Health Care Practitioner, facility or supplier.
2. It is incurred by a Covered Person while coverage is in force under this Policy and any attached Riders as the result of a Sickness or an Injury.
3. It is incurred for events shown in the Benefits Section, any attached Riders and on the Schedule of Benefits.
4. The occurrence includes treatment, services or supplies which are Medically Necessary.

**Covered Person:**

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

**Custodial Care:**

Care, regardless of setting, that is primarily for the purpose of meeting the personal needs of the patient, including but not limited to:

1. assisting in the activities of daily living;
2. providing help in walking or getting in or out of bed;
3. assisting with bathing, dressing, feeding, homemaking, or preparation of special diets;
4. supervision of medication;
5. providing companionship; or
6. ensuring safety.

**Durable Medical Equipment:**

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

**Effective Date:**

The date coverage under this Policy begins for a Covered Person. The Covered Person's coverage begins at 12:01 a.m. local time, at Your residence. The effective date of the policy will be the date recorded by Us at our home office. It is not the date the application is signed. The policy will become effective when all underwriting requirements have been satisfied and required premium paid. The Effective Date for Covered Dependents added after the Policy Effective Date will be determined by Us.

**Emergency Room:**

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

**Emergency Treatment:**

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

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

**Experimental or Investigational Services:**

Treatment, services or supplies which are:

1. Not given to be of benefit for diagnosis or treatment of a Sickness or an Injury; or
2. Not generally used or recognized by the medical community as safe, effective and appropriate for diagnosis or treatment of a Sickness or an Injury; or
3. In the research or investigational stage, provided or performed in a special setting for research purposes or under a controlled environment or clinical protocol; or
4. Obsolete or ineffective for the treatment of a Sickness or an Injury; or

**Health Care Practitioner:**

A person licensed by the state or other geographic area in which the treatment or services are rendered to treat the kind of Sickness or Injury for which a claim is made. The Health Care Practitioner must be practicing within the limits of his or her license and in the geographic area in which he or she is licensed. The term Health Care Practitioner does not include any Covered Person or any Covered Person's Immediate Family Member. Benefits will be paid only if the services provided are covered under this Policy and any attached Riders.

**Home Health Care:**

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

**Hospice:**

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

**Hospital:**

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

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

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

**Immediate Family Member:**

An Immediate Family Member is:

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

**Injury:**

Physical damage to the structure or function of the body caused by an outside force, which may be physical or chemical, as a result of an Accident.

**Inpatient:**

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

**Maximum Benefit:**

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

**Maximum Lifetime Benefit:**

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

**Medical Supply Provider:**

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

**Medically Necessary or Medical Necessity:**

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

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

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

**Medicare:**

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

**Mental/Nervous Disorders and Substance Abuse:**

Any disorder classified as such in the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association.

**Outpatient:**

Treatments, services and/or supplies rendered on anything other than an Inpatient basis.

**Personal Medical Equipment:**

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

**Policy:**

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

**Policyholder:**

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

**Pre-Existing Condition:**

A condition and related complications:

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

**Rehabilitation Services:**

Specialized treatment received on an Inpatient basis for a Sickness or an Injury that meets all of the following requirements:

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

**Retail Health Clinic:**

A facility that meets all of the following requirements:

1. Is licensed by the state in accordance with the laws for the specific services being provided in that facility;
2. Is staffed by a Health Care Practitioner in accordance with the laws of that state;
3. Is attached to or is part of a store or retail facility;

4. Is separate from a Hospital, Emergency Room, acute medical rehabilitation facility, free-standing facility, Skilled Nursing Facility, subacute rehabilitation facility, or Urgent Care Facility, and any Health Care Practitioner's office located therein even when services are performed after normal business hours;
5. Provides general medical treatment of services for a Sickness or Injury, or provides preventive medical services;
6. Does not provide room and board or overnight services.

**Scheduled Benefit:**

The fixed benefit amount payable upon occurrence of a Covered Event under the terms of this Policy and any attached Riders. The Scheduled Benefit for a Covered Event is shown on the Schedule of Benefits.

**Sickness:**

A disease or an illness of a Covered Person that first manifested itself after the Covered Person's Effective Date under this Policy and any attached Riders and while coverage is in force. Sickness includes Complications of Pregnancy, but not the pregnancy itself.

**Skilled Nursing Facility:**

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

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

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

**Urgent Care:**

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

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

**Urgent Care Facility:**

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

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

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

Family Life Insurance Company.

**You, Your:**

The person listed on the Schedule of Benefits as the Policyholder.

**EFFECTIVE DATE AND TERMINATION DATE**

**Eligibility and Effective Date of Policyowner:**

A person who is eligible may elect to be covered under this Policy by completing the application process and submitting any required premium. You must be a resident of the state where this Policy is issued. Evidence of insurability according to Our underwriting and eligibility criteria must also be provided. Your coverage will take effect on Your Effective Date as shown on the Schedule of Benefits.

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

### Eligibility and Effective Date of Dependents:

The following information explains how to apply for coverage for additional dependants:

- **Adding a Newborn Child:** A newborn child can be added on the date the child was born. You must send Us written notice of the birth of the child and We must receive any required additional premium within 90 days of birth. The Effective Date of coverage will be on the date the child is born. If these requirements are not met, Your newborn child will be covered for Sickness or Injury, including Covered Events related to the necessary care and treatment of medically diagnosed congenital defects only for the first 90 days from birth.
- **Adding an Adopted Child:** A newly adopted child can be added on the date the child is adopted or You become a party in a suit for adoption, whichever is earlier. You must send Us written notice of the adoption or suit for adoption of the child and We must receive any required additional premium within 60 days of the adoption or suit for adoption of the child, whichever is earlier. The Effective Date of coverage will be on the earlier of the date the child is adopted or You become a party in a suit for adoption. If these requirements are not met, Your newly adopted child will be covered for Sickness or Injury only for the first 60 days from the date of adoption or suit for adoption. A child is no longer considered adopted if, prior to legal adoption, You relinquish legal obligation for support of the child and the child is removed from placement or when You are no longer party to a suit for adoption of the child.
- **Adding a Child for Whom a Court Order Requires You to Provide Insurance:** A child for whom a court order requires You or your Covered Dependent spouse to provide this insurance will be covered for the first 31 days from the time We receive a medical support order or notice of a medical support order. Any required additional premium must be received within 31 days from Our notice or receipt of the court order. If these requirements are not met, the child will only be covered for the first 31 days from the date We receive the medical support order or notice of the medical support order.
- **Adding Any other Dependent:** To add any other dependents, an application must be completed and sent to Us along with any required premium. Evidence of insurability must also be provided. The Effective Date of coverage will be on the Effective Date for that Covered Person shown on the Schedule of Benefits.

### Termination Date:

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

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

1. The end of the month You attain age 65. Covered Dependents may apply for coverage without evidence of insurability. The request for coverage must be made within 30 days of You attaining age 65.
2. The date We receive a request in writing to terminate this Policy on or on a later date that is requested by You for termination;
3. The date this Policy lapses for nonpayment of premium subject to the Grace Period provision in the Premium Provision section;
4. The date all policies the same as this one are non-renewed in the state in which this Policy was issued or the state in which You presently reside;
5. The date We terminate or nonrenew all individual market hospital-indemnity insurance policies in the state in which this Policy was issue or the state in which You presently reside. We will give You advance notice, as required by state law, of the termination of Your coverage;
6. The date You move to a state where We do not provide insurance under a Policy with the same Policy design as this Policy, We reserve the right to terminate this coverage; or

Coverage of a Covered Dependent will terminate on:

1. The date We receive a request in writing to terminate coverage for a Covered Dependent or on a later date that is requested by You for termination of a Covered Dependent;
2. The date a Covered Dependent no longer meets the Covered Dependent definition in this Policy. We will pay benefits to the end of the time for which We have accepted premiums.

If coverage terminates due to Your death, your spouse will become the named Policyholder provided your spouse is a Covered Person under this Policy on the date of death.

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

**Covered Dependent Conversion:**

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

1. The Covered Dependent's insurance terminated due to a valid decree of divorce between You and the Covered Dependent. The Covered Dependent will be issued a Policy, which We are currently issuing, that most nearly approximates the coverage of this Policy, without evidence of insurability and with the same effective date as the Covered Dependent's coverage under this Policy; or
2. The Covered Dependent's insurance terminates due to Your death, or You attain age 65; or
3. A Covered Dependent child's insurance terminates because the child no longer meets the eligibility requirements for a Covered Dependent.

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

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

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

## HOSPITAL CONFINEMENT AND OTHER FIXED INDEMNITY BENEFITS

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

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

We will pay the corresponding Scheduled Benefit amount shown on the Schedule of Benefits when a Covered Event described below is rendered to a Covered Person and is Medically Necessary.

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

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

Benefits are limited to the Calendar Year Maximum Daily Hospital Confinement Benefit shown on the Schedule of Benefits.

### **Hospital Admission Benefits:**

We will pay the corresponding Scheduled Benefit amount when a Covered Person is confined for the first time as a resident Inpatient during the Calendar Year. A maximum of one benefit per Covered Person per year is payable. Confinement as a resident Inpatient means assigned to a Hospital bed for an overnight stay for Medically Necessary reasons resulting from Injury or Sickness on the advice of a Health Care Practitioner.

### **Emergency Room/Urgent Care Facility Visit Benefits:**

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

Benefits are limited to the Calendar Year Maximum Emergency Room/Urgent Care Facility Benefit shown on the Schedule of Benefits.

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

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

### **Anesthesia Benefits:**

We will pay an Anesthesia Benefit equal to 20% of the surgical benefit amount shown in the Surgical Schedule when a Covered Person is administered anesthesia as part of a surgery that is a Covered Event. Benefits are limited to the Calendar Year Maximum Benefit shown on the Schedule of Benefits.

### **Surgical Services Benefits:**

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

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

**Assistant Surgeon Benefit:**

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

**PRE-EXISTING CONDITIONS LIMITATION****Pre-Existing Conditions Limitation:**

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

**EXCLUSIONS**

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

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

- weight reduction is Medically Necessary or appropriate or regardless of potential benefits for co-morbid conditions, weight reduction or weight control surgery, treatment or programs, any type of gastric bypass surgery, suction lipectomy, physical fitness programs, exercise equipment or exercise therapy, including health club membership visits or services; nutritional counseling.
12. Organ, tissue or cellular material donation by a Covered Person, including administrative visits for registry, computer search for donor matches, preliminary donor typing, donor counseling, donor identification and donor activation.
  13. Chemical peels, reconstructive or plastic surgery that does not alleviate a functional impairment and other confinement or treatment visits that are primarily for Cosmetic Services as determined by Us.
  14. Capsular contraction, augmentation or reduction mammoplasty, except for all stages and revisions of reconstruction of the breast following a Medically Necessary mastectomy for treatment of cancer, including reconstruction of the other breast to produce a symmetrical appearance and treatment of lymphedemas.
  15. Removal or replacement of a prosthesis, Durable Medical Equipment or Personal Medical Equipment, except for internal breast prostheses following a Medically Necessary mastectomy for treatment of cancer and services are received in accordance with the Hospital Confinement and Other Fixed Indemnity Benefits Section.
  16. Prophylactic treatment, services or surgery including, but not limited to, prophylactic mastectomy or any other treatment, services or surgery to prevent a disease process from becoming evident in the organ or tissue at a later date.
  17. Treatment, services, and supplies for:
    - a. Home Health Care;
    - b. Hospice Care;
    - c. Skilled Nursing Facility care, Inpatient rehabilitation services;
    - d. Custodial Care, respite care, rest care, supportive care, homemaker services;
    - e. Phone, facsimile, internet or e-mail consultation, compressed digital interactive video, audio or clinical data transmission using computer imaging by way of still-image capture and store forward;
    - f. Treatment, services or supplies that are furnished primarily for the personal comfort or convenience of the Covered Person, Covered Person's family, a Health Care Practitioner or provider;
    - g. Treatment or services provided by a standby Health Care Practitioner; or
    - h. Treatment or services provided by a masseur, masseuse or massage therapist, massage therapy, a rolfer.
  18. Treatment, services, and supplies for growth hormone therapy, including growth hormone medication and its derivatives or other drugs used to stimulate, promote or delay growth or to delay puberty to allow for increased growth.
  19. Treatment, services and supplies related to the following conditions, regardless of underlying causes: sex transformation, gender dysphoric disorder, gender reassignment, and treatment of sexual function, dysfunction or inadequacy, treatment to enhance, restore or improve sexual energy, performance or desire.
  20. Treatment, services and supplies related to: maternity, pregnancy (except Complications of Pregnancy), routine well newborn care at birth including nursery care, abortion.
  21. Any prescription drugs whether purchased, dispensed, or received from or by a physician, pharmacy, hospital, emergency room or any other medical facility, including contraceptive drugs or devices.
  22. Treatment for or treatment use of:
    - a. Genetic testing or counseling, genetic services and related procedures for screening purposes including, but not limited to, amniocentesis and chronic villi testing;
    - b. Services, drugs or medicines used to treat males or females for an infertility diagnosis regardless of intended use including, but not limited to: artificial insemination, in vitro fertilization, reversal of reproductive sterilization, any treatment to promote conception;
    - c. Sterilization;
    - d. Cryopreservation of sperm or eggs;
    - e. Surrogate pregnancy;
    - f. Fetal surgery, treatment or services;
    - g. Umbilical cord stem cell or other blood component harvest and storage in the absence of a Sickness or an Injury; or
    - h. Circumcision;
  23. Spinal and other adjustments, manipulations, subluxation treatment and/or services.
  24. Treatment for: behavior modification or behavioral (conduct) problems; learning disabilities, developmental delays, attention deficit disorders, hyperactivity, educational testing, training or materials, memory improvement, cognitive enhancement or training, vocational or work hardening programs, transitional living.
  25. Treatment for or through use of:
    - a. Non-medical items, self-care or self-help programs;
    - b. Aroma therapy;

- c. Meditation or relaxation therapy;
  - d. Naturopathic medicine;
  - e. Treatment of hyperhidrosis (excessive sweating);
  - f. Acupuncture, biofeedback, neurotherapy, electrical stimulation;
  - g. Inpatient treatment of chronic pain disorders;
  - h. Treatment of spider veins;
  - i. Family or marriage counseling;
  - j. Applied behavior therapy treatment for autistic spectrum disorders;
  - k. Smoking deterrence or cessation;
  - l. Snoring or sleep disorders;
  - m. Change in skin coloring or pigmentation; or
  - n. Stress Management.
26. A Sickness or Injury resulting from abuse or overdose of any illegal or controlled substance, except when administered in accordance with the advice of the Covered Person's Health Care Practitioner.
  27. Treatment of Sickness or an Injury when a contributing cause of the condition was the Covered Person's voluntary attempt to commit or participation in or commission of a felony, whether or not charged, or as a consequence of the Covered Person being under the influence of any illegal or non-prescribed controlled substance while committing a felony.
  28. Services ordered, directed or performed by a Health Care Practitioner or supplies purchased from a Medical Supply Provider who is a Covered Person, an Immediate Family Member, employer of a Covered Person or a person who ordinarily resides with a Covered Person.
  29. Any amount in excess of the Maximum Lifetime Benefit or any other Maximum Benefit limitation for covered Scheduled Benefits.
  30. Treatment that does not meet the definition of a Covered Event in this Policy including, but not limited to, treatment that is not Medically Necessary.
  31. Treatment, services and supplies for Experimental or Investigational Services.
  32. Treatment incurred outside of the United States.
  33. Sickness or Injury caused or aggravated by suicide, attempted suicide or self-inflicted Sickness or Injury.

## **CLAIM PROVISIONS**

### **Notice of Claim:**

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

### **Claim Forms:**

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

### **Proof of Loss:**

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

The proof of loss must include all of the following:

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

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

**Assignment Accepted:**

You may assign benefits under this Policy. Benefit payments may be assigned to another person in whole or in part. We will not honor any assignment of this Policy unless it is in writing and filed with Us at Our home office. We are not responsible for the validity of an assignment. If You assign benefits to a provider involved in the Covered Event, the assigned amount paid will not be in excess of the amount shown on the provider's statement submitted at proof of loss. Any Scheduled Benefit amount in excess of the billed amount will be paid directly to You, unless otherwise expressly assigned by You.

**Right to Collect Information:**

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

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

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

**Physical Examination and Autopsy:**

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

**Payment of Benefits:**

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

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

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

**Overpayment:**

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

**Rights of Administration:**

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

**Claims Involving Misrepresentation or Fraud:**

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

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

**Workers' Compensation Not Affected:**

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

**Claim Appeal:**

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

**PREMIUM PROVISIONS****Consideration:**

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

**Premium Payment:**

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

**Changes in Premiums:**

We have the right to change premiums on your Policy anniversary date. If We change premiums, We will do so only:

1. If We change the premiums for all policies of this form and attained age in Your state of issue;
2. If such change is in accordance with the laws and regulations of Your state of issue; and
3. If We give You 30 days notice (or longer if required by the state in which this Policy is issued) before such change becomes effective.

**Refund of Unearned Premiums:**

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

**Grace Period:**

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

**Reinstatement:**

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

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

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

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

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

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

## **OTHER PROVISIONS**

### **Policy Changes:**

This Policy may be changed at any time. We will give You 30 days notice prior to any change. No change in this Policy will be valid unless approved by one of Our executive officers and included with this Policy. No agent or other employee of Our Company has authority to waive or change any Policy provision or waive any other applicable application or application requirements.

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

### **Clerical Error:**

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

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

### **Conformity with State Statutes:**

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

### **Enforcement of Policy Provisions:**

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

### **Entire Contract:**

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

### **Representations Made on Application Form:**

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

### **Extension of Benefits:**

On the date this coverage terminates, We may extend benefits during a Confinement Period that is a result of a Sickness that commenced or an Injury sustained while this Policy was in force. Benefits are payable only for Covered Events relating to the Sickness or Injury that directly caused the confinement. Newly diagnosed conditions and complications of the condition that caused the initial confinement are not eligible for benefits during the Extension of Benefits. The Covered Person must be under the care of a Health Care Practitioner for the Inpatient stay. Medical documentation

verifying the Hospital stay must be sent to Us within 90 days after termination. Benefits are subject to all the terms, limits and conditions in this Policy. Premium payment will not be required during the extension of benefits period.

