

State: Arkansas Filing Company: Freedom Life Insurance Company of America
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: EHBC-2014-IP-AR-FLIC
Project Name/Number: EHBC-2014-IP-AR-FLIC/EHBC-2014-IP-AR-FLIC

Filing at a Glance

Company: Freedom Life Insurance Company of America
Product Name: EHBC-2014-IP-AR-FLIC
State: Arkansas
TOI: H16I Individual Health - Major Medical
Sub-TOI: H16I.005A Individual - Preferred Provider (PPO)
Filing Type: Form/Rate
Date Submitted: 09/26/2013
SERFF Tr Num: USHG-129213923
SERFF Status: Closed-Approved-Closed
State Tr Num: ACA OFF EXCHANGE CHILD ONLY
State Status: Approved-Closed
Co Tr Num: EHBC-2014-IP-AR-FLIC

Implementation: On Approval
Date Requested:
Author(s): Shelley Kuhleman, Tom Kennedy, Diana Ivie, Erica Gibbs
Reviewer(s): Rosalind Minor (primary), arthur lucker
Disposition Date: 10/30/2013
Disposition Status: Approved-Closed
Implementation Date: 01/01/2014

State Filing Description:

State: Arkansas Filing Company: Freedom Life Insurance Company of America
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: EHBC-2014-IP-AR-FLIC
Project Name/Number: EHBC-2014-IP-AR-FLIC/EHBC-2014-IP-AR-FLIC

General Information

Project Name: EHBC-2014-IP-AR-FLIC Status of Filing in Domicile: Pending
Project Number: EHBC-2014-IP-AR-FLIC Date Approved in Domicile:
Requested Filing Mode: Review & Approval Domicile Status Comments: Filing pending in domicile state.
Explanation for Combination/Other: Market Type: Individual
Submission Type: New Submission Individual Market Type: Individual
Overall Rate Impact: Filing Status Changed: 10/30/2013
State Status Changed: 10/30/2013
Deemer Date: Created By: Erica Gibbs
Submitted By: Erica Gibbs Corresponding Filing Tracking Number: USHG-129212848
PPACA: Non-Grandfathered Immed Mkt Reforms
PPACA Notes: null
Include Exchange Intentions: No

Filing Description:
Please see attached cover letter.

Company and Contact

Filing Contact Information

Erica Gibbs, Product Analyst gibbon@ushealthgroup.com
801 Cherry Street, Unit 33 817-878-3327 [Phone]
Arlington, TX 76102 817-878-3310 [FAX]

Filing Company Information

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

Filing Fees

Fee Required? Yes
Fee Amount: \$300.00
Retaliatory? Yes
Fee Explanation: \$100 per form x 3 = \$300
Per Company: No

Table with 4 columns: Company, Amount, Date Processed, Transaction #. Row 1: Freedom Life Insurance Company of America, \$300.00, 09/26/2013, 74535861

State Specific

State: Arkansas

Filing Company:

Freedom Life Insurance Company of America

TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)

Product Name: EHBC-2014-IP-AR-FLIC

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	10/30/2013	10/30/2013

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	arthur lucker	10/10/2013	10/10/2013
Pending Industry Response	Rosalind Minor	10/09/2013	10/09/2013
Pending Industry Response	Rosalind Minor	10/03/2013	10/03/2013
Pending Industry Response	Rosalind Minor	09/30/2013	09/30/2013
Pending Industry Response	Rosalind Minor	09/27/2013	09/27/2013

Response Letters

Responded By	Created On	Date Submitted
Tom Kennedy	10/18/2013	10/18/2013
Tom Kennedy	10/10/2013	10/10/2013
Erica Gibbs	10/04/2013	10/04/2013
Erica Gibbs	09/30/2013	09/30/2013
Erica Gibbs	09/27/2013	09/27/2013

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Supporting Document	Objection Letter & Response 10-21-13	Tom Kennedy	10/22/2013	10/22/2013

SERFF Tracking #: USHG-129213923 State Tracking #: ACA OFF EXCHANGE CHILD ONLY Company Tracking #: EHBC-2014-IP-AR-FLIC

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Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Filing Fee	Note To Reviewer	Erica Gibbs	09/26/2013	09/26/2013

State: Arkansas

Filing Company:

Freedom Life Insurance Company of America

TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)

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Disposition

Disposition Date: 10/30/2013

Implementation Date: 01/01/2014

Status: Approved-Closed

HHS Status: HHS Approved

State Review: Reviewed by Actuary

Comment:

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 req'd):	Minimum % Change (where req'd):
Freedom Life Insurance Company of America	New Product	0.000%	0.000%	\$0	0	\$0	0.000%	0.000%

Percent Change Approved:

Minimum: %

Maximum: %

Weighted Average: %

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Actuarial Memorandum and Certifications	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Unified Rate Review Template	Approved-Closed	Yes

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document	Consumer Disclosure Form	Approved-Closed	Yes
Supporting Document	Cover Letter	Approved-Closed	Yes
Supporting Document	Demonstration of In-Network versus Out-Of-Network PPO Penalty Compliance	Approved-Closed	Yes
Supporting Document	Coverage Schedule 1	Approved-Closed	Yes
Supporting Document	Coverage Schedule 2	Approved-Closed	Yes
Supporting Document	Coverage Schedule 3	Approved-Closed	Yes
Supporting Document	Coverage Schedule 4	Approved-Closed	Yes
Supporting Document	Response Letter 10-4-13	Approved-Closed	Yes
Supporting Document	Response Letter & Attachment 10-18-13	Approved-Closed	Yes
Supporting Document	Objection Letter & Response 10-21-13	Approved-Closed	Yes
Form	EHBCAPP-2014-NOARB-FLIC	Approved-Closed	Yes
Form (revised)	EHBC-2014-IP-AR-FLIC	Approved-Closed	Yes
Form	EHBC-2014-IP-AR-FLIC	Replaced	Yes
Form	EHBC-2013-IP-AR-2014-FLIC	Replaced	Yes
Form (revised)	EHBC-2014-OC-AR-FLIC	Approved-Closed	Yes
Form	EHBC-2014-OC-AR-FLIC	Replaced	Yes
Form	EHBC-2014-IP-AR-FLIC-1	Approved-Closed	Yes
Form	EHBC-2014-IP-AR-FLIC-2	Approved-Closed	Yes
Form	EHBC-2014-IP-AR-FLIC-3	Approved-Closed	Yes
Form	EHBC-2014-IP-AR-FLIC-4	Approved-Closed	Yes
Rate	2014 EHBC Rates	Approved-Closed	Yes

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Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	10/10/2013
Submitted Date	10/10/2013
Respond By Date	10/24/2013

Dear Erica Gibbs,

Introduction:

This will acknowledge receipt of the captioned filing.

Objection 1

- Actuarial Memorandum and Certifications (Supporting Document)
- Unified Rate Review Template (Supporting Document)

Comments: Attached is a file containing INS's request for additional information.

Conclusion:

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,
arthur lucker



INS CONSULTANTS, INC.

Insurance Regulatory Consultants

419 S. 2nd Street
New Market, Suite 206
Philadelphia, PA 19147
Phone: (215) 625-9877
Fax: (215) 627-7104

TO: Erica Gibbs (gibbse@ushealthgroup.com)
Product Analyst
USHEALTH Group
801 Cherry Street, Unit 33
Fort Worth, TX 76102

FROM: Gary Rosen, FSA, MAAA
INS Consultants, Inc.

DATE: October 10, 2013

SUBJECT: Freedom Life Insurance Company of America
Individual Health – PPO
HIOS Issuer ID: 61273
SERFF Tracking Numbers: USHG-129212848, USHG- 129213923

INS has reviewed the material filed in support of the subject rate filings. Based on that review, we have identified certain aspects of the filings which require clarification and/or additional information; these items are discussed below. Upon receipt of the requested information, we will continue our review of the subject filings.

1. Please confirm that “Allowed Claims” include claims for Essential Health Benefits (EHB) as well as benefits other than EHB.
2. Please describe quantitatively, including an Excel spreadsheet with formulas, the derivation of the Changes in the Morbidity of the Insured Population factor of 1.69, as stated in Section V of the Part III Actuarial Memorandum.
3. Please describe quantitatively, including an Excel spreadsheet with formulas, the derivation of the Changes in Demographics factor, as stated in Section V of the Part III Actuarial Memorandum.
4. Please describe quantitatively, including an Excel spreadsheet with formulas, the derivation of the Utilization per 1,000 and Average Cost/Service costs for each Benefit Category in Section II of Worksheet 1 of the Uniform Rate Review Template (URRT) in the Credibility Manual. Please also include the derivation of the factors built into the projection of these costs.

5. Please describe quantitatively, including an Excel spreadsheet with formulas, the development of the 66.5% Projection Period Paid to Allowed Ratio found in Section III, Worksheet 1 of the URRT.
6. The Projected ACA Reinsurance Recoveries, Net of Reinsurance Premium is shown in Section III, Worksheet 1 of the URRT as \$22.57 PMPM. Please describe quantitatively, including an Excel spreadsheet with formulas, how the Gross Projected PPACA Reinsurance Recoveries of \$27.82 was determined. Further, be sure to include a quantitative explanation of the determination of the 10.0% of incurred claims factor that was used. Finally, please provide the following details regarding the Projected ACA Reinsurance Recoveries:
 - What proportion of currently insured members fell within the payout parameters?
 - What proportion of newly insured members is anticipated to fall within the payout parameters?
 - What proportion of total claims expense is anticipated to fall within the payout parameters?
 - What assumption, if any, was made regarding the amount of recoverables due that will actually be recovered?
7. Please split the Taxes and Fees of \$10.77 per member per month (PMPM), as shown Section III, Worksheet 1 of the URRT into its component parts, showing each component in dollars and percentage of premium.
8. Please describe quantitatively, including an Excel spreadsheet with formulas, the development of the AV Pricing Values for each plan as found in Section I, Worksheet 2 of the URRT.
9. Please describe quantitatively, including an Excel spreadsheet with formulas, the development of the “Pooled 2012 Per Member Per Month Allowed Claims – Manual” of \$179.82 found in Exhibit A of the Part III Actuarial Memorandum.
10. Please describe quantitatively, including an Excel spreadsheet with formulas, the development of the “Underwriting Wear Off in Experience” factor of 1.112 found in Exhibit A of the Part III Actuarial Memorandum.
11. Please describe quantitatively, including an Excel spreadsheet with formulas, the development of the “Average Area Factor Adjustment” of .798 found in Exhibit A of the Part III Actuarial Memorandum.
12. Please describe quantitatively, including an Excel spreadsheet with formulas, the development of the seven area factors used in Arkansas.
13. Please identify the fixed reference plan selected as the basis for the AV Pricing Values, as required by the Part III Actuarial Memorandum and Certification Instructions.

14. Please describe quantitatively, including an Excel spreadsheet with formulas, the development of the single risk pool rate, starting with the projected index rate, adjusted for the three market-wide adjustments, and then adjusted by the five plan-specific allowed modifiers, as described on Page 8-10 of the American Academy of Actuaries' Exposure Draft, "Addendum to Actuarial Practices Relating to Preparing, Reviewing, and Commenting on Rate Filings Prepared in Accordance with the Affordable Care Act" (April 2013).
15. Please describe quantitatively, including an Excel spreadsheet with formulas, the derivation of the premium rates by Plan from the projected index rate, if the premium rates were not calculated by the methodology described in the above question. Also, please explain the reason for the deviation in the two methods.
16. Please describe quantitatively, including an Excel spreadsheet with formulas, the derivation of the 1.20 Tobacco User Factor.
17. In order to participate in the applicable open enrollment periods, issuers must have their plans approved by October 1, 2013. As a result, FLICA is required to issue coverage on a year-round guaranteed issue basis until the next open enrollment period. Please state if FLICA has accounted for this in its pricing, and if it has please describe the methodology that was used to do so.

Thank you.

Gary B. Rosen, FSA, MAAA

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Project Name/Number: EHBC-2014-IP-AR-FLIC/EHBC-2014-IP-AR-FLIC

Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	10/09/2013
Submitted Date	10/09/2013
Respond By Date	11/09/2013

Dear Erica Gibbs,

Introduction:

This will acknowledge receipt of the captioned filing.

Objection 1

- Coverage Schedule 1 (Supporting Document)
- Coverage Schedule 2 (Supporting Document)
- Coverage Schedule 3 (Supporting Document)
- Coverage Schedule 4 (Supporting Document)
- EHBC-2014-IP-AR-FLIC-1, EHBC-2014-IP-AR-FLIC-1 (Form)

Comments: Our Bulletin 9-85 states in part that the difference in benefit levels, i.e. deductibles and co-pay provisions, etc. offered to the insured must not be so great as to practically require that the health care service be rendered by a particular hospital or person. The Department will presume that a difference exceeding 25% in benefit levels effectively negates an insured's freedom to utilize non-panel providers.

With respect to the deductible and coinsurance for Non-Participating Providers, in order to evaluate the relationship of the in-network and out-of-network benefits offered in a major medical insurance policy, the following steps are a guide to determine compliance with the Bulletin:

1. Network discount assumptions in an actuarial claim cost model are set to 0% to standardize the model so a true benefit differential between the in-network (INN) vs. out-of-network (OON) can be calculated.
2. The in-network benefit structure is entered into an actuarial claim cost model, except:
 - i. The benefits offered in-network, but not offered out-of-network, are not included so that a relativity for a consistent set of benefits can be performed.
3. As a result of the above adjustments, an INN incurred claims per member per month (pmpm) value is calculated.
4. The OON benefit structure is entered into an actuarial claim cost model
5. The OON incurred claims pmpm is calculated.
6. The ratio of the INN pmpm and the OON pmpm is calculated.
7. If the value $[(INN \text{ pmpm} \div OON \text{ pmpm}) - 1]$ is:
 - i. Less than 20%, then it is concluded that the proposed benefit schedule complies with Bulletin 9-85.
 - ii. Greater than 30%, then it is concluded that the proposed benefit schedule does not comply with Bulletin 9-85.
 - iii. Greater than 20% but less than 30%, then additional information is requested of the insurer, such as:
 - h Copies of the insurer's internal calculation of the above INN and OON pmpm values;
 - h Copies of the insurer's in-network and out-of network continuance tables so additional calculations can be made

The appropriate conclusion would be made based on the evaluation of the additional information.

Conclusion:

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make

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a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

*Sincerely,
Rosalind Minor*

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Project Name/Number: EHBC-2014-IP-AR-FLIC/EHBC-2014-IP-AR-FLIC

Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 10/03/2013
Submitted Date 10/03/2013
Respond By Date 11/03/2013

Dear Erica Gibbs,

Introduction:

This will acknowledge receipt of the captioned filing.

Objection 1

- EHBC-2014-IP-AR-FLIC, EHBC-2014-IP-AR-FLIC (Form)

Comments:

Does your policy provide for services provided in an after-hours or urgent care center? Also, are benefits provided for observation services ordered in conjunction with an emergency room visit or outpatient visit as outlined in the Benchmark Plan?

Objection 2

- EHBC-2014-IP-AR-FLIC, EHBC-2014-IP-AR-FLIC (Form)

Comments:

Under the Transplant provision on Page 25 of the policy, the amount of \$10,000 per transplant for covered expenses allowed for professional fees of a provider and facility fees appear to be a limitation not found in the Benchmark Plan.

Objection 3

- EHBC-2014-IP-AR-FLIC, EHBC-2014-IP-AR-FLIC (Form)

Comments:

Does your policy provide benefits for In Vitro as required by ACA 23-85-137 and Rule and Regulation. Since In-Vitro is considered an EHB, there can not be a limit of \$15,000.

Objection 4

- EHBC-2014-IP-AR-FLIC, EHBC-2014-IP-AR-FLIC (Form)

Comments:

Benefits must be covered for genetic testing to determine presence of existing anomaly or disease.

Objection 5

- EHBC-2014-IP-AR-FLIC, EHBC-2014-IP-AR-FLIC (Form)

Comments:

With respect to Mental Health and substance Use Disorder Treatment and In reviewing the plans, we have discovered Mental Health and Substance Use Disorder Treatment benefit offerings that do not meet the requirements of the Arkansas benchmark or federal standards. As such, we will require the following changes to your policies:

Eligible practitioners for professional services must include licensed mental health and substance abuse practitioners practicing within the scope of their license and according to the patients specific treatment plan.

Any services beyond outpatient diagnosis, treatment, crisis stabilization, medication management, psychological and neuropsychological testing services may be provided by an outpatient hospital or other covered facility. A plan may not restrict eligible facilities to hospitals and may not exclude licensed, accredited treatment modalities such as residential treatment. An eligible

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facility will be licensed by Arkansas and be accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), CARF International, or Council on Accreditation (COA) for the specific mental health or substance abuse treatment service it is providing (for example, outpatient, intensive outpatient, partial hospitalization, or residential treatment). It is expected that care is delivered in the least restrictive setting.

Finally, the benchmark plan provides for coverage of family and marital counseling when provided as part of the treatment plan. This cannot be an excluded service

We also want to bring to your attention that chronic substance use disorder is included in the final definition of medically frail and consumers with chronic substance use disorders will not be served by the Private Option.

Objection 6

- EHBC-2014-IP-AR-FLIC, EHBC-2014-IP-AR-FLIC (Form)

Comments:

On Page 27, item 14, do you cover Specialist Office Visits under professional service provided by a provider. If so, please incorporate specialist into the language.

Objection 7

- EHBC-2014-IP-AR-FLIC, EHBC-2014-IP-AR-FLIC (Form)

Comments:

With respect to Outpatient Therapy on Page 28, in reviewing plans, we have discovered that the habilitative developmental services benefit is not being offered at actuarial parity with rehabilitative or habilitative therapy services. Because carriers do not have experience providing developmental services, the AID directs carriers to develop a multiplier formula for determining service limits that are at parity with rehabilitative or habilitative therapy services in year one. For example, if a therapy visit unit (one hour) rate is \$100 and a developmental services unit (one hour) rate is \$25, we would expect the plan to cover 4 units of developmental services for every one unit of therapy services. Due to the nature of habilitative service needs, we recommend service limits be defined units (example one hour) and allow the service to be provided in the same or different days. For example, a consumer may receive one, two, or four units (hours) per day. It should be noted that habilitative services are by definition often longer term than rehabilitative services. Further, it should be noted that many individuals requiring habilitative services may also have a disability determination and therefore not be Private Option eligible and are likely to be served under Arkansas standard Medicaid program.

Rehabilitative services are required to provide 30 days of out-patient and 60 days of in-patient services. Because developmental services do not have inpatient services (as rehabilitative services do), we have found 180 hours of habilitative developmental services to be at parity with this benefit.

Developmental services will be provided according to an approved treatment plan and by an Arkansas licensed or certified developmental services provider.

Inpatient Rehabilitative Services covered at 60 visits per calendar year.

Outpatient Rehabilitation Services covered at 30 visits per calendar year.

Habilitative Developmental Services are covered at 180 units(1 hr.=1 unit) per calendar year.

Habilitative Services 30 visits.

Objection 8

- EHBC-2014-IP-AR-FLIC, EHBC-2014-IP-AR-FLIC (Form)

Comments:

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Under the EHB for Maternity and newborn care, benefits are to be covered for maternity and obstetrics, including pre and post natal care. Also, are services provided by a certified nurse midwife. Please refer to the Benchmark Plan, Page 14.

Objection 9

- EHBC-2014-IP-AR-FLIC, EHBC-2014-IP-AR-FLIC (Form)

Comments:

I could not locate in the policy case management communications made by PCP. Case Management is part of the EHB for preventive and wellness services. Please refer to the Benchmark Plan, item 3.1(4) on Page 12.

Objection 10

- EHBC-2014-IP-AR-FLIC, EHBC-2014-IP-AR-FLIC (Form)

Comments:

With respect to Pediatric Dental Care, does your policy cover restorations and hospital services as outlined in the Benchmark Pediatric Dental Plan?

Objection 11

- EHBC-2014-IP-AR-FLIC, EHBC-2014-IP-AR-FLIC (Form)

Comments:

As outlined in the Pediatric Vision Benchmark Plan, your policy must contain benefits for Surgical evaluation, eye Prosthesis, polishing service and vision therapy developmental testing.

Conclusion:

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

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Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	09/30/2013
Submitted Date	09/30/2013
Respond By Date	10/30/2013

Dear Erica Gibbs,

Introduction:

This will acknowledge receipt of the captioned filing.

Objection 1

- Coverage Schedule 1 (Supporting Document)
- Coverage Schedule 2 (Supporting Document)
- Coverage Schedule 3 (Supporting Document)
- Coverage Schedule 4 (Supporting Document)

Comments:

The Schedule of Benefits must be attached to the Form tab and not the supporting documentation tab.

Also, your schedule of benefits must also outline the covered benefits and services. Please refer to the Benchmark Plan Schedule of Benefits for additional information which is needed to be included in your schedules. The Benchmark Schedules are located at: <http://hbe.arkansas.gov/FFE/Plan/Schedule.pdf>.

Thank you for your cooperation.

Conclusion:

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

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Sincerely,

Rosalind Minor

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Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	09/27/2013
Submitted Date	09/27/2013
Respond By Date	10/27/2013

Dear Erica Gibbs,

Introduction:

This will acknowledge receipt of the captioned filing.

Objection 1

- EHBC-2013-IP-AR-2014-FLIC, EHBC-2013-IP-AR-2014-FLIC (Form)

Comments:

As outlined under our Bulletin 5-2013, Multiple metal and cost sharing levels may be submitted in the same SERFF filing. Schedule pages for each cost-sharing level within a metal and/or metal plan filings must have a unique form number and CANNOT CONTAIN VARIABLE MATERIAL. The filing description must contain a description of the metal and/or cost sharing levels utilized and to which forms those levels relate.

Conclusion:

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

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Sincerely,

Rosalind Minor

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Response Letter

Response Letter Status Submitted to State
 Response Letter Date 10/18/2013
 Submitted Date 10/18/2013

Dear Rosalind Minor,

Introduction:

We are in receipt of your correspondence dated 10/10/2013 regarding the above referenced filing.

Response 1

Comments:

See attached letter and Excel spreadsheet.

Related Objection 1

Applies To:

- Actuarial Memorandum and Certifications (Supporting Document)
- Unified Rate Review Template (Supporting Document)

Comments: Attached is a file containing INS's request for additional information.

Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	Response Letter & Attachment 10-18-13
Comments:	
Attachment(s):	20131010 Arkansas Objection Response Final.pdf AR Objection Response.xlsx

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

Your continued review of our filing is appreciated.

Sincerely,

Tom Kennedy

State: Arkansas Filing Company: Freedom Life Insurance Company of America
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: EHBC-2014-IP-AR-FLIC
Project Name/Number: EHBC-2014-IP-AR-FLIC/EHBC-2014-IP-AR-FLIC

Response Letter

Response Letter Status Submitted to State
Response Letter Date 10/10/2013
Submitted Date 10/10/2013

Dear Rosalind Minor,

Introduction:

We are in receipt of your correspondence dated October 9, 2013 regarding the above referenced filing.

Response 1

Comments:

We have followed the steps outlined above using a Milliman Health Cost Guidelines actuarial continuance table from their 2012 models. The resulting incurred claim costs were demonstrated in our previous attachment titled "Demonstration of In-Network versus Out-Of-Network PPO Penalty Compliance". Since we have a signed confidentiality agreement with Milliman we are not allow to copy, use, or disclose to any third parties any part of the Guidelines.

Related Objection 1

Applies To:

- Coverage Schedule 1 (Supporting Document)
- Coverage Schedule 2 (Supporting Document)
- Coverage Schedule 3 (Supporting Document)
- Coverage Schedule 4 (Supporting Document)
- EHBC-2014-IP-AR-FLIC-1, EHBC-2014-IP-AR-FLIC-1 (Form)

State: Arkansas **Filing Company:** Freedom Life Insurance Company of America
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: EHBC-2014-IP-AR-FLIC
Project Name/Number: EHBC-2014-IP-AR-FLIC/EHBC-2014-IP-AR-FLIC

Comments: Our Bulletin 9-85 states in part that the difference in benefit levels, i.e. deductibles and co-pay provisions, etc. offered to the insured must not be so great as to practically require that the health care service be rendered by a particular hospital or person. The Department will presume that a difference exceeding 25% in benefit levels effectively negates an insured's freedom to utilize non-panel providers.

With respect to the deductible and coinsurance for Non-Participating Providers, in order to evaluate the relationship of the in-network and out-of-network benefits offered in a major medical insurance policy, the following steps are a guide to determine compliance with the Bulletin:

- 1. Network discount assumptions in an actuarial claim cost model are set to 0% to standardize the model so a true benefit differential between the in-network (INN) vs. out-of-network (OON) can be calculated.*
- 2. The in-network benefit structure is entered into an actuarial claim cost model, except:*
 - i. The benefits offered in-network, but not offered out-of-network, are not included so that a relativity for a consistent set of benefits can be performed.*
 - 3. As a result of the above adjustments, an INN incurred claims per member per month (pmpm) value is calculated.*
 - 4. The OON benefit structure is entered into an actuarial claim cost model*
 - 5. The OON incurred claims pmpm is calculated.*
 - 6. The ratio of the INN pmpm and the OON pmpm is calculated.*
 - 7. If the value [(INN pmpm divided by OON pmpm) - 1] is:*
 - i. Less than 20%, then it is concluded that the proposed benefit schedule complies with Bulletin 9-85.*
 - ii. Greater than 30%, then it is concluded that the proposed benefit schedule does not comply with Bulletin 9-85.*
 - iii. Greater than 20% but less than 30%, then additional information is requested of the insurer, such as:*
 - h Copies of the insurer's internal calculation of the above INN and OON pmpm values;*
 - h Copies of the insurer's in-network and out-of network continuance tables so additional calculations can be made*

The appropriate conclusion would be made based on the evaluation of the additional information.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

Your continued review of our filing is appreciated.

Sincerely,

Tom Kennedy

State: Arkansas **Filing Company:** Freedom Life Insurance Company of America
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: EHBC-2014-IP-AR-FLIC
Project Name/Number: EHBC-2014-IP-AR-FLIC/EHBC-2014-IP-AR-FLIC

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	10/04/2013
Submitted Date	10/04/2013

Dear Rosalind Minor,

Introduction:

Please see the attached response letter.

Response 1

Comments:

N/A

Related Objection 1

Applies To:

- EHBC-2014-IP-AR-FLIC, EHBC-2014-IP-AR-FLIC (Form)

Comments:

Does your policy provide for services provided in an after-hours or urgent care center? Also, are benefits provided for observation services ordered in conjunction with an emergency room visit or outpatient visit as outlined in the Benchmark Plan?

Changed Items:

Supporting Document Schedule Item Changes	
Satisfied - Item:	Response Letter 10-4-13
Comments:	
Attachment(s):	Response Letter 10-4-13.doc.pdf

State: Arkansas

Filing Company:

Freedom Life Insurance Company of America

TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)

Product Name: EHBC-2014-IP-AR-FLIC

Project Name/Number: EHBC-2014-IP-AR-FLIC/EHBC-2014-IP-AR-FLIC

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	EHBC-2014-IP-AR-FLIC	EHBC-2014-IP-AR-FLIC	POL	Initial			EHBC-2014-IP-AR-FLIC.pdf	Date Submitted: 10/04/2013 By: Erica Gibbs
<i>Previous Version</i>								
1	<i>EHBC-2014-IP-AR-FLIC</i>	<i>EHBC-2014-IP-AR-FLIC</i>	<i>POL</i>	<i>Initial</i>			<i>EHBC-2014-IP-AR-FLIC.pdf</i>	<i>Date Submitted: 09/27/2013 By: Erica Gibbs</i>
<i>Previous Version</i>								
1	<i>EHBC-2013-IP-AR-2014-FLIC</i>	<i>EHBC-2013-IP-AR-2014-FLIC</i>	<i>POL</i>	<i>Initial</i>			<i>EHBC-2014-IP-AR-FLIC.pdf</i>	<i>Date Submitted: 09/26/2013 By: Erica Gibbs</i>
2	EHBC-2014-OC-AR-FLIC	EHBC-2014-OC-AR-FLIC	OUT	Initial			EHBC-2014-OC-AR-FLIC.pdf	Date Submitted: 10/04/2013 By: Erica Gibbs
<i>Previous Version</i>								
2	<i>EHBC-2014-OC-AR-FLIC</i>	<i>EHBC-2014-OC-AR-FLIC</i>	<i>OUT</i>	<i>Initial</i>			<i>EHBC-2014-OC-AR-FLIC.pdf</i>	<i>Date Submitted: 09/26/2013 By: Erica Gibbs</i>

No Rate/Rule Schedule items changed.

Response 2**Comments:**

N/A

Related Objection 2

Applies To:

- EHBC-2014-IP-AR-FLIC, EHBC-2014-IP-AR-FLIC (Form)

State: Arkansas

Filing Company:

Freedom Life Insurance Company of America

TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)

Product Name: EHBC-2014-IP-AR-FLIC

Project Name/Number: EHBC-2014-IP-AR-FLIC/EHBC-2014-IP-AR-FLIC

Comments:

Under the Transplant provision on Page 25 of the policy, the amount of \$10,000 per transplant for covered expenses allowed for professional fees of a provider and facility fees appear to be a limitation not found in the Benchmark Plan.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	EHBC-2014-IP-AR-FLIC	EHBC-2014-IP-AR-FLIC	POL	Initial			EHBC-2014-IP-AR-FLIC.pdf	Date Submitted: 10/04/2013 By: Erica Gibbs
<i>Previous Version</i>								
1	EHBC-2014-IP-AR-FLIC	EHBC-2014-IP-AR-FLIC	POL	Initial			EHBC-2014-IP-AR-FLIC.pdf	Date Submitted: 09/27/2013 By: Erica Gibbs
<i>Previous Version</i>								
1	EHBC-2013-IP-AR-2014-FLIC	EHBC-2013-IP-AR-2014-FLIC	POL	Initial			EHBC-2014-IP-AR-FLIC.pdf	Date Submitted: 09/26/2013 By: Erica Gibbs

No Rate/Rule Schedule items changed.

Response 3

Comments:

N/A

Related Objection 3

Applies To:

- EHBC-2014-IP-AR-FLIC, EHBC-2014-IP-AR-FLIC (Form)

State: Arkansas

Filing Company:

Freedom Life Insurance Company of America

TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)

Product Name: EHBC-2014-IP-AR-FLIC

Project Name/Number: EHBC-2014-IP-AR-FLIC/EHBC-2014-IP-AR-FLIC

Comments:

Does your policy provide benefits for In Vitro as required by ACA 23-85-137 and Rule and Regulation. Since In-Vitro is considered an EHB, there can not be a limit of \$15,000.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes								
Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	EHBC-2014-IP-AR-FLIC	EHBC-2014-IP-AR-FLIC	POL	Initial			EHBC-2014-IP-AR-FLIC.pdf	Date Submitted: 10/04/2013 By: Erica Gibbs
<i>Previous Version</i>								
1	EHBC-2014-IP-AR-FLIC	EHBC-2014-IP-AR-FLIC	POL	Initial			EHBC-2014-IP-AR-FLIC.pdf	Date Submitted: 09/27/2013 By: Erica Gibbs
<i>Previous Version</i>								
1	EHBC-2013-IP-AR-2014-FLIC	EHBC-2013-IP-AR-2014-FLIC	POL	Initial			EHBC-2014-IP-AR-FLIC.pdf	Date Submitted: 09/26/2013 By: Erica Gibbs

No Rate/Rule Schedule items changed.

Response 4

Comments:

N/A

Related Objection 4

Applies To:

- EHBC-2014-IP-AR-FLIC, EHBC-2014-IP-AR-FLIC (Form)

Comments:

Benefits must be covered for genetic testing to determine presence of existing anomaly or disease.

State: Arkansas

Filing Company:

Freedom Life Insurance Company of America

TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)

Product Name: EHBC-2014-IP-AR-FLIC

Project Name/Number: EHBC-2014-IP-AR-FLIC/EHBC-2014-IP-AR-FLIC

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes								
Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	EHBC-2014-IP-AR-FLIC	EHBC-2014-IP-AR-FLIC	POL	Initial			EHBC-2014-IP-AR-FLIC.pdf	Date Submitted: 10/04/2013 By: Erica Gibbs
<i>Previous Version</i>								
1	<i>EHBC-2014-IP-AR-FLIC</i>	<i>EHBC-2014-IP-AR-FLIC</i>	<i>POL</i>	<i>Initial</i>			<i>EHBC-2014-IP-AR-FLIC.pdf</i>	<i>Date Submitted: 09/27/2013 By: Erica Gibbs</i>
<i>Previous Version</i>								
1	<i>EHBC-2013-IP-AR-2014-FLIC</i>	<i>EHBC-2013-IP-AR-2014-FLIC</i>	<i>POL</i>	<i>Initial</i>			<i>EHBC-2014-IP-AR-FLIC.pdf</i>	<i>Date Submitted: 09/26/2013 By: Erica Gibbs</i>

No Rate/Rule Schedule items changed.

Response 5**Comments:**

N/A

Related Objection 5

Applies To:

- EHBC-2014-IP-AR-FLIC, EHBC-2014-IP-AR-FLIC (Form)

State:	Arkansas	Filing Company:	Freedom Life Insurance Company of America
TOI/Sub-TOI:	H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)		
Product Name:	EHBC-2014-IP-AR-FLIC		
Project Name/Number:	EHBC-2014-IP-AR-FLIC/EHBC-2014-IP-AR-FLIC		

Comments:

With respect to Mental Health and substance Use Disorder Treatment and In reviewing the plans, we have discovered Mental Health and Substance Use Disorder Treatment benefit offerings that do not meet the requirements of the Arkansas benchmark or federal standards. As such, we will require the following changes to your policies:

Eligible practitioners for professional services must include licensed mental health and substance abuse practitioners practicing within the scope of their license and according to the patients specific treatment plan.

Any services beyond outpatient diagnosis, treatment, crisis stabilization, medication management, psychological and neuropsychological testing services may be provided by an outpatient hospital or other covered facility. A plan may not restrict eligible facilities to hospitals and may not exclude licensed, accredited treatment modalities such as residential treatment. An eligible facility will be licensed by Arkansas and be accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), CARF International, or Council on Accreditation (COA) for the specific mental health or substance abuse treatment service it is providing (for example, outpatient, intensive outpatient, partial hospitalization, or residential treatment). It is expected that care is delivered in the least restrictive setting.

Finally, the benchmark plan provides for coverage of family and marital counseling when provided as part of the treatment plan. This cannot be an excluded service

We also want to bring to your attention that chronic substance use disorder is included in the final definition of medically frail and consumers with chronic substance use disorders will not be served by the Private Option.

Changed Items:

No Supporting Documents changed.

State: Arkansas

Filing Company:

Freedom Life Insurance Company of America

TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)

Product Name: EHBC-2014-IP-AR-FLIC

Project Name/Number: EHBC-2014-IP-AR-FLIC/EHBC-2014-IP-AR-FLIC

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	EHBC-2014-IP-AR-FLIC	EHBC-2014-IP-AR-FLIC	POL	Initial			EHBC-2014-IP-AR-FLIC.pdf	Date Submitted: 10/04/2013 By: Erica Gibbs
<i>Previous Version</i>								
1	<i>EHBC-2014-IP-AR-FLIC</i>	<i>EHBC-2014-IP-AR-FLIC</i>	<i>POL</i>	<i>Initial</i>			<i>EHBC-2014-IP-AR-FLIC.pdf</i>	<i>Date Submitted: 09/27/2013 By: Erica Gibbs</i>
<i>Previous Version</i>								
1	<i>EHBC-2013-IP-AR-2014-FLIC</i>	<i>EHBC-2013-IP-AR-2014-FLIC</i>	<i>POL</i>	<i>Initial</i>			<i>EHBC-2014-IP-AR-FLIC.pdf</i>	<i>Date Submitted: 09/26/2013 By: Erica Gibbs</i>

No Rate/Rule Schedule items changed.

Response 6**Comments:**

N/A

Related Objection 6

Applies To:

- EHBC-2014-IP-AR-FLIC, EHBC-2014-IP-AR-FLIC (Form)

Comments:

On Page 27, item 14, do you cover Specialist Office Visits under professional service provided by a provider. If so, please incorporate specialist into the language.

Changed Items:

No Supporting Documents changed.

State: Arkansas

Filing Company:

Freedom Life Insurance Company of America

TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)

Product Name: EHBC-2014-IP-AR-FLIC

Project Name/Number: EHBC-2014-IP-AR-FLIC/EHBC-2014-IP-AR-FLIC

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	EHBC-2014-IP-AR-FLIC	EHBC-2014-IP-AR-FLIC	POL	Initial			EHBC-2014-IP-AR-FLIC.pdf	Date Submitted: 10/04/2013 By: Erica Gibbs
<i>Previous Version</i>								
1	EHBC-2014-IP-AR-FLIC	EHBC-2014-IP-AR-FLIC	POL	Initial			EHBC-2014-IP-AR-FLIC.pdf	Date Submitted: 09/27/2013 By: Erica Gibbs
<i>Previous Version</i>								
1	EHBC-2013-IP-AR-2014-FLIC	EHBC-2013-IP-AR-2014-FLIC	POL	Initial			EHBC-2014-IP-AR-FLIC.pdf	Date Submitted: 09/26/2013 By: Erica Gibbs

No Rate/Rule Schedule items changed.

Response 7**Comments:**

N/A

Related Objection 7

Applies To:

- EHBC-2014-IP-AR-FLIC, EHBC-2014-IP-AR-FLIC (Form)

State:	Arkansas	Filing Company:	Freedom Life Insurance Company of America
TOI/Sub-TOI:	H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)		
Product Name:	EHBC-2014-IP-AR-FLIC		
Project Name/Number:	EHBC-2014-IP-AR-FLIC/EHBC-2014-IP-AR-FLIC		

Comments:

With respect to Outpatient Therapy on Page 28, in reviewing plans, we have discovered that the habilitative developmental services benefit is not being offered at actuarial parity with rehabilitative or habilitative therapy services. Because carriers do not have experience providing developmental services, the AID directs carriers to develop a multiplier formula for determining service limits that are at parity with rehabilitative or habilitative therapy services in year one. For example, if a therapy visit unit (one hour) rate is \$100 and a developmental services unit (one hour) rate is \$25, we would expect the plan to cover 4 units of developmental services for every one unit of therapy services. Due to the nature of habilitative service needs, we recommend service limits be defined units (example one hour) and allow the service to be provided in the same or different days. For example, a consumer may receive one, two, or four units (hours) per day. It should be noted that habilitative services are by definition often longer term than rehabilitative services. Further, it should be noted that many individuals requiring habilitative services may also have a disability determination and therefore not be Private Option eligible and are likely to be served under Arkansas standard Medicaid program.

Rehabilitative services are required to provide 30 days of out-patient and 60 days of in-patient services. Because developmental services do not have inpatient services (as rehabilitative services do), we have found 180 hours of habilitative developmental services to be at parity with this benefit.

Developmental services will be provided according to an approved treatment plan and by an Arkansas licensed or certified developmental services provider.

Inpatient Rehabilitative Services covered at 60 visits per calendar year.

Outpatient Rehabilitation Services covered at 30 visits per calendar year.

Habilitative Developmental Services are covered at 180 units(1 hr.=1 unit) per calendar year.

Habilitative Services 30 visits.

Changed Items:

No Supporting Documents changed.

State: Arkansas

Filing Company:

Freedom Life Insurance Company of America

TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)

Product Name: EHBC-2014-IP-AR-FLIC

Project Name/Number: EHBC-2014-IP-AR-FLIC/EHBC-2014-IP-AR-FLIC

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	EHBC-2014-IP-AR-FLIC	EHBC-2014-IP-AR-FLIC	POL	Initial			EHBC-2014-IP-AR-FLIC.pdf	Date Submitted: 10/04/2013 By: Erica Gibbs
<i>Previous Version</i>								
1	<i>EHBC-2014-IP-AR-FLIC</i>	<i>EHBC-2014-IP-AR-FLIC</i>	<i>POL</i>	<i>Initial</i>			<i>EHBC-2014-IP-AR-FLIC.pdf</i>	<i>Date Submitted: 09/27/2013 By: Erica Gibbs</i>
<i>Previous Version</i>								
1	<i>EHBC-2013-IP-AR-2014-FLIC</i>	<i>EHBC-2013-IP-AR-2014-FLIC</i>	<i>POL</i>	<i>Initial</i>			<i>EHBC-2014-IP-AR-FLIC.pdf</i>	<i>Date Submitted: 09/26/2013 By: Erica Gibbs</i>

No Rate/Rule Schedule items changed.

Response 8**Comments:**

N/A

Related Objection 8

Applies To:

- EHBC-2014-IP-AR-FLIC, EHBC-2014-IP-AR-FLIC (Form)

Comments:

Under the EHB for Maternity and newborn care, benefits are to be covered for maternity and obstetrics, including pre and post natal care. Also, are services provided by a certified nurse midwife. Please refer to the Benchmark Plan, Page 14.

Changed Items:

No Supporting Documents changed.

State: Arkansas

Filing Company:

Freedom Life Insurance Company of America

TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)

Product Name: EHBC-2014-IP-AR-FLIC

Project Name/Number: EHBC-2014-IP-AR-FLIC/EHBC-2014-IP-AR-FLIC

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	EHBC-2014-IP-AR-FLIC	EHBC-2014-IP-AR-FLIC	POL	Initial			EHBC-2014-IP-AR-FLIC.pdf	Date Submitted: 10/04/2013 By: Erica Gibbs
<i>Previous Version</i>								
1	<i>EHBC-2014-IP-AR-FLIC</i>	<i>EHBC-2014-IP-AR-FLIC</i>	<i>POL</i>	<i>Initial</i>			<i>EHBC-2014-IP-AR-FLIC.pdf</i>	<i>Date Submitted: 09/27/2013 By: Erica Gibbs</i>
<i>Previous Version</i>								
1	<i>EHBC-2013-IP-AR-2014-FLIC</i>	<i>EHBC-2013-IP-AR-2014-FLIC</i>	<i>POL</i>	<i>Initial</i>			<i>EHBC-2014-IP-AR-FLIC.pdf</i>	<i>Date Submitted: 09/26/2013 By: Erica Gibbs</i>

No Rate/Rule Schedule items changed.

Response 9**Comments:**

N/A

Related Objection 9

Applies To:

- EHBC-2014-IP-AR-FLIC, EHBC-2014-IP-AR-FLIC (Form)

Comments:

I could not locate in the policy case management communications made by PCP. Case Management is part of the EHB for preventive and wellness services. Please refer to the Benchmark Plan, item 3.1(4) on Page 12.

Changed Items:

No Supporting Documents changed.

State: Arkansas

Filing Company:

Freedom Life Insurance Company of America

TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)

Product Name: EHBC-2014-IP-AR-FLIC

Project Name/Number: EHBC-2014-IP-AR-FLIC/EHBC-2014-IP-AR-FLIC

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	EHBC-2014-IP-AR-FLIC	EHBC-2014-IP-AR-FLIC	POL	Initial			EHBC-2014-IP-AR-FLIC.pdf	Date Submitted: 10/04/2013 By: Erica Gibbs
<i>Previous Version</i>								
1	EHBC-2014-IP-AR-FLIC	EHBC-2014-IP-AR-FLIC	POL	Initial			EHBC-2014-IP-AR-FLIC.pdf	Date Submitted: 09/27/2013 By: Erica Gibbs
<i>Previous Version</i>								
1	EHBC-2013-IP-AR-2014-FLIC	EHBC-2013-IP-AR-2014-FLIC	POL	Initial			EHBC-2014-IP-AR-FLIC.pdf	Date Submitted: 09/26/2013 By: Erica Gibbs

No Rate/Rule Schedule items changed.

Response 10**Comments:**

N/A

Related Objection 10

Applies To:

- EHBC-2014-IP-AR-FLIC, EHBC-2014-IP-AR-FLIC (Form)

Comments:

With respect to Pediatric Dental Care, does your policy cover restorations and hospital services as outlined in the Benchmark Pediatric Dental Plan?

Changed Items:

No Supporting Documents changed.

State: Arkansas

Filing Company:

Freedom Life Insurance Company of America

TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)

Product Name: EHBC-2014-IP-AR-FLIC

Project Name/Number: EHBC-2014-IP-AR-FLIC/EHBC-2014-IP-AR-FLIC

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	EHBC-2014-IP-AR-FLIC	EHBC-2014-IP-AR-FLIC	POL	Initial			EHBC-2014-IP-AR-FLIC.pdf	Date Submitted: 10/04/2013 By: Erica Gibbs
<i>Previous Version</i>								
1	<i>EHBC-2014-IP-AR-FLIC</i>	<i>EHBC-2014-IP-AR-FLIC</i>	<i>POL</i>	<i>Initial</i>			<i>EHBC-2014-IP-AR-FLIC.pdf</i>	<i>Date Submitted: 09/27/2013 By: Erica Gibbs</i>
<i>Previous Version</i>								
1	<i>EHBC-2013-IP-AR-2014-FLIC</i>	<i>EHBC-2013-IP-AR-2014-FLIC</i>	<i>POL</i>	<i>Initial</i>			<i>EHBC-2014-IP-AR-FLIC.pdf</i>	<i>Date Submitted: 09/26/2013 By: Erica Gibbs</i>

No Rate/Rule Schedule items changed.

Response 11**Comments:**

N/A

Related Objection 11

Applies To:

- EHBC-2014-IP-AR-FLIC, EHBC-2014-IP-AR-FLIC (Form)

Comments:

As outlined in the Pediatric Vision Benchmark Plan, your policy must contain benefits for Surgical evaluation, eye Prosthesis, polishing service and vision therapy developmental testing.

Changed Items:

No Supporting Documents changed.

SERFF Tracking #:

USHG-129213923

State Tracking #:

ACA OFF EXCHANGE CHILD ONLY

Company Tracking #:

EHBC-2014-IP-AR-FLIC

State: Arkansas

Filing Company:

Freedom Life Insurance Company of America

TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)

Product Name: EHBC-2014-IP-AR-FLIC

Project Name/Number: EHBC-2014-IP-AR-FLIC/EHBC-2014-IP-AR-FLIC

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	EHBC-2014-IP-AR-FLIC	EHBC-2014-IP-AR-FLIC	POL	Initial			EHBC-2014-IP-AR-FLIC.pdf	Date Submitted: 10/04/2013 By: Erica Gibbs
<i>Previous Version</i>								
1	<i>EHBC-2014-IP-AR-FLIC</i>	<i>EHBC-2014-IP-AR-FLIC</i>	<i>POL</i>	<i>Initial</i>			<i>EHBC-2014-IP-AR-FLIC.pdf</i>	<i>Date Submitted: 09/27/2013 By: Erica Gibbs</i>
<i>Previous Version</i>								
1	<i>EHBC-2013-IP-AR-2014-FLIC</i>	<i>EHBC-2013-IP-AR-2014-FLIC</i>	<i>POL</i>	<i>Initial</i>			<i>EHBC-2014-IP-AR-FLIC.pdf</i>	<i>Date Submitted: 09/26/2013 By: Erica Gibbs</i>

No Rate/Rule Schedule items changed.

Conclusion:

Sincerely,
Erica Gibbs

State: Arkansas **Filing Company:** Freedom Life Insurance Company of America
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: EHBC-2014-IP-AR-FLIC
Project Name/Number: EHBC-2014-IP-AR-FLIC/EHBC-2014-IP-AR-FLIC

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	09/30/2013
Submitted Date	09/30/2013

Dear Rosalind Minor,

Introduction:

Response 1

Comments:

Our policies do not have co-payments or varying coinsurance, so the schedule of benefits from the Benchmark would not reflect our policy form accurately. Our policy schedule outlines the required deductibles and coinsurance for our Sickness and Injury Benefits, our Wellness and Screening Benefits, and our Prescription Drug Benefits.

I did put the Coverage Schedule Pages 1-4 under the Form tab rather than Supporting Documentation.

Related Objection 1

Applies To:

- Coverage Schedule 1 (Supporting Document)*
- Coverage Schedule 2 (Supporting Document)*
- Coverage Schedule 3 (Supporting Document)*
- Coverage Schedule 4 (Supporting Document)*

Comments:

The Schedule of Benefits must be attached to the Form tab and not the supporting documentation tab.

