

SERFF Tracking Number: CEUL-127150532 State: Arkansas
Filing Company: Central United Life Insurance Company State Tracking Number: 48647
Company Tracking Number:
TOI: H14I Individual Health - Hospital Indemnity Sub-TOI: H14I.000 Health - Hospital Indemnity
Product Name: Essential Benefits - Replacement
Project Name/Number: /

Filing at a Glance

Company: Central United Life Insurance Company

Product Name: Essential Benefits - Replacement SERFF Tr Num: CEUL-127150532 State: Arkansas

Replacement

TOI: H14I Individual Health - Hospital Indemnity SERFF Status: Closed-Approved- Closed State Tr Num: 48647

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: 05/12/2011

Date Submitted: 05/02/2011

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name:

Status of Filing in Domicile: Pending

Project Number:

Date Approved in Domicile:

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: 05/12/2011

State Status Changed: 05/12/2011

Deemer Date:

Created By: Rebecca Podowski

Submitted By: Rebecca Podowski

Corresponding Filing Tracking Number:

Filing Description:

We are filing an updated version of our hospital indemnity plan. This policy is specifically designed for individuals and offers the insured fixed indemnity benefits payable when an insured experiences a hospital confinement or undergoes a surgical procedure, in addition to limited outpatient and assistant surgeon services. This policy form (CHCS11) will be replacing our current hospital indemnity plan (CHCS10-AR), which was approved on 11/19/2010. We are now offering the insured the option to increase the amounts of units purchased, as indicated on our new application and updated surgical schedule.

Please note, the purpose of this filing is to replace the base policy, CHCS10-AR and update our outline of coverage. We

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wish to retain use of the previously approved application (form number CHCSAPP10) and schedule pages (CHCS10-PS, CHCS10-SS) from our previous filing.

This policy will be marketed to individuals with the applications and outlines of coverage (new and previously approved).

Central United Life Insurance Company appreciates the Department's time in reviewing our 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

Central United Life Insurance Company CoCode: 61883 State of Domicile: Arkansas
 Wortham Tower Group Code: 117 Company Type:
 2727 Allen Parkway Group Name: State ID Number:
 Suite 500 FEIN Number: 42-0884060
 Houston, TX 77019-2100
 (713) 529-0045 ext. [Phone]

Filing Fees

Fee Required? Yes
 Fee Amount: \$200.00
 Retaliatory? No
 Fee Explanation: \$50 per form
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Central United Life Insurance Company	\$200.00	05/02/2011	47159182

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	05/12/2011	05/12/2011

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	05/04/2011	05/04/2011	Rebecca Podowski	05/06/2011	05/06/2011

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Application	Rebecca Podowski	05/06/2011	05/06/2011

SERFF Tracking Number: CEUL-127150532 State: Arkansas
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Disposition

Disposition Date: 05/12/2011

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):
Central United 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
Form (revised)	Base Policy	Approved-Closed	Yes
Form	Base Policy	Replaced	Yes
Form	Surgical Schedule	Approved-Closed	Yes
Form	Policy Schedule	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Rate	CULIC CHCS11 Rates	Approved-Closed	Yes

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Objection Letter

Objection Letter Status Pending Industry Response

Objection Letter Date 05/04/2011

Submitted Date 05/04/2011

Respond By Date

Dear Rebecca Podowski,

This will acknowledge receipt of the captioned filing.

Objection 1

- Base Policy, CHCS11 (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

- Base Policy, CHCS11 (Form)

Comment:

Coverage for newborn infants must be for at least 90 days. Refer to ACA 23-79-129.

Objection 3

- Base Policy, CHCS11 (Form)

Comment:

For 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

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Response Letter

Response Letter Status Submitted to State
 Response Letter Date 05/06/2011
 Submitted Date 05/06/2011

Dear Rosalind Minor,

Comments:

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

Response 1

Comments: We have revised our handicapped provision.

Related Objection 1

Applies To:

- Base Policy, CHCS11 (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
Base Policy	CHCS11		Policy/Contract/Fraternal Certificate	Initial		50.350	CHCS11-AR redlined.pdf, CHCS11-AR.pdf
Previous Version							
Base Policy	CHCS11		Policy/Contract/Fraternal Certificate	Initial		50.350	CHCS11.pdf

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No Rate/Rule Schedule items changed.

Response 2

Comments: We have revised our time period.

Related Objection 1

Applies To:

- Base Policy, CHCS11 (Form)

Comment:

Coverage for newborn infants must be for at least 90 days. Refer to 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
Base Policy	CHCS11		Policy/Contract/Fraternal Certificate	Initial		50.350	CHCS11-AR redlined.pdf,CHCS11-AR.pdf

Previous Version

Base Policy	CHCS11		Policy/Contract/Fraternal Certificate	Initial		50.350	CHCS11.pdf
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No Rate/Rule Schedule items changed.

Response 3

Comments: We have revised our time period.

Related Objection 1

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 Product Name: Essential Benefits - Replacement
 Project Name/Number: /

Applies To:

- Base Policy, CHCS11 (Form)

Comment:

For 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
Base Policy	CHCS11		Policy/Contract/Fraternal Certificate	Initial		50.350	CHCS11-AR redlined.pdf,CHCS11-AR.pdf
Previous Version							
Base Policy	CHCS11		Policy/Contract/Fraternal Certificate	Initial		50.350	CHCS11.pdf

No Rate/Rule Schedule items changed.

Please let me know if you require any additional information to conclude your review of this filing.

Sincerely,

Leigh Floyd, Rebecca Podowski

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Amendment Letter

Submitted Date: 05/06/2011

Comments:

Although our filing description states we wish to use the previously approved application filed, we have decided to revise application CHCSAPP10-AR, and have attached it for your review. The new application form number will be CHCSAPP11-AR.

Please note, we are currently revising our policy forms to satisfy the objections listed. We will be submitting them shortly.

Thank you for your patience in reviewing this filing.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
CHCSAPP11-AR	Application/EApplication Enrollment Form		Initial					CHCSAPP11-AR.pdf

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Form Schedule

Lead Form Number:

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 05/12/2011	CHCS11	Policy/Cont ract/Fraternal Certificate	Base Policy	Initial		50.350	CHCS11-AR redlined.pdf CHCS11- AR.pdf
Approved-Closed 05/12/2011	CHCS11- SS	Schedule Pages	Surgical Schedule	Initial			CHCS11- SS.pdf
Approved-Closed 05/12/2011	CHCS11- PS	Schedule Pages	Policy Schedule	Initial			CHCS11- PS.pdf
Approved-Closed 05/12/2011	COMBOAP P	Application/ Enrollment Form	Application	Initial			COMBO- APP.pdf
Approved-Closed 05/12/2011	CHCSAPP 11-AR	Application/ Enrollment Form	Application	Initial			CHCSAPP11- AR.pdf

CENTRAL UNITED LIFE INSURANCE COMPANY

Administrative Office: [10700 Northwest Freeway, Houston, TX 77092] [800-669-9030]

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 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 POLICY 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. 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. We reserve the right to terminate this Policy for You and any Covered Dependents.

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 Central United Life Insurance Company on the Effective Date.

THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES

TABLE OF CONTENTS

	Page
Definitions	3
Effective Date and Termination	10
Hospital Confinement and Other Fixed Indemnity Benefits	12
Pre-Existing Conditions Limitation	13
Exclusions	13
Claim Provisions	16
Premium Provisions	18
Other Provisions	19
Schedule of Benefits	Attached
Surgical Schedule	Attached

DEFINITIONS

Within 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 unintentionally and unexpectedly, independent of disease, bodily infirmity or any other cause, resulting in injury to an Covered Person that is not due to any fault or misconduct on the part of the injured Covered 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.

[Brand Name Drug:

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

Calendar Year:

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

Complications of Pregnancy:

Complications of Pregnancy include the following:

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

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. Any dependent child(ren) for whom You have applied for insurance under this Policy and for whom premium payments are made. At the time of application, a dependent child must be:
 - (a) dependent upon You for his or her support;
 - (b) unmarried;
 - (c) under the age of 21 (or 25 if a full-time student); and
 - (d) Your child or Your spouse's child, Your grandchild, natural born, legally adopted, or pending legal adoption and is in placement in the residence of the Named Insured. A dependent child includes a stepchild or a child under a medical support order.

Coverage of an Insured Child ends on the premium due date following: the attainment of age 21 (or age 25 if enrolled full-time in an accredited college or university); or marriage, whichever occurs first. However, coverage may be continued for a physically or mentally handicapped child who is incapable of self-sustaining employment and is dependent on You for support. ~~Proof of this must be received at least 31 days before such child attains age 21. We reserve the right to require additional proof of such incapacity and dependency; however, We will not require such proof more than once a year after the 2-year period the dependent child attains age 25. 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.

Covered Event:

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

1. The treatment, services or supplies provided in connection with the event are provided by a Health Care Practitioner, facility or supplier.
2. It is incurred by a Covered Person while coverage is in force under this Policy as the result of a Sickness or an Injury
3. It is incurred for Events shown in the Benefits section 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 assisting in the activities of daily living, providing help in walking or getting in or out of bed, assisting with bathing, dressing, feeding, homemaking, or preparation of special diets, supervision of medication, providing companionship, or 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 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:

Bona fide 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

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.

[Generic Drug:

A Prescription Drug that:

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

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

Health Care Practitioner:

A person licensed by the state or other geographic area in which the treatment or services are rendered to treat the 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.

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:

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

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

Immediate Family Member:

An Immediate Family Member is:

1. You or Your spouse;
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.

Laboratory Services:

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

Maximum Benefit:

The maximum amount of benefits, as shown in the Benefits Schedule, that We will pay for each Covered Person under this Policy. This Policy has varying types of Maximum Benefit limitations. Each Maximum Benefit limitation is stated on the Schedule of Benefits corresponding to the applicable benefit provision. 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.

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.

Occupational Therapy:

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

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

Office Visits:

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

1. Hospital's Outpatient department,
2. an Emergency Room,

3. a Free-Standing Facility, or
4. an Urgent Care Facility.

[Off-Label Drug:

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

Outpatient:

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.

[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 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.]

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. functional activities of daily living, and
10. alleviating pain.

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

Radiology Services:

Diagnostic imaging procedures and testing 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),

Rehabilitation Unit:

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

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

Retail Health Clinic:

A facility that meets all of the following requirements:

1. Is licensed by the state in accordance with the laws for the specific services being provided in that facility;
2. Is staffed by a Health Care Practitioner in accordance with the laws of that state;
3. Is attached to or is part of a store or retail facility;
4. Is separate from a Hospital, Emergency Room, acute medical rehabilitation facility, Free-Standing Facility, Skilled Nursing Facility, sub acute rehabilitation facility, or Urgent Care Facility, and any Health Care Practitioner's office located therein even when services are performed after normal business hours;
5. Provides general medical treatment of services for a Sickness or Injury, or provides preventive medical services;
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. 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 and while this Policy 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.

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, and
4. swallowing disorders.

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:

Central United Life Insurance Company.

You, Your:

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

EFFECTIVE DATE AND TERMINATION

Eligibility and Effective Date of Policyholder:

A person who is eligible may elect to be covered under this Policy by completing the Application process and submitting 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 that is issued in Your new state of residence. The new Policy will be effective on the date You become 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.