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

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

**Misstatements:**

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

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

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

**Legal Action:**

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

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

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

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

**FAMILY LIFE INSURANCE COMPANY**

[10700 Northwest Freeway  
Houston, TX 77092]

**SCHEDULE OF BENEFITS**

**Hospital Confinement and Other Fixed Indemnity Policy**

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

Policyholder: [Name] Effective Date: [XX/XX/XXXX]

[Covered [Spouse's Name]  
Dependents:] [Dependent Child(ren)'s Name]

Policy Number: [XXXXXX]

Initial Payment Option [Monthly] Initial Modal Premium: [\$XXX.XX]  
Mode:

DESCRIPTION OF COVERAGE	BENEFIT AMOUNT	MODAL PREMIUM
<b>POLICY</b>		<b>[\$XXX.XX]</b>
Inpatient Hospital Confinement Benefit	[\$500 per unit] [1-10 units]	
Calendar Year Maximum Daily Hospital Confinement Benefit	[\$200,000]	
Hospital Admission Benefit	[\$100 per unit] [1-5 units]	
Calendar Year Maximum Hospital Admission Benefit	[1] per calendar year	
Surgical Services Benefit		
Surgical Benefit	Surgical Scheduled Amounts [1-2 units]	
Anesthesia Benefit	[20% of Surgical Benefit]	
Assistant Surgeon Benefit	[20% of Surgical Benefit]	
Surgical Services Benefit Calendar Year Maximum	[\$25,000]	
Ambulance Benefit		
Ground	[\$100 per unit] [1-5 units]	
Air	[\$1,000 per unit] [1-5 units]	
Calendar Year Maximum Ambulance Benefit	[2] One Way Trips	
Emergency Room/Urgent Care Facility Visit Benefit	[\$50 per unit] [1-5 units]	
Calendar Year Maximum for the Emergency Room/Urgent Care Facility Benefit	[1 Visit]	
Lifetime Maximum Policy Amount per Covered Person	[\$2,000,000]	
<b>OPTIONAL RIDERS</b>		
<b>[Internal Cancer Rider</b>		<b>[\$XXX.XX]</b>
Monthly Benefit Amount	[\$100 per unit] [1-10 units]	
Maximum Benefit Period	[6-12] Months ]	
<b>[Intensive Care Unit Rider</b>		<b>[\$XXX.XX]</b>
Daily Benefit Amount	[\$100 per unit] [1-30 units]	
Calendar Year Maximum	[10 Days] ]	

**[First Occurrence Benefit Rider**

Coma, Internal Cancer, End Stage Renal Failure or Paralysis	[\$1,000 per unit, years 1-5] [1-10 units]	[\$XXX.XX]
Coronary Artery Bypass Surgery , Major Human Organ Transplant, Heart Attack or Stroke ]	[\$2,000 per unit, years 6 +] [1-10 units]	
	[\$500 per unit, years 1-5] [1-10 units]	
	[\$1,000 per unit, years 6 +] [1-10 units]	

**[Outpatient Sickness and Injury Rider**

Outpatient Office Visit	[\$50 per Visit]	[\$XXX.XX]
Calendar Year Maximum for Office Visit Benefit	[6 Visits]	
Outpatient Medical Events		
Specialty Laboratory Services		
Surgical Pathology Test	[\$100]	
Specialty Radiology Services		
Mammogram	[\$100]	
CT Scan	[\$200]	
MRI Scan	[\$250]	
PET Scan	[\$250]	
All Other Radiology and Laboratory Services	[\$25]	
Physical Therapy, Occupational Therapy and Speech Therapy	[\$25]	
Calendar Year Maximum Benefit For All Outpatient Medical Events	[\$1,500]	
Allergy Shots & Immunization (Covered Dependent Children Only)		
Allergy Shot	[\$10]	
Immunization	[\$20]	
Calendar Year Maximum Allergy Shots and Immunizations Benefit	[\$100] ]	
<b>[Prescription Drug Rider</b>		
Generic Drug Co-Pay	[\$10]	
Brand Drug Co-Pay	[\$25]	
Calendar Year Maximum Prescription Drug Benefit	[\$750] ]	

## Family Life Insurance Company

[10700 Northwest Freeway, Houston, TX 77092]

## Surgical Schedule

When the covered surgical procedure listed below is performed, we will pay the corresponding Scheduled Benefit shown, subject to the conditions and limitations of the Surgical Services Benefits provision.

### SURGICAL EVENT ON CARDIOVASCULAR SYSTEM

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

### SURGICAL EVENT ON DIGESTIVE SYSTEM

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

Cholecystectomy – laparoscopic, with or without Exploration of common duct .....	\$810
Cholecystectomy – laparoscopic, with graph .....	\$820
Pancreatectomy, total .....	\$1,960
Exploratory laparotomy; exploratory celiotomy ...	\$840
Repair inguinal hernia; sliding; any age .....	\$620
Repair initial femoral hernia .....	\$620

### SURGICAL EVENT ON EAR

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

### SURGICAL EVENT ON EYE

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

### SURGICAL EVENT RELATED TO GYNECOLOGY

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

**SURGICAL EVENT MUSCULOSKELETAL SYSTEM**

Muscle biopsy, superficial .....	\$200
Muscle biopsy, deep .....	\$290
Arthrocentesis, large joint.....	\$80
Removal of implant; superficial, (e.g., buried wire, pin or rod) (separate procedure).....	\$380
Closed treatment of mandibular fracture with interdental fixation .....	\$920
Arthrodesis, including laminectomy and/or diskectomy .....	\$1,650
Closed treatment of clavicular fracture; without manipulation .....	\$220
Open treatment of clavicular fracture, with or without internal or external fixation .....	\$770
Closed treatment of proximal humeral (surgical or anatomical neck) fracture, with or without manipulation.....	\$330
Open treatment of proximal humeral (surgical or anatomical neck) fracture, with or without internal or external fixation, with or without repair of tuberosity(s).....	\$940
Closed treatment of shoulder dislocation, with manipulation; without anesthesia .....	\$310
Closed treatment of shoulder dislocation, with manipulation; requiring anesthesia .....	\$410
Open treatment of acute shoulder dislocation .....	\$620
Arthroscopy – shoulder .....	\$710
Arthrotomy, elbow, including exploration, drainage, or removal of foreign body .....	\$500
Treatment of closed elbow dislocation; without anesthesia .....	\$370
Treatment of closed elbow dislocation; requiring anesthesia .....	\$390
Open treatment of acute or chronic elbow dislocation .....	\$760
Closed treatment of ulnar shaft fracture; without manipulation .....	\$260
Open treatment of ulnar shaft fracture .....	\$660
Closed treatment of radial and ulnar shaft fractures .....	\$280
Open treatment; fixation of radius or ulna .....	\$710
Open treatment; fixation of radius AND ulna .....	\$960
Closed treatment of distal radial fracture (e.g., Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid; without manipulation .....	\$300
Open treatment of distal radial fracture or epiphyseal separation, with internal fixation .....	\$780
Arthrotomy, with exploration, drainage, or removal of loose or foreign body; interphalangeal joint, each .....	\$400
Excision of lesion of tendon sheath or joint capsule (e.g., cyst, mucous cyst, or ganglion), hand or finger .....	\$570
Closed treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb; without manipulation, each .....	\$200
Open treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb; without manipulation, each .....	\$630

Amputation, finger or thumb, primary or secondary, any joint or phalanx, single including neurectomies; with direct closure .....	\$660
Arthrotomy, hip, including exploration or removal of loose or foreign body .....	\$1,040
Closed treatment of femoral fracture, proximal end, neck; without manipulation .....	\$500
Closed treatment of femoral fracture, proximal end, neck; with manipulation .....	\$820
Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement .....	\$1,290
Arthroplasty, hip .....	\$1,560
Arthroscopy, knee .....	\$790
Arthrotomy, knee, with exploration, drainage, or removal of foreign body .....	\$780
Amputation, thigh, through femur, any level .....	\$910
Amputation, thigh, through femur, any level; open, circular (guillotine) .....	\$760
Closed reduction of fracture of tibia, shaft .....	\$350
Closed treatment of tibial shaft fracture (with or without fibular fracture); with manipulation .....	\$560
Open treatment of fracture of tibia, shaft .....	\$950
Closed treatment of proximal fibula or shaft fracture; without manipulation .....	\$310
Open treatment of proximal fibula or shaft fracture, with or without internal or external fixation.....	\$760
Closed treatment of distal fibular fracture (lateral malleolus); without manipulation .....	\$320
Open treatment of distal fibular fracture (lateral malleolus) .....	\$760
Closed treatment of bimalleolar ankle fracture, (including Potts); without manipulation .....	\$340
Closed treatment of bimalleolar ankle fracture, (including Potts); with manipulation .....	\$490
Open treatment of bimalleolar ankle fracture, with or without internal or external fixation .....	\$830
Excision of lesion, tendon, tendon sheath, or capsule (including synovectomy) (e.g., cyst or ganglion); toes, wrist, forearm, foot, ankle .....	\$460
Carpal Tunnel surgery .....	\$450
Closed treatment of fracture great toe .....	\$150
Open treatment of fracture great toe .....	\$700
Closed treatment of fracture of toes, other than great toes, without manipulation, each .....	\$130
Open treatment of fracture of toes, other than great toes, without manipulation, each .....	\$590
Amputation, toe; interphalangeal joint .....	\$610

**SURGICAL EVENT ON NERVOUS SYSTEM**

Burr hole (s) with evacuation and/or drainage of hematoma, extradural or subdural .....	\$1,340
Burr holes, intracerebral .....	\$1,320
Craniectomy or craniotomy for evacuation of hematoma, supratentorial;extradural or subdural. .....	\$2,220
Craniectomy or craniotomy for evacuation of hematoma, infratentorial; extradural or subdural.. ..	\$1,940
Craniectomy, trephination, bone flap craniotomy; for excision of brain tumor, supratentorial, except meningioma .....	\$2,320

Spinal puncture, lumbar, diagnostic .....	\$160
Injection procedure for myelography and/or computed tomography, spinal (other than C1-C2 and posterior fossa) .....	\$210
Injection procedure for diskography .....	\$340
Laminectomy with decompression of spinal cord and discectomy, cervical .....	\$1,580
Laminotomy and/or excision of herniated intervertebral disk, single interspace .....	\$1,510
Sympathectomy, cervical.....	\$720
Sympathectomy, lumbar .....	\$720

**SURGICAL EVENT ON RESPIRATORY SYSTEM**

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

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

Incision and drainage of abscess; simple or single.....	\$120
Incision and drainage of pilonidal cyst .....	\$170
Biopsy of skin, subcutaneous tissue and/or mucous membrane, single lesion .....	\$100
Biopsy of each additional lesion in addition to primary procedure .....	\$50
Excision, benign lesions including margins, except skin tag, 2cm or less .....	\$160
Excision, benign lesions including margins, except skin tag, over 2 cm .....	\$310
Excision of pilonidal cyst or sinus, simple .....	\$280
Excision of pilonidal cyst or sinus, extensive .....	\$590
Excision of pilonidal cyst or sinus, complicated ...	\$710
Destruction of benign or premalignant lesions; one lesion .....	\$80
Destruction of benign or premalignant lesions, second thru 14 lesions, each .....	\$50
Wart destruction, up to 14 .....	\$110
Wart destruction 15 or more .....	\$130
Excision of cyst, fibroadenoma, or other benign or malignant tumor, aberrant breast tissue, duct lesion, nipple or areolar lesion, open, male or female, one or more lesions .....	\$510

Mastectomy, simple, complete .....	\$1,090
Radical mastectomy, including breast, pectoral muscles and axillary lymph nodes .....	\$1,210
Immediate insertion of breast prosthesis following mastopexy, Mastectomy or in reconstruction.....	\$1,050
Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion .....	\$1,690
Breast reconstruction with latissimus dorsi flap, without prosthetic implant .....	\$1,860
Breast reconstruction with free flap .....	\$3,040
Breast reconstruction with other technique .....	\$1,510
Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM) .....	\$2,270

**SURGICAL EVENT RELATED TO THYROID**

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

**SURGICAL EVENT RELATED TO URINARY SYSTEM**

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

**SURGICAL EVENT FOR TRANSPLANTS**

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

## Family Life Insurance Company

[10700 Northwest Freeway, Houston, TX 77092]

## Surgical Schedule

When the covered surgical procedure listed below is performed, we will pay the corresponding Scheduled Benefit shown, subject to the conditions and limitations of the Surgical Services Benefits provision.

### SURGICAL EVENT ON CARDIOVASCULAR SYSTEM

Insertion of electrode leads and pulse generator..	\$1,440
Upgrade of implanted pacemaker system, including conversion of a single chamber system to a dual chamber system.....	\$780
Valvotomy, mitral valve; closed heart .....	\$2,400
Valvotomy, pulmonary valve, closed heart Transventricular .....	\$2,055
Valvuloplasty, mitral valve, with cardiopulmonary Bypass .....	\$4,635
Valvuloplasty, open, with cardiopulmonary bypass .....	\$3,855
Valvuloplasty, open, with inflow occlusion .....	\$2,325
Repair atrial septal defect, secundum, with cardiopulmonary bypass, with or without patch ...	\$2,790
Ligation, division, and stripping, short or long saphenous vein .....	\$780
Ligation, division, and stripping, of short and long saphenous vein, bilateral .....	\$780
Catheterization – left heart .....	\$1,470

### SURGICAL EVENT ON DIGESTIVE SYSTEM

Biopsy of salivary gland, needle .....	\$165
Biopsy of salivary gland, incisional .....	\$480
Tonsillectomy, with or without adenoidectomy, under 12 years of age .....	\$465
Tonsillectomy, with or without adenoidectomy, 12 and over years of age .....	\$465
Excision, local; ulcer or benign tumor of stomach.	\$1,605
Gastrectomy, total .....	\$3,225
Colectomy, total, with proctectomy; with ileostomy.	\$3,240
Incision and drainage of appendicular abscess, Open .....	\$1,260
Appendectomy open.....	\$1,050
Appendectomy laparoscopic.....	\$975
Proctectomy; complete, combined abdominoperineal, with colostomy .....	\$3,120
Colonoscopy, diagnostic or preventive screening.	\$600
Colonoscopy with biopsy .....	\$705
Colonoscopy with removal of tumor, polyp or other lesions .....	\$810
Upper Gastro-Intestinal (GI) Endoscopy with Biopsy .....	\$510
Upper Gastro-Intestinal (GI) Endoscopy – diagnostic .....	\$435
Incision of rectal fistula, superficial .....	\$750
Fissurectomy, with or without sphincterotomy .....	\$675
Hemorrhoidectomy, external, complete .....	\$705
Hemorrhoidectomy, internal and external, complete.....	\$780
Cholecystectomy (removal of gall bladder) – open without exploration of common duct .....	\$1,770
Cholecystectomy – open with exploration of common duct .....	\$2,055

Cholecystectomy – laparoscopic, with or without Exploration of common duct .....	\$1,215
Cholecystectomy – laparoscopic, with graph .....	\$1,230
Pancreatectomy, total .....	\$2,940
Exploratory laparotomy; exploratory celiotomy ...	\$1,260
Repair inguinal hernia; sliding; any age .....	\$930
Repair initial femoral hernia .....	\$930

### SURGICAL EVENT ON EAR

Tympanostomy .....	\$300
Stapes mobilization .....	\$1,305
Fenestration of semicircular canal .....	\$1,395

### SURGICAL EVENT ON EYE

Removal of foreign body, conjunctival, superficial	\$90
Removal of foreign body, corneal, with or without slit lamp .....	\$105
Excision or transposition of pterygium; without graft .....	\$375
Cataract removal, intra capsular, extracapsular, with insertion of intraocular lens .....	\$1,215
Repair of retinal detachment; scleral buckling, with or without implant .....	\$1,995
Muscle operation involving one or more muscles in one or both eyes .....	\$1,140

### SURGICAL EVENT RELATED TO GYNECOLOGY

Incision and drainage of Bartholin's gland abscess.....	\$195
Excision of Bartholin's gland or cyst .....	\$495
Anterior colporrhaphy, repair of cystocele, with or without repair of urethrocele .....	\$1,095
Posterior colporrhaphy, repair of rectocele with or without perineorrhaphy .....	\$1,110
Combined anteroposterior colporrhaphy .....	\$1,380
Cautery of cervix; electro or thermal .....	\$210
Dilation and curettage, diagnostic and/or therapeutic (non-obstetrical) .....	\$405
Total abdominal hysterectomy (corpus and cervix), with or without removal of tube (s), with or without removal of ovary (s) .....	\$1,650
Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary (s) .....	\$1,590
Radical abdominal hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with or without removal of tube (s), with or without removal of ovary (s) .....	\$2,910
Salpingectomy, complete or partial, unilateral or bilateral (separate procedure) .....	\$1,275
Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure) .....	\$1,185

Hysteroscopy – biopsy ..... \$615  
 Hysteroscopy – ablation ..... \$2,400

**SURGICAL EVENT MUSCULOSKELETAL SYSTEM**

Muscle biopsy, superficial ..... \$300  
 Muscle biopsy, deep ..... \$435  
 Arthrocentesis, large joint..... \$120  
 Removal of implant; superficial, (e.g., buried wire, pin or rod) (separate procedure)..... \$570  
 Closed treatment of mandibular fracture with interdental fixation ..... \$1,380  
 Arthrodesis, including laminectomy and/or diskectomy ..... \$2,475  
 Closed treatment of clavicular fracture; without manipulation ..... \$330  
 Open treatment of clavicular fracture, with or without internal or external fixation ..... \$1,155  
 Closed treatment of proximal humeral (surgical or anatomical neck) fracture, with or without manipulation..... \$495  
 Open treatment of proximal humeral (surgical or anatomical neck) fracture, with or without internal or external fixation, with or without repair of tuberosity(s)..... \$1,410  
 Closed treatment of shoulder dislocation, with manipulation; without anesthesia ..... \$465  
 Closed treatment of shoulder dislocation, with manipulation; requiring anesthesia ..... \$615  
 Open treatment of acute shoulder dislocation .... \$930  
 Arthroscopy – shoulder ..... \$1,065  
 Arthrotomy, elbow, including exploration, drainage, or removal of foreign body ..... \$750  
 Treatment of closed elbow dislocation; without anesthesia ..... \$555  
 Treatment of closed elbow dislocation; requiring anesthesia ..... \$585  
 Open treatment of acute or chronic elbow dislocation ..... \$1,140  
 Closed treatment of ulnar shaft fracture; without manipulation ..... \$390  
 Open treatment of ulnar shaft fracture ..... \$990  
 Closed treatment of radial and ulnar shaft fractures ..... \$420  
 Open treatment; fixation of radius or ulna ..... \$1,065  
 Open treatment; fixation of radius AND ulna ..... \$1,440  
 Closed treatment of distal radial fracture (e.g., Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid; without manipulation ..... \$450  
 Open treatment of distal radial fracture or epiphyseal separation, with internal fixation ..... \$1,170  
 Arthrotomy, with exploration, drainage, or removal of loose or foreign body; interphalangeal joint, each ..... \$600  
 Excision of lesion of tendon sheath or joint capsule (e.g., cyst, mucous cyst, or ganglion), hand or finger ..... \$855  
 Closed treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb; without manipulation, each ..... \$300  
 Open treatment of phalangeal shaft fracture,

proximal or middle phalanx, finger or thumb; without manipulation, each ..... \$945

Amputation, finger or thumb, primary or secondary, any joint or phalanx, single including neurectomies; with direct closure ..... \$990  
 Arthrotomy, hip, including exploration or removal of loose or foreign body ..... \$1,560  
 Closed treatment of femoral fracture, proximal end, neck; without manipulation ..... \$750  
 Closed treatment of femoral fracture, proximal end, neck; with manipulation ..... \$1,230  
 Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement ..... \$1,935  
 Arthroplasty, hip ..... \$2,340  
 Arthroscopy, knee ..... \$1,185  
 Arthrotomy, knee, with exploration, drainage, or removal of foreign body ..... \$1,170  
 Amputation, thigh, through femur, any level ..... \$1,365  
 Amputation, thigh, through femur, any level; open, circular (guillotine) ..... \$1,140  
 Closed reduction of fracture of tibia, shaft ..... \$525  
 Closed treatment of tibial shaft fracture (with or without fibular fracture); with manipulation ..... \$840  
 Open treatment of fracture of tibia, shaft ..... \$1,425  
 Closed treatment of proximal fibula or shaft fracture; without manipulation ..... \$465  
 Open treatment of proximal fibula or shaft fracture, with or without internal or external fixation..... \$1,140  
 Closed treatment of distal fibular fracture (lateral malleolus); without manipulation ..... \$480  
 Open treatment of distal fibular fracture (lateral malleolus) ..... \$1,140  
 Closed treatment of bimalleolar ankle fracture, (including Potts); without manipulation ..... \$510  
 Closed treatment of bimalleolar ankle fracture, (including Potts); with manipulation ..... \$735  
 Open treatment of bimalleolar ankle fracture, with or without internal or external fixation ..... \$1,245  
 Excision of lesion, tendon, tendon sheath, or capsule (including synovectomy) (e.g., cyst or ganglion); toes, wrist, forearm, foot, ankle ..... \$690  
 Carpal Tunnel surgery ..... \$675  
 Closed treatment of fracture great toe ..... \$225  
 Open treatment of fracture great toe ..... \$1,050  
 Closed treatment of fracture of toes, other than great toes, without manipulation, each ..... \$195  
 Open treatment of fracture of toes, other than great toes, without manipulation, each ..... \$885  
 Amputation, toe; interphalangeal joint ..... \$915

**SURGICAL EVENT ON NERVOUS SYSTEM**

Burr hole (s) with evacuation and/or drainage of hematoma, extradural or subdural ..... \$2,010  
 Burr holes, intracerebral ..... \$1,980  
 Craniectomy or craniotomy for evacuation of hematoma, supratentorial,extradural or subdural. \$3,330  
 Craniectomy or craniotomy for evacuation of

hematoma, infratentorial; extradural or subdural..	\$2,910
Craniectomy, trephination, bone flap craniotomy; for excision of brain tumor, supratentorial, except meningioma .....	\$3,480
Spinal puncture, lumbar, diagnostic .....	\$240
Injection procedure for myelography and/or computed tomography, spinal (other than C1-C2 and posterior fossa) .....	\$315
Injection procedure for diskography .....	\$510
Laminectomy with decompression of spinal cord and discectomy, cervical .....	\$2,370
Laminotomy and/or excision of herniated intervertebral disk, single interspace .....	\$2,265
Sympathectomy, cervical.....	\$1,080
Sympathectomy, lumbar .....	\$1,080