Also, your schedule of benefits must also outline the covered benefits and services. Please refer to the Benchmark Plan Schedule of Benefits for additional information which is needed to be included in your schedules. The Benchmark Schedules are located at: <http://hbe.arkansas.gov/FFE/Plan/Schedule.pdf>.

Thank you for your cooperation.

Changed Items:

No Supporting Documents changed.

State: Arkansas

Filing Company:

Freedom Life Insurance Company of America

TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)

Product Name: EHBC-2014-IP-AR-FLIC

Project Name/Number: EHBC-2014-IP-AR-FLIC/EHBC-2014-IP-AR-FLIC

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	EHBC-2014-IP-AR-FLIC-1	EHBC-2014-IP-AR-FLIC-1	SCH	Initial			Coverage Schedule 1.pdf	Date Submitted: 09/30/2013 By: Erica Gibbs
2	EHBC-2014-IP-AR-FLIC-2	EHBC-2014-IP-AR-FLIC-2	SCH	Initial			Coverage Schedule 2.pdf	Date Submitted: 09/30/2013 By: Erica Gibbs
3	EHBC-2014-IP-AR-FLIC-3	EHBC-2014-IP-AR-FLIC-3	SCH	Initial			Coverage Schedule 3.pdf	Date Submitted: 09/30/2013 By: Erica Gibbs
4	EHBC-2014-IP-AR-FLIC-4	EHBC-2014-IP-AR-FLIC-4	SCH	Initial			Coverage Schedule 4.pdf	Date Submitted: 09/30/2013 By: Erica Gibbs

No Rate/Rule Schedule items changed.

Conclusion:

Sincerely,
Erica Gibbs

State: Arkansas **Filing Company:** Freedom Life Insurance Company of America
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: EHBC-2014-IP-AR-FLIC
Project Name/Number: EHBC-2014-IP-AR-FLIC/EHBC-2014-IP-AR-FLIC

Response Letter

Response Letter Status	Submitted to State
Response Letter Date	09/27/2013
Submitted Date	09/27/2013

Dear Rosalind Minor,

Introduction:

Response 1

Comments:

Please see attached Coverage Schedules under the Supporting Documents tab, one for each metal plan we are planning to offer.

The Form Schedule Item that has been changed is just a mistake in naming the Form, it is the same document uploaded.

Related Objection 1

Applies To:

- EHBC-2013-IP-AR-2014-FLIC, EHBC-2013-IP-AR-2014-FLIC (Form)

Comments:

As outlined under our Bulletin 5-2013, Multiple metal and cost sharing levels may be submitted in the same SERFF filing. Schedule pages for each cost-sharing level within a metal and/or metal plan filings must have a unique form number and CANNOT CONTAIN VARIABLE MATERIAL. The filing description must contain a description of the metal and/or cost sharing levels utilized and to which forms those levels relate.

Changed Items:

SERFF Tracking #:

USHG-129213923

State Tracking #:

ACA OFF EXCHANGE CHILD ONLY

Company Tracking #:

EHBC-2014-IP-AR-FLIC

State:

Arkansas

Filing Company:

Freedom Life Insurance Company of America

TOI/Sub-TOI:

H161 Individual Health - Major Medical/H161.005A Individual - Preferred Provider (PPO)

Product Name:

EHBC-2014-IP-AR-FLIC

Project Name/Number:

EHBC-2014-IP-AR-FLIC/EHBC-2014-IP-AR-FLIC

Supporting Document Schedule Item Changes

Satisfied - Item:	Coverage Schedule 1
Comments:	Please see attached Coverage Schedule 1, related to EHBC-2014-IP-AR-FLIC.
Attachment(s):	Coverage Schedule 1.pdf
Satisfied - Item:	Coverage Schedule 2
Comments:	Please see attached Coverage Schedule 2, related to EHBC-2014-IP-AR-FLIC.
Attachment(s):	Coverage Schedule 2.pdf
Satisfied - Item:	Coverage Schedule 3
Comments:	Please see attached Coverage Schedule 2, related to EHBC-2014-IP-AR-FLIC.
Attachment(s):	Coverage Schedule 3.pdf
Satisfied - Item:	Coverage Schedule 4
Comments:	Please see attached Coverage Schedule 2, related to EHBC-2014-IP-AR-FLIC.
Attachment(s):	Coverage Schedule 4.pdf

SERFF Tracking #:

USHG-129213923

State Tracking #:

ACA OFF EXCHANGE CHILD ONLY

Company Tracking #:

EHBC-2014-IP-AR-FLIC

State:

Arkansas

Filing Company:

Freedom Life Insurance Company of America

TOI/Sub-TOI:

H161 Individual Health - Major Medical/H161.005A Individual - Preferred Provider (PPO)

Product Name:

EHBC-2014-IP-AR-FLIC

Project Name/Number:

EHBC-2014-IP-AR-FLIC/EHBC-2014-IP-AR-FLIC

Supporting Document Schedule Item Changes

Satisfied - Item:	Coverage Schedule 1
Comments:	Please see attached Coverage Schedule 1, related to EHBC-2014-IP-AR-FLIC.
Attachment(s):	Coverage Schedule 1.pdf
Satisfied - Item:	Coverage Schedule 2
Comments:	Please see attached Coverage Schedule 2, related to EHBC-2014-IP-AR-FLIC.
Attachment(s):	Coverage Schedule 2.pdf
Satisfied - Item:	Coverage Schedule 3
Comments:	Please see attached Coverage Schedule 2, related to EHBC-2014-IP-AR-FLIC.
Attachment(s):	Coverage Schedule 3.pdf
Satisfied - Item:	Coverage Schedule 4
Comments:	Please see attached Coverage Schedule 2, related to EHBC-2014-IP-AR-FLIC.
Attachment(s):	Coverage Schedule 4.pdf

SERFF Tracking #:

USHG-129213923

State Tracking #:

ACA OFF EXCHANGE CHILD ONLY

Company Tracking #:

EHBC-2014-IP-AR-FLIC

State:

Arkansas

Filing Company:

Freedom Life Insurance Company of America

TOI/Sub-TOI:

H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)

Product Name:

EHBC-2014-IP-AR-FLIC

Project Name/Number:

EHBC-2014-IP-AR-FLIC/EHBC-2014-IP-AR-FLIC

Supporting Document Schedule Item Changes

Satisfied - Item:	Coverage Schedule 1
Comments:	Please see attached Coverage Schedule 1, related to EHBC-2014-IP-AR-FLIC.
Attachment(s):	Coverage Schedule 1.pdf
Satisfied - Item:	Coverage Schedule 2
Comments:	Please see attached Coverage Schedule 2, related to EHBC-2014-IP-AR-FLIC.
Attachment(s):	Coverage Schedule 2.pdf
Satisfied - Item:	Coverage Schedule 3
Comments:	Please see attached Coverage Schedule 2, related to EHBC-2014-IP-AR-FLIC.
Attachment(s):	Coverage Schedule 3.pdf
Satisfied - Item:	Coverage Schedule 4
Comments:	Please see attached Coverage Schedule 2, related to EHBC-2014-IP-AR-FLIC.
Attachment(s):	Coverage Schedule 4.pdf

State: Arkansas **Filing Company:** Freedom Life Insurance Company of America
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: EHBC-2014-IP-AR-FLIC
Project Name/Number: EHBC-2014-IP-AR-FLIC/EHBC-2014-IP-AR-FLIC

Supporting Document Schedule Item Changes

Satisfied - Item:	Coverage Schedule 1
Comments:	Please see attached Coverage Schedule 1, related to EHBC-2014-IP-AR-FLIC.
Attachment(s):	Coverage Schedule 1.pdf
Satisfied - Item:	Coverage Schedule 2
Comments:	Please see attached Coverage Schedule 2, related to EHBC-2014-IP-AR-FLIC.
Attachment(s):	Coverage Schedule 2.pdf
Satisfied - Item:	Coverage Schedule 3
Comments:	Please see attached Coverage Schedule 2, related to EHBC-2014-IP-AR-FLIC.
Attachment(s):	Coverage Schedule 3.pdf
Satisfied - Item:	Coverage Schedule 4
Comments:	Please see attached Coverage Schedule 2, related to EHBC-2014-IP-AR-FLIC.
Attachment(s):	Coverage Schedule 4.pdf

Form Schedule Item Changes

Item No.	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments	Submitted
1	EHBC-2014-IP-AR-FLIC	EHBC-2014-IP-AR-FLIC	POL	Initial			EHBC-2014-IP-AR-FLIC.pdf	Date Submitted: 09/27/2013 By: Erica Gibbs
<i>Previous Version</i>								
1	EHBC-2013-IP-AR-2014-FLIC	EHBC-2013-IP-AR-2014-FLIC	POL	Initial			EHBC-2014-IP-AR-FLIC.pdf	Date Submitted: 09/26/2013 By: Erica Gibbs

No Rate/Rule Schedule items changed.

SERFF Tracking #:

USHG-129213923

State Tracking #:

ACA OFF EXCHANGE CHILD ONLY

Company Tracking #:

EHBC-2014-IP-AR-FLIC

State:

Arkansas

Filing Company:

Freedom Life Insurance Company of America

TOI/Sub-TOI:

H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)

Product Name:

EHBC-2014-IP-AR-FLIC

Project Name/Number:

EHBC-2014-IP-AR-FLIC/EHBC-2014-IP-AR-FLIC

Conclusion:

Sincerely,
Erica Gibbs

SERFF Tracking #:

USHG-129213923

State Tracking #:

ACA OFF EXCHANGE CHILD ONLY

Company Tracking #:

EHBC-2014-IP-AR-FLIC

State:

Arkansas

Filing Company:

Freedom Life Insurance Company of America

TOI/Sub-TOI:

H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)

Product Name:

EHBC-2014-IP-AR-FLIC

Project Name/Number:

EHBC-2014-IP-AR-FLIC/EHBC-2014-IP-AR-FLIC

Amendment Letter

Submitted Date: 10/22/2013

Comments:

See attached objection letter and response.

Changed Items:

No Form Schedule Items Changed.

No Rate Schedule Items Changed.

Supporting Document Schedule Item Changes

Satisfied - Item:	Objection Letter & Response 10-21-13
Comments:	
Attachment(s):	FLICA 129213923 RAI_10-21-2013 Objection & Response.pdf

State: Arkansas Filing Company: Freedom Life Insurance Company of America
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: EHBC-2014-IP-AR-FLIC
Project Name/Number: EHBC-2014-IP-AR-FLIC/EHBC-2014-IP-AR-FLIC

Note To Reviewer

Created By:

Erica Gibbs on 09/26/2013 04:24 PM

Last Edited By:

Rosalind Minor

Submitted On:

10/30/2013 09:58 AM

Subject:

Filing Fee

Comments:

Hi,

I accidentally paid \$100 per form in fees rather than \$100 per policy and was wondering if there was a way to refund the extra fees (\$200)?

Thanks,
Erica Gibbs

State:

Arkansas

Filing Company:

Freedom Life Insurance Company of America

TOI/Sub-TOI:

H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)

Product Name:

EHBC-2014-IP-AR-FLIC

Project Name/Number:

EHBC-2014-IP-AR-FLIC/EHBC-2014-IP-AR-FLIC

Form Schedule

Lead Form Number:

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1	Approved-Closed 10/30/2013	EHBCAPP-2014- NOARB-FLIC	EHBAPP- 2014- NOARB- FLIC	AEF	Initial			EHBCAPP-2014- NOARB-FLIC.pdf
2	Approved-Closed 10/30/2013	EHBC-2014-IP-AR- FLIC	EHBC- 2014-IP-AR- FLIC	POL	Initial			EHBC-2014-IP- AR-FLIC.pdf
3	Approved-Closed 10/30/2013	EHBC-2014-OC-AR- FLIC	EHBC- 2014-OC- AR-FLIC	OUT	Initial			EHBC-2014-OC- AR-FLIC.pdf
4	Approved-Closed 10/30/2013	EHBC-2014-IP-AR- FLIC-1	EHBC- 2014-IP-AR- FLIC-1	SCH	Initial			Coverage Schedule 1.pdf
5	Approved-Closed 10/30/2013	EHBC-2014-IP-AR- FLIC-2	EHBC- 2014-IP-AR- FLIC-2	SCH	Initial			Coverage Schedule 2.pdf
6	Approved-Closed 10/30/2013	EHBC-2014-IP-AR- FLIC-3	EHBC- 2014-IP-AR- FLIC-3	SCH	Initial			Coverage Schedule 3.pdf
7	Approved-Closed 10/30/2013	EHBC-2014-IP-AR- FLIC-4	EHBC- 2014-IP-AR- FLIC-4	SCH	Initial			Coverage Schedule 4.pdf

Form Type Legend:

State: Arkansas**Filing Company:**

Freedom Life Insurance Company of America

TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)**Product Name:** EHBC-2014-IP-AR-FLIC**Project Name/Number:** EHBC-2014-IP-AR-FLIC/EHBC-2014-IP-AR-FLIC

ADV	Advertising	AEF	Application/Enrollment Form
CER	Certificate	CERA	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	FND	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	NOC	Notice of Coverage
OTH	Other	OUT	Outline of Coverage
PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages

ESSENTIAL HEALTH BENEFIT PLAN APPLICATION

Primary Applicant Information

APP

Application Type:		<input type="radio"/> New Coverage		<input type="radio"/> Open Enrollment		<input type="radio"/> Special Enrollment		<input type="radio"/> Change/Modification to Existing Coverage	
Requested Effective Date:		____/____/____(MM/DD/YYYY)							
A. Applicant Information <i>(For Child Only Coverage, the application must be completed by Parent or Legal Guardian.)</i>									
Name		_____		Height: _____		Weight: _____			
First		MI		Last		Gender		<input type="radio"/> Male <input type="radio"/> Female	
Social Security #:		_____		Date of Birth: _____		Birth Place: _____			
Employer Name Address: _____									
Work Phone Number: _____					Occupation/Duties: _____				
Resident Address									
Address: _____				Home Phone: () _____					
City: _____				Business Phone: () _____					
State: _____ Zip Code: _____				Cell Phone: () _____					
Email: _____				Best time to call: _____					
B. Parent or Legal Guardian Information									
Name		_____							
First		MI		Last					
Parent or Legal Guardian Address Information if different from above									
Address: _____				Home Phone: () _____					
City: _____				Business Phone: () _____					
State: _____ Zip Code: _____				Cell Phone: () _____					
Email: _____				Relation to Child: _____					

Family Information

Additional Applicant Information									
C. Name: _____					F. Name _____				
First		MI		Last	First		MI		Last
<input type="radio"/> M or <input type="radio"/> F		DOB _____		Ht. _____	DOB _____		Ht. _____		Wt. _____
Employer Name & Address: _____					Employer Name & Address: _____				
Work Phone # _____ Social Security # _____					Work Phone # _____ Social Security # _____				
C. Name: _____					F. Name _____				
First		MI		Last	First		MI		Last
<input type="radio"/> M or <input type="radio"/> F		DOB _____		Ht. _____	DOB _____		Ht. _____		Wt. _____
Employer Name & Address: _____					Employer Name & Address: _____				
Work Phone # _____ Social Security # _____					Work Phone # _____ Social Security # _____				
D. Name _____					G. Name _____				
First		MI		Last	First		MI		Last
<input type="radio"/> M or <input type="radio"/> F		DOB _____		Ht. _____	DOB _____		Ht. _____		Wt. _____
Employer Name & Address: _____					Employer Name & Address: _____				
Work Phone # _____ Social Security # _____					Work Phone # _____ Social Security # _____				

3100 Burnett Plaza • 801 Cherry Street, Unit 33 • Fort Worth, TX • 76102

Fraud Notice

APP

Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

Applicant's Acknowledgments and Authorizations

The undersigned individual(s) ("Parent or Legal Guardian") and/or ("Applicant") understand, certify to, agree with and affirm each of the following statements, as being true and correct:

- [1.] Parent or Legal Guardian submits my/our application(s) to Freedom Life Insurance Company of America ("Company") for plan of coverage identified on such application(s) ("Application"), and understand that the Company will evaluate the information provided for all family members listed on the Application as part of its issuing process.
- [2.] The answers recorded to the questions on the Application were provided to the Agent by Parent or Legal Guardian.
- [3.] The Company will verify the information contained on the Application in a recorded telephone call. This recorded verification call is a routine process for individuals applying for coverage with the Company, and the recording will be made a part of Applicant's file with the Company. The Company will attempt to place a call using the telephone number(s) listed on the first page of the Application for the purposes of completing this verification call. If no one is available when the Company attempts this verification call, the Parent or Legal Guardian of the Applicant should call the Company at 1-800-387-9027 for the purposes of scheduling a time when the call can be completed.
- [4.] The plan of coverage applied for on the Application shall not be effective until either the applicable policy of insurance has been actually issued by the Company, with first premium paid by Parent or Legal Guardian.
- [5.] Applicant and Parent or Legal Guardian received a copy of the Company's notice related to certain federal legislation entitled the Health Insurance Portability and Accountability Act ("HIPAA") of 1996, the Women's Health and Cancer Rights Act of 1998 ("WHCR"), the Financial Services Modernization Act of 1999 and also known as the Gramm-Leach-Bliley Act ("GLB") and the Patient Protection and Affordable Care Act of 2010 ("PPACA") in connection with the Application and Applicant has reviewed the HIPAA, WHCR, GLB and PPACA sections of such notice in connection with the Application.
- [6.] The Parent or Legal Guardian acknowledges they read and signed the Authorization to Use and Disclose Protected Health Information form.
- [7.] The Agent is not an officer of the Company and has no authority from the Company to change, waive, alter or amend (i) the language or provisions of any insurance policy, (ii) the Application for insurance coverage, or (iii) any other requirement of the Company.
- [8.] The Agent does not have any authority from the Company to make any representations or binding commitments on behalf of the Company about the conditions under which the Company will issue coverage or the effective date of any coverage to be issued by the Company.
- [9.] Should payment of such required premium not be timely made to the Company, or if such payment is returned by Parent or Legal Guardian's bank for insufficiency of funds or in any other way not honored by my/our bank, the applicable policy of insurance is withdrawn, void and of no effect.
- [10.] Acknowledge that any fraudulent statement or material misrepresentation on the Application and/or amendments may result in contract rescission.

Parent or Legal Guardian Attestation: I/we hereby certify and affirm my/our review and understanding of each of the statements above, all of which are true and correct. If my/our electronic signature(s) cannot be provided, then a verbal electronic signature(s) will be obtained during a recorded telephone interview before coverage will be considered.

Dated at _____

(City)

(State)

(Month)

(Day)

(Year)

✘ _____

Signature of Parent or Legal Guardian

Agent Information

I certify that I have truly and accurately recorded on each Application form the information supplied by the Parent or Legal Guardian and that I am not aware of any other information that might have an adverse effect on the insurability of any person here proposed for insurance. I certify that I have reviewed the Application, and that each has been completed in full for submission to Freedom Life Insurance Company of America.

Agent Name: _____

(Please Print)

Agent Number: _____

Agent's Signature _____

Date: _____

FREEDOM LIFE INSURANCE COMPANY OF AMERICA

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

ESSENTIAL HEALTH BENEFITS POLICY

The coverage of all **Minor Dependent Insureds** is governed and determined by the terms, conditions, definitions, limitations and exclusions contained in this **Policy**. Certain phrases and words have the first letter of each word capitalized and the entire word or phrase printed in bold face type. These are generally defined phrases and words, and as such have the express meaning set forth in Section II. DEFINITIONS. This **Policy** is a legal contract between **You** and the **Company**. Please read it carefully!

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

IMPORTANT NOTICE ABOUT STATEMENTS IN THE APPLICATION: Please read the copy of **Your** application for coverage, which is attached to and part of this **Policy**, to see if any information inquired about or contained in the application is incorrect, incomplete or missing. Contact **Us** immediately if any information contained in the application is incorrect, incomplete or missing. Any incorrect or incomplete statements or answers, as well as any missing information could cause a claim to be denied or the coverage under this **Policy** to be reformed or voided.

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

YOUR 30 DAY RIGHT TO RETURN THIS POLICY

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



SECRETARY



PRESIDENT

**THIS POLICY PROVIDES ESSENTIAL HEALTH BENEFITS COVERAGE UNDER FEDERAL LAW;
BUT IT IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE UNDER STATE LAW.**

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I. Policy Schedule

A. GENERAL INFORMATION

Policy form: [EHBC-2014-IP-AR-FLIC]

Policyowner: []

Minor Dependent Insured: Age at Issue: []

Policy Number: []

Issue Date: []

Other Minor Dependent Insureds on Issue Date:

[]
[]

Beneficiary: []

Initial Premium: []

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

First Renewal Date: []

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

B. COVERAGE SCHEDULES

[1]. DEDUCTIBLE SCHEDULES:

The following deductibles are to be paid by the **Minor Dependent Insured** in addition to the **Minor Dependent Insured Coinsurance Percentage** before any **Sickness and Injury Benefits** or **Wellness and Screening Benefits** are payable by **Us** for **Covered Expenses**:

- A. **Calendar Year Deductible per Minor Dependent Insured:** [\$950, \$2,000, \$3,500, \$6,250]; and
- B. **Separate Deductible For Non-Participating Providers:** [\$2,850, \$6,000, \$10,500, \$18,750]

[2]. COINSURANCE PAYMENT SCHEDULES – PARTICIPATING PROVIDERS AND PARTICIPATING PHARMACIES:

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

- A. **Company Insurance Percentage:** [100%]
(**Sickness and Injury Benefits** and **Wellness and Screening Benefits**)
- B. **Insured Coinsurance Percentage:** [0%]; and
(**Sickness and Injury Benefits** and **Wellness and Screening Benefits**)
- C. **Insured Maximum Participating Provider Coinsurance Payment:** [\$950, \$2,000, \$3,500, \$6,250]

[3]. COINSURANCE PAYMENT SCHEDULES – NON-PARTICIPATING PROVIDERS AND NON-PARTICIPATING PHARMACIES:

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

- A. **Company Insurance Percentage:** [100%]
(**Sickness and Injury Benefits** and **Wellness and Screening Benefits**)
- B. **Minor Dependent Insured Coinsurance Percentage:** [0%]; and
(**Sickness and Injury Benefits** and **Wellness and Screening Benefits**)
- C. **Minor Dependent Insured Maximum Non-Participating Provider Coinsurance Payment:** [\$2,850, \$6,000, \$10,500, \$18,750]

II. DEFINITIONS

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

“**Accident**”, “**Accidentally**” means an event or occurrence that was unplanned and unintended by the **Minor Dependent Insured** that was the sole cause of **Injuries** sustained or suffered by such **Minor Dependent Insured** and that takes place on or after the **Issue Date**.

“**Adult Wellness Preventive Care**” means the evidence-based items or services that, at the time services are **Provided**, have in effect a rating of “A” or “B” in the current list of preventive services recommended for adults by the United States Preventive Services Task Force (USPSTF). (See current USPSFT A & B recommendation chart.)

“**Adverse Determination**” means a determination by **Us** that an admission, availability of care, continued stay or other **Health Care Service** has been reviewed and, based upon the information provided, the requested payment for the service is denied, reduced or terminated, because:

1. the requested **Health Care Service** does not meet **Our Policy** requirements for **Medical Necessity**; or
2. the requested **Health Care Service** has been found to be “experimental/investigational.”

To be considered as an **Adverse Determination**, the **Adverse Determination** must be a **Final Adverse Determination**, except as provided herein. The **Adverse Determination** must involve treatment, services, equipment, supplies or drugs that would require **Your Policy** to expend five hundred dollars [\$500] or more of expenditures.

Adverse Determination does NOT include a determination by **Us** to deny a **Health Care Service** or **Benefit** based upon:

1. an express exclusion within the **Policy**, other than a general exclusion for “**Medical Necessity**” or “experimental/investigational”;
2. an express limitation within the **Policy** with respect to the number of visits, treatments, supplies or services for a covered **Benefit** in a given **Calendar Year**;
3. an express limitation within the **Policy** with respect to a maximum dollar limitation with respect to a covered **Benefit** in a given **Calendar Year** period;
4. a determination by **Us** that an individual is not eligible to be an Insured;
5. a determination by **Us** that treatment, service or supplies were requested or obtained by a **Covered Minor Dependent Insured** through fraud or material misrepresentation;
6. the procedure for determining the **Minor Dependent Insured’s** access to a **Provider**, including but not limited to any primary care gatekeeper, referral or network access provision;
7. Illegality of services or the means or methods of administering them;
8. FDA or other government agency determinations, reports or statements; or
9. Licensure, permit or accreditation status of a **Provider**.

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

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

“**Autism Spectrum Disorder**” means the following three conditions, defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders:

1. Autistic Disorder;
2. Asperger’s Syndrome; and
3. Other Pervasive Developmental Disorder.

“Behavioral Therapy” means interactive therapies derived from evidence-based research, including applied behavior analysis, which includes discrete trial training, pivotal response training, intensive intervention programs and early intensive behavioral intervention.

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

“Benefit(s)” means **Sickness and Injury Benefits**, and **Wellness and Screening Benefits**.

“Bitewing X-ray” means an x-ray showing exposed portions of the back teeth of an **Insured**. This type of x-ray is primarily used for the detection of hidden decay between teeth.

“Bone Marrow Transplants” means the **Medically Necessary** transplantation, combined transplantation, and sequential transplantation procedures, sometimes referred to as “Bone Marrow Reconstitution or Support” in which **Medically Necessary** human blood precursor cells are administered following myelosuppressive or ablative therapy are received by a **Minor Dependent Insured** while coverage for such **Minor Dependent Insured** under this **Policy** is in full force and effect. Such cells may be derived from such **Insured** in an autologous harvest, or from a matched donor for an allogeneic transplant.

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

“Breast Reconstruction” means **Medically Necessary** reconstruction of a breast incident to a **Mastectomy** to restore or achieve breast symmetry. **Breast Reconstruction** includes surgical reconstruction of the non-diseased breast to produce symmetrical appearance of a breast on which **Mastectomy** surgery has been performed, as well as **Mastectomy** bras/camisoles and external prosthetics that meet external prosthetic placement needs, prostheses and services and other supplies that are **Medically Necessary** for any physical complication, including lymphedemas, at all stages of the reconstruction incident to a **Mastectomy**.

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

“Calendar Year Deductible” means the amount of **Covered Expenses** each **Minor Dependent Insured** must incur within a **Calendar Year** for services rendered by **Participating Providers** before any applicable **Sickness and Injury Benefits** or **Wellness and Screening Benefits** are payable under this **Policy**.

No **Sickness and Injury Benefits** or **Wellness and Screening Benefits** are payable under this **Policy** for services rendered by **Participating Providers** until after the **Calendar Year Deductible** is satisfied and fully payable by either **You** or such **Minor Dependent Insured**. The amount of the **Calendar Year Deductible** is shown on the **Policy Schedule** and applies per **Calendar Year** separately to each **Minor Dependent Insured**.

The amount of the **Separate Deductible For Non-Participating Providers** may not be used to satisfy the **Calendar Year Deductible**.

“Childhood Wellness Preventive Care” means the evidence-based items or services that, at the time services are **Provided**, have in effect a rating of “A” or “B” in the current list of preventive services recommended for each infant, child and adolescent **Minor Dependent Insured** by the United States Preventive Services Task Force (USPSTF). To the extent not addressed by the USPSTF, **Child Wellness Preventive Care** also includes evidence-informed preventive care and screenings **Provided** for the appropriate age in the comprehensive guidelines supported by the Health Resources and Services Administration and by the American Academy of Pediatrics (AAP) and Bright Futures.

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

“Cochlear Implant” means an implantable hearing device inserted into the modiolus of the cochlea and into the cranial bone and its associated speech processor.

“Company” means Freedom Life Insurance Company of America.

“Company Insurance Percentage” means the portion of the **Covered Expenses We** must pay to or on behalf of a **Minor Dependent Insured** for **Benefits** under this **Policy**, after satisfaction by the **Minor Dependent Insured** of (i) all applicable deductibles and (ii) the amount of the applicable **Minor Dependent Insured Coinsurance Percentage**. The **Company Insurance Percentage** is shown on the **Policy Schedule for Covered Expenses for Sickness and Injury Benefits and Wellness and Screening Benefits** at (i) **Participating Providers**; (ii) **Participating Pharmacies**; (iii) **Non-Participating Providers**; and (iv) **Non-Participating Pharmacies**.

“Complications of Pregnancy” means:

1. Conditions (when the pregnancy is not terminated), which diagnoses are due to maternal risk, 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; and
2. Non-elective **Emergency** cesarean sections, termination of ectopic pregnancy, and spontaneous termination of pregnancy occurring during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy does not include false labor, occasional spotting, **Provider** prescribed rest during the period of pregnancy, morning sickness, and hyperemesis gravidarum. Nor does it include pre-eclampsia and similar conditions associated with the management of a difficult pregnancy unless such condition constitutes a nosologically distinct complication.

“Confinement” or **“Confined”** means **Inpatient** services received as a resident bed patient for not less than eight (8) hours in a **Hospital**. A period of **Confinement** begins on the date of admission to the **Hospital** as an **Inpatient** and ends on the date of discharge.

“Covered Expenses” means the amount of expenses actually incurred by a **Minor Dependent Insured**, on or after the **Issue Date** of this **Policy** and before such **Insured’s Termination of Coverage** hereunder, as a result of the **Minor Dependent Insured** being **Provided Medically Necessary** or **Dentally Necessary** medical, dental, surgical, or diagnostic services, supplies, care, and other applicable treatment listed in the **SICKNESS AND INJURY BENEFITS**, or the **WELLNESS AND SCREENING BENEFITS** Sections of this **Policy**, applicable up to but not exceeding the amount of each of the following:

1. the **Maximum Allowable Charge** for each applicable medical, dental, surgical or diagnostic service, supply, care or other applicable treatment; and
2. the amount of any other applicable coverage limit or excluded amount set forth in any limitation or exclusion that is contained in any Section in this **Policy** and/or in any exclusionary or limiting rider, amendment or endorsement attached hereto.

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

“Craniofacial Anomaly” means an abnormality of the head and/or facial bones that is present at birth such as: positional head deformity, craniosynostosis, cleft lip and cleft palate, hemifacial microsomia, and Treacher Collins syndrome.

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

“Dental Injury” means damage or harm **Accidentally** sustained to the physical structure of the teeth or gums of an **Insured** that is the direct cause of the loss independent of disease, bodily infirmity, or any other cause, which occurs while this **Policy** is in force and effect for such **Minor Dependent Insured**.

“Dentally Necessary” means, for the covered items and services listed in the **PEDIATRIC DENTAL CARE** section of this **Policy**, any applicable diagnostic test, laboratory test, examination, surgery, medical treatment, service or supply listed therein that is **Provided** to a **Minor Dependent Insured**:

1. by or at the appropriate order, or upon the approval of a **Dentist**;
2. for the recognized diagnosis or care and treatment of a **Dental Injury** or **Dental Sickness**;
3. in a manner appropriate and necessary for the symptoms, diagnosis or treatment of such **Dental Injury** or **Dental Sickness**;
4. in the most cost effective setting and manner available to treat the **Dental Injury** or **Dental Sickness**;
5. not primarily for the convenience of a **Minor Dependent Insured, Family**, or a **Dentist**;
6. not investigational or experimental in nature;
7. reasonably designed to either prevent certain future **Dental Sickness** or permit early diagnoses of certain **Dental Sickness**;
8. prescribed, performed and/or ordered by a **Dentist**; and
9. appropriate and performed according to and within generally accepted standards for the practice of dentistry.

The fact that a **Dentist** prescribed, ordered, recommended or approved a service, supply, or treatment does not in and of itself make it **Dentally Necessary**.

“**Dental Sickness**” means illness or disease afflicting the physical structure of the teeth or gums of a **Minor Dependent Insured**, while this **Policy** is in force and effect for such **Minor Dependent Insured**.

“**Dentist**” means a person who has successfully completed the prescribed course of studies in dentistry at a dental college officially recognized and accredited in the country in which it is located, and which person has been licensed in the profession of dentistry by the state in which the dental service or **Oral Surgery** is received by a **Minor Dependent Insured**. A **Dentist** must be acting within the scope of such license while rendering professional dental services to or performing **Oral Surgery** on a **Minor Dependent Insured**, and in each instance must be reasonable, appropriate and necessary **Pediatric Dental Care** and treatment of the **Minor Dependent Insured**. A **Dentist** cannot be a member of the **Insured’s** family.

“**Denture**” means a removable replacement for a natural tooth or teeth of a **Minor Dependent Insured**.

“**Diabetes Equipment**” means blood glucose monitors, insulin pumps and associated appurtenances, insulin infusion devices, and podiatric appliances, including foot orthotics, for the prevention of complications associated with diabetes.

“**Diabetes Self-Management Training**” means training provided by a health care practitioner or **Provider** who is licensed, registered or certified in this state to provide appropriate health care services for the treatment of diabetes.

Diabetes Self-Management Training includes:

1. training provided after the initial diagnosis of diabetes, including nutritional counseling and proper use of **Diabetes Equipment** and **Diabetes Supplies**;
2. training authorized on the diagnosis of a **Provider** or other health care practitioner due to a significant change in the **Minor Dependent Insured’s** symptoms or condition which necessitates changes in the self-management regime; and
3. periodic or episodic continuing education training when prescribed by an appropriate health care practitioner as warranted by the development of new techniques and treatments for diabetes.

“**Diabetes Supplies**” means (a) test strips for blood glucose monitors; (b) visual reading and urine test strips; (c) lancets and lancet devices; (d) insulin and insulin analogs; (e) injection aids; (f) syringes; (g) prescriptive oral agents for controlling blood sugar levels; and (h) glucagon emergency kits.

“**Durable Medical Equipment**” means the equipment which is designed and intended for repeated use, primarily and customarily used to serve a medical purpose, generally not useful to a person in the absence of **Sickness** or **Injury**, and is appropriate for use in the home for the treatment or as a result of a **Sickness** or **Injury**.

“**Emergency**” means a medical condition which manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (i) placing the health of the **Minor Dependent Insured** (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

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

“**Endodontic**” means the treatment of diseases of the tooth **Pulp** and the tissues surrounding the root of the tooth of an **Insured**.

“**External Review**” means a process, independent of all affected parties, to determine if a **Health Care Service** is **Medically Necessary** or experimental/investigational.

“**Extraction**” means the removal of a natural tooth or teeth of a **Minor Dependent Insured**.

“**Family**” means the spouse, son or daughter, brother or sister, parent, grandparent or a designated caregiver of a **Minor Dependent Insured**.

“**Final Adverse Determination**” means an **Adverse Determination** involving a covered **Benefit** that has been upheld by **Us** at the completion of **Our Internal Grievance Procedure**.

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

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

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

“**Gastric Pacemaker**” means a medical device that uses an external programmer and implanted electrical leads to the stomach and transmits low-frequency, high-energy electrical stimulations to the stomach to entrain and pace the gastric slow waves to treat **Gastroparesis**.

“**Gastroparesis**” means a disorder that slows or stops the movement of food from the stomach to the small intestine.

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

“**Habilitation**” means services provided in order for a person to attain and maintain a skill or function that was never learned or acquired and is due to a disabling condition, including **Autism Spectrum Disorder**.

Habilitation does not mean custodial care, respite care, day care, therapeutic recreation, vocational training or residential treatment.

“**Habilitative Services**” includes physical, occupational, and speech therapies and developmental services and durable medical equipment for developmental delay, developmental disability, developmental speech or language disorder, developmental coordination disorder, and mix developmental disorder, including **Autism Spectrum Disorder**.

“**Health Care Services**” means services for the diagnosis, prevention, treatment, cure or relief of a health condition, **Sickness**, **Injury** or disease, as used within the GRIEVANCE PROCEDURES section.

“**Hearing Examination**” means a test administered to determine a complete hearing diagnostic evaluation for the treatment of **Sickness** or **Injury**.

“**High Risk for Colorectal Cancer**” means a person who has (i) a personal history of colorectal cancer or adenomatous polyps; (ii) a person history of inflammatory bowel disease; (iii) a strong family history of colorectal cancer or polyps; or (iv) a known family history of a hereditary colorectal cancer syndrome, such as familial adenomatous polyposis or hereditary non-polyposis colon cancer.

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

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

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

“**Hospital**” means a place which:

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

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

Hospital does not mean:

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

“**Implantable Osseointegrated Hearing Aid**” means a hearing aid for a person with one-sided deafness and normal hearing in the other ear due to congenital defects or **Sickness** or **Injury**.

“**Independent Review Organization**” means an entity that conducts independent **External Reviews** of **Adverse Determinations** and **Final Adverse Determinations**.

“**Inherited Metabolic Disorder**” means a disease caused by an inherited abnormality of body chemistry and includes a disease tested under a newborn screening program.

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

“**Injury**” means damage or harm **Accidentally** sustained to the physical structure of the body of a **Minor Dependent Insured** that is the direct cause of the loss independent of disease, bodily infirmity, or any other cause.

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

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

“Insured Maximum Participating Provider Coinsurance Payment” means the maximum amount, including the **Calendar Year Deductible** that an **Insured** is required to pay in a **Calendar Year** under the **Insured Coinsurance Percentage** for services rendered at **Participating Providers** and **Participating Pharmacies**. **Covered Expenses** incurred for services rendered at **Participating Providers** and **Participating Pharmacies** that are covered under the **SICKNESS AND INJURY BENEFITS** and the **WELLNESS AND SCREENING BENEFITS** sections and applied by the **Company** toward satisfaction of the **Calendar Year Deductible**, contained in this **Policy** or any rider attached to this **Policy**, will be credited or applied toward satisfaction of the **Minor Dependent Insured Maximum Participating Provider Coinsurance Payment**. The amount of the **Insured Maximum Participating Provider Coinsurance Payment** is shown on the **Policy Schedule**.

“Minor Dependent Insured Maximum Non-Participating Provider Coinsurance Payment” means the maximum amount, after the satisfaction of the **Separate Deductible For Non-Participating Providers** that an **Insured** is required to pay in a **Calendar Year** under the **Minor Dependent Insured Coinsurance Percentage** for services rendered at **Non-Participating Providers** and **Non-Participating Pharmacies**. **Covered Expenses** incurred for services rendered at **Non-Participating Providers** and **Non-Participating Pharmacies** that are covered under the **SICKNESS AND INJURY BENEFITS** and the **WELLNESS AND SCREENING BENEFITS** Sections and applied by the **Company** toward satisfaction of the **Separate Deductible For Non-Participating Providers** contained in this **Policy** or any rider attached to this **Policy** will not be credited or applied toward satisfaction of the **Minor Dependent Insured Maximum Non-Participating Provider Coinsurance Payment**. The amount of the **Minor Dependent Insured Maximum Non-Participating Provider Coinsurance Payment** is shown on the **Policy Schedule**.

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

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

“Internal Grievance Procedure” means the procedure by which **We** handle and resolve grievances, and provide **Insureds** with prompt and meaningful review on the issue of denial, in whole or part, of **Health Care Services**.

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

“**Mammogram**” means the X-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression device, screens, and films and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast.

“**Mastectomy**” means the **Medically Necessary** surgical removal of all or part of the breast as a result of breast cancer. **Mastectomy** does not include biopsies or other exploratory or diagnostic procedures used to detect the presence of cancer, nor does it include prophylactic removal of all or part of the breast.

“**Maximum Allowable Charge**” means the following:

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

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

“**Medical Foods**” means modified low protein food product that are: (i) formulated to be consumed or administered under the supervision of a **Provider**; and (ii) processed or formulated to contain less than one gram of protein per unit of serving, but does not include a natural food that is naturally low in protein.

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

1. For the covered items and services listed in the SICKNESS AND INJURY BENEFITS Section of this **Policy**, **Medical Necessity** and **Medically Necessary** is any applicable **Confinement** of a **Minor Dependent Insured**, as well as any other diagnostic test, laboratory test, examination, surgery, medical treatment, service or supply listed therein that is **Provided** to a **Minor Dependent Insured**:
 - a) by or at the appropriate order, or upon the approval of a **Provider**;
 - b) for the medically recognized diagnosis or care and treatment of an **Injury** or **Sickness**;
 - c) in a manner appropriate and necessary for the symptoms, diagnosis or treatment of such **Injury** or **Sickness**;
 - d) according to and within generally accepted standards for medical practice;
 - e) in the most cost effective setting and manner available to treat the **Injury** or **Sickness**;

- f) not primarily for the convenience of a **Minor Dependent Insured, Family, or a Provider**; and
 - g) not investigational or experimental in nature.
2. For the covered items and services listed in the WELLNESS AND SCREENING BENEFITS Section of this **Policy, Medical Necessity** and **Medically Necessary** is any applicable diagnostic test, laboratory test, examination, or medical treatment, service or supply listed therein that is **Provided** to a **Minor Dependent Insured**:
- a) reasonably designed to either prevent certain future **Sickness** or permit early diagnoses of certain **Sickness**;
 - b) prescribed, performed and/or ordered by a **Provider**;
 - c) appropriate and performed according to and within generally accepted standards for medical practice;
 - d) rendered in the most cost effective setting and manner available, and
 - e) not primarily for the convenience of a **Minor Dependent Insured, a Family, or a Provider**.

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

“Consumable Medical Supplies” means items which are (i) consumed or diminished with use so that they cannot withstand repeated use; (ii) is primarily or customarily used to serve a medical purpose; and (iii) generally are not useful to a person in the absence of a **Sickness** or **Injury**.

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

“Mental and Emotional Disorders” means a neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

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

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

“Non-Participating Provider” means a **Hospital, Provider, Ambulatory Surgical Center, Skilled Nursing Home, Non-Participating Pharmacy**, or other licensed practitioner of the healing arts for which **Sickness and Injury Benefits** or **Wellness and Screening Benefits** are payable under this **Policy** that, at the time **Covered Expenses** are incurred, has not entered into or has terminated a prior agreement to provide health care services and/or pharmaceutical services to **Minor Dependent Insureds** under this **Policy** at discounted rates.

“Oral Surgery” means surgery of the oral mouth cavity, including teeth, tongue and gums.

“Orthotic Device” means an external device that is (i) intended to restore physiological function or cosmesis to an **Insured**; and (ii) is custom designed, fabricated, assembled, fitted, or adjusted for the **Minor Dependent Insured**.

Orthotic Device does not mean canes, crutches, corsets, dental appliances, elastic hoses or supports, fabric supports, generic arch supports, low temperature plastic splints, soft cervical collars, trusses, or other similar devices that do not have significant impact on the neuromuscular, musculoskeletal, or neuromusculoskeletal functions of the body.

Orthotic Device does not mean those carried in stock and sold without therapeutic modification by a corset shop, department store, drug store, surgical supply facility, or similar retail entity.

“Orthotic Service” means the evaluation and treatment of a condition that requires the use of an orthotic device.

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

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

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

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

“**Pediatric Dental Care**” means oral health prevention, maintenance, and treatment of **Dental Injury** or **Dental Sickness** to an **Insured** up to age nineteen (19). **Pediatric Dental Care** does not include any type of cosmetic dentistry, unless **Dentally Necessary** to correct dental conditions caused by **Dental Injury** or **Dental Sickness**.

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

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

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

“**Policyowner**” means the schedule of **Policy** information that commences on page 3 of this **Policy**.

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

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

“**Preferred Drug List**” means a list either created or sponsored by **Us**, which identifies certain **Brand Name Drugs** that may be preferred. The **Preferred Drug List** is updated from time to time and may be found on the Internet at www.ushealthgroup.com in the prescription services location of the website. **You** may also call the toll free Rx Help Desk number on your ID card. When a **Preferred Brand Drug** which had been considered a **Covered Expense** is removed from the **Preferred Drug List** the drug will continue to be considered a **Covered Expense** until the **Policy** renewal date.

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

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

“Prophylaxis” means the **Dentally Necessary** professional cleaning and scaling of the teeth of an **Insured**.

“Prosthetic Device” means an external device that is (i) intended to replace an absent external body part for the purpose of restoring physiological function or cosmesis to a **Minor Dependent Insured**; and (ii) custom-designed, fabricated, assembled, fitted, or adjusted for the **Minor Dependent Insured** using the device prior to or concurrent with delivery to the **Minor Dependent Insured**.

Prosthetic Device does not include artificial eye, artificial ear, dental appliance, cosmetic devices, devices used exclusively for athletic purposes, an artificial facial device, or other device that does not have impact on the neuromuscular, musculoskeletal, or neuromusculoskeletal functions of the body.

“Prosthetic Service” means the evaluation and treatment of a condition that requires the use of a **Prosthetic Device**.

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

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

“Provider” means any licensed practitioner of the healing arts as recognized by the laws of the state in which he or she practices medicine, in treating an **Injury** or **Sickness**. The **Provider** must be acting within the scope of such license while rendering **Medically Necessary** professional service to a **Minor Dependent Insured**, and cannot be a member of the **Minor Dependent Insured’s Family**.

“Pulp” means the soft tissue inside the Crown and roots of a tooth composed of nerves, blood vessels and other tissue of a **Minor Dependent Insured**.

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

“Retrospective Review” means a review of **Medical Necessity** conducted after services have been **Provided** to a **Covered Minor Dependent Insured**, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment.

“Separate Deductible For Non-Participating Providers” means the amount of **Covered Expenses** a **Minor Dependent Insured** must incur in a **Calendar Year** for services rendered by **Non-Participating Providers** before any applicable **Sickness and Injury Benefits** or **Wellness and Screening Benefits** are payable under this **Policy**.

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

The amount of the **Calendar Year Deductible** may not be used to satisfy the **Separate Deductible For Non-Participating Providers**.

“Severe Traumatic Brain Injury” means a sudden trauma causing damage to the brain as a result of the head suddenly and violently hitting an object or an object piercing the skull and entering the brain tissue with an extended period of unconsciousness or amnesia after the injury or a Glasgow Coma Scale below nine (9) within the first forty-eight (48) hours of injury.

“Sickness” means illness or disease afflicting a **Minor Dependent Insured**, including **Complications of Pregnancy**, while this **Policy** is in force and effect for such **Minor Dependent Insured**.

“Sickness and Injury Benefit(s)” mean only treatments, procedures, services, and supplies that are specifically enumerated in Section V.A. SICKNESS AND INJURY BENEFITS. If a treatment, procedure, service, or supply is not specifically enumerated in the SICKNESS AND INJURY BENEFITS Section, then fees charged or expenses associated with such items are not covered under this **Policy** as a **Sickness and Injury Benefit**. Payments by **Us** for **Sickness and Injury Benefits** are subject to all definitions, exclusions, limitations and provisions contained herein, including but not limited to the satisfaction and payability by **You** or the applicable **Minor Dependent Insured** of all applicable deductibles, as well as the limitation of the **Company Insurance Percentage**.

“Skilled Nursing Home” means a place which:

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

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

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

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

“Sound Natural Teeth” means natural teeth that are free of active clinical decay, have at least 50% bony support, and are functional in the arch.

“Specialized Hospital” means a licensed facility specializing in the treatment of **Mental and Emotional Disorders** and **Substance Abuse**.

“Stem Cell Transplants” means the **Medically Necessary** insertion or transplantation, combined insertion or transplantation, sequential insertion or transplantation procedures, in which any **Medically Necessary** form of stem cells are received by an **Insured** while coverage for such **Minor Dependent Insured** under this **Policy** is in full force and effect.

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

“**Substance Abuse**” means the chronic, habitual, or compulsive use of any intoxicating matter that, when introduced into the body, is capable of altering human behavior or mental functioning and with extended use, may cause psychological dependence and impaired mental, social or educational functioning. Nicotine addiction is not considered substance abuse for adults who are twenty-one (21) years of age or older.

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

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

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

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

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

“**Vision Examination**” means a general evaluation of the complete visual system for the prevention, maintenance, and treatment of **Sickness** or **Injury**.

“**Vision Materials**” means corrective lenses and/or frames or corrective contact lenses.

“**Waiting Period**” means the period of time beginning with the date **Your** completed application for coverage is received by **Us**, and ending on the **Issue Date** of this **Policy**.

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

“**Wellness and Screening Benefit(s)**” means only treatments, procedures, services, and supplies that are specifically enumerated in the Section V.B. WELLNESS AND SCREENING BENEFITS. If a treatment, procedure, service, or supply is not specifically enumerated in the WELLNESS AND SCREENING BENEFITS Section, then fees charged or expenses associated with such items are not covered under this **Policy** as a **Wellness and Screening Benefit**.