Eligibility and Effective Date of Dependents:

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

- **Adding a Newborn Child:** A newborn child can be added on the date the child was born. In order to extend coverage past the initial ~~90~~34 days, 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 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 ~~34-90~~ 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. In order to extend coverage past the initial ~~34~~60 days, 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 ~~34-60~~ days of the adoption or suit for adoption of the child, whichever is earlier. The Effective Date of coverage will be the earlier of the date the child is adopted or You becomes 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 ~~34-60~~ days from the date of adoption or suit for adoption.
- **Adding a Child for Whom a Court Order Requires You to Provide Insurance:** A child for whom a court order requires You or Covered Dependent spouse to provide this insurance will be covered for the first 31 days from the time We receive a medical support order or notice of a medical support order. In order to extend coverage past the initial 31 days, 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:

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 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.
2. The date We receive a request in writing to terminate this Policy 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 issued or the state in which You presently reside. We will give You advance notice, as required by state law, of the termination of Your coverage;
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.

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 a like or 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 subject 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 Person receives one of the services below as the result of a Covered Event which 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 due to Sickness or Injury.

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 Physician.

Emergency Room/Urgent Care Facility 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.

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.

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.

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.

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.

Office Visit Benefits:

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

1. 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.

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.

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 a charge for an Office Visit occurs in addition to the shot or immunization charge, then the corresponding Office Visit Benefit is payable, subject to the Office Visit calendar year maximum indicated in the Schedule of Benefits.

[Outpatient Prescription Order Benefits:

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

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

1. Prescription Drugs as defined in this policy;
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.

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 Policy.]

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 Worker's Compensation, Employers' Liability or similar laws even when the Covered Person does not file a claim for benefits. This exclusion will not apply to a Covered Person who is not required to have coverage under any Worker's Compensation, Employers' Liability or similar law and does not have such coverage. However, the

Covered Person must receive services in accordance with the Hospital Confinement and Other Fixed Indemnity Benefits section.

2. War or any act of war, whether declared or undeclared.
3. Participation in the military service of any country or international organization.
4. Treatment, services or supplies that:
 - a. Are not part of a specifically listed Covered Event shown on the 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/services 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 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 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. [Contraceptive procedures, contraceptive drugs or devices, not dispensed from a pharmacy, including, but not limited to, contraceptive patches, contraceptive vaginal rings, diaphragms, injectable contraceptives and contraceptive implants.]
 23. 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;
 24. Spinal and other adjustments, manipulations, subluxation treatment and/or services.
 25. Treatment for: behavior modification or behavioral (conduct) problems; learning disabilities, developmental delays, attention deficit disorders, hyperactivity, educational testing, training or materials, memory improvement, cognitive enhancement or training, vocational or work hardening programs, transitional living, except for Outpatient diabetes self-management training and education for treatment of a Covered Person with diabetes.
 26. Treatment for or through use of:
 - a. Non-medical items, self-care or self-help programs;
 - b. Aroma therapy;
 - c. Meditation or relaxation therapy;
 - d. Naturopathic medicine;
 - e. Treatment of hyperhidrosis (excessive sweating);
 - f. Acupuncture, biofeedback, neurotherapy, electrical stimulation;
 - g. Inpatient treatment of chronic pain disorders;
 - h. Treatment of spider veins;
 - 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.
 27. 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.
 28. 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.

29. 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.
30. Any amount in excess of the Maximum Lifetime Benefit or any other Maximum Benefit limitation for covered Scheduled Benefits.
31. 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.
32. Treatment, services and supplies for Experimental or Investigational Services.
33. Treatment incurred outside of the United States.
34. Sickness or Injury caused or aggravated by suicide, attempted suicide or self-inflicted Sickness or Injury.

[PRESCRIPTION DRUG EXCLUSIONS

In addition to the Exclusions and Limitations listed above, 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. Drugs or medicines obtained from pharmacy provider sources outside the United States.
2. Vitamins and/or vitamin combinations even if they are prescribed by a Health Care Practitioner.
3. Any prescription products, drugs or medicines in the following categories, whether or not prescribed by a Health Care Practitioner:
 - a. Herbal or homeopathic medicines or products;
 - b. Minerals;
 - c. Appetite suppressants;
 - d. Dietary or nutritional substances or dietary supplements;
 - e. Nutraceuticals;
 - f. Medical Foods; or
 - g. Durable medical equipment/supplies.
4. 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.
5. 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.
6. 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.
7. Unit-dose drugs, drugs or medicines used to treat onychomycosis (nail fungus), botulinum toxin and its derivatives.
8. Drugs or medicines prescribed for treatment of a condition that is specifically excluded under this Policy.
9. Drugs, medicines or supplies that are illegal under federal law, such as marijuana, even if they are prescribed for medical use in a state.
10. Duplicate prescriptions, replacement of lost, stolen, destroyed, spilled or damaged prescriptions; Prescription Order refills in excess of the number specified on the Health Care Practitioner's Prescription Order; prescriptions refilled more frequently than the prescribed dosage indicates, prescriptions refilled after one year from the Health Care Practitioner's original Prescription Order, any administration for drug injections or any other drugs or medicines obtained other than through a pharmacy.]

CLAIM PROVISIONS

Notice of Claim:

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

Claim Forms:

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

Proof of Loss:

We must receive written or electronic proof of loss for which the claim is made. Proof of loss must be provided to Us within 90 calendar days after a covered loss occurs or as soon as reasonably possible, but in no event later than 12 months from the date proof of loss is otherwise required, unless You 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 office. We are not responsible for the validity of an assignment. If You assign benefits to a provider involved in the Covered Event, the full benefit amount will be paid to the provider.

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.

Worker's Compensation Not Affected:

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

Claim Appeal:

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

PREMIUM PROVISIONS

Consideration:

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

Premium Payment:

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

Changes in Premiums:

We have the right to change premiums. If We change premiums, We will do so only if:

1. We change the premiums for all policies of this form and attained age in Your state of issue;
2. 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.
3. Such change is in accordance with the laws and regulations of Your state of issue; and
4. 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 time coverage will continue in-force. If the full premium due is not received at Our office by the end of the Grace Period, the Policy 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 premium 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 the 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:

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:

The Entire Contract of insurance includes the Policy, Schedule of Benefits, Surgical Schedule, the application form and any attached 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 attached to the policy.

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.

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

CENTRAL UNITED LIFE INSURANCE COMPANY

Administrative Office: [10700 Northwest Freeway, Houston, TX 77092] [800-669-9030]

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 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 POLICY 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. 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. We reserve the right to terminate this Policy for You and any Covered Dependents.

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 Central United Life Insurance Company on the Effective Date.

THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES

TABLE OF CONTENTS

	Page
Definitions	3
Effective Date and Termination	10
Hospital Confinement and Other Fixed Indemnity Benefits	12
Pre-Existing Conditions Limitation	13
Exclusions	13
Claim Provisions	16
Premium Provisions	18
Other Provisions	19
Schedule of Benefits	Attached
Surgical Schedule	Attached

DEFINITIONS

Within 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 unintentionally and unexpectedly, independent of disease, bodily infirmity or any other cause, resulting in injury to an Covered Person that is not due to any fault or misconduct on the part of the injured Covered 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.

[Brand Name Drug:

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

Calendar Year:

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

Complications of Pregnancy:

Complications of Pregnancy include the following:

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

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. Any dependent child(ren) for whom You have applied for insurance under this Policy and for whom premium payments are made. At the time of application, a dependent child must be:
 - (a) dependent upon You for his or her support;
 - (b) unmarried;
 - (c) under the age of 21 (or 25 if a full-time student); and
 - (d) Your child or Your spouse's child, Your grandchild, natural born, legally adopted, or pending legal adoption and is in placement in the residence of the Named Insured. A dependent child includes a stepchild or a child under a medical support order.

Coverage of an Insured Child ends on the premium due date following: the attainment of age 21 (or age 25 if enrolled full-time in an accredited college or university); or marriage, whichever occurs first. However, coverage may be continued for a physically or mentally handicapped child who is incapable of self-sustaining employment and is dependent on You for support. 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.

Covered Event:

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

1. The treatment, services or supplies provided in connection with the event are provided by a Health Care Practitioner, facility or supplier.
2. It is incurred by a Covered Person while coverage is in force under this Policy as the result of a Sickness or an Injury
3. It is incurred for Events shown in the Benefits section 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 assisting in the activities of daily living, providing help in walking or getting in or out of bed, assisting with bathing, dressing, feeding, homemaking, or preparation of special diets, supervision of medication, providing companionship, or 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 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

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.

[Generic Drug:

A Prescription Drug that:

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

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

Health Care Practitioner:

A person licensed by the state or other geographic area in which the treatment or services are rendered to treat the 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.

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:

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

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

Immediate Family Member:

An Immediate Family Member is:

1. You or Your spouse;
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.

Laboratory Services:

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

Maximum Benefit:

The maximum amount of benefits, as shown in the Benefits Schedule, that We will pay for each Covered Person under this Policy. This Policy has varying types of Maximum Benefit limitations. Each Maximum Benefit limitation is stated on the Schedule of Benefits corresponding to the applicable benefit provision. 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.

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.

Occupational Therapy:

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

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

Office Visits:

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

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

[Off-Label Drug:

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

Outpatient:

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.

[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 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.]

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. functional activities of daily living, and
10. alleviating pain.

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

Radiology Services:

Diagnostic imaging procedures and testing 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),

Rehabilitation Unit:

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

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

Retail Health Clinic:

A facility that meets all of the following requirements:

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

4. Is separate from a Hospital, Emergency Room, acute medical rehabilitation facility, Free-Standing Facility, Skilled Nursing Facility, sub acute rehabilitation facility, or Urgent Care Facility, and any Health Care Practitioner's office located therein even when services are performed after normal business hours;
5. Provides general medical treatment of services for a Sickness or Injury, or provides preventive medical services;
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. 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 and while this Policy 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.

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, and
4. swallowing disorders.

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:

Central United Life Insurance Company.

You, Your:

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

EFFECTIVE DATE AND TERMINATION

Eligibility and Effective Date of Policyholder:

A person who is eligible may elect to be covered under this Policy by completing the Application process and submitting 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 that is issued in Your new state of residence. The new Policy will be effective on the date You become 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.

Eligibility and Effective Date of Dependents:

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

- **Adding a Newborn Child:** A newborn child can be added on the date the child was born. In order to extend coverage past the initial 90 days, 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 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. In order to extend coverage past the initial 60 days, 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 the earlier of the date the child is adopted or You becomes 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.
- **Adding a Child for Whom a Court Order Requires You to Provide Insurance:** A child for whom a court order requires You or Covered Dependent spouse to provide this insurance will be covered for the first 31 days from the time We receive a medical support order or notice of a medical support order. In order to extend coverage past the initial 31 days, 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:

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 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.
2. The date We receive a request in writing to terminate this Policy 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 issued or the state in which You presently reside. We will give You advance notice, as required by state law, of the termination of Your coverage;
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.