**SURGICAL EVENT ON RESPIRATORY SYSTEM**

Excision of nasal polyp(s), simple .....	\$360
Excision of nasal polyp(s), extensive requiring hospitalization .....	\$690
Submucous resection, classic, nasal septum .....	\$1,005
Laryngectomy; total, without radical neck dissection .....	\$3,420
Laryngectomy; total, with radical neck dissection.	\$4,260
Bronchoscopy, diagnostic without biopsy .....	\$480
Bronchoscopy with bronchial or endobronchial biopsy .....	\$510
Bronchoscopy with removal of foreign body .....	\$525
Bronchoscopy with excision of tumor .....	\$420
Thoracotomy, exploratory, including biopsy .....	\$1,590
Lobectomy, total, subtotal, or segmentation, single lobe .....	\$2,820
Bilobectomy .....	\$2,655
Pulmonary resection with concomitant thoracoplasty .....	\$3,435

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

Incision and drainage of abscess; simple or single.....	\$180
Incision and drainage of pilonidal cyst .....	\$255
Biopsy of skin, subcutaneous tissue and/or mucous membrane, single lesion .....	\$150
Biopsy of each additional lesion in addition to primary procedure .....	\$75
Excision, benign lesions including margins, except skin tag, 2cm or less .....	\$240
Excision, benign lesions including margins, except skin tag, over 2 cm .....	\$465
Excision of pilonidal cyst or sinus, simple .....	\$420
Excision of pilonidal cyst or sinus, extensive .....	\$885
Excision of pilonidal cyst or sinus, complicated ...	\$1,065
Destruction of benign or premalignant lesions; one lesion .....	\$120
Destruction of benign or premalignant lesions, second thru 14 lesions, each .....	\$75
Wart destruction, up to 14 .....	\$165
Wart destruction 15 or more .....	\$195
Excision of cyst, fibroadenoma, or other benign or malignant tumor, aberrant breast tissue, duct	

Mastectomy, simple, complete .....	\$1,635
Radical mastectomy, including breast, pectoral muscles and axillary lymph nodes .....	\$1,815
Immediate insertion of breast prosthesis following mastopexy, Mastectomy or in reconstruction.....	\$1,575
Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion .....	\$2,535
Breast reconstruction with latissimus dorsi flap, without prosthetic implant .....	\$2,790
Breast reconstruction with free flap .....	\$4,560
Breast reconstruction with other technique .....	\$2,265
Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM) .....	\$3,405

**SURGICAL EVENT RELATED TO THYROID**

Excision of cyst or adenoma of thyroid .....	\$1,080
Partial thyroidectomy unilateral .....	\$1,155
Thyroidectomy, total or complete .....	\$1,605
Total or subtotal for malignancy with limited neck dissection .....	\$2,190
Total or subtotal for malignancy with radical neck dissection .....	\$2,790
Thyroidectomy, removal of all remaining thyroid tissue following previous removal of a portion of thyroid .....	\$1,815

**SURGICAL EVENT RELATED TO URINARY SYSTEM**

Cystoscopy .....	\$315
Nephrectomy .....	\$1,710
Kidney lithotripsy .....	\$1,395
Excision or fulguration of Skene's glands .....	\$345

**SURGICAL EVENT FOR TRANSPLANTS**

Heart Transplant .....	\$8,190
Lung Transplant .....	\$5,520
Heart/Lung Transplant .....	\$5,820
Liver Transplant .....	\$7,995
Kidney Transplant .....	\$4,155
Pancreas Transplant .....	\$4,110
Bone Marrow/Stem Cell Transplant .....	\$210
Cornea Transplant .....	\$1,920
Skin Transplant .....	\$960

**FAMILY LIFE INSURANCE**  
*Home Office: [Houston, TX]*  
*Administrative Office: [10700 Northwest Freeway Houston, TX 77092] [800-877-7705]*

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**INTERNAL CANCER RIDER**

**PLEASE READ THIS RIDER CAREFULLY.**

This Rider is effective as of the Policy Effective Date.

This Rider is made a part of the Policy to which it is attached. This Rider is issued in consideration of the application and receipt of the first Premium. All Definitions, Provisions, Limitations and Exceptions of the Policy apply to this Rider, except as modified by this Rider. Where there is a conflict between this Rider and the Policy, the provisions of this Rider will control.

**DEFINITIONS**

**Internal Cancer:** A disease which is manifested by the presence of a malignancy characterized by the uncontrolled and abnormal growth and spread of malignant cells in any part of the body. This includes Hodgkin's Disease, leukemia, lymphoma, carcinoma, sarcoma, malignant tumor or malignant melanoma.

Precancerous, premalignant or nonmalignant conditions, conditions with malignant potential, and skin cancer conditions are not to be construed as cancer in interpreting this policy.

**Positive Diagnosis:** Cancer must be positively diagnosed by a legally licensed physician of medicine certified by the American Board of Pathology to practice pathologic Anatomy, or a certified Osteopathic pathologist. Diagnosis must be based on a microscopic examination of fixed tissue, or preparations from the hemic system. The pathologist establishing the diagnosis shall base his judgment on the criteria of malignancy as accepted by the American Board of Pathology or the Osteopathic Board of Pathology after a study of the histocytologic architecture or pattern of the suspect tumor, tissue, or specimen. Clinical diagnosis of cancer shall be accepted as evidence that cancer exists in an insured when a pathological diagnosis cannot be made, provided such medical evidence substantially documents the diagnosis of cancer and the insured receives treatment for cancer.

**Skin Cancer:** Basal cell carcinoma, squamous cell carcinoma, melanoma or any other Cancer of the dermis or epidermis except malignant melanoma.

**BENEFITS**

If a Covered Person receives a Positive Diagnosis of any type of Internal Cancer, We will pay the Monthly Benefit Amount shown on the Schedule of Benefits for this Rider. We will pay this amount each month beginning on the month the Covered Person receives such Positive Diagnosis and during the Covered Person's lifetime but not to exceed [6] months.

Once a benefit has been paid to a Covered Person, no additional benefits are payable to that Covered Person and their coverage under the rider will terminate.

**TERMINATION**

This Rider ends on the earlier of the date:

- a. Your coverage terminates under the Policy to which the Rider is attached; or
- b. any Premium for this Rider is not paid before the end of the Grace Period; or
- c. You give Us a written request to end this Rider.

Coverage for a Covered Dependent will end under this Rider when such person ceases to be a Covered Dependent, as defined in the Policy.

## PREMIUMS

While this Rider is in force, Premiums are due based on the terms of the Policy to which this Rider is attached.

**Other than as stated above, this Rider shall not alter, waive or extend any other provisions of the Policy to which this Rider is attached.**

[ *Mary Lou Rainey*

[Mary Lou Rainey  
Secretary]

*Dan George* ]

[Dan George  
President]

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

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**PRESCRIPTION DRUG RIDER**

**PLEASE READ THIS RIDER CAREFULLY.**

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**DEFINITIONS**

**Brand Name Drug:**

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

**Compounded Medication:**

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

**Generic Drug:**

A Prescription Drug that:

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

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

**Pharmacy:**

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

**Prescription Drug:**

Any medication that:

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

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

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

1. Once final FDA approval has been granted, the usage of a device for the particular Sickness or Injury for which the device was approved will be recognized as appropriate if:
  - a. It is supported by conclusive evidence that exists in clinical studies that are published in generally accepted peer-reviewed medical literature or review articles; and
  - b. The FDA has not determined the medical device to be contraindicated for the particular Sickness or Injury for which the device has been prescribed.
2. Once final FDA approval has been granted, the usage of a drug or biological product will be recognized as

appropriate for a particular Sickness or Injury if the FDA has not determined the drug or biological product to be contraindicated for the particular Sickness or Injury for which the drug or biological product has been prescribed and the prescribed usage is recognized as appropriate medical treatment by:

- a. The American Medical Association Drug Evaluation; or
  - b. The American Hospital Formulary Service Drug Information; or
  - c. Conclusive evidence in clinical studies that are published in generally accepted peer-reviewed medical literature or review articles.
3. For any other treatment, services or supplies, conclusive evidence from generally accepted peer-reviewed literature must exist that shows or indicates:
- a. The treatment, services or supplies have a definite positive effect on health outcomes. Such evidence must include well-designed investigations that have been reproduced by non-affiliated authoritative sources, with measurable results, backed up by the positive endorsements of national medical bodies or panels regarding scientific efficacy and rationale; and
  - b. Over time, the treatment, services or supplies lead to improvement in health outcomes which show that the beneficial effects outweigh any harmful effects; and
  - c. The treatment, services or supplies are at least as effective in improving health outcomes as established technology, or are useable in appropriate clinical contexts in which established technology is not employable.

#### **Prescription Order:**

The request by a Health Care Practitioner for:

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

### **BENEFITS**

#### **Prescription Order Benefits:**

We will pay the corresponding Scheduled Benefit amount when a Covered Person fills a Prescription Order through an outpatient pharmacy.

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

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

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

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

All Benefits are limited to the Calendar Year Maximum Outpatient Prescription Drug Benefit shown in the Schedule of Benefits.

### **EXCLUSIONS**

In addition to the Exclusions and Limitations under the Policy to which this Rider is attached, We will not pay benefits for claims resulting, whether directly or indirectly from Events or loss related to or resulting from any of the following:

- a. Drugs or medicines obtained from pharmacy provider sources outside the United States.
- b. Vitamins and/or vitamin combinations even if they are prescribed by a Health Care Practitioner.

- c. Any prescription products, drugs or medicines in the following categories, whether or not prescribed by a Health Care Practitioner:
  - 1. Herbal or homeopathic medicines or products;
  - 2. Minerals;
  - 3. Appetite suppressants;
  - 4. Dietary or nutritional substances or dietary supplements;
  - 5. Nutraceuticals;
  - 6. Medical Foods; or
  - 7. Durable medical equipment/supplies.
- d. Drugs or medicines that have an over-the-counter equivalent or contain the same or therapeutically equivalent active ingredient(s) as over-the-counter medication, as determined by Us.
- e. Drugs or medicines: administered or dispensed at or by the rest home, sanitarium, extended care facility, convalescent care facility, Skilled Nursing Facility or similar institution, dispensed at or by a Hospital, an Emergency Room, a Free-Standing Facility, an Urgent Care Facility, a Health Care Practitioner's office or other Inpatient or Outpatient setting for take home by the Covered Person.
- f. Drugs or medicines used to treat, impact or influence: athletic performance; body conditioning, strengthening, or energy; social phobias, slowing the normal processes of aging, daytime drowsiness, overactive bladder, dry mouth, excessive salivation, genetic make-up or genetic predisposition, prevention or treatment of hair loss, excessive hair growth or abnormal hair patterns.
- g. Unit-dose drugs, drugs or medicines used to treat onychomycosis (nail fungus), botulinum toxin and its derivatives.
- h. Drugs or medicines prescribed for treatment of a condition that is specifically excluded under this Rider.
- i. Drugs, medicines or supplies that are illegal under federal law, such as marijuana, even if they are prescribed for medical use in a state.
- j. Duplicate prescriptions, replacement of lost, stolen, destroyed, spilled or damaged prescriptions; Prescription Order refills in excess of the number specified on the Health Care Practitioner's Prescription Order; prescriptions refilled more frequently than the prescribed dosage indicates, prescriptions refilled after one year from the Health Care Practitioner's original Prescription Order, any administration for drug injections or any other drugs or medicines obtained other than through a pharmacy.

**TERMINATION**

This Rider ends on the earlier of the date:

- a. Your coverage terminates under the Policy to which the Rider is attached; or
- b. any Premium for this Rider is not paid before the end of the Grace Period; or
- c. You give Us a written request to end this Rider.

Coverage for a Covered Dependent will end under this Rider when such person ceases to be a Covered Dependent, as defined in the Policy.

**PREMIUMS**

While this Rider is in force, Premiums are due based on the terms of the Policy to which this Rider is attached.

**Other than as stated above, this Rider shall not alter, waive or extend any other provisions of the Policy to which this Rider is attached.**



[Mary Lou Rainey  
Secretary]



[Dan George  
President]

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Home Office: [Houston, TX]

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

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## FIRST OCCURRENCE BENEFIT RIDER

### PLEASE READ THIS RIDER CAREFULLY.

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### DEFINITIONS

**Coma:** A continuous state of profound unconsciousness, classified on the Glasgow Coma Scale as seven or below and characterized by the absence of:

- a. spontaneous eye movements;
- b. response to painful stimuli; and
- c. vocalization.

The condition cannot be drug induced, and must require intubation for respiratory assistance.

**Coronary Artery Bypass Surgery:** Open heart surgery, to correct narrowing or blockage of one or more coronary arteries with bypass grafts, but excluding procedures such as, but not limited to, balloon angioplasty, laser relief, stents or other non-surgical procedures. This surgery requires placement of patient on a cardiac pulmonary bypass machine.

**End Stage Renal Failure:** Irreversible failure of the function of both kidneys requiring a Covered Person to undergo regular hemodialysis or peritoneal dialysis at least weekly.

**Heart Attack:** A myocardial infarction, coronary thrombosis, or coronary occlusion which is first manifested after the Rider Effective Date. The attack must be positively diagnosed by a Physician based upon generally accepted diagnostic criteria such as:

- a. clinical picture of myocardial infarction;
- b. new EKG findings consistent with myocardial infarction; and
- c. elevation of cardiac enzymes above standard laboratory levels of normal (in case of CPK, a CPK-MB measurement must be used).

Confirming diagnostic data from one or more of the following test results, or other diagnostic tests as may be determined, may also be required in support of a diagnosis of myocardial infarction:

- a. thallium;
- b. PECT;
- c. Stress echo results; or
- d. Cardiac catheterization.

**Internal Cancer:** A disease which is manifested by the presence of a malignancy characterized by the uncontrolled and abnormal growth and spread of malignant cells in any part of the body. This includes Hodgkin's Disease, leukemia, lymphoma, carcinoma, sarcoma, malignant tumor or malignant melanoma.

Precancerous, premalignant or nonmalignant conditions, conditions with malignant potential, and skin cancer conditions are not to be construed as cancer in interpreting this policy.

**Major Human Organ Transplant:** A surgery in which a Covered Person receives, as a result of a surgical transplant, one or more of the following organs: kidney, liver, heart, heart-lung, lung or pancreas. It does not include transplants involving mechanical or nonhuman organs.

**Paralysis:** Spinal cord injuries resulting in paraplegia or quadriplegia (complete and total loss of use of two or more limbs) confirmed by the Covered Person's attending Physician.

**Stroke:** An acute cerebral vascular incident producing permanent, neurological impairment and resulting in paralysis or other measurable objective neurological defect persisting for at least 30 days. Diagnosis of a Stroke must be evidenced by a clinical picture of permanent neurological damage provided from a CAT scan and/or an MRI, or such other diagnostic tests as may be required.

Stroke does not include Transient Ischemic Attacks and attacks of Vertebrobasilar Ischemia.

### BENEFITS

#### First Occurrence Benefits

One First Occurrence Benefit is payable per Covered Person. If an event does not occur within the first 5 years this rider is in force, the First Occurrence Benefit will double. A benefit may be paid in one of two ways:

1. The First Occurrence Benefit listed in the Schedule of Benefits is payable if one of the following health events occurs for the first time in the Covered Person's lifetime and while this Rider is in force for the Covered Person.
  - Coma (non drug induced)
  - End Stage Renal Failure
  - Internal Cancer
  - Paralysis
2. A benefit equal to 50% of the First Occurrence Benefit listed in the Schedule of Benefits is payable if one of the following health events occurs for the first time in the Covered Person's lifetime and while this Rider is in force for the Covered Person.
  - Coronary Artery Bypass Surgery
  - Heart Attack
  - Major Human Organ Transplant
  - Stroke

The Company must be provided with a diagnosis by a Physician accompanied by documentation supported by clinical, radiological, histological and laboratory evidence satisfactory to the Company. The Company may, at its expense, require an examination or further tests by a Physician of its choice.

Once a benefit has been paid to a Covered Person, no additional benefits are payable to that Covered Person and their coverage under the rider will terminate.

### TERMINATION

This Rider ends on the earlier of the date:

- a. Your coverage terminates under the Policy to which the Rider is attached; or
- b. any Premium for this Rider is not paid before the end of the Grace Period; or
- c. You give Us a written request to end this Rider

Coverage for a Covered Dependent will end under this Rider when such person ceases to be a Covered Dependent, as defined in the Policy.

### PREMIUMS

While this Rider is in force, Premiums are due based on the terms of the Policy to which this Rider is attached.

**Other than as stated above, this Rider shall not alter, waive or extend any other provisions of the Policy to which this Rider is attached.**



[Mary Lou Rainey  
Secretary]



[Dan George  
President]

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*Home Office: [Houston, TX]*

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

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**INTENSIVE CARE UNIT RIDER**

**PLEASE READ THIS RIDER CAREFULLY.**

This Rider is effective as of the Policy Effective Date.

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**DEFINITIONS**

**Intensive Care Unit:** A Hospital area of special care including Intensive Cardiac and Coronary Care units, which is separate and apart from the surgical recovery room, or other rooms, beds or wards normally used for patient confinement. It does not include step-down units, progressive care units, sub-acute units, intermediate care units, private monitored rooms, observation units or other lesser treatment units. In addition, such a unit must provide the following:

- a. 24 hour continuous nursing care attended by nurses assigned to the unit on a full-time basis; and
- b. direction and/or supervision by a full-time Health Care Practitioner director or a standing "intensive care" committee of the medical staff; and
- c. special medical apparatus used to treat the critically ill.

**BENEFITS**

If a Covered Person is confined in a Hospital's Intensive Care Unit due to an Injury or Sickness, We will pay the Daily Benefit Amount shown on the Schedule of Benefits. We will pay this amount for each day of confinement for which there is a room and board charge by the Hospital; but not to exceed the Calendar Year Maximum as shown on the Schedule of Benefits.

**TERMINATION**

This Rider ends on the earlier of the date:

- a. Your coverage terminates under the Policy to which the Rider is attached; or
- b. any Premium for this Rider is not paid before the end of the Grace Period; or
- c. You give Us a written request to end this Rider.

Coverage for a Covered Dependent will end under this Rider when such person ceases to be a Covered Dependent, as defined in the Policy.

**PREMIUMS**

While this Rider is in force, Premiums are due based on the terms of the Policy to which this Rider is attached.

**Other than as stated above, this Rider shall not alter, waive or extend any other provisions of the Policy to which this Rider is attached.**



[Mary Lou Rainey  
Secretary]



[Dan George  
President]

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Home Office: [Houston, TX]

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

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## OUTPATIENT SICKNESS AND INJURY RIDER

### PLEASE READ THIS RIDER CAREFULLY.

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### DEFINITIONS

#### **Free-Standing Facility:**

A facility that provides interventional services:

1. On an Outpatient basis which require hands-on care by a Health Care Practitioner and;
2. Includes the administration of general or regional anesthesia or conscious sedation to patients.

This type of facility may also be referred to as:

1. an ambulatory surgical center;
2. an interventional diagnostic testing facility;
3. a facility that exclusively performs endoscopic procedures or a dialysis unit;

A designated area within a Health Care Practitioner's office or clinic that is used exclusively to provide interventional services and administer anesthesia or conscious sedation is also considered to be a Free-Standing Facility. Room and board and overnight services are not covered.