“**You**”, “**Your**” and “**Yours**” means the individual listed on the **Policy Schedule** as the **Policyowner**.

III. WHEN COVERAGE BEGINS AND ENDS

A. EFFECTIVE DATE

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

B. ELIGIBILITY AND ADDITIONS

You may submit an application to add the following minors to this **Policy** meeting the qualifications of the definition of a **Minor Dependent Insured** who are: (i) **Your** natural or adopted dependent children who are under the age of twenty-six (26) regardless of marital status, student status, financial dependency or residency requirements; (ii) **Your** grandchildren who are considered **Your** dependents for federal income tax purposes and who are under age twenty-six (26); (iii) any children which **You** are required to insure under a medical support order; (iv) any child whom **You**, intend to adopt and have become a party to a suit for that purpose; and (v) any child who is in **Your** custody under a temporary court order that grants **You** guardianship of the minor child. Any eligible dependent (other than a newborn or adoptee) will be added to this **Policy** when **We** approve the written application for such coverage and accept payment of any necessary premium.

C. ENROLLMENT

1. INITIAL OPEN ENROLLMENT PERIOD

The initial open enrollment period begins October 1, 2013 and extends through March 31, 2014.

If **We** receive **Your** completed enrollment application for this **Policy** prior to December 16, 2013, the **Issue Date** for **Your** coverage will be January 1, 2014, as long as the **Initial Premium** payment for all **Minor Dependent Insureds** is received by January 1, 2014. If **We** receive **Your** completed enrollment application for this **Policy** between December 16, 2013 and December 31, 2013, the **Issue Date** for **Your** coverage will be February 1, 2014, as long as the **Initial Premium** payment for all **Minor Dependent Insureds** is received by February 1, 2014.

If **Your** completed enrollment application for this **Policy** is received by **Us** during the first and fifteenth day of any calendar month between January and March of 2014, the **Issue Date** for **Your** coverage will be the first day of the following calendar month, as long as the **Initial Premium** payment for all **Minor Dependent Insureds** is received by such first day of the following calendar month. If **Your** completed enrollment application for this **Policy** is received by **Us** between the sixteenth and last day of any calendar month between January and March of 2014, the **Issue Date** for **Your** coverage will be the first day of the second following calendar month, as long as the **Initial Premium** payment for all **Minor Dependent Insureds** is received by such first day of the second following calendar month.

2. SUBSEQUENT ANNUAL OPEN ENROLLMENT PERIODS

For coverage effective dates on January 1, 2015, and on January 1 of each calendar year thereafter, the following subsequent annual open enrollment periods shall apply:

1. If **We** receive **Your** completed enrollment application for this **Policy** between October 15, 2014 and December 7, 2014, the **Issue Date** for **Your** coverage will be January 1, 2015, as long as the **Initial Premium** payment for all **Minor Dependent Insureds** is received by January 1, 2015; and
2. If **We** receive **Your** completed enrollment application for this **Policy** between October 15 and December 7 of any calendar year following 2014, the **Issue Date** for **Your** coverage will be January 1 of the next following calendar year, as long as the **Initial Premium** payment for all **Minor Dependent Insureds** is received by January 1, of such calendar year.

If **We** do not receive **Your** completed enrollment application for this **Policy** between (i) October 15, 2014 and December 7, 2014, (ii) October 15 and December 7 of any calendar year following 2014, or (iii) as a result of a qualifying event within one of the special enrollment periods set forth in Section C.3, below, the **Issue Date** for **Your** coverage will be subject to a [thirty (30) – two hundred seventy five (275)] day **Waiting Period**, depending upon the date(s) upon which **We** receive **Your** completed application for this **Policy** and the **Initial Premium** payment for all **Minor Dependent Insureds**.

3. SPECIAL ENROLLMENT PERIODS

Qualifying Events

Outside of the annual open enrollment period, **You**, can enroll for coverage, with no **Waiting Period**, within sixty (60) days of the occurrence of one of the following qualifying events:

- a. the **Minor Dependent Insured(s)** lose minimum essential health benefits coverage under a separate plan, unless such loss of coverage is due to the following:
 - 1) failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage; or
 - 2) rescission of coverage based upon an act, practice or omission that constitutes fraud, including an intentional misrepresentation of material fact, prohibited by the terms of the policy or certificate.
- b. the **Minor Dependent Insured(s)** lose coverage under a public or private health insurance policy or any other health benefit plan due to the employee's termination of employment or eligibility, the reduction in the number of hours of employment, the termination of the other plan's coverage, the death of the spouse, legal separation or divorce, or the termination of employer contributions toward the coverage;
- c. **You** request enrollment after the **Minor Dependent Insured(s)** exhaust creditable coverage that is provided under a COBRA continuation provision;
- d. **You** gain a dependent through marriage, birth, adoption or placement for adoption, or custody by court order (or temporary orders) in a civil suit or other judicial proceeding granting custody or conservatorship;

Required Notice and Premium Payment

We must receive **Your** notice of the particular qualifying event under Sections C.3. a – e, and the **Initial Premium** payment for all **Minor Dependent Insureds** within sixty (60) days of the occurrence of such event. If **Your** notice of the specific qualifying event and the **Initial Premium** payment for all **Minor Dependent Insureds** are not received within sixty (60) days of the occurrence of such event, the **Issue Date** for **Your** coverage will be subject to a [thirty (30) – one hundred eighty (180) day] **Waiting Period**.

Effective Date of Coverage Due to Special Enrollment Qualifying Event

Provided we receive **Your** notice of the particular qualifying event, together with the **Initial Premium** payment for all **Minor Dependent Insureds**, within sixty (60) days of the occurrence of such event, **Your** coverage will become effective based on the particular type of qualifying event, and according to the following schedule:

If **You** enroll a **Minor Dependent Insured** because they lost minimum essential coverage, the coverage will begin on the first day of the month following their loss of coverage.

Benefits under this **Policy** are automatically payable for a period of ninety (90) days with respect to a newly born child of **Yours** from the instant of the child's birth; to a child adopted by **You**, regardless of the age at which the child was adopted; and to a child who has been placed for adoption with **You** and for whom the application and approval procedures for adoption have been completed to the same extent that such coverage under this **Policy** applies to other **Minor Dependent Insureds**. If **You** desire to continue coverage for such dependent beyond the initial ninety (90) day period, **You** must notify us to continue coverage under this **Policy** and pay the applicable premium required within ninety (90) days of birth or adoption to continue such coverage.

If **You** wish to have automatic coverage under this **Policy** for any child whom **You** are seeking adoption or custody in a civil suit or other judicial custody proceeding filed or initiated after the **Issue Date**, **You** must notify **Us** within sixty (60) days after **You**: (i) become a party in such civil suit in which such adoption of the child is sought; or (ii) obtain custody of the child under the first court order (including temporary orders) that

grants conservatorship and/or custody of the child. **You** must also pay any additional premium required for such additional coverage within such sixty (60) day period.

In all other cases of qualifying events specified above, the effective date of **Your** coverage will depend on when **We** receive **Your** application and the **Initial Premium** payment for all **Minor Dependent Insureds**. If **Your** application is received between the first and fifteenth day of the calendar month, the **Issue Date** for **Your** coverage will be the first day of the following calendar month, as long as **Your Initial Premium** payment for all **Minor Dependent Insureds** is received by such date. If **Your** application is received between the sixteenth day and the last day of the calendar month, the **Issue Date** for **Your** coverage will be the first day of the second calendar month next following, as long as **Your Initial Premium** payment for all **Minor Dependent Insureds** is received by such date. In each such instance, the availability of coverage under this **Policy** will be subject to the **Waiting Period**.] Provided, however, if, on the business day of **Our** first receipt of **Your** enrollment application during any period of open enrollment, special enrollment or other enrollment for coverage under this type of **Policy** and payment of the **Initial Premium** for all **Minor Dependent Insureds** for this coverage, **You** and all **Other Minor Dependent Insureds** have current, in-force coverage previously issued by **Us** under (i) a major medical insurance policy or certificate of coverage that constitutes a grandfathered health plan under federal law, or (ii) any form number beginning with GASDCYD-2011-C, GASDCYD-2011-IP, GASDCYD-2012, UWFI-2013-R, UWFI-2013-IR, ACC-2013-C, ACC-2013-IP, SPD-2013-C, or SPD-2013-IP, the **Issue Date** will be that same business day, without the application of any other **Waiting Period**. This limited right to an accelerated **Issue Date** and waiver of any otherwise applicable **Waiting Period** for this type of coverage is only available one time for **You** and each of the **Other Minor Dependent Insureds**.

D. TERMINATION OF COVERAGE

1. TERMINATIONS SUBJECT TO RIGHT OF CONVERSION

Subject to the Section III. E. POLICY OF CONVERSION below, an applicable **Minor Dependent Insured's** coverage under this **Policy** ends on the earlier of the following:

- a. the premium due date in the month following such **Minor Dependent Insured's** twenty-six (26th) birthday.

2. TERMINATIONS BY POLICYOWNER NOT SUBJECT TO RIGHT OF CONVERSION

Section III.E. POLICY OF CONVERSION notwithstanding, the following described actions by the **Policyowner** will result in a termination of each applicable **Minor Dependent Insured's** coverage under this **Policy** with no right of conversion, in which event the coverage ends on the earlier of the following:

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

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

Section III.E. POLICY OF CONVERSION notwithstanding, **We** may refuse to renew and cancel coverage for all **Minor Dependent Insureds** under this **Policy** with no right of conversion for the following reasons:

- a. **We** are required by the order of an appropriate regulatory authority to non-renew or cancel the **Policy**;
- b. **We** cease offering and renewing coverage of the same form of coverage as this **Policy** in **Your** state upon a minimum of ninety (90) days prior written notice mailed to **Your** last known address with an opportunity for **You** to convert to any similar medical expense policy or Policy that **We** are then actively marketing and offering to new applicants in **Your** state;
- c. **We** elect to discontinue offering all similar types of coverage under any individual medical-surgical expense policy forms in **Your** state and to terminate all such certificates of coverage and individual policies in **Your** state, including **Your** form of coverage, in which case the commissioner of insurance

- for **You** state and **You** will be given a minimum of one hundred eighty (180) days prior written notice of the termination, mailed to **Your** last known address;
- d. the date **We** receive due proof that fraud or intentional misrepresentation of material fact existed in applying for this **Policy** or in filing a claim for **Benefits** under this **Policy**; or
 - e. **You** no longer reside in the service area of our **Participating Provider** network.

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

Section III.E. POLICY OF CONVERSION notwithstanding, **We** may refuse to renew and cancel coverage for each **Minor Dependent Insured** under this **Policy** with no right of conversion for the following reasons:

- a. the date **We** receive due proof that fraud or intentional misrepresentation of material fact existed in applying for this **Policy** or in filing a claim for **Benefits** under this **Policy**.

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

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

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

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

E. POLICY OF CONVERSION

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

if his or her coverage ceases due to his or her reaching the limiting age of twenty-six (26).

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

1. a **Minor Dependent Insured's** coverage under this **Policy** ceases because the **Policy** was terminated because of failure to pay the required premiums in the time allowed;
2. **We** were required by the order of an appropriate regulatory authority to non-renew or cancel the **Policy**;
3. **We** cease offering and renewing coverage under the same form of coverage as this **Policy** in **Your** state upon a minimum of ninety (90) days prior written notice mailed to **Your** last known address with an

opportunity for **You** to convert to any similar medical expense policy or certificate that **We** are then actively marketing and offering to new applicants in **Your** state;

4. **We** elect to discontinue offering all similar types of coverage under any individual medical-surgical expense policy forms in **Your** state and to terminate all such certificates of coverage and individual policies in **Your** state, including **Your** form of coverage, in which case the commissioner of insurance for **Your** state and **You** will be given a minimum of one hundred eighty (180) days prior written notice of the termination, mailed to **Your** last known address;
5. **You** voluntarily terminated coverage under this **Policy** for any **Minor Dependent Insured** by notifying **Us** of the date **You** desired such coverage to terminate;
6. **We** received due proof that fraud or intentional misrepresentation of material fact existed in applying for this **Policy** or in filing a claim for **Benefits** under this **Policy**; or
7. The **Minor Dependent Insured** is or could be covered by **Medicare**;
8. **You** no longer reside in the service area of our **Participating Provider** network.

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

IV. PREMIUM

A. INITIAL PREMIUM

The **Initial Premium** specified on the **Policy Schedule** is due and payable to the **Company** at its home office on or before the **Issue Date**. This **Initial Premium** payment will keep this **Policy** in force until the **First Renewal Date**. The amount of the **Initial Premium** and the **First Renewal Date** are shown on the **Policy Schedule**. **Initial Premium** has been determined by **Us** for this **Policy** on a **Class** basis. **Your Class** for **Initial Premium** was determined by **Us** based upon several factors, including, among other things, a combination of the following: (i) **Your** zip code (either first 3 or first 5 digits); (ii) **Your** county of residence; (iii) **Your** state of residence; (iv) the number, age and tobacco use of each **Minor Dependent Insured** listed on the **Policy Schedule**; and (v) the plan of coverage contained in this **Policy** on the **Issue Date**, including its deductibles, **Benefits**, limitations, and exclusions.

B. RENEWAL PREMIUM

1. CALCULATION - PAYMENT

The current **Mode Of Premium Payment** is shown on the **Policy Schedule**. **Renewal Premium** is payable on or before its due date, and must be paid to the **Company** at its home office. Any **Renewal Premium** not paid on or before its due date is a premium in default. If a **Renewal Premium** payment default is not corrected and properly paid before the end of the grace period, coverage under this **Policy** will terminate.

Renewal Premium rates for this **Policy** may be increased by **Us** for any renewal period after the **Issue Date**, if after the **Issue Date**:

- a. **You** add **Minor Dependent Insureds** to this **Policy**;
- b. **You** change the amount of the **Calendar Year Deductible** shown on the **Policy Schedule**;
- c. **You** change the **Minor Dependent Insured Coinsurance Percentage** shown on the **Policy Schedule**;
- d. **You** change any other coverage option;
- e. **You** change residence to a different zip code;
- f. **You** change the **Mode Of Premium Payment**;

- g. **You** add optional coverage riders, if any;
- h. **You** change after the **Issue Date** to a different optional **Participating Provider** network available in **Your** state, if any;
- i. a change occurs in the relationship between **Us** and **Your Participating Provider** network;
- j. the **Participating Provider** network availability changes for **Your** state;
- k. the **Participating Provider** negotiated discounts change; and/or
- l. a change occurs in **Sickness and Injury Benefits**, and/or **Wellness and Screening Benefits**, by amendatory endorsement pursuant to any federal or state law or regulation.

The current table of premium rates upon which the **Initial Premium** and the **First Renewal Premium** were calculated for this **Policy** may include scheduled increases in the amount of **Renewal Premium** based upon the future attained age of each **Minor Dependent Insured**. Additionally, the current table of premium rates upon which the **Initial Premium** and **First Renewal Premium** were calculated and any subsequent table of premium rates upon which the **Renewal Premium** for any renewal period is to be calculated may be changed from time to time by **Us**. Accordingly, the amount of **Renewal Premium** may be increased for any renewal period based upon items a. through l. above as well as the following:

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

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

2. RENEWAL PREMIUM CHECK OR DRAFT NOT HONORED

Any premium payment made by a check or draft which is not honored at the bank upon which it is drawn shall be of no effect toward coverage under this **Policy** unless and until valid restitution is made to **Us** within the time provided herein for making such premium payment.

3. GRACE PERIOD

Unless at least thirty-one (31) days prior to a **Renewal Premium** due date **We** have mailed to **You** written notice of **Our** intention not to renew this **Policy** pursuant to the provisions of Section III. D. TERMINATION OF COVERAGE, a grace period of thirty-one (31) days from such due date is given for the late payment of the **Renewal Premium** due. If **You** make payment of the required **Renewal Premium** during such grace period, then this **Policy** will remain in force for **Benefit** claims arising during such grace period. However, if the **Company** has received notification of **Your** intention to cancel any **Minor Dependent Insured's** coverage under this **Policy**, there is no grace period for the late payment of any **Renewal Premium** that would otherwise have been due for such **Minor Dependent Insured** but for such cancellation.

4. REINSTATEMENT

If the **Renewal Premium** is not paid before the grace period ends, **Your** coverage will lapse. If the **Renewal Premium** is received after the grace period ends but within forty-five (45) days of the **Renewal Premium** due date, acceptance of such premium by **Us** (or by an agent authorized to accept payment) will reinstate this **Policy** as of the date of acceptance of the late premium. If the **Renewal Premium** is received forty-five (45) days after the **Renewal Premium** due date, **Your** coverage will terminate and **You** may apply for coverage with **Us** during an annual open enrollment period or a special enrollment period.

The reinstated **Policy** will cover only **Covered Expenses** that result from an **Injury** sustained after the date of reinstatement or from **Sickness** that begins more than ten (10) days after the date of reinstatement.

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

V. BENEFITS AND CLAIM PROCEDURES

Minor Dependent Insureds have the right to obtain medical care from the **Provider** and **Hospital** of their choice, as well as **Prescription Drugs** from a pharmacy of their choice; however, all applicable **Benefit** payments by **Us** under this BENEFITS AND CLAIMS PROCEDURES Section of the **Policy** are limited to the applicable **Company Insurance Percentage** of **Covered Expenses** incurred by a **Minor Dependent Insured**. Coverage under this Section of the **Policy** will be reduced for medical services, supplies, care or treatment obtained from a **Non-Participating Provider**, as well as **Prescription Drugs** from a **Non-Participating Pharmacy**. The difference between both the **Company Insurance Percentages** and the **Minor Dependent Insured Coinsurance Percentages** for: (i) **Participating Providers** and **Non-Participating Providers**; and (ii) **Participating Pharmacies** and **Non-Participating Pharmacies** are shown in the **Policy Schedule**.

Covered Expenses incurred by a **Minor Dependent Insured** for **Sickness and Injury Benefits** and **Wellness and Screening Benefits** are subject to all applicable deductibles and the **Minor Dependent Insured Coinsurance Percentage**, unless otherwise specified.

A. SICKNESS AND INJURY BENEFITS

Subject to all applicable definitions, exclusions, limitations, non-waiver, and other provisions contained in this **Policy**, as well as any riders, endorsements, or amendments attached to hereto, **We** promise to pay to or on behalf of each **Minor Dependent Insured** the **Company Insurance Percentage** of the amount of professional fees and other applicable medical diagnostic or treatment expenses and charges that constitute **Covered Expenses** incurred by each **Minor Dependent Insured** for the following described **Inpatient** and **Outpatient** services that are **Provided** as a result of **Sickness** or **Injuries**, but only after: (i) each of the applicable deductibles has been first satisfied by deduction from such **Covered Expenses** and applied to the applicable **Minor Dependent Insured** for payment; and (ii) the applicable **Minor Dependent Insured Coinsurance Percentage** of the **Covered Expenses** remaining after satisfaction of all applicable deductibles is, likewise, satisfied by deduction from the remaining **Covered Expenses** and applied to the applicable **Minor Dependent Insured** for payment, unless otherwise specified:

1. INPATIENT HOSPITAL CARE

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

- a. **Hospital** - semi-private daily room and board;
- b. **Intensive Care Unit** of the **Hospital** - daily room and board (Note, daily room and board will be at the semi-private rate for admission to units or areas of the applicable **Hospital** which are step-down units from the **Intensive Care Unit**, including, sub-acute intensive care units, progressive care units, intermediate care units, private monitored rooms, observation units or other facilities not meeting the standards set forth in the definition of an **Intensive Care Unit**);

- c. **Hospital** miscellaneous medications, **Prescription Drugs**, services and supplies - (Note, miscellaneous charges by a **Hospital** for personal convenience items, including but not limited to television, telephone, internet and radio are not considered **Covered Expenses**); and
- d. **Provider** Visits – (Note: limited one (1) **Provider** visit per treating **Provider** per day while the **Minor Dependent Insured** is an **Inpatient**. **Sickness and Injury Benefits** are not payable for professional fees for visits at the **Hospital** following surgery by a Surgeon, Anesthesiologist or Nurse Anesthetist whose professional fees in connection with the surgery constitute **Covered Expenses**, unless the visit is to evaluate or treat an **Injury** or **Sickness** other than that which resulted in the **Minor Dependent Insured's** covered surgery).

2. INPATIENT SURGERY

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

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

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

3. INPATIENT LABORATORY AND DIAGNOSTIC TESTS

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

4. INPATIENT RADIATION THERAPY AND CHEMOTHERAPY

Services **Provided** by a **Hospital**, **Provider** or other medical facility in connection with radiation therapy and chemotherapy received on an **Inpatient** basis by a **Minor Dependent Insured** due to **Sickness**.

5. INPATIENT THERAPY

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

- a. Occupational therapy;
- b. Rehabilitation therapy (limited to sixty (60) visits per **Calendar Year**);
- c. Cardiac and pulmonary rehabilitation therapy;

- d. Radio-frequency thermal therapy, only in connection with primary procedure of an orthopedic condition;
- e. Neurologic rehabilitation, for up to sixty (60) days, per **Minor Dependent Insured**, per lifetime:
 - (a) When the **Minor Dependent Insured** is suffering from a **Severe Traumatic Brain Injury**; and
 - (b) When admission to the **Inpatient Provider** is within seven (7) days of release from a **Hospital**.
- f. Cognitive rehabilitation, only in connection with a **Severe Traumatic Brain Injury**; and
- g. **Habilitative Services** (limited to thirty (30) visits per **Calendar Year**).

6. INPATIENT TREATMENT OF MENTAL AND EMOTIONAL DISORDERS

Inpatient services Provided for a **Minor Dependent Insured** by a **Provider** licensed by the State of Arkansas and accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), CARF International, or Council on Accreditation (COA) for the treatment and evaluation of **Mental and Emotional Disorders**.

7. BREAST RECONSTRUCTION INCIDENT TO MASTECTOMY

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

8. HOSPITAL CONFINEMENT INCIDENT TO MASTECTOMY

Hospital Confinement in connection with a **Mastectomy**, for no less than forty-eight (48) hours, unless the decision to discharge the **Minor Dependent Insured** earlier than the forty-eight (48) hours is made by both the **Provider** and the **Minor Dependent Insured**.

9. TRANSPLANTS

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

Transplant services include the **Minor Dependent Insured's** medical, surgical and **Hospital** services, **Inpatient** immunosuppressive medications, **Covered Expenses** for organ procurement and, if **Medically Necessary**, compatibility testing undertaken prior to procurement.

The maximum amount of **Covered Expenses** allowed for professional fees of a **Provider** and facility fees for the harvesting of applicable donor organs or donor bone marrow is \$10,000 per transplant, to the extent that any **Benefits** hereunder remain and are available under the **Policy** for the applicable **Minor Dependent Insured** recipient.

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

- a. any non-human (including animal or mechanical) **Solid Organ Transplant**;
- b. transplants approved for a specific medical condition, but applied to another condition;
- c. the purchase price of any organ, tissue, blood, bone marrow, cells, or stem cells that are sold and not donated;
- d. any donor charge or donor expense incurred that does not constitute **Covered Expenses** allowed for professional fees and facility fees incurred in connection with the harvesting of applicable donor organs or donor bone marrow; and
- e. any transplantation (including grafts) that does not constitute **Solid Organ Transplants, Bone Marrow Transplants, and/or Stem Cell Transplants**.

[Transplant travel **Benefits** are not available for cornea transplants. **Benefits** for transportation, lodging and food are available only for the **Minor Dependent Insured** of a pre-approved organ/tissue transplant from a transplant facility, receiving authorized transplant related services during any of the following:

- a. Evaluation,
- b. Candidacy,
- c. Transplant event, or
- d. Post-transplant care.

All claims filed for **Covered Expenses** for travel must include detailed receipts. Transportation mileage will be calculated by **Us** based on the home address of the **Minor Dependent Insured** and the transplant site. **Covered Expenses** for travel for the **Minor Dependent Insured** receiving the transplant will include:

- a. Transportation to and from the transplant site in a personal vehicle will be reimbursed at [37.5] cents per mile when the transplant site is more than sixty (60) miles one way from the **Minor Dependent Insured's** home; and
- b. Lodging and food while at, or traveling to and from the transplant site, [limited to \$50-150 per day];

In addition to the **Minor Dependent Insured's Covered Expenses** associated with the items above, such **Covered Expenses** will also be considered for one companion to accompany the **Minor Dependent Insured**. The term companion includes **Your** member of your **Family**, or **Your** legal guardian. **Covered Expenses** are limited to [\$10,000] per transplant.

Transplant travel **Benefits** are not available if the **Minor Dependent Insured** is a donor. In addition to other exclusions in this **Policy**, **Benefits** will not be provided for the following: miscellaneous charges while lodging, including but not limited to personal convenience items movies, wireless internet, telephone, radio, cleaning supplies and shipping charges.]

10. EMERGENCY ROOM SERVICES

Services **Provided** by a **Hospital** or a **Provider** in the emergency room of the **Hospital** for the following items received by a **Minor Dependent Insured** on an **Emergency** basis:

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

This **Benefit** is not subject to the **Separate Deductible for Non-Participating Providers** or the **Non-Participating Provider Minor Dependent Insured Coinsurance Percentage**.

11. EMERGENCY TRANSPORTATION TO HOSPITAL BY AMBULANCE

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

12. OUTPATIENT TREATMENT OF ACCIDENTAL INJURIES

Services **Provided** by a **Hospital**, an **Emergency Care Facility** or a **Provider** in connection with the **Outpatient** treatment of **Injuries** received by a **Minor Dependent Insured**.

13. OUTPATIENT SURGERY AT A HOSPITAL OR AN AMBULATORY SURGICAL CENTER

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

- a. **Hospital** or **Ambulatory Surgical Center** – (expenses that constitute **Covered Expenses** will be considered for **Sickness and Injury Benefit** payment for the pre-operation, operation and recovery rooms, as well as for medications, **Prescription Drugs**, and other miscellaneous items, services and supplies; provided that miscellaneous charges for any personal convenience items, including but not limited to television, telephone, and radio are not considered **Covered Expenses**);
- b. Primary Surgeon;
- c. Assistant Surgeon – (professional fees that constitute **Covered Expenses** will be considered for a **Sickness and Injury Benefit** payment for one assistant surgeon in connection with surgery for which **Sickness and Injury Benefits** are payable hereunder for the professional fees of the primary surgeon);
- d. Anesthesiologist or Nurse Anesthetist – (professional fees that constitute **Covered Expenses** will be considered for a **Sickness and Injury Benefit** payment for either an anesthesiologist or a nurse anesthetist administration and monitoring of anesthesia, during surgery for which **Sickness and Injury Benefits** are payable hereunder for the professional fees of the primary surgeon);
- e. Pathologist – (professional Fees that constitute **Covered Expenses** will be considered for a **Sickness and Injury Benefit** payment for a pathologist's evaluation and/or interpretation of any tissue specimen removed during or in connection with such surgery); and
- f. Second Surgical Opinion - Up to [\$250] of professional fees for a second surgical opinion if:
 - 1) the **Minor Dependent Insured's Provider** determines that surgery is needed;
 - 2) the surgery is not excluded from this **Policy** or any riders, amendments or endorsements attached hereto;
 - 3) the **Minor Dependent Insured** is examined in person by another qualified **Provider** for the purpose of obtaining a second surgical opinion; and
 - 4) the **Provider** issuing the second surgical opinion sends **Us** a written report.

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

14. OUTPATIENT PROVIDER OFFICE VISITS

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

15. OUTPATIENT PRESCRIPTIONS

We will pay **Covered Expenses** incurred by a **Minor Dependent Insured** for **Prescription Drugs** filled at a **Participating Pharmacy**. **Covered Expenses** for such **Prescriptions** shall not exceed the amount of the cost of the least expensive drug, medicine or **Prescription Drug** that may be used to treat the **Minor Dependent Insured's Sickness** or **Injury**, all in accordance with the following schedule:

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

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

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

16. OUTPATIENT LABORATORY AND DIAGNOSTIC TESTS

Services **Provided** by a **Hospital, Provider** or other medical facility in connection with the performance and interpretation of laboratory and diagnostic tests received on an **Outpatient** basis by a **Minor Dependent Insured** due to **Injuries** or **Sickness**.

17. OUTPATIENT RADIATION THERAPY AND CHEMOTHERAPY

Services **Provided** by a **Hospital, Provider** or other medical facility in connection with radiation therapy and chemotherapy received on an **Outpatient** basis by a **Minor Dependent Insured** due to **Sickness**.

18. OUTPATIENT DIALYSIS

Services **Provided** by a **Hospital, Provider** or other medical facility in connection with dialysis received on an **Outpatient** basis by a **Minor Dependent Insured** due to **Sickness**

19. OUTPATIENT THERAPY

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

- a. Occupational therapy (not to exceed thirty (30) visits per **Covered Minor Dependent Insured** per **Calendar Year**);
- b. Rehabilitation therapy (not to exceed thirty (30) visits per **Covered Minor Dependent Insured** per **Calendar Year**);
- c. Cardiac and pulmonary rehabilitation therapy (not to exceed thirty-six (36) visits per **Covered Minor Dependent Insured** per **Calendar Year**);
- d. Radio-frequency thermal therapy, only in connection with primary procedure of an orthopedic condition;
- e. Cognitive rehabilitation, only in connection with a **Severe Traumatic Brain Injury**;
- f. Habilitative Developmental Services (limited to one-hundred and eighty (180) units (one (1) hour being one (1) unit) per **Calendar Year**); and
- g. **Habilitation Services** (not to exceed thirty (30) visits per **Covered Minor Dependent Insured** per **Calendar Year**).

20. OUTPATIENT TREATMENT OF MENTAL AND EMOTIONAL DISORDERS

Outpatient services **Provided** by a **Provider** licensed by the State of Arkansas and accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), CARF International, or Council on Accreditation (COA) for treatment of **Mental and Emotional Disorders**. Services include

testing and evaluation for psychological testing, developmental testing, neurobehavioral testing, and neuropsychological testing, limited to fifteen (15) hours per **Minor Dependent Insured** per **Calendar Year**. Services for **Mental and Emotional Disorders** include family and marital counseling when provided as part of a treatment plan.

21. HOME HEALTH CARE

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

- a. The **Minor Dependent Insured** had first been **Confined** in a **Hospital** or was a resident at a **Skilled Nursing Home** due to an **Injury** or **Sickness**;
- b. The **Home Health Care Plan** of the **Minor Dependent Insured** begins no later than thirty (30) days after discharge from the **Hospital** or **Skilled Nursing Home**;
- c. The **Home Health Care Plan** is reviewed at thirty (30) day intervals by the **Provider**; and
- d. The **Home Health Care Plan** is for the same or related **Injury** or **Sickness** as the **Hospital** or **Skilled Nursing Home Confinement**.

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

Payment under this coverage is limited to a maximum of fifty (50) visits per **Minor Dependent Insured** per **Calendar Year**.

22. HOSPICE CARE

Services **Provided** to a **Minor Dependent Insured** for **Hospice Care** due to **Injuries** or **Sickness**, if:

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

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

23. MEDICAL EQUIPMENT AND SUPPLIES

Medical Equipment and supplies **Provided** to a **Minor Dependent Insured** as a result of **Injury** or **Sickness** includes:

- a. Blood, plasma, and derivatives, if not replaced;
- b. Initial replacement of natural limbs and eyes when loss occurs while this **Policy** is in force;
- c. Initial permanent lens immediately following cataract surgery, except the replacements will not be covered;
- d. Casts, non-dental splints, trusses, crutches and braces;
- e. Purchase or rental (not to exceed the purchase price) of a wheelchair, hospital bed, or other **Durable Medical Equipment Provided** to a **Minor Dependent Insured** in each event required for therapeutic treatment of **Injuries** or **Sickness** on an **Outpatient** basis; ⁴
- f. **Consumable Medical Supplies**, limited to a thirty-one (31) day supply per month;

- g. **Cochlear Implants**, one (1) per **Minor Dependent Insured** up to \$35,000 per lifetime; **Auditory Brain Stem Implant**, one (1) per lifetime for **Minor Dependent Insureds** age twelve (12) and over; and **Implantable Osseointegrated Hearing Aids**;
- h. Initial acquisition of eyeglasses or contact lenses within the first six (6) months following cataract surgery;
- i. Oxygen and its administration;
- j. Ostomy supplies that are limited to pouches, face plates and belts, irrigation sleeves, bags and ostomy irrigation catheters, and skin barriers; and
- k. **Orthotic Devices, Orthotic Services, Prosthetic Devices, and Prosthetic Services** when prescribed by a **Provider** when **Medically Necessary**. Replacement and repair only when necessary due to anatomical change or normal use.

24. GASTRIC PACEMAKERS

Gastric Pacemakers Provided to a **Minor Dependent Insured** when **Medically Necessary** to treat **Gastroparesis**.

25. SKILLED NURSING HOME

Daily room and board and miscellaneous charges for other services **Provided** to a **Minor Dependent Insured** due to **Injuries** or **Sickness** for residential care received in a **Skilled Nursing Home** for up to a maximum of sixty (60) days in a twelve (12) month period, if:

- a. the **Minor Dependent Insured** has first been **Confined** in a **Hospital** for seven (7) or more consecutive days;
- b. the **Skilled Nursing Home** stay begins within thirty (30) days after discharge from the **Hospital**;
- c. the **Skilled Nursing Home** stay is for the same or related **Injury** or **Sickness** as the **Hospital Confinement**; and
- d. the **Minor Dependent Insured's Provider** certifies the need for **Skilled Nursing Home Confinement**.

26. SUPPLIES AND SERVICES ASSOCIATED WITH THE TREATMENT OF DIABETES

The following **Outpatient** services **Provided** to a **Minor Dependent Insured** for care received during for the treatment of diabetes and associated conditions:

- a. **Diabetes Equipment**;
- b. **Diabetes Supplies**; and
- c. **Diabetes Self-Management Training**.

27. INHERITED METABOLIC DISORDERS

Medical Foods prescribed or ordered under the supervision of a **Provider**, as **Medically Necessary** for the treatment of an **Inherited Metabolic Disorder** or for the treatment of a **Sickness** in which a **Minor Dependent Insured** is unable to sustain weight and strength commensurate with the **Minor Dependent Insured's** overall health status.

Inherited Metabolic Disorders triggering **Medical Food** coverage are:

- a. Part of the newborn screening program as prescribed by **Your Provider**, and involve amino acid, carbohydrate or fat metabolism;
- b. Have medically standard methods of diagnosis, treatment and monitoring including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues; and
- c. Require specifically processed or treated **Medical Foods** that are generally available only under the supervision and direction of a **Provider**, that must be consumed throughout life and without which the **Minor Dependent Insured** may suffer serious mental or physical impairment.

For non-inherited disorders, enteral nutrition is considered **Medically Necessary** when the **Minor Dependent Insured** has:

- a. A permanent non-function or **Sickness** of the gastrointestinal structures that normally permit food to reach the small bowel; or
- b. A **Sickness** of the small bowel which impairs digestion and absorption of an oral diet consisting of solid or semi-solid foods.

The following are not considered **Medically Necessary** and are not covered as a **Medical Food**, metabolic supplement or gastric disorder formula:

- a. Standard oral infant formula;
- b. Food thickeners, baby food, or other regular grocery products;
- c. Nutrition for a diagnosis of anorexia; or
- d. Nutrition for nausea associated with mood disorder and end-stage disease.

28. MATERNITY AND NEWBORN CARE

Services **Provided** by a **Hospital**, a certified nurse midwife, or a **Provider** for (i) a **Minor Dependent Insured's** routine pregnancy, including normal labor and delivery, (ii) cesarean section deliveries that are not performed on an **Emergency** basis, and (iii) **Complications of Pregnancy**.

Hospital Confinement for a mother who is a **Minor Dependent Insured** and her newborn child for a period of time up to forty-eight (48) hours following vaginal delivery, and up to ninety-six (96) hours following delivery by cesarean section, shall be considered a **Medically Necessary Inpatient Confinement**. **Hospital Confinement** in which the length of stay exceeds these periods shall be subject to the definition and the requirements of **Medical Necessity** and **Medically Necessary** and the requirements of **Pre-Certification of Treatment**.

Services for the care and treatment of **Your** newborn child or newborn adoptee including care for **Injury, Sickness**, congenital defects, birth abnormalities, and premature birth.

MATERNITY AND NEWBORN CARE **Provided** by a **Non-Participating Provider** limited to the **Maximum Allowable Charge** or \$2,000, whichever is less.

29. SUBSTANCE ABUSE SERVICES

Services **Provided** by a **Provider** licensed by the State of Arkansas and accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), CARF International, or Council on Accreditation (COA) for the treatment of **Substance Abuse**. This includes rehabilitation services and residential services.

Voluntary residential treatment is limited to a maximum of seven (7) days per **Minor Dependent Insured** per **Calendar Year** and **Outpatient Substance Abuse** services limited to a maximum of thirty (30) visits per **Minor Dependent Insured** per **Calendar Year**.

30. HEARING AIDS

Services **Provided** to a **Minor Dependent Insured** for hearing aids due to hearing loss that has been verified by a **Provider**. The hearing aids shall be **Medically Necessary** to meet the needs of the **Minor Dependent Insured** according to accepted professional standards. **Covered Expenses** include up to \$1,400 per ear every three (3) years.

Covered Expenses with respect to hearing aids are not subject to either the **Calendar Year Deductible** or the **Minor Dependent Insured Coinsurance Percentage**.

31. CRANIOFACIAL ANOMALY

Services **Provided** to a **Minor Dependent Insured** for the treatment and correction of a **Craniofacial Anomaly**, as well as secondary conditions and treatment attributable to a **Craniofacial Anomaly**, if

surgery and treatment **Provided** are **Medically Necessary** to improve functional impairment resulting from a **Craniofacial Anomaly**, including:

- a. corrective surgery and related medical care;
- b. vision care related to a **Craniofacial Anomaly**;
- c. dental care related to a **Craniofacial Anomaly**; and
- d. use of at least one (1) hearing aid.

32. CHIROPRACTIC SERVICES

Diagnostic and treatment services **Provided** by a **Provider** in connection with conservative management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain and improve function. The following are specifically excluded from chiropractic care and osteopathic services:

- a. Services of a chiropractor or osteopath which are not within his scope of practice, as defined by state law;
- b. Charges for care not **Provided** in an office setting;
- c. Maintenance or preventive treatment consisting of routine, long term or not **Medically Necessary** care provided to prevent reoccurrences or to maintain the **Minor Dependent Insured's** current status; and
- d. Vitamin therapy.

Payment under this coverage is limited to a maximum of thirty (30) visits per **Minor Dependent Insured** per **Calendar Year**.

33. TEMPOROMANDIBULAR JOINT (TMJ) DISORDER

Services **Provided** by a **Hospital** or a **Provider** for **Covered Expenses** which are **Medically Necessary** to treat TMJ disorder which is a result of:

- a. An **Accident** or trauma;
- b. A congenital defect;
- c. A developmental defect; or
- d. A pathology.

Covered Expenses include diagnosis, treatment and surgery that is recognized by the medical or dental profession as effective and appropriate treatment for TMJ, including intra-oral splints that stabilize the jaw joint.

34. INFERTILITY SERVICES

Services **Provided** to a **Minor Dependent Insured** for infertility evaluation. Services for treatment related to diagnosed infertility, including, but not limited to artificial insemination are not covered.

35. FAMILY PLANNING SERVICES (CONTRACEPTION AND VOLUNTARY STERILIZATION)

Services **Provided** to a **Minor Dependent Insured** for **Covered Expenses** for family planning services including:

- a. Medical history;
- b. Physical examination;
- c. Related laboratory tests;
- d. Medical supervision in accordance with generally accepted medical practice;
- e. Information and counseling on contraception;
- f. Implanted/injected and oral contraceptives; and
- g. After appropriate counseling, medical services connected with surgical therapies (vasectomy or tubal ligation).

36. DENTAL ANESTHESIA

Services **Provided** for general anesthesia in connection with dental services or **Oral Surgery** at a **Hospital** or **Ambulatory Surgical Center** if the **Minor Dependent Insured**:

- a. is under seven (7) years of age who is determined, by two (2) **Dentists**, to require dental treatment in a **Hospital** or **Ambulatory Surgical Center** for a significantly complex dental condition;
- b. is diagnosed with a serious mental or physical condition; or
- c. is a person with significant behavioral problem, as determined by a **Provider** licensed under the Arkansas Medical Practices Act.

37. DENTAL SERVICES – ACCIDENT ONLY

Services **Provided** by a **Hospital** or a **Provider** for the treatment of a fractured jaw or a **Dental Injury** to **Sound Natural Teeth**. **Benefits** are payable for the services of a **Provider**, **Dentist**, or dental surgeon, for treatment of an **Accidental Dental Injury** when treatment is sought within seventy-two (72) hours of injury.

38. PEDIATRIC DENTAL CARE

Services **Provided** for **Pediatric Dental Care** by a **Dentist** to a **Minor Dependent Insured**, up to age twenty-one (21), in connection with the following **Pediatric Dental Care** services:

- a. **Emergency Room** services **Provided** by a **Dentist**.
- b. **Preventive Pediatric Dental Care** - includes procedures which help to prevent oral disease from occurring, including:
 - 1) **Prophylaxis** - scaling and polishing the teeth at six (6) month intervals;
 - 2) Topical fluoride application at six (6) month intervals, excluding fluoride varnish;
 - 3) Sealants on first and second permanent molars, once; and
 - 4) Space maintainers.
- c. **Routine Pediatric Dental Care** – services **Provided** in the office of a **Dentist** which includes:
 - 1) Dental examinations, visits and consultations once within a five (5) month consecutive period (when primary teeth erupt);
 - 2) **Bitewing X-rays** at six (6) month intervals, full mouth x-rays every five (5) years, and panoramic x-rays every five (5) years;
 - 3) Procedures for simple **Extractions** and care of abscesses and surgical **Extractions**; and other routine **Oral Surgery** not requiring hospitalization, including preoperative care and postoperative care;
 - 4) General anesthesia and analgesia and non-intravenous conscious sedation;
- d. **Restorations** – amalgam and composite resin restorations; stainless steel crowns. Anterior crowns, porcelain to metal crowns. .
- e. **Endodontics** - includes procedures for treatment of diseased tooth **Pulp** and the tissues surrounding the root of the tooth, where hospitalization is not required.
- f. **Gum Therapy**
- g. **Prosthodontics** - includes services as follows:
 - 1) Removable complete or partial **Dentures**.
- h. **Consultations** – consultations **Provided** by an oral surgeon when requested by an oral surgeon or other **Provider** for further evaluation and management of a specific problem, twice (2) per **Calendar Year**.
- i. Hospital Services – Inpatient and Outpatient
 - 1) **Inpatient**: for dental treatment when the **Minor Dependent Insured's** age, medical or mental problems, or extensiveness of treatment makes **Inpatient** services **Dentally Necessary**;
 - 2) **Outpatient**: for dental treatment when the **Minor Dependent Insured's** age, medical or mental problems, or extensiveness of treatment makes **Outpatient** services **Dentally Necessary**.

39. PEDIATRIC VISION

Services **Provided** for a **Minor Dependent Insured**, age twenty-one (21) and under, including

- a. One (1) **Vision Examination** per **Calendar Year**;
- b. One (1) pair of glasses with plastic or polycarbonate lenses per **Calendar Year**;
- c. Contact lenses, only if **Medically Necessary**;
- d. Eye prosthesis and polishing services;
- e. Vision therapy development testing
 - 1) Orthoptic and pleoptic training with continuing medical direction and evaluation;
 - 2) Sensorimotor examination; and
 - 3) Developmental testing with interpretation and report; and
- f. Surgical evaluation for a **Minor Dependent Insured** with one of the following conditions:
 - 1) Ptosis;
 - 2) Congenital cataracts;
 - 3) Exotropia or vertical tropia; or
 - 4) Exotropia in **Minor Dependent Insureds** between the ages of twelve (12) and twenty-one (21).

40. GENETIC TESTING

Genetic molecular testing and related counseling to determine the presence of an existing anomaly or disease.

B. WELLNESS AND SCREENING BENEFITS

1. WELLNESS AND PREVENTIVE BENEFITS:

WELLNESS AND PREVENTIVE BENEFITS are not subject to either the **Calendar Year Deductible** or the **Minor Dependent Insured Coinsurance Percentage**, but are subject to any applicable **Separate Deductible For Non-Participating Providers** and the **Non-Participating Provider Minor Dependent Insured Coinsurance Percentage**. Therefore, subject to all applicable definitions, exclusions, limitations, and other provisions contained in this **Policy**, as well as any riders, endorsements, or amendments attached hereto, including applicable **Separate Deductible For Non-Participating Providers** and the **Non-Participating Provider Minor Dependent Insured Coinsurance Percentage**, **We** will pay to or on behalf of each **Minor Dependent Insured** the **Company Insurance Percentage** of the amount of professional fees and other applicable medical diagnostic or treatment expenses and charges that constitute **Covered Expenses** incurred by each applicable **Minor Dependent Insured** for the following described WELLNESS AND PREVENTIVE BENEFITS:

a. ADULT WELLNESS AND PREVENTIVE CARE

Services **Provided to You** for necessary **Adult Wellness Preventive Care** by a **Provider** for evidence-based items or services that have in effect, at the time services are **Provided**, a rating of "A" or "B" in the current list of preventive services recommended for adults by the United States Preventive Services Task Force (USPSTF), and to the extent addressed by the USPSTF.

Adult Wellness Preventive Care does not include charges by **Providers** for any spinal manipulations, physical therapy, occupational therapy, or other **Outpatient** therapy or treatment, or any form of medical or surgical treatment of an **Injury** or **Sickness**.

Adult Wellness Preventive Care services **Provided** by a **Non-Participating Provider** are subject to the **Separate Deductible For Non-Participating Providers** and the **Non-Participating Provider Minor Dependent Insured Coinsurance Percentage**. Additionally, if the **Adult Wellness Preventive Care** services are billed separately from an office visit, or if the primary purpose of the office visit was not for the delivery of such **Adult Wellness Preventive Care** services, **We** will impose any applicable deductibles or coinsurance with respect to the office visit.

b. CHILDHOOD WELLNESS AND PREVENTIVE CARE

Services **Provided** by a **Provider** to each infant, child, and adolescent **Minor Dependent Insured** for **Medically Necessary Childhood Wellness Preventive Care** for evidence-based items or services that have in effect, at the time of services are **Provided**, a rating of "A" or "B" at ages recommended by the United States Preventive Services Task Force (USPSTF), and to the extent addressed by the USPSTF. **Child Wellness Preventive Care** also includes evidence-informed preventive care and screenings **Provided** for the appropriate age in the comprehensive guidelines supported by the Health Resources and Services Administration and by the American Academy of Pediatrics (AAP) and Bright Futures. **Childhood Wellness Preventive Care** does not include charges by **Providers** for any spinal manipulations, physical therapy, occupational therapy, or other **Outpatient** therapy or treatment, or any form of medical or surgical treatment of an **Injury** or **Sickness**.

Childhood Wellness Preventive Care services **Provided** by a **Non-Participating Provider** are subject to the **Separate Deductible For Non-Participating Providers** and the **Non-Participating Provider Minor Dependent Insured Coinsurance Percentage** with the exception of **Benefits** for screening tests performed by **Non-Participating Providers** for hearing loss for children age twenty-four (24) months and younger, which are not subject to any otherwise applicable deductible. Additionally, if the **Childhood Wellness Preventive Care** services are billed separately from an office visit, or if the primary purpose of the office visit was not for the delivery of such **Childhood Wellness Preventive Care** services, **We** will impose any applicable deductibles or coinsurance with respect to the office visit.

c. IMMUNIZATIONS

Services for routine immunizations **Provided** to each **Minor Dependent Insured** as currently recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC) at the time services are **Provided**.

Immunizations **Provided** by a **Non-Participating Provider** are subject to the **Separate Deductible For Non-Participating Providers** and the **Non-Participating Provider Minor Dependent Insured Coinsurance Percentage**. If the immunizations are billed separately from an office visit, or if the primary purpose of the office visit was not for the delivery of such immunizations, then **We** may impose any applicable deductibles or coinsurance with respect to the office visit. Immunization **Benefits** do not include charges for immunizations for occupational hazards or international travel, except as recommended by the CDC.