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 a like or 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 subject 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 Person receives one of the services below as the result of a Covered Event which 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 due to Sickness or Injury.

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 Physician.

Emergency Room/Urgent Care Facility 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.

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.

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.

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.

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.

Office Visit Benefits:

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

1. 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.

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.

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 a charge for an Office Visit occurs in addition to the shot or immunization charge, then the corresponding Office Visit Benefit is payable, subject to the Office Visit calendar year maximum indicated in the Schedule of Benefits.

[Outpatient Prescription Order Benefits:

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

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

1. Prescription Drugs as defined in this policy;
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.

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 Policy.]

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 Worker's Compensation, Employers' Liability or similar laws even when the Covered Person does not file a claim for benefits. This exclusion will not apply to a Covered Person who is not required to have coverage under any Worker's Compensation, Employers' Liability or similar law and does not have such coverage. However, the

Covered Person must receive services in accordance with the Hospital Confinement and Other Fixed Indemnity Benefits section.

2. War or any act of war, whether declared or undeclared.
3. Participation in the military service of any country or international organization.
4. Treatment, services or supplies that:
 - a. Are not part of a specifically listed Covered Event shown on the 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/services 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 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 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. [Contraceptive procedures, contraceptive drugs or devices, not dispensed from a pharmacy, including, but not limited to, contraceptive patches, contraceptive vaginal rings, diaphragms, injectable contraceptives and contraceptive implants.]
 23. 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;
 24. Spinal and other adjustments, manipulations, subluxation treatment and/or services.
 25. Treatment for: behavior modification or behavioral (conduct) problems; learning disabilities, developmental delays, attention deficit disorders, hyperactivity, educational testing, training or materials, memory improvement, cognitive enhancement or training, vocational or work hardening programs, transitional living, except for Outpatient diabetes self-management training and education for treatment of a Covered Person with diabetes.
 26. Treatment for or through use of:
 - a. Non-medical items, self-care or self-help programs;
 - b. Aroma therapy;
 - c. Meditation or relaxation therapy;
 - d. Naturopathic medicine;
 - e. Treatment of hyperhidrosis (excessive sweating);
 - f. Acupuncture, biofeedback, neurotherapy, electrical stimulation;
 - g. Inpatient treatment of chronic pain disorders;
 - h. Treatment of spider veins;
 - 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.
 27. 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.
 28. 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.

29. 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.
30. Any amount in excess of the Maximum Lifetime Benefit or any other Maximum Benefit limitation for covered Scheduled Benefits.
31. 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.
32. Treatment, services and supplies for Experimental or Investigational Services.
33. Treatment incurred outside of the United States.
34. Sickness or Injury caused or aggravated by suicide, attempted suicide or self-inflicted Sickness or Injury.

[PRESCRIPTION DRUG EXCLUSIONS

In addition to the Exclusions and Limitations listed above, 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. Drugs or medicines obtained from pharmacy provider sources outside the United States.
2. Vitamins and/or vitamin combinations even if they are prescribed by a Health Care Practitioner.
3. Any prescription products, drugs or medicines in the following categories, whether or not prescribed by a Health Care Practitioner:
 - a. Herbal or homeopathic medicines or products;
 - b. Minerals;
 - c. Appetite suppressants;
 - d. Dietary or nutritional substances or dietary supplements;
 - e. Nutraceuticals;
 - f. Medical Foods; or
 - g. Durable medical equipment/supplies.
4. 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.
5. 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.
6. 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.
7. Unit-dose drugs, drugs or medicines used to treat onychomycosis (nail fungus), botulinum toxin and its derivatives.
8. Drugs or medicines prescribed for treatment of a condition that is specifically excluded under this Policy.
9. Drugs, medicines or supplies that are illegal under federal law, such as marijuana, even if they are prescribed for medical use in a state.
10. Duplicate prescriptions, replacement of lost, stolen, destroyed, spilled or damaged prescriptions; Prescription Order refills in excess of the number specified on the Health Care Practitioner's Prescription Order; prescriptions refilled more frequently than the prescribed dosage indicates, prescriptions refilled after one year from the Health Care Practitioner's original Prescription Order, any administration for drug injections or any other drugs or medicines obtained other than through a pharmacy.]

CLAIM PROVISIONS

Notice of Claim:

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

Claim Forms:

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

Proof of Loss:

We must receive written or electronic proof of loss for which the claim is made. Proof of loss must be provided to Us within 90 calendar days after a covered loss occurs or as soon as reasonably possible, but in no event later than 12 months from the date proof of loss is otherwise required, unless You 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 office. We are not responsible for the validity of an assignment. If You assign benefits to a provider involved in the Covered Event, the full benefit amount will be paid to the provider.

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.

Worker's Compensation Not Affected:

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

Claim Appeal:

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

PREMIUM PROVISIONS

Consideration:

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

Premium Payment:

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

Changes in Premiums:

We have the right to change premiums. If We change premiums, We will do so only if:

1. We change the premiums for all policies of this form and attained age in Your state of issue;
2. 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.
3. Such change is in accordance with the laws and regulations of Your state of issue; and
4. 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 time coverage will continue in-force. If the full premium due is not received at Our office by the end of the Grace Period, the Policy 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 premium 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 the 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:

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:

The Entire Contract of insurance includes the Policy, Schedule of Benefits, Surgical Schedule, the application form and any attached 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 attached to the policy.

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.

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

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]

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..	\$1,920
Upgrade of implanted pacemaker system, including conversion of a single chamber system to a dual chamber system.....	\$1,040
Valvotomy, mitral valve; closed heart	\$3,200
Valvotomy, pulmonary valve, closed heart Transventricular	\$2,740
Valvuloplasty, mitral valve, with cardiopulmonary Bypass	\$6,180
Valvuloplasty, open, with cardiopulmonary bypass	\$5,140
Valvuloplasty, open, with inflow occlusion	\$3,100
Repair atrial septal defect, secundum, with cardiopulmonary bypass, with or without patch ...	\$3,720
Ligation, division, and stripping, short or long saphenous vein	\$1,040
Ligation, division, and stripping, of short and long saphenous vein, bilateral	\$1,040
Catheterization – left heart	\$1,960

SURGICAL EVENT ON DIGESTIVE SYSTEM

Biopsy of salivary gland, needle	\$220
Biopsy of salivary gland, incisional	\$640
Tonsillectomy, with or without adenoidectomy, under 12 years of age	\$620
Tonsillectomy, with or without adenoidectomy, 12 and over years of age	\$620
Excision, local; ulcer or benign tumor of stomach.	\$2,140
Gastrectomy, total	\$4,300
Colectomy, total, with proctectomy; with ileostomy.	\$4,320
Incision and drainage of appendicular abscess, Open	\$1,680
Appendectomy open.....	\$1,400
Appendectomy laparoscopic.....	\$1,300
Proctectomy; complete, combined abdominoperineal, with colostomy	\$4,160
Colonoscopy, diagnostic or preventive screening.	\$800
Colonoscopy with biopsy	\$940
Colonoscopy with removal of tumor, polyp or other lesions	\$1,080
Upper Gastro-Intestinal (GI) Endoscopy with Biopsy	\$640
Upper Gastro-Intestinal (GI) Endoscopy – diagnostic	\$580
Incision of rectal fistula, superficial	\$1,000
Fissurectomy, with or without sphincterotomy	\$900
Hemorrhoidectomy, external, complete	\$940
Hemorrhoidectomy, internal and external, complete.....	\$1,040
Cholecystectomy (removal of gall bladder) – open without exploration of common duct	\$2,360
Cholecystectomy – open with exploration of common duct	\$2,740
Cholecystectomy – laparoscopic, with or without Exploration of common duct	\$1,620

Cholecystectomy – laparoscopic, with graph	\$1,640
Pancreatectomy, total	\$3,920
Exploratory laparotomy; exploratory celiotomy ...	\$1,680
Repair inguinal hernia; sliding; any age	\$1,240
Repair initial femoral hernia	\$1,240

SURGICAL EVENT ON EAR

Tympanostomy	\$400
Stapes mobilization	\$1,740
Fenestration of semicircular canal	\$1,860

SURGICAL EVENT ON EYE

Removal of foreign body, conjunctival, superficial	\$120
Removal of foreign body, corneal, with or without slit lamp	\$140
Excision or transposition of pterygium; without graft	\$500
Cataract removal, intra capsular, extracapsular, with insertion of intraocular lens	\$1,620
Repair of retinal detachment; scleral buckling, with or without implant	\$2,660
Muscle operation involving one or more muscles in one or both eyes	\$1,520

SURGICAL EVENT RELATED TO GYNECOLOGY

Incision and drainage of Bartholin's gland abscess.....	\$260
Excision of Bartholin's gland or cyst	\$660
Anterior colporrhaphy, repair of cystocele, with or without repair of urethrocele	\$1,460
Posterior colporrhaphy, repair of rectocele with or without perineorrhaphy	\$1,480
Combined anteroposterior colporrhaphy	\$1,840
Cautery of cervix; electro or thermal	\$280
Dilation and curettage, diagnostic and/or therapeutic (non-obstetrical)	\$540
Total abdominal hysterectomy (corpus and cervix), with or without removal of tube (s), with or without removal of ovary (s)	\$2,200
Supracervical abdominal hysterectomy (subtotal hysterectomy), with or without removal of tube(s), with or without removal of ovary (s)	\$2,120
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)	\$3,880
Salpingectomy, complete or partial, unilateral or bilateral (separate procedure)	\$1,700
Salpingo-oophorectomy, complete or partial, unilateral or bilateral (separate procedure)	\$1,580
Hysteroscopy – biopsy	\$820
Hysteroscopy – ablation	\$3,200

SURGICAL EVENT MUSCULOSKELETAL SYSTEM

Muscle biopsy, superficial	\$400
Muscle biopsy, deep	\$580
Arthrocentesis, large joint.....	\$160
Removal of implant; superficial, (e.g., buried wire, pin or rod) (separate procedure).....	\$760
Closed treatment of mandibular fracture with interdental fixation	\$1,840
Arthrodesis, including laminectomy and/or diskectomy	\$3,300
Closed treatment of clavicular fracture; without manipulation	\$440
Open treatment of clavicular fracture, with or without internal or external fixation	\$1,540
Closed treatment of proximal humeral (surgical or anatomical neck) fracture, with or without manipulation.....	\$660
Open treatment of proximal humeral (surgical or anatomical neck) fracture, with or without internal or external fixation, with or without repair of tuberosity(s).....	\$1,880
Closed treatment of shoulder dislocation, with manipulation; without anesthesia	\$620
Closed treatment of shoulder dislocation, with manipulation; requiring anesthesia	\$820
Open treatment of acute shoulder dislocation	\$1,240
Arthroscopy – shoulder	\$1,420
Arthrotomy, elbow, including exploration, drainage, or removal of foreign body	\$1000
Treatment of closed elbow dislocation; without anesthesia	\$740
Treatment of closed elbow dislocation; requiring anesthesia	\$780
Open treatment of acute or chronic elbow dislocation	\$1,520
Closed treatment of ulnar shaft fracture; without manipulation	\$520
Open treatment of ulnar shaft fracture	\$1,320
Closed treatment of radial and ulnar shaft fractures	\$560
Open treatment; fixation of radius or ulna	\$1,420
Open treatment; fixation of radius AND ulna	\$1,920
Closed treatment of distal radial fracture (e.g., Colles or Smith type) or epiphyseal separation, with or without fracture of ulnar styloid; without manipulation	\$600
Open treatment of distal radial fracture or epiphyseal separation, with internal fixation	\$1,560
Arthrotomy, with exploration, drainage, or removal of loose or foreign body; interphalangeal joint, each	\$800
Excision of lesion of tendon sheath or joint capsule (e.g., cyst, mucous cyst, or ganglion), hand or finger	\$1,140
Closed treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb; without manipulation, each	\$400
Open treatment of phalangeal shaft fracture, proximal or middle phalanx, finger or thumb; without manipulation, each	\$1,260