These facilities must meet all of the following requirements:

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

#### **Laboratory Services:**

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

#### **Occupational Therapy:**

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

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

#### **Office Visits:**

An in-person, face-to-face meeting or consultation between a Covered Person and a Health Care Practitioner in the Health Care Practitioner's office or a Retail Health Clinic. During this meeting, the Health Care Practitioner evaluates and manages the Covered Person's Sickness or Injury or provides preventive medicine services. For the purpose of this Rider, an Office Visit does not include services received in a:

1. Hospital's Outpatient department;
2. an Emergency Room;
3. a Free-Standing Facility;
4. or an Urgent Care Facility.

**Physical Medicine:**

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

**Physical Therapy:**

The treatment of a Sickness or an Injury, by a Health Care Practitioner who is a physical therapist, using therapeutic exercise and other services that focus on improving:

1. posture;
2. locomotion;
3. strength;
4. endurance;
5. balance;
6. coordination;
7. joint mobility;
8. flexibility;
9. or functional activities of daily living and alleviating pain.

**Radiology Services:**

Diagnostic imaging procedures and testing that are performed to diagnose a condition, determine the nature of a condition, or provide preventative screening including, but not limited to:

1. X-rays;
2. Positron Emission Tomography (PET) scans;
3. Magnetic Resonance Imaging (MRI) and;
4. Computerized Axial Tomography (CT)

**Speech Therapy:**

The treatment of a Sickness or an Injury, by a Health Care Practitioner who is a speech therapist, using rehabilitative techniques to improve function for:

1. voice;
2. speech;
3. language;
4. or swallowing disorders.

**Telehealth Services:**

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

**Telemedicine Services:**

A medical inquiry initiated by a Health Care Practitioner for the purpose of assistance with a patient's:

1. assessment;
2. diagnosis;
3. consultation;
4. treatment;
5. or the transfer of medical data that requires the use of modern telecommunications technology.

**BENEFITS****Office Visit Benefits:**

We will pay the corresponding Scheduled Benefit for an Office Visit for a Covered Person during which any of the following professional services are rendered in a Health Care Practitioner's Office for a Sickness or an Injury:

- a. Measuring height, weight and blood pressure;
- b. Obtaining a health history;
- c. Performing a physical examination;
- d. Making a medical decision;
- e. Explaining treatment options;
- f. Developing a treatment plan; or
- g. Instructions for management of the condition.

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

**Outpatient Medical Event Benefits:** We will pay the corresponding Scheduled Benefit amount upon occurrence of an Event wherein the Covered Person receives one of the following for treatment of a Sickness or Injury

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

Benefits for are limited to the Calendar Year Maximum Outpatient Medical Event Benefit shown on the Schedule of Benefits.

**Allergy Shots and Immunization Benefits (Covered Dependent Children Only):**

We will pay the corresponding Scheduled Benefit amount for each allergy shot received by a Covered Dependent child. We will also pay the corresponding Scheduled Benefit amount for each immunization received by a Covered Dependent child as recommended by:

1. The United States Preventive Service Task Force;
2. or the Advisory Committee on Immunization Practices on the date the immunization is rendered.

If the administration of the shot or immunization occurs during an office visit, an Outpatient office visit is payable.

Benefits are limited to the Allergy Shots and Immunizations Benefit Calendar Year Maximum shown on the Schedule of Benefits.

**TERMINATION**

This Rider ends on the earlier of the date:

- a. Your coverage terminates under the Policy to which the Rider is attached; or
- b. any Premium for this Rider is not paid before the end of the Grace Period; or
- c. You give Us a written request to end this Rider.

Coverage for a Covered Dependent will end under this Rider when such person ceases to be a Covered Dependent, as defined in the Policy.

**PREMIUMS**

While this Rider is in force, Premiums are due based on the terms of the Policy to which this Rider is attached.

**Other than as stated above, this Rider shall not alter, waive or extend any other provisions of the Policy to which this Rider is attached.**

[ *Mary Lou Rainey* ] [ *Dan George* ]  
[Mary Lou Rainey Secretary] [Dan George President]

SERFF Tracking Number: CEUL-127130886 State: Arkansas  
 Filing Company: Family Life Insurance Company State Tracking Number: 48523  
 Company Tracking Number:  
 TOI: H14I Individual Health - Hospital Indemnity Sub-TOI: H14I.000 Health - Hospital Indemnity  
 Product Name: Secure Care  
 Project Name/Number: /

**Rate Information**

Rate data applies to filing.

**Filing Method:**

**Rate Change Type:**

Neutral

**Overall Percentage of Last Rate Revision:**

%

**Effective Date of Last Rate Revision:**

**Filing Method of Last Filing:**

**Company Rate Information**

Company Name:	Company Rate Change:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
Family Life Insurance Company	N/A	%	%				%	%

SERFF Tracking Number: CEUL-127130886 State: Arkansas  
 Filing Company: Family Life Insurance Company State Tracking Number: 48523  
 Company Tracking Number:  
 TOI: H14I Individual Health - Hospital Indemnity Sub-TOI: H14I.000 Health - Hospital Indemnity  
 Product Name: Secure Care  
 Project Name/Number: /

## Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
Approved-Closed 04/25/2011	FHCS11 Rate	FHCS11, FHCS11-RX, FHCS11-CX, FHCS11-FOB, FHCS11-OPSI, FHCS11-ICU	New		FHCS11 Rate.pdf

**Exhibit I - Premiums**  
**Hospital Confinement and Surgical Fixed Indemnity Insurance Policy**  
**Policy Form – FHCS11**

**Monthly Premiums Per Unit Selected**

Package	Benefits	Individual Adult Rate Per Unit				Child Rate Per Unit
		18-29	30-39	40-49	50-64	
IP Base Plan	Daily Hospital Confinement	13.03	15.68	19.13	24.54	6.99
	First Admission Hospitalization	0.52	0.62	0.76	0.97	0.42
	Surgical Benefit & Anesthesia	21.27	25.60	31.23	40.06	14.82
	Ambulance	0.26	0.31	0.38	0.49	0.55
	Emergency Room	0.50	0.60	0.73	0.93	0.97
OP Package Rider	OP Office Visit	8.28	9.97	12.16	15.60	12.22
	Diagnostic X-Ray & Lab	5.73	6.90	8.42	10.79	5.55
	Specialty Radiology	2.36	2.85	3.47	4.45	1.71
	Allergy & Immunization - Child					1.57
	RX (Optional within OP Rider)	11.23	13.52	16.49	21.15	9.29
Internal Cancer Rider	Internal Cancer	0.02	0.05	0.18	0.70	0.01
ICU Rider	Daily ICU	0.48	0.57	0.70	0.89	0.40
First Occurrence Rider	First Occurrence	0.12	0.28	0.85	3.04	0.09

**Tier Rates**

---

Employee	=Adult Rate
Employee & Spouse	=2*Adult Rate
Employee & Child(ren)	=Adult Rate + 1.8*Child Rate
Employee & Family	=2*Adult Rate + 2.2*Child Rate
Employee, Spouse, & 1 Child	=2*Adult Rate + Child Rate
Child Only	=Child Rate

SERFF Tracking Number: CEUL-127130886 State: Arkansas  
 Filing Company: Family Life Insurance Company State Tracking Number: 48523  
 Company Tracking Number:  
 TOI: H14I Individual Health - Hospital Indemnity Sub-TOI: H14I.000 Health - Hospital Indemnity  
 Product Name: Secure Care  
 Project Name/Number: /

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<p><b>Satisfied - Item:</b> Flesch Certification  <b>Comments:</b>  <b>Attachment:</b>            Readability certificate.pdf</p>	Approved-Closed	04/25/2011
<p><b>Satisfied - Item:</b> Application  <b>Comments:</b>  <b>Attachment:</b>            FHCSAPP11.pdf</p>	Approved-Closed	04/25/2011
<p><b>Satisfied - Item:</b> Outline of Coverage  <b>Comments:</b>  <b>Attachment:</b>            FHCS11-OC.pdf</p>	Approved-Closed	04/25/2011
<p><b>Satisfied - Item:</b> Variability  <b>Comments:</b>  <b>Attachment:</b>            VARIABILITY STATEMENT.pdf</p>	Approved-Closed	04/25/2011

# Readability Certification

**Company Name:** Family Life Insurance Company

**NAIC:** 63053

Form Number	Description of Form	Score
FHCS11	Hospital Confinement and Surgical Fixed Indemnity Policy	50.0
FHCSAPP11	Application	42.6
FHCS11-PS	Policy Schedule	--
FHCS11-SS	Surgical Schedule	--
FHCS11-OC	Outline of Coverage	54.3
FHCS11-FOB	First Occurrence Benefit Rider	51.1
FHCS11-ICU	ICU Rider	69.0
FHCS11-CX	Internal Cancer Rider	54.5
FHCS11-OPSI	Outpatient Sickness and Injury Rider	51.9
FHCS11-RX	Prescription Drug Rider	57.7

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

*Mary Lou Rainey*

Authorized Signature

Mary Lou Rainey

Name

Secretary

Title

February 14, 2011

Date

# FAMILY LIFE INSURANCE COMPANY

10700 Northwest Freeway  
Houston, Texas 77092

## HOSPITAL INDEMNITY APPLICATION

**HOME OFFICE USE ONLY**

Pol. No. \_\_\_\_\_

Pol. Date \_\_\_\_\_

No. Units \_\_\_\_\_

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

FIRST	MI	LAST	Social Security Number	Relationship	Sex	DOB	Age	Ht.	Wt. Now	Wt. 1 Yr Ago

2. (a) Requested Coverage Effective Date \_\_\_\_\_  Individual  Individual and Spouse  One Parent Family  Two Parent Family

(b) Hospital Indemnity Plan: \_\_\_\_\_

(c)  First Occurrence \_\_\_\_\_  ICU \_\_\_\_\_  Internal Cancer Benefit \_\_\_\_\_

Outpatient Rider \_\_\_\_\_  Prescription Drug Rider \_\_\_\_\_

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

(c) Premium Mode:  Annual  Quarterly  Semi-Annual  Monthly  \_\_\_\_\_ Mode Premium \$ \_\_\_\_\_  
(EFT/CC only)

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

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

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

7. Mailing Address:  Business  Home \_\_\_\_\_

8. Mail Policy to:  Insured  Agent  Other \_\_\_\_\_

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

Explain: \_\_\_\_\_

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

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

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

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

14. Have you or any person proposed for insurance within the past 5 years been diagnosed as having or been told by a doctor that they had or have any of the following conditions?  YES  NO If yes, circle the applicable conditions shown below. **If yes to any conditions, do not submit application.**

- |   |  |  |
|---|--|--|
| <ul style="list-style-type: none"> <li>a. Addison's Disease</li> <li>b. Acquired Immune Deficiency Syndrome (AIDS), or tested positive for antibodies to the Acquired Immune Deficiency Syndrome (AIDS) virus or Human Immunodeficiency Virus (HIV)</li> <li>c. Alcoholism &amp; Substance Abuse</li> <li>d. Cataracts uncorrected</li> <li>e. Cerebral Palsy</li> <li>f. Cirrhosis of the Liver</li> <li>g. Coronary Bypass</li> </ul> | <ul style="list-style-type: none"> <li>h. Currently (or within 3 months) hospitalized or confined to any health care institution</li> <li>i. Diabetes (except cases treated by diet alone)</li> <li>j. Functionally limiting musculoskeletal disease or disorder</li> <li>k. Grand Mal Epilepsy</li> <li>l. Heart Attack</li> <li>m. Hemophilia</li> <li>n. Hernia uncorrected</li> <li>o. Hepatitis (other than Virus A)</li> <li>p. Hodgkin's Disease</li> </ul> | <ul style="list-style-type: none"> <li>q. Internal Cancer within 10 years</li> <li>r. Leukemia</li> <li>s. Lung Disorder (Chronic)</li> <li>t. Mental or Nervous Disorder or disease or disorder of the Central Nervous System</li> <li>u. Multiple Sclerosis</li> <li>v. Paralysis</li> <li>w. Ulcerative Colitis</li> <li>x. Chronic Kidney Disease</li> </ul> |
|---|--|--|

15. To the best of my knowledge and belief, no person to be covered under the terms of this policy has now or during the past ten years has had cancer in any form including carcinoma in situ, except  NONE  \_\_\_\_\_ who is (are) to be excluded from coverage under this policy. CHECK ONE BOX.
16. I hereby represent that to the best of my knowledge, information and belief, no person to be insured under this policy is now or has ever been diagnosed or treated for (check condition):  NONE
- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Addison's disease            | <input type="checkbox"/> amyotrophic lateral sclerosis | <input type="checkbox"/> diphtheria          | <input type="checkbox"/> encephalitis         |
| <input type="checkbox"/> epilepsy                     | <input type="checkbox"/> legionnaires' disease         | <input type="checkbox"/> lupus erythematosus | <input type="checkbox"/> meningitis           |
| <input type="checkbox"/> multiple sclerosis           | <input type="checkbox"/> muscular dystrophy            | <input type="checkbox"/> myasthenia gravis   | <input type="checkbox"/> Niemann-Pick disease |
| <input type="checkbox"/> osteomyelitis                | <input type="checkbox"/> poliomyelitis                 | <input type="checkbox"/> Reye's syndrome     | <input type="checkbox"/> rheumatic fever      |
| <input type="checkbox"/> Rocky Mountain spotted fever | <input type="checkbox"/> sickle cell anemia            | <input type="checkbox"/> Tay-Sachs disease   | <input type="checkbox"/> tetanus              |
| <input type="checkbox"/> toxic epidermal necrolysis   | <input type="checkbox"/> toxic shock syndrome          | <input type="checkbox"/> tuberculosis        | <input type="checkbox"/> tularemia            |
| <input type="checkbox"/> typhoid fever                | <input type="checkbox"/> Whipple's disease             | <input type="checkbox"/> whooping cough      |   |
- State name(s) of who is (are) to be excluded from the dread disease condition checked. \_\_\_\_\_

17. I hereby represent that to the best of my knowledge, information and belief, within the last 6 months no person to be insured, has (1) undergone a biopsy, (2) had an elevated PSA (Prostate Specific Antigen) or (3) received medical advice or consultation or had medical tests advised or performed, including those during the course of routine check ups where the results were other than normal or still pending for cancer, except  NONE  \_\_\_\_\_ who is (are) to be excluded from coverage under this policy. CHECK ONE BOX
- 18.a. Are you, your spouse or anyone to be insured pregnant?  Yes  No If Yes, coverage cannot be issued under this Intensive Care Policy/Rider to any applicant.
- 18.b. Has any person to be insured ever received medical care for or been diagnosed with heart disease, heart surgery, any abnormalities of the heart, chest pain, heart attack, stroke, pacemaker implanted, blood vessel surgery, or been diagnosed or treated with high blood pressure unless controlled by diet and/or medication for at least one year?  Yes  No
18. c. If Yes, list the name(s) of persons: \_\_\_\_\_ Those persons will not be issued coverage under this Policy/Rider.
19. Will the insurance applied for replace existing insurance policy or contract in any company(s)?  Yes  No

**WARNING:** Any Person knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be committing a fraudulent insurance act, which is a crime.

I, the proposed insured(s), understand that the policy(s) issuance is based on all statements and answers indicated above, which are complete and true to the best of my knowledge and belief. I further understand that any rider(s) attached after the policy effective date will not be effective until the effective date specified in the rider(s) and will not pay benefits for any claims which occur prior to the effective date stated in the rider(s). I acknowledge receipt of the outline of coverage.

I also represent that I have read, or had read to me, the completed application and realize that any false statement or misrepresentation thereon which materially affects the insurance company's acceptance of any person for coverage under a policy or rider may result in loss of coverage for that person subject to policy provisions. None of the coverage in this application may be issued in any state where the said coverage has not been approved.

**AUTHORIZATION:** I hereby authorize any licensed physician, medical practitioner, pharmacy, or pharmacy related facility, hospital, clinic, or other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau, Inc. (MIB), consumer reporting agency or employer, or other organization, institution or person having any record of me or any member of my family available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me or a member of my family and any other non-medical information of me or a member of my family to give to Family Life Insurance Company, it's reinsurers or its legal representative, or any medical or pharmaceutical records retrieval service Family Life Insurance Company may engage, any and all such information as permitted by law and the rules of MIB, Inc. I understand that I am authorizing Family Life Insurance Company to receive my health information, prescription drug usage history and my non-medical information. I understand that prescription drug usage may be used to verify the presence of certain medical conditions and that such history will not be used to decline coverage. These medical conditions will be confirmed by a telephone interview prior to being used in the underwriting process. I also authorize any consumer reporting agency to prepare or procure an investigative consumer report on me. I understand the information obtained by use of the Authorization will be used by Family Life Insurance Company to determine eligibility for insurance and/or eligibility for benefits under an existing policy. I agree that a photographic copy or a facsimile of this Authorization shall be as

valid as the original. I or my authorized representative is entitled to a copy of the authorization. This authorization will remain valid for twenty-four (24) months and may be revoked at any time. The revocation of the authorization must be submitted in writing.

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

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

**DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.**

THE EFFECTIVE DATE OF THE POLICY WILL BE THE DATE RECORDED BY THE HOME OFFICE. IT IS NOT THE DATE THIS APPLICATION IS SIGNED. THE POLICY WILL BECOME EFFECTIVE WHEN ALL UNDERWRITING REQUIREMENTS HAVE BEEN SATISFIED.

Signed at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_.  
City State

X \_\_\_\_\_ X \_\_\_\_\_  
Signature of Proposed Insured/Telephone Number Signature of Proposed Insured Spouse

**AGENT'S STATEMENT**

YES NO

- 1. Will the insurance applied for replace existing insurance policy or contract in any company(s)? .....
- 2. If a replacement(s), and if state regulations require it, have you given the applicant:
  - a. Notice to Applicant Regarding Replacement of Accident and Sickness Insurance? .....
  - b. Completed all replacements forms, if required in your state? .....
- 3. Have you complied with state regulations on disclosure? .....
- 4. All information recorded by me on this application is true and accurate to the best of my knowledge. ....

Agent No. Soliciting Agent Signature Date

( ) \_\_\_\_\_  
Soliciting Agent Phone #

\_\_\_\_\_   
Print Agent Name



**Family Life Insurance Company**

[10700 Northwest Freeway

Houston, TX 77092]

[800-877-7705]

**OUTLINE OF COVERAGE  
FOR FORM FHCS11  
HOSPITAL CONFINEMENT AND OTHER FIXED INDEMNITY INSURANCE  
REQUIRED OUTLINE OF COVERAGE**

This outline of coverage provides a very brief description of the important features of Your Policy. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth, in detail, the rights and obligations of both You and Your insurance company.

**PLEASE READ YOUR POLICY CAREFULLY TO UNDERSTAND POLICY LIMITATIONS.**

**The capitalized terms used in this Outline of Coverage are defined in your Policy.**

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

**SECTION 1: GENERAL PROVISIONS:**

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

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

**THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES. THIS POLICY HAS LIMITED BENEFITS AND ANNUAL MAXIMUMS.**

**HOSPITAL CONFINEMENT AND OTHER FIXED INDEMNITY POLICY:**

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

**PAYMENT OF BENEFITS:**

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

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

1. The treatment, services or supplies provided in connection with the event are provided by a Health Care Practitioner, facility or supplier.
2. It is incurred by a Covered Person while coverage is in force under this policy as the result of Sickness or an Injury or for preventive medical services as specified in the Hospital Confinement and Other Fixed Indemnity Benefits section and the Schedule of Benefits.

3. It is incurred for events shown in the Hospital Confinement and Other Fixed Indemnity Benefits section and on the Schedule of Benefits.
4. The occurrence includes treatment, services or supplies which are Medically Necessary.