2. SCREENING AND EXAMINATION BENEFITS:

SCREENING AND EXAMINATION BENEFITS are subject to all applicable definitions, exclusions, limitations, and other provisions contained in this **Policy**, as well as any riders, endorsements, or amendments attached hereto. **We** promise to pay to or on behalf of each **Minor Dependent Insured** the **Company Insurance Percentage** of the amount of professional fees and other applicable medical diagnostic or treatment expenses and charges that constitute **Covered Expenses** incurred by each **Insured** for the following described SCREENING AND EXAMINATION BENEFITS, but only after (i) each of the applicable deductibles has been first satisfied by deduction from such **Covered Expenses** and applied to the applicable **Minor Dependent Insured** for payment, and (ii) the applicable **Minor Dependent Insured Coinsurance Percentage** for the **Covered Expenses** remaining after satisfaction of all applicable deductibles is, likewise, satisfied by deduction from the remaining **Covered Expenses** and applied to the applicable **Minor Dependent Insured** for payment:

a. MAMMOGRAPHY SCREENING

1) For female **Minor Dependent Insureds** thirty-five (35) to thirty-nine (39) years of age, a single baseline **Mammogram** to detect the presence of occult breast cancer; and

2) For female **Minor Dependent Insureds** of any age a **Mammogram** upon recommendation of the **Provider**, when the female **Minor Dependent Insured** has a prior history of breast cancer or when the female **Minor Dependent Insureds'** mother or sister had a history of breast cancer.

Mammography **Benefits** for female **Minor Dependent Insureds** ages forty (40) and over are covered under the ADULT WELLNESS PREVENTIVE CARE provision.

b. PROSTATE CANCER SCREENING

Services **Provided** during an annual physical examination for the detection of prostate cancer for each male **Minor Dependent Insured** who is age forty (40) years or older.

The prostate cancer screening must be performed by a **Provider**, and shall consist of a digital rectal examination and upon the recommendation of the **Provider**, a specific antigen blood test.

Covered Expenses with respect to prostate cancer screenings are not subject to either the **Calendar Year Deductible** or the **Minor Dependent Insured Coinsurance Percentage**.

c. COLORECTAL CANCER SCREENING

Screening **Provided** to a **Minor Dependent Insured** under age fifty (50) who are at **High Risk for Colorectal Cancer**.

Colorectal cancer screening **Benefits** for **Minor Dependent Insureds** ages fifty (50) and over are covered under the ADULT WELLNESS PREVENTIVE CARE provision.

d. ROUTINE ANNUAL PHYSICAL EXAMINATION

Services **Provided** to **Minor Dependent Insureds** ages twenty-two (22) and up for necessary annual physical exam visit, by a **Participating Provider** no more than once every twelve (12) months up to a **Calendar Year** per **Minor Dependent Insured** per **Calendar Year**.

Benefits under this section do not include charges (i) by **Participating Providers** for any spinal manipulations, physical therapy, occupational therapy, or other **Outpatient** therapy or treatment, or any form of medical or surgical treatment of an **Injury** or **Sickness**, or (ii) for any service, care, test or treatment by a **Non-Participating Provider**.

e. HEARING EXAMINATION

Services **Provided** by a **Hospital** or a **Provider** for one **Hearing Examination** per adult **Minor Dependent Insured** per **Calendar Year**.

f. VISION EXAMINATION

Services **Provided** for one **Vision Examination** per **Minor Dependent Insured** age twenty-two (22) and up every two (2) years. If a **Vision Examination** results in a **Minor Dependent Insured** needing corrective **Vision Materials** for their visual health and welfare, those **Vision Materials** prescribed by **Providers** will be **Provided**, subject to certain limitations and exclusions of the **Policy**, as follows:

- 1) Lenses - Up to two (2) lenses provided per **Minor Dependent Insured** per **Calendar Year**.
- 2) Frame – One (1) frame provided per **Minor Dependent Insured** per **Calendar Year**.
- 3) Contact Lenses - Contact lenses **Provided** when **Medically Necessary**, not to exceed the cost of lenses and frames.

C. PRE-CERTIFICATION OF TREATMENT

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

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

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

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

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

D. CLAIM PROCEDURES, INVESTIGATION AND PAYMENT

1. NOTICE OF CLAIM

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

2. CLAIM FORMS AND ADDITIONAL INFORMATION TO BE PROVIDED

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

3. PROOFS OF LOSS

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

4. CLAIMS REVIEW, INVESTIGATION, ADJUSTMENT AND ADJUDICATION

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

5. PAYMENT OF CLAIMS

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

6. TIME OF PAYMENT OF CLAIMS

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

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

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

VI. DEDUCTIBLES

A. CALENDAR YEAR DEDUCTIBLE

No **Sickness and Injury Benefits** or **Wellness and Screening Benefits** are payable under this **Policy** for any **Covered Expenses** incurred by a **Minor Dependent Insured**, until after the **Calendar Year Deductible** is satisfied and fully payable each **Calendar Year** by such **Minor Dependent Insured**, unless otherwise specified. In addition to the **Calendar Year Deductible**, the **Separate Deductible For Non-Participating Providers** will apply to services rendered by **Non-Participating Providers**.

The amount of the **Separate Deductible For Non-Participating Providers** may not be used to satisfy the **Calendar Year Deductible**.

B. SEPARATE DEDUCTIBLE FOR NON-PARTICIPATING PROVIDERS

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

The amount of the **Calendar Year Deductible** may not be used to satisfy the **Separate Deductible For Non-Participating Providers**.

VII. LIMITATIONS, EXCLUSIONS AND NON-WAIVER

A. LIMITATIONS

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

1. **Minor Dependent Insureds** have the right to obtain **Prescriptions** from the pharmacy of their choice. However, if a **Minor Dependent Insured**: (i) uses a **Non-Participating Pharmacy** to fill a **Prescription**; or (ii) does not present his/her correct ID card when the **Prescription** is filled at a **Participating Pharmacy**, then such **Minor Dependent Insured** must pay the applicable pharmacy in full and file a claim form with the **Company** for reimbursement. In either event, the **Minor Dependent Insured** will be reimbursed by the **Company** at the discounted or negotiated rate for such **Prescription** that would have been paid to a **Participating Pharmacy** by the **Company** under this **Policy** if the **Minor Dependent Insured** had used a **Participating Pharmacy** and properly presented the correct ID card at the time the **Prescription** was filled;
2. Pre-authorization may be required by the **Company** prior to the time that **Prescriptions** for certain **Prescription Drugs** are filled;
3. If as the result of an **Emergency Sickness** or an **Emergency Injury** services are rendered for a **Minor Dependent Insured** by a **Non-Participating Provider** when a **Participating Provider** was not reasonably available in connection with either (i) on an **Outpatient** basis in the emergency room of a **Hospital** or (ii) an **Emergency Inpatient** admission to a **Hospital**, then the **Covered Expenses** incurred will be reimbursed by **Us** as if such **Non-Participating Provider** were a **Participating Provider** up to the point when the **Minor Dependent Insured** can be safely transferred to a **Participating Provider**. If the **Minor Dependent Insured** refuses or is unwilling to be transferred to the care of a **Participating Provider** after such **Minor Dependent Insured** can be safely transferred, then reimbursement shall thereafter be reduced to the **Company's Insurance Percentage for Non-Participating Providers**; and
4. **Sickness and Injury Benefits** and **Wellness and Screening Benefits** under this **Policy** for any **Minor Dependent Insured** who is eligible for or has coverage under **Medicare**, and/or amendments thereto, regardless of whether such **Minor Dependent Insured** is enrolled in **Medicare** shall be limited to only the **Usual and Customary** charges for services, supplies, care or treatment covered under this **Policy** that are not or would not have been payable or reimbursable by **Medicare** and/or its amendments (assuming such enrollment), subject to all provisions, limitations, exclusions, reductions and maximum benefits set forth in this **Policy**.

B. EXCLUSIONS

Coverage under this **Policy** is limited as provided by the definitions, limitations, exclusions, and terms contained in each and every Section of this **Policy**. In addition, this **Policy** does not provide coverage for expenses charged to a **Minor Dependent Insured** or any payment obligation for **Us** under this **Policy** for any of the following, all of which are excluded from coverage:

1. the amount of any professional fees or other medical expenses or charges for treatments, care, procedures, services or supplies which do not constitute **Covered Expenses**;
2. **Covered Expenses** incurred before the **Policy Issue Date**;

3. the amount of any professional fees or other medical expenses contained on a billing statement to a **Minor Dependent Insured** which exceed the amount of the **Maximum Allowable Charge**;
4. any professional fees or other medical expenses for treatments, care, procedures, services or supplies which are not specifically enumerated in the SICKNESS AND INJURY BENEFITS, or WELLNESS AND SCREENING BENEFITS Sections of this **Policy** and any optional coverage rider attached hereto;
5. **Covered Expenses You or Your** covered family members are not required to pay, which are covered by other insurance, or that would not have been billed if no insurance existed;
6. any professional fees or expenses for which the **Minor Dependent Insured** and/or any covered family member are not legally liable for payment;
7. any professional fees or expenses for which the **Minor Dependent Insured** and/or any covered family member were once legally liable for payment, but from which liability the **Minor Dependent Insured** and/or family member were released;
8. treatment of the teeth, the surrounding tissue or structure, including the gums and tooth sockets. This exclusion does not apply to treatment: (a) due to **Injury** to natural teeth (treatment must be **Provided** within ninety (90) days of the date of the **Injury**); (b) for malignant tumors, or (c) which are otherwise **Provided** for in the SICKNESS AND INJURY BENEFITS section of this **Policy**;
9. **Injury** or **Sickness** due to any act of war (whether declared or undeclared);
10. services provided by any state or Federal government agency, including the Veterans Administration unless, by law, a **Minor Dependent Insured** must pay for such services;
11. **Covered Expenses** that are payable under any motor vehicle no fault law insurance policy or certificate;
12. charges that are payable or reimbursable by either:
 - a) a plan or program of any governmental agency (except Medicaid), or
 - b) **Medicare** Part A, Part B and/or Part D (If the applicable **Minor Dependent Insured** does not enroll in **Medicare**, We will estimate the charges that would have been paid if such enrollment had occurred);
13. drugs or medication not used for a Food and Drug Administration (FDA) approved use or indication;
14. administration of experimental drugs or substances or investigational use or experimental use of **Prescription Drugs** except for any **Prescription Drug** prescribed to treat a covered chronic, disabling, life-threatening **Sickness** or **Injury**, but only if the investigational or experimental drug in question:
 - a) has been approved by the FDA for at least one indication; and
 - b) is recognized for treatment of the indication for which the drug is prescribed in:
 - 1) a standard drug reference compendia; or
 - 2) substantially accepted peer-reviewed medical literature.
 - c) drugs labeled "Caution –limited by Federal law to investigational use";
15. experimental procedures or treatment methods not approved by the American Medical Association or other appropriate medical society;
16. any **Injury** or **Sickness** covered by any Workers' Compensation insurance coverage, or similar coverage underwritten in connection with any Occupational Disease Law, or Employer's Liability Law, regardless of whether you file a claim for benefits thereunder;
17. eyeglasses, contact lenses, radial keratotomy, lasik surgery, hearing aids and exams for their prescription or fitting, except as **Provided** for in the SICKNESS AND INJURY BENEFITS and WELLNESS AND SCREENING BENEFITS sections of this **Policy**;
18. any damage or harm to the physical structure of the body of a **Minor Dependent Insured** occurring while the **Minor Dependent Insured** is
 - intoxicated or under the influence of alcohol or any drug, narcotic or hallucinogens unless administered via a prescription and on the advice of a **Provider**, and taken in accordance with the limits of such advice.
 - A **Minor Dependent Insured** is conclusively determined to be intoxicated by drug or alcohol if (ii) a chemical test administered
 - in the jurisdiction where either the **Accident** occurred or the **Minor Dependent Insured** was medically treated is at or above the
 - legal limit set by that jurisdiction or (ii) the level of alcohol was such that a person's coordination, ability to reason, was impaired, regardless of the legal limit set by that jurisdiction;
19. intentionally self-inflicted **Injury**, suicide or any suicide attempt while sane or insane;
20. serving in one of the branches of the armed forces of any foreign country or any international authority;
21. voluntary abortions, abortifacients or any other drug or device that terminates a pregnancy;
22. services **Provided** by **You** or a **Provider** who is a member of a **Minor Dependent Insured's** family;
23. any loss to which a contributing cause was the **Minor Dependent Insured's** being engaged in or attempting to engage in an illegal occupation or illegal activity;
24. participation in aviation, except as fare-paying passenger traveling on a regular scheduled commercial airline flight;

25. cosmetic surgery or reconstructive procedures, except for **Medically Necessary** cosmetic surgery or reconstructive procedures performed under the following circumstances: (i) where such cosmetic surgery is incidental to or following surgery resulting from trauma or infection; (ii) to correct a normal bodily function; or (iii) such cosmetic surgery constitutes **Breast Reconstruction** that is incident to a **Mastectomy**; provided any of the above occurred while the **Minor Dependent Insured** was covered under this **Policy**.
26. Charges for breast reduction or augmentation or complications arising from these procedures;
27. **Prescription Drugs** or other medicines and products used for cosmetic purposes or indications;
28. reversal or attempted reversal of a previous elective attempt to induce or facilitate sterilization;
29. fertility hormone therapy and/or fertility devices for any type fertility therapy, artificial insemination or any other direct conception;
30. any operation or treatment performed, **Prescription** or medication prescribed in connection with sex transformations or any type of sexual or erectile dysfunction, including complications arising from any such operation or treatment;
31. appetite suppressants, including but not limited to, anorectics or any other drugs used for the purpose of weight control, or services, or treatments;
32. **Prescriptions**, treatment or services for behavioral or learning disorders, Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD);
33. any professional fees or other medical expenses incurred as the result of an **Injury** which was caused or contributed by a **Minor Dependent Insured** racing any land or water vehicle;
34. any professional fees or other medical expenses incurred for the diagnosis, care or treatment of **Mental and Emotional Disorders**, and **Substance Abuse** except as **Provided** for in the SICKNESS AND INJURY BENEFITS section of this **Policy**;
35. **Outpatient Prescription Drugs** that are dispensed by a **Provider**, **Hospital** or other state-licensed facility;
36. **Prescription Drugs** produced from blood, blood plasma and blood products, derivatives, Hemofil M, Factor VIII, and synthetic blood products, or immunization agents, biological or allergy sera, hematinics, blood or blood products administered on an **Outpatient** basis;
37. level one controlled substances;
38. **Prescription Drugs** used to treat or cure hair loss or baldness;
39. compounded **Prescription Drugs**;
40. fluoride products;
41. allergy kits intended for future emergency treatment of possible future allergic reactions;
42. replacement of a prior filled prescription for **Prescription Drugs** that was covered and is replaced because the original prescription was lost, stolen or damaged;
43. **Prescription Drugs**, which have an over the counter equivalent that may be obtained without a **Prescription**, even though such **Prescription Drugs** were prescribed by a **Provider**;
44. any intentional misuse or abuse of **Prescription Drugs**, including **Prescription Drugs** purchased by a **Minor Dependent Insured** for consumption by someone other than such **Minor Dependent Insured**;
45. **Prescription Drugs** that are classified as anti-fungal medication used for treatment of onychomycosis;
46. **Prescription Drugs** that are classified as tobacco cessation products;
47. charges for blood, blood plasma, or derivatives that has been replaced;
48. Temporomandibular Joint Disorder (TMJ) and Craniomandibular Disorder (CMD), except as **Provided** for in the SICKNESS AND INJURY BENEFITS section of this **Policy**;
49. treatment received outside of the United States;
50. services or supplies for personal convenience, including custodial care or homemaker services;
51. open vertical banded gastroplasty, laparoscopic vertical banded gastroplasty, open sleeve gastrectomy, laparoscopic sleeve gastrectomy, and open adjustable gastric banding.
52. any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations, except as **Provided** for in the **Benefit** entitled **Substance Abuse Services** section of this **Policy**;
53. any services for treatment of mental and emotional disorders that have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain;
54. services for treatment of chronic mental conditions not subject to favorable modification according to generally accepted standards of medical practice;
55. services for developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders; developmental language disorders, or articulation disorders;

56. services for counseling for the following: for activities of an educational nature, for borderline intellectual functioning, for occupational problems and for any relation to consciousness raising;
57. services for vocational or religious counseling ;
58. I.Q. testing;
59. services for occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline;
60. services for biofeedback are not covered for reasons other than pain management;
61. treatment for **Autism Spectrum Disorder** performed by the following: Sensory Integration, LOVAAS Therapy and Music Therapy;
62. non-medical ancillary services including, but not limited to, vocational rehabilitation, behavioral training, sleep therapy, employment counseling, driving safety, and services, training or educational therapy for learning disabilities, developmental delays, and mental retardation;
63. purchase or rental of **Durable Medical Equipment** and prosthetics are not covered when due to misuse, damage and replacement when lost; and
64. miscellaneous charges while lodging, including but not limited to personal convenience items movies, wireless internet, telephone, radio, cleaning supplies and shipping charges.

C. NON-WAIVER

Expenses that are mistakenly applied by **Us** to the **Calendar Year Deductible** or erroneously paid by **Us** under any Section or provision of this **Policy** including **Prescription Drugs** shall not:

- a) constitute a waiver of or modification to any conditions, terms, definitions or limitations contained in the **Policy**, specifically including, but not by way of limitation, the definitions of **Sickness** and **Injury**, , as well as any exclusion, limitation and/or exclusionary riders which may be attached to the **Policy**, or otherwise operate to alter, amend, affect, abridge or modify the **Policy** to which it is attached;
- b) create or establish coverage of any medical condition illness, disease or injury under the **Policy** or under any exclusion, limitation and/or exclusionary riders which may be attached to the **Policy**; or
- c) affect, alter, amend, abridge, constitute or act as a waiver of the **Company's** ability to rely upon, assert and apply such terms, definitions, limitations or exclusions of the **Policy** or any amendments thereto.

VIII. GRIEVANCE PROCEDURES

The Arkansas External Review Regulation requires **Us** to provide **You** with the opportunity for an independent review of any **Adverse Determination** or **Final Adverse Determination**. **You** have the right to request an **External Review** once **Your Internal Grievance Procedures** have been exhausted, unless otherwise stated. The criteria for the Grievance Procedures, including the **External Review** process by an **Independent Review Organization** to examine any **Adverse Determinations**, is outlined below.

INTERNAL GRIEVANCE PROCEDURES

You have the right to appeal any denial of a claim for **Benefits** by submitting a written request, via facsimile or mail, for reconsideration.

Requests for reconsideration must be filed within sixty (60) days of receipt of the written notification of denial. Within ten (10) days from receipt of the request for reconsideration, **We** will acknowledge receipt. Within thirty (30) days from receipt of the request for reconsideration, **We** will review **Your** request and provide a written response describing the final determination. If **You** are not satisfied with the **Final Adverse Determination**, **You** may request an **External Review**.

EXTERNAL GRIEVANCE PROCEDURES

I. Notice of Right to External Review -

Adverse Determinations: **You** may file a request for an expedited **External Review** to be conducted at the same time **You** file a request for a review of an appeal as set forth in the **Internal Grievance Procedure**, if:

- (A) **You** have a medical condition where the timeframe for completion of an expedited review of an appeal in **Our Internal Grievance Procedures** would seriously jeopardize **Your** life or health or would jeopardize **Your** ability to regain maximum function; or
- (B) The **Adverse Determination** involves a denial of coverage based on a determination that the recommended or requested **Health Care Service** or treatment is “experimental” or “investigational” and **Your Provider** certifies in writing and supports such certification with reasoning, rationale, or evidence that the recommended or requested **Health Care Service** or treatment would be significantly less effective if not promptly initiated.

The **Independent Review Organization** conducting the **External Review** will determine whether **You** will be required to complete the **Internal Grievance Procedures** prior to the expedited External Grievance Procedures. **You** may file an appeal under **Our Internal Grievance Procedures**, if **We** have not issued a written decision to **You** within thirty (30) days following the date **You** filed the appeal with **Us** for a pre-service claim or within sixty (60) days following the date **You** filed the appeal with **Us** for a post-service claim and **You** have not requested or agreed to a delay, **You** may file a request for **External Review** and shall be considered to have exhausted **Our Internal Grievance Procedures**.

Final Adverse Determinations: **You** may file a request for an expedited **External Review** to be conducted at the same time **You** file a request for a review of an appeal as set forth in the **Internal Grievance Procedure**, if:

- (A) **You** have a medical condition where the timeframe for completion of an expedited review of an appeal in **Our Internal Grievance Procedures** would seriously jeopardize **Your** life or health or would jeopardize **Your** ability to regain maximum function.
- (B) If the **Final Adverse Determination** concerns:
 - (i) an admission, availability of care, continued stay or **Health Care Service** for which **You** received **Emergency** services, but has not been discharged from a facility; or
 - (ii) a denial of coverage based on a determination that the recommended or requested **Health Care Service** or treatment is “experimental” or “investigational” and **Your Provider** certifies in writing and supports such certification with reasoning, rationale, or evidence that the recommended or requested **Health Care Service** or treatment would be significantly less effective if not promptly initiated.

You have the right to seek assistance from the Arkansas Department of Insurance at any time.

Commissioner [Jay Bradford]	E-mail: insurance.Consumers@mail.state.ar.us
Arkansas Dept. of Insurance	Phone: 501-371-2640 or 800-852-5494
1200 West 3 rd Street	Fax: 501-371-2749
Little Rock, Arkansas 72201	

All requests for **External Reviews** shall be made in writing or via electronic media to **Us** at the mailing address and facsimile telephone number identified below:

Freedom Life Insurance Company of America	
Attn.: Vice President of Claims	
Claims and Communications Dept.	
3100 Burnett, 801 Cherry Street, Unit 33	Phone: 800-387-9027
Fort Worth, Texas 76102	Fax: 817-878-3440

Please be advised when filing a request for an **External Review**, **You** will be required to authorize the release of any of **Your** medical records that may be required to be reviewed for the purpose of reaching a decision on the **External Review**. This authorization will allow **Us** to disclose **Your** protected health information, including medical records, that are pertinent to the **External Review**.

II. Standard External Review -

Within sixty (60) days after the date of receipt of a notice of an **Adverse Determination** or **Final Adverse Determination**, **You** may file a request for an **External Review** with **Us**, as specified below:

- (A) At the time **We** receive a request for an **External Review**, **We** shall assign an **Independent Review Organization** (from the list of approved **Independent Review Organizations** compiled and maintained by the Arkansas Insurance Commissioner) to conduct a preliminary review of the request to determine if:

- the request for the **External Review** meets the applicability standards as set out above;
 - **You** have exhausted **Our Internal Grievance Procedures**; and
 - **You** have provided all the information and forms required to process an **External Review**, including the authorization to release medical records.
- (B) Within five (5) business days after receipt of the request for **External Review**, the **Independent Review Organization** assigned shall complete the preliminary review and notify **You, Your Provider** and Freedom Life Insurance Company of America in writing as to whether:
- the request is complete; and
 - the request has been accepted for **External Review**.

The **Independent Review Organization** shall include in the notice provided a statement that **You, Your Provider** and Freedom Life Insurance Company of America may submit in writing to the **Independent Review Organization** within seven (7) business days following the date of receipt of the notice additional information and supporting documentation that the **Independent Review Organization** shall consider when conducting the **External Review**.

If the request:

- is not complete, the assigned **Independent Review Organization** shall, within five (5) business days, inform **You, Your Provider** and Freedom Life Insurance Company of America what information or materials are needed to make the request complete; or
- is not accepted for **External Review**, the assigned **Independent Review Organization** shall
- inform **You, Your Provider** and Freedom Life Insurance Company of America in writing within five (5) business days of the reasons for non-acceptance.

Upon receipt of any information submitted by **You**, the assigned **Independent Review Organization** shall forward copies of the information to **Us**.

- (C) In reaching a decision to accept or reject a matter for **External Review**, the assigned **Independent Review Organization** is not bound by any decisions or conclusions reached during **Our Internal Grievance Procedures**.
- (D) Within seven (7) business days after the receipt of the notice provided in part (B) above, **We** shall provide to the assigned **Independent Review Organization, You** and **Your Provider** the documents and any information considered in making the **Adverse Determination** or **Final Adverse Determination**, together with any additional information **We** deem necessary. If **We** fail to provide the documents or information, this will not delay the **External Review**; instead, the **Independent Review Organization** may terminate the **External Review** and make a decision to reverse any **Adverse Determination** or **Final Adverse Determination**. Immediately upon making such a decision, the **Independent Review Organization** shall notify **You, Your Provider** and Freedom Life Insurance Company of America.
- (E) Upon receipt of the information, if any, required to be forwarded to **Us** as stated in (B) above, **We** may reconsider any prior **Adverse Determination** or **Final Adverse Determination** for the **External Review**. This reconsideration by **Us** shall not delay or terminate the **External Review**. The **External Review** may only be terminated if **We** decide, upon completion of our reconsideration, to reverse **Our Adverse Determination** or **Final Adverse Determination** and provide coverage or payment for the **Health Care Services** that is the subject of the **Adverse Determination** or **Final Adverse Determination**.

Immediately upon making the decision to reverse **Our Adverse Determination** or **Final Adverse Determination**, **We** shall notify **You** and **Your Provider**, as well as the assigned **Independent Review Organization**, in writing of **Our** decision. The assigned **Independent Review Organization** shall terminate the **External Review** upon receipt of this notice from **Us**.

- (F) In exercising its independent medical judgment in reviewing an **Adverse Determination**, in addition to the documents and information provided, the assigned **Independent Review Organization**, to the extent the information or documents are available, shall consider the following in reaching a decision:
- the **Minor Dependent Insured's** medical records;
 - the **Provider's** professional recommendation;

- consulting reports from appropriate health care professionals and other documents submitted by **Us, You or Your Provider**;
- the applicable terms of coverage under **Your** contract of insurance to ensure that the **Independent Review Organization's** decision is not contrary to the terms of the coverage;
- the most appropriate practice guidelines, which may include generally accepted practice guidelines, evidence-based practice guidelines or any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;
- any applicable written screening procedures, decision abstracts, clinical protocols and practice guidelines used by **Us** to determine the necessity and appropriateness of **Health Care Services**; and
- if the **Adverse Determination** involves a denial of coverage based on a determination that the recommended or requested **Health Care Service** is "experimental" or "investigational" , the **Independent Review Organization** shall also consider whether: (a) the recommended or requested **Health Care Service** or treatment has been approved by the federal Food and Drug Administration for the condition, while realizing that treatments or services are often legitimately used for purposes other than those listed in the FDA approval; or (b) medical or scientific evidence demonstrates that the expected benefits of the recommended or requested **Health Care Service** or treatment is more likely than not to be more beneficial to **You** than any available standard **Health Care Service** or treatment and the adverse risks of the recommended or requested **Health Care Service** or treatment would not be substantially increased over those of available standard **Health Care Services** or treatments.

(G) Within forty-five (45) calendar days after the date of receipt of the request for an **External Review**, the assigned **Independent Review Organization** shall provide written notice of its decision to uphold, reverse, or partially uphold or reverse the **Adverse Determination** or **Final Adverse Determination** to **You, Your Provider** and Freedom Life Insurance Company of America.

III. Expedited External Review -

- (A) Except as provided under item (E) below, **You** may make a request for an expedited **External Review** with **Us** at the time **You** receive an **Adverse Determination** or **Final Adverse Determination**. At the time **You** elect to make a request for an expedited **External Review**, **You** and **Your Provider** shall submit additional information and supporting documentation that the **Independent Review Organization** shall consider when conducting the expedited **External Review**.
- (B) An expedited **External Review** may NOT be provided for an **Adverse Determination** or **Final Adverse Determination** involving a **Retrospective Review**.
- (C) At the time **We** receive a request for an expedited **External Review**, **We** immediately shall assign an **Independent Review Organization** (from the list compiled and maintained by the Arkansas Insurance Commissioner) to determine whether the request meets the reviewability requirements, and then initiate the expedited **External Review** if all the requirements are met.
- (D) At the time **We** assign an **Independent Review Organization** to conduct the expedited **External Review**, **We** shall immediately provide or transmit all pertinent documentation and information to the assigned **Independent Review Organization**.
- (E) As expeditiously as **Your** medical condition or circumstances require, but in no event more than seventy-two (72) hours after the date of receipt of the request for an expedited **External Review** that meets the reviewability requirements, the assigned **Independent Review Organization** shall:
- Make a decision to uphold or reverse the **Adverse Determination** or **Final Adverse Determination**; and
 - Notify **You, Your Provider** and Freedom Life Insurance Company of America of the decision.

IV. Binding Nature of External Review Decision -

All **External Reviews** conducted will be fair and impartial, and in compliance with the standards approved by the Arkansas Insurance Commissioner.

An **External Review** decision is binding on **Us**, except to the extent that **We** have other remedies available under applicable federal or state law. An **External Review** decision is binding on the **Covered Minor Dependent Insured**, except to the extent that **You** have other remedies available under applicable federal or state law. A **Covered Minor Dependent Insured** may NOT file a subsequent request for an **External Review** involving the same **Adverse Determination** or **Final Adverse Determination** for which **You** have already received an **External Review** decision.

V. Filing Fees and Funding –

- (A) Except in the case of a request for an expedited **External Review**, at the time of filing a request for **External Review**, the **Covered Minor Dependent Insured** shall submit to the **Independent Review Organization** a filing fee of [\$25.00], along with the information and documentation to be used by the **Independent Review Organization** in conducting the **External Review**. However, upon application by the **Covered Minor Dependent Insured**, the Arkansas Insurance Commissioner may waive the filing fee upon a showing of undue financial hardship.
- (B) The filing fee shall be refunded to the **Minor Dependent Insured** who paid the fee if the **External Review** results in the reversal, in whole or part, of **Our Adverse Determination** or **Final Adverse Determination** that was subject of the **External Review**.

We shall pay the cost of the **Independent Review Organization** for conducting the **External Review** or expedited **External Review**, and shall not charge back the cost of any **External Review** to the **Covered Minor Dependent Insured's Provider**.

IX. INSURANCE WITH OTHER INSURERS

If a **Minor Dependent Insured** maintains other valid coverage, not with this **Company**, providing benefits for the same loss on a provision of service or an expense incurred basis and of which this **Company** has not been given written notice prior to the occurrence or commencement of loss, the only liability under this **Policy** shall be for such proportion of the loss as the amount which would otherwise have been payable hereunder plus the total of the like amounts under all such other valid coverage for the same loss of which this **Company** had notice bears to the total like amounts under all valid coverage for such loss, and for the return of such portion of the premiums paid shall exceed the pro rata portion for the amount so determined.

Other valid coverage means any other health insurance coverage **You** maintain under any of the following: any coverage which constitutes minimum essential coverage under federal law, an essential health benefits plan under federal law, a grandfathered health plan under federal law, a group health plan or group health insurance coverage: individual health insurance coverage; a government or church plan any union, employer, or employee health benefit plan; Title XIX of the Social Security Act [142 U.S.C.A. Section 1396 et seq.]; other than coverage consisting solely of benefits under Section 1928 [42 U.S.C.A. Section 1396s]; Chapter 55 of Title 10, United States Code; a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a public health plan offered under Chapter 89 of Title 5, United States Code; or a health benefit plan under section 2504(e) of Title 22, United States Code. Other valid insurance coverage does not include coverage under Medicare and/or amendments thereto.

X. UNIFORM PROVISIONS

A. ENTIRE CONTRACT- CHANGES

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

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

No change in this **Policy** will be valid unless it is:

1. noted on or attached to this **Policy**;
2. signed by one of **Our** officers; and
3. delivered to the **Policyowner**, as shown on the **Policy Schedule**.

B. OTHER INSURANCE WITH US

You may have only one policy or certificate providing essential health benefits, major medical or medical and surgical coverage with **Us**. If through error, **We** issue more than one like policy or certificate to **You**, only one policy or certificate chosen by **You** or **Your** estate, as the case may be, will stay in force. **We** will return the money **You** paid for the other policy(ies) or certificate(s).

C. CONFORMITY WITH STATE STATUTES

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

D. MISSTATEMENT OF AGE

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

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

E. LEGAL ACTION

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

F. SUBROGATION

We shall be subrogated to all rights of recovery which any **Minor Dependent Insured** may acquire against any party for ordinary negligence, gross negligence, strict liability in tort or any willful or intentional act or omissions resulting in **Injury** or **Sickness** for which **We** pay **Sickness and Injury Benefits, and Wellness and Screening Benefits** but only to the extent of the **Benefits** provided. Any **Minor Dependent Insured**, by receiving **Benefits** under this **Policy**, in such case, shall be deemed to have assigned such rights of recovery to **Us** and have agreed to do whatever may be necessary to secure the recovery, including, but not limited to, the execution of any and all appropriate documents or papers. The **Minor Dependent Insured** also agrees to execute and deliver all necessary instruments, to furnish such information and assistance, and to take any action **We** may require to facilitate enforcement of **Our** rights.

THIS CONCLUDES THIS POLICY

FREEDOM LIFE INSURANCE COMPANY OF AMERICA

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

ESSENTIAL HEALTH BENEFITS POLICY

OUTLINE OF COVERAGE

READ YOUR POLICY CAREFULLY - This Outline of Coverage provides a description of the important features of **Your Policy**. This is not an insurance contract and only the actual **Policy** provisions will control. The **Policy** itself sets forth, in detail, the rights and obligations of both **You** and **Your** insurance company. It is, therefore, important that **You READ YOUR POLICY CAREFULLY!**

ESSENTIAL HEALTH BENEFIT PLAN – The **Policy** is designed to provide an **Minor Dependent Insured**, the covered items and services listed in the **Sickness and Injury Benefits** and **Wellness and Screening Benefits** sections of the **Policy** while coverage for such **Minor Dependent Insured** under the **Policy** is in full force and effect, subject to all applicable definitions, exclusions, limitations, reductions, and other provisions of the **Policy**, as well as any riders, endorsements, or amendments attached to the **Policy**.

THIS POLICY PROVIDES ESSENTIAL HEALTH BENEFITS COVERAGE UNDER FEDERAL LAW. IT IS A MAJOR MEDICAL EXPENSE POLICY WITH A PARTICIPATING PROVIDER NETWORK. IT IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE UNDER STATE LAW.

Deductible Options:

Calendar Year Deductible:	Platinum	Gold	Silver	Bronze
Participating Provider	\$950	\$2,000	\$3,500	\$6,250
Non-Participating Provider	\$2,850	\$6,000	\$10,500	\$18,750

Coinsurance Options:

Participating Provider	100%
Non-Participating Provider	100%

Covered Expenses incurred by an **Minor Dependent Insured** for **Medically Necessary Sickness and Injury Benefits** and **Wellness and Screening Benefits** are subject to the **Calendar Year Deductible**, the **Separate Deductible For Non-Participating Providers**, and the **Minor Dependent Insured Coinsurance Percentage**, unless otherwise stated herein and all applicable definitions, exclusions, limitations, non-waiver, waiting periods, and other provisions contained in the **Policy**, as well as any riders, endorsements, or amendments attached to the **Policy**.

A. SICKNESS AND INJURY BENEFITS

1. INPATIENT HOSPITAL CARE: **Hospital** semi-private room and board; **Intensive Care Unit**, miscellaneous medications, **Prescription Drugs**, services and supplies and **Provider** visits (limited to one (1) visit per treating **Provider** per day).
2. INPATIENT OR OUTPATIENT SURGERY: Services **Provided** by a **Hospital** or **Ambulatory Surgical Center**, Primary Surgeon, Assistant Surgeon, Anesthesiologist or Nurse Anesthetist, Pathologist fees and second surgical opinion.
3. INPATIENT OR OUTPATIENT LABORATORY AND DIAGNOSTIC TESTS: Services **Provided** by a **Hospital** or a **Provider** in connection with the performance and interpretation of laboratory and diagnostic tests.
4. INPATIENT OR OUTPATIENT RADIATION THERAPY AND CHEMOTHERAPY: Services **Provided** by a **Hospital** or a **Provider** in connection with radiation therapy and chemotherapy

5. INPATIENT OR OUTPATIENT THERAPY: Services **Provided** by a **Hospital** or a **Provider** in connection with Occupational Therapy, Rehabilitation Therapy, Cardiac and Pulmonary Rehabilitation Therapy, Radio-frequency Thermal Therapy, Neurologic Rehabilitation, Cognitive Rehabilitation, and **Habilitative Services**. Outpatient Cardiac and Pulmonary Rehabilitation Therapy is not to exceed thirty-six (36) **Outpatient** treatment sessions per **Calendar Year**.
6. MENTAL AND EMOTIONAL DISORDERS: Services **Provided** for the treatment and evaluation of **Mental and Emotional Disorders** received on an **Inpatient** and **Outpatient** basis by an **Minor Dependent Insured**.
7. BREAST RECONSTRUCTION: Services **Provided** by a **Hospital** and a **Provider** in connection with **Breast Reconstruction** performed at a **Hospital**. **Hospital Confinement** incident to a **Mastectomy** for no less than forty-eight (48) hours, unless decision to discharge earlier is made by both the **Provider** and the **Minor Dependent Insured**.
8. TRANSPLANTS: Services **Provided** by a **Hospital** and **Providers** in connection with the performance of for all **Solid Organ Transplants, Bone Marrow Transplants** and/or **Stem Cell Transplants**. Harvesting of applicable donor or donor bone marrow is \$10,000 per transplant. Travel for the **Minor Dependent Insured** receiving the transplant will include: a) transportation to and from the transplant site in a personal vehicle will be reimbursed at [37.5] cents per mile when the transplant site is more than sixty (60) miles from the **Minor Dependent Insured's** home; and b) lodging [limited to \$50-150 per day] for the **Minor Dependent Insured** and one companion.
9. EMERGENCY ROOM SERVICES: Items received by an **Minor Dependent Insured** on an **Emergency** basis including: a) **Emergency** room services and supplies; b) **Provider** services for surgery; c) x-ray and laboratory examinations; d) prescription drugs administered prior to discharge; e) surgical dressings, casts, splints, trusses, braces and crutches; and f) services for a registered nurse (R.N.).
10. EMERGENCY TRANSPORTATION TO HOSPITAL BY AMBULANCE: Transportation of an **Minor Dependent Insured** by either local ground ambulance or local air ambulance to the nearest **Hospital**. Expenses charged for air ambulance are not payable if such **Minor Dependent Insured's** medical condition was did not result in an **Inpatient** admission and **Confinement**
11. OUTPATIENT TREATMENT OF ACCIDENTAL INJURIES: Services **Provided** by a **Hospital**, an **Emergency Care Facility** or a **Provider** in connection with **Outpatient** treatment of **Injuries**.
11. OUTPATIENT PROVIDER OFFICE VISITS: Professional services **Provided** for a **Medically Necessary** visit for the purpose of evaluation, diagnosis and treatment of an **Injury** or **Sickness**.
12. OUTPATIENT PRESCRIPTIONS: **Prescription Drugs** filled at a **Participating Pharmacy**. Expenses for **Prescriptions** shall not exceed the amount of the cost of the least expensive drug, medicine or **Prescription Drug** that may be used to treat the **Minor Dependent Insured's** **Sickness** or **Injury**.
13. OUTPATIENT DIALYSIS: Services **Provided** at **Hospital** or other **Provider** in connection with dialysis.
14. HOME HEALTH CARE: Services specified in a **Home Health Care Plan**, up to the amount of the semi-private room rate for the same or related **Injury** or **Sickness** as the **Hospital** or **Skilled Nursing Home Confinement** and must begin thirty (30) days after discharge. Services are limited to a maximum of fifty (50) visits per **Minor Dependent Insured** per **Calendar Year**.
15. HOSPICE CARE: **Hospice Care** due to **Injuries** or **Sickness**, if: a) such **Hospice Care** is provided for which **expenses** were incurred by such **Minor Dependent Insured** for **Hospital Confinement**; b) the **Minor Dependent Insured's** **Provider** certifies the life expectancy of the **Minor Dependent Insured** is six (6) months or less; and c) the **Minor Dependent Insured's** **Provider** recommends a **Hospice Care** program.
16. MEDICAL EQUIPMENT: Medical Equipment and supplies **Provided** to an **Minor Dependent Insured** as a result of **Injury** or **Sickness**.

17. GASTRIC PACEMAKERS: **Gastric Pacemakers Provided** to an **Minor Dependent Insured** to treat **Gastroparesis**.
18. SKILLED NURSING HOME CARE: Daily room and board and miscellaneous charges for other services **Provided** for the same or related **Injury** or **Sickness** after a minimum of seven (7) consecutive days **Hospital Confinement**. Skilled Nursing Home Care must begin thirty (30) days after **Hospital** discharge and the **Minor Dependent Insured's Provider** must certify the need for **Skilled Nursing Home Confinement**, limited to a maximum of sixty (60) days in a twelve (12) month period.
19. SUPPLIES AND SERVICES ASSOCIATED WITH THE TREATMENT OF DIABETES: **Diabetes Equipment, Diabetes Supplies** and **Diabetes Self-Management Training**.
20. INHERITED METABOLIC DISORDERS: **Medical Foods**, metabolic supplements and gastric disorder formulas prescribed or ordered under the supervision of a **Provider**, as **Medically Necessary** for the treatment of an **Inherited Metabolic Disorder**.
21. MATERNITY AND NEWBORN CARE: The **Minor Dependent Insured's** routine pregnancy, including normal labor and delivery, cesarean section deliveries that are not performed on an emergency basis, and complications of pregnancy. Services for care and treatment of **Your** newborn child or adoptee.
22. SUBSTANCE ABUSE: Services **Provided** by a **Specialized Hospital** or a **Provider** for the treatment of **Substance Abuse**. This **Benefit** includes **Inpatient** and **Outpatient** rehabilitation services, and residential services.
23. HEARING AIDS: Services **Provided** to an **Minor Dependent Insured** for hearing aids that are **Medically Necessary**, up to \$1,400 per year, every three (3) years.
24. CRANIOFACIAL ANOMALY: Services **Provided** to an **Minor Dependent Insured** for the treatment and correction of a **Craniofacial Anomaly** and associated secondary conditions.
25. CHIROPRACTIC SERVICES: Diagnostic and treatment services **Provided** in connection with conservative management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain and improve function, limited to thirty (30) visits per **Calendar Year**.
26. TEMPROMANDIBULAR JOINT (TMJ) DISORDER: Services **Provided** by a **Provider** for **Medically Necessary** treatment of TMJ disorder caused by **Accident** or trauma, congenital defect, developmental defect, or a pathology.
27. INFERTILITY SERVICES: Services **Provided** to an **Minor Dependent Insured** to diagnose the underlying medical cause of infertility. All other infertility services are not covered under this **Policy**.
28. FAMILY PLANNING: Services and devices **Provided** to an **Minor Dependent Insured** for family planning services including: medical history, physical examination, related laboratory tests, medical supervision, information and counseling on contraception, implanted, injected and oral contraceptives, and surgical therapies.
29. DENTAL ANESTHESIA: Services **Provided** for general anesthesia and associated **Covered Expenses** for **Minor Dependent Insureds**: age seven (7) or under, diagnosed with a serious mental or physical condition, or with significant behavioral problems.
30. DENTAL SERVICES – ACCIDENT ONLY: Services **Provided** by a Hospital or **Provider** for the treatment of a fractured jaw or **Dental Injury** to **Sound Natural Teeth** when treatment sought within seventy-two (72) hours of injury.
31. PEDIATRIC DENTAL CARE: Services **Provided** for **Pediatric Dental Care** by a **Dentist** to an **Minor Dependent Insured**, up to age nineteen (19) for: **Emergency Room** Services; Preventive Pediatric Dental Care; Routine Pediatric Dental Care; Gum Therapy; and Prosthodontics.

32. PEDIATRIC VISION: Services **Provided** for **Insureds** age twenty-one (21) and under for pediatric vision care.
33. GENETIC TESTING: Genetic molecular testing and related counseling to determine the presence of an existing anomaly or disease.

B. WELLNESS AND SCREENING BENEFITS

1. ADULT WELLNESS AND PREVENTIVE CARE: Services for evidence-based items or services that have a rating of "A" or "B" in the current list of the United States Preventive Services Task Force .. **Adult Wellness Preventive Care Provided** by a **Participating Provider** is not subject to the **Calendar Year Deductible** or the **Minor Dependent Insured Coinsurance Percentage**. **Adult Wellness Preventive Care** services **Provided** by a **Non-Participating Provider** are subject to the applicable deductibles and coinsurance.. If the **Adult Wellness Preventive Care** services are billed separately from an office visit, or if the primary purpose of the office visit was not for the delivery of such **Adult Wellness Preventive Care** services, **We** will impose any applicable deductibles or coinsurance with respect to the office visit.
2. CHILDHOOD WELLNESS AND PREVENTIVE CARE: Services for evidence-based items or services that are Provided, a rating of "A" or "B" by the United States Preventive Services Task Force (USPSTF). **Child Wellness Preventive Care** also includes preventive care and screenings in the guidelines of the Health Resources and Services Administration, American Academy of Pediatrics (AAP) and Bright Futures. **Childhood Wellness Preventive Care Provided** by a **Participating Provider** are not subject to the **Calendar Year Deductible** or the **Minor Dependent Insured Coinsurance Percentage**. **Childhood Wellness Preventive Care** services **Provided** by a **Non-Participating Provider** are subject to the applicable deductibles and coinsurance with the exception of **Benefits** for screening tests for hearing loss for children age twenty-four (24) months and younger. If the **Childhood Wellness Preventive Care** services are billed separately from an office visit, or if the primary purpose of the office visit was not for the delivery of such **Childhood Wellness Preventive Care** services, **We** will impose any applicable deductibles or coinsurance with respect to the office visit.
3. IMMUNIZATIONS: Routine immunizations as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC) received by a **Participating Provider** are not subject to the **Calendar Year Deductible** or the **Minor Dependent Insured Coinsurance Percentage**. Immunizations **Provided** by a **Non-Participating Provider** are subject all applicable deductibles. If the immunizations are billed separately from an office visit, or if the primary purpose of the office visit was not for the delivery of such immunizations, then **We** may impose any applicable deductibles or coinsurance with respect to the office visit. Immunization **Benefits** do not include charges for immunizations for occupational hazards or international travel, except as recommended by the CDC.
4. MAMMOGRAPHY SCREENING: For female **Minor Dependent Insureds** thirty-five (35) to thirty-nine (39) years of age, a single baseline **Mammogram** to detect the presence of occult breast cancer and **Mammograms** for female **Minor Dependent Insureds** with a family history of breast cancer upon recommendation of a **Provider**. Mammography **Benefits** for female **Minor Dependent Insureds** ages forty (40) and over are covered under the ADULT WELLNESS PREVENTIVE CARE provision.
5. PROSTATE CANCER SCREENING: Services **Provided** during an annual physical examination for the detection of prostate cancer, and a prostate-specific antigen test used for the detection of prostate cancer for each male **Minor Dependent Insured** over forty (40). The prostate cancer screening shall consist of a prostate-specific antigen blood test and a digital rectal examination.
6. COLORECTAL CANCER SCREENING: Screening **Provided** to **Minor Dependent Insureds** under age fifty (50) who are **High Risk for Colorectal Cancer**. Colorectal cancer screening for **Minor Dependent Insureds** over fifty (50) covered but ADULT WELLNESS AND PREVENTIVE CARE provision.
7. ROUTINE ANNUAL PHYSICAL EXAMINATION: Services **Provided** to **Minor Dependent Insureds** ages twenty-two (22) and up for necessary annual physical exam visit, by a **Participating Provider** no more than once in a 12 month period.
8. HEARING EXAMINATION: Services **Provided** by a **Hospital** or **Provider** for one **Hearing Examination** per adult **Minor Dependent Insured** per **Calendar Year**.

9. VISION EXAMINATION: One **Vision Examination** per **Minor Dependent Insured**, up to age twenty (20), per **Calendar Year** and one **Vision Examination** per **Minor Dependent Insured** age twenty (20) and over every two (2) years. **Vision Materials** prescribed by **Providers** will be Provided, subject to certain limitations and exclusions in the **Policy**.