Amputation, finger or thumb, primary or secondary, any joint or phalanx, single including neurectomies; with direct closure	\$1,320
Arthrotomy, hip, including exploration or removal of loose or foreign body	\$2,080
Closed treatment of femoral fracture, proximal end, neck; without manipulation	\$1000
Closed treatment of femoral fracture, proximal end, neck; with manipulation	\$1,640
Open treatment of femoral fracture, proximal end, neck, internal fixation or prosthetic replacement	\$2,580
Arthroplasty, hip	\$3,120
Arthroscopy, knee	\$1,580
Arthrotomy, knee, with exploration, drainage, or removal of foreign body	\$1,560
Amputation, thigh, through femur, any level	\$1,820
Amputation, thigh, through femur, any level; open, circular (guillotine)	\$1,520
Closed reduction of fracture of tibia, shaft	\$700
Closed treatment of tibial shaft fracture (with or without fibular fracture); with manipulation	\$1,120
Open treatment of fracture of tibia, shaft	\$1,900
Closed treatment of proximal fibula or shaft fracture; without manipulation	\$620
Open treatment of proximal fibula or shaft fracture, with or without internal or external fixation.....	\$1,520
Closed treatment of distal fibular fracture (lateral malleolus); without manipulation	\$640
Open treatment of distal fibular fracture (lateral malleolus)	\$1,520
Closed treatment of bimalleolar ankle fracture, (including Potts); without manipulation	\$680
Closed treatment of bimalleolar ankle fracture, (including Potts); with manipulation	\$980
Open treatment of bimalleolar ankle fracture, with or without internal or external fixation	\$1,660
Excision of lesion, tendon, tendon sheath, or capsule (including synovectomy) (e.g., cyst or ganglion); toes, wrist, forearm, foot, ankle	\$920
Carpal Tunnel surgery	\$900
Closed treatment of fracture great toe	\$300
Open treatment of fracture great toe	\$1,400
Closed treatment of fracture of toes, other than great toes, without manipulation, each	\$260
Open treatment of fracture of toes, other than great toes, without manipulation, each	\$1,180
Amputation, toe; interphalangeal joint	\$1,220

SURGICAL EVENT ON NERVOUS SYSTEM

Burr hole (s) with evacuation and/or drainage of hematoma, extradural or subdural	\$2,680
Burr holes, intracerebral	\$2,640
Craniectomy or craniotomy for evacuation of hematoma, supratentorial;extradural or subdural.	\$4,440
Craniectomy or craniotomy for evacuation of hematoma, infratentorial; extradural or subdural..	\$3,880
Craniectomy, trephination, bone flap craniotomy; for excision of brain tumor, supratentorial, except meningioma	\$4,640

Spinal puncture, lumbar, diagnostic	\$320
Injection procedure for myelography and/or computed tomography, spinal (other than C1-C2 and posterior fossa)	\$420
Injection procedure for diskography	\$680
Laminectomy with decompression of spinal cord and discectomy, cervical	\$3,160
Laminotomy and/or excision of herniated intervertebral disk, single interspace	\$3,120
Sympathectomy, cervical.....	\$1,440
Sympathectomy, lumbar	\$1,440

SURGICAL EVENT ON RESPIRATORY SYSTEM

Excision of nasal polyp(s), simple	\$480
Excision of nasal polyp(s), extensive requiring hospitalization	\$920
Submucous resection, classic, nasal septum	\$1,340
Laryngectomy; total, without radical neck dissection	\$4,560
Laryngectomy; total, with radical neck dissection.	\$5,680
Bronchoscopy, diagnostic without biopsy	\$640
Bronchoscopy with bronchial or endobronchial biopsy	\$680
Bronchoscopy with removal of foreign body	\$700
Bronchoscopy with excision of tumor	\$560
Thoracotomy, exploratory, including biopsy	\$2,120
Lobectomy, total, subtotal, or segmentation, single lobe	\$3,760
Bilobectomy	\$3,540
Pulmonary resection with concomitant thoracoplasty	\$4,580

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

Incision and drainage of abscess; simple or single.....	\$240
Incision and drainage of pilonidal cyst	\$340
Biopsy of skin, subcutaneous tissue and/or mucous membrane, single lesion	\$200
Biopsy of each additional lesion in addition to primary procedure	\$100
Excision, benign lesions including margins, except skin tag, 2cm or less	\$320
Excision, benign lesions including margins, except skin tag, over 2 cm	\$620
Excision of pilonidal cyst or sinus, simple	\$560
Excision of pilonidal cyst or sinus, extensive	\$1,180
Excision of pilonidal cyst or sinus, complicated ...	\$1,420
Destruction of benign or premalignant lesions; one lesion	\$160
Destruction of benign or premalignant lesions, second thru 14 lesions, each	\$100
Wart destruction, up to 14	\$220
Wart destruction 15 or more	\$260
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	\$1,020

Mastectomy, simple, complete	\$2,180
Radical mastectomy, including breast, pectoral muscles and axillary lymph nodes	\$2,420
Immediate insertion of breast prosthesis following mastopexy, Mastectomy or in reconstruction.....	\$2,100
Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion	\$3,380
Breast reconstruction with latissimus dorsi flap, without prosthetic implant	\$3,720
Breast reconstruction with free flap	\$6,080
Breast reconstruction with other technique	\$3,020
Breast reconstruction with transverse rectus abdominis myocutaneous flap (TRAM)	\$4,540

SURGICAL EVENT RELATED TO THYROID

Excision of cyst or adenoma of thyroid	\$1,440
Partial thyroidectomy unilateral	\$1,440
Thyroidectomy, total or complete	\$2,140
Total or subtotal for malignancy with limited neck dissection	\$2,920
Total or subtotal for malignancy with radical neck dissection	\$3,720
Thyroidectomy, removal of all remaining thyroid tissue following previous removal of a portion of thyroid	\$2,420

SURGICAL EVENT RELATED TO URINARY SYSTEM

Cystoscopy	\$420
Nephrectomy	\$2,280
Kidney lithotripsy	\$1,860
Excision or fulguration of Skene's glands	\$460

SURGICAL EVENT FOR TRANSPLANTS

Heart Transplant	\$10,920
Lung Transplant	\$7,360
Heart/Lung Transplant	\$7,760
Liver Transplant	\$10,660
Kidney Transplant	\$5,540
Pancreas Transplant	\$5,480
Bone Marrow/Stem Cell Transplant	\$280
Cornea Transplant	\$2,560
Skin Transplant	\$1,280]

CENTRAL UNITED 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 [1-800-669-9030]

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
Lifetime Maximum Policy Amount per Covered Person	[\$2,000,000]	
POLICY		[\$XXX.XX]
Inpatient Hospital Confinement Benefit	[\$2000 / \$3000] per day	
Calendar Year Maximum Daily Hospital Confinement Benefit	[\$100,000 / \$200,000] per calendar year	
Hospital Admission Benefit	[\$1,000 / \$2,000]	
Calendar Year Maximum	1 per calendar year	
Emergency Room/Urgent Care Facility Visit Benefit	[\$125/\$250]	
Calendar Year Maximum Benefit	[1 Visit]	
Ambulance Benefit		
Ground	[\$100]	
Air	[\$1,000]	
Calendar Year Maximum Ambulance Benefit	[2] One Way Trips	
Surgical Services Benefits		
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	[\$50,000]	
Office Visit Benefit	[\$50 per Visit]	
Calendar Year Maximum	[3 / 6 Visits]	
Outpatient Medical Event Benefits		
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	[\$1,000 / \$1,500]	

CHCS11-PS

Allergy Shots & Immunization (Covered Dependent Children Only)	
Allergy Shot	[\$10]
Immunization	[\$20]
Calendar Year Maximum Allergy Shots and Immunizations Benefit	[\$100]
[Prescription Drug Order Benefits	
Generic Drug Benefit	[\$10]
Brand Drug Benefit	[\$25]
Calendar Year Maximum	[\$750]

CENTRAL UNITED LIFE INSURANCE COMPANY/FAMILY LIFE INSURANCE COMPANY

[10700 Northwest Freeway, Houston, TX 77092]

- New Application
- Group No. _____
- Reinstatement
- Benefit Increase

Med-Life Circle of Protection - Combination Application

Requested Effective Date: _____

APPLICANT'S INFORMATION				
Name (Last, First, Middle Initial)	Date of Birth	Height (Ft.)	Weight (Lbs.)	Gender (M or F)
Address (Street, City, State, ZIP Code)				
Telephone Numbers (Home, Work and Cell)			Email Address	
Social Security Number	Primary Employer	Type of Business		
Current Occupation – Describe and give exact duties				
Beneficiary Insured/Relation		Contingent Beneficiary/Relation		
Beneficiary Spouse/Relation		Contingent Beneficiary/Relation		

DEPENDENT'S INFORMATION					
Name (Print Full Name)	Social Security Number	Gender (M or F)	Date of Birth	Height	Weight (Lbs.)