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

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

**SCHEDULE OF BENEFITS**

<b>Maximum Lifetime Benefit:</b>	[\$2,000,000] per Covered Person. All benefit payments apply to the Maximum Lifetime Benefit.
<b>Inpatient Hospital Confinement Benefits:</b>	<ul style="list-style-type: none"> <li>• Scheduled Benefit per Inpatient Day of a Confinement Period: \$[500 per unit] [1-10 units].</li> <li>• All Inpatient Hospital Confinement Benefits are limited to a Maximum Benefit of \$[200,000] per Calendar Year, per Covered Person.</li> </ul>
<b>Hospital Admission Benefits:</b>	<ul style="list-style-type: none"> <li>• Scheduled Benefit per Hospital Admission Event: \$[100 per unit] [1-5 units].</li> <li>• Maximum Benefit of [1] Covered Event per Calendar Year, per Covered Person.</li> </ul>
<b>Emergency Room/ Urgent Care Facility Visit Benefits:</b>	<ul style="list-style-type: none"> <li>• Scheduled Benefit per Emergency Room/Urgent Care visit: \$[50 per unit] [1-5 units].</li> <li>• All Emergency Room Visits/Urgent Care Visit Benefits combined are limited to a Maximum Benefit of [1] visit[s], per Calendar Year, per Covered Person.</li> </ul>
<b>Professional Ground or Air Ambulance Services Benefits:</b>	<ul style="list-style-type: none"> <li>• Scheduled Benefit per trip by ground ambulance: \$[100 per unit] [1-5 units].</li> <li>• Scheduled Benefit per trip by air ambulance: \$[1,000 per unit] [1-5 units].</li> <li>• All Professional Ground or Air Ambulance Services Benefits combined are limited to a Maximum Benefit of [2] one-way trip[s] per Calendar Year, per Covered Person.</li> </ul>
<b>Surgical Services Benefits:</b>	<p>The following Surgical Services Benefits are limited to a Maximum Benefit of \$[25,000] per Calendar Year, per Covered Person.</p> <ul style="list-style-type: none"> <li>• <b>Surgical Benefits:</b> The Scheduled Benefit for surgical Covered Events is the amount shown in the policy's Surgical Schedule for the corresponding surgical event. Two or more surgical events performed during the same operative session are considered one operation and the Surgical Services Benefit will be paid based on the event with the highest Scheduled Benefit shown in the Surgical Schedule.</li> <li>• <b>Anesthesia Benefits:</b> 20% of the Surgical Benefit as listed in the Surgical Schedule per Anesthesia event.</li> <li>• <b>Assisting Surgeon Benefits:</b> If an Assistant Surgeon is required to assist the Surgeon during the operation, We will pay a benefit equal to 20% of the benefit amount shown in the Surgical Schedule for the operation.</li> </ul>

**Inpatient Hospital Confinement Benefit:**

We will pay the corresponding Scheduled Benefit amount for each day of Inpatient room and board during a Confinement Period under the orders of a Health Care Practitioner for care of a Sickness or an Injury. Benefits are limited to the Calendar Year Maximum Inpatient Hospital Confinement Benefit shown on the Schedule of Benefits.

**Hospital Admission Benefits:**

We will pay the corresponding Scheduled Benefit amount if a Covered Person is confined for the first time as a resident Inpatient during the Calendar Year. A maximum of one benefit per year per insured is payable. Confinement as a resident Inpatient means assigned to a Hospital bed for an overnight stay for Medically Necessary reasons resulting from Injury or Sickness on the advice of a Health Care Practitioner.

**Emergency Room/Urgent Care Visits Benefits:**

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

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

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

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

**Surgical Benefits:**

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

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

**Anesthesia Benefits:**

We will pay an Anesthesia Benefit equal to 20% of the surgical benefit amount shown in the Surgical Schedule when a Covered Person is administered anesthesia as part of a Covered Event. Benefits are limited to the Calendar Year Maximum Surgical Services Benefit shown on the Schedule of Benefits.

**Assisting Surgeon Benefits:**

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

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

**OPTIONAL RIDERS SCHEDULE OF BENEFITS**

**[OUTPATIENT SICKNESS AND INJURY RIDER**

<b>Office Visit Benefits:</b>	<ul style="list-style-type: none"> <li>• Outpatient Office Visit: \$[50] per Office Visit in a Health Care Practitioner's office.</li> <li>• Calendar Year Maximum of [6] visit[s] per Calendar Year, per Covered Person.</li> </ul>																
<b>Outpatient Medical Event Benefits:</b>	<ul style="list-style-type: none"> <li>• All Outpatient Medical Event Benefits combined are limited to a Maximum Benefit of \$[1,500] per Calendar Year, per Covered Person.</li> <li>• Scheduled Benefits: <table border="1" data-bbox="495 441 1477 913"> <thead> <tr> <th align="center">Event</th> <th align="center">Scheduled Benefit</th> </tr> </thead> <tbody> <tr> <td><b>Specialty Laboratory Services</b> Surgical Pathology Test</td> <td align="center">\$[100]</td> </tr> <tr> <td><b>Specialty Radiology Services</b> Mammogram</td> <td align="center">\$[100]</td> </tr> <tr> <td>Computerized Tomography Scan (CT)</td> <td align="center">\$[200]</td> </tr> <tr> <td>Magnetic Resonance Imaging (MRI)</td> <td align="center">\$[250]</td> </tr> <tr> <td>Positron Emission Tomography Scan (PET)</td> <td align="center">\$[250]</td> </tr> <tr> <td><b>All Other Radiology and Laboratory Services</b></td> <td align="center">\$[25]</td> </tr> <tr> <td><b>Physical Therapy, Occupational Therapy, Speech Therapy</b></td> <td align="center">\$[25]</td> </tr> </tbody> </table> </li> </ul>	Event	Scheduled Benefit	<b>Specialty Laboratory Services</b> Surgical Pathology Test	\$[100]	<b>Specialty Radiology Services</b> Mammogram	\$[100]	Computerized Tomography Scan (CT)	\$[200]	Magnetic Resonance Imaging (MRI)	\$[250]	Positron Emission Tomography Scan (PET)	\$[250]	<b>All Other Radiology and Laboratory Services</b>	\$[25]	<b>Physical Therapy, Occupational Therapy, Speech Therapy</b>	\$[25]
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<b>Allergy and Immunization Injection Benefits (Covered Dependent Children Only):</b>	<ul style="list-style-type: none"> <li>• Scheduled Benefit per Allergy Injection: \$[10].</li> <li>• Scheduled Benefit per Immunization Injection: \$[20].</li> <li>• All Immunization and Allergy Injection Benefits combined are limited to a Maximum Benefit of \$[100] per Calendar Year, per Covered Dependent child.</li> </ul>																

**Office Visit Benefits:**

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

- Measuring height, weight and blood pressure;
- Obtaining a health history;
- Performing a physical examination;
- Making a medical decision;
- Explaining treatment options;
- Developing a treatment plan; or
- Instructions for management of the condition.

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

**Outpatient Medical Event Benefits:**

We will pay the corresponding Scheduled Benefit amount upon occurrence of an Event wherein the Covered Person receives one of the following for treatment of a Sickness or Injury:

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

Benefits for are limited to the Calendar Year Maximum Outpatient Medical Event Benefit shown on the Schedule of Benefits.

**Allergy Shots and Immunization Benefits (Covered Dependent Children Only):**

We will pay the corresponding Scheduled Benefit amount for each allergy shot received by a Covered Dependent child. We will also pay the corresponding Scheduled Benefit amount for each immunization received by a Covered Dependent child as recommended by the United States Preventive Service Task Force or the Advisory Committee on Immunization Practices on the date the immunization is rendered. If the administration of the shot or immunization occurs during an office visit, an Outpatient office visit is payable.

Benefits are limited to the Calendar Year Maximum Allergy Shots and Immunizations Benefit shown on the Schedule of Benefits.]

**[PRESCRIPTION DRUG RIDER**

<b>Prescription Order Benefits:</b>	<ul style="list-style-type: none"><li>• Scheduled Benefit per Generic Prescription Drug: \$[10].</li><li>• Scheduled Benefit per Brand Name Prescription Drug \$[25].</li><li>• If a Generic Prescription Drug is available and You receive a Brand Name Prescription Drug, only the Scheduled Benefit for the Generic Prescription Drug will be paid.</li><li>• All Outpatient Prescription Order Benefits are limited to a Maximum Benefit of \$[750] per Calendar Year, per Covered Person.]</li></ul>
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**Prescription Order Benefits:**

We will pay the corresponding Scheduled Benefit amount when a Covered Person fills a Prescription Order through an outpatient pharmacy.

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

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

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

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

All Benefits are limited to the Calendar Year Maximum Outpatient Prescription Drug Benefit shown in the Schedule of Benefits.]

**[FIRST OCCURRENCE BENEFIT RIDER**

<b>First Occurrence Benefit Amount:</b>	Coma, Internal Cancer, End Stage Renal Failure or Paralysis: <ul style="list-style-type: none"><li>• [\$1,000 per unit, years 1-5] [1-10 units]</li><li>• [\$2,000 per unit, years 6 +] [1-10 units]</li></ul> Coronary Artery Bypass Surgery , Major Human Organ Transplant, Heart Attack or Stroke: <ul style="list-style-type: none"><li>• [\$500 per unit, years 1-5] [1-10 units]</li><li>• [\$1,000 per unit, years 6 +] [1-10 units]</li></ul>
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**First Occurrence Benefits:**

One First Occurrence Benefit is payable per Covered Person. If an event does not occur within the first 5 years this rider is in force, the First Occurrence Benefit will double. A benefit may be paid in one of two ways:

1. The First Occurrence Benefit listed in the Schedule of Benefits is payable if one of the following health events occurs for the first time in the Covered Person’s lifetime and while this Rider is in force for the Covered Person.
  - Coma (non drug induced)
  - End Stage Renal Failure
  - Internal Cancer
  - Paralysis
  
2. A benefit equal to 50% of the First Occurrence Benefit listed in the Schedule of Benefits is payable if one of the following health events occurs for the first time in the Covered Person’s lifetime and while this Rider is in force for the Covered Person.
  - Coronary Artery Bypass Surgery
  - Heart Attack
  - Major Human Organ Transplant
  - Stroke

The Company must be provided with a diagnosis by a Physician accompanied by documentation supported by clinical, radiological, histological and laboratory evidence satisfactory to the Company. The Company may, at its expense, require an examination or further tests by a Physician of its choice.

Once a benefit has been paid to a Covered Person, no additional benefits are payable to that Covered Person and their coverage under the rider will terminate.]

**[INTERNAL CANCER RIDER**

<b>Internal Cancer Benefit:</b>	<ul style="list-style-type: none"> <li>• Monthly Benefit Amount     [\$100 per unit] [1-10 units]</li> <li>• Maximum Benefit Period     [6-12 Months] ]</li> </ul>
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**Internal Cancer Benefits:**

If a Covered Person receives a Positive Diagnosis of any type of Internal Cancer, We will pay the Monthly Benefit Amount shown on the Schedule of Benefits for this Rider. We will pay this amount each month beginning on the month the Covered Person receives such Positive Diagnosis and during the Covered Person’s lifetime but not to exceed [6] months.

Once a benefit has been paid to a Covered Person, no additional benefits are payable to that Covered Person and their coverage under the rider will terminate.]

**[INTENSIVE CARE UNIT RIDER**

<b>Daily Benefit Amount:</b>	<ul style="list-style-type: none"> <li>• Daily Benefit Amount: [\$100 per unit, [1-30 units]</li> <li>• Calendar Year Maximum: [10 Days] Per Covered Person</li> </ul>
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**Intensive Care Unit Benefits:** If a Covered Person is confined in a Hospital’s Intensive Care Unit due to an Injury or Sickness, We will pay the Daily Benefit Amount shown on the Schedule of Benefits. We will pay this amount for each day of confinement for which there is a room and board charge by the Hospital; but not to exceed the Calendar Year Maximum as shown on the Schedule of Benefits.]

**SECTION 3: LIMITATIONS AND EXCLUSIONS:**

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

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

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

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

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

#### **[PRESCRIPTION DRUG RIDER EXCLUSIONS**

In addition to the Exclusions and Limitations under the Policy to which this Rider is attached, We will not pay benefits for claims resulting, whether directly or indirectly from Events or loss related to or resulting from any of the following:

- a. Drugs or medicines obtained from pharmacy provider sources outside the United States.
- b. Vitamins and/or vitamin combinations even if they are prescribed by a Health Care Practitioner.
- c. Any prescription products, drugs or medicines in the following categories, whether or not prescribed by a Health Care Practitioner:
  1. Herbal or homeopathic medicines or products;
  2. Minerals;
  3. Appetite suppressants;
  4. Dietary or nutritional substances or dietary supplements;
  5. Nutraceuticals;
  6. Medical Foods; or
  7. Durable medical equipment/supplies.
- d. Drugs or medicines that have an over-the-counter equivalent or contain the same or therapeutically equivalent active ingredient(s) as over-the-counter medication, as determined by Us.
- e. Drugs or medicines: administered or dispensed at or by the rest home, sanitarium, extended care

facility, convalescent care facility, Skilled Nursing Facility or similar institution, dispensed at or by a Hospital, an Emergency Room, a Free-Standing Facility, an Urgent Care Facility, a Health Care Practitioner's office or other Inpatient or Outpatient setting for take home by the Covered Person.

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

#### **SECTION 4: RENEWABILITY PROVISIONS:**

The Policy is Conditionally Renewable. This means that You have the right to renew the Policy until You attain age 65 if You pay the correct premium when due or within the Grace Period.

#### **SECTION 5: PREMIUM:**

You have the right to renew this Policy until the Policy anniversary on or after Your 65<sup>th</sup> birthday if You pay the correct premium when due or within the Grace Period. We retain the right to change the premium rates on this Policy. See the Premium Provisions section of this Policy. Premiums are based on Your attained age. The premium may change if a new table of rates is applicable to the Policy. The change in the table of rates will apply to all Covered Person in the same class on the date of the change. Class is defined as attained age and underwriting class.

We have the right to change premiums on Your Policy anniversary date. If We change premiums, We will do so only:

1. If We change the premiums for all policies of this form and attained age in Your state of issue;
2. If such change is in accordance with the laws and regulations of Your state of issue; and
3. If We give You 30 days notice (or longer if required by the state in which this policy is issued) before such change becomes effective.

There is a grace period of 31 days for the payment of each premium due after the initial premium during which period coverage will continue in-force.

# FAMILY LIFE INSURANCE COMPANY

## HOSPITAL CONFINEMENT AND SURGICAL FIXED INDEMNITY INSURANCE POLICY

### VARIABILITY STATEMENT

#### ALL FORMS

- The address, telephone number and names of officers are bracketed to allow for changes in the event these items are changed.
- The benefit amounts have been bracketed to show the ranges of benefits allowed. Please note, at this time, we are only selling those options specifically identified in the policy (schedule of benefits), and application. If we chose to update or change the units, this will only be done within the scope of the actuarial memorandum. The outpatient prescription drug benefit is bracketed to allow the benefit to be removed.

#### POLICY SCHEDULE

- The information on the Policy Schedule are bracketed to allow for variables in the amount of benefits as described above as well as for personalization of the policy issued.

#### OUTLINE OF COVERAGE

- The riders on the Outline of Coverage are bracketed to show the benefits provided if the insured chooses to purchase the riders.

#### INTERNAL CANCER RIDER

- The monthly benefit can be increased with additional units purchased.

Form Name	Form Number
Hospital Confinement and Surgical Fixed Indemnity Policy	FHCS11
Hospital Confinement and Surgical Fixed Indemnity Outline of Coverage	FHCS11-OC
Intensive Care Unit Rider	FHCS11-ICU
First Occurrence Benefit Rider	FHCS11-FOB
Prescription Drug Rider	FHCS11-RX
Internal Cancer Rider	FHCS11-CX
Outpatient Sickness and Injury Rider	FHCS11-OPSI

SERFF Tracking Number: CEUL-127130886 State: Arkansas  
 Filing Company: Family Life Insurance Company State Tracking Number: 48523  
 Company Tracking Number:  
 TOI: H14I Individual Health - Hospital Indemnity Sub-TOI: H14I.000 Health - Hospital Indemnity  
 Product Name: Secure Care  
 Project Name/Number: /

## Superseded Schedule Items

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

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
04/21/2011	Form	Secure Care policy	04/25/2011	FHCS11-AR.pdf (Superseded) FHCS11-AR REDLINED.pdf (Superseded)
04/18/2011	Form	Secure Care policy	04/21/2011	FHCS11.pdf (Superseded)

**FAMILY LIFE INSURANCE COMPANY**

*Home Office: [Houston, TX]*

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

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**HOSPITAL CONFINEMENT AND OTHER FIXED INDEMNITY INSURANCE POLICY**

Limited Hospital Confinement and Other Fixed Indemnity Benefits

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

The insurance described in this Policy is effective on the date shown in the Schedule of Benefits only if You are eligible for the insurance, become insured, subject to the terms, limits and conditions of this Policy. This Policy is evidence of Your coverage.

**PLEASE READ YOUR POLICY AND SCHEDULE OF BENEFITS CAREFULLY AND BECOME FAMILIAR WITH ITS TERMS, LIMITS, EXCLUSIONS AND BENEFIT PROVISIONS.**

**CONDITIONALLY RENEWABLE:** You have the right to renew this Policy until you attain age 65 if You pay the correct premium when due or within the Grace Period. We retain the right to change the premium rates on this Policy. See the Premium Provisions section of this Policy. Premiums are based on Your attained age and will change on your Policy anniversary date. (Your Policy anniversary date is the same month and day as the Policy Effective Date for each succeeding year this Policy remains in force). The premium may change if a new table of rates is applicable to the Policy. The change in the table of rates will apply to all Covered Persons in the same class on the date of the change. Class is defined as attained age and underwriting class.

**RIGHT TO EXAMINE POLICY FOR 10 DAYS**

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

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

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

[   ]

[Mary Lou Rainey  
Secretary]

[Dan George  
President]

Executed by Family Life Insurance Company on the Effective Date.

THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES

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## DEFINITIONS

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

### **Accident or Accidental:**

An unforeseen and unplanned event that occurs:

1. Unintentionally and unexpectedly;
2. independent of disease, bodily infirmity or any other cause; and
3. Resulting in injury to an Insured Person that is not due to any fault or misconduct on the part of the injured Insured Person.

Accident shall include pregnancy following an act of rape of a Covered Person that was reported to the Police within seven days following its occurrence. The seven day requirement for notification to the police shall be extended to 180 days in the case of an act of rape or incest of a female under 13 years of age.

### **Calendar Year:**

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

### **Complications of Pregnancy:**

Complications of Pregnancy include the following:

1. Conditions requiring Hospital confinement (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy including but not limited to, acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, Health Care Practitioner-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting distinct complication of pregnancy; and
2. Non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

### **Confinement Period:**

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

### **Cosmetic Services:**

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

### **Covered Dependent:**

A Covered Dependent is:

1. Your lawful spouse; or
2. Your naturally born child, legally adopted child, a child in which You are a party to a suit in which adoption is sought, a stepchild, a grandchild dependent upon You for federal income tax purposes at the time of the child's application for coverage, a child for whom You are the legal guardian, or a child for whom You are required to provide medical support by court or administrative order:
  - a. Who is unmarried; and
  - b. Who is under age 26.
3. Enrolled for coverage under the policy and eligible to receive benefits.

If Your unmarried child is age 26 or older, the child will be considered a Covered Dependent if You give Us proof that the child is not capable of self-sustaining employment because of mental incapacity or physical handicap and is chiefly dependent on You for support and maintenance. You must give Us proof that the child meets these requirements at the same time that You first enroll for coverage under this Policy or within 31 days after the child reaches the normal age for termination. Additional proof may be requested periodically after the date the child reaches the normal age for termination.

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

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

**Covered Event:**

A medical event for which this Policy and any attached Riders provides a Scheduled Benefit and that meets all of the following requirements:

1. The treatment, services or supplies provided in connection with the event are provided by a Health Care Practitioner, facility or supplier.
2. It is incurred by a Covered Person while coverage is in force under this Policy and any attached Riders as the result of a Sickness or an Injury.
3. It is incurred for events shown in the Benefits Section, any attached Riders and on the Schedule of Benefits.
4. The occurrence includes treatment, services or supplies which are Medically Necessary.

**Covered Person:**

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

**Custodial Care:**

Care, regardless of setting, that is primarily for the purpose of meeting the personal needs of the patient, including but not limited to:

1. assisting in the activities of daily living;
2. providing help in walking or getting in or out of bed;
3. assisting with bathing, dressing, feeding, homemaking, or preparation of special diets;
4. supervision of medication;
5. providing companionship; or
6. ensuring safety.

**Durable Medical Equipment:**

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

**Effective Date:**

The date coverage under this Policy begins for a Covered Person. The Covered Person's coverage begins at 12:01 a.m. local time, at Your residence. The effective date of the policy will be the date recorded by Us at our home office. It is not the date the application is signed. The policy will become effective when all underwriting requirements have been satisfied and required premium paid. The Effective Date for Covered Dependents added after the Policy Effective Date will be determined by Us.