C. LIMITATIONS, EXCLUSIONS AND NON-WAIVER

LIMITATIONS

• **[Minor Dependent Insureds** have the right to obtain **Prescriptions** from the pharmacy of their choice. However, if an **Minor Dependent Insured**: (i) uses a **Non-Participating Pharmacy** to fill a **Prescription**; or (ii) does not present his/her correct ID card when the **Prescription** is filled at a **Participating Pharmacy**, then such **Minor Dependent Insured** must pay the applicable pharmacy in full and file a claim form with the **Company** for reimbursement unless a **Non-Participating Pharmacy** accepts assignment of **Benefits**. In the event an **Minor Dependent Insured** must pay the applicable pharmacy in full, the **Minor Dependent Insured** will be reimbursed by the **Company** at the discounted or negotiated rate for such **Prescription** that would have been paid to a **Participating Pharmacy** by the **Company** under the **Policy** if the **Minor Dependent Insured** had used a **Participating Pharmacy** and properly presented the correct ID card at the time the **Prescription** was filled;] • Pre-authorization may be required by the **Company** prior to the time that **Prescriptions** for certain **Prescription Drugs** are filled;] • If as the result of an **Emergency Sickness** or an **Emergency Injury** services are rendered for an **Minor Dependent Insured** by a **Non-Participating Provider** when a **Participating Provider** was not reasonably available in connection with either (i) on an **Outpatient** basis in the emergency room of a **Hospital** or (ii) an **Emergency Inpatient** admission to a **Hospital**, then the **Covered Expenses** incurred will be reimbursed by **Us** as if such **Non-Participating Provider** were a **Participating Provider** up to the point when the **Minor Dependent Insured** can be safely transferred to a **Participating Provider**. If the **Minor Dependent Insured** refuses or is unwilling to be transferred to the care of a **Participating Provider** after such **Minor Dependent Insured** can be safely transferred, then reimbursement shall thereafter be reduced to the **Company's Insurance Percentage for Non-Participating Providers**; • **Sickness and Injury Benefits** and **Wellness and Screening Benefits** under the **Policy** for any **Minor Dependent Insured** who is eligible for or has coverage under **Medicare**, and/or amendments thereto, regardless of whether such **Minor Dependent Insured** is enrolled in **Medicare**, shall be limited to only the **Usual and Customary** charges for services, supplies, care or treatment covered under the **Policy** that are not or would not have been payable or reimbursable by **Medicare** and/or its amendments (assuming such enrollment), subject to all provisions, limitations, exclusions, reductions and maximum benefits set forth in the **Policy**.

EXCLUSIONS

Coverage under the **Policy** is limited as provided by the definitions, limitations, exclusions, and terms contained in each and every Section of the **Policy**. In addition, the **Policy** does not provide coverage for expenses charged to an **Minor Dependent Insured** or any payment obligation for **Us** under the **Policy** for any of the following, all of which are excluded from coverage:

- the amount of any professional fees or other medical expenses or charges for treatments, care, procedures, services or supplies which do not constitute **Covered Expenses**; • **Covered Expenses** incurred before the **Policy Issue Date**; • the amount of any professional fees or other medical expenses contained on a billing statement to an **Minor Dependent Insured** which exceed the amount of the **Maximum Allowable Charge**; • any professional fees or other medical expenses for treatments, care, procedures, services or supplies which are not specifically enumerated in the **SICKNESS AND INJURY BENEFITS**, or **WELLNESS AND SCREENING BENEFITS** Sections of this **Policy** and any optional coverage rider attached hereto; • **Covered Expenses You** or **Your** covered family members are not required to pay, which are covered by other insurance, or that would not have been billed if no insurance existed; • any professional fees or expenses for which the **Minor Dependent Insured** and/or any covered family member are not legally liable for payment; • any professional fees or expenses for which the **Minor Dependent Insured** and/or any covered family member were once legally liable for payment, but from which liability the **Minor Dependent Insured** and/or family member were released; • treatment of the teeth, the surrounding tissue or structure,

including the gums and tooth sockets. This exclusion does not apply to treatment: (a) due to **Injury** to natural teeth (treatment must be **Provided** within ninety (90) days of the date of the **Injury**); (b) for malignant tumors, or (c) which are otherwise **Provided** for in the SICKNESS AND INJURY BENEFITS section of this **Policy**; • **Injury** or **Sickness** due to any act of war (whether declared or undeclared); • services provided by any state or Federal government agency, including the Veterans Administration unless, by law, an **Minor Dependent Insured** must pay for such services; • **Covered Expenses** that are payable under any motor vehicle no fault law insurance policy or certificate; • charges that are payable or reimbursable by either: a) a plan or program of any governmental agency (except Medicaid), or b) **Medicare** Part A, Part B and/or Part D (If the applicable **Minor Dependent Insured** does not enroll in **Medicare**, **We** will estimate the charges that would have been paid if such enrollment had occurred); • drugs or medication not used for a Food and Drug Administration (FDA) approved use or indication, unless used for the treatment of cancer or HIV; • administration of experimental drugs or substances or investigational use or experimental use of **Prescription Drugs** except for any **Prescription Drug** prescribed to treat a covered chronic, disabling, life-threatening **Sickness** or **Injury**, but only if the investigational or experimental drug in question: a) has been approved by the FDA for at least one indication; and b) is recognized for treatment of the indication for which the drug is prescribed in: 1) a standard drug reference compendia; or 2) substantially accepted peer-reviewed medical literature. c) drugs labeled "Caution – limited by Federal law to investigational use"; • experimental procedures or treatment methods not approved by the American Medical Association or other appropriate medical society; • any **Injury** or **Sickness** covered by any Workers' Compensation insurance coverage, or similar coverage underwritten in connection with any Occupational Disease Law, or Employer's Liability Law, regardless of whether you file a claim for benefits thereunder; • eyeglasses, contact lenses, radial keratotomy, lasik surgery, hearing aids and exams for their prescription or fitting, except as **Provided** for in the SICKNESS AND INJURY BENEFITS and WELLNESS AND SCREENING BENEFITS sections of this **Policy**; • any damage or harm to the physical structure of the body of an **Minor Dependent Insured** occurring while the **Minor Dependent Insured** is intoxicated or under the influence of alcohol or any drug, narcotic or hallucinogens unless administered via a prescription and on the advice of a **Provider**, and taken in accordance with the limits of such advice. An **Minor Dependent Insured** is conclusively determined to be intoxicated by drug or alcohol if (i) a chemical test administered in the jurisdiction where either the **Accident** occurred or the **Minor Dependent Insured** was medically treated is at or above the legal limit set by that jurisdiction or (ii) the level of alcohol was such that a person's coordination, ability to reason, was impaired, regardless of the legal limit set by that jurisdiction; • intentionally self-inflicted **Injury**, suicide or any suicide attempt while sane or insane; • serving in one of the branches of the armed forces of any foreign country or any international authority; • voluntary abortions, abortifacients or any other drug or device that terminates a pregnancy; • services **Provided** by **You** or a **Provider** who is a member of an **Minor Dependent Insured's** family; • any loss to which a contributing cause was the **Minor Dependent Insured's** being engaged in or attempting to engage in an illegal occupation or illegal activity; • participation in aviation, except as fare-paying passenger traveling on a regular scheduled commercial airline flight; • cosmetic surgery or reconstructive procedures, except for **Medically Necessary** cosmetic surgery or reconstructive procedures performed under the following circumstances: (i) where such cosmetic surgery is incidental to or following surgery resulting from trauma or infection; (ii) to correct a normal bodily function; or (iii) such cosmetic surgery constitutes **Breast Reconstruction** that is incident to a **Mastectomy**; provided any of the above occurred while the **Minor Dependent Insured** was covered under this **Policy**; • Charges for breast reduction or augmentation or complications arising from these procedures; • **Prescription Drugs** or other medicines and products used for cosmetic purposes or indications; • reversal or attempted reversal of a previous elective attempt to induce or facilitate sterilization; • fertility hormone therapy and/or fertility devices for any type fertility therapy, artificial insemination or any other direct conception; • any operation or treatment performed, **Prescription** or medication prescribed in connection with sex transformations or any type of sexual or erectile dysfunction, including complications arising from any such operation or treatment; • infertility services, including the treatment of male and female infertility; • appetite suppressants, including but not limited to, anorectics or any other drugs used for the purpose of weight control, or services, or treatments; • **Prescriptions**, treatment or services for behavioral or learning disorders, Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD); • any professional fees or other medical expenses incurred as the result of an **Injury** which was caused or contributed by an **Minor Dependent Insured** racing any land or water vehicle; • any professional fees or other medical expenses incurred for the diagnosis, care or treatment of **Serious Mental Illness** and **Substance Abuse** except as **Provided** for in the SICKNESS AND INJURY BENEFITS

section of this **Policy**; • **Outpatient Prescription Drugs** that are dispensed by a **Provider, Hospital** or other state-licensed facility; • **Prescription Drugs** produced from blood, blood plasma and blood products, derivatives, Hemofil M, Factor VIII, and synthetic blood products, or immunization agents, biological or allergy sera, hematinics, blood or blood products administered on an **Outpatient** basis; • level one controlled substances; • **Prescription Drugs** used to treat or cure hair loss or baldness; • compounded **Prescription Drugs**; • fluoride products; • allergy kits intended for future emergency treatment of possible future allergic reactions; • replacement of a prior filled prescription for **Prescription Drugs** that was covered and is replaced because the original prescription was lost, stolen or damaged; • **Prescription Drugs**, which have an over the counter equivalent that may be obtained without a **Prescription**, even though such **Prescription Drugs** were prescribed by a **Provider**; • any intentional misuse or abuse of **Prescription Drugs**, including **Prescription Drugs** purchased by an **Minor Dependent Insured** for consumption by someone other than such **Minor Dependent Insured**; • **Prescription Drugs** that are classified as anti-fungal medication used for treatment of onychomycosis; • **Prescription Drugs** that are classified as tobacco cessation products; • charges for blood, blood plasma, or derivatives that has been replaced; • Temporomandibular Joint Disorder (TMJ) and Craniomandibular Disorder (CMD), except as **Provided** for in the SICKNESS AND INJURY BENEFITS section of this **Policy**; • services or supplies for personal convenience, including custodial care or homemaker services; • treatment received outside of the United States; • bariatric surgery, including but not limited to, open vertical banded gastroplasty, laparoscopic vertical banded gastroplasty, open sleeve gastrectomy, laparoscopic sleeve gastrectomy, and open adjustable gastric banding; • any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations, except as **Provided** for in the **Benefit** entitled **Substance Abuse Services** section of this **Policy**; • any services for treatment of **Mental and Emotional Disorders** that have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain; • services for treatment of chronic mental conditions not subject to favorable modification according to generally accepted standards of medical practice; • services for developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders; developmental language disorders, or articulation disorders; • services for counseling for the following: for activities of an educational nature, for borderline intellectual functioning, for occupational problems and for any relation to consciousness raising; • services for vocational or religious counseling; • I.Q. testing; • services for occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline; • services for biofeedback are not covered for reasons other than pain management; • treatment for **Autism Spectrum Disorder** performed by the following: Sensory Integration, LOVAAS Therapy and Music Therapy; • non-medical ancillary services including, but not limited to, vocational rehabilitation, behavioral training, sleep therapy, employment counseling, driving safety, and services, training or educational therapy for learning disabilities, developmental delays, and mental retardation; • purchase or rental of **Durable Medical Equipment** and prosthetics are not covered when due to misuse, damage and replacement when lost; • miscellaneous charges while lodging, including but not limited to personal convenience items movies, wireless internet, telephone, radio, cleaning supplies and shipping charges; • routine foot care, except as **Provided** for in the SUPPLIES AND SERVICES ASSOCIATED WITH THE TREATMENT OF DIABETES section of the **Policy**.

NON-WAIVER

Expenses that are mistakenly applied by **Us** to the **Calendar Year Deductible** or erroneously paid by **Us** under any Section or provision of this **Policy** [including **Prescription Drugs**] shall not: • constitute a waiver of or modification to any conditions, terms, definitions or limitations contained in the **Policy**, specifically including, but not by way of limitation, the definitions of **Sickness** and **Injury**, as well as any exclusion, limitation and/or exclusionary riders which may be attached to the **Policy**, or otherwise operate to alter, amend, affect, abridge or modify the **Policy** to which it is attached; • create or establish coverage of any medical condition illness, disease or injury under the **Policy** or under any exclusion, limitation and/or exclusionary riders which may be attached to the **Policy**; or • affect, alter, amend, abridge, constitute or act as a waiver of the **Company's** ability to rely upon, assert and apply such terms, definitions, limitations or exclusions of the **Policy** or any amendments thereto.

D. RENEWABILITY

The **Policy** is guaranteed renewable, subject to the **Company's** right to adjust **Renewal Premiums** and discontinue or terminate the **Policy** as provided in the **Policy**. The **Initial Premium** for coverage of all **Minor Dependent Insureds** under the **Policy** is due and payable on or before the **Issue Date**. **Renewal Premiums** are due and payable in accordance with the terms set forth in the **Policy**. You may renew coverage under the **Policy**, as applicable, by timely payment of the proper amount of **Renewal Premium** when due or within the grace period.

You will be given a grace period of thirty-one (31) days following the premium due date to pay **Your** premium. The **Policy** will remain in effect during the grace period.

- E. RIGHT TO RETURN POLICY** - If **You** are not satisfied with the **Policy**, **You** may return it to **Us** within thirty (30) days after **You** receive it. **You** may return it to **Us** by mail or to the agent who sold it. **We** will then refund any premiums paid and the **Policy** will be voided as of the **Issue Date**.

I. Policy Schedule

A. GENERAL INFORMATION

Policy form: [EHBC-2014-IP-AR-FLIC-1]

Primary Insured: []

Age at Issue: []

Policy Number: []

Issue Date: []

Other Insureds on Issue Date:
[]

Beneficiary: []

Initial Premium: []

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

First Renewal Date: []

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

B. COVERAGE SCHEDULES

[1]. DEDUCTIBLE SCHEDULES:

The following deductibles are to be paid by the **Insured** in addition to the **Insured Coinsurance Percentage** before any **Sickness and Injury Benefits** or **Wellness and Screening Benefits** are payable by **Us** for **Covered Expenses**:

- A. **Calendar Year Deductible per Insured:** \$6,250; and
- B. **Separate Deductible For Non-Participating Providers:** \$18,750

[2]. COINSURANCE PAYMENT SCHEDULES – PARTICIPATING PROVIDERS AND PARTICIPATING PHARMACIES:

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

- A. **Company Insurance Percentage:** 100%
(**Sickness and Injury Benefits** and **Wellness and Screening Benefits**)
- B. **Insured Coinsurance Percentage:** 0%; and
(**Sickness and Injury Benefits** and **Wellness and Screening Benefits**)
- C. **Insured Maximum Participating Provider Coinsurance Payment:** \$6,250

[3]. COINSURANCE PAYMENT SCHEDULES – NON-PARTICIPATING PROVIDERS AND NON-PARTICIPATING PHARMACIES:

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

- A. **Company Insurance Percentage:** 100%
(**Sickness and Injury Benefits** and **Wellness and Screening Benefits**)
- B. **Insured Coinsurance Percentage:** 0%; and
(**Sickness and Injury Benefits** and **Wellness and Screening Benefits**)
- C. **Insured Maximum Non-Participating Provider Coinsurance Payment:** \$18,750

I. Policy Schedule

A. GENERAL INFORMATION

Policy form: [EHBC-2014-IP-AR-FLIC-2]

Primary Insured: []

Age at Issue: []

Policy Number: []

Issue Date: []

Other Insureds on Issue Date:
[]
[]

Beneficiary: []

Initial Premium: []

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

First Renewal Date: []

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

B. COVERAGE SCHEDULES

[1]. DEDUCTIBLE SCHEDULES:

The following deductibles are to be paid by the **Insured** in addition to the **Insured Coinsurance Percentage** before any **Sickness and Injury Benefits** or **Wellness and Screening Benefits** are payable by **Us** for **Covered Expenses**:

- A. **Calendar Year Deductible per Insured:** \$3,500; and
- B. **Separate Deductible For Non-Participating Providers:** \$10,500

[2]. COINSURANCE PAYMENT SCHEDULES – PARTICIPATING PROVIDERS AND PARTICIPATING PHARMACIES:

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

- A. **Company Insurance Percentage:** 100%
(**Sickness and Injury Benefits** and **Wellness and Screening Benefits**)
- B. **Insured Coinsurance Percentage:** 0%; and
(**Sickness and Injury Benefits** and **Wellness and Screening Benefits**)
- C. **Insured Maximum Participating Provider Coinsurance Payment:** \$3,500

[3]. COINSURANCE PAYMENT SCHEDULES – NON-PARTICIPATING PROVIDERS AND NON-PARTICIPATING PHARMACIES:

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

- A. **Company Insurance Percentage:** 100%
(**Sickness and Injury Benefits** and **Wellness and Screening Benefits**)
- B. **Insured Coinsurance Percentage:** 0%; and
(**Sickness and Injury Benefits** and **Wellness and Screening Benefits**)
- C. **Insured Maximum Non-Participating Provider Coinsurance Payment:** \$10,500

I. Policy Schedule

A. GENERAL INFORMATION

Policy form: [EHBC-2014-IP-AR-FLIC-3]

Primary Insured: []

Age at Issue: []

Policy Number: []

Issue Date: []

Other Insureds on Issue Date:
[]

Beneficiary: []

Initial Premium: []

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

First Renewal Date: []

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

B. COVERAGE SCHEDULES

[1]. DEDUCTIBLE SCHEDULES:

The following deductibles are to be paid by the **Insured** in addition to the **Insured Coinsurance Percentage** before any **Sickness and Injury Benefits** or **Wellness and Screening Benefits** are payable by **Us** for **Covered Expenses**:

- A. **Calendar Year Deductible per Insured:** \$2,000; and
- B. **Separate Deductible For Non-Participating Providers:** \$6,000

[2]. COINSURANCE PAYMENT SCHEDULES – PARTICIPATING PROVIDERS AND PARTICIPATING PHARMACIES:

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

- A. **Company Insurance Percentage:** 100%
(**Sickness and Injury Benefits** and **Wellness and Screening Benefits**)
- B. **Insured Coinsurance Percentage:** 0%; and
(**Sickness and Injury Benefits** and **Wellness and Screening Benefits**)
- C. **Insured Maximum Participating Provider Coinsurance Payment:** \$2,000

[3]. COINSURANCE PAYMENT SCHEDULES – NON-PARTICIPATING PROVIDERS AND NON-PARTICIPATING PHARMACIES:

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

- A. **Company Insurance Percentage:** 100%
(**Sickness and Injury Benefits** and **Wellness and Screening Benefits**)
- B. **Insured Coinsurance Percentage:** 0%; and
(**Sickness and Injury Benefits** and **Wellness and Screening Benefits**)
- C. **Insured Maximum Non-Participating Provider Coinsurance Payment:** \$6,000

I. Policy Schedule

A. GENERAL INFORMATION

Policy form: [EHBC-2014-IP-AR-FLIC-4]

Primary Insured: []

Age at Issue: []

Policy Number: []

Issue Date: []

Other Insureds on Issue Date:
[]

Beneficiary: []

Initial Premium: []

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

First Renewal Date: []

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

B. COVERAGE SCHEDULES

[1]. DEDUCTIBLE SCHEDULES:

The following deductibles are to be paid by the **Insured** in addition to the **Insured Coinsurance Percentage** before any **Sickness and Injury Benefits** or **Wellness and Screening Benefits** are payable by **Us** for **Covered Expenses**:

- A. **Calendar Year Deductible per Insured:** \$950; and
- B. **Separate Deductible For Non-Participating Providers:** \$2,850

[2]. COINSURANCE PAYMENT SCHEDULES – PARTICIPATING PROVIDERS AND PARTICIPATING PHARMACIES:

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

- A. **Company Insurance Percentage:** 100%
(**Sickness and Injury Benefits** and **Wellness and Screening Benefits**)
- B. **Insured Coinsurance Percentage:** 0%; and
(**Sickness and Injury Benefits** and **Wellness and Screening Benefits**)
- C. **Insured Maximum Participating Provider Coinsurance Payment:** \$950

[3]. COINSURANCE PAYMENT SCHEDULES – NON-PARTICIPATING PROVIDERS AND NON-PARTICIPATING PHARMACIES:

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

- A. **Company Insurance Percentage:** 100%
(**Sickness and Injury Benefits** and **Wellness and Screening Benefits**)
- B. **Insured Coinsurance Percentage:** 0%; and
(**Sickness and Injury Benefits** and **Wellness and Screening Benefits**)
- C. **Insured Maximum Non-Participating Provider Coinsurance Payment:** \$2,850

SERFF Tracking #:

USHG-129213923

State Tracking #:

ACA OFF EXCHANGE CHILD ONLY

Company Tracking #:

EHBC-2014-IP-AR-FLIC

State: Arkansas

Filing Company:

Freedom Life Insurance Company of America

TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)

Product Name: EHBC-2014-IP-AR-FLIC

Project Name/Number: EHBC-2014-IP-AR-FLIC/EHBC-2014-IP-AR-FLIC

Rate Information

Rate data applies to filing.

Filing Method: SERFF

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 req'd):	Minimum % Change (where req'd):
Freedom Life Insurance Company of America	New Product	0.000%	0.000%	\$0	0	\$0	0.000%	0.000%

Product Type:	HMO	PPO	EPO	POS	HSA	HDHP	FFS	Other
Covered Lives:								
Policy Holders:								

State: Arkansas Filing Company: Freedom Life Insurance Company of America
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: EHBC-2014-IP-AR-FLIC
Project Name/Number: EHBC-2014-IP-AR-FLIC/EHBC-2014-IP-AR-FLIC

Rate Review Detail

COMPANY:

Company Name: Freedom Life Insurance Company of America
HHS Issuer Id: 61273
Product Names: EHBC-2014-IP-AR-FLIC
Trend Factors: An underlying base trend of 10% was assumed in the pricing of this product.

FORMS:

New Policy Forms: EHBC-2014-IP-AR-FLIC
Affected Forms:
Other Affected Forms:

REQUESTED RATE CHANGE INFORMATION:

Change Period: Annual
Member Months: 0
Benefit Change: None
Percent Change Requested: Min: 0.0 Max: 0.0 Avg: 0.0

PRIOR RATE:

Total Earned Premium: 0.00
Total Incurred Claims: 0.00
Annual \$: Min: 0.00 Max: 0.00 Avg: 0.00

REQUESTED RATE:

Projected Earned Premium: 11,523.00
Projected Incurred Claims: 8,757.00
Annual \$: Min: 142.81 Max: 228.28 Avg: 151.62

SERFF Tracking #:

USHG-129213923

State Tracking #:

ACA OFF EXCHANGE CHILD ONLY

Company Tracking #:

EHBC-2014-IP-AR-FLIC

State:

Arkansas

Filing Company:

Freedom Life Insurance Company of America

TOI/Sub-TOI:

H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)

Product Name:

EHBC-2014-IP-AR-FLIC

Project Name/Number:

EHBC-2014-IP-AR-FLIC/EHBC-2014-IP-AR-FLIC

Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments
1		2014 EHBC Rates	EHBC-2014-IP-AR-FLIC	New		20140101_EHBC-2014-IP-AR-FLIC_Rate_Pages.pdf,

Freedom Life Insurance Company of America
Rating Factors for Forms EHB-2014-IP-AR-FLIC & EHBC-2014-IP-AR-FLIC

Attained Age	Factor
0 - 20	0.635
21	1.000
22	1.000
23	1.000
24	1.000
25	1.004
26	1.024
27	1.048
28	1.087
29	1.119
30	1.135
31	1.159
32	1.183
33	1.198
34	1.214
35	1.222
36	1.230
37	1.238
38	1.246
39	1.262
40	1.278
41	1.302
42	1.325
43	1.357
44	1.397
45	1.444
46	1.500
47	1.563
48	1.635
49	1.706
50	1.786
51	1.865
52	1.952
53	2.040
54	2.135
55	2.230
56	2.333
57	2.437
58	2.548
59	2.603
60	2.714
61	2.810
62	2.873
63	2.952
64 +	3.000

Monthly Base Rate	\$385.82
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1/1/2014 Trend Factor	1.00
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2014 Reinsurance Factor	0.918
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Tobacco User Factor	1.20
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AV Pricing Factors	
Bronze	0.635
Silver	0.751
Gold	0.877
Platinum	1.015

Modal Factors	
Quarterly	3
Semi-Annual	6
Annual	12

A rate is calculated for each individual on the policy. However, only the oldest three child dependents under age 21 will be charged a premium rate.

Actual final rate may vary due to rounding.

Freedom Life Insurance Company of America
Area Factors for Forms EHB-2014-IP-AR-FLIC & EHBC-2014-IP-AR-FLIC

State Rating Area	Area Factor
1	1.035
2	0.945
3	0.934
4	1.089
5	1.043
6	1.063
7	0.852

State: Arkansas **Filing Company:** Freedom Life Insurance Company of America
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: EHBC-2014-IP-AR-FLIC
Project Name/Number: EHBC-2014-IP-AR-FLIC/EHBC-2014-IP-AR-FLIC

Supporting Document Schedules

Bypassed - Item:	Health - Actuarial Justification
Bypass Reason:	See Part III Actuarial Memorandum attached in Actuarial Memorandum and Certifications section.
Attachment(s):	
Item Status:	Approved-Closed
Status Date:	10/30/2013

Satisfied - Item:	Flesch Certification
Comments:	Please see attached Readability Certification.
Attachment(s):	Readability Cert.pdf
Item Status:	Approved-Closed
Status Date:	10/30/2013

Satisfied - Item:	Application
Comments:	Please see attached Application.
Attachment(s):	
Item Status:	Approved-Closed
Status Date:	10/30/2013

Satisfied - Item:	Outline of Coverage
Comments:	Please see attached Outline of Coverage.
Attachment(s):	
Item Status:	Approved-Closed
Status Date:	10/30/2013

Satisfied - Item:	Unified Rate Review Template
Comments:	

State: Arkansas **Filing Company:** Freedom Life Insurance Company of America
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: EHBC-2014-IP-AR-FLIC
Project Name/Number: EHBC-2014-IP-AR-FLIC/EHBC-2014-IP-AR-FLIC

Attachment(s):	URRT AR FLIC 09_25_2013 11 03.xlsm UnifiedRateReviewSubmission_2013092511413.xml
Item Status:	Approved-Closed
Status Date:	10/30/2013

Satisfied - Item:	PPACA Uniform Compliance Summary
Comments:	Please see attached PPACA Uniform Compliance Summary.
Attachment(s):	PPACA Uniform Compliance Survey.pdf
Item Status:	Approved-Closed
Status Date:	10/30/2013

Bypassed - Item:	Consumer Disclosure Form
Bypass Reason:	Not yet available.
Attachment(s):	
Item Status:	Approved-Closed
Status Date:	10/30/2013

Satisfied - Item:	Cover Letter
Comments:	Please see attached cover letter.
Attachment(s):	AR Cover Letter Child Only.pdf
Item Status:	Approved-Closed
Status Date:	10/30/2013

Satisfied - Item:	Demonstration of In-Network versus Out-Of-Network PPO Penalty Compliance
Comments:	
Attachment(s):	AR EHB-2014 PPO Penalty Compliance Demonstration.pdf
Item Status:	Approved-Closed
Status Date:	10/30/2013

State: Arkansas **Filing Company:** Freedom Life Insurance Company of America
TOI/Sub-TOI: H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)
Product Name: EHBC-2014-IP-AR-FLIC
Project Name/Number: EHBC-2014-IP-AR-FLIC/EHBC-2014-IP-AR-FLIC

Satisfied - Item:	Coverage Schedule 1
Comments:	Please see attached Coverage Schedule 1, related to EHBC-2014-IP-AR-FLIC.
Attachment(s):	Coverage Schedule 1.pdf
Item Status:	Approved-Closed
Status Date:	10/30/2013

Satisfied - Item:	Coverage Schedule 2
Comments:	Please see attached Coverage Schedule 2, related to EHBC-2014-IP-AR-FLIC.
Attachment(s):	Coverage Schedule 2.pdf
Item Status:	Approved-Closed
Status Date:	10/30/2013

Satisfied - Item:	Coverage Schedule 3
Comments:	Please see attached Coverage Schedule 2, related to EHBC-2014-IP-AR-FLIC.
Attachment(s):	Coverage Schedule 3.pdf
Item Status:	Approved-Closed
Status Date:	10/30/2013

Satisfied - Item:	Coverage Schedule 4
Comments:	Please see attached Coverage Schedule 2, related to EHBC-2014-IP-AR-FLIC.
Attachment(s):	Coverage Schedule 4.pdf
Item Status:	Approved-Closed
Status Date:	10/30/2013

Satisfied - Item:	Response Letter 10-4-13
Comments:	
Attachment(s):	Response Letter 10-4-13.doc.pdf
Item Status:	Approved-Closed

SERFF Tracking #:

USHG-129213923

State Tracking #:

ACA OFF EXCHANGE CHILD ONLY

Company Tracking #:

EHBC-2014-IP-AR-FLIC

State:

Arkansas

Filing Company:

Freedom Life Insurance Company of America

TOI/Sub-TOI:

H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)

Product Name:

EHBC-2014-IP-AR-FLIC

Project Name/Number:

EHBC-2014-IP-AR-FLIC/EHBC-2014-IP-AR-FLIC

Status Date:	10/30/2013
Satisfied - Item:	Response Letter & Attachment 10-18-13
Comments:	
Attachment(s):	20131010 Arkansas Objection Response Final.pdf AR Objection Response.xlsx
Item Status:	Approved-Closed
Status Date:	10/30/2013
Satisfied - Item:	Objection Letter & Response 10-21-13
Comments:	
Attachment(s):	FLICA 129213923 RAI_10-21-2013 Objection & Response.pdf
Item Status:	Approved-Closed
Status Date:	10/30/2013

SERFF Tracking #:

USHG-129213923

State Tracking #:

ACA OFF EXCHANGE CHILD ONLY

Company Tracking #:

EHBC-2014-IP-AR-FLIC

State:

Arkansas

Filing Company:

Freedom Life Insurance Company of America

TOI/Sub-TOI:

H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)

Product Name:

EHBC-2014-IP-AR-FLIC

Project Name/Number:

EHBC-2014-IP-AR-FLIC/EHBC-2014-IP-AR-FLIC

Attachment URRT AR FLIC 09_25_2013 11 03.xlsm is not a PDF document and cannot be reproduced here.

Attachment UnifiedRateReviewSubmission_2013092511413.xml is not a PDF document and cannot be reproduced here.

Attachment AR Objection Response.xlsx is not a PDF document and cannot be reproduced here.

FREEDOM LIFE INSURANCE COMPANY OF AMERICA

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

READABILITY CERTIFICATION

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

<u>Form Number</u>	<u>Flesch Score</u>
EHBC-2014-IP-AR-FLIC	43.25

Name: Ranita Grauwiler

Signature:  _____

Title: Vice President – Product Development

Dated: September 20, 2013

PPACA Uniform Compliance Summary

Please select the appropriate check box below to indicate which product is amended by this filing.

- INDIVIDUAL HEALTH BENEFIT PLANS** (Complete [SECTION A](#) only)
- SMALL / LARGE GROUP HEALTH BENEFIT PLANS** (Complete [SECTION B](#) only)

This form filing compliance summary is to be submitted with your [endorsement][contract] to comply with the immediate market reform requirements of the Patient Protection and Affordable Care Act (PPACA). These PPACA requirements apply only to policies for health insurance coverage referred to as “major medical” in the statute, which is comprehensive health coverage that includes PPO and HMO coverage. This form includes the requirements for grandfathered (coverage in effect prior to March 23, 2010) and non-grandfathered plans, and relevant statutes. Refer to the relevant statute to ensure compliance. Complete each item to confirm that diligent consideration has been given to each. *(If submitting your filings electronically, bookmark the provision(s) in the form(s) that satisfy the requirement and identify the page/paragraph on this form.)*

***For all filings, include the Type of Insurance (TOI) in the first column.**

Check box if this is a paper filing.

COMPANY INFORMATION

Company Name	NAIC Number	SERFF Tracking Number(s) *if applicable	Form Number(s) of Policy being endorsed	Rate Impact
Freedom Life Insurance Company of America	62324	USHG-129213923	EHBC-2014-IP-AR-FLIC	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No

PPACA Uniform Compliance Summary

Reset Form

SECTION A – Individual Health Benefit Plans

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
Individual Major Medical PPO	Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19	<i>[Sections 2704 and 1255 of the PHSA/Section 1201 of the PPACA]</i>	N/A	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation: No pre-existing condition exclusions			
	Page Number:			
Individual Major Medical PPO	Eliminate Annual Dollar Limits on Essential Benefits Except allows for “restricted” annual dollar limits for essential benefits for plan years prior to January 1, 2014.	<i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation: No annual dollar limits on essential benefits			
	Page Number:			
Individual Major Medical PPO	Eliminate Lifetime Dollar Limits on Essential Benefits	<i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation: No lifetime dollar limits on essential benefits.			
	Page Number:			
Individual Major Medical PPO	Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.	<i>[Section 2712 of the PHSA/Section 1001 of PPACA]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation: Not applicable.			
	Page Number:			

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
Individual Major Medical PPO	Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services.	<i>[Section 2713 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number: pp. 33-36			
Individual Major Medical PPO	Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26.	<i>[Section 2714 of the PHSA/Section 1001 of the PPACA]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number: p. 17			
Individual Major Medical PPO	Appeals Process – Requires establishment of an internal claims appeal process and external review process.	<i>[Section 2719 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number: pp. 41-45			
Individual Major Medical PPO	Emergency Services – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.	<i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i>	N/A	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number: p. 26			

PPACA Uniform Compliance Summary

SECTION A – Individual Health Benefit Plans

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
Individual Major Medical PPO	Access to Pediatricians – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child’s PCP if the provider is in-network.	<i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i>	N/A	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation: No designation required.			
	Page Number:			
Individual Major Medical PPO	Access to OB/GYNs – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.	<i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i>	N/A	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation: No referral requirements required.			
	Page Number:			

PPACA Uniform Compliance Summary

Reset Form

SECTION B – Group Health Benefit Plans (Small and Large)				
TOI	Category	Statute Section	Grandfathered	Non-Grandfathered

	Eliminate Pre-existing Condition Exclusions for Enrollees Under Age 19	<i>[Sections 2704 of the PHSA/Section 1201 of the PPACA]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			
	Eliminate Annual Dollar Limits on Essential Benefits – Except allows for “restricted” annual dollar limits for essential benefits for plan years prior to January 1, 2014.	<i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			
	Eliminate Lifetime Dollar Limits on Essential Benefits	<i>[Section 2711 of the PHSA/Section 1001 of the PPACA]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			
	Prohibit Rescissions – Except for fraud or intentional misrepresentation of material fact.	<i>[Section 2712 of the PHSA/Section 1001 of PPACA]</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Explanation:			
	Page Number:			

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	Preventive Services – Requires coverage and prohibits the imposition of cost-sharing for specified preventative services Explanation: Page Number:	<i>[Section 2713 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Extends Dependent Coverage for Children Until age 26 – If a policy offers dependent coverage, it must include dependent coverage until age 26. ◇ Explanation: Page Number:	<i>[Section 2714 of the PHSA/Section 1001 of the PPACA]</i>	<input type="checkbox"/> Yes [◇] <input type="checkbox"/> No If no , please explain.	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.
	Appeals Process – Requires establishment of an internal claims appeal process and external review process. Explanation: Page Number:	<i>[Section 2719 of the PHSA/Section 1001 of the PPACA]</i>	N/A	<input type="checkbox"/> Yes <input type="checkbox"/> No If no , please explain.

◇ For plan years beginning before January 1, 2014, grandfathered group plans are not required to extend coverage to a child until the age of 26 if such child is eligible to enroll in another employee-sponsored plan

PPACA Uniform Compliance Summary

SECTION B – Group Health Benefit Plans (Small and Large)

TOI	Category	Statute Section	Grandfathered	Non-Grandfathered
	<p>Emergency Services – Requires plans that cover emergency services to provide such coverage without the need for prior authorization, regardless of the participating status of the provider, and at the in-network cost-sharing level.</p> <p>Explanation:</p> <p>Page Number:</p>	<p><i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i></p>	N/A	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If no, please explain.</p>
	<p>Access to Pediatricians – Mandates that if designation of a PCP for a child is required, the person be permitted to designate a physician who specialized in pediatrics as the child’s PCP if the provider is in-network.</p> <p>Explanation:</p> <p>Page Number:</p>	<p><i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i></p>	N/A	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If no, please explain.</p>
	<p>Access to OB/GYNs – Prohibits authorization or referral requirements for obstetrical or gynecological care provided by in-network providers who specialize in obstetrics or gynecology.</p> <p>Explanation:</p> <p>Page Number:</p>	<p><i>[Section 2719A of the PHSA/Section 10101 of the PPACA]</i></p>	N/A	<p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If no, please explain.</p>

FREEDOM LIFE INSURANCE COMPANY OF AMERICA

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

September 23, 2013

Commissioner Jay Bradford
Commissioner of Insurance
1200 West Third Street
Little Rock, AR 72201-1904

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

New Submission

EHBC-2014-IP-AR-FLIC
EHBAPP-2014-FLIC

Essential Health Benefits Policy
Application

Dear Commissioner Bradford:

The forms listed above are hereby submitted for your review and approval. The forms are new and are not intended to replace any forms previously filed with your Department.

Form EHBC-2014-IP-AR-FLIC is an individual, child-only essential health benefits major medical policy that provides benefits for medical and surgical expenses on an inpatient and outpatient basis, subject to the provisions and limitations set forth therein. Benefits are provided for both participating and non-participating providers. The policy will be marketed to individuals, by licensed agents in your state, using form EHBAPP-2014-NOARB-FLIC, listed above and simultaneously submitted for approval by your Department. This policy is not intended to be sold on the exchange.

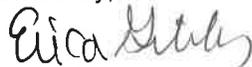
Form 3453-P-FLIC-A was previously filed with your Department on August 25, 2005 and will be available for use with the above policy form.

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

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

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

Sincerely,



Erica Gibbs
Product Analyst
Phone: 817-878-3327
gibbse@ushealthgroup.com

Freedom Life Insurance Company

Arkansas Forms EHB-2014-IP-AR-FLIC & EHBC-2014-IP-AR-FLIC PPO In-Network Versus Out-of-Network Compliance Demonstration

Insured Deductible		Insured Coinsurance Percentage		Insured Coinsurance Maximum Out of Pocket		Insured Annual Maximum Out of Pocket		Average Claims Paid		Ratio
In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network vs. Out-of-Network
\$950	\$2,850	0%	0%	\$0	\$0	\$950	\$2,850	\$8,409	\$7,452	11.39%
\$2,000	\$6,000	0%	0%	\$0	\$0	\$2,000	\$6,000	\$7,827	\$6,460	17.46%
\$3,500	\$10,500	0%	0%	\$0	\$0	\$3,500	\$10,500	\$7,207	\$5,516	23.46%
\$6,250	\$15,400	0%	0%	\$0	\$0	\$6,250	\$15,400	\$6,397	\$4,808	24.84%

* We have reduced the Out-of-Network deductible on the Bronze plan from \$18,750 to \$15,400 to be compliant with the 25% differential required by AR Reg. 23-98-102.

I. Policy Schedule

A. GENERAL INFORMATION

Policy form: [EHBC-2014-IP-AR-FLIC-1]

Primary Insured: []

Age at Issue: []

Policy Number: []

Issue Date: []

Other Insureds on Issue Date:
[]

Beneficiary: []

Initial Premium: []

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

First Renewal Date: []

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

B. COVERAGE SCHEDULES

[1]. DEDUCTIBLE SCHEDULES:

The following deductibles are to be paid by the **Insured** in addition to the **Insured Coinsurance Percentage** before any **Sickness and Injury Benefits** or **Wellness and Screening Benefits** are payable by **Us** for **Covered Expenses**:

- A. **Calendar Year Deductible per Insured:** \$6,250; and
- B. **Separate Deductible For Non-Participating Providers:** \$18,750

[2]. COINSURANCE PAYMENT SCHEDULES – PARTICIPATING PROVIDERS AND PARTICIPATING PHARMACIES:

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

- A. **Company Insurance Percentage:** 100%
(**Sickness and Injury Benefits** and **Wellness and Screening Benefits**)
- B. **Insured Coinsurance Percentage:** 0%; and
(**Sickness and Injury Benefits** and **Wellness and Screening Benefits**)
- C. **Insured Maximum Participating Provider Coinsurance Payment:** \$6,250

[3]. COINSURANCE PAYMENT SCHEDULES – NON-PARTICIPATING PROVIDERS AND NON-PARTICIPATING PHARMACIES:

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

- A. **Company Insurance Percentage:** 100%
(**Sickness and Injury Benefits** and **Wellness and Screening Benefits**)
- B. **Insured Coinsurance Percentage:** 0%; and
(**Sickness and Injury Benefits** and **Wellness and Screening Benefits**)
- C. **Insured Maximum Non-Participating Provider Coinsurance Payment:** \$18,750

I. Policy Schedule

A. GENERAL INFORMATION

Policy form: [EHBC-2014-IP-AR-FLIC-2]

Primary Insured: []

Age at Issue: []

Policy Number: []

Issue Date: []

Other Insureds on Issue Date:
[]
[]

Beneficiary: []

Initial Premium: []

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

First Renewal Date: []

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

B. COVERAGE SCHEDULES

[1]. DEDUCTIBLE SCHEDULES:

The following deductibles are to be paid by the **Insured** in addition to the **Insured Coinsurance Percentage** before any **Sickness and Injury Benefits** or **Wellness and Screening Benefits** are payable by **Us** for **Covered Expenses**:

- A. **Calendar Year Deductible per Insured:** \$3,500; and
- B. **Separate Deductible For Non-Participating Providers:** \$10,500

[2]. COINSURANCE PAYMENT SCHEDULES – PARTICIPATING PROVIDERS AND PARTICIPATING PHARMACIES:

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

- A. **Company Insurance Percentage:** 100%
(**Sickness and Injury Benefits** and **Wellness and Screening Benefits**)
- B. **Insured Coinsurance Percentage:** 0%; and
(**Sickness and Injury Benefits** and **Wellness and Screening Benefits**)
- C. **Insured Maximum Participating Provider Coinsurance Payment:** \$3,500

[3]. COINSURANCE PAYMENT SCHEDULES – NON-PARTICIPATING PROVIDERS AND NON-PARTICIPATING PHARMACIES:

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

- A. **Company Insurance Percentage:** 100%
(**Sickness and Injury Benefits** and **Wellness and Screening Benefits**)
- B. **Insured Coinsurance Percentage:** 0%; and
(**Sickness and Injury Benefits** and **Wellness and Screening Benefits**)
- C. **Insured Maximum Non-Participating Provider Coinsurance Payment:** \$10,500

I. Policy Schedule

A. GENERAL INFORMATION

Policy form: [EHBC-2014-IP-AR-FLIC-3]

Primary Insured: []

Age at Issue: []

Policy Number: []

Issue Date: []

Other Insureds on Issue Date:
[]

Beneficiary: []

Initial Premium: []

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

First Renewal Date: []

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

B. COVERAGE SCHEDULES

[1]. DEDUCTIBLE SCHEDULES:

The following deductibles are to be paid by the **Insured** in addition to the **Insured Coinsurance Percentage** before any **Sickness and Injury Benefits** or **Wellness and Screening Benefits** are payable by **Us** for **Covered Expenses**:

- A. **Calendar Year Deductible per Insured:** \$2,000; and
- B. **Separate Deductible For Non-Participating Providers:** \$6,000

[2]. COINSURANCE PAYMENT SCHEDULES – PARTICIPATING PROVIDERS AND PARTICIPATING PHARMACIES:

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

- A. **Company Insurance Percentage:** 100%
(**Sickness and Injury Benefits** and **Wellness and Screening Benefits**)
- B. **Insured Coinsurance Percentage:** 0%; and
(**Sickness and Injury Benefits** and **Wellness and Screening Benefits**)
- C. **Insured Maximum Participating Provider Coinsurance Payment:** \$2,000

[3]. COINSURANCE PAYMENT SCHEDULES – NON-PARTICIPATING PROVIDERS AND NON-PARTICIPATING PHARMACIES:

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

- A. **Company Insurance Percentage:** 100%
(**Sickness and Injury Benefits** and **Wellness and Screening Benefits**)
- B. **Insured Coinsurance Percentage:** 0%; and
(**Sickness and Injury Benefits** and **Wellness and Screening Benefits**)
- C. **Insured Maximum Non-Participating Provider Coinsurance Payment:** \$6,000

I. Policy Schedule

A. GENERAL INFORMATION

Policy form: [EHBC-2014-IP-AR-FLIC-4]

Primary Insured: []

Age at Issue: []

Policy Number: []

Issue Date: []

Other Insureds on Issue Date:
[]

Beneficiary: []

Initial Premium: []

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

First Renewal Date: []

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

B. COVERAGE SCHEDULES

[1]. DEDUCTIBLE SCHEDULES:

The following deductibles are to be paid by the **Insured** in addition to the **Insured Coinsurance Percentage** before any **Sickness and Injury Benefits** or **Wellness and Screening Benefits** are payable by **Us** for **Covered Expenses**:

- A. **Calendar Year Deductible per Insured:** \$950; and
- B. **Separate Deductible For Non-Participating Providers:** \$2,850

[2]. COINSURANCE PAYMENT SCHEDULES – PARTICIPATING PROVIDERS AND PARTICIPATING PHARMACIES:

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

- A. **Company Insurance Percentage:** 100%
(**Sickness and Injury Benefits** and **Wellness and Screening Benefits**)
- B. **Insured Coinsurance Percentage:** 0%; and
(**Sickness and Injury Benefits** and **Wellness and Screening Benefits**)
- C. **Insured Maximum Participating Provider Coinsurance Payment:** \$950

[3]. COINSURANCE PAYMENT SCHEDULES – NON-PARTICIPATING PROVIDERS AND NON-PARTICIPATING PHARMACIES:

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

- A. **Company Insurance Percentage:** 100%
(**Sickness and Injury Benefits** and **Wellness and Screening Benefits**)
- B. **Insured Coinsurance Percentage:** 0%; and
(**Sickness and Injury Benefits** and **Wellness and Screening Benefits**)
- C. **Insured Maximum Non-Participating Provider Coinsurance Payment:** \$2,850

FREEDOM LIFE INSURANCE COMPANY OF AMERICA

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

October 4, 2013

ATTN: Ms. Rosalind Minor
Arkansas Department of Insurance
1200 West Third Street
Little Rock, AR 72201-1904

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

SERFF Tracking #: USHG-129213923

Dear Ms. Minor:

Please accept this letter as our response to your objection letter dated October 3, 2013. For ease of review, I have restated the objections in italics and have addressed each objection as follows:

Objection 1

Does your policy provide for services provided in an after-hours or urgent care center? Also, are benefits provided for observation services ordered in conjunction with an emergency room visit or outpatient visit as outlined in the Benchmark Plan?

Yes, these benefits would be covered under our definition of Emergency Care Facility and Emergency Room Services:

Page 8:

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

Page 26:

10. EMERGENCY ROOM SERVICES

Services **Provided** by a **Hospital** or a **Provider** in the emergency room of the **Hospital** for the following items received by a **Minor Dependent Insured** on an **Emergency** basis:

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

This **Benefit** is not subject to the **Separate Deductible for Non-Participating Providers** or the **Non-Participating Provider Minor Dependent Insured Coinsurance Percentage**.

Objection 2

Under the Transplant provision on Page 25 of the policy, the amount of \$10,000 per transplant for covered expenses allowed for professional fees of a provider and facility fees appear to be a limitation not found in the Benchmark Plan.

This has been removed from our policy.

Objection 3

Does your policy provide benefits for In Vitro as required by ACA 23-85-137 and Rule and Regulation 1? Since In-Vitro is considered an EHB, there cannot be a limit of \$15,000.

Since this is a child-only policy, we do not think that covering in vitro fertilization is necessary as the person insured on a child-only policy is not the policyholder, but rather a minor dependent insured of the policyholder. ACA 23-85-137 calls for in vitro fertilization for a policyholder and their spouse only. We respectfully ask that you reconsider this objection.