COVERAGE APPLIED FOR						
MED-LIFE HEALTH INSURANCE	Plan Type: <input type="checkbox"/> Plan 1 <input type="checkbox"/> Plan 3 <input type="checkbox"/> Plan 2 <input type="checkbox"/> Plan 4	Surgical Benefit Amt: <input type="checkbox"/> 1 Unit <input type="checkbox"/> 2 Units	Coverage Applied For: <input type="checkbox"/> Individual <input type="checkbox"/> Individual/Children <input type="checkbox"/> Individual/Spouse <input type="checkbox"/> Family	Premiums:		
Note: This policy does not provide benefits for Loss or Losses due to Pre-Existing Conditions, as defined in the policy, unless waived by the Company by policy endorsement.						
24-HOUR ACCIDENT EXPENSE POLICY	Benefit Amount: <input type="checkbox"/> 1.0 Units <input type="checkbox"/> 2.0 Units	Coverage Applied For: <input type="checkbox"/> Individual <input type="checkbox"/> Individual/Spouse <input type="checkbox"/> Single Parent <input type="checkbox"/> Family <input type="checkbox"/> Child(ren) Only	Optional Rider: Accident Disability <input type="checkbox"/> Yes <input type="checkbox"/> No Income Benefit: <input type="checkbox"/> 12 Months Occupation: <input type="checkbox"/> Type 1 Benefit Amount: <input type="checkbox"/> 1.0 Units	Duration _____ <input type="checkbox"/> 24 Months <input type="checkbox"/> Type 2 <input type="checkbox"/> 2.0 Units	Premiums:	
CRITICAL ILLNESS/CPR	<input type="checkbox"/> Without Cancer <input type="checkbox"/> With Cancer	Coverage Applied For: <input type="checkbox"/> Individual <input type="checkbox"/> One Parent <input type="checkbox"/> Two Parent	Plan: <input type="checkbox"/> [\$5,000] <input type="checkbox"/> [\$7,500] <input type="checkbox"/> [\$10,000]	Premiums:		
CRITICAL PROTECTION PLUS	Term: 20 years	<input type="checkbox"/> Plan A – [\$25,000] w/Return of Premium <input type="checkbox"/> Critical Illness Rider: [\$12,500]	<input type="checkbox"/> Plan B – [\$35,000] w/Return of Premium <input type="checkbox"/> Critical Illness Rider: [\$17,500]	<input type="checkbox"/> Plan C – [\$50,000] w/Return of Premium <input type="checkbox"/> Critical Illness Rider: [\$25,000]	Premiums:	

FOR ALL COVERAGES	
1.	Have you or anyone proposed for the coverage been diagnosed or been treated by a member of the medical Profession as having Acquired Immune Deficiency Syndrome (AIDS), "AIDS" related complex (ARC) or "AIDS" related conditions, or tested positive for Human Immunodeficiency virus (HIV) or its antibodies? If "yes" provide details. <input type="checkbox"/> Yes <input type="checkbox"/> No
2.	Do all members to be insured reside in the home of the applicant? If "no" provide details <input type="checkbox"/> Yes <input type="checkbox"/> No
3.	Are all applicants citizens of the U.S.? If "no" provide details. <input type="checkbox"/> Yes <input type="checkbox"/> No
4.	Has any applicant been declined for insurance due to health reasons? If "yes" provide details. <input type="checkbox"/> Yes <input type="checkbox"/> No
5.	Are you or your spouse now pregnant? If "yes" provide details <input type="checkbox"/> Yes <input type="checkbox"/> No
6.	Is any applicant currently taking prescription medication? If "Yes" give their name, name of medication(s) and prescribed dosage <input type="checkbox"/> Yes <input type="checkbox"/> No
7.	Do you have existing life or health coverage? If "Yes" provide face amount of any Life Insurance policies below <input type="checkbox"/> Yes <input type="checkbox"/> No
8.	Is policy intended to replace any other Insurance now in force? If "yes" provide company name, policy number & type of coverage <input type="checkbox"/> Yes <input type="checkbox"/> No
9.	Are you currently employed? If "yes" provide date of employment with your current employer, and number of hours worked per week. <input type="checkbox"/> Yes <input type="checkbox"/> No
Provide additional information requested for questions 1-9 in the space provided below:	

MED-LIFE HEALTH INSURANCE QUESTIONS

1. Has any person proposed for insurance had surgery within the last 5 years? Yes No If yes, provide details (date, reasons, results) _____
2. Has any person had surgery advised but not yet performed? Yes No If yes, provide details. _____
3. Has any person proposed for insurance been treated (including medication), within the last 12 months, by a physician for elevated blood pressure? Yes No If yes, please list the person(s), types of 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. _____
4. Have you or any person proposed for insurance within the past 5 years been diagnosed as having or been told by a doctor that they had any of the following conditions? Yes No If yes, circle the applicable conditions shown below and provide details in the Comment Section below.

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

Provide details for any "Yes" answers to question 4:

24 HOUR ACCIDENT EXPENSE POLICY QUESTIONS

1. Has anyone proposed for coverage had a driver's license suspended or revoked within the past 3 years? Yes No
2. Has anyone proposed for coverage had a DWI or DUI within the past 3 years? Yes No
3. Has anyone proposed for coverage a member/participant in a semi-professional or professional sport? Yes No
4. Is anyone proposed for coverage currently under treatment or has any person proposed for coverage been under treatment for drug or alcohol abuse in the past 3 years? Yes No
5. If applying for Non Payroll Coverage: Is any person proposed for coverage blind, bedridden, confined to a wheelchair, unable to walk without a cane or crutch; or in the past five years, has any person proposed for insurance had an Epileptic Seizure, stroke, Parkinson's disease, or Alzheimer's disease? Yes No
6. DI Rider Only: Have you been diagnosed by or received treatment from a member of the medical profession for cancer, heart or vascular disease, chronic obstructive pulmonary disease, renal disease, rheumatoid arthritis, liver disease, sickle cell anemia, asthma requiring steroid therapy, ulcerative colitis, insulin dependent diabetes, Parkinson's disease, seizures, mental and/or nervous disorder, musculoskeletal, knee or back disorder? Yes No

CRITICAL ILLNESS/CPR QUESTIONS

1. Is there any reason you or your spouse are not physically capable of full-time employment? Yes No
2. During the past 10 years, has any person to be insured received medical care for or had:
 - a. any intestinal or urinary tract bleeding, rheumatic fever, heart disease, heart surgery, chest pain, heart attack, stroke, pacemaker implanted, blood vessel surgery or high blood pressure? Yes No
If "Yes" to high blood pressure, give most current blood pressure reading, date, and treatment/medication: _____
 - b. emphysema, chronic bronchitis, tuberculosis, asthma requiring steroid treatment or lung disorders? Yes No
 - c. liver disease, hepatitis, diabetes, multiple sclerosis, or systemic disease such as lupus? Yes No
 - d. mental illness requiring medication or hospitalization, suicide attempted, more than two fainting episodes, medical treatment for alcoholism or drug abuse? Yes No
 - e. kidney failure, internal cancer, malignant melanoma, leukemia, lymphoma or any malignancy prior to this date? Yes No
 - f. hospitalization, or been advised to have any diagnostic tests or surgery? Yes No
 - g. any abnormal blood study results, including high cholesterol, triglycerides or liver enzymes? Yes No
3. Has any parent of any person to be insured at age 50 or less died of colorectal, breast or other internal cancers, diabetes, polycystic kidney disease, heart attack, or stroke? Yes No

CRITICAL PROTECTION PLUS QUESTIONS

1. Has any proposed insured used tobacco in any form within the past 12 months? Yes No
2. In the past seven (7) years, has any person to be insured been diagnosed by a doctor as having heart trouble, stroke, cancer, lung disease or disorder, diabetes, liver or kidney disease, organ transplant, paralysis, loss of 2 or more limbs, blindness, AIDS, ARC, or immune deficiency, mental illness requiring medication, treatment for alcoholism or drug abuse or has been hospitalized or advised to have any diagnostic tests or surgery for any condition? Yes No
3. In the past seven (7) years have any of the proposed insured's used narcotics, cocaine, hallucinogens, barbiturates, heroin, marijuana or any other drugs not prescribed by a physician? Yes No

Provide salary information for all individuals proposed for coverage:

INSURED'S AUTHORIZATION AND SIGNATURE

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager or other medical facility, insurance or reinsurance company, MIB, Inc., Division of Motor Vehicles, the Veterans Administration or other medical or medically-related facility, insurance company or other organization, institution or person, that has any records or knowledge of me or my health or having any non-medical information concerning me to give Central United Life Insurance Company (CUL)/Family Life Insurance Company (FLIC), or its reinsurers, any such information. All information used or disclosed pursuant to authorization may be subject to redisclosure by the recipient and may no longer be protected.

I understand that I am authorizing CUL/FLIC 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. The released information received by CUL/FLIC will remain protected by federal and/or state regulations.

I understand that the information requested is necessary for evaluation and underwriting of my application for the Policy for which I have applied; to determine eligibility for insurance, risk rating or policy issue determinations; obtain reinsurance; administer claims and determine or fulfill responsibility for coverage and provision of benefits; and to conduct other legally permissible activities that relate to any coverage I have, or have applied for, with CUL/FLIC.

I understand that telephone interviews may be a part of the application process and that any information obtained from such telephone interviews may be used to decline my application for coverage. I understand that failure to provide the authorization to CUL/FLIC will result in the rejection of the Insurance Policy coverage. I understand that I may revoke this authorization at any time by notifying CUL/FLIC in writing at their Administrative Office: [10700 Northwest Freeway, Houston, Texas 77092]. I understand that such revocation will not have any effect on actions CUL/FLIC took prior to their receiving the revocation notice.

I understand that this authorization will be valid for twenty-four (24) months from the date signed if used in connection with an application for an insurance policy, reinstatement of an insurance policy, change in policy benefits; or for the duration of a claim if used for the purpose of collecting information with a claim for benefits under a policy. A photocopy of this authorization will be treated in the same manner as the original.

To the best of my knowledge and belief, all of the answers to the questions contained in this application are true and complete and I understand and agree that: (a) the insurance shall not take effect unless and until the application has been accepted and approved by the Company, the full first premium has been paid, and the policy has been delivered to the applicant; and (b) oral statements between the agent and myself are not binding on the Company unless accepted by the Company in writing.

I, the undersigned applicant, certify that I have read, or had read to me, the completed application and that I realize that any false statements or misrepresentations therein material to the risk may result in loss of coverage under the policy to which this application is a part.

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for Insurance is guilty of a crime and may be subject to fines and confinement in prison.

NOTICE: ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO CUL/FLIC. DO NOT MAKE THE 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 AND PREMIUMS PAID.

(Signature of Proposed Insured)

(Signature of Applicant, if other than Proposed Insured)

Signed At (City/State)

Dated (Day/Month/Year)



CENTRAL UNITED LIFE INSURANCE COMPANY
 [10700 Northwest Freeway
 Houston, Texas 77092]

HOME OFFICE USE ONLY	
Pol. No.	_____
Pol. Date	_____
No. Units	_____

HOSPITAL INDEMNITY APPLICATION

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

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

2. (a) Requested Coverage Effective Date _____ Individual Individual and Spouse One Parent Family Two Parent Family
 (b) Hospital Indemnity Benefit _____ (c) [Classic] [Elite]
3. Insured SS# _____ Spouse SS# _____
4. (a) Method of Payment: Bank Draft Direct Bill Credit Card List Bill (b) Group # _____
 (c) Premium Mode: Annual Quarterly Semi-Annual Monthly _____ Mode Premium \$ _____
5. Applicant's Home Address _____ City _____ State _____ Zip _____ Phone _____
6. Business: Name (Applicant) _____ Occupation: _____
7. Business: Name (Spouse) _____ Occupation: _____
8. MAILING ADDRESS: Business Home _____
9. Do all the members to be insured reside in the home of the applicant? YES NO If "No" which member? _____
 Explain: _____
10. Has any person proposed for insurance been declined for insurance due to health reasons? YES NO If yes, provide details and dates.