**Emergency Room:**

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

**Emergency Treatment:**

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

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

**Experimental or Investigational Services:**

Treatment, services or supplies which are:

1. Not given to be of benefit for diagnosis or treatment of a Sickness or an Injury; or
2. Not generally used or recognized by the medical community as safe, effective and appropriate for diagnosis or treatment of a Sickness or an Injury; or
3. In the research or investigational stage, provided or performed in a special setting for research purposes or under a controlled environment or clinical protocol; or
4. Obsolete or ineffective for the treatment of a Sickness or an Injury; or

**Health Care Practitioner:**

A person licensed by the state or other geographic area in which the treatment or services are rendered to treat the kind of Sickness or Injury for which a claim is made. The Health Care Practitioner must be practicing within the limits of his or her license and in the geographic area in which he or she is licensed. The term Health Care Practitioner does not include any Covered Person or any Covered Person's Immediate Family Member. Benefits will be paid only if the services provided are covered under this Policy and any attached Riders.

**Home Health Care:**

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

**Hospice:**

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

**Hospital:**

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

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

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

**Immediate Family Member:**

An Immediate Family Member is:

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

**Injury:**

Physical damage to the structure or function of the body caused by an outside force, which may be physical or chemical, as a result of an Accident.

**Inpatient:**

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

**Maximum Benefit:**

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

**Maximum Lifetime Benefit:**

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

**Medical Supply Provider:**

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

**Medically Necessary or Medical Necessity:**

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

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

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

**Medicare:**

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

**Mental/Nervous Disorders and Substance Abuse:**

Any disorder classified as such in the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association.

**Outpatient:**

Treatments, services and/or supplies rendered on anything other than an Inpatient basis.

**Personal Medical Equipment:**

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

**Policy:**

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

**Policyholder:**

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

**Pre-Existing Condition:**

A condition and related complications:

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

**Rehabilitation Services:**

Specialized treatment received on an Inpatient basis for a Sickness or an Injury that meets all of the following requirements:

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

**Retail Health Clinic:**

A facility that meets all of the following requirements:

1. Is licensed by the state in accordance with the laws for the specific services being provided in that facility;
2. Is staffed by a Health Care Practitioner in accordance with the laws of that state;
3. Is attached to or is part of a store or retail facility;

4. Is separate from a Hospital, Emergency Room, acute medical rehabilitation facility, free-standing facility, Skilled Nursing Facility, subacute rehabilitation facility, or Urgent Care Facility, and any Health Care Practitioner's office located therein even when services are performed after normal business hours;
5. Provides general medical treatment of services for a Sickness or Injury, or provides preventive medical services;
6. Does not provide room and board or overnight services.

**Scheduled Benefit:**

The fixed benefit amount payable upon occurrence of a Covered Event under the terms of this Policy and any attached Riders. The Scheduled Benefit for a Covered Event is shown on the Schedule of Benefits.

**Sickness:**

A disease or an illness of a Covered Person that first manifested itself after the Covered Person's Effective Date under this Policy and any attached Riders and while coverage is in force. Sickness includes Complications of Pregnancy, but not the pregnancy itself.

**Skilled Nursing Facility:**

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

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

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

**Urgent Care:**

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

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

**Urgent Care Facility:**

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

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

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

Family Life Insurance Company.

**You, Your:**

The person listed on the Schedule of Benefits as the Policyholder.

**EFFECTIVE DATE AND TERMINATION DATE**

**Eligibility and Effective Date of Policyowner:**

A person who is eligible may elect to be covered under this Policy by completing the application process and submitting any required premium. You must be a resident of the state where this Policy is issued. Evidence of insurability according to Our underwriting and eligibility criteria must also be provided. Your coverage will take effect on Your Effective Date as shown on the Schedule of Benefits.

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

### Eligibility and Effective Date of Dependents:

The following information explains how to apply for coverage for additional dependants:

- **Adding a Newborn Child:** A newborn child can be added on the date the child was born. You must send Us written notice of the birth of the child and We must receive any required additional premium within 90 days of birth. The Effective Date of coverage will be on the date the child is born. If these requirements are not met, Your newborn child will be covered for Sickness or Injury, including Covered Events related to the necessary care and treatment of medically diagnosed congenital defects only for the first 90 days from birth.
- **Adding an Adopted Child:** A newly adopted child can be added on the date the child is adopted or You become a party in a suit for adoption, whichever is earlier. You must send Us written notice of the adoption or suit for adoption of the child and We must receive any required additional premium within 60 days of the adoption or suit for adoption of the child, whichever is earlier. The Effective Date of coverage will be on the earlier of the date the child is adopted or You become a party in a suit for adoption. If these requirements are not met, Your newly adopted child will be covered for Sickness or Injury only for the first 60 days from the date of adoption or suit for adoption. A child is no longer considered adopted if, prior to legal adoption, You relinquish legal obligation for support of the child and the child is removed from placement or when You are no longer party to a suit for adoption of the child.
- **Adding a Child for Whom a Court Order Requires You to Provide Insurance:** A child for whom a court order requires You or your Covered Dependent spouse to provide this insurance will be covered for the first 31 days from the time We receive a medical support order or notice of a medical support order. Any required additional premium must be received within 31 days from Our notice or receipt of the court order. If these requirements are not met, the child will only be covered for the first 31 days from the date We receive the medical support order or notice of the medical support order.
- **Adding Any other Dependent:** To add any other dependents, an application must be completed and sent to Us along with any required premium. Evidence of insurability must also be provided. The Effective Date of coverage will be on the Effective Date for that Covered Person shown on the Schedule of Benefits.

### Termination Date:

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

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

1. The end of the month You attain age 65. Covered Dependents may apply for coverage without evidence of insurability. The request for coverage must be made within 30 days of You attaining age 65.
2. The date We receive a request in writing to terminate this Policy on or on a later date that is requested by You for termination;
3. The date this Policy lapses for nonpayment of premium subject to the Grace Period provision in the Premium Provision section;
4. The date all policies the same as this one are non-renewed in the state in which this Policy was issued or the state in which You presently reside;
5. The date We terminate or nonrenew all individual market hospital-indemnity insurance policies in the state in which this Policy was issue or the state in which You presently reside. We will give You advance notice, as required by state law, of the termination of Your coverage;
6. The date You move to a state where We do not provide insurance under a Policy with the same Policy design as this Policy, We reserve the right to terminate this coverage; or

Coverage of a Covered Dependent will terminate on:

1. The date We receive a request in writing to terminate coverage for a Covered Dependent or on a later date that is requested by You for termination of a Covered Dependent;
2. The date a Covered Dependent no longer meets the Covered Dependent definition in this Policy. We will pay benefits to the end of the time for which We have accepted premiums.

If coverage terminates due to Your death, your spouse will become the named Policyholder provided your spouse is a Covered Person under this Policy on the date of death.

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

**Covered Dependent Conversion:**

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

1. The Covered Dependent's insurance terminated due to a valid decree of divorce between You and the Covered Dependent. The Covered Dependent will be issued a Policy, which We are currently issuing, that most nearly approximates the coverage of this Policy, without evidence of insurability and with the same effective date as the Covered Dependent's coverage under this Policy; or
2. The Covered Dependent's insurance terminates due to Your death, or You attain age 65; or
3. A Covered Dependent child's insurance terminates because the child no longer meets the eligibility requirements for a Covered Dependent.

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

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

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

## HOSPITAL CONFINEMENT AND OTHER FIXED INDEMNITY BENEFITS

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

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

We will pay the corresponding Scheduled Benefit amount shown on the Schedule of Benefits when a Covered Event described below is rendered to a Covered Person and is Medically Necessary.

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

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

Benefits are limited to the Calendar Year Maximum Daily Hospital Confinement Benefit shown on the Schedule of Benefits.

### **Hospital Admission Benefits:**

We will pay the corresponding Scheduled Benefit amount when a Covered Person is confined for the first time as a resident Inpatient during the Calendar Year. A maximum of one benefit per Covered Person per year is payable. Confinement as a resident Inpatient means assigned to a Hospital bed for an overnight stay for Medically Necessary reasons resulting from Injury or Sickness on the advice of a Health Care Practitioner.

### **Emergency Room/Urgent Care Facility Visit Benefits:**

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

Benefits are limited to the Calendar Year Maximum Emergency Room/Urgent Care Facility Benefit shown on the Schedule of Benefits.

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

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

### **Anesthesia Benefits:**

We will pay an Anesthesia Benefit equal to 20% of the surgical benefit amount shown in the Surgical Schedule when a Covered Person is administered anesthesia as part of a surgery that is a Covered Event. Benefits are limited to the Calendar Year Maximum Benefit shown on the Schedule of Benefits.

### **Surgical Services Benefits:**

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

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

**Assistant Surgeon Benefit:**

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

**PRE-EXISTING CONDITIONS LIMITATION****Pre-Existing Conditions Limitation:**

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

**EXCLUSIONS**

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

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

- weight reduction is Medically Necessary or appropriate or regardless of potential benefits for co-morbid conditions, weight reduction or weight control surgery, treatment or programs, any type of gastric bypass surgery, suction lipectomy, physical fitness programs, exercise equipment or exercise therapy, including health club membership visits or services; nutritional counseling.
12. Organ, tissue or cellular material donation by a Covered Person, including administrative visits for registry, computer search for donor matches, preliminary donor typing, donor counseling, donor identification and donor activation.
  13. Chemical peels, reconstructive or plastic surgery that does not alleviate a functional impairment and other confinement or treatment visits that are primarily for Cosmetic Services as determined by Us.
  14. Capsular contraction, augmentation or reduction mammoplasty, except for all stages and revisions of reconstruction of the breast following a Medically Necessary mastectomy for treatment of cancer, including reconstruction of the other breast to produce a symmetrical appearance and treatment of lymphedemas.
  15. Removal or replacement of a prosthesis, Durable Medical Equipment or Personal Medical Equipment, except for internal breast prostheses following a Medically Necessary mastectomy for treatment of cancer and services are received in accordance with the Hospital Confinement and Other Fixed Indemnity Benefits Section.
  16. Prophylactic treatment, services or surgery including, but not limited to, prophylactic mastectomy or any other treatment, services or surgery to prevent a disease process from becoming evident in the organ or tissue at a later date.
  17. Treatment, services, and supplies for:
    - a. Home Health Care;
    - b. Hospice Care;
    - c. Skilled Nursing Facility care, Inpatient rehabilitation services;
    - d. Custodial Care, respite care, rest care, supportive care, homemaker services;
    - e. Phone, facsimile, internet or e-mail consultation, compressed digital interactive video, audio or clinical data transmission using computer imaging by way of still-image capture and store forward;
    - f. Treatment, services or supplies that are furnished primarily for the personal comfort or convenience of the Covered Person, Covered Person's family, a Health Care Practitioner or provider;
    - g. Treatment or services provided by a standby Health Care Practitioner; or
    - h. Treatment or services provided by a masseur, masseuse or massage therapist, massage therapy, a rolfer.
  18. Treatment, services, and supplies for growth hormone therapy, including growth hormone medication and its derivatives or other drugs used to stimulate, promote or delay growth or to delay puberty to allow for increased growth.
  19. Treatment, services and supplies related to the following conditions, regardless of underlying causes: sex transformation, gender dysphoric disorder, gender reassignment, and treatment of sexual function, dysfunction or inadequacy, treatment to enhance, restore or improve sexual energy, performance or desire.
  20. Treatment, services and supplies related to: maternity, pregnancy (except Complications of Pregnancy), routine well newborn care at birth including nursery care, abortion.
  21. Any prescription drugs whether purchased, dispensed, or received from or by a physician, pharmacy, hospital, emergency room or any other medical facility, including contraceptive drugs or devices.
  22. Treatment for or treatment use of:
    - a. Genetic testing or counseling, genetic services and related procedures for screening purposes including, but not limited to, amniocentesis and chronic villi testing;
    - b. Services, drugs or medicines used to treat males or females for an infertility diagnosis regardless of intended use including, but not limited to: artificial insemination, in vitro fertilization, reversal of reproductive sterilization, any treatment to promote conception;
    - c. Sterilization;
    - d. Cryopreservation of sperm or eggs;
    - e. Surrogate pregnancy;
    - f. Fetal surgery, treatment or services;
    - g. Umbilical cord stem cell or other blood component harvest and storage in the absence of a Sickness or an Injury; or
    - h. Circumcision;
  23. Spinal and other adjustments, manipulations, subluxation treatment and/or services.
  24. Treatment for: behavior modification or behavioral (conduct) problems; learning disabilities, developmental delays, attention deficit disorders, hyperactivity, educational testing, training or materials, memory improvement, cognitive enhancement or training, vocational or work hardening programs, transitional living.
  25. Treatment for or through use of:
    - a. Non-medical items, self-care or self-help programs;
    - b. Aroma therapy;

- c. Meditation or relaxation therapy;
  - d. Naturopathic medicine;
  - e. Treatment of hyperhidrosis (excessive sweating);
  - f. Acupuncture, biofeedback, neurotherapy, electrical stimulation;
  - g. Inpatient treatment of chronic pain disorders;
  - h. Treatment of spider veins;
  - i. Family or marriage counseling;
  - j. Applied behavior therapy treatment for autistic spectrum disorders;
  - k. Smoking deterrence or cessation;
  - l. Snoring or sleep disorders;
  - m. Change in skin coloring or pigmentation; or
  - n. Stress Management.
26. A Sickness or Injury resulting from abuse or overdose of any illegal or controlled substance, except when administered in accordance with the advice of the Covered Person's Health Care Practitioner.
  27. Treatment of Sickness or an Injury when a contributing cause of the condition was the Covered Person's voluntary attempt to commit or participation in or commission of a felony, whether or not charged, or as a consequence of the Covered Person being under the influence of any illegal or non-prescribed controlled substance while committing a felony.
  28. Services ordered, directed or performed by a Health Care Practitioner or supplies purchased from a Medical Supply Provider who is a Covered Person, an Immediate Family Member, employer of a Covered Person or a person who ordinarily resides with a Covered Person.
  29. Any amount in excess of the Maximum Lifetime Benefit or any other Maximum Benefit limitation for covered Scheduled Benefits.
  30. Treatment that does not meet the definition of a Covered Event in this Policy including, but not limited to, treatment that is not Medically Necessary.
  31. Treatment, services and supplies for Experimental or Investigational Services.
  32. Treatment incurred outside of the United States.
  33. Sickness or Injury caused or aggravated by suicide, attempted suicide or self-inflicted Sickness or Injury.

## **CLAIM PROVISIONS**

### **Notice of Claim:**

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

### **Claim Forms:**

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

### **Proof of Loss:**

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

The proof of loss must include all of the following:

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

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

**Assignment Accepted:**

You may assign benefits under this Policy. Benefit payments may be assigned to another person in whole or in part. We will not honor any assignment of this Policy unless it is in writing and filed with Us at Our home office. We are not responsible for the validity of an assignment. If You assign benefits to a provider involved in the Covered Event, the assigned amount paid will not be in excess of the amount shown on the provider's statement submitted at proof of loss. Any Scheduled Benefit amount in excess of the billed amount will be paid directly to You, unless otherwise expressly assigned by You.

**Right to Collect Information:**

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

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

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

**Physical Examination and Autopsy:**

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

**Payment of Benefits:**

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

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

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

**Overpayment:**

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

**Rights of Administration:**

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

**Claims Involving Misrepresentation or Fraud:**

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

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

**Workers' Compensation Not Affected:**

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

**Claim Appeal:**

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

**PREMIUM PROVISIONS****Consideration:**

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

**Premium Payment:**

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

**Changes in Premiums:**

We have the right to change premiums on your Policy anniversary date. If We change premiums, We will do so only:

1. If We change the premiums for all policies of this form and attained age in Your state of issue;
2. If such change is in accordance with the laws and regulations of Your state of issue; and
3. If We give You 30 days notice (or longer if required by the state in which this Policy is issued) before such change becomes effective.

**Refund of Unearned Premiums:**

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

**Grace Period:**

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

**Reinstatement:**

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

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

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

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

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

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

## **OTHER PROVISIONS**

### **Policy Changes:**

This Policy may be changed at any time. We will give You 30 days notice prior to any change. No change in this Policy will be valid unless approved by one of Our executive officers and included with this Policy. No agent or other employee of Our Company has authority to waive or change any Policy provision or waive any other applicable application or application requirements.

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

### **Clerical Error:**

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

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

### **Conformity with State Statutes:**

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

### **Enforcement of Policy Provisions:**

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

### **Entire Contract:**

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

### **Representations Made on Application Form:**

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

### **Extension of Benefits:**

On the date this coverage terminates, We may extend benefits during a Confinement Period that is a result of a Sickness that commenced or an Injury sustained while this Policy was in force. Benefits are payable only for Covered Events relating to the Sickness or Injury that directly caused the confinement. Newly diagnosed conditions and complications of the condition that caused the initial confinement are not eligible for benefits during the Extension of Benefits. The Covered Person must be under the care of a Health Care Practitioner for the Inpatient stay. Medical documentation

verifying the Hospital stay must be sent to Us within 90 days after termination. Benefits are subject to all the terms, limits and conditions in this Policy. Premium payment will not be required during the extension of benefits period.

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

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

**Misstatements:**

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

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

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

**Legal Action:**

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

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

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

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

**FAMILY LIFE INSURANCE COMPANY**

*Home Office: [Houston, TX]*

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

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**HOSPITAL CONFINEMENT AND OTHER FIXED INDEMNITY INSURANCE POLICY**

Limited Hospital Confinement and Other Fixed Indemnity Benefits

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

The insurance described in this Policy is effective on the date shown in the Schedule of Benefits only if You are eligible for the insurance, become insured, subject to the terms, limits and conditions of this Policy. This Policy is evidence of Your coverage.

**PLEASE READ YOUR POLICY AND SCHEDULE OF BENEFITS CAREFULLY AND BECOME FAMILIAR WITH ITS TERMS, LIMITS, EXCLUSIONS AND BENEFIT PROVISIONS.**

**CONDITIONALLY RENEWABLE:** You have the right to renew this Policy until you attain age 65 if You pay the correct premium when due or within the Grace Period. We retain the right to change the premium rates on this Policy. See the Premium Provisions section of this Policy. Premiums are based on Your attained age and will change on your Policy anniversary date. (Your Policy anniversary date is the same month and day as the Policy Effective Date for each succeeding year this Policy remains in force). The premium may change if a new table of rates is applicable to the Policy. The change in the table of rates will apply to all Covered Persons in the same class on the date of the change. Class is defined as attained age and underwriting class.

**RIGHT TO EXAMINE POLICY FOR 10 DAYS**

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

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

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

[   ]

[Mary Lou Rainey  
Secretary]

[Dan George  
President]

Executed by Family Life Insurance Company on the Effective Date.

THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES

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## DEFINITIONS

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

### **Accident or Accidental:**

An unforeseen and unplanned event that occurs:

1. Unintentionally and unexpectedly;
2. independent of disease, bodily infirmity or any other cause; and
3. Resulting in injury to an Insured Person that is not due to any fault or misconduct on the part of the injured Insured Person.

Accident shall include pregnancy following an act of rape of a Covered Person that was reported to the Police within seven days following its occurrence. The seven day requirement for notification to the police shall be extended to 180 days in the case of an act of rape or incest of a female under 13 years of age.

### **Calendar Year:**

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

### **Complications of Pregnancy:**

Complications of Pregnancy include the following:

1. Conditions requiring Hospital confinement (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy including but not limited to, acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, Health Care Practitioner-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting distinct complication of pregnancy; and
2. Non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

### **Confinement Period:**

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

### **Cosmetic Services:**

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

### **Covered Dependent:**

A Covered Dependent is:

1. Your lawful spouse; or
2. Your naturally born child, legally adopted child, a child in which You are a party to a suit in which adoption is sought, a stepchild, a grandchild dependent upon You for federal income tax purposes at the time of the child's application for coverage, a child for whom You are the legal guardian, or a child for whom You are required to provide medical support by court or administrative order:
  - a. Who is unmarried; and
  - b. Who is under age 26.
3. Enrolled for coverage under the policy and eligible to receive benefits.