Objection 4

Benefits must be covered for genetic testing to determine the presence of existing anomaly or disease.

Please see the added genetic testing benefit on page 34:

40. GENETIC TESTING

Genetic molecular testing and related counseling to determine the presence of an existing anomaly or disease.

Objection 5

With respect to Mental Health and Substance Use Disorder Treatment and in reviewing the plans, we have discovered Mental Health and Substance Use Disorder Treatment benefit offerings that do not meet the requirements of the Arkansas benchmark or federal standards. As such, we will require the following changes to your policies:

- *Eligible practitioners for professional services must include licensed mental health and substance abuse practitioners practicing within the scope of their license and according to the patient's specific treatment plan.*
- *Any services beyond outpatient diagnosis, treatment, crisis stabilization, medication management, psychological and neuropsychological testing services may be provided by an outpatient hospital or other covered facility. A plan may not restrict eligible facilities to hospitals and may not exclude licensed, accredited treatment modalities such as residential treatment. An eligible facility will be licensed by Arkansas and be accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), CARF International, or Council on Accreditation (COA) for the specific mental health or substance abuse treatment service it is providing (for example, outpatient, intensive outpatient, partial hospitalization, or residential treatment). It is expected that care is delivered in the least restrictive setting.*
- *Finally, the benchmark plan provides for coverage of family and marital counseling when provided as part of the treatment plan. This cannot be an excluded service*

We also want to bring to your attention that chronic substance use disorder is included in the final definition of medically frail and consumers with chronic substance use disorders will not be served by the Private Option.

Please see the amended language below.

Page 25:

6. INPATIENT TREATMENT OF MENTAL AND EMOTIONAL DISORDERS

Inpatient services Provided for a Minor Dependent Insured by a Provider licensed by the State of Arkansas and accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), CARF International, or Council on Accreditation (COA) for the

treatment and evaluation of **Mental and Emotional Disorders**.

Page 28-29:

20. OUTPATIENT TREATMENT OF MENTAL AND EMOTIONAL DISORDERS

Outpatient services Provided by a **Provider** licensed by the State of Arkansas and accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), CARF International, or Council on Accreditation (COA) for treatment of **Mental and Emotional Disorders**. Services include testing and evaluation for psychological testing, developmental testing, neurobehavioral testing, and neuropsychological testing, limited to fifteen (15) hours per **Minor Dependent Insured** per **Calendar Year**. Services for **Mental and Emotional Disorders** include family and marital counseling when provided as part of a treatment plan.

Page 31:

29. SUBSTANCE ABUSE SERVICES

Services **Provided** by a **Provider** licensed by the State of Arkansas and accredited by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), CARF International, or Council on Accreditation (COA) for the treatment of **Substance Abuse**. This includes rehabilitation services and residential services.

Objection 6

On Page 27, item 14, do you cover Specialist Office Visits under professional service provided by a provider. If so, please incorporate specialist into the language.

Our definition of Provider covers specialists and our policy does not require designations of providers or referrals to specialists. Please see the definition of provider from page 14:

“Provider” means any licensed practitioner of the healing arts as recognized by the laws of the state in which he or she practices medicine, in treating an **Injury** or **Sickness**. The **Provider** must be acting within the scope of such license while rendering **Medically Necessary** professional service to an **Insured**, and cannot be a member of the **Insured’s Family**.

Objection 7

With respect to Outpatient Therapy on Page 28, in reviewing plans, we have discovered that the habilitative developmental services benefit is not being offered at actuarial parity with rehabilitative or habilitative therapy services. Because carriers do not have experience providing developmental services, the AID directs carriers to develop a “multiplier” formula for determining service limits that are at parity with rehabilitative or habilitative therapy services in year one. For example, if a therapy visit unit (one hour) rate is \$100 and a developmental services unit (one hour) rate is \$25, we would expect the plan to cover 4 units of developmental services for every one unit of therapy services. Due to the nature of habilitative service needs, we recommend service limits be defined units (example one hour) and allow the service to be provided in the same or different days. For example, a consumer may receive one, two, or four units (hours) per day. It should be noted that habilitative services are by definition often longer term than rehabilitative services. Further, it should be noted that many individuals requiring habilitative services may also have a disability determination and therefore not be Private Option eligible and are likely to be served under Arkansas’s standard Medicaid program.

Rehabilitative services are required to provide 30 days of out-patient and 60 days of in-patient services. Because developmental services do not have inpatient services (as rehabilitative services do), we have found 180 hours of habilitative developmental services to be at parity with this benefit.

Developmental services will be provided according to an approved treatment plan and by an Arkansas licensed or certified developmental services provider.

*Inpatient Rehabilitative Services covered at 60 visits per calendar year.
Outpatient Rehabilitation Services covered at 30 visits per calendar year.*

*Habilitative Developmental Services are covered at 180 units(1 hr.=1 unit) per calendar year.
Habilitative Services – 30 visits.*

Inpatient and Outpatient Therapies now have limits matching these limits:

Page 24-25:

5. INPATIENT THERAPY

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

- a. Occupational therapy;
- b. Rehabilitation therapy (limited to sixty (60) visits per **Calendar Year**);
- c. Cardiac and pulmonary rehabilitation therapy;
- d. Radio-frequency thermal therapy, only in connection with primary procedure of an orthopedic condition;
- e. Neurologic rehabilitation, for up to sixty (60) days, per **Minor Dependent Insured**, per lifetime:
 - (a) When the **Minor Dependent Insured** is suffering from a **Severe Traumatic Brain Injury**; and
 - (b) When admission to the **Inpatient Provider** is within seven (7) days of release from a **Hospital**.
- f. Cognitive rehabilitation, only in connection with a **Severe Traumatic Brain Injury**; and
- g. **Habilitative Services** (limited to thirty (30) visits per **Calendar Year**).

Page 28:

19. OUTPATIENT THERAPY

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

- a. Occupational therapy (not to exceed thirty (30) visits per **Covered Minor Dependent Insured** per **Calendar Year**);
- b. Rehabilitation therapy (not to exceed thirty (30) visits per **Covered Minor Dependent Insured** per **Calendar Year**);
- c. Cardiac and pulmonary rehabilitation therapy (not to exceed thirty-six (36) visits per **Covered Minor Dependent Insured** per **Calendar Year**);
- d. Radio-frequency thermal therapy, only in connection with primary procedure of an orthopedic condition;
- e. Cognitive rehabilitation, only in connection with a **Severe Traumatic Brain Injury**;
- f. **Habilitative Developmental Services** (limited to one-hundred and eighty (180) units (one (1) hour being one (1) unit) per **Calendar Year**); and
- g. **Habilitation Services** (not to exceed thirty (30) visits per **Covered Minor Dependent Insured** per **Calendar Year**).

Objection 8

Under the EHB for Maternity and newborn care, benefits are to be covered for maternity and obstetrics, including pre and post natal care. Also, are services provided by a certified nurse midwife. Please refer to the Benchmark Plan, Page 14.

The Maternity benefit on page 31 includes benefits for routine pregnancy (pre-natal), delivery, and hospital confinement following delivery (post-natal).

Please see that certified nurse midwife has been added to page 31 (also below) as a covered provider for maternity/obstetrics.

Services **Provided** by a **Hospital**, a certified nurse midwife, or a **Provider** for (i) an **Insured's** routine pregnancy, including normal labor and delivery, (ii) cesarean section deliveries that are not performed on an **Emergency** basis, and (iii) **Complications of Pregnancy**.

Hospital Confinement for a mother who is an **Insured** and her newborn child for a period of time up to forty-eight (48) hours following vaginal delivery, and up to ninety-six (96) hours following delivery by cesarean section, shall be considered a **Medically Necessary Inpatient Confinement**. **Hospital Confinement** in which the length of stay exceeds these periods shall be subject to the definition and the requirements of **Medical Necessity** and **Medically Necessary** and the requirements of **Pre-Certification of Treatment**.

Objection 9

I could not locate in the policy case management communications made by PCP. Case Management is part of the EHB for preventive and wellness services. Please refer to the Benchmark Plan, item 3.1(4) on Page 12.

We are offering an individual plan that does not require a PCP and Insureds can go to any provider, unlike a group policy. We don't think this is needed and respectfully ask that you reconsider this objection.

Objection 10

With respect to Pediatric Dental Care, does your policy cover consultations, restorations and hospital services as outlined in the Benchmark Pediatric Dental Plan?

Please see the amended Pediatric Dental Care section on page 33:

38. PEDIATRIC DENTAL CARE

Services **Provided** for **Pediatric Dental Care** by a **Dentist** to a **Minor Dependent Insured**, up to age twenty-one (21), in connection with the following **Pediatric Dental Care** services:

- a. **Emergency Room services Provided** by a **Dentist**.
- b. **Preventive Pediatric Dental Care** - includes procedures which help to prevent oral disease from occurring, including:
 - 1) **Prophylaxis** - scaling and polishing the teeth at six (6) month intervals;
 - 2) Topical fluoride application at six (6) month intervals, excluding fluoride varnish;
 - 3) Sealants on first and second permanent molars, once; and
 - 4) Space maintainers.
- c. **Routine Pediatric Dental Care** – services **Provided** in the office of a **Dentist** which includes:
 - 1) Dental examinations, visits and consultations once within a five (5) month consecutive period (when primary teeth erupt);
 - 2) **Bitewing X-rays** at six (6) month intervals, full mouth x-rays every five (5) years, and panoramic x-rays every five (5) years;
 - 3) Procedures for simple **Extractions** and care of abscesses and surgical **Extractions**; and other routine **Oral Surgery** not requiring hospitalization, including preoperative care and postoperative care;
 - 4) General anesthesia and analgesia and non-intravenous conscious sedation;
- d. **Restorations** – amalgam and composite resin restorations; stainless steel crowns. Anterior crowns, porcelain to metal crowns. .
- e. **Endodontics** - includes procedures for treatment of diseased tooth **Pulp** and the tissues surrounding the root of the tooth, where hospitalization is not required.
- f. **Gum Therapy**
- g. **Prosthetics** - includes services as follows:
 - 1) Removable complete or partial **Dentures**.
- h. **Consultations** – consultations **Provided** by an oral surgeon when requested by an oral surgeon or other **Provider** for further evaluation and management of a specific problem, twice (2) per **Calendar Year**.
- i. **Hospital Services** – Inpatient and Outpatient

- 1) **Inpatient:** for dental treatment when the **Minor Dependent Insured's** age, medical or mental problems, or extensiveness of treatment makes **Inpatient** services **Dentally Necessary**;
- 2) **Outpatient:** for dental treatment when the **Minor Dependent Insured's** age, medical or mental problems, or extensiveness of treatment makes **Outpatient** services **Dentally Necessary**.

Objection 11

As outlined in the Pediatric Vision Benchmark Plan, your policy must contain benefits for Surgical evaluation, Eye prosthesis, polishing service and vision therapy developmental testing.

Please see the added section on Pediatric Vision on page 33-34:

39. PEDIATRIC VISION

Services **Provided** for a **Minor Dependent Insured**, age twenty-one (21) and under, including

- a. One (1) **Vision Examination per Calendar Year**;
- b. One (1) pair of glasses with plastic or polycarbonate lenses per **Calendar Year**;
- c. Contact lenses, only if **Medically Necessary**;
- d. Eye prosthesis and polishing services;
- e. Vision therapy development testing
 - 1) Orthoptic and pleoptic training with continuing medical direction and evaluation;
 - 2) Sensorimotor examination; and
 - 3) Developmental testing with interpretation and report; and
- f. Surgical evaluation for a **Minor Dependent Insured** with one of the following conditions:
 - 1) Ptosis;
 - 2) Congenital cataracts;
 - 3) Exotropia or vertical tropia; or
 - 4) Exotropia in **Minor Dependent Insureds** between the ages of twelve (12) and twenty-one (21).

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

Sincerely,



Erica Gibbs
Product Analyst
Phone: 800-387-9027 ext. 327
gibbse@ushealthgroup.com

Freedom Life Insurance Company of America

3100 Burnett Plaza ♦ 801 Cherry Street, Unit 33, ♦ Fort Worth, Texas 76102 ♦ 1-800-221-9039

October 18, 2013

Arthur Lucker
Arkansas Department of Insurance
1200 West 3rd Street
Little Rock, AR 72201-1904

Re: **Freedom Life Insurance Company of America**

Current SERFF Tracking # USHG-129212848
NAIC # 62324
EHB-2014-IP-AR-FLIC & EHBC-2014-IP-AR-FLIC Form/Rate Filing

Dear Mr. Lucker:

Thank you for reviewing our form/rate filing. This letter is in response to the objection letter and attachment dated October 10, 2013 for the USHG-129212848 filing. Please see the response to the objection letter below.

Objection 1

Please confirm that “Allowed Claims” include claims for Essential Health Benefits (EHB) as well as benefits other than EHB.

The Allowed Claims used in developing the rates are based on our current Non-Grandfathered Major Medical policies that provide essential health benefits. There are no material covered benefits in excess of the Essential Health Benefits.

Objection 2

Please describe quantitatively, including an Excel spreadsheet with formulas, the derivation of the Changes in the Morbidity of the Insured Population factor of 1.69, as stated in Section V of the Part III Actuarial Memorandum.

We analyzed and used the data within the "Cost of the Future Newly Insured under the Affordable Care Act (ACA)" study prepared by Optum Health and commissioned by the Society of Actuaries. The increase due to morbidity for Arkansas in this study is 1.41 over the current market average. We estimated that an additional 20% load was necessary to account for the new

requirement to issue coverage on a year-round guaranteed issue basis until the next open enrollment period in 2014. The final formula for our change in morbidity of the insured population factor is $1.41 \times 1.20 = 1.69$.

Objection 3

Please describe quantitatively, including an Excel spreadsheet with formulas, the derivation of the Changes in Demographics factor, as stated in Section V of the Part III Actuarial Memorandum.

Please see Exhibit Q3 in attachment “AR EHB Objection Response 101013 Attachment” for an example of the derivation of the Changes in Demographics factor. This factor corresponds to Item L in Exhibit A of the Actuarial Memorandum Part III. Arkansas data alone is given 0% credibility. Therefore, nationwide claims data was used to develop the rates. In order to adjust this data to reflect expected Arkansas claims the ratio of the current average nationwide area factors to the current average Arkansas area factors was used as a multiplicative factor for the claims data. The average area factors were derived by applying our current area factors to the expected geographic distribution and calculating a state and nationwide average.

The final formula = Arkansas Average Area Factor (.503) / Nationwide Average Area Factor (.631) = .798

Objection 4

Please describe quantitatively, including an Excel spreadsheet with formulas, the derivation of the Utilization per 1,000 and Average Cost/Service costs for each Benefit Category in Section II of Worksheet 1 of the Uniform Rate Review Template (URRT) in the Credibility Manual. Please also include the derivation of the factors built into the projection of these costs.

Please see Exhibit Q4.1 in attachment “AR EHB Objection Response 101013 Attachment” for the derivation of the Utilization per 1,000 and Average Cost/Service costs calculations and the respective projections of these results. These figures are based on our non-grandfathered block of business for all of our affiliate companies.

Derivation of Utilization per 1,000:

The 2012 experience was split by each mandated claim category for the URRT. The annual claim counts were then summed for each category. These claim counts were divided by the sum of member months over the experience period to arrive at an average claim count per member per month. This was multiplied by 12,000 to get the Utilization per 1,000 per year.

Derivation of Average Cost/Service costs:

The 2012 Allowed Claims were split by each mandated claim category for the URRT. The annual Allowed Claims were then summed by each category. These values were divided by the annual claim counts to arrive at the Average Cost/Service cost.

The projection of the Utilization per 1,000 costs is calculated in the following way:

Utilization per 1,000 in Experience x Changes in Morbidity factor x Underwriting Wear Off factor x approx. 1/3 of the 10% trend assumption trended two years.

The projection of the Average Cost per Service Costs is calculated in the following way:

Average Cost per Service Costs x Essential Health Benefits Increase factor x Projected Average Induced Demand factor x Average Area Factor Adjustment x approx. 2/3 of the 10% trend assumption trended two years.

Derivation of Projection Factors:

Changes in Morbidity: Please see the answer to Objection 2.

Underwriting Wear Off: Please see the answer to Objection 10.

Essential Health Benefits Increase: We used a Milliman Health Cost Guidelines actuarial continuance table from their 2012 models. Since we have a signed confidentiality agreement with Milliman we are not allowed to copy, use or disclose to any third parties any part of the guidelines. The breakdown of the results can be seen in the actuarial memorandum.

Projected Average Induced Demand: Please see Exhibit Q4 in attachment "AR EHB Objection Response 101013 Attachment"

Trend: Our trend assumption utilized in our projections is 10% and was estimated based on the 2012 Segal Health Plan Cost Trend Survey and other industry studies. The estimated portion of this assumption due to increases in medical cost is 6.6%, and the estimated portion due to increased utilization is 3.2%.

Objection 5

Please describe quantitatively, including an Excel spreadsheet with formulas, the development of the 66.5% Projection Period Paid to Allowed Ratio found in Section III, Worksheet 1 of the URRT.

Please see Exhibit Q5 in attachment "AR EHB Objection Response 101013 Attachment"

The 66.5% Projection Period Paid to Allowed Ratio was developed using our expected proportion of each metal tier multiplied by their respective AV values. The proportion allocated for each metal tier used the assumptions that the current in force business will take policies most similar to their current benefits and new business will follow the following distribution: 50%

Bronze, 40% Silver, 5% Gold and 5% Platinum. The AV values do not include the HHS defined induced utilization factors.

Objection 6

The Projected ACA Reinsurance Recoveries, Net of Reinsurance Premium is shown in Section III, Worksheet 1 of the URRT as \$22.57 PMPM. Please describe quantitatively, including an Excel spreadsheet with formulas, how the Gross Projected PPACA Reinsurance Recoveries of \$27.82 was determined. Further, be sure to include a quantitative explanation of the determination of the 10.0% of incurred claims factor that was used.

Please see Exhibit Q6 in attachment “AR EHB Objection Response 101013 Attachment”

The Gross Projected PPACA Reinsurance Recoveries of \$27.82 PMPM was calculated by multiplying the projected Total Allowed Claims in Section IV of Worksheet 2 of the URRT by the average actuarial value then taking 10% of this result to get the amount recovered.

The 10% was derived by analyzing the continuance in our experience and making certain assumptions on the availability of federal funds for 2014 and beyond. Assuming all funds are available, we calculated that we would receive 17% of the claims back from the reinsurance program. This value was calculated by adjusting the Allowed Claims in 2012 by the product of the nationwide average morbidity increase of 1.3, the nationwide average benefit increase of 1.26, the nationwide average underwriting wear off of 1.112 and the two years trend of 1.21. We then applied an average deductible of \$5,540 (assumed 55% of 2014 business would be current non-grandfathered plans that would convert to the Bronze plan with \$6,250 deductible, and 45% of 2014 business would be new issues with a weighted average deductible of \$4,673 - 50% at \$6,250 Bronze deductible, 40% at \$3,500 Silver deductible, & 5% each - Gold at \$2,000 deductible & Platinum at \$950 deductible, i.e., $.55 \times 6,250 + .45 \times 4,673 = 5,540$) to the allowed claims as an estimate of incurred claims, and then applied 80% to the claims that fell in the \$60K to \$250K corridor to determine the percentage of incurred claims we would receive back from the reinsurance program.

The second consideration is whether or not we would receive back all of the 17% from the federal reinsurance program. We did additional analysis of other companies' estimated recoveries and determined that most companies were in the 8 to 15% range. We believe it is prudent to remain conservative on how much we will receive back given that the calculation of the sufficient amount of funding needed and the distribution of the reinsurance payouts are out of our control. We estimated that 60% of the recoveries would be payable, and therefore, we decided that 10% ($17\% \times 60\% = \text{approx. } 10\%$) was an appropriate assumption given the uncertainty.

Finally, please provide the following details regarding the Projected ACA Reinsurance Recoveries

- **What proportion of currently insured members fell within the payout parameters?**
- **What proportion of newly insured members is anticipated to fall within the payout parameters?**

We did not vary our assumption between new business and currently insured members. The proportion of nationwide insured members projected to fall within the payout parameters is .9%.

- **What proportion of total claims expense is anticipated to fall within the payout parameters?**

21.2% of total claims expense is anticipated to fall within the payout parameters.

- **What assumption, if any, was made regarding the amount of recoverable due that will actually be recovered?**

We assumed that 60% would actually be recovered.

Objection 7

Please split the Taxes and Fees of \$10.77 per member per month (PMPM), as shown Section III, Worksheet 1 of the URRT into its component parts, showing each component in dollars and percentage of premium.

Category	Percent of Premium	PMPM amount
Arkansas Premium Tax	2.50%	8.41
ACA Insurer Fee	0.64%	2.16
PCORI Fee	0.06%	0.20
Total	3.20%	10.77

Objection 8

Please describe quantitatively, including an Excel spreadsheet with formulas, the development of the AV Pricing Values for each plan as found in Section I, Worksheet 2 of the URRT.

Please see Exhibit Q8 in attachment “AR EHB Objection Response 101013 Attachment”

The AV pricing value relies on a projection of future continuance curves and is dependent upon the effects of various ACA mandates (i.e. guarantee issue and EHB benefits). In developing rates, we have estimated assumptions for these effects and have adjusted our experience accordingly. We therefore felt it reasonable to also adjust the Actuarial Value calculated by the

HHS prescribed AV Calculator in order to reflect our pricing assumptions. Our approach was to take a 50/50 blend of our internally calculated AV and the AV from the HHS Calculator. The AV based on our experience was calculated by adjusting our 2012 Non-Grandfathered Allowed Claims for Underwriting Wear Off in the experience, Trend, increased benefits and the Guarantee Issue Mandate. We then applied the cost sharing for each plan design to the adjusted Allowed Claims on a policyholder basis to arrive at a projected Incurred Claim amount for 2014. The calculated AV is equal to the projected Incurred Claims divided by the projected Allowed Claims for 2014. In calculating this 50/50 blend, we approximated an increase to the AV from the HHS calculator of 1.09 for Bronze, 1.06 for Silver, 1.03 for Gold and 1.00 for Platinum plans. All these values are then multiplied by the respective HHS defined induced utilization factors.

The final AV pricing values are below:

Bronze: $.583 \times 1.09 = .635 \times 1.00 = .635$
Silver: $.688 \times 1.06 = .729 \times 1.03 = .751$
Gold: $.788 \times 1.03 = .812 \times 1.08 = .877$
Platinum: $.883 \times 1.00 = .883 \times 1.15 = 1.015$

Objection 9

Please describe quantitatively, including an Excel spreadsheet with formulas, the development of the “Pooled 2012 Per Member Per Month Allowed Claims – Manual” of \$179.82 found in Exhibit A of the Part III Actuarial Memorandum.

Please see Exhibit Q9 in attachment “AR EHB Objection Response 101013 Attachment”.

PMPM Allowed Claim amounts for the experience period were calculated for both nationwide and Arkansas data. We consider data having 500 or less life years to have zero credibility. Arkansas data had approximately 119 life years in the experience period and was therefore given 0% credibility. We consider data having 2,000 or more life years to have 100% credibility. Nationwide data had approximately 13,453 life years in the experience period and was therefore given 100% credibility. The \$179.82 PMPM allowed claims is the total annual nationwide allowed claims in the experience period divided by the total nationwide member months in the experience period.

Objection 10

Please describe quantitatively, including an Excel spreadsheet with formulas, the development of the “Underwriting Wear Off in Experience” factor of 1.112 found in Exhibit A of the Part III Actuarial Memorandum.

Please see Exhibit Q10 in attachment “AR EHB Objection Response 101013 Attachment”.

The Underwriting Wear Off adjustment was based on the non-grandfathered plan's expected loss ratios at the average duration in the experience period (16.54 months) and an estimation of the current individual market average duration (24.13 months). This adjustment was applied in order to more accurately utilize the research done in the SOA study, "Cost of the Future Newly Insured under the Affordable Care Act (ACA)". The SOA study compares the estimated current non-group market's claims cost to the projected 2014 claims cost once certain provisions, including the guaranteed issue mandate, of the ACA are implemented. Our experience period only includes Non-Grandfathered policies sold on or after March 2010. Because of this our experience for 2012 includes exposure that is still in the earlier durations and would reflect a lower claims cost due to underwriting than the data in the SOA study which includes Grandfathered as well as Non-Grandfathered experience. We estimated the increase necessary to adjust for this difference by using our current major medical expected durational claims curves at duration 24.13 and 16.54. The result is as follows: Underwriting Wear Off = 69.39% (expected Loss Ratio at duration 24.13) / 62.38% (expected Loss Ratio at duration 16.54) = 1.112. These Loss Ratios were calculated holding age and trend constant so as to only reflect Underwriting Wear Off. We approximated the current market average duration by using our major medical persistency assumptions projected through all durations and arriving at an average duration of 24.13.

Objection 11

Please describe quantitatively, including an Excel spreadsheet with formulas, the development of the "Average Area Factor Adjustment" of .798 found in Exhibit A of the Part III Actuarial Memorandum.

Please see the answer to Objection 3.

Objection 12

Please describe quantitatively, including an Excel spreadsheet with formulas, the development of the seven area factors used in Arkansas.

Please see Exhibit Q12 in attachment "AR EHB Objection Response 101013 Attachment".

The seven area factors were developed by weighting our current area factors in Arkansas by the expected geographic distribution within the state and setting the average equal to 1. The first step was to group our current area factors by the seven mandated area factors in Arkansas and calculate the average area factor by expected geographic distribution in each area. This number is then divided by the state average area factor as described in Objection 3 of this objection response (.503).

Objection 13

Please identify the fixed reference plan selected as the basis for the AV Pricing Values, as required by the Part III Actuarial Memorandum and Certification Instructions.

The fixed reference plan used as the basis for the AV Pricing Values is the Bronze plan.

Objection 14

Please describe quantitatively, including an Excel spreadsheet with formulas, the development of the single risk pool rate, starting with the projected index rate, adjusted for the three market-wide adjustments, and then adjusted by the five plan-specific allowed modifiers, as described on Page 8-10 of the American Academy of Actuaries' Exposure Draft, "Addendum to Actuarial Practices Relating to Preparing, Reviewing, and Commenting on Rate Filings Prepared in Accordance with the Affordable Care Act" (April 2013).

Please see Exhibit Q14 in attachment "AR EHB Objection Response 101013 Attachment". The example given in Exhibit Q14 is for a Bronze plan.

Objection 15

Please describe quantitatively, including an Excel spreadsheet with formulas, the derivation of the premium rates by Plan from the projected index rate, if the premium rates were not calculated by the methodology described in the above question. Also, please explain the reason for the deviation in the two methods.

We used the prescribed methodology.

Objection 16

Please describe quantitatively, including an Excel spreadsheet with formulas, the derivation of the 1.20 Tobacco User Factor.

Since we do not have credible data on smokers, we relied upon the general industry trends observable in available EHB filings and other industry studies. Based on our research, we arrived at a 20% load which seems reasonable based on our findings.

Objection 17

In order to participate in the applicable open enrollment periods, issuers must have their plans approved by October 1, 2013. As a result, FLICA is required to issue coverage on a year-round guaranteed issue basis until the next open enrollment period. Please state if FLICA has accounted for this in its pricing, and if it has please describe the methodology that was used to do so.

We loaded an additional 20% to account for this change as noted in Objection #2 above. We have no specific data or studies to back this adjustment, but feel it is reasonable to add something to account for this change.



INS CONSULTANTS, INC.

Insurance Regulatory Consultants

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New Market, Suite 206
Philadelphia, PA 19147
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TO: Erica Gibbs (gibbse@ushealthgroup.com)
Product Analyst
USHEALTH Group
801 Cherry Street, Unit 33
Fort Worth, TX 76102

FROM: Gary Rosen, FSA, MAAA
INS Consultants, Inc.

DATE: October 21, 2013

SUBJECT: Freedom Life Insurance Company of America
Individual Health – PPO
HIOS Issuer ID: 61273
SERFF Tracking Numbers: USHG-129212848, USHG- 129213923

INS has reviewed the material filed in support of the subject rate filings. Based on that review, we have identified certain aspects of the filings which require clarification and/or additional information; these items are discussed below. Upon receipt of the requested information, we will continue our review of the subject filings.

1. Please describe quantitatively, including an Excel spreadsheet with formulas, the development of the company's projected Medical Loss Ratio (the Actuarial Memorandum only indicates that it is expected to exceed 80%).

Thank you.

Gary B. Rosen, FSA, MAAA

MLR Calculation Response

Our priced for loss ratio is 76.0% in your state, which is approximately an 80% Medical Loss Ratio as defined by the Affordable Care Act. A calculation of the projected Medical Loss Ratio (MLR) is shown below:

MLR = (Incurred Claims + Quality Improvement Expense) / (Earned Premium - Taxes and Fees)

= (76.0% + 0.6%) / (100% - 3.2%) = (76.6% / 96.8%) = 79.13%, which when adjusted for credibility (Arkansas is anticipated to have zero credibility for 2014, but if we are optimistic and estimate 5,000 life years exposed in 2014, we have an additive value of .037, or 3.7%), so we would have 79.13% + 3.7% = 82.83%, which exceeds the 80% requirement.

State:

Arkansas

Filing Company:

Freedom Life Insurance Company of America

TOI/Sub-TOI:

H16I Individual Health - Major Medical/H16I.005A Individual - Preferred Provider (PPO)

Product Name:

EHBC-2014-IP-AR-FLIC

Project Name/Number:

EHBC-2014-IP-AR-FLIC/EHBC-2014-IP-AR-FLIC

Superseded Schedule Items

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

Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
09/26/2013	Replaced 10/30/2013	Form	EHBC-2014-IP-AR-FLIC	10/04/2013	EHBC-2014-IP-AR-FLIC.pdf (Superseded)
09/23/2013	Replaced 10/30/2013	Form	EHBC-2013-IP-AR-2014-FLIC	09/26/2013	EHBC-2014-IP-AR-FLIC.pdf
09/23/2013	Replaced 10/30/2013	Form	EHBC-2014-OC-AR-FLIC	10/04/2013	EHBC-2014-OC-AR-FLIC.pdf (Superseded)

FREEDOM LIFE INSURANCE COMPANY OF AMERICA

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

ESSENTIAL HEALTH BENEFITS POLICY

The coverage of all **Minor Dependent Insureds** is governed and determined by the terms, conditions, definitions, limitations and exclusions contained in this **Policy**. Certain phrases and words have the first letter of each word capitalized and the entire word or phrase printed in bold face type. These are generally defined phrases and words, and as such have the express meaning set forth in Section II. DEFINITIONS. This **Policy** is a legal contract between **You** and the **Company**. Please read it carefully!

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

IMPORTANT NOTICE ABOUT STATEMENTS IN THE APPLICATION: Please read the copy of **Your** application for coverage, which is attached to and part of this **Policy**, to see if any information inquired about or contained in the application is incorrect, incomplete or missing. Contact **Us** immediately if any information contained in the application is incorrect, incomplete or missing. Any incorrect or incomplete statements or answers, as well as any missing information could cause a claim to be denied or the coverage under this **Policy** to be reformed or voided.

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

YOUR 30 DAY RIGHT TO RETURN THIS POLICY

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



SECRETARY



PRESIDENT

**THIS POLICY PROVIDES ESSENTIAL HEALTH BENEFITS COVERAGE UNDER FEDERAL LAW;
BUT IT IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE UNDER STATE LAW.**

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I. Policy Schedule

A. GENERAL INFORMATION

Policy form: [EHBC-2014-IP-AR-FLIC]

Policyowner: []

Minor Dependent Insured: Age at Issue: []

Policy Number: []

Issue Date: []

Other Minor Dependent Insureds on Issue Date:

[]
[]

Beneficiary: []

Initial Premium: []

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

First Renewal Date: []

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

B. COVERAGE SCHEDULES

[1]. DEDUCTIBLE SCHEDULES:

The following deductibles are to be paid by the **Minor Dependent Insured** in addition to the **Minor Dependent Insured Coinsurance Percentage** before any **Sickness and Injury Benefits** or **Wellness and Screening Benefits** are payable by Us for **Covered Expenses**:

- A. **Calendar Year Deductible per Minor Dependent Insured:** [\$950, \$2,000, \$3,500, \$6,250]; and
- B. **Separate Deductible For Non-Participating Providers:** [\$2,850, \$6,000, \$10,500, \$18,750]

[2]. COINSURANCE PAYMENT SCHEDULES – PARTICIPATING PROVIDERS AND PARTICIPATING PHARMACIES:

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

- A. **Company Insurance Percentage:** [100%]
(**Sickness and Injury Benefits** and **Wellness and Screening Benefits**)
- B. **Insured Coinsurance Percentage:** [0%]; and
(**Sickness and Injury Benefits** and **Wellness and Screening Benefits**)
- C. **Insured Maximum Participating Provider Coinsurance Payment:** [\$950, \$2,000, \$3,500, \$6,250]

[3]. COINSURANCE PAYMENT SCHEDULES – NON-PARTICIPATING PROVIDERS AND NON-PARTICIPATING PHARMACIES:

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

- A. **Company Insurance Percentage:** [100%]
(**Sickness and Injury Benefits** and **Wellness and Screening Benefits**)
- B. **Minor Dependent Insured Coinsurance Percentage:** [0%]; and
(**Sickness and Injury Benefits** and **Wellness and Screening Benefits**)
- C. **Minor Dependent Insured Maximum Non-Participating Provider Coinsurance Payment:** [\$2,850, \$6,000, \$10,500, \$18,750]

II. DEFINITIONS

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

“**Accident**”, “**Accidentally**” means an event or occurrence that was unplanned and unintended by the **Minor Dependent Insured** that was the sole cause of **Injuries** sustained or suffered by such **Minor Dependent Insured** and that takes place on or after the **Issue Date**.

“**Adult Wellness Preventive Care**” means the evidence-based items or services that, at the time services are **Provided**, have in effect a rating of “A” or “B” in the current list of preventive services recommended for adults by the United States Preventive Services Task Force (USPSTF). (See current USPSFT A & B recommendation chart.)

“**Adverse Determination**” means a determination by **Us** that an admission, availability of care, continued stay or other **Health Care Service** has been reviewed and, based upon the information provided, the requested payment for the service is denied, reduced or terminated, because:

1. the requested **Health Care Service** does not meet **Our Policy** requirements for **Medical Necessity**; or
2. the requested **Health Care Service** has been found to be “experimental/investigational.”

To be considered as an **Adverse Determination**, the **Adverse Determination** must be a **Final Adverse Determination**, except as provided herein. The **Adverse Determination** must involve treatment, services, equipment, supplies or drugs that would require **Your Policy** to expend five hundred dollars [\$500] or more of expenditures.

Adverse Determination does NOT include a determination by **Us** to deny a **Health Care Service** or **Benefit** based upon:

1. an express exclusion within the **Policy**, other than a general exclusion for “**Medical Necessity**” or “experimental/investigational”;
2. an express limitation within the **Policy** with respect to the number of visits, treatments, supplies or services for a covered **Benefit** in a given **Calendar Year**;
3. an express limitation within the **Policy** with respect to a maximum dollar limitation with respect to a covered **Benefit** in a given **Calendar Year** period;
4. a determination by **Us** that an individual is not eligible to be an Insured;
5. a determination by **Us** that treatment, service or supplies were requested or obtained by a **Covered Minor Dependent Insured** through fraud or material misrepresentation;
6. the procedure for determining the **Minor Dependent Insured’s** access to a **Provider**, including but not limited to any primary care gatekeeper, referral or network access provision;
7. Illegality of services or the means or methods of administering them;
8. FDA or other government agency determinations, reports or statements; or
9. Licensure, permit or accreditation status of a **Provider**.

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

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

“**Autism Spectrum Disorder**” means the following three conditions, defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders:

1. Autistic Disorder;
2. Asperger’s Syndrome; and
3. Other Pervasive Developmental Disorder.

“Behavioral Therapy” means interactive therapies derived from evidence-based research, including applied behavior analysis, which includes discrete trial training, pivotal response training, intensive intervention programs and early intensive behavioral intervention.

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

“Benefit(s)” means **Sickness and Injury Benefits**, and **Wellness and Screening Benefits**.

“Bitewing X-ray” means an x-ray showing exposed portions of the back teeth of an **Insured**. This type of x-ray is primarily used for the detection of hidden decay between teeth.

“Bone Marrow Transplants” means the **Medically Necessary** transplantation, combined transplantation, and sequential transplantation procedures, sometimes referred to as “Bone Marrow Reconstitution or Support” in which **Medically Necessary** human blood precursor cells are administered following myelosuppressive or ablative therapy are received by a **Minor Dependent Insured** while coverage for such **Minor Dependent Insured** under this **Policy** is in full force and effect. Such cells may be derived from such **Insured** in an autologous harvest, or from a matched donor for an allogeneic transplant.

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

“Breast Reconstruction” means **Medically Necessary** reconstruction of a breast incident to a **Mastectomy** to restore or achieve breast symmetry. **Breast Reconstruction** includes surgical reconstruction of the non-diseased breast to produce symmetrical appearance of a breast on which **Mastectomy** surgery has been performed, as well as **Mastectomy** bras/camisoles and external prosthetics that meet external prosthetic placement needs, prostheses and services and other supplies that are **Medically Necessary** for any physical complication, including lymphedemas, at all stages of the reconstruction incident to a **Mastectomy**.

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

“Calendar Year Deductible” means the amount of **Covered Expenses** each **Minor Dependent Insured** must incur within a **Calendar Year** for services rendered by **Participating Providers** before any applicable **Sickness and Injury Benefits** or **Wellness and Screening Benefits** are payable under this **Policy**.

No **Sickness and Injury Benefits** or **Wellness and Screening Benefits** are payable under this **Policy** for services rendered by **Participating Providers** until after the **Calendar Year Deductible** is satisfied and fully payable by either **You** or such **Minor Dependent Insured**. The amount of the **Calendar Year Deductible** is shown on the **Policy Schedule** and applies per **Calendar Year** separately to each **Minor Dependent Insured**.

The amount of the **Separate Deductible For Non-Participating Providers** may not be used to satisfy the **Calendar Year Deductible**.

“Childhood Wellness Preventive Care” means the evidence-based items or services that, at the time services are **Provided**, have in effect a rating of “A” or “B” in the current list of preventive services recommended for each infant, child and adolescent **Minor Dependent Insured** by the United States Preventive Services Task Force (USPSTF). To the extent not addressed by the USPSTF, **Child Wellness Preventive Care** also includes evidence-informed preventive care and screenings **Provided** for the appropriate age in the comprehensive guidelines supported by the Health Resources and Services Administration and by the American Academy of Pediatrics (AAP) and Bright Futures.

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

“Cochlear Implant” means an implantable hearing device inserted into the modiolus of the cochlea and into the cranial bone and its associated speech processor.

“Company” means Freedom Life Insurance Company of America.

“Company Insurance Percentage” means the portion of the **Covered Expenses We** must pay to or on behalf of a **Minor Dependent Insured** for **Benefits** under this **Policy**, after satisfaction by the **Minor Dependent Insured** of (i) all applicable deductibles and (ii) the amount of the applicable **Minor Dependent Insured Coinsurance Percentage**. The **Company Insurance Percentage** is shown on the **Policy Schedule for Covered Expenses for Sickness and Injury Benefits and Wellness and Screening Benefits** at (i) **Participating Providers**; (ii) **Participating Pharmacies**; (iii) **Non-Participating Providers**; and (iv) **Non-Participating Pharmacies**.

“Complications of Pregnancy” means:

1. Conditions (when the pregnancy is not terminated), which diagnoses are due to maternal risk, 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; and
2. Non-elective **Emergency** cesarean sections, termination of ectopic pregnancy, and spontaneous termination of pregnancy occurring during a period of gestation in which a viable birth is not possible.

Complications of Pregnancy does not include false labor, occasional spotting, **Provider** prescribed rest during the period of pregnancy, morning sickness, and hyperemesis gravidarum. Nor does it include pre-eclampsia and similar conditions associated with the management of a difficult pregnancy unless such condition constitutes a nosologically distinct complication.

“Confinement” or **“Confined”** means **Inpatient** services received as a resident bed patient for not less than eight (8) hours in a **Hospital**. A period of **Confinement** begins on the date of admission to the **Hospital** as an **Inpatient** and ends on the date of discharge.

“Covered Expenses” means the amount of expenses actually incurred by a **Minor Dependent Insured**, on or after the **Issue Date** of this **Policy** and before such **Insured’s Termination of Coverage** hereunder, as a result of the **Minor Dependent Insured** being **Provided Medically Necessary** or **Dentally Necessary** medical, dental, surgical, or diagnostic services, supplies, care, and other applicable treatment listed in the SICKNESS AND INJURY BENEFITS, or the WELLNESS AND SCREENING BENEFITS Sections of this **Policy**, applicable up to but not exceeding the amount of each of the following:

1. the **Maximum Allowable Charge** for each applicable medical, dental, surgical or diagnostic service, supply, care or other applicable treatment; and
2. the amount of any other applicable coverage limit or excluded amount set forth in any limitation or exclusion that is contained in any Section in this **Policy** and/or in any exclusionary or limiting rider, amendment or endorsement attached hereto.

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

“Craniofacial Anomaly” means an abnormality of the head and/or facial bones that is present at birth such as: positional head deformity, craniosynostosis, cleft lip and cleft palate, hemifacial microsomia, and Treacher Collins syndrome.

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

“Dental Injury” means damage or harm **Accidentally** sustained to the physical structure of the teeth or gums of an **Insured** that is the direct cause of the loss independent of disease, bodily infirmity, or any other cause, which occurs while this **Policy** is in force and effect for such **Minor Dependent Insured**.

“Dentally Necessary” means, for the covered items and services listed in the PEDIATRIC DENTAL CARE section of this **Policy**, any applicable diagnostic test, laboratory test, examination, surgery, medical treatment, service or supply listed therein that is **Provided** to a **Minor Dependent Insured**:

1. by or at the appropriate order, or upon the approval of a **Dentist**;
2. for the recognized diagnosis or care and treatment of a **Dental Injury** or **Dental Sickness**;
3. in a manner appropriate and necessary for the symptoms, diagnosis or treatment of such **Dental Injury** or **Dental Sickness**;
4. in the most cost effective setting and manner available to treat the **Dental Injury** or **Dental Sickness**;
5. not primarily for the convenience of a **Minor Dependent Insured, Family, or a Dentist**;
6. not investigational or experimental in nature;
7. reasonably designed to either prevent certain future **Dental Sickness** or permit early diagnoses of certain **Dental Sickness**;
8. prescribed, performed and/or ordered by a **Dentist**; and
9. appropriate and performed according to and within generally accepted standards for the practice of dentistry.

The fact that a **Dentist** prescribed, ordered, recommended or approved a service, supply, or treatment does not in and of itself make it **Dentally Necessary**.

“**Dental Sickness**” means illness or disease afflicting the physical structure of the teeth or gums of a **Minor Dependent Insured**, while this **Policy** is in force and effect for such **Minor Dependent Insured**.

“**Dentist**” means a person who has successfully completed the prescribed course of studies in dentistry at a dental college officially recognized and accredited in the country in which it is located, and which person has been licensed in the profession of dentistry by the state in which the dental service or **Oral Surgery** is received by a **Minor Dependent Insured**. A **Dentist** must be acting within the scope of such license while rendering professional dental services to or performing **Oral Surgery** on a **Minor Dependent Insured**, and in each instance must be reasonable, appropriate and necessary **Pediatric Dental Care** and treatment of the **Minor Dependent Insured**. A **Dentist** cannot be a member of the **Insured’s** family.

“**Denture**” means a removable replacement for a natural tooth or teeth of a **Minor Dependent Insured**.

“**Diabetes Equipment**” means blood glucose monitors, insulin pumps and associated appurtenances, insulin infusion devices, and podiatric appliances, including foot orthotics, for the prevention of complications associated with diabetes.

“**Diabetes Self-Management Training**” means training provided by a health care practitioner or **Provider** who is licensed, registered or certified in this state to provide appropriate health care services for the treatment of diabetes.

Diabetes Self-Management Training includes:

1. training provided after the initial diagnosis of diabetes, including nutritional counseling and proper use of **Diabetes Equipment** and **Diabetes Supplies**;
2. training authorized on the diagnosis of a **Provider** or other health care practitioner due to a significant change in the **Minor Dependent Insured’s** symptoms or condition which necessitates changes in the self-management regime; and
3. periodic or episodic continuing education training when prescribed by an appropriate health care practitioner as warranted by the development of new techniques and treatments for diabetes.

“**Diabetes Supplies**” means (a) test strips for blood glucose monitors; (b) visual reading and urine test strips; (c) lancets and lancet devices; (d) insulin and insulin analogs; (e) injection aids; (f) syringes; (g) prescriptive oral agents for controlling blood sugar levels; and (h) glucagon emergency kits.

“**Durable Medical Equipment**” means the equipment which is designed and intended for repeated use, primarily and customarily used to serve a medical purpose, generally not useful to a person in the absence of **Sickness** or **Injury**, and is appropriate for use in the home for the treatment or as a result of a **Sickness** or **Injury**.

“**Emergency**” means a medical condition which manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: (i) placing the health of the **Minor Dependent Insured** (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

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

“Endodontic” means the treatment of diseases of the tooth **Pulp** and the tissues surrounding the root of the tooth of an **Insured**.

“External Review” means a process, independent of all affected parties, to determine if a **Health Care Service** is **Medically Necessary** or experimental/investigational.

“Extraction” means the removal of a natural tooth or teeth of a **Minor Dependent Insured**.

“Family” means the spouse, son or daughter, brother or sister, parent, grandparent or a designated caregiver of a **Minor Dependent Insured**.

“Final Adverse Determination” means an **Adverse Determination** involving a covered **Benefit** that has been upheld by **Us** at the completion of **Our Internal Grievance Procedure**.

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

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

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

“Gastric Pacemaker” means a medical device that uses an external programmer and implanted electrical leads to the stomach and transmits low-frequency, high-energy electrical stimulations to the stomach to entrain and pace the gastric slow waves to treat **Gastroparesis**.

“Gastroparesis” means a disorder that slows or stops the movement of food from the stomach to the small intestine.

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

“Habilitation” means services provided in order for a person to attain and maintain a skill or function that was never learned or acquired and is due to a disabling condition, including **Autism Spectrum Disorder**.

Habilitation does not mean custodial care, respite care, day care, therapeutic recreation, vocational training or residential treatment.

“Habilitative Services” includes physical, occupational, and speech therapies and developmental services and durable medical equipment for developmental delay, developmental disability, developmental speech or language disorder, developmental coordination disorder, and mix developmental disorder, including **Autism Spectrum Disorder**.

“Health Care Services” means services for the diagnosis, prevention, treatment, cure or relief of a health condition, **Sickness, Injury** or disease, as used within the GRIEVANCE PROCEDURES section.

“Hearing Examination” means a test administered to determine a complete hearing diagnostic evaluation for the treatment of **Sickness** or **Injury**.

“**High Risk for Colorectal Cancer**” means a person who has (i) a personal history of colorectal cancer or adenomatous polyps; (ii) a person history of inflammatory bowel disease; (iii) a strong family history of colorectal cancer or polyps; or (iv) a known family history of a hereditary colorectal cancer syndrome, such as familial adenomatous polyposis or hereditary non-polyposis colon cancer.

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

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

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

“**Hospital**” means a place which:

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

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

Hospital does not mean:

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

“**Implantable Osseointegrated Hearing Aid**” means a hearing aid for a person with one-sided deafness and normal hearing in the other ear due to congenital defects or **Sickness** or **Injury**.

“**Independent Review Organization**” means an entity that conducts independent **External Reviews** of **Adverse Determinations** and **Final Adverse Determinations**.

“**Inherited Metabolic Disorder**” means a disease caused by an inherited abnormality of body chemistry and includes a disease tested under a newborn screening program.

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

“**Injury**” means damage or harm **Accidentally** sustained to the physical structure of the body of a **Minor Dependent Insured** that is the direct cause of the loss independent of disease, bodily infirmity, or any other cause.