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

12. Has any person had surgery advised by a physician but not yet performed? YES NO If yes, provide details _____
13. Has any person proposed for insurance been treated, within the last twelve months, by a physician for elevated blood pressure?
 YES NO If yes, please list the name(s) of the person (s), types on treatment including medication, date last seen by a physician, last blood pressure reading, and how long blood pressure has been under control and date diagnosed _____
14. Have you or any person proposed for insurance within the past 5 years been diagnosed as having or been told by a doctor that they had any of the following conditions? YES NO If yes to any conditions, state the name of the person and details.
- | | | |
|---|--|--|
| a. Addison's Disease | i. Diabetes (except cases treated by diet alone) | q. Internal Cancer within 5 years |
| b. AIDS, or tested positive for antibodies to the AIDS virus or HIV virus | j. Functionally limiting musculoskeletal disease or disorder | r. Leukemia |
| c. Alcoholism & Substance Abuse | k. Grand Mal Epilepsy | s. Lung Disorder (Chronic) |
| d. Cataracts uncorrected | l. Heart Attack | t. Mental or Nervous Disorder or disease or disorder of the Central Nervous System |
| e. Cerebral Palsy | m. Hemophilia | u. Multiple Sclerosis |
| f. Cirrhosis of the Liver | n. Hernia uncorrected | v. Paralysis |
| g. Coronary Bypass | o. Hepatitis (other than Virus A) | w. Ulcerative Colitis |
| h. Currently (or within 3 months) hospitalized or confined to any health care institution | p. Hodgkin's Disease | |

(Please continue on next page)

Details of "Yes" answers above. Attach additional sheet if necessary.

Question No.	Name	Details	Date

FRAUD: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

15. Mail Policy to: Insured Agent Other _____

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 Central United Life Insurance Company, its reinsurers or its legal representative, or any medical or pharmaceutical records retrieval service Central United Life Insurance Company may engage, any and all such information as permitted by law and the rules of MIB, Inc. 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 Central United 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, 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 Central United 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 Central United 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 Central United 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, Central United 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

X _____

Signature of Additional Insured/Telephone Number

Agent's Statement	YES	NO
1. Will the insurance applied for replace existing insurance policy or contract in any company(s)?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
b. Completed all replacements forms, if required in your state?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you complied with state regulations on disclosure?	<input type="checkbox"/>	<input type="checkbox"/>
4. All information recorded by me on this application is true and accurate to the best of my knowledge	<input type="checkbox"/>	<input type="checkbox"/>

Agent No. _____ Soliciting Agent Signature _____ Date _____

(_____) _____

Soliciting Agent Phone # Print Agent Name

**Notice of Information Practices
Including Fair Credit Reporting Act Notice and MIB, Inc. Notice**

**To obtain further information contact:
Central United Life Insurance Company
[10700 Northwest Freeway, Houston, TX 77092]**

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

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

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

MIB, Inc. Notice

While the information regarding your insurability is treated as confidential, Central United Life Insurance Company or its reinsurers may make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. Should you apply for life or health insurance, or submit a claim for benefits to another member company, The Medical Information Bureau, upon request from that member company, will supply the information in its file. Upon written request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek correction in accordance with the procedure set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's Information Office is P.O. Box 105, Essex Station, Boston, Massachusetts 02112, Telephone (617) 426-3660. We or our reinsurers may also release information in our file to other life insurance companies to whom you apply for life or health insurance or to whom a claim for benefits may be submitted.

SERFF Tracking Number: CEUL-127150532 State: Arkansas
 Filing Company: Central United Life Insurance Company State Tracking Number: 48647
 Company Tracking Number:
 TOI: H14I Individual Health - Hospital Indemnity Sub-TOI: H14I.000 Health - Hospital Indemnity
 Product Name: Essential Benefits - Replacement
 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):
Central United Life Insurance Company	N/A	%	%				%	%

SERFF Tracking Number: CEUL-127150532 State: Arkansas
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 Company Tracking Number:
 TOI: H14I Individual Health - Hospital Indemnity Sub-TOI: H14I.000 Health - Hospital Indemnity
 Product Name: Essential Benefits - Replacement
 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 05/12/2011	CULIC CHCS11 Rates	CHCS11	New		CULIC CHCS11 Rates.pdf

Exhibit I - Premiums
Hospital Confinement and Surgical Fixed Indemnity Insurance Policy
Policy Form – CHCS11

Monthly Attained Age Premiums

	Tier	Classic Option A	Classic Option B	Elite Option A	Elite Option B	Elite Option C	Elite Option D	Surgical Rider
Ages 18-29	Individual	\$102.71	\$89.37	\$122.85	\$109.11	\$111.18	\$97.44	\$26.38
	Individual & Spouse	\$205.41	\$178.74	\$245.70	\$218.21	\$222.37	\$194.88	\$52.76
	Individual & Child(ren)	\$227.09	\$204.90	\$280.35	\$247.44	\$262.07	\$229.16	\$51.20
	Individual & Family	\$357.43	\$319.95	\$438.20	\$387.29	\$406.78	\$355.87	\$83.10
	Individual, Spouse, & 1 Child	\$274.51	\$242.93	\$333.20	\$295.06	\$306.19	\$268.06	\$66.55
	Child Only	\$69.10	\$64.18	\$87.50	\$76.85	\$83.83	\$73.17	\$13.79
Ages 30-39	Individual	\$123.59	\$107.54	\$147.83	\$131.29	\$133.79	\$117.25	\$31.74
	Individual & Spouse	\$247.18	\$215.08	\$295.65	\$262.58	\$267.58	\$234.50	\$63.49
	Individual & Child(ren)	\$247.97	\$223.07	\$305.33	\$269.62	\$284.67	\$248.97	\$56.56
	Individual & Family	\$399.20	\$356.29	\$488.16	\$431.65	\$451.99	\$395.49	\$93.82
	Individual, Spouse, & 1 Child	\$316.28	\$279.27	\$383.15	\$339.43	\$351.40	\$307.68	\$77.28
	Child Only	\$69.10	\$64.18	\$87.50	\$76.85	\$83.83	\$73.17	\$13.79
Ages 40-49	Individual	\$150.76	\$131.19	\$180.33	\$160.16	\$163.21	\$143.03	\$38.72
	Individual & Spouse	\$301.53	\$262.37	\$360.66	\$320.31	\$326.41	\$286.07	\$77.45
	Individual & Child(ren)	\$275.14	\$246.72	\$337.83	\$298.49	\$314.09	\$274.75	\$63.54
	Individual & Family	\$453.54	\$403.58	\$553.16	\$489.39	\$510.83	\$447.05	\$107.78
	Individual, Spouse, & 1 Child	\$370.62	\$326.56	\$448.16	\$397.16	\$410.24	\$359.24	\$91.24
	Child Only	\$69.10	\$64.18	\$87.50	\$76.85	\$83.83	\$73.17	\$13.79
Ages 50-64	Individual	\$193.39	\$168.28	\$231.32	\$205.44	\$209.36	\$183.48	\$49.67
	Individual & Spouse	\$386.79	\$336.56	\$462.64	\$410.89	\$418.71	\$366.96	\$99.35
	Individual & Child(ren)	\$317.77	\$283.81	\$388.82	\$343.78	\$360.24	\$315.19	\$74.49
	Individual & Family	\$538.81	\$477.77	\$655.15	\$579.96	\$603.13	\$527.94	\$129.68
	Individual, Spouse, & 1 Child	\$455.89	\$400.75	\$550.14	\$487.74	\$502.54	\$440.13	\$113.14
	Child Only	\$69.10	\$64.18	\$87.50	\$76.85	\$83.83	\$73.17	\$13.79

SERFF Tracking Number: CEUL-127150532 State: Arkansas
 Filing Company: Central United Life Insurance Company State Tracking Number: 48647
 Company Tracking Number:
 TOI: H14I Individual Health - Hospital Indemnity Sub-TOI: H14I.000 Health - Hospital Indemnity
 Product Name: Essential Benefits - Replacement
 Project Name/Number: /

Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachment: Readability certificate.pdf	Approved-Closed	05/12/2011

	Item Status:	Status Date:
Bypassed - Item: Application Bypass Reason: See form schedule Comments:	Approved-Closed	05/12/2011

	Item Status:	Status Date:
Satisfied - Item: Outline of Coverage Comments: Attachment: CHCS11-OC.pdf	Approved-Closed	05/12/2011

Readability Certification

Company Name: Central United Life Insurance Company
NAIC: 61883

Form Number	Description of Form	Score
CHCS11	Hospital Confinement and Surgical Fixed Indemnity Policy	50.35

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

April 29, 2011

Date

Central United Life Insurance Company

[10700 Northwest Freeway

Houston, TX 77092]

[800-669-9030]

OUTLINE OF COVERAGE

FOR FORM CHCS11

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.

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

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE COVERAGE.

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

HOSPITAL CONFINEMENT AND OTHER FIXED INDEMNITY PLAN:

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

PAYMENT OF BENEFITS:

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

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

1. The treatment, services or supplies provided in connection with the Event are provided by a Health Care Practitioner, facility or supplier.
2. It is incurred by a Covered Person while coverage is in force under this plan as the result of Sickness or an Injury 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 PLAN:

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

SCHEDULE OF BENEFITS

Maximum Lifetime Benefit:	\$[2,000,000] – All benefit payments apply to the Maximum Lifetime Benefit.																					
Inpatient Hospital Confinement Benefits:	<ul style="list-style-type: none"> Scheduled Benefit per Inpatient Day of a Confinement Period: \$[100-10,000]. Maximum Benefit of \$[100,000-200,000] per Calendar Year, per Covered Person. 																					
Hospital Admission Benefits:	Scheduled Benefit per Hospital Admission Event: \$[10-10,000].																					
Emergency Room and Urgent Care Facility Visit Benefits:	<ul style="list-style-type: none"> Scheduled Benefit per Emergency Room visit: \$[10-500]. Scheduled Benefit per Urgent Care visit: \$[10-500]. Maximum Benefit of [1-5] visit[s], per Calendar Year, per Covered Person. 																					
Professional Ground or Air Ambulance Services Benefits:	<ul style="list-style-type: none"> Scheduled Benefit per trip by ground ambulance: \$[10-1,000]. Scheduled Benefit per trip by air ambulance: \$[500-10,000]. Maximum Benefit of [1-5] one-way trip[s] per Calendar Year, per Covered Person. 																					
Surgical Services Benefits:	<p>The following Surgical Services Benefits are limited to a Maximum Benefit of \$[5,000-250,000] per Calendar Year, per Covered Person.</p> <ul style="list-style-type: none"> Surgical Benefits: 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. Anesthesia Benefits: 20% of the Surgical Benefit amount payable as listed in the Surgical Schedule. Assistant Surgeon Benefits: If an Assistant Surgeon is required to assist the Surgeon during the operation, We will pay a maximum of 20% of the Surgical benefit amount payable as listed in the Surgical Schedule. 																					
Office Visit Benefits:	<ul style="list-style-type: none"> Scheduled Benefit: \$[25-500] per Office Visit in a Health Care Practitioner’s office. Maximum Benefit of [1-12] visit[s] per Calendar Year, per Covered Person. 																					
Outpatient Medical Event Benefits:	<ul style="list-style-type: none"> All Outpatient Medical Event Benefits combined are limited to a Maximum Benefit of \$[250-10,000] per Calendar Year, per Covered Person. Scheduled Benefits: <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: center;">Events</th> <th style="text-align: center;">Scheduled Benefit</th> </tr> </thead> <tbody> <tr> <td colspan="2">Specialty Laboratory Services</td> </tr> <tr> <td>Surgical Pathology</td> <td style="text-align: right;">\$[10-1,000]</td> </tr> <tr> <td colspan="2">Specialty Radiology Services</td> </tr> <tr> <td>Mammogram</td> <td style="text-align: right;">\$[10-2,500]</td> </tr> <tr> <td>Computerized Tomography Scan (CT)</td> <td style="text-align: right;">\$[10-2,500]</td> </tr> <tr> <td>Magnetic Resonance Imaging (MRI)</td> <td style="text-align: right;">\$[10-2,500]</td> </tr> <tr> <td>Positron Emission Tomography Scan (PET)</td> <td style="text-align: right;">\$[10-2,500]</td> </tr> <tr> <td>All Other Radiology & Laboratory Services</td> <td style="text-align: right;">\$[10-1,000]</td> </tr> <tr> <td>Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST)</td> <td style="text-align: right;">\$[10-1,000]</td> </tr> </tbody> </table>		Events	Scheduled Benefit	Specialty Laboratory Services		Surgical Pathology	\$[10-1,000]	Specialty Radiology Services		Mammogram	\$[10-2,500]	Computerized Tomography Scan (CT)	\$[10-2,500]	Magnetic Resonance Imaging (MRI)	\$[10-2,500]	Positron Emission Tomography Scan (PET)	\$[10-2,500]	All Other Radiology & Laboratory Services	\$[10-1,000]	Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST)	\$[10-1,000]
Events	Scheduled Benefit																					
Specialty Laboratory Services																						
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All Other Radiology & Laboratory Services	\$[10-1,000]																					
Physical Therapy (PT), Occupational Therapy (OT), Speech Therapy (ST)	\$[10-1,000]																					