If Your unmarried child is age 26 or older, the child will be considered a Covered Dependent if You give Us proof that the child is not capable of self-sustaining employment because of mental incapacity or physical handicap and is chiefly dependent on You for support and maintenance. You must give Us proof that the child meets these requirements at the same time that You first enroll for coverage under this Policy or within 31 days after the child reaches the normal age for termination. Additional proof may be requested periodically ~~but not more often than annually after the initial 2-year period following after~~ the date the child reaches the normal age for termination.

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

1. Attains age 26 (except for a mentally incapacitated or physically handicapped child as described above; or

2. Marries; or
3. Is over age 26 and is capable of self-sustaining employment because he or she is no longer mentally incapacitated or physically handicapped.

**Covered Event:**

A medical event for which this Policy and any attached Riders provides a Scheduled Benefit and that meets all of the following requirements:

1. The treatment, services or supplies provided in connection with the event are provided by a Health Care Practitioner, facility or supplier.
2. It is incurred by a Covered Person while coverage is in force under this Policy and any attached Riders as the result of a Sickness or an Injury.
3. It is incurred for events shown in the Benefits Section, any attached Riders and on the Schedule of Benefits.
4. The occurrence includes treatment, services or supplies which are Medically Necessary.

**Covered Person:**

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

**Custodial Care:**

Care, regardless of setting, that is primarily for the purpose of meeting the personal needs of the patient, including but not limited to:

1. assisting in the activities of daily living;
2. providing help in walking or getting in or out of bed;
3. assisting with bathing, dressing, feeding, homemaking, or preparation of special diets;
4. supervision of medication;
5. providing companionship; or
6. ensuring safety.

**Durable Medical Equipment:**

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

**Effective Date:**

The date coverage under this Policy begins for a Covered Person. The Covered Person's coverage begins at 12:01 a.m. local time, at Your residence. The effective date of the policy will be the date recorded by Us at our home office. It is not the date the application is signed. The policy will become effective when all underwriting requirements have been satisfied and required premium paid. The Effective Date for Covered Dependents added after the Policy Effective Date will be determined by Us.

**Emergency Room:**

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

**Emergency Treatment:**

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

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

**Experimental or Investigational Services:**

Treatment, services or supplies which are:

1. Not given to be of benefit for diagnosis or treatment of a Sickness or an Injury; or
2. Not generally used or recognized by the medical community as safe, effective and appropriate for diagnosis or treatment of a Sickness or an Injury; or
3. In the research or investigational stage, provided or performed in a special setting for research purposes or under a controlled environment or clinical protocol; or
4. Obsolete or ineffective for the treatment of a Sickness or an Injury; or

**Health Care Practitioner:**

A person licensed by the state or other geographic area in which the treatment or services are rendered to treat the kind of Sickness or Injury for which a claim is made. The Health Care Practitioner must be practicing within the limits of his or her license and in the geographic area in which he or she is licensed. The term Health Care Practitioner does not include any Covered Person or any Covered Person's Immediate Family Member. Benefits will be paid only if the services provided are covered under this Policy and any attached Riders.

**Home Health Care:**

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

**Hospice:**

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

**Hospital:**

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

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

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

**Immediate Family Member:**

An Immediate Family Member is:

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

**Injury:**

Physical damage to the structure or function of the body caused by an outside force, which may be physical or chemical, as a result of an Accident.

**Inpatient:**

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

**Maximum Benefit:**

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

**Maximum Lifetime Benefit:**

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

**Medical Supply Provider:**

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

**Medically Necessary or Medical Necessity:**

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

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

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

**Medicare:**

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

**Mental/Nervous Disorders and Substance Abuse:**

Any disorder classified as such in the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association.

**Outpatient:**

Treatments, services and/or supplies rendered on anything other than an Inpatient basis.

**Personal Medical Equipment:**

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

**Policy:**

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

**Policyholder:**

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

**Pre-Existing Condition:**

A condition and related complications:

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

**Rehabilitation Services:**

Specialized treatment received on an Inpatient basis for a Sickness or an Injury that meets all of the following requirements:

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

**Retail Health Clinic:**

A facility that meets all of the following requirements:

1. Is licensed by the state in accordance with the laws for the specific services being provided in that facility;
2. Is staffed by a Health Care Practitioner in accordance with the laws of that state;
3. Is attached to or is part of a store or retail facility;

4. Is separate from a Hospital, Emergency Room, acute medical rehabilitation facility, free-standing facility, Skilled Nursing Facility, subacute rehabilitation facility, or Urgent Care Facility, and any Health Care Practitioner's office located therein even when services are performed after normal business hours;
5. Provides general medical treatment of services for a Sickness or Injury, or provides preventive medical services;
6. Does not provide room and board or overnight services.

**Scheduled Benefit:**

The fixed benefit amount payable upon occurrence of a Covered Event under the terms of this Policy and any attached Riders. The Scheduled Benefit for a Covered Event is shown on the Schedule of Benefits.

**Sickness:**

A disease or an illness of a Covered Person that first manifested itself after the Covered Person's Effective Date under this Policy and any attached Riders and while coverage is in force. Sickness includes Complications of Pregnancy, but not the pregnancy itself.

**Skilled Nursing Facility:**

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

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

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

**Urgent Care:**

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

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

**Urgent Care Facility:**

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

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

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

Family Life Insurance Company.

**You, Your:**

The person listed on the Schedule of Benefits as the Policyholder.

**EFFECTIVE DATE AND TERMINATION DATE**

**Eligibility and Effective Date of Policyowner:**

A person who is eligible may elect to be covered under this Policy by completing the application process and submitting any required premium. You must be a resident of the state where this Policy is issued. Evidence of insurability according to Our underwriting and eligibility criteria must also be provided. Your coverage will take effect on Your Effective Date as shown on the Schedule of Benefits.

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

### Eligibility and Effective Date of Dependents:

The following information explains how to apply for coverage for additional dependants:

- **Adding a Newborn Child:** A newborn child can be added on the date the child was born. You must send Us written notice of the birth of the child and We must receive any required additional premium within 31-90 days of birth. The Effective Date of coverage will be on the date the child is born. If these requirements are not met, Your newborn child will be covered for Sickness or Injury, including Covered Events related to the necessary care and treatment of medically diagnosed congenital defects only for the first 31-90 days from birth.
- **Adding an Adopted Child:** A newly adopted child can be added on the date the child is adopted or You become a party in a suit for adoption, whichever is earlier. You must send Us written notice of the adoption or suit for adoption of the child and We must receive any required additional premium within 31-60 days of the adoption or suit for adoption of the child, whichever is earlier. The Effective Date of coverage will be on the earlier of the date the child is adopted or You become a party in a suit for adoption. If these requirements are not met, Your newly adopted child will be covered for Sickness or Injury only for the first 31-60 days from the date of adoption or suit for adoption. A child is no longer considered adopted if, prior to legal adoption, You relinquish legal obligation for support of the child and the child is removed from placement or when You are no longer party to a suit for adoption of the child.
- **Adding a Child for Whom a Court Order Requires You to Provide Insurance:** A child for whom a court order requires You or your Covered Dependent spouse to provide this insurance will be covered for the first 31 days from the time We receive a medical support order or notice of a medical support order. Any required additional premium must be received within 31 days from Our notice or receipt of the court order. If these requirements are not met, the child will only be covered for the first 31 days from the date We receive the medical support order or notice of the medical support order.
- **Adding Any other Dependent:** To add any other dependents, an application must be completed and sent to Us along with any required premium. Evidence of insurability must also be provided. The Effective Date of coverage will be on the Effective Date for that Covered Person shown on the Schedule of Benefits.

### Termination Date:

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

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

1. The end of the month You attain age 65. Covered Dependents may apply for coverage without evidence of insurability. The request for coverage must be made within 30 days of You attaining age 65.
2. The date We receive a request in writing to terminate this Policy on or on a later date that is requested by You for termination;
3. The date this Policy lapses for nonpayment of premium subject to the Grace Period provision in the Premium Provision section;
4. The date all policies the same as this one are non-renewed in the state in which this Policy was issued or the state in which You presently reside;
5. The date We terminate or nonrenew all individual market hospital-indemnity insurance policies in the state in which this Policy was issue or the state in which You presently reside. We will give You advance notice, as required by state law, of the termination of Your coverage;
6. The date You move to a state where We do not provide insurance under a Policy with the same Policy design as this Policy, We reserve the right to terminate this coverage; or

Coverage of a Covered Dependent will terminate on:

1. The date We receive a request in writing to terminate coverage for a Covered Dependent or on a later date that is requested by You for termination of a Covered Dependent;
2. The date a Covered Dependent no longer meets the Covered Dependent definition in this Policy. We will pay benefits to the end of the time for which We have accepted premiums.

If coverage terminates due to Your death, your spouse will become the named Policyholder provided your spouse is a Covered Person under this Policy on the date of death.

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

### **Covered Dependent Conversion:**

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

1. The Covered Dependent's insurance terminated due to a valid decree of divorce between You and the Covered Dependent. The Covered Dependent will be issued a Policy, which We are currently issuing, that most nearly approximates the coverage of this Policy, without evidence of insurability and with the same effective date as the Covered Dependent's coverage under this Policy; or
2. The Covered Dependent's insurance terminates due to Your death, or You attain age 65; or
3. A Covered Dependent child's insurance terminates because the child no longer meets the eligibility requirements for a Covered Dependent.

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

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

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

## HOSPITAL CONFINEMENT AND OTHER FIXED INDEMNITY BENEFITS

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

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

We will pay the corresponding Scheduled Benefit amount shown on the Schedule of Benefits when a Covered Event described below is rendered to a Covered Person and is Medically Necessary.

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

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

Benefits are limited to the Calendar Year Maximum Daily Hospital Confinement Benefit shown on the Schedule of Benefits.

### **Hospital Admission Benefits:**

We will pay the corresponding Scheduled Benefit amount when a Covered Person is confined for the first time as a resident Inpatient during the Calendar Year. A maximum of one benefit per Covered Person per year is payable. Confinement as a resident Inpatient means assigned to a Hospital bed for an overnight stay for Medically Necessary reasons resulting from Injury or Sickness on the advice of a Health Care Practitioner.

### **Emergency Room/Urgent Care Facility Visit Benefits:**

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

Benefits are limited to the Calendar Year Maximum Emergency Room/Urgent Care Facility Benefit shown on the Schedule of Benefits.

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

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

### **Anesthesia Benefits:**

We will pay an Anesthesia Benefit equal to 20% of the surgical benefit amount shown in the Surgical Schedule when a Covered Person is administered anesthesia as part of a surgery that is a Covered Event. Benefits are limited to the Calendar Year Maximum Benefit shown on the Schedule of Benefits.

### **Surgical Services Benefits:**

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

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

**Assistant Surgeon Benefit:**

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

**PRE-EXISTING CONDITIONS LIMITATION****Pre-Existing Conditions Limitation:**

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

**EXCLUSIONS**

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

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

- weight reduction is Medically Necessary or appropriate or regardless of potential benefits for co-morbid conditions, weight reduction or weight control surgery, treatment or programs, any type of gastric bypass surgery, suction lipectomy, physical fitness programs, exercise equipment or exercise therapy, including health club membership visits or services; nutritional counseling.
12. Organ, tissue or cellular material donation by a Covered Person, including administrative visits for registry, computer search for donor matches, preliminary donor typing, donor counseling, donor identification and donor activation.
  13. Chemical peels, reconstructive or plastic surgery that does not alleviate a functional impairment and other confinement or treatment visits that are primarily for Cosmetic Services as determined by Us.
  14. Capsular contraction, augmentation or reduction mammoplasty, except for all stages and revisions of reconstruction of the breast following a Medically Necessary mastectomy for treatment of cancer, including reconstruction of the other breast to produce a symmetrical appearance and treatment of lymphedemas.
  15. Removal or replacement of a prosthesis, Durable Medical Equipment or Personal Medical Equipment, except for internal breast prostheses following a Medically Necessary mastectomy for treatment of cancer and services are received in accordance with the Hospital Confinement and Other Fixed Indemnity Benefits Section.
  16. Prophylactic treatment, services or surgery including, but not limited to, prophylactic mastectomy or any other treatment, services or surgery to prevent a disease process from becoming evident in the organ or tissue at a later date.
  17. Treatment, services, and supplies for:
    - a. Home Health Care;
    - b. Hospice Care;
    - c. Skilled Nursing Facility care, Inpatient rehabilitation services;
    - d. Custodial Care, respite care, rest care, supportive care, homemaker services;
    - e. Phone, facsimile, internet or e-mail consultation, compressed digital interactive video, audio or clinical data transmission using computer imaging by way of still-image capture and store forward;
    - f. Treatment, services or supplies that are furnished primarily for the personal comfort or convenience of the Covered Person, Covered Person's family, a Health Care Practitioner or provider;
    - g. Treatment or services provided by a standby Health Care Practitioner; or
    - h. Treatment or services provided by a masseur, masseuse or massage therapist, massage therapy, a rolfer.
  18. Treatment, services, and supplies for growth hormone therapy, including growth hormone medication and its derivatives or other drugs used to stimulate, promote or delay growth or to delay puberty to allow for increased growth.
  19. Treatment, services and supplies related to the following conditions, regardless of underlying causes: sex transformation, gender dysphoric disorder, gender reassignment, and treatment of sexual function, dysfunction or inadequacy, treatment to enhance, restore or improve sexual energy, performance or desire.
  20. Treatment, services and supplies related to: maternity, pregnancy (except Complications of Pregnancy), routine well newborn care at birth including nursery care, abortion.
  21. Any prescription drugs whether purchased, dispensed, or received from or by a physician, pharmacy, hospital, emergency room or any other medical facility, including contraceptive drugs or devices.
  22. Treatment for or treatment use of:
    - a. Genetic testing or counseling, genetic services and related procedures for screening purposes including, but not limited to, amniocentesis and chronic villi testing;
    - b. Services, drugs or medicines used to treat males or females for an infertility diagnosis regardless of intended use including, but not limited to: artificial insemination, in vitro fertilization, reversal of reproductive sterilization, any treatment to promote conception;
    - c. Sterilization;
    - d. Cryopreservation of sperm or eggs;
    - e. Surrogate pregnancy;
    - f. Fetal surgery, treatment or services;
    - g. Umbilical cord stem cell or other blood component harvest and storage in the absence of a Sickness or an Injury; or
    - h. Circumcision;
  23. Spinal and other adjustments, manipulations, subluxation treatment and/or services.
  24. Treatment for: behavior modification or behavioral (conduct) problems; learning disabilities, developmental delays, attention deficit disorders, hyperactivity, educational testing, training or materials, memory improvement, cognitive enhancement or training, vocational or work hardening programs, transitional living.
  25. Treatment for or through use of:
    - a. Non-medical items, self-care or self-help programs;
    - b. Aroma therapy;

- c. Meditation or relaxation therapy;
  - d. Naturopathic medicine;
  - e. Treatment of hyperhidrosis (excessive sweating);
  - f. Acupuncture, biofeedback, neurotherapy, electrical stimulation;
  - g. Inpatient treatment of chronic pain disorders;
  - h. Treatment of spider veins;
  - i. Family or marriage counseling;
  - j. Applied behavior therapy treatment for autistic spectrum disorders;
  - k. Smoking deterrence or cessation;
  - l. Snoring or sleep disorders;
  - m. Change in skin coloring or pigmentation; or
  - n. Stress Management.
26. A Sickness or Injury resulting from abuse or overdose of any illegal or controlled substance, except when administered in accordance with the advice of the Covered Person's Health Care Practitioner.
  27. Treatment of Sickness or an Injury when a contributing cause of the condition was the Covered Person's voluntary attempt to commit or participation in or commission of a felony, whether or not charged, or as a consequence of the Covered Person being under the influence of any illegal or non-prescribed controlled substance while committing a felony.
  28. Services ordered, directed or performed by a Health Care Practitioner or supplies purchased from a Medical Supply Provider who is a Covered Person, an Immediate Family Member, employer of a Covered Person or a person who ordinarily resides with a Covered Person.
  29. Any amount in excess of the Maximum Lifetime Benefit or any other Maximum Benefit limitation for covered Scheduled Benefits.
  30. Treatment that does not meet the definition of a Covered Event in this Policy including, but not limited to, treatment that is not Medically Necessary.
  31. Treatment, services and supplies for Experimental or Investigational Services.
  32. Treatment incurred outside of the United States.
  33. Sickness or Injury caused or aggravated by suicide, attempted suicide or self-inflicted Sickness or Injury.

## CLAIM PROVISIONS

### **Notice of Claim:**

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

### **Claim Forms:**

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

### **Proof of Loss:**

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

The proof of loss must include all of the following:

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

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

**Assignment Accepted:**

You may assign benefits under this Policy. Benefit payments may be assigned to another person in whole or in part. We will not honor any assignment of this Policy unless it is in writing and filed with Us at Our home office. We are not responsible for the validity of an assignment. If You assign benefits to a provider involved in the Covered Event, the assigned amount paid will not be in excess of the amount shown on the provider's statement submitted at proof of loss. Any Scheduled Benefit amount in excess of the billed amount will be paid directly to You, unless otherwise expressly assigned by You.

**Right to Collect Information:**

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

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

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

**Physical Examination and Autopsy:**

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

**Payment of Benefits:**

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

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

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

**Overpayment:**

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

**Rights of Administration:**

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

**Claims Involving Misrepresentation or Fraud:**

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

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

**Workers' Compensation Not Affected:**

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

**Claim Appeal:**

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

**PREMIUM PROVISIONS****Consideration:**

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

**Premium Payment:**

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

**Changes in Premiums:**

We have the right to change premiums on your Policy anniversary date. If We change premiums, We will do so only:

1. If We change the premiums for all policies of this form and attained age in Your state of issue;
2. If such change is in accordance with the laws and regulations of Your state of issue; and
3. If We give You 30 days notice (or longer if required by the state in which this Policy is issued) before such change becomes effective.

**Refund of Unearned Premiums:**

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

**Grace Period:**

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

**Reinstatement:**

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

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

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

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

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

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

## OTHER PROVISIONS

### **Policy Changes:**

This Policy may be changed at any time. We will give You 30 days notice prior to any change. No change in this Policy will be valid unless approved by one of Our executive officers and included with this Policy. No agent or other employee of Our Company has authority to waive or change any Policy provision or waive any other applicable application or application requirements.

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

### **Clerical Error:**

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

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

### **Conformity with State Statutes:**

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

### **Enforcement of Policy Provisions:**

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

### **Entire Contract:**

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

### **Representations Made on Application Form:**

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

### **Extension of Benefits:**

On the date this coverage terminates, We may extend benefits during a Confinement Period that is a result of a Sickness that commenced or an Injury sustained while this Policy was in force. Benefits are payable only for Covered Events relating to the Sickness or Injury that directly caused the confinement. Newly diagnosed conditions and complications of the condition that caused the initial confinement are not eligible for benefits during the Extension of Benefits. The Covered Person must be under the care of a Health Care Practitioner for the Inpatient stay. Medical documentation

verifying the Hospital stay must be sent to Us within 90 days after termination. Benefits are subject to all the terms, limits and conditions in this Policy. Premium payment will not be required during the extension of benefits period.

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

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

**Misstatements:**

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

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

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

**Legal Action:**

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

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

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

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

**FAMILY LIFE INSURANCE COMPANY**

*Home Office: [Houston, TX]*

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

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**HOSPITAL CONFINEMENT AND OTHER FIXED INDEMNITY INSURANCE POLICY**

Limited Hospital Confinement and Other Fixed Indemnity Benefits

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

The insurance described in this Policy is effective on the date shown in the Schedule of Benefits only if You are eligible for the insurance, become insured, subject to the terms, limits and conditions of this Policy. This Policy is evidence of Your coverage.

**PLEASE READ YOUR POLICY AND SCHEDULE OF BENEFITS CAREFULLY AND BECOME FAMILIAR WITH ITS TERMS, LIMITS, EXCLUSIONS AND BENEFIT PROVISIONS.**

**CONDITIONALLY RENEWABLE:** You have the right to renew this Policy until you attain age 65 if You pay the correct premium when due or within the Grace Period. We retain the right to change the premium rates on this Policy. See the Premium Provisions section of this Policy. Premiums are based on Your attained age and will change on your Policy anniversary date. (Your Policy anniversary date is the same month and day as the Policy Effective Date for each succeeding year this Policy remains in force). The premium may change if a new table of rates is applicable to the Policy. The change in the table of rates will apply to all Covered Persons in the same class on the date of the change. Class is defined as attained age and underwriting class.