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

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

“Insured Maximum Participating Provider Coinsurance Payment” means the maximum amount, including the **Calendar Year Deductible** that an **Insured** is required to pay in a **Calendar Year** under the **Insured Coinsurance Percentage** for services rendered at **Participating Providers** and **Participating Pharmacies**. **Covered Expenses** incurred for services rendered at **Participating Providers** and **Participating Pharmacies** that are covered under the **SICKNESS AND INJURY BENEFITS** and the **WELLNESS AND SCREENING BENEFITS** sections and applied by the **Company** toward satisfaction of the **Calendar Year Deductible**, contained in this **Policy** or any rider attached to this **Policy**, will be credited or applied toward satisfaction of the **Minor Dependent Insured Maximum Participating Provider Coinsurance Payment**. The amount of the **Insured Maximum Participating Provider Coinsurance Payment** is shown on the **Policy Schedule**.

“Minor Dependent Insured Maximum Non-Participating Provider Coinsurance Payment” means the maximum amount, after the satisfaction of the **Separate Deductible For Non-Participating Providers** that an **Insured** is required to pay in a **Calendar Year** under the **Minor Dependent Insured Coinsurance Percentage** for services rendered at **Non-Participating Providers** and **Non-Participating Pharmacies**. **Covered Expenses** incurred for services rendered at **Non-Participating Providers** and **Non-Participating Pharmacies** that are covered under the **SICKNESS AND INJURY BENEFITS** and the **WELLNESS AND SCREENING BENEFITS** Sections and applied by the **Company** toward satisfaction of the **Separate Deductible For Non-Participating Providers** contained in this **Policy** or any rider attached to this **Policy** will not be credited or applied toward satisfaction of the **Minor Dependent Insured Maximum Non-Participating Provider Coinsurance Payment**. The amount of the **Minor Dependent Insured Maximum Non-Participating Provider Coinsurance Payment** is shown on the **Policy Schedule**.

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

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

“Internal Grievance Procedure” means the procedure by which **We** handle and resolve grievances, and provide **Insureds** with prompt and meaningful review on the issue of denial, in whole or part, of **Health Care Services**.

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

“**Mammogram**” means the X-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression device, screens, and films and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast.

“**Mastectomy**” means the **Medically Necessary** surgical removal of all or part of the breast as a result of breast cancer. **Mastectomy** does not include biopsies or other exploratory or diagnostic procedures used to detect the presence of cancer, nor does it include prophylactic removal of all or part of the breast.

“**Maximum Allowable Charge**” means the following:

1. For **Providers**, **Maximum Allowable Charge** is the actual expense incurred by a **Minor Dependent Insured** for the applicable service, supplies, care, or treatment **Provided**, after any reduction, adjustment, and/or discount pursuant to any **Participating Provider** agreements or other network agreements, negotiated rates, fee schedules or arrangements that determine or prescribe the actual amount of charges or fees that the **Provider**:
 - a) agreed to accept as payment in full for such services, supplies, care or treatment, and
 - b) ultimately charged such **Minor Dependent Insured**, regardless of any higher amount that may have been placed on the **Provider’s** billing statement of charges.

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

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

“**Medical Foods**” means modified low protein food product that are: (i) formulated to be consumed or administered under the supervision of a **Provider**; and (ii) processed or formulated to contain less than one gram of protein per unit of serving, but does not include a natural food that is naturally low in protein.

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

1. For the covered items and services listed in the SICKNESS AND INJURY BENEFITS Section of this **Policy**, **Medical Necessity** and **Medically Necessary** is any applicable **Confinement** of a **Minor Dependent Insured**, as well as any other diagnostic test, laboratory test, examination, surgery, medical treatment, service or supply listed therein that is **Provided** to a **Minor Dependent Insured**:
 - a) by or at the appropriate order, or upon the approval of a **Provider**;
 - b) for the medically recognized diagnosis or care and treatment of an **Injury** or **Sickness**;
 - c) in a manner appropriate and necessary for the symptoms, diagnosis or treatment of such **Injury** or **Sickness**;
 - d) according to and within generally accepted standards for medical practice;
 - e) in the most cost effective setting and manner available to treat the **Injury** or **Sickness**;

- f) not primarily for the convenience of a **Minor Dependent Insured, Family, or a Provider**; and
 - g) not investigational or experimental in nature.
2. For the covered items and services listed in the WELLNESS AND SCREENING BENEFITS Section of this **Policy, Medical Necessity** and **Medically Necessary** is any applicable diagnostic test, laboratory test, examination, or medical treatment, service or supply listed therein that is **Provided** to a **Minor Dependent Insured**:
- a) reasonably designed to either prevent certain future **Sickness** or permit early diagnoses of certain **Sickness**;
 - b) prescribed, performed and/or ordered by a **Provider**;
 - c) appropriate and performed according to and within generally accepted standards for medical practice;
 - d) rendered in the most cost effective setting and manner available, and
 - e) not primarily for the convenience of a **Minor Dependent Insured, a Family, or a Provider**.

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

“Consumable Medical Supplies” means items which are (i) consumed or diminished with use so that they cannot withstand repeated use; (ii) is primarily or customarily used to serve a medical purpose; and (iii) generally are not useful to a person in the absence of a **Sickness** or **Injury**.

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

“Mental and Emotional Disorders” means a neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

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

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

“Non-Participating Provider” means a **Hospital, Provider, Ambulatory Surgical Center, Skilled Nursing Home, Non-Participating Pharmacy**, or other licensed practitioner of the healing arts for which **Sickness and Injury Benefits** or **Wellness and Screening Benefits** are payable under this **Policy** that, at the time **Covered Expenses** are incurred, has not entered into or has terminated a prior agreement to provide health care services and/or pharmaceutical services to **Minor Dependent Insureds** under this **Policy** at discounted rates.

“Oral Surgery” means surgery of the oral mouth cavity, including teeth, tongue and gums.

“Orthotic Device” means an external device that is (i) intended to restore physiological function or cosmesis to an **Insured**; and (ii) is custom designed, fabricated, assembled, fitted, or adjusted for the **Minor Dependent Insured**.

Orthotic Device does not mean canes, crutches, corsets, dental appliances, elastic hoses or supports, fabric supports, generic arch supports, low temperature plastic splints, soft cervical collars, trusses, or other similar devices that do not have significant impact on the neuromuscular, musculoskeletal, or neuromusculoskeletal functions of the body.

Orthotic Device does not mean those carried in stock and sold without therapeutic modification by a corset shop, department store, drug store, surgical supply facility, or similar retail entity.

“Orthotic Service” means the evaluation and treatment of a condition that requires the use of an orthotic device.

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

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

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

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

“**Pediatric Dental Care**” means oral health prevention, maintenance, and treatment of **Dental Injury** or **Dental Sickness** to an **Insured** up to age nineteen (19). **Pediatric Dental Care** does not include any type of cosmetic dentistry, unless **Dentally Necessary** to correct dental conditions caused by **Dental Injury** or **Dental Sickness**.

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

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

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

“**Policyowner**” means the schedule of **Policy** information that commences on page 3 of this **Policy**.

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

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

“**Preferred Drug List**” means a list either created or sponsored by **Us**, which identifies certain **Brand Name Drugs** that may be preferred. The **Preferred Drug List** is updated from time to time and may be found on the Internet at www.ushealthgroup.com in the prescription services location of the website. **You** may also call the toll free Rx Help Desk number on your ID card. When a **Preferred Brand Drug** which had been considered a **Covered Expense** is removed from the **Preferred Drug List** the drug will continue to be considered a **Covered Expense** until the **Policy** renewal date.

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

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

“Prophylaxis” means the **Dentally Necessary** professional cleaning and scaling of the teeth of an **Insured**.

“Prosthetic Device” means an external device that is (i) intended to replace an absent external body part for the purpose of restoring physiological function or cosmesis to a **Minor Dependent Insured**; and (ii) custom-designed, fabricated, assembled, fitted, or adjusted for the **Minor Dependent Insured** using the device prior to or concurrent with delivery to the **Minor Dependent Insured**.

Prosthetic Device does not include artificial eye, artificial ear, dental appliance, cosmetic devices, devices used exclusively for athletic purposes, an artificial facial device, or other device that does not have impact on the neuromuscular, musculoskeletal, or neuromusculoskeletal functions of the body.

“Prosthetic Service” means the evaluation and treatment of a condition that requires the use of a **Prosthetic Device**.

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

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

“Provider” means any licensed practitioner of the healing arts as recognized by the laws of the state in which he or she practices medicine, in treating an **Injury** or **Sickness**. The **Provider** must be acting within the scope of such license while rendering **Medically Necessary** professional service to a **Minor Dependent Insured**, and cannot be a member of the **Minor Dependent Insured’s Family**.

“Pulp” means the soft tissue inside the Crown and roots of a tooth composed of nerves, blood vessels and other tissue of a **Minor Dependent Insured**.

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

“Retrospective Review” means a review of **Medical Necessity** conducted after services have been **Provided** to a **Covered Minor Dependent Insured**, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment.

“Separate Deductible For Non-Participating Providers” means the amount of **Covered Expenses** a **Minor Dependent Insured** must incur in a **Calendar Year** for services rendered by **Non-Participating Providers** before any applicable **Sickness and Injury Benefits** or **Wellness and Screening Benefits** are payable under this **Policy**.

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

The amount of the **Calendar Year Deductible** may not be used to satisfy the **Separate Deductible For Non-Participating Providers**.

“Severe Traumatic Brain Injury” means a sudden trauma causing damage to the brain as a result of the head suddenly and violently hitting an object or an object piercing the skull and entering the brain tissue with an extended period of unconsciousness or amnesia after the injury or a Glasgow Coma Scale below nine (9) within the first forty-eight (48) hours of injury.

“Sickness” means illness or disease afflicting a **Minor Dependent Insured**, including **Complications of Pregnancy**, while this **Policy** is in force and effect for such **Minor Dependent Insured**.

“Sickness and Injury Benefit(s)” mean only treatments, procedures, services, and supplies that are specifically enumerated in Section V.A. SICKNESS AND INJURY BENEFITS. If a treatment, procedure, service, or supply is not specifically enumerated in the SICKNESS AND INJURY BENEFITS Section, then fees charged or expenses associated with such items are not covered under this **Policy** as a **Sickness and Injury Benefit**. Payments by **Us** for **Sickness and Injury Benefits** are subject to all definitions, exclusions, limitations and provisions contained herein, including but not limited to the satisfaction and payability by **You** or the applicable **Minor Dependent Insured** of all applicable deductibles, as well as the limitation of the **Company Insurance Percentage**.

“Skilled Nursing Home” means a place which:

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

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

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

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

“Sound Natural Teeth” means natural teeth that are free of active clinical decay, have at least 50% bony support, and are functional in the arch.

“Specialized Hospital” means a licensed facility specializing in the treatment of **Mental and Emotional Disorders** and **Substance Abuse**.

“Stem Cell Transplants” means the **Medically Necessary** insertion or transplantation, combined insertion or transplantation, sequential insertion or transplantation procedures, in which any **Medically Necessary** form of stem cells are received by an **Insured** while coverage for such **Minor Dependent Insured** under this **Policy** is in full force and effect.

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

“**Substance Abuse**” means the chronic, habitual, or compulsive use of any intoxicating matter that, when introduced into the body, is capable of altering human behavior or mental functioning and with extended use, may cause psychological dependence and impaired mental, social or educational functioning. Nicotine addiction is not considered substance abuse for adults who are twenty-one (21) years of age or older.

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

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

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

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

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

“**Vision Examination**” means a general evaluation of the complete visual system for the prevention, maintenance, and treatment of **Sickness** or **Injury**.

“**Vision Materials**” means corrective lenses and/or frames or corrective contact lenses.

“**Waiting Period**” means the period of time beginning with the date **Your** completed application for coverage is received by **Us**, and ending on the **Issue Date** of this **Policy**.

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

“**Wellness and Screening Benefit(s)**” means only treatments, procedures, services, and supplies that are specifically enumerated in the Section V.B. WELLNESS AND SCREENING BENEFITS. If a treatment, procedure, service, or supply is not specifically enumerated in the WELLNESS AND SCREENING BENEFITS Section, then fees charged or expenses associated with such items are not covered under this **Policy** as a **Wellness and Screening Benefit**.

“**You**”, “**Your**” and “**Yours**” means the individual listed on the **Policy Schedule** as the **Policyowner**.

III. WHEN COVERAGE BEGINS AND ENDS

A. EFFECTIVE DATE

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

B. ELIGIBILITY AND ADDITIONS

You may submit an application to add the following minors to this **Policy** meeting the qualifications of the definition of a **Minor Dependent Insured** who are: (i) **Your** natural or adopted dependent children who are under the age of twenty-six (26) regardless of marital status, student status, financial dependency or residency requirements; (ii) **Your** grandchildren who are considered **Your** dependents for federal income tax purposes and who are under age twenty-six (26); (iii) any children which **You** are required to insure under a medical support order; (iv) any child whom **You**, intend to adopt and have become a party to a suit for that purpose; and (v) any child who is in **Your** custody under a temporary court order that grants **You** guardianship of the minor child. Any eligible dependent (other than a newborn or adoptee) will be added to this **Policy** when **We** approve the written application for such coverage and accept payment of any necessary premium.

C. ENROLLMENT

1. INITIAL OPEN ENROLLMENT PERIOD

The initial open enrollment period begins October 1, 2013 and extends through March 31, 2014.

If **We** receive **Your** completed enrollment application for this **Policy** prior to December 16, 2013, the **Issue Date** for **Your** coverage will be January 1, 2014, as long as the **Initial Premium** payment for all **Minor Dependent Insureds** is received by January 1, 2014. If **We** receive **Your** completed enrollment application for this **Policy** between December 16, 2013 and December 31, 2013, the **Issue Date** for **Your** coverage will be February 1, 2014, as long as the **Initial Premium** payment for all **Minor Dependent Insureds** is received by February 1, 2014.

If **Your** completed enrollment application for this **Policy** is received by **Us** during the first and fifteenth day of any calendar month between January and March of 2014, the **Issue Date** for **Your** coverage will be the first day of the following calendar month, as long as the **Initial Premium** payment for all **Minor Dependent Insureds** is received by such first day of the following calendar month. If **Your** completed enrollment application for this **Policy** is received by **Us** between the sixteenth and last day of any calendar month between January and March of 2014, the **Issue Date** for **Your** coverage will be the first day of the second following calendar month, as long as the **Initial Premium** payment for all **Minor Dependent Insureds** is received by such first day of the second following calendar month.

2. SUBSEQUENT ANNUAL OPEN ENROLLMENT PERIODS

For coverage effective dates on January 1, 2015, and on January 1 of each calendar year thereafter, the following subsequent annual open enrollment periods shall apply:

1. If **We** receive **Your** completed enrollment application for this **Policy** between October 15, 2014 and December 7, 2014, the **Issue Date** for **Your** coverage will be January 1, 2015, as long as the **Initial Premium** payment for all **Minor Dependent Insureds** is received by January 1, 2015; and
2. If **We** receive **Your** completed enrollment application for this **Policy** between October 15 and December 7 of any calendar year following 2014, the **Issue Date** for **Your** coverage will be January 1 of the next following calendar year, as long as the **Initial Premium** payment for all **Minor Dependent Insureds** is received by January 1, of such calendar year.

If **We** do not receive **Your** completed enrollment application for this **Policy** between (i) October 15, 2014 and December 7, 2014, (ii) October 15 and December 7 of any calendar year following 2014, or (iii) as a result of a qualifying event within one of the special enrollment periods set forth in Section C.3, below, the **Issue Date** for **Your** coverage will be subject to a [thirty (30) – two hundred seventy five (275)] day **Waiting Period**, depending upon the date(s) upon which **We** receive **Your** completed application for this **Policy** and the **Initial Premium** payment for all **Minor Dependent Insureds**.

3. SPECIAL ENROLLMENT PERIODS

Qualifying Events

Outside of the annual open enrollment period, **You**, can enroll for coverage, with no **Waiting Period**, within sixty (60) days of the occurrence of one of the following qualifying events:

- a. the **Minor Dependent Insured(s)** lose minimum essential health benefits coverage under a separate plan, unless such loss of coverage is due to the following:
 - 1) failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage; or
 - 2) rescission of coverage based upon an act, practice or omission that constitutes fraud, including an intentional misrepresentation of material fact, prohibited by the terms of the policy or certificate.
- b. the **Minor Dependent Insured(s)** lose coverage under a public or private health insurance policy or any other health benefit plan due to the employee's termination of employment or eligibility, the reduction in the number of hours of employment, the termination of the other plan's coverage, the death of the spouse, legal separation or divorce, or the termination of employer contributions toward the coverage;
- c. **You** request enrollment after the **Minor Dependent Insured(s)** exhaust creditable coverage that is provided under a COBRA continuation provision;
- d. **You** gain a dependent through marriage, birth, adoption or placement for adoption, or custody by court order (or temporary orders) in a civil suit or other judicial proceeding granting custody or conservatorship;

Required Notice and Premium Payment

We must receive **Your** notice of the particular qualifying event under Sections C.3. a – e, and the **Initial Premium** payment for all **Minor Dependent Insureds** within sixty (60) days of the occurrence of such event. If **Your** notice of the specific qualifying event and the **Initial Premium** payment for all **Minor Dependent Insureds** are not received within sixty (60) days of the occurrence of such event, the **Issue Date** for **Your** coverage will be subject to a [thirty (30) – one hundred eighty (180) day] **Waiting Period**.

Effective Date of Coverage Due to Special Enrollment Qualifying Event

Provided we receive **Your** notice of the particular qualifying event, together with the **Initial Premium** payment for all **Minor Dependent Insureds**, within sixty (60) days of the occurrence of such event, **Your** coverage will become effective based on the particular type of qualifying event, and according to the following schedule:

If **You** enroll a **Minor Dependent Insured** because they lost minimum essential coverage, the coverage will begin on the first day of the month following their loss of coverage.

Benefits under this **Policy** are automatically payable for a period of ninety (90) days with respect to a newly born child of **Yours** from the instant of the child's birth; to a child adopted by **You**, regardless of the age at which the child was adopted; and to a child who has been placed for adoption with **You** and for whom the application and approval procedures for adoption have been completed to the same extent that such coverage under this **Policy** applies to other **Minor Dependent Insureds**. If **You** desire to continue coverage for such dependent beyond the initial ninety (90) day period, **You** must notify us to continue coverage under this **Policy** and pay the applicable premium required within ninety (90) days of birth or adoption to continue such coverage.

If **You** wish to have automatic coverage under this **Policy** for any child whom **You** are seeking adoption or custody in a civil suit or other judicial custody proceeding filed or initiated after the **Issue Date**, **You** must notify **Us** within sixty (60) days after **You**: (i) become a party in such civil suit in which such adoption of the child is sought; or (ii) obtain custody of the child under the first court order (including temporary orders) that grants conservatorship and/or custody of the child. **You** must also pay any additional premium required for such additional coverage within such sixty (60) day period.

In all other cases of qualifying events specified above, the effective date of **Your** coverage will depend on when **We** receive **Your** application and the **Initial Premium** payment for all **Minor Dependent Insureds**. If

Your application is received between the first and fifteenth day of the calendar month, the **Issue Date** for **Your** coverage will be the first day of the following calendar month, as long as **Your Initial Premium** payment for all **Minor Dependent Insureds** is received by such date. If **Your** application is received between the sixteenth day and the last day of the calendar month, the **Issue Date** for **Your** coverage will be the first day of the second calendar month next following, as long as **Your Initial Premium** payment for all **Minor Dependent Insureds** is received by such date. In each such instance, the availability of coverage under this **Policy** will be subject to the **Waiting Period**.] Provided, however, if, on the business day of **Our** first receipt of **Your** enrollment application during any period of open enrollment, special enrollment or other enrollment for coverage under this type of **Policy** and payment of the **Initial Premium** for all **Minor Dependent Insureds** for this coverage, **You** and all **Other Minor Dependent Insureds** have current, in-force coverage previously issued by **Us** under (i) a major medical insurance policy or certificate of coverage that constitutes a grandfathered health plan under federal law, or (ii) any form number beginning with GASDCYD-2011-C, GASDCYD-2011-IP, GASDCYD-2012, UWFI-2013-R, UWFI-2013-IR, ACC-2013-C, ACC-2013-IP, SPD-2013-C, or SPD-2013-IP, the **Issue Date** will be that same business day, without the application of any other **Waiting Period**. This limited right to an accelerated **Issue Date** and waiver of any otherwise applicable **Waiting Period** for this type of coverage is only available one time for **You** and each of the **Other Minor Dependent Insureds**.

D. TERMINATION OF COVERAGE

1. TERMINATIONS SUBJECT TO RIGHT OF CONVERSION

Subject to the Section III. E. POLICY OF CONVERSION below, an applicable **Minor Dependent Insured's** coverage under this **Policy** ends on the earlier of the following:

- a. the premium due date in the month following such **Minor Dependent Insured's** twenty-six (26th) birthday.

2. TERMINATIONS BY POLICYOWNER NOT SUBJECT TO RIGHT OF CONVERSION

Section III.E. POLICY OF CONVERSION notwithstanding, the following described actions by the **Policyowner** will result in a termination of each applicable **Minor Dependent Insured's** coverage under this **Policy** with no right of conversion, in which event the coverage ends on the earlier of the following:

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

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

Section III.E. POLICY OF CONVERSION notwithstanding, **We** may refuse to renew and cancel coverage for all **Minor Dependent Insureds** under this **Policy** with no right of conversion for the following reasons:

- a. **We** are required by the order of an appropriate regulatory authority to non-renew or cancel the **Policy**;
- b. **We** cease offering and renewing coverage of the same form of coverage as this **Policy** in **Your** state upon a minimum of ninety (90) days prior written notice mailed to **Your** last known address with an opportunity for **You** to convert to any similar medical expense policy or Policy that **We** are then actively marketing and offering to new applicants in **Your** state;
- c. **We** elect to discontinue offering all similar types of coverage under any individual medical-surgical expense policy forms in **Your** state and to terminate all such certificates of coverage and individual policies in **Your** state, including **Your** form of coverage, in which case the commissioner of insurance for **Your** state and **You** will be given a minimum of one hundred eighty (180) days prior written notice of the termination, mailed to **Your** last known address;
- d. the date **We** receive due proof that fraud or intentional misrepresentation of material fact existed in applying for this **Policy** or in filing a claim for **Benefits** under this **Policy**; or
- e. **You** no longer reside in the service area of our **Participating Provider** network.

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

Section III.E. POLICY OF CONVERSION notwithstanding, **We** may refuse to renew and cancel coverage for each **Minor Dependent Insured** under this **Policy** with no right of conversion for the following reasons:

- a. the date **We** receive due proof that fraud or intentional misrepresentation of material fact existed in applying for this **Policy** or in filing a claim for **Benefits** under this **Policy**.

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

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

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

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

E. POLICY OF CONVERSION

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

if his or her coverage ceases due to his or her reaching the limiting age of twenty-six (26).

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

1. a **Minor Dependent Insured's** coverage under this **Policy** ceases because the **Policy** was terminated because of failure to pay the required premiums in the time allowed;
2. **We** were required by the order of an appropriate regulatory authority to non-renew or cancel the **Policy**;
3. **We** cease offering and renewing coverage under the same form of coverage as this **Policy** in **Your** state upon a minimum of ninety (90) days prior written notice mailed to **Your** last known address with an opportunity for **You** to convert to any similar medical expense policy or certificate that **We** are then actively marketing and offering to new applicants in **Your** state;
4. **We** elect to discontinue offering all similar types of coverage under any individual medical-surgical expense policy forms in **Your** state and to terminate all such certificates of coverage and individual policies in **Your** state, including **Your** form of coverage, in which case the commissioner of insurance for **Your** state and

You will be given a minimum of one hundred eighty (180) days prior written notice of the termination, mailed to **Your** last known address;

5. **You** voluntarily terminated coverage under this **Policy** for any **Minor Dependent Insured** by notifying **Us** of the date **You** desired such coverage to terminate;
6. **We** received due proof that fraud or intentional misrepresentation of material fact existed in applying for this **Policy** or in filing a claim for **Benefits** under this **Policy**; or
7. The **Minor Dependent Insured** is or could be covered by **Medicare**;
8. **You** no longer reside in the service area of our **Participating Provider** network.

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

IV. PREMIUM

A. INITIAL PREMIUM

The **Initial Premium** specified on the **Policy Schedule** is due and payable to the **Company** at its home office on or before the **Issue Date**. This **Initial Premium** payment will keep this **Policy** in force until the **First Renewal Date**. The amount of the **Initial Premium** and the **First Renewal Date** are shown on the **Policy Schedule**. **Initial Premium** has been determined by **Us** for this **Policy** on a **Class** basis. **Your Class** for **Initial Premium** was determined by **Us** based upon several factors, including, among other things, a combination of the following: (i) **Your** zip code (either first 3 or first 5 digits); (ii) **Your** county of residence; (iii) **Your** state of residence; (iv) the number, age and tobacco use of each **Minor Dependent Insured** listed on the **Policy Schedule**; and (v) the plan of coverage contained in this **Policy** on the **Issue Date**, including its deductibles, **Benefits**, limitations, and exclusions.

B. RENEWAL PREMIUM

1. CALCULATION - PAYMENT

The current **Mode Of Premium Payment** is shown on the **Policy Schedule**. **Renewal Premium** is payable on or before its due date, and must be paid to the **Company** at its home office. Any **Renewal Premium** not paid on or before its due date is a premium in default. If a **Renewal Premium** payment default is not corrected and properly paid before the end of the grace period, coverage under this **Policy** will terminate.

Renewal Premium rates for this **Policy** may be increased by **Us** for any renewal period after the **Issue Date**, if after the **Issue Date**:

- a. **You** add **Minor Dependent Insureds** to this **Policy**;
- b. **You** change the amount of the **Calendar Year Deductible** shown on the **Policy Schedule**;
- c. **You** change the **Minor Dependent Insured Coinsurance Percentage** shown on the **Policy Schedule**;
- d. **You** change any other coverage option;
- e. **You** change residence to a different zip code;
- f. **You** change the **Mode Of Premium Payment**;
- g. **You** add optional coverage riders, if any;
- h. **You** change after the **Issue Date** to a different optional **Participating Provider** network available in **Your** state, if any;
- i. a change occurs in the relationship between **Us** and **Your Participating Provider** network;
- j. the **Participating Provider** network availability changes for **Your** state;

- k. the **Participating Provider** negotiated discounts change; and/or
- l. a change occurs in **Sickness and Injury Benefits**, and/or **Wellness and Screening Benefits**, by amendatory endorsement pursuant to any federal or state law or regulation.

The current table of premium rates upon which the **Initial Premium** and the **First Renewal Premium** were calculated for this **Policy** may include scheduled increases in the amount of **Renewal Premium** based upon the future attained age of each **Minor Dependent Insured**. Additionally, the current table of premium rates upon which the **Initial Premium** and **First Renewal Premium** were calculated and any subsequent table of premium rates upon which the **Renewal Premium** for any renewal period is to be calculated may be changed from time to time by **Us**. Accordingly, the amount of **Renewal Premium** may be increased for any renewal period based upon items a. through l. above as well as the following:

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

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

2. RENEWAL PREMIUM CHECK OR DRAFT NOT HONORED

Any premium payment made by a check or draft which is not honored at the bank upon which it is drawn shall be of no effect toward coverage under this **Policy** unless and until valid restitution is made to **Us** within the time provided herein for making such premium payment.

3. GRACE PERIOD

Unless at least thirty-one (31) days prior to a **Renewal Premium** due date **We** have mailed to **You** written notice of **Our** intention not to renew this **Policy** pursuant to the provisions of Section III. D. TERMINATION OF COVERAGE, a grace period of thirty-one (31) days from such due date is given for the late payment of the **Renewal Premium** due. If **You** make payment of the required **Renewal Premium** during such grace period, then this **Policy** will remain in force for **Benefit** claims arising during such grace period. However, if the **Company** has received notification of **Your** intention to cancel any **Minor Dependent Insured's** coverage under this **Policy**, there is no grace period for the late payment of any **Renewal Premium** that would otherwise have been due for such **Minor Dependent Insured** but for such cancellation.

4. REINSTATEMENT

If the **Renewal Premium** is not paid before the grace period ends, **Your** coverage will lapse. If the **Renewal Premium** is received after the grace period ends but within forty-five (45) days of the **Renewal Premium** due date, acceptance of such premium by **Us** (or by an agent authorized to accept payment) will reinstate this **Policy** as of the date of acceptance of the late premium. If the **Renewal Premium** is received

forty-five (45) days after the **Renewal Premium** due date, **Your** coverage will terminate and **You** may apply for coverage with **Us** during an annual open enrollment period or a special enrollment period.

The reinstated **Policy** will cover only **Covered Expenses** that result from an **Injury** sustained after the date of reinstatement or from **Sickness** that begins more than ten (10) days after the date of reinstatement.

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

V. BENEFITS AND CLAIM PROCEDURES

Minor Dependent Insureds have the right to obtain medical care from the **Provider** and **Hospital** of their choice, as well as **Prescription Drugs** from a pharmacy of their choice; however, all applicable **Benefit** payments by **Us** under this BENEFITS AND CLAIMS PROCEDURES Section of the **Policy** are limited to the applicable **Company Insurance Percentage** of **Covered Expenses** incurred by a **Minor Dependent Insured**. Coverage under this Section of the **Policy** will be reduced for medical services, supplies, care or treatment obtained from a **Non-Participating Provider**, as well as **Prescription Drugs** from a **Non-Participating Pharmacy**. The difference between both the **Company Insurance Percentages** and the **Minor Dependent Insured Coinsurance Percentages** for: (i) **Participating Providers** and **Non-Participating Providers**; and (ii) **Participating Pharmacies** and **Non-Participating Pharmacies** are shown in the **Policy Schedule**.

Covered Expenses incurred by a **Minor Dependent Insured** for **Sickness and Injury Benefits** and **Wellness and Screening Benefits** are subject to all applicable deductibles and the **Minor Dependent Insured Coinsurance Percentage**, unless otherwise specified.

A. SICKNESS AND INJURY BENEFITS

Subject to all applicable definitions, exclusions, limitations, non-waiver, and other provisions contained in this **Policy**, as well as any riders, endorsements, or amendments attached to hereto, **We** promise to pay to or on behalf of each **Minor Dependent Insured** the **Company Insurance Percentage** of the amount of professional fees and other applicable medical diagnostic or treatment expenses and charges that constitute **Covered Expenses** incurred by each **Minor Dependent Insured** for the following described **Inpatient** and **Outpatient** services that are **Provided** as a result of **Sickness** or **Injuries**, but only after: (i) each of the applicable deductibles has been first satisfied by deduction from such **Covered Expenses** and applied to the applicable **Minor Dependent Insured** for payment; and (ii) the applicable **Minor Dependent Insured Coinsurance Percentage** of the **Covered Expenses** remaining after satisfaction of all applicable deductibles is, likewise, satisfied by deduction from the remaining **Covered Expenses** and applied to the applicable **Minor Dependent Insured** for payment, unless otherwise specified:

1. INPATIENT HOSPITAL CARE

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

- a. **Hospital** - semi-private daily room and board;
- b. **Intensive Care Unit** of the **Hospital** - daily room and board (Note, daily room and board will be at the semi-private rate for admission to units or areas of the applicable **Hospital** which are step-down units from the **Intensive Care Unit**, including, sub-acute intensive care units, progressive care units, intermediate care units, private monitored rooms, observation units or other facilities not meeting the standards set forth in the definition of an **Intensive Care Unit**);
- c. **Hospital** miscellaneous medications, **Prescription Drugs**, services and supplies - (Note, miscellaneous charges by a **Hospital** for personal convenience items, including but not limited to television, telephone, internet and radio are not considered **Covered Expenses**); and
- d. **Provider** Visits – (Note: limited one (1) **Provider** visit per treating **Provider** per day while the **Minor Dependent Insured** is an **Inpatient**. **Sickness and Injury Benefits** are not payable for professional fees for visits at the **Hospital** following surgery by a Surgeon, Anesthesiologist or Nurse Anesthetist whose professional fees in connection with the surgery constitute **Covered**

Expenses, unless the visit is to evaluate or treat an **Injury** or **Sickness** other than that which resulted in the **Minor Dependent Insured's** covered surgery).

2. INPATIENT SURGERY

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

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

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

3. INPATIENT LABORATORY AND DIAGNOSTIC TESTS

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

4. INPATIENT RADIATION THERAPY AND CHEMOTHERAPY

Services **Provided** by a **Hospital**, **Provider** or other medical facility in connection with radiation therapy and chemotherapy received on an **Inpatient** basis by a **Minor Dependent Insured** due to **Sickness**.

5. INPATIENT THERAPY

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

- a. Occupational therapy;
- b. Rehabilitation therapy;
- c. Cardiac and pulmonary rehabilitation therapy;
- d. Radio-frequency thermal therapy, only in connection with primary procedure of an orthopedic condition;
- e. Neurologic rehabilitation, for up to sixty (60) days, per **Minor Dependent Insured**, per lifetime:
 - (a) When the **Minor Dependent Insured** is suffering from a **Severe Traumatic Brain Injury**; and
 - (b) When admission to the **Inpatient Provider** is within seven (7) days of release from a **Hospital**.
- f. Cognitive rehabilitation, only in connection with a **Severe Traumatic Brain Injury**
- g. **Habilitative Services**

6. INPATIENT TREATMENT OF MENTAL AND EMOTIONAL DISORDERS

Services **Provided** by a **Hospital**, **Specialized Hospital** or a **Provider** for the treatment and evaluation of **Mental and Emotional Disorders** received on an **Inpatient** basis by a **Minor Dependent Insured**.

7. BREAST RECONSTRUCTION INCIDENT TO MASTECTOMY

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

8. HOSPITAL CONFINEMENT INCIDENT TO MASTECTOMY

Hospital Confinement in connection with a **Mastectomy**, for no less than forty-eight (48) hours, unless the decision to discharge the **Minor Dependent Insured** earlier than the forty-eight (48) hours is made by both the **Provider** and the **Minor Dependent Insured**.

9. TRANSPLANTS

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

Transplant services include the **Minor Dependent Insured's** medical, surgical and **Hospital** services, **Inpatient** immunosuppressive medications, **Covered Expenses** for organ procurement and, if **Medically Necessary**, compatibility testing undertaken prior to procurement.

The maximum amount of **Covered Expenses** allowed for professional fees of a **Provider** and facility fees for the harvesting of applicable donor organs or donor bone marrow is \$10,000 per transplant, to the extent that any **Benefits** hereunder remain and are available under the **Policy** for the applicable **Minor Dependent Insured** recipient.

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

- a. any non-human (including animal or mechanical) **Solid Organ Transplant**;
- b. transplants approved for a specific medical condition, but applied to another condition;
- c. the purchase price of any organ, tissue, blood, bone marrow, cells, or stem cells that are sold and not donated;
- d. any donor charge or donor expense incurred that does not constitute **Covered Expenses** allowed for professional fees and facility fees incurred in connection with the harvesting of applicable donor organs or donor bone marrow; and
- e. any transplantation (including grafts) that does not constitute **Solid Organ Transplants**, **Bone Marrow Transplants**, and/or **Stem Cell Transplants**.

[Transplant travel **Benefits** are not available for cornea transplants. **Benefits** for transportation, lodging and food are available only for the **Minor Dependent Insured** of a pre-approved organ/tissue transplant from a transplant facility, receiving authorized transplant related services during any of the following:

- a. Evaluation,
- b. Candidacy,
- c. Transplant event, or
- d. Post-transplant care.

All claims filed for **Covered Expenses** for travel must include detailed receipts. Transportation mileage will be calculated by **Us** based on the home address of the **Minor Dependent Insured** and the transplant site. **Covered Expenses** for travel for the **Minor Dependent Insured** receiving the transplant will include:

- a. Transportation to and from the transplant site in a personal vehicle will be reimbursed at [37.5] cents per mile when the transplant site is more than sixty (60) miles one way from the **Minor Dependent Insured's** home; and
- b. Lodging and food while at, or traveling to and from the transplant site, [limited to \$50-150 per day];

In addition to the **Minor Dependent Insured's Covered Expenses** associated with the items above, such **Covered Expenses** will also be considered for one companion to accompany the **Minor Dependent Insured**. The term companion includes **Your** member of your **Family**, or **Your** legal guardian. **Covered Expenses** are limited to [\$10,000] per transplant.

Transplant travel **Benefits** are not available if the **Minor Dependent Insured** is a donor. In addition to other exclusions in this **Policy**, **Benefits** will not be provided for the following: miscellaneous charges while lodging, including but not limited to personal convenience items movies, wireless internet, telephone, radio, cleaning supplies and shipping charges.]

10. EMERGENCY ROOM SERVICES

Services **Provided** by a **Hospital** or a **Provider** in the emergency room of the **Hospital** for the following items received by a **Minor Dependent Insured** on an **Emergency** basis:

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

This **Benefit** is not subject to the **Separate Deductible for Non-Participating Providers** or the **Non-Participating Provider Minor Dependent Insured Coinsurance Percentage**.

11. EMERGENCY TRANSPORTATION TO HOSPITAL BY AMBULANCE

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

12. OUTPATIENT TREATMENT OF ACCIDENTAL INJURIES

Services **Provided** by a **Hospital**, an **Emergency Care Facility** or a **Provider** in connection with the **Outpatient** treatment of **Injuries** received by a **Minor Dependent Insured**.

13. OUTPATIENT SURGERY AT A HOSPITAL OR AN AMBULATORY SURGICAL CENTER

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

- a. **Hospital** or **Ambulatory Surgical Center** – (expenses that constitute **Covered Expenses** will be considered for **Sickness and Injury Benefit** payment for the pre-operation, operation and recovery rooms, as well as for medications, **Prescription Drugs**, and other miscellaneous items, services and supplies; provided that miscellaneous charges for any personal convenience items, including but not limited to television, telephone, and radio are not considered **Covered Expenses**);
- b. Primary Surgeon;
- c. Assistant Surgeon – (professional fees that constitute **Covered Expenses** will be considered for a **Sickness and Injury Benefit** payment for one assistant surgeon in connection with surgery for which **Sickness and Injury Benefits** are payable hereunder for the professional fees of the primary surgeon);
- d. Anesthesiologist or Nurse Anesthetist – (professional fees that constitute **Covered Expenses** will be considered for a **Sickness and Injury Benefit** payment for either an anesthesiologist or a nurse anesthetist administration and monitoring of anesthesia, during surgery for which **Sickness and Injury Benefits** are payable hereunder for the professional fees of the primary surgeon);
- e. Pathologist – (professional Fees that constitute **Covered Expenses** will be considered for a **Sickness and Injury Benefit** payment for a pathologist's evaluation and/or interpretation of any tissue specimen removed during or in connection with such surgery); and
- f. Second Surgical Opinion - Up to [\$250] of professional fees for a second surgical opinion if:
 - 1) the **Minor Dependent Insured's Provider** determines that surgery is needed;
 - 2) the surgery is not excluded from this **Policy** or any riders, amendments or endorsements attached hereto;
 - 3) the **Minor Dependent Insured** is examined in person by another qualified **Provider** for the purpose of obtaining a second surgical opinion; and
 - 4) the **Provider** issuing the second surgical opinion sends **Us** a written report.

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

14. OUTPATIENT PROVIDER OFFICE VISITS

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

15. OUTPATIENT PRESCRIPTIONS

We will pay **Covered Expenses** incurred by a **Minor Dependent Insured** for **Prescription Drugs** filled at a **Participating Pharmacy**. **Covered Expenses** for such **Prescriptions** shall not exceed the amount of the cost of the least expensive drug, medicine or **Prescription Drug** that may be used to treat the **Minor Dependent Insured's Sickness** or **Injury**, all in accordance with the following schedule:

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

Expenses for such **Prescription** shall be limited to the cost of the **Preferred Brand Drug** at such pharmacy; and

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

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

16. OUTPATIENT LABORATORY AND DIAGNOSTIC TESTS

Services **Provided** by a **Hospital, Provider** or other medical facility in connection with the performance and interpretation of laboratory and diagnostic tests received on an **Outpatient** basis by a **Minor Dependent Insured** due to **Injuries** or **Sickness**.

17. OUTPATIENT RADIATION THERAPY AND CHEMOTHERAPY

Services **Provided** by a **Hospital, Provider** or other medical facility in connection with radiation therapy and chemotherapy received on an **Outpatient** basis by a **Minor Dependent Insured** due to **Sickness**.

18. OUTPATIENT DIALYSIS

Services **Provided** by a **Hospital, Provider** or other medical facility in connection with dialysis received on an **Outpatient** basis by a **Minor Dependent Insured** due to **Sickness**

19. OUTPATIENT THERAPY

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

- a. Occupational therapy (not to exceed thirty (30) visits per **Covered Minor Dependent Insured** per **Calendar Year**);
- b. Rehabilitation therapy (not to exceed thirty (30) visits per **Covered Minor Dependent Insured** per **Calendar Year**);
- c. Cardiac and pulmonary rehabilitation therapy (not to exceed thirty-six (36) visits per **Covered Minor Dependent Insured** per **Calendar Year**);
- d. Radio-frequency thermal therapy, only in connection with primary procedure of an orthopedic condition;
- e. Cognitive rehabilitation, only in connection with a **Severe Traumatic Brain Injury**; and
- f. **Habilitation Services** (not to exceed thirty (30) visits per **Covered Minor Dependent Insured** per **Calendar Year**).

20. OUTPATIENT TREATMENT OF MENTAL AND EMOTIONAL DISORDERS

Services **Provided** by a **Specialized Hospital** or a **Provider** for treatment of **Mental and Emotional Disorders**. Services include testing and evaluation for psychological testing, developmental testing, neurobehavioral testing, and neuropsychological testing, limited to fifteen (15) hours per **Minor Dependent Insured** per **Calendar Year**.

21. HOME HEALTH CARE

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

- a. The **Minor Dependent Insured** had first been **Confined** in a **Hospital** or was a resident at a **Skilled Nursing Home** due to an **Injury** or **Sickness**;
- b. The **Home Health Care Plan** of the **Minor Dependent Insured** begins no later than thirty (30) days after discharge from the **Hospital** or **Skilled Nursing Home**;
- c. The **Home Health Care Plan** is reviewed at thirty (30) day intervals by the **Provider**; and
- d. The **Home Health Care Plan** is for the same or related **Injury** or **Sickness** as the **Hospital** or **Skilled Nursing Home Confinement**.

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

Payment under this coverage is limited to a maximum of fifty (50) visits per **Minor Dependent Insured** per **Calendar Year**.

22. HOSPICE CARE

Services **Provided** to a **Minor Dependent Insured** for **Hospice Care** due to **Injuries** or **Sickness**, if:

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

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

23. MEDICAL EQUIPMENT AND SUPPLIES

Medical Equipment and supplies **Provided** to a **Minor Dependent Insured** as a result of **Injury** or **Sickness** includes:

- a. Blood, plasma, and derivatives, if not replaced;
- b. Initial replacement of natural limbs and eyes when loss occurs while this **Policy** is in force;
- c. Initial permanent lens immediately following cataract surgery, except the replacements will not be covered;
- d. Casts, non-dental splints, trusses, crutches and braces;
- e. Purchase or rental (not to exceed the purchase price) of a wheelchair, hospital bed, or other **Durable Medical Equipment Provided** to a **Minor Dependent Insured** in each event required for therapeutic treatment of **Injuries** or **Sickness** on an **Outpatient** basis; ‘
- f. **Consumable Medical Supplies**, limited to a thirty-one (31) day supply per month;
- g. **Cochlear Implants**, one (1) per **Minor Dependent Insured** up to \$35,000 per lifetime; **Auditory Brain Stem Implant**, one (1) per lifetime for **Minor Dependent Insureds** age twelve (12) and over; and **Implantable Osseointegrated Hearing Aids**;
- h. Initial acquisition of eyeglasses or contact lenses within the first six (6) months following cataract surgery;
- i. Oxygen and its administration;

- j. Ostomy supplies that are limited to pouches, face plates and belts, irrigation sleeves, bags and ostomy irrigation catheters, and skin barriers; and
- k. **Orthotic Devices, Orthotic Services, Prosthetic Devices, and Prosthetic Services** when prescribed by a **Provider** when **Medically Necessary**. Replacement and repair only when necessary due to anatomical change or normal use.

24. GASTRIC PACEMAKERS

Gastric Pacemakers Provided to a **Minor Dependent Insured** when **Medically Necessary** to treat **Gastroparesis**.

25. SKILLED NURSING HOME

Daily room and board and miscellaneous charges for other services **Provided** to a **Minor Dependent Insured** due to **Injuries** or **Sickness** for residential care received in a **Skilled Nursing Home** for up to a maximum of sixty (60) days in a twelve (12) month period, if:

- a. the **Minor Dependent Insured** has first been **Confined** in a **Hospital** for seven (7) or more consecutive days;
- b. the **Skilled Nursing Home** stay begins within thirty (30) days after discharge from the **Hospital**;
- c. the **Skilled Nursing Home** stay is for the same or related **Injury** or **Sickness** as the **Hospital Confinement**; and
- d. the **Minor Dependent Insured's Provider** certifies the need for **Skilled Nursing Home Confinement**.

26. SUPPLIES AND SERVICES ASSOCIATED WITH THE TREATMENT OF DIABETES

The following **Outpatient** services **Provided** to a **Minor Dependent Insured** for care received during for the treatment of diabetes and associated conditions:

- a. **Diabetes Equipment**;
- b. **Diabetes Supplies**; and
- c. **Diabetes Self-Management Training**.

27. INHERITED METABOLIC DISORDERS

Medical Foods prescribed or ordered under the supervision of a **Provider**, as **Medically Necessary** for the treatment of an **Inherited Metabolic Disorder** or for the treatment of a **Sickness** in which a **Minor Dependent Insured** is unable to sustain weight and strength commensurate with the **Minor Dependent Insured's** overall health status.

Inherited Metabolic Disorders triggering **Medical Food** coverage are:

- a. Part of the newborn screening program as prescribed by **Your Provider**, and involve amino acid, carbohydrate or fat metabolism;
- b. Have medically standard methods of diagnosis, treatment and monitoring including quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues; and
- c. Require specifically processed or treated **Medical Foods** that are generally available only under the supervision and direction of a **Provider**, that must be consumed throughout life and without which the **Minor Dependent Insured** may suffer serious mental or physical impairment.

For non-inherited disorders, enteral nutrition is considered **Medically Necessary** when the **Minor Dependent Insured** has:

- a. A permanent non-function or **Sickness** of the gastrointestinal structures that normally permit food to reach the small bowel; or
- b. A **Sickness** of the small bowel which impairs digestion and absorption of an oral diet consisting of solid or semi-solid foods.

The following are not considered **Medically Necessary** and are not covered as a **Medical Food**, metabolic supplement or gastric disorder formula:

- a. Standard oral infant formula;
- b. Food thickeners, baby food, or other regular grocery products;
- c. Nutrition for a diagnosis of anorexia; or
- d. Nutrition for nausea associated with mood disorder and end-stage disease.

28. MATERNITY AND NEWBORN CARE

Services **Provided** by a **Hospital** or a **Provider** for (i) a **Minor Dependent Insured's** routine pregnancy, including normal labor and delivery, (ii) cesarean section deliveries that are not performed on an **Emergency** basis, and (iii) **Complications of Pregnancy**.

Hospital Confinement for a mother who is a **Minor Dependent Insured** and her newborn child for a period of time up to forty-eight (48) hours following vaginal delivery, and up to ninety-six (96) hours following delivery by cesarean section, shall be considered a **Medically Necessary Inpatient Confinement**. **Hospital Confinement** in which the length of stay exceeds these periods shall be subject to the definition and the requirements of **Medical Necessity** and **Medically Necessary** and the requirements of **Pre-Certification of Treatment**.

Services for the care and treatment of **Your** newborn child or newborn adoptee including care for **Injury, Sickness**, congenital defects, birth abnormalities, and premature birth.

MATERNITY AND NEWBORN CARE **Provided** by a **Non-Participating Provider** limited to the **Maximum Allowable Charge** or \$2,000, whichever is less.

29. SUBSTANCE ABUSE SERVICES

Services **Provided** by a **Specialized Hospital** or a **Provider** for the treatment of **Substance Abuse**. This includes rehabilitation services and residential services.