Allergy and Immunization Injection Benefits: (Covered Dependent Child Only)	<ul style="list-style-type: none"> • Scheduled Benefit per Allergy Injection: \$[5-250]. • Scheduled Benefit per Immunization Injection: \$[5-250]. • Maximum Benefit of \$[50-1,000] per Calendar Year, per Dependent child.
[Prescription Order Benefits:	<ul style="list-style-type: none"> • Scheduled Benefit per Generic Prescription Drug: \$[5-50]. • Scheduled Benefit per Brand Name Prescription Drug \$[10-100]. • 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. • Maximum Benefit of \$[100-2,500] per Calendar Year, per Covered Person.]

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.

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 Physician.

Emergency Room/Urgent Care Visits Benefits:

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

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.

Surgical Benefits:

We will pay the corresponding Scheduled Benefit when a 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 paid based on the procedure with the highest Scheduled Benefit shown in the Surgical Schedule. If a surgical procedure is performed that is not specifically named in the Surgical Schedule, a benefit will be paid for the procedure identified in the Surgical Schedule that is most similar (in terms of technique and location on the body) to the procedure undergone by the Covered Person.

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.

Assistant 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 Surgical Benefit amount shown in the Surgical Schedule for the operation.

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 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.

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

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 a charge for an Office Visit occurs in addition to the shot or immunization charge, then the corresponding Office Visit Benefit is payable, subject to the Office Visit calendar year maximum indicated in the Schedule of Benefits.

[Prescription Order Benefits:

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

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

- a. Prescription Drugs that are fully approved 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;
- b. Prescription Drugs in dosages, dosage forms, dosage regimens and duration of treatment that are Medically Necessary for the treatment of Sickness or Injury; and
- c. Prescription Drugs that are within the quality, supply, or other limits that We determine is appropriate for a Prescription Drug.

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

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 Policy.]

SECTION 3: LIMITATIONS AND EXCLUSIONS:

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

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

1. A Sickness or Injury that is the result of a work-related condition that is eligible for benefits under Worker's Compensation, Employers' Liability or similar laws even when the Covered Person does not file a claim for benefits. This exclusion will not apply to a Covered Person who is not required to have coverage under any Worker's Compensation, Employers' Liability or similar law and does not have such coverage. However, the Covered Person must receive services in accordance with the Hospital Confinement and Other Fixed Indemnity Benefits section.
2. War or any act of war, whether declared or undeclared.
3. Participation in the military service of any country or international organization.
4. Treatment, services or supplies that:
 - a. Are not parts of a specifically listed Covered Event shown on the Schedule of Benefits;
 - b. Are due to complications of a non-covered service;
 - c. Are incurred before the Covered Persons' Effective Date or after the termination date of coverage, except as provided under the Extension of Benefits provision in the Other Provision section of the Policy; or
 - d. Are provided in a student health center or by or through a school system.
5. Glasses, contact lenses, vision therapy, exercise or training, surgery including any complications arising therefrom to correct visual acuity including, but not limited to, lasik and other laser surgery, radial keratotomy services or surgery to correct astigmatism, nearsightedness (myopia) and/or farsightedness (presbyopia), vision care that is routine.
6. Hearing care that is routine; any artificial hearing device, cochlear implant, auditory prostheses or other electrical, digital, mechanical or surgical means of enhancing, creating or restoring auditory comprehension.
7. Treatment for foot conditions including, but not limited to:
 - a. Flat foot conditions;
 - b. Foot supportive devices, including orthotics and corrective shoes;
 - c. Foot subluxation treatment;
 - d. Corns, bunions, calluses, toenails, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet; or
 - e. Hygienic foot care that is routine.
8. Dental treatment, dental care that is routine, bridges, crowns, caps, dentures, dental implants or other dental prostheses, dental braces or dental appliances, extraction of teeth, orthodontic treatment, odontogenic cysts, and other treatment or complication of teeth and gum tissue, except as otherwise covered for a 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 and 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 a Cosmetic Service as determined by Us.
14. Capsular contraction, augmentation or reduction mammoplasty, except for all stages and revisions of reconstruction of the breast following a Medically Necessary mastectomy for treatment of cancer,

- including reconstruction of the other breast to produce a symmetrical appearance and treatment of lymphedemas.
15. Removal or replacement of a prosthesis, Durable Medical Equipment or Personal Medical Equipment, except for internal breast prostheses following a Medically Necessary mastectomy for treatment of cancer and services are received in accordance with the Hospital Confinement and Other Fixed Indemnity Benefits section.
 16. Prophylactic treatment, services or surgery including, but not limited to, prophylactic mastectomy or any other treatment, services or surgery performed to prevent a disease process from becoming evident in the organ or tissue at a later date.
 17. Treatment, services, and supplies for:
 - a. Home Health Care;
 - b. Hospice Care;
 - c. Skilled Nursing Facility care; Inpatient rehabilitation services;
 - d. Custodial Care, respite care, rest care, supportive care, homemaker services;
 - e. Phone, facsimile, internet or e-mail consultations, compressed digital interactive video, audio or clinical data transmission using computer imaging by way of still-image capture and store forward.
 - f. Treatment, services or supplies that are furnished primarily for the personal comfort or convenience of the Covered Person, Covered Person's family, a Health Care Practitioner or provider;
 - g. Treatment or services provided by a standby Health Care Practitioner; or
 - h. Treatment or services provided by a masseur, masseuse or massage therapist, massage therapy, a rolfer.
 18. Treatment, services and supplies for growth hormone therapy, including growth hormone medication and its derivatives or other drugs used to stimulate, promote or delay growth or to delay puberty to allow for increased growth.
 19. Treatment, services and supplies related to the following conditions, regardless of underlying causes: sex transformation, gender dysphoric disorder, gender reassignment, treatment of sexual function, dysfunction or inadequacy, treatment to enhance, restore or improve sexual energy, performance or desire.
 20. Treatment, services and supplies related to: maternity, pregnancy (except Complications of Pregnancy), routine well newborn care at birth including nursery care, abortion.
 21. [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. [Contraceptive procedures, contraceptive drugs or devices, not dispensed from a pharmacy, including, but not limited to, contraceptive patches, contraceptive vaginal rings, diaphragms, injectable contraceptives and contraceptive implants.]
 23. Treatment for or through use of:
 - a. Genetic testing or counseling, genetic services and related procedures for screening purposes including, but not limited to, amniocentesis and 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.
 24. Spinal and other adjustments, manipulations, subluxation treatment and/or services.
 25. Treatment for: behavior modification or behavioral (conduct) problems, learning disabilities, developmental delays, attention deficit disorders, hyperactivity, educational testing, training or materials, except for Outpatient diabetes self-management training and education for treatment of a Covered Person with diabetes, memory improvement, cognitive enhancement or training, vocational or work hardening programs, transitional living.
 26. Treatment for or through use of:
 - a. Non-medical items, self-care or self-help programs;

- b. Aroma therapy;
 - c. Meditation or relaxation therapy;
 - d. Naturopathic medicine;
 - e. Treatment of hyperhidrosis (excessive sweating);
 - f. Acupuncture, biofeedback, neurotherapy, electrical stimulation;
 - g. Inpatient treatment of chronic pain disorders;
 - h. Treatment of spider veins;
 - 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.
27. 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.
 28. Treatment of a Sickness or an Injury when a contributing cause of the condition was the Covered Person's voluntary attempt to commit or participation in or commission of a felony, whether or not charged, or as a consequence of the Covered Person being under the influence of any illegal or non-prescribed controlled substance while committing a felony.
 29. 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.
 30. Any amount in excess of the Maximum Lifetime Benefit or any other Maximum Benefit limitation for covered Scheduled Benefits.
 31. Treatment that does not meet the definition of a Covered Event in the Policy including, but not limited to, treatment that is not Medically Necessary.
 32. Treatment, services and supplies for Experimental or Investigational Services.
 33. Treatment incurred outside of the United States, including drugs or medicines obtained from pharmacy provider sources outside the United States.
 34. Sickness or Injury caused or aggravated by suicide, attempted suicide or self-inflicted Sickness or Injury.

[Prescription Drug Benefit Exclusions:

In addition to the Exclusions and Limitations under the Policy, 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. Drugs or medicines obtained from pharmacy provider sources outside the United States.
2. Vitamins and/or vitamin combinations even if they are prescribed by a Health Care Practitioner.
3. Any prescription products, drugs or medicines in the following categories, whether or not prescribed by a Health Care Practitioner:
 - a. Herbal or homeopathic medicines or products;
 - b. Minerals;
 - c. Appetite suppressants;
 - d. Dietary or nutritional substances or dietary supplements;
 - e. Nutraceuticals;
 - f. Medical foods; or
 - g. Durable medical equipment/supplies.
4. 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.
5. Drugs or medicines: administered or dispensed at or by a rest home, sanitarium, extended care facility, convalescent care facility, Skilled Nursing Facility or similar institution, dispensed at or by a Hospital, an Emergency Room, a Free-Standing Facility, an Urgent Care Facility, a Health Care Practitioner's office or other Inpatient or Outpatient setting for take home by the Covered Person.
6. Drugs or medicines used to treat, impact or influence: athletic performance, body conditioning, strengthening, or energy, social phobias, slowing the normal process of aging, daytime drowsiness, overactive bladder, dry mouth, excessive salivation, genetic make-up or genetic predisposition, prevention or treatment of hair loss, excessive hair growth or abnormal hair patterns.