**RIGHT TO EXAMINE POLICY FOR 10 DAYS**

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

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

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

[   ]

[Mary Lou Rainey  
Secretary] [Dan George  
President]

Executed by Family Life Insurance Company on the Effective Date.

**THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES**

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## DEFINITIONS

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

### **Accident or Accidental:**

An unforeseen and unplanned event that occurs:

1. Unintentionally and unexpectedly;
2. independent of disease, bodily infirmity or any other cause; and
3. Resulting in injury to an Insured Person that is not due to any fault or misconduct on the part of the injured Insured Person.

Accident shall include pregnancy following an act of rape of a Covered Person that was reported to the Police within seven days following its occurrence. The seven day requirement for notification to the police shall be extended to 180 days in the case of an act of rape or incest of a female under 13 years of age.

### **Calendar Year:**

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

### **Complications of Pregnancy:**

Complications of Pregnancy include the following:

1. Conditions requiring Hospital confinement (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy including but not limited to, acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, Health Care Practitioner-prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia, and similar conditions associated with the management of a difficult pregnancy not constituting distinct complication of pregnancy; and
2. Non-elective cesarean section, termination of ectopic pregnancy, and spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

### **Confinement Period:**

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

### **Cosmetic Services:**

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

### **Covered Dependent:**

A Covered Dependent is:

1. Your lawful spouse; or
2. Your naturally born child, legally adopted child, a child in which You are a party to a suit in which adoption is sought, a stepchild, a grandchild dependent upon You for federal income tax purposes at the time of the child's application for coverage, a child for whom You are the legal guardian, or a child for whom You are required to provide medical support by court or administrative order:
  - a. Who is unmarried; and
  - b. Who is under age 26.
3. Enrolled for coverage under the policy and eligible to receive benefits.

If Your unmarried child is age 26 or older, the child will be considered a Covered Dependent if You give Us proof that the child is not capable of self-sustaining employment because of mental incapacity or physical handicap and is chiefly dependent on You for support and maintenance. You must give Us proof that the child meets these requirements at the same time that You first enroll for coverage under this Policy or within 31 days after the child reaches the normal age for termination. Additional proof may be requested periodically but not more often than annually after the initial 2-year period following the date the child reaches the normal age for termination.

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

1. Attains age 26 (except for a mentally incapacitated or physically handicapped child as described above; or
2. Marries; or

3. Is over age 26 and is capable of self-sustaining employment because he or she is no longer mentally incapacitated or physically handicapped.

**Covered Event:**

A medical event for which this Policy and any attached Riders provides a Scheduled Benefit and that meets all of the following requirements:

1. The treatment, services or supplies provided in connection with the event are provided by a Health Care Practitioner, facility or supplier.
2. It is incurred by a Covered Person while coverage is in force under this Policy and any attached Riders as the result of a Sickness or an Injury.
3. It is incurred for events shown in the Benefits Section, any attached Riders and on the Schedule of Benefits.
4. The occurrence includes treatment, services or supplies which are Medically Necessary.

**Covered Person:**

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

**Custodial Care:**

Care, regardless of setting, that is primarily for the purpose of meeting the personal needs of the patient, including but not limited to:

1. assisting in the activities of daily living;
2. providing help in walking or getting in or out of bed;
3. assisting with bathing, dressing, feeding, homemaking, or preparation of special diets;
4. supervision of medication;
5. providing companionship; or
6. ensuring safety.

**Durable Medical Equipment:**

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

**Effective Date:**

The date coverage under this Policy begins for a Covered Person. The Covered Person's coverage begins at 12:01 a.m. local time, at Your residence. The effective date of the policy will be the date recorded by Us at our home office. It is not the date the application is signed. The policy will become effective when all underwriting requirements have been satisfied and required premium paid. The Effective Date for Covered Dependents added after the Policy Effective Date will be determined by Us.

**Emergency Room:**

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

**Emergency Treatment:**

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

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

**Experimental or Investigational Services:**

Treatment, services or supplies which are:

1. Not given to be of benefit for diagnosis or treatment of a Sickness or an Injury; or
2. Not generally used or recognized by the medical community as safe, effective and appropriate for diagnosis or treatment of a Sickness or an Injury; or
3. In the research or investigational stage, provided or performed in a special setting for research purposes or under a controlled environment or clinical protocol; or
4. Obsolete or ineffective for the treatment of a Sickness or an Injury; or

**Health Care Practitioner:**

A person licensed by the state or other geographic area in which the treatment or services are rendered to treat the kind of Sickness or Injury for which a claim is made. The Health Care Practitioner must be practicing within the limits of his or her license and in the geographic area in which he or she is licensed. The term Health Care Practitioner does not include any Covered Person or any Covered Person's Immediate Family Member. Benefits will be paid only if the services provided are covered under this Policy and any attached Riders.

**Home Health Care:**

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

**Hospice:**

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

**Hospital:**

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

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

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

**Immediate Family Member:**

An Immediate Family Member is:

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

**Injury:**

Physical damage to the structure or function of the body caused by an outside force, which may be physical or chemical, as a result of an Accident.

**Inpatient:**

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

**Maximum Benefit:**

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

**Maximum Lifetime Benefit:**

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

**Medical Supply Provider:**

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

**Medically Necessary or Medical Necessity:**

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

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

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

**Medicare:**

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

**Mental/Nervous Disorders and Substance Abuse:**

Any disorder classified as such in the *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association.

**Outpatient:**

Treatments, services and/or supplies rendered on anything other than an Inpatient basis.

**Personal Medical Equipment:**

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

**Policy:**

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

**Policyholder:**

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

**Pre-Existing Condition:**

A condition and related complications:

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

**Rehabilitation Services:**

Specialized treatment received on an Inpatient basis for a Sickness or an Injury that meets all of the following requirements:

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

**Retail Health Clinic:**

A facility that meets all of the following requirements:

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

**Scheduled Benefit:**

The fixed benefit amount payable upon occurrence of a Covered Event under the terms of this Policy and any attached Riders. The Scheduled Benefit for a Covered Event is shown on the Schedule of Benefits.

**Sickness:**

A disease or an illness of a Covered Person that first manifested itself after the Covered Person’s Effective Date under this Policy and any attached Riders and while coverage is in force. Sickness includes Complications of Pregnancy, but not the pregnancy itself.

**Skilled Nursing Facility:**

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

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

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

**Urgent Care:**

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

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

**Urgent Care Facility:**

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

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

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

Family Life Insurance Company.

**You, Your:**

The person listed on the Schedule of Benefits as the Policyholder.

**EFFECTIVE DATE AND TERMINATION DATE**

**Eligibility and Effective Date of Policyowner:**

A person who is eligible may elect to be covered under this Policy by completing the application process and submitting any required premium. You must be a resident of the state where this Policy is issued. Evidence of insurability according to Our underwriting and eligibility criteria must also be provided. Your coverage will take effect on Your Effective Date as shown on the Schedule of Benefits.

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

**Eligibility and Effective Date of Dependents:**

The following information explains how to apply for coverage for additional dependants:

- **Adding a Newborn Child:** A newborn child can be added on the date the child was born. You must send Us written notice of the birth of the child and We must receive any required additional premium within 31 days of birth. The Effective Date of coverage will be on the date the child is born. If these requirements are not met, Your newborn child will be covered for Sickness or Injury, including Covered Events related to the necessary care and treatment of medically diagnosed congenital defects only for the first 31 days from birth.

- **Adding an Adopted Child:** A newly adopted child can be added on the date the child is adopted or You become a party in a suit for adoption, whichever is earlier. You must send Us written notice of the adoption or suit for adoption of the child and We must receive any required additional premium within 31 days of the adoption or suit for adoption of the child, whichever is earlier. The Effective Date of coverage will be on the earlier of the date the child is adopted or You become a party in a suit for adoption. If these requirements are not met, Your newly adopted child will be covered for Sickness or Injury only for the first 31 days from the date of adoption or suit for adoption. A child is no longer considered adopted if, prior to legal adoption, You relinquish legal obligation for support of the child and the child is removed from placement or when You are no longer party to a suit for adoption of the child.
- **Adding a Child for Whom a Court Order Requires You to Provide Insurance:** A child for whom a court order requires You or your Covered Dependent spouse to provide this insurance will be covered for the first 31 days from the time We receive a medical support order or notice of a medical support order. Any required additional premium must be received within 31 days from Our notice or receipt of the court order. If these requirements are not met, the child will only be covered for the first 31 days from the date We receive the medical support order or notice of the medical support order.
- **Adding Any other Dependent:** To add any other dependents, an application must be completed and sent to Us along with any required premium. Evidence of insurability must also be provided. The Effective Date of coverage will be on the Effective Date for that Covered Person shown on the Schedule of Benefits.

**Termination Date:**

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

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

1. The end of the month You attain age 65. Covered Dependents may apply for coverage without evidence of insurability. The request for coverage must be made within 30 days of You attaining age 65.
2. The date We receive a request in writing to terminate this Policy on or on a later date that is requested by You for termination;
3. The date this Policy lapses for nonpayment of premium subject to the Grace Period provision in the Premium Provision section;
4. The date all policies the same as this one are non-renewed in the state in which this Policy was issued or the state in which You presently reside;
5. The date We terminate or nonrenew all individual market hospital-indemnity insurance policies in the state in which this Policy was issue or the state in which You presently reside. We will give You advance notice, as required by state law, of the termination of Your coverage;
6. The date You move to a state where We do not provide insurance under a Policy with the same Policy design as this Policy, We reserve the right to terminate this coverage; or

Coverage of a Covered Dependent will terminate on:

1. The date We receive a request in writing to terminate coverage for a Covered Dependent or on a later date that is requested by You for termination of a Covered Dependent;
2. The date a Covered Dependent no longer meets the Covered Dependent definition in this Policy. We will pay benefits to the end of the time for which We have accepted premiums.

If coverage terminates due to Your death, your spouse will become the named Policyholder provided your spouse is a Covered Person under this Policy on the date of death.

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

**Covered Dependent Conversion:**

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

1. The Covered Dependent's insurance terminated due to a valid decree of divorce between You and the Covered Dependent. The Covered Dependent will be issued a Policy, which We are currently issuing, that most nearly approximates the coverage of this Policy, without evidence of insurability and with the same effective date as the Covered Dependent's coverage under this Policy; or
2. The Covered Dependent's insurance terminates due to Your death, or You attain age 65; or
3. A Covered Dependent child's insurance terminates because the child no longer meets the eligibility requirements for a Covered Dependent.

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

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

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

## HOSPITAL CONFINEMENT AND OTHER FIXED INDEMNITY BENEFITS

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

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

We will pay the corresponding Scheduled Benefit amount shown on the Schedule of Benefits when a Covered Event described below is rendered to a Covered Person and is Medically Necessary.

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

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

Benefits are limited to the Calendar Year Maximum Daily Hospital Confinement Benefit shown on the Schedule of Benefits.

### **Hospital Admission Benefits:**

We will pay the corresponding Scheduled Benefit amount when a Covered Person is confined for the first time as a resident Inpatient during the Calendar Year. A maximum of one benefit per Covered Person per year is payable. Confinement as a resident Inpatient means assigned to a Hospital bed for an overnight stay for Medically Necessary reasons resulting from Injury or Sickness on the advice of a Health Care Practitioner.

### **Emergency Room/Urgent Care Facility Visit Benefits:**

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

Benefits are limited to the Calendar Year Maximum Emergency Room/Urgent Care Facility Benefit shown on the Schedule of Benefits.

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

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

### **Anesthesia Benefits:**

We will pay an Anesthesia Benefit equal to 20% of the surgical benefit amount shown in the Surgical Schedule when a Covered Person is administered anesthesia as part of a surgery that is a Covered Event. Benefits are limited to the Calendar Year Maximum Benefit shown on the Schedule of Benefits.

### **Surgical Services Benefits:**

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

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

**Assistant Surgeon Benefit:**

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

**PRE-EXISTING CONDITIONS LIMITATION****Pre-Existing Conditions Limitation:**

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

**EXCLUSIONS**

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

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

- surgery, suction lipectomy, physical fitness programs, exercise equipment or exercise therapy, including health club membership visits or services; nutritional counseling.
12. Organ, tissue or cellular material donation by a Covered Person, including administrative visits for registry, computer search for donor matches, preliminary donor typing, donor counseling, donor identification and donor activation.
  13. Chemical peels, reconstructive or plastic surgery that does not alleviate a functional impairment and other confinement or treatment visits that are primarily for Cosmetic Services as determined by Us.
  14. Capsular contraction, augmentation or reduction mammoplasty, except for all stages and revisions of reconstruction of the breast following a Medically Necessary mastectomy for treatment of cancer, including reconstruction of the other breast to produce a symmetrical appearance and treatment of lymphedemas.
  15. Removal or replacement of a prosthesis, Durable Medical Equipment or Personal Medical Equipment, except for internal breast prostheses following a Medically Necessary mastectomy for treatment of cancer and services are received in accordance with the Hospital Confinement and Other Fixed Indemnity Benefits Section.
  16. Prophylactic treatment, services or surgery including, but not limited to, prophylactic mastectomy or any other treatment, services or surgery to prevent a disease process from becoming evident in the organ or tissue at a later date.
  17. Treatment, services, and supplies for:
    - a. Home Health Care;
    - b. Hospice Care;
    - c. Skilled Nursing Facility care, Inpatient rehabilitation services;
    - d. Custodial Care, respite care, rest care, supportive care, homemaker services;
    - e. Phone, facsimile, internet or e-mail consultation, compressed digital interactive video, audio or clinical data transmission using computer imaging by way of still-image capture and store forward;
    - f. Treatment, services or supplies that are furnished primarily for the personal comfort or convenience of the Covered Person, Covered Person's family, a Health Care Practitioner or provider;
    - g. Treatment or services provided by a standby Health Care Practitioner; or
    - h. Treatment or services provided by a masseur, masseuse or massage therapist, massage therapy, a rolfer.
  18. Treatment, services, and supplies for growth hormone therapy, including growth hormone medication and its derivatives or other drugs used to stimulate, promote or delay growth or to delay puberty to allow for increased growth.
  19. Treatment, services and supplies related to the following conditions, regardless of underlying causes: sex transformation, gender dysphoric disorder, gender reassignment, and treatment of sexual function, dysfunction or inadequacy, treatment to enhance, restore or improve sexual energy, performance or desire.
  20. Treatment, services and supplies related to: maternity, pregnancy (except Complications of Pregnancy), routine well newborn care at birth including nursery care, abortion.
  21. Any prescription drugs whether purchased, dispensed, or received from or by a physician, pharmacy, hospital, emergency room or any other medical facility, including contraceptive drugs or devices.
  22. Treatment for or treatment use of:
    - a. Genetic testing or counseling, genetic services and related procedures for screening purposes including, but not limited to, amniocentesis and chronic villi testing;
    - b. Services, drugs or medicines used to treat males or females for an infertility diagnosis regardless of intended use including, but not limited to: artificial insemination, in vitro fertilization, reversal of reproductive sterilization, any treatment to promote conception;
    - c. Sterilization;
    - d. Cryopreservation of sperm or eggs;
    - e. Surrogate pregnancy;
    - f. Fetal surgery, treatment or services;
    - g. Umbilical cord stem cell or other blood component harvest and storage in the absence of a Sickness or an Injury; or
    - h. Circumcision;
  23. Spinal and other adjustments, manipulations, subluxation treatment and/or services.
  24. Treatment for: behavior modification or behavioral (conduct) problems; learning disabilities, developmental delays, attention deficit disorders, hyperactivity, educational testing, training or materials, memory improvement, cognitive enhancement or training, vocational or work hardening programs, transitional living.
  25. Treatment for or through use of:
    - a. Non-medical items, self-care or self-help programs;
    - b. Aroma therapy;
    - c. Meditation or relaxation therapy;
    - d. Naturopathic medicine;
    - e. Treatment of hyperhidrosis (excessive sweating);

- f. Acupuncture, biofeedback, neurotherapy, electrical stimulation;
  - g. Inpatient treatment of chronic pain disorders;
  - h. Treatment of spider veins;
  - i. Family or marriage counseling;
  - j. Applied behavior therapy treatment for autistic spectrum disorders;
  - k. Smoking deterrence or cessation;
  - l. Snoring or sleep disorders;
  - m. Change in skin coloring or pigmentation; or
  - n. Stress Management.
26. A Sickness of Injury resulting from abuse or overdose of any illegal or controlled substance, except when administered in accordance with the advice of the Covered Person's Health Care Practitioner.
  27. Treatment of Sickness or an Injury when a contributing cause of the condition was the Covered Person's voluntary attempt to commit or participation in or commission of a felony, whether or not charged, or as a consequence of the Covered Person being under the influence of any illegal or non-prescribed controlled substance while committing a felony.
  28. Services ordered, directed or performed by a Health Care Practitioner or supplies purchased from a Medical Supply Provider who is a Covered Person, an Immediate Family Member, employer of a Covered Person or a person who ordinarily resides with a Covered Person.
  29. Any amount in excess of the Maximum Lifetime Benefit or any other Maximum Benefit limitation for covered Scheduled Benefits.
  30. Treatment that does not meet the definition of a Covered Event in this Policy including, but not limited to, treatment that is not Medically Necessary.
  31. Treatment, services and supplies for Experimental or Investigational Services.
  32. Treatment incurred outside of the United States.
  33. Sickness or Injury caused or aggravated by suicide, attempted suicide or self-inflicted Sickness or Injury.

## **CLAIM PROVISIONS**

### **Notice of Claim:**

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

### **Claim Forms:**

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

### **Proof of Loss:**

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

The proof of loss must include all of the following:

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

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

surgeon. A statement from the facility where the surgery took place will not constitute valid proof of loss for Surgical Services Benefits.

**Assignment Accepted:**

You may assign benefits under this Policy. Benefit payments may be assigned to another person in whole or in part. We will not honor any assignment of this Policy unless it is in writing and filed with Us at Our home office. We are not responsible for the validity of an assignment. If You assign benefits to a provider involved in the Covered Event, the assigned amount paid will not be in excess of the amount shown on the provider's statement submitted at proof of loss. Any Scheduled Benefit amount in excess of the billed amount will be paid directly to You, unless otherwise expressly assigned by You.

**Right to Collect Information:**

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

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

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

**Physical Examination and Autopsy:**

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

**Payment of Benefits:**

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

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

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

**Overpayment:**

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

**Rights of Administration:**

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

**Claims Involving Misrepresentation or Fraud:**

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

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

**Workers' Compensation Not Affected:**

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

**Claim Appeal:**

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

**PREMIUM PROVISIONS**

**Consideration:**

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

**Premium Payment:**

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

**Changes in Premiums:**

We have the right to change premiums on your Policy anniversary date. If We change premiums, We will do so only:

1. If We change the premiums for all policies of this form and attained age in Your state of issue;
2. If such change is in accordance with the laws and regulations of Your state of issue; and
3. If We give You 30 days notice (or longer if required by the state in which this Policy is issued) before such change becomes effective.

**Refund of Unearned Premiums:**

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

**Grace Period:**

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

**Reinstatement:**

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

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

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

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

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

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

## OTHER PROVISIONS

### **Policy Changes:**

This Policy may be changed at any time. We will give You 30 days notice prior to any change. No change in this Policy will be valid unless approved by one of Our executive officers and included with this Policy. No agent or other employee of Our Company has authority to waive or change any Policy provision or waive any other applicable application or application requirements.

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

### **Clerical Error:**

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

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

### **Conformity with State Statutes:**

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

### **Enforcement of Policy Provisions:**

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

### **Entire Contract:**

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

### **Representations Made on Application Form:**

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

### **Extension of Benefits:**

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

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

1. The date on which the Covered Person is no longer continuously confined in a Hospital;
2. Payment of any applicable Maximum Benefit under this Policy;

3. 90 days from the date coverage would have terminated under this Policy if there was no extension of benefit;
4. The date the Covered Person is eligible for Medicare; or
5. The earliest date otherwise permitted by law.

**Misstatements:**

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

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

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

**Legal Action:**

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

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

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

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