7. Unit-dose drugs; drugs or medicines used to treat onychomycosis (nail fungus); botulinum toxin and its derivatives.
8. Drugs or medicines prescribed for treatment of a condition that is specifically excluded under the Policy.
9. Drugs, medicines or supplies that are illegal under federal law, such as marijuana, even if they are prescribed for medical use in a state.
10. Duplicate prescriptions, replacement of lost, stolen, destroyed, spilled or damaged prescriptions; Prescription Order refills in excess of the number specified on the Health Care Practitioner's Prescription Order; Prescriptions refilled after one year from the Health Care Practitioner's original Prescription Order, any administration for drug injections or any other drugs or medicines obtained other than through a pharmacy.]

SECTION 4: RENEWABILITY PROVISIONS:

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

SECTION 5: PREMIUM:

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. If We change premiums, We will do so only if:

1. We change the premiums for all policies of this form and issue age in Your state of issue;
2. A new table of rates is applicable to the Policy.
3. Such change is in accordance with the laws and regulations of Your state of issue; and
4. 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.

SERFF Tracking Number: CEUL-127150532 State: Arkansas
 Filing Company: Central United Life Insurance Company State Tracking Number: 48647
 Company Tracking Number:
 TOI: H14I Individual Health - Hospital Indemnity Sub-TOI: H14I.000 Health - Hospital Indemnity
 Product Name: Essential Benefits - Replacement
 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)
05/02/2011	Form	Base Policy	05/06/2011	CHCS11.pdf (Superceded)

CENTRAL UNITED LIFE INSURANCE COMPANY

Administrative Office: [10700 Northwest Freeway, Houston, TX 77092] [800-669-9030]

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 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 POLICY 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. 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. We reserve the right to terminate this Policy for You and any Covered Dependents.

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 Central United Life Insurance Company on the Effective Date.

THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES

TABLE OF CONTENTS

	Page
Definitions	3
Effective Date and Termination	10
Hospital Confinement and Other Fixed Indemnity Benefits	12
Pre-Existing Conditions Limitation	13
Exclusions	13
Claim Provisions	16
Premium Provisions	18
Other Provisions	19
Schedule of Benefits	Attached
Surgical Schedule	Attached

DEFINITIONS

Within 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 unintentionally and unexpectedly, independent of disease, bodily infirmity or any other cause, resulting in injury to an Covered Person that is not due to any fault or misconduct on the part of the injured Covered 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.

[Brand Name Drug:

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

Calendar Year:

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

Complications of Pregnancy:

Complications of Pregnancy include the following:

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

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. Any dependent child(ren) for whom You have applied for insurance under this Policy and for whom premium payments are made. At the time of application, a dependent child must be:
 - (a) dependent upon You for his or her support;
 - (b) unmarried;
 - (c) under the age of 21 (or 25 if a full-time student); and
 - (d) Your child or Your spouse's child, Your grandchild, natural born, legally adopted, or pending legal adoption and is in placement in the residence of the Named Insured. A dependent child includes a stepchild or a child under a medical support order.

Coverage of an Insured Child ends on the premium due date following: the attainment of age 21 (or age 25 if enrolled full-time in an accredited college or university); or marriage, whichever occurs first. However, coverage may be continued for a physically or mentally handicapped child who is incapable of self-sustaining employment and is dependent on You for support. Proof of this must be received at least 31 days before such child attains age 21. We reserve the right to require additional proof of such incapacity and dependency; however, We will not require such proof more than once a year after the 2-year period the dependent child attains age 25.

Covered Event:

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

1. The treatment, services or supplies provided in connection with the event are provided by a Health Care Practitioner, facility or supplier.
2. It is incurred by a Covered Person while coverage is in force under this Policy as the result of a Sickness or an Injury
3. It is incurred for Events shown in the Benefits section 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 assisting in the activities of daily living, providing help in walking or getting in or out of bed, assisting with bathing, dressing, feeding, homemaking, or preparation of special diets, supervision of medication, providing companionship, or 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 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

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.

[Generic Drug:

A Prescription Drug that:

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

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

Health Care Practitioner:

A person licensed by the state or other geographic area in which the treatment or services are rendered to treat the 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.

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:

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

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

Immediate Family Member:

An Immediate Family Member is:

1. You or Your spouse;
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.

Laboratory Services:

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

Maximum Benefit:

The maximum amount of benefits, as shown in the Benefits Schedule, that We will pay for each Covered Person under this Policy. This Policy has varying types of Maximum Benefit limitations. Each Maximum Benefit limitation is stated on the Schedule of Benefits corresponding to the applicable benefit provision. 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.

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.

Occupational Therapy:

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

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

Office Visits:

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

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

[Off-Label Drug:

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

Outpatient:

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.

[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 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.]

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. functional activities of daily living, and
10. alleviating pain.

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

Radiology Services:

Diagnostic imaging procedures and testing 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),

Rehabilitation Unit:

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

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

Retail Health Clinic:

A facility that meets all of the following requirements:

1. Is licensed by the state in accordance with the laws for the specific services being provided in that facility;
2. Is staffed by a Health Care Practitioner in accordance with the laws of that state;
3. Is attached to or is part of a store or retail facility;
4. Is separate from a Hospital, Emergency Room, acute medical rehabilitation facility, Free-Standing Facility, Skilled Nursing Facility, sub acute rehabilitation facility, or Urgent Care Facility, and any Health Care Practitioner's office located therein even when services are performed after normal business hours;
5. Provides general medical treatment of services for a Sickness or Injury, or provides preventive medical services;
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. 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 and while this Policy 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.

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, and
4. swallowing disorders.

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:

Central United Life Insurance Company.

You, Your:

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

EFFECTIVE DATE AND TERMINATION

Eligibility and Effective Date of Policyholder:

A person who is eligible may elect to be covered under this Policy by completing the Application process and submitting 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 that is issued in Your new state of residence. The new Policy will be effective on the date You become 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.

Eligibility and Effective Date of Dependents:

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

- **Adding a Newborn Child:** A newborn child can be added on the date the child was born. In order to extend coverage past the initial 31 days, 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 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. In order to extend coverage past the initial 31 days, 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 the earlier of the date the child is adopted or You becomes 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.
- **Adding a Child for Whom a Court Order Requires You to Provide Insurance:** A child for whom a court order requires You or Covered Dependent spouse to provide this insurance will be covered for the first 31 days from the time We receive a medical support order or notice of a medical support order. In order to extend coverage past the initial 31 days, 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:

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 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.
2. The date We receive a request in writing to terminate this Policy 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 issued or the state in which You presently reside. We will give You advance notice, as required by state law, of the termination of Your coverage;
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.

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 a like or 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 subject 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 Person receives one of the services below as the result of a Covered Event which 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 due to Sickness or Injury.

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 Physician.

Emergency Room/Urgent Care Facility 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.

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.

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.

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.

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.

Office Visit Benefits:

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

1. 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.

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.

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 a charge for an Office Visit occurs in addition to the shot or immunization charge, then the corresponding Office Visit Benefit is payable, subject to the Office Visit calendar year maximum indicated in the Schedule of Benefits.

[Outpatient Prescription Order Benefits:

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

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

1. Prescription Drugs as defined in this policy;
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.

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 Policy.]

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

- a. Are not part of a specifically listed Covered Event shown on the 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/services 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 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 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. [Contraceptive procedures, contraceptive drugs or devices, not dispensed from a pharmacy, including, but not limited to, contraceptive patches, contraceptive vaginal rings, diaphragms, injectable contraceptives and contraceptive implants.]
23. 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;
24. Spinal and other adjustments, manipulations, subluxation treatment and/or services.
25. Treatment for: behavior modification or behavioral (conduct) problems; learning disabilities, developmental delays, attention deficit disorders, hyperactivity, educational testing, training or materials, memory improvement, cognitive enhancement or training, vocational or work hardening programs, transitional living, except for Outpatient diabetes self-management training and education for treatment of a Covered Person with diabetes.
26. Treatment for or through use of:
 - a. Non-medical items, self-care or self-help programs;
 - b. Aroma therapy;
 - c. Meditation or relaxation therapy;
 - d. Naturopathic medicine;
 - e. Treatment of hyperhidrosis (excessive sweating);
 - f. Acupuncture, biofeedback, neurotherapy, electrical stimulation;
 - g. Inpatient treatment of chronic pain disorders;
 - h. Treatment of spider veins;
 - 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.
27. 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.
28. 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.
29. 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.
30. Any amount in excess of the Maximum Lifetime Benefit or any other Maximum Benefit limitation for covered Scheduled Benefits.
31. 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.
32. Treatment, services and supplies for Experimental or Investigational Services.
33. Treatment incurred outside of the United States.
34. Sickness or Injury caused or aggravated by suicide, attempted suicide or self-inflicted Sickness or Injury.

[PRESCRIPTION DRUG EXCLUSIONS

In addition to the Exclusions and Limitations listed above, 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. Drugs or medicines obtained from pharmacy provider sources outside the United States.
2. Vitamins and/or vitamin combinations even if they are prescribed by a Health Care Practitioner.
3. Any prescription products, drugs or medicines in the following categories, whether or not prescribed by a Health Care Practitioner:
 - a. Herbal or homeopathic medicines or products;
 - b. Minerals;
 - c. Appetite suppressants;
 - d. Dietary or nutritional substances or dietary supplements;
 - e. Nutraceuticals;
 - f. Medical Foods; or
 - g. Durable medical equipment/supplies.
4. 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.
5. 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.
6. 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.
7. Unit-dose drugs, drugs or medicines used to treat onychomycosis (nail fungus), botulinum toxin and its derivatives.
8. Drugs or medicines prescribed for treatment of a condition that is specifically excluded under this Policy.
9. Drugs, medicines or supplies that are illegal under federal law, such as marijuana, even if they are prescribed for medical use in a state.
10. Duplicate prescriptions, replacement of lost, stolen, destroyed, spilled or damaged prescriptions; Prescription Order refills in excess of the number specified on the Health Care Practitioner's Prescription Order; prescriptions refilled more frequently than the prescribed dosage indicates, prescriptions refilled after one year from the Health Care Practitioner's original Prescription Order, any administration for drug injections or any other drugs or medicines obtained other than through a pharmacy.]

CLAIM PROVISIONS

Notice of Claim:

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

Claim Forms:

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

Proof of Loss:

We must receive written or electronic proof of loss for which the claim is made. Proof of loss must be provided to Us within 90 calendar days after a covered loss occurs or as soon as reasonably possible, but in no event later than 12 months from the date proof of loss is otherwise required, unless You 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 office. We are not responsible for the validity of an assignment. If You assign benefits to a provider involved in the Covered Event, the full benefit amount will be paid to the provider.

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.

Worker's Compensation Not Affected:

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

Claim Appeal:

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

PREMIUM PROVISIONS

Consideration:

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

Premium Payment:

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

Changes in Premiums:

We have the right to change premiums. If We change premiums, We will do so only if:

1. We change the premiums for all policies of this form and attained age in Your state of issue;
2. 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.
3. Such change is in accordance with the laws and regulations of Your state of issue; and
4. 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 time coverage will continue in-force. If the full premium due is not received at Our office by the end of the Grace Period, the Policy 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 premium 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 the 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:

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:

The Entire Contract of insurance includes the Policy, Schedule of Benefits, Surgical Schedule, the application form and any attached 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 attached to the policy.

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.

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