Voluntary residential treatment is limited to a maximum of seven (7) days per **Minor Dependent Insured** per **Calendar Year** and **Outpatient Substance Abuse** services limited to a maximum of thirty (30) visits per **Minor Dependent Insured** per **Calendar Year**.

30. HEARING AIDS

Services **Provided** to a **Minor Dependent Insured** for hearing aids due to hearing loss that has been verified by a **Provider**. The hearing aids shall be **Medically Necessary** to meet the needs of the **Minor Dependent Insured** according to accepted professional standards. **Covered Expenses** include up to \$1,400 per ear every three (3) years.

Covered Expenses with respect to hearing aids are not subject to either the **Calendar Year Deductible** or the **Minor Dependent Insured Coinsurance Percentage**.

31. CRANIOFACIAL ANOMALY

Services **Provided** to a **Minor Dependent Insured** for the treatment and correction of a **Craniofacial Anomaly**, as well as secondary conditions and treatment attributable to a **Craniofacial Anomaly**, if surgery and treatment **Provided** are **Medically Necessary** to improve functional impairment resulting from a **Craniofacial Anomaly**, including:

- a. corrective surgery and related medical care;
- b. vision care related to a **Craniofacial Anomaly**;
- c. dental care related to a **Craniofacial Anomaly**; and
- d. use of at least one (1) hearing aid.

32. CHIROPRACTIC SERVICES

Diagnostic and treatment services **Provided** by a **Provider** in connection with conservative management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain and improve function. The following are specifically excluded from chiropractic care and osteopathic services:

- a. Services of a chiropractor or osteopath which are not within his scope of practice, as defined by state law;
- b. Charges for care not **Provided** in an office setting;
- c. Maintenance or preventive treatment consisting of routine, long term or not **Medically Necessary** care provided to prevent reoccurrences or to maintain the **Minor Dependent Insured's** current status; and
- d. Vitamin therapy.

Payment under this coverage is limited to a maximum of thirty (30) visits per **Minor Dependent Insured** per **Calendar Year**.

33. TEMPOROMANDIBULAR JOINT (TMJ) DISORDER

Services **Provided** by a **Hospital** or a **Provider** for **Covered Expenses** which are **Medically Necessary** to treat TMJ disorder which is a result of:

- a. An **Accident** or trauma;
- b. A congenital defect;
- c. A developmental defect; or
- d. A pathology.

Covered Expenses include diagnosis, treatment and surgery that is recognized by the medical or dental profession as effective and appropriate treatment for TMJ, including intra-oral splints that stabilize the jaw joint.

34. INFERTILITY SERVICES

Services **Provided** to a **Minor Dependent Insured** for infertility evaluation. Services for treatment related to diagnosed infertility, including, but not limited to artificial insemination are not covered.

35. FAMILY PLANNING SERVICES (CONTRACEPTION AND VOLUNTARY STERILIZATION)

Services **Provided** to a **Minor Dependent Insured** for **Covered Expenses** for family planning services including:

- a. Medical history;
- b. Physical examination;
- c. Related laboratory tests;
- d. Medical supervision in accordance with generally accepted medical practice;
- e. Information and counseling on contraception;
- f. Implanted/injected and oral contraceptives; and
- g. After appropriate counseling, medical services connected with surgical therapies (vasectomy or tubal ligation).

36. DENTAL ANESTHESIA

Services **Provided** for general anesthesia in connection with dental services or **Oral Surgery** at a **Hospital** or **Ambulatory Surgical Center** if the **Minor Dependent Insured**:

- a. is under seven (7) years of age who is determined, by two (2) **Dentists**, to require dental treatment in a **Hospital** or **Ambulatory Surgical Center** for a significantly complex dental condition;
- b. is diagnosed with a serious mental or physical condition; or

c. is a person with significant behavioral problem, as determined by a **Provider** licensed under the Arkansas Medical Practices Act.

37. DENTAL SERVICES – ACCIDENT ONLY

Services **Provided** by a **Hospital** or a **Provider** for the treatment of a fractured jaw or a **Dental Injury** to **Sound Natural Teeth**. **Benefits** are payable for the services of a **Provider**, **Dentist**, or dental surgeon, for treatment of an **Accidental Dental Injury** when treatment is sought within seventy-two (72) hours of injury.

38. PEDIATRIC DENTAL CARE

Services **Provided** for **Pediatric Dental Care** by a **Dentist** to a **Minor Dependent Insured**, up to age nineteen (19), in connection with the following **Pediatric Dental Care** services:

- a. **Emergency Room** services **Provided** by a **Dentist**.
- b. **Preventive Pediatric Dental Care** - includes procedures which help to prevent oral disease from occurring, including:
 - 1) **Prophylaxis** - scaling and polishing the teeth at six (6) month intervals;
 - 2) Topical fluoride application at six (6) month intervals, excluding fluoride varnish;
 - 3) Sealants on first and second permanent molars, once; and
 - 4) Space maintainers.
- c. **Routine Pediatric Dental Care** – services **Provided** in the office of a **Dentist** which includes:
 - 1) Dental examinations, visits and consultations once within a five (5) month consecutive period (when primary teeth erupt);
 - 2) **Bitewing X-rays** at six (6) month intervals, full mouth x-rays every five (5) years, and panoramic x-rays every five (5) years;
 - 3) Procedures for simple **Extractions** and care of abscesses and surgical **Extractions**; and other routine **Oral Surgery** not requiring hospitalization, including preoperative care and postoperative care;
 - 4) General anesthesia and analgesia and non-intravenous conscious sedation;
 - 5) Silver amalgam and tooth colored composite fillings;
- d. Stainless steel crowns for first molars and stainless steel crowns for all other permanent teeth and metal and porcelain crowns. **Endodontics** - includes procedures for treatment of diseased tooth **Pulp** and the tissues surrounding the root of the tooth, where hospitalization is not required.
- e. **Gum Therapy**
- f. **Prosthodontics** - includes services as follows:
 - 1) Removable complete or partial **Dentures**.

B. WELLNESS AND SCREENING BENEFITS

1. WELLNESS AND PREVENTIVE BENEFITS:

WELLNESS AND PREVENTIVE BENEFITS are not subject to either the **Calendar Year Deductible** or the **Minor Dependent Insured Coinsurance Percentage**, but are subject to any applicable **Separate Deductible For Non-Participating Providers** and the **Non-Participating Provider Minor Dependent Insured Coinsurance Percentage**. Therefore, subject to all applicable definitions, exclusions, limitations, and other provisions contained in this **Policy**, as well as any riders, endorsements, or amendments attached hereto, including applicable **Separate Deductible For Non-Participating Providers** and the **Non-Participating Provider Minor Dependent Insured Coinsurance Percentage**, **We** will pay to or on behalf of each **Minor Dependent Insured** the **Company Insurance Percentage** of the amount of professional fees and other applicable medical diagnostic or treatment expenses and charges that constitute **Covered Expenses** incurred by each applicable **Minor Dependent Insured** for the following described WELLNESS AND PREVENTIVE BENEFITS:

a. ADULT WELLNESS AND PREVENTIVE CARE

Services **Provided to You** for necessary **Adult Wellness Preventive Care** by a **Provider** for evidence-based items or services that have in effect, at the time services are **Provided**, a rating of "A" or "B" in the current list of preventive services recommended for adults by the United States Preventive Services Task Force (USPSTF), and to the extent addressed by the USPSTF.

Adult Wellness Preventive Care does not include charges by **Providers** for any spinal manipulations, physical therapy, occupational therapy, or other **Outpatient** therapy or treatment, or any form of medical or surgical treatment of an **Injury** or **Sickness**.

Adult Wellness Preventive Care services **Provided** by a **Non-Participating Provider** are subject to the **Separate Deductible For Non-Participating Providers** and the **Non-Participating Provider Minor Dependent Insured Coinsurance Percentage**. Additionally, if the **Adult Wellness Preventive Care** services are billed separately from an office visit, or if the primary purpose of the office visit was not for the delivery of such **Adult Wellness Preventive Care** services, **We** will impose any applicable deductibles or coinsurance with respect to the office visit.

b. CHILDHOOD WELLNESS AND PREVENTIVE CARE

Services **Provided** by a **Provider** to each infant, child, and adolescent **Minor Dependent Insured** for **Medically Necessary Childhood Wellness Preventive Care** for evidence-based items or services that have in effect, at the time of services are **Provided**, a rating of "A" or "B" at ages recommended by the United States Preventive Services Task Force (USPSTF), and to the extent addressed by the USPSTF. **Child Wellness Preventive Care** also includes evidence-informed preventive care and screenings **Provided** for the appropriate age in the comprehensive guidelines supported by the Health Resources and Services Administration and by the American Academy of Pediatrics (AAP) and Bright Futures. **Childhood Wellness Preventive Care** does not include charges by **Providers** for any spinal manipulations, physical therapy, occupational therapy, or other **Outpatient** therapy or treatment, or any form of medical or surgical treatment of an **Injury** or **Sickness**.

Childhood Wellness Preventive Care services **Provided** by a **Non-Participating Provider** are subject to the **Separate Deductible For Non-Participating Providers** and the **Non-Participating Provider Minor Dependent Insured Coinsurance Percentage** with the exception of **Benefits** for screening tests performed by **Non-Participating Providers** for hearing loss for children age twenty-four (24) months and younger, which are not subject to any otherwise applicable deductible. Additionally, if the **Childhood Wellness Preventive Care** services are billed separately from an office visit, or if the primary purpose of the office visit was not for the delivery of such **Childhood Wellness Preventive Care** services, **We** will impose any applicable deductibles or coinsurance with respect to the office visit.

c. IMMUNIZATIONS

Services for routine immunizations **Provided** to each **Minor Dependent Insured** as currently recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC) at the time services are **Provided**.

Immunizations **Provided** by a **Non-Participating Provider** are subject to the **Separate Deductible For Non-Participating Providers** and the **Non-Participating Provider Minor Dependent Insured Coinsurance Percentage**. If the immunizations are billed separately from an office visit, or if the primary purpose of the office visit was not for the delivery of such immunizations, then **We** may impose any applicable deductibles or coinsurance with respect to the office visit. Immunization **Benefits** do not include charges for immunizations for occupational hazards or international travel, except as recommended by the CDC.

2. SCREENING AND EXAMINATION BENEFITS:

SCREENING AND EXAMINATION BENEFITS are subject to all applicable definitions, exclusions, limitations, and other provisions contained in this **Policy**, as well as any riders, endorsements, or

amendments attached hereto. **We** promise to pay to or on behalf of each **Minor Dependent Insured** the **Company Insurance Percentage** of the amount of professional fees and other applicable medical diagnostic or treatment expenses and charges that constitute **Covered Expenses** incurred by each **Insured** for the following described SCREENING AND EXAMINATION BENEFITS, but only after (i) each of the applicable deductibles has been first satisfied by deduction from such **Covered Expenses** and applied to the applicable **Minor Dependent Insured** for payment, and (ii) the applicable **Minor Dependent Insured Coinsurance Percentage** for the **Covered Expenses** remaining after satisfaction of all applicable deductibles is, likewise, satisfied by deduction from the remaining **Covered Expenses** and applied to the applicable **Minor Dependent Insured** for payment:

a. MAMMOGRAPHY SCREENING

1) For female **Minor Dependent Insureds** thirty-five (35) to thirty-nine (39) years of age, a single baseline **Mammogram** to detect the presence of occult breast cancer; and

2) For female **Minor Dependent Insureds** of any age a **Mammogram** upon recommendation of the **Provider**, when the female **Minor Dependent Insured** has a prior history of breast cancer or when the female **Minor Dependent Insureds'** mother or sister had a history of breast cancer.

Mammography **Benefits** for female **Minor Dependent Insureds** ages forty (40) and over are covered under the ADULT WELLNESS PREVENTIVE CARE provision.

b. PROSTATE CANCER SCREENING

Services **Provided** during an annual physical examination for the detection of prostate cancer for each male **Minor Dependent Insured** who is age forty (40) years or older.

The prostate cancer screening must be performed by a **Provider**, and shall consist of a digital rectal examination and upon the recommendation of the **Provider**, a specific antigen blood test.

Covered Expenses with respect to prostate cancer screenings are not subject to either the **Calendar Year Deductible** or the **Minor Dependent Insured Coinsurance Percentage**.

c. COLORECTAL CANCER SCREENING

Screening **Provided** to a **Minor Dependent Insured** under age fifty (50) who are at **High Risk for Colorectal Cancer**.

Colorectal cancer screening **Benefits** for **Minor Dependent Insureds** ages fifty (50) and over are covered under the ADULT WELLNESS PREVENTIVE CARE provision.

d. ROUTINE ANNUAL PHYSICAL EXAMINATION

Services **Provided** to **Minor Dependent Insureds** ages twenty-two (22) and up for necessary annual physical exam visit, by a **Participating Provider** no more than once every twelve (12) months up to a **Calendar Year** per **Minor Dependent Insured** per **Calendar Year**.

Benefits under this section do not include charges (i) by **Participating Providers** for any spinal manipulations, physical therapy, occupational therapy, or other **Outpatient** therapy or treatment, or any form of medical or surgical treatment of an **Injury** or **Sickness**, or (ii) for any service, care, test or treatment by a **Non-Participating Provider**.

e. HEARING EXAMINATION

Services **Provided** by a **Hospital** or a **Provider** for one **Hearing Examination** per adult **Minor Dependent Insured** per **Calendar Year**.

f. VISION EXAMINATION

Services **Provided** for one **Vision Examination** per **Minor Dependent Insured** age twenty (20) and up every two (2) years and one (1) **Vision Examination** per **Minor Dependent Insured** age nineteen (19) and under per **Calendar Year**. If a **Vision Examination** results in a **Minor Dependent Insured** needing

corrective **Vision Materials** for their visual health and welfare, those **Vision Materials** prescribed by **Providers** will be **Provided**, subject to certain limitations and exclusions of the **Policy**, as follows:

- 1) Lenses - Up to two (2) lenses provided per **Minor Dependent Insured** per **Calendar Year**.
- 2) Frame – One (1) frame provided per **Minor Dependent Insured** per **Calendar Year**.
- 3) Contact Lenses - Contact lenses **Provided** when **Medically Necessary**, not to exceed the cost of lenses and frames.

C. PRE-CERTIFICATION OF TREATMENT

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

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

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

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

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

D. CLAIM PROCEDURES, INVESTIGATION AND PAYMENT

1. NOTICE OF CLAIM

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

2. CLAIM FORMS AND ADDITIONAL INFORMATION TO BE PROVIDED

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

otherwise as part of the completion of a proper proof of loss. **We** must receive information requested within the time limit stated in the Section V D 3. PROOFS OF LOSS.

3. PROOFS OF LOSS

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

4. CLAIMS REVIEW, INVESTIGATION, ADJUSTMENT AND ADJUDICATION

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

5. PAYMENT OF CLAIMS

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

6. TIME OF PAYMENT OF CLAIMS

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

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

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

VI. DEDUCTIBLES

A. CALENDAR YEAR DEDUCTIBLE

No **Sickness and Injury Benefits** or **Wellness and Screening Benefits** are payable under this **Policy** for any **Covered Expenses** incurred by a **Minor Dependent Insured**, until after the **Calendar Year Deductible** is satisfied and fully payable each **Calendar Year** by such **Minor Dependent Insured**, unless otherwise specified. In addition to the **Calendar Year Deductible**, the **Separate Deductible For Non-Participating Providers** will apply to services rendered by **Non-Participating Providers**.

The amount of the **Separate Deductible For Non-Participating Providers** may not be used to satisfy the **Calendar Year Deductible**.

B. SEPARATE DEDUCTIBLE FOR NON-PARTICIPATING PROVIDERS

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

The amount of the **Calendar Year Deductible** may not be used to satisfy the **Separate Deductible For Non-Participating Providers**.

VII. LIMITATIONS, EXCLUSIONS AND NON-WAIVER

A. LIMITATIONS

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

1. **Minor Dependent Insureds** have the right to obtain **Prescriptions** from the pharmacy of their choice. However, if a **Minor Dependent Insured**: (i) uses a **Non-Participating Pharmacy** to fill a **Prescription**; or (ii) does not present his/her correct ID card when the **Prescription** is filled at a **Participating Pharmacy**, then such **Minor Dependent Insured** must pay the applicable pharmacy in full and file a claim form with the **Company** for reimbursement. In either event, the **Minor Dependent Insured** will be reimbursed by the **Company** at the discounted or negotiated rate for such **Prescription** that would have been paid to a **Participating Pharmacy** by the **Company** under this **Policy** if the **Minor Dependent Insured** had used a **Participating Pharmacy** and properly presented the correct ID card at the time the **Prescription** was filled;
2. Pre-authorization may be required by the **Company** prior to the time that **Prescriptions** for certain **Prescription Drugs** are filled;
3. If as the result of an **Emergency Sickness** or an **Emergency Injury** services are rendered for a **Minor Dependent Insured** by a **Non-Participating Provider** when a **Participating Provider** was not reasonably available in connection with either (i) on an **Outpatient** basis in the emergency room of a **Hospital** or (ii) an **Emergency Inpatient** admission to a **Hospital**, then the **Covered Expenses** incurred will be reimbursed by **Us** as if such **Non-Participating Provider** were a **Participating Provider** up to the point when the **Minor Dependent Insured** can be safely transferred to a **Participating Provider**. If the **Minor Dependent Insured** refuses or is unwilling to be transferred to the care of a **Participating Provider** after such **Minor Dependent Insured** can be safely transferred, then reimbursement shall thereafter be reduced to the **Company's Insurance Percentage for Non-Participating Providers**; and
4. **Sickness and Injury Benefits** and **Wellness and Screening Benefits** under this **Policy** for any **Minor Dependent Insured** who is eligible for or has coverage under **Medicare**, and/or amendments thereto, regardless of whether such **Minor Dependent Insured** is enrolled in **Medicare** shall be limited to only the **Usual and Customary** charges for services, supplies, care or treatment covered under this **Policy** that are not or would not have been payable or reimbursable by **Medicare** and/or its amendments (assuming such

enrollment), subject to all provisions, limitations, exclusions, reductions and maximum benefits set forth in this **Policy**.

B. EXCLUSIONS

Coverage under this **Policy** is limited as provided by the definitions, limitations, exclusions, and terms contained in each and every Section of this **Policy**. In addition, this **Policy** does not provide coverage for expenses charged to a **Minor Dependent Insured** or any payment obligation for **Us** under this **Policy** for any of the following, all of which are excluded from coverage:

1. the amount of any professional fees or other medical expenses or charges for treatments, care, procedures, services or supplies which do not constitute **Covered Expenses**;
2. **Covered Expenses** incurred before the **Policy Issue Date**;
3. the amount of any professional fees or other medical expenses contained on a billing statement to a **Minor Dependent Insured** which exceed the amount of the **Maximum Allowable Charge**;
4. any professional fees or other medical expenses for treatments, care, procedures, services or supplies which are not specifically enumerated in the SICKNESS AND INJURY BENEFITS, or WELLNESS AND SCREENING BENEFITS Sections of this **Policy** and any optional coverage rider attached hereto;
5. **Covered Expenses You** or **Your** covered family members are not required to pay, which are covered by other insurance, or that would not have been billed if no insurance existed;
6. any professional fees or expenses for which the **Minor Dependent Insured** and/or any covered family member are not legally liable for payment;
7. any professional fees or expenses for which the **Minor Dependent Insured** and/or any covered family member were once legally liable for payment, but from which liability the **Minor Dependent Insured** and/or family member were released;
8. treatment of the teeth, the surrounding tissue or structure, including the gums and tooth sockets. This exclusion does not apply to treatment: (a) due to **Injury** to natural teeth (treatment must be **Provided** within ninety (90) days of the date of the **Injury**); (b) for malignant tumors, or (c) which are otherwise **Provided** for in the SICKNESS AND INJURY BENEFITS section of this **Policy**;
9. **Injury** or **Sickness** due to any act of war (whether declared or undeclared);
10. services provided by any state or Federal government agency, including the Veterans Administration unless, by law, a **Minor Dependent Insured** must pay for such services;
11. **Covered Expenses** that are payable under any motor vehicle no fault law insurance policy or certificate;
12. charges that are payable or reimbursable by either:
 - a) a plan or program of any governmental agency (except Medicaid), or
 - b) **Medicare** Part A, Part B and/or Part D (If the applicable **Minor Dependent Insured** does not enroll in **Medicare**, **We** will estimate the charges that would have been paid if such enrollment had occurred);
13. drugs or medication not used for a Food and Drug Administration (FDA) approved use or indication;
14. administration of experimental drugs or substances or investigational use or experimental use of **Prescription Drugs** except for any **Prescription Drug** prescribed to treat a covered chronic, disabling, life-threatening **Sickness** or **Injury**, but only if the investigational or experimental drug in question:
 - a) has been approved by the FDA for at least one indication; and
 - b) is recognized for treatment of the indication for which the drug is prescribed in:
 - 1) a standard drug reference compendia; or
 - 2) substantially accepted peer-reviewed medical literature.
 - c) drugs labeled "Caution –limited by Federal law to investigational use";
15. experimental procedures or treatment methods not approved by the American Medical Association or other appropriate medical society;
16. any **Injury** or **Sickness** covered by any Workers' Compensation insurance coverage, or similar coverage underwritten in connection with any Occupational Disease Law, or Employer's Liability Law, regardless of whether you file a claim for benefits thereunder;
17. eyeglasses, contact lenses, radial keratotomy, lasik surgery, hearing aids and exams for their prescription or fitting, except as **Provided** for in the SICKNESS AND INJURY BENEFITS and WELLNESS AND SCREENING BENEFITS sections of this **Policy**;
18. any damage or harm to the physical structure of the body of a **Minor Dependent Insured** occurring while the **Minor Dependent Insured** is intoxicated or under the influence of alcohol or any drug, narcotic or hallucinogens unless administered via a prescription and on the advice of a **Provider**, and taken in accordance with the limits of such advice.

A **Minor Dependent Insured** is conclusively determined to be intoxicated by drug or alcohol if (ii) a chemical test administered

in the jurisdiction where either the **Accident** occurred or the **Minor Dependent Insured** was medically treated is at or above the

legal limit set by that jurisdiction or (ii) the level of alcohol was such that a person's coordination, ability to reason, was impaired, regardless of the legal limit set by that jurisdiction;

19. intentionally self-inflicted **Injury**, suicide or any suicide attempt while sane or insane;
20. serving in one of the branches of the armed forces of any foreign country or any international authority;
21. voluntary abortions, abortifacients or any other drug or device that terminates a pregnancy;
22. services **Provided** by **You** or a **Provider** who is a member of a **Minor Dependent Insured's** family;
23. any loss to which a contributing cause was the **Minor Dependent Insured's** being engaged in or attempting to engage in an illegal occupation or illegal activity;
24. participation in aviation, except as fare-paying passenger traveling on a regular scheduled commercial airline flight;
25. cosmetic surgery or reconstructive procedures, except for **Medically Necessary** cosmetic surgery or reconstructive procedures performed under the following circumstances: (i) where such cosmetic surgery is incidental to or following surgery resulting from trauma or infection; (ii) to correct a normal bodily function; or (iii) such cosmetic surgery constitutes **Breast Reconstruction** that is incident to a **Mastectomy**; provided any of the above occurred while the **Minor Dependent Insured** was covered under this **Policy**.
26. Charges for breast reduction or augmentation or complications arising from these procedures;
27. **Prescription Drugs** or other medicines and products used for cosmetic purposes or indications;
28. reversal or attempted reversal of a previous elective attempt to induce or facilitate sterilization;
29. fertility hormone therapy and/or fertility devices for any type fertility therapy, artificial insemination or any other direct conception;
30. any operation or treatment performed, **Prescription** or medication prescribed in connection with sex transformations or any type of sexual or erectile dysfunction, including complications arising from any such operation or treatment;
31. appetite suppressants, including but not limited to, anorectics or any other drugs used for the purpose of weight control, or services, or treatments;
32. **Prescriptions**, treatment or services for behavioral or learning disorders, Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD);
33. any professional fees or other medical expenses incurred as the result of an **Injury** which was caused or contributed by a **Minor Dependent Insured** racing any land or water vehicle;
34. any professional fees or other medical expenses incurred for the diagnosis, care or treatment of **Mental and Emotional Disorders**, and **Substance Abuse** except as **Provided** for in the SICKNESS AND INJURY BENEFITS section of this **Policy**;
35. **Outpatient Prescription Drugs** that are dispensed by a **Provider**, **Hospital** or other state-licensed facility;
36. **Prescription Drugs** produced from blood, blood plasma and blood products, derivatives, Hemofil M, Factor VIII, and synthetic blood products, or immunization agents, biological or allergy sera, hematinics, blood or blood products administered on an **Outpatient** basis;
37. level one controlled substances;
38. **Prescription Drugs** used to treat or cure hair loss or baldness;
39. compounded **Prescription Drugs**;
40. fluoride products;
41. allergy kits intended for future emergency treatment of possible future allergic reactions;
42. replacement of a prior filled prescription for **Prescription Drugs** that was covered and is replaced because the original prescription was lost, stolen or damaged;
43. **Prescription Drugs**, which have an over the counter equivalent that may be obtained without a **Prescription**, even though such **Prescription Drugs** were prescribed by a **Provider**;
44. any intentional misuse or abuse of **Prescription Drugs**, including **Prescription Drugs** purchased by a **Minor Dependent Insured** for consumption by someone other than such **Minor Dependent Insured**;
45. **Prescription Drugs** that are classified as anti-fungal medication used for treatment of onychomycosis;
46. **Prescription Drugs** that are classified as tobacco cessation products;
47. charges for blood, blood plasma, or derivatives that has been replaced;
48. Temporomandibular Joint Disorder (TMJ) and Craniomandibular Disorder (CMD), except as **Provided** for in the SICKNESS AND INJURY BENEFITS section of this **Policy**;

49. treatment received outside of the United States;
50. services or supplies for personal convenience, including custodial care or homemaker services;
51. open vertical banded gastroplasty, laparoscopic vertical banded gastroplasty, open sleeve gastrectomy, laparoscopic sleeve gastrectomy, and open adjustable gastric banding.
52. any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations, except as **Provided** for in the **Benefit** entitled **Substance Abuse Services** section of this **Policy**;
53. any services for treatment of mental and emotional disorders that have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain;
54. services for treatment of chronic mental conditions not subject to favorable modification according to generally accepted standards of medical practice;
55. services for developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders; developmental language disorders, or articulation disorders;
56. services for counseling for the following: for activities of an educational nature, for borderline intellectual functioning, for occupational problems and for any relation to consciousness raising;
57. services for vocational or religious counseling ;
58. I.Q. testing;
59. services for occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline;
60. services for biofeedback are not covered for reasons other than pain management;
61. treatment for **Autism Spectrum Disorder** performed by the following: Sensory Integration, LOVAAS Therapy and Music Therapy;
62. non-medical ancillary services including, but not limited to, vocational rehabilitation, behavioral training, sleep therapy, employment counseling, driving safety, and services, training or educational therapy for learning disabilities, developmental delays, and mental retardation;
63. purchase or rental of **Durable Medical Equipment** and prosthetics are not covered when due to misuse, damage and replacement when lost; and
64. miscellaneous charges while lodging, including but not limited to personal convenience items movies, wireless internet, telephone, radio, cleaning supplies and shipping charges.

C. NON-WAIVER

Expenses that are mistakenly applied by **Us** to the **Calendar Year Deductible** or erroneously paid by **Us** under any Section or provision of this **Policy** including **Prescription Drugs** shall not:

- a) constitute a waiver of or modification to any conditions, terms, definitions or limitations contained in the **Policy**, specifically including, but not by way of limitation, the definitions of **Sickness** and **Injury**, , as well as any exclusion, limitation and/or exclusionary riders which may be attached to the **Policy**, or otherwise operate to alter, amend, affect, abridge or modify the **Policy** to which it is attached;
- b) create or establish coverage of any medical condition illness, disease or injury under the **Policy** or under any exclusion, limitation and/or exclusionary riders which may be attached to the **Policy**; or
- c) affect, alter, amend, abridge, constitute or act as a waiver of the **Company's** ability to rely upon, assert and apply such terms, definitions, limitations or exclusions of the **Policy** or any amendments thereto.

VIII. GRIEVANCE PROCEDURES

The Arkansas External Review Regulation requires **Us** to provide **You** with the opportunity for an independent review of any **Adverse Determination** or **Final Adverse Determination**. **You** have the right to request an **External Review** once **Your Internal Grievance Procedures** have been exhausted, unless otherwise stated. The criteria for the Grievance Procedures, including the **External Review** process by an **Independent Review Organization** to examine any **Adverse Determinations**, is outlined below.

INTERNAL GRIEVANCE PROCEDURES

You have the right to appeal any denial of a claim for **Benefits** by submitting a written request, via facsimile or mail, for reconsideration.

Requests for reconsideration must be filed within sixty (60) days of receipt of the written notification of denial. Within ten (10) days from receipt of the request for reconsideration, **We** will acknowledge receipt. Within thirty (30) days from receipt of the request for reconsideration, **We** will review **Your** request and provide a written response describing the final determination. If **You** are not satisfied with the **Final Adverse Determination**, **You** may request an **External Review**.

EXTERNAL GRIEVANCE PROCEDURES

I. Notice of Right to External Review -

Adverse Determinations: **You** may file a request for an expedited **External Review** to be conducted at the same time **You** file a request for a review of an appeal as set forth in the **Internal Grievance Procedure**, if:

- (A) **You** have a medical condition where the timeframe for completion of an expedited review of an appeal in **Our Internal Grievance Procedures** would seriously jeopardize **Your** life or health or would jeopardize **Your** ability to regain maximum function; or
- (B) The **Adverse Determination** involves a denial of coverage based on a determination that the recommended or requested **Health Care Service** or treatment is “experimental” or “investigational” and **Your Provider** certifies in writing and supports such certification with reasoning, rationale, or evidence that the recommended or requested **Health Care Service** or treatment would be significantly less effective if not promptly initiated.

The **Independent Review Organization** conducting the **External Review** will determine whether **You** will be required to complete the **Internal Grievance Procedures** prior to the expedited External Grievance Procedures. **You** may file an appeal under **Our Internal Grievance Procedures**, if **We** have not issued a written decision to **You** within thirty (30) days following the date **You** filed the appeal with **Us** for a pre-service claim or within sixty (60) days following the date **You** filed the appeal with **Us** for a post-service claim and **You** have not requested or agreed to a delay, **You** may file a request for **External Review** and shall be considered to have exhausted **Our Internal Grievance Procedures**.

Final Adverse Determinations: **You** may file a request for an expedited **External Review** to be conducted at the same time **You** file a request for a review of an appeal as set forth in the **Internal Grievance Procedure**, if:

- (A) **You** have a medical condition where the timeframe for completion of an expedited review of an appeal in **Our Internal Grievance Procedures** would seriously jeopardize **Your** life or health or would jeopardize **Your** ability to regain maximum function.
- (B) If the **Final Adverse Determination** concerns:
 - (i) an admission, availability of care, continued stay or **Health Care Service** for which **You** received **Emergency** services, but has not been discharged from a facility; or
 - (ii) a denial of coverage based on a determination that the recommended or requested **Health Care Service** or treatment is “experimental” or “investigational” and **Your Provider** certifies in writing and supports such certification with reasoning, rationale, or evidence that the recommended or requested **Health Care Service** or treatment would be significantly less effective if not promptly initiated.

You have the right to seek assistance from the Arkansas Department of Insurance at any time.

Commissioner [Jay Bradford]

Arkansas Dept. of Insurance

1200 West 3rd Street

Little Rock, Arkansas 72201

E-mail: insurance.Consumers@mail.state.ar.us

Phone: 501-371-2640 or 800-852-5494

Fax: 501-371-2749

All requests for **External Reviews** shall be made in writing or via electronic media to **Us** at the mailing address and facsimile telephone number identified below:

Freedom Life Insurance Company of America

Attn.: Vice President of Claims

Claims and Communications Dept.

3100 Burnett, 801 Cherry Street, Unit 33

Fort Worth, Texas 76102

Phone: 800-387-9027

Fax: 817-878-3440

Please be advised when filing a request for an **External Review**, **You** will be required to authorize the release of any of **Your** medical records that may be required to be reviewed for the purpose of reaching a decision on the **External Review**. This authorization will allow **Us** to disclose **Your** protected health information, including medical records, that are pertinent to the **External Review**.

II. Standard External Review -

Within sixty (60) days after the date of receipt of a notice of an **Adverse Determination** or **Final Adverse Determination**, **You** may file a request for an **External Review** with **Us**, as specified below:

- (A) At the time **We** receive a request for an **External Review**, **We** shall assign an **Independent Review Organization** (from the list of approved **Independent Review Organizations** compiled and maintained by the Arkansas Insurance Commissioner) to conduct a preliminary review of the request to determine if:
- the request for the **External Review** meets the applicability standards as set out above;
 - **You** have exhausted **Our Internal Grievance Procedures**; and
 - **You** have provided all the information and forms required to process an **External Review**, including the authorization to release medical records.
- (B) Within five (5) business days after receipt of the request for **External Review**, the **Independent Review Organization** assigned shall complete the preliminary review and notify **You**, **Your Provider** and Freedom Life Insurance Company of America in writing as to whether:
- the request is complete; and
 - the request has been accepted for **External Review**.

The **Independent Review Organization** shall include in the notice provided a statement that **You**, **Your Provider** and Freedom Life Insurance Company of America may submit in writing to the **Independent Review Organization** within seven (7) business days following the date of receipt of the notice additional information and supporting documentation that the **Independent Review Organization** shall consider when conducting the **External Review**.

If the request:

- is not complete, the assigned **Independent Review Organization** shall, within five (5) business days, inform **You**, **Your Provider** and Freedom Life Insurance Company of America what information or materials are needed to make the request complete; or
- is not accepted for **External Review**, the assigned **Independent Review Organization** shall
- inform **You**, **Your Provider** and Freedom Life Insurance Company of America in writing within five (5) business days of the reasons for non-acceptance.

Upon receipt of any information submitted by **You**, the assigned **Independent Review Organization** shall forward copies of the information to **Us**.

- (C) In reaching a decision to accept or reject a matter for **External Review**, the assigned **Independent Review Organization** is not bound by any decisions or conclusions reached during **Our Internal Grievance Procedures**.
- (D) Within seven (7) business days after the receipt of the notice provided in part (B) above, **We** shall provide to the assigned **Independent Review Organization**, **You** and **Your Provider** the documents and any information considered in making the **Adverse Determination** or **Final Adverse Determination**, together with any additional information **We** deem necessary. If **We** fail to provide the documents or information, this will not delay the **External Review**; instead, the **Independent Review Organization** may terminate the **External Review** and make a decision to reverse any **Adverse Determination** or **Final Adverse Determination**. Immediately upon making such a decision, the **Independent Review Organization** shall notify **You**, **Your Provider** and Freedom Life Insurance Company of America.
- (E) Upon receipt of the information, if any, required to be forwarded to **Us** as stated in (B) above, **We** may reconsider any prior **Adverse Determination** or **Final Adverse Determination** for the **External Review**. This reconsideration by **Us** shall not delay or terminate the **External Review**. The **External Review** may only be terminated if **We** decide, upon completion of our reconsideration, to reverse **Our Adverse**

Determination or Final Adverse Determination and provide coverage or payment for the **Health Care Services** that is the subject of the **Adverse Determination or Final Adverse Determination**.

Immediately upon making the decision to reverse **Our Adverse Determination or Final Adverse Determination**, **We** shall notify **You** and **Your Provider**, as well as the assigned **Independent Review Organization**, in writing of **Our** decision. The assigned **Independent Review Organization** shall terminate the **External Review** upon receipt of this notice from **Us**.

- (F) In exercising its independent medical judgment in reviewing an **Adverse Determination**, in addition to the documents and information provided, the assigned **Independent Review Organization**, to the extent the information or documents are available, shall consider the following in reaching a decision:
- the **Minor Dependent Insured's** medical records;
 - the **Provider's** professional recommendation;
 - consulting reports from appropriate health care professionals and other documents submitted by **Us, You or Your Provider**;
 - the applicable terms of coverage under **Your** contract of insurance to ensure that the **Independent Review Organization's** decision is not contrary to the terms of the coverage;
 - the most appropriate practice guidelines, which may include generally accepted practice guidelines, evidence-based practice guidelines or any other practice guidelines developed by the federal government, national or professional medical societies, boards and associations;
 - any applicable written screening procedures, decision abstracts, clinical protocols and practice guidelines used by **Us** to determine the necessity and appropriateness of **Health Care Services**; and
 - if the **Adverse Determination** involves a denial of coverage based on a determination that the recommended or requested **Health Care Service** is "experimental" or "investigational" , the **Independent Review Organization** shall also consider whether: (a) the recommended or requested **Health Care Service** or treatment has been approved by the federal Food and Drug Administration for the condition, while realizing that treatments or services are often legitimately used for purposes other than those listed in the FDA approval; or (b) medical or scientific evidence demonstrates that the expected benefits of the recommended or requested **Health Care Service** or treatment is more likely than not to be more beneficial to **You** than any available standard **Health Care Service** or treatment and the adverse risks of the recommended or requested **Health Care Service** or treatment would not be substantially increased over those of available standard **Health Care Services** or treatments.
- (G) Within forty-five (45) calendar days after the date of receipt of the request for an **External Review**, the assigned **Independent Review Organization** shall provide written notice of its decision to uphold, reverse, or partially uphold or reverse the **Adverse Determination or Final Adverse Determination** to **You, Your Provider** and Freedom Life Insurance Company of America.

III. Expedited External Review -

- (A) Except as provided under item (E) below, **You** may make a request for an expedited **External Review** with **Us** at the time **You** receive an **Adverse Determination or Final Adverse Determination**. At the time **You** elect to make a request for an expedited **External Review**, **You** and **Your Provider** shall submit additional information and supporting documentation that the **Independent Review Organization** shall consider when conducting the expedited **External Review**.
- (B) An expedited **External Review** may NOT be provided for an **Adverse Determination or Final Adverse Determination** involving a **Retrospective Review**.
- (C) At the time **We** receive a request for an expedited **External Review**, **We** immediately shall assign an **Independent Review Organization** (from the list compiled and maintained by the Arkansas Insurance Commissioner) to determine whether the request meets the reviewability requirements, and then initiate the expedited **External Review** if all the requirements are met.
- (D) At the time **We** assign an **Independent Review Organization** to conduct the expedited **External Review**, **We** shall immediately provide or transmit all pertinent documentation and information to the assigned **Independent Review Organization**.

- (E) As expeditiously as **You** medical condition or circumstances require, but in no event more than seventy-two (72) hours after the date of receipt of the request for an expedited **External Review** that meets the reviewability requirements, the assigned **Independent Review Organization** shall:
- Make a decision to uphold or reverse the **Adverse Determination** or **Final Adverse Determination**; and
 - Notify **You**, **Your Provider** and Freedom Life Insurance Company of America of the decision.

IV. Binding Nature of External Review Decision -

All **External Reviews** conducted will be fair and impartial, and in compliance with the standards approved by the Arkansas Insurance Commissioner.

An **External Review** decision is binding on **Us**, except to the extent that **We** have other remedies available under applicable federal or state law. An **External Review** decision is binding on the **Covered Minor Dependent Insured**, except to the extent that **You** have other remedies available under applicable federal or state law. A **Covered Minor Dependent Insured** may NOT file a subsequent request for an **External Review** involving the same **Adverse Determination** or **Final Adverse Determination** for which **You** have already received an **External Review** decision.

V. Filing Fees and Funding –

- (A) Except in the case of a request for an expedited **External Review**, at the time of filing a request for **External Review**, the **Covered Minor Dependent Insured** shall submit to the **Independent Review Organization** a filing fee of [\$25.00], along with the information and documentation to be used by the **Independent Review Organization** in conducting the **External Review**. However, upon application by the **Covered Minor Dependent Insured**, the Arkansas Insurance Commissioner may waive the filing fee upon a showing of undue financial hardship.
- (B) The filing fee shall be refunded to the **Minor Dependent Insured** who paid the fee if the **External Review** results in the reversal, in whole or part, of **Our Adverse Determination** or **Final Adverse Determination** that was subject of the **External Review**.

We shall pay the cost of the **Independent Review Organization** for conducting the **External Review** or expedited **External Review**, and shall not charge back the cost of any **External Review** to the **Covered Minor Dependent Insured's Provider**.

IX. INSURANCE WITH OTHER INSURERS

If a **Minor Dependent Insured** maintains other valid coverage, not with this **Company**, providing benefits for the same loss on a provision of service or an expense incurred basis and of which this **Company** has not been given written notice prior to the occurrence or commencement of loss, the only liability under this **Policy** shall be for such proportion of the loss as the amount which would otherwise have been payable hereunder plus the total of the like amounts under all such other valid coverage for the same loss of which this **Company** had notice bears to the total like amounts under all valid coverage for such loss, and for the return of such portion of the premiums paid shall exceed the pro rata portion for the amount so determined.

Other valid coverage means any other health insurance coverage **You** maintain under any of the following: any coverage which constitutes minimum essential coverage under federal law, an essential health benefits plan under federal law, a grandfathered health plan under federal law, a group health plan or group health insurance coverage: individual health insurance coverage; a government or church plan any union, employer, or employee health benefit plan; Title XIX of the Social Security Act [142 U.S.C.A. Section 1396 et seq.]; other than coverage consisting solely of benefits under Section 1928 [42 U.S.C.A. Section 1396s]; Chapter 55 of Title 10, United States Code; a medical care program of the Indian Health Service or of a tribal organization; a state health benefits risk pool; a public health plan offered under Chapter 89 of Title 5, United States Code; or a health benefit plan under section 2504(e) of Title 22, United States Code. Other valid insurance coverage does not include coverage under Medicare and/or amendments thereto.

X. UNIFORM PROVISIONS

A. ENTIRE CONTRACT- CHANGES

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

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

No change in this **Policy** will be valid unless it is:

1. noted on or attached to this **Policy**;
2. signed by one of **Our** officers; and
3. delivered to the **Policyowner**, as shown on the **Policy Schedule**.

B. OTHER INSURANCE WITH US

You may have only one policy or certificate providing essential health benefits, major medical or medical and surgical coverage with **Us**. If through error, **We** issue more than one like policy or certificate to **You**, only one policy or certificate chosen by **You** or **Your** estate, as the case may be, will stay in force. **We** will return the money **You** paid for the other policy(ies) or certificate(s).

C. CONFORMITY WITH STATE STATUTES

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

D. MISSTATEMENT OF AGE

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

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

E. LEGAL ACTION

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

F. SUBROGATION

We shall be subrogated to all rights of recovery which any **Minor Dependent Insured** may acquire against any party for ordinary negligence, gross negligence, strict liability in tort or any willful or intentional act or omissions resulting in **Injury** or **Sickness** for which **We** pay **Sickness and Injury Benefits**, and **Wellness and Screening Benefits** but only to the extent of the **Benefits** provided. Any **Minor Dependent Insured**, by receiving **Benefits**

under this **Policy**, in such case, shall be deemed to have assigned such rights of recovery to **Us** and have agreed to do whatever may be necessary to secure the recovery, including, but not limited to, the execution of any and all appropriate documents or papers. The **Minor Dependent Insured** also agrees to execute and deliver all necessary instruments, to furnish such information and assistance, and to take any action **We** may require to facilitate enforcement of **Our** rights.

THIS CONCLUDES THIS POLICY

FREEDOM LIFE INSURANCE COMPANY OF AMERICA

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

ESSENTIAL HEALTH BENEFITS POLICY

OUTLINE OF COVERAGE

READ YOUR POLICY CAREFULLY - This Outline of Coverage provides a description of the important features of **Your Policy**. This is not an insurance contract and only the actual **Policy** provisions will control. The **Policy** itself sets forth, in detail, the rights and obligations of both **You** and **Your** insurance company. It is, therefore, important that **You READ YOUR POLICY CAREFULLY!**

ESSENTIAL HEALTH BENEFIT PLAN – The **Policy** is designed to provide an **Minor Dependent Insured**, the covered items and services listed in the **Sickness and Injury Benefits** and **Wellness and Screening Benefits** sections of the **Policy** while coverage for such **Minor Dependent Insured** under the **Policy** is in full force and effect, subject to all applicable definitions, exclusions, limitations, reductions, and other provisions of the **Policy**, as well as any riders, endorsements, or amendments attached to the **Policy**.

THIS POLICY PROVIDES ESSENTIAL HEALTH BENEFITS COVERAGE UNDER FEDERAL LAW. IT IS A MAJOR MEDICAL EXPENSE POLICY WITH A PARTICIPATING PROVIDER NETWORK. IT IS NOT A POLICY OF WORKERS' COMPENSATION INSURANCE UNDER STATE LAW.

Deductible Options:

Calendar Year Deductible:	Platinum	Gold	Silver	Bronze
Participating Provider	\$950	\$2,000	\$3,500	\$6,250
Non-Participating Provider	\$2,850	\$6,000	\$10,500	\$18,750

Coinsurance Options:

Participating Provider	100%
Non-Participating Provider	100%

Covered Expenses incurred by an **Minor Dependent Insured** for **Medically Necessary Sickness and Injury Benefits** and **Wellness and Screening Benefits** are subject to the **Calendar Year Deductible**, the **Separate Deductible For Non-Participating Providers**, and the **Minor Dependent Insured Coinsurance Percentage**, unless otherwise stated herein and all applicable definitions, exclusions, limitations, non-waiver, waiting periods, and other provisions contained in the **Policy**, as well as any riders, endorsements, or amendments attached to the **Policy**.

A. SICKNESS AND INJURY BENEFITS

1. INPATIENT HOSPITAL CARE: **Hospital** semi-private room and board; **Intensive Care Unit**, miscellaneous medications, **Prescription Drugs**, services and supplies and **Provider** visits (limited to one (1) visit per treating **Provider** per day).
2. INPATIENT OR OUTPATIENT SURGERY: Services **Provided** by a **Hospital** or **Ambulatory Surgical Center**, Primary Surgeon, Assistant Surgeon, Anesthesiologist or Nurse Anesthetist, Pathologist fees and second surgical opinion.
3. INPATIENT OR OUTPATIENT LABORATORY AND DIAGNOSTIC TESTS: Services **Provided** by a **Hospital** or a **Provider** in connection with the performance and interpretation of laboratory and diagnostic tests.
4. INPATIENT OR OUTPATIENT RADIATION THERAPY AND CHEMOTHERAPY: Services **Provided** by a **Hospital** or a **Provider** in connection with radiation therapy and chemotherapy

5. INPATIENT OR OUTPATIENT THERAPY: Services **Provided** by a **Hospital** or a **Provider** in connection with Occupational Therapy, Rehabilitation Therapy, Cardiac and Pulmonary Rehabilitation Therapy, Radio-frequency Thermal Therapy, Neurologic Rehabilitation, Cognitive Rehabilitation, and **Habilitative Services**. Outpatient Cardiac and Pulmonary Rehabilitation Therapy is not to exceed thirty-six (36) **Outpatient** treatment sessions per **Calendar Year**.
6. MENTAL AND EMOTIONAL DISORDERS: Services **Provided** for the treatment and evaluation of **Mental and Emotional Disorders** received on an **Inpatient** and **Outpatient** basis by an **Minor Dependent Insured**.
7. BREAST RECONSTRUCTION: Services **Provided** by a **Hospital** and a **Provider** in connection with **Breast Reconstruction** performed at a **Hospital**. **Hospital Confinement** incident to a **Mastectomy** for no less than forty-eight (48) hours, unless decision to discharge earlier is made by both the **Provider** and the **Minor Dependent Insured**.
8. TRANSPLANTS: Services **Provided** by a **Hospital** and **Providers** in connection with the performance of for all **Solid Organ Transplants, Bone Marrow Transplants** and/or **Stem Cell Transplants**. Harvesting of applicable donor or donor bone marrow is \$10,000 per transplant. Travel for the **Minor Dependent Insured** receiving the transplant will include: a) transportation to and from the transplant site in a personal vehicle will be reimbursed at [37.5] cents per mile when the transplant site is more than sixty (60) miles from the **Minor Dependent Insured's** home; and b) lodging [limited to \$50-150 per day] for the **Minor Dependent Insured** and one companion.
9. EMERGENCY ROOM SERVICES: Items received by an **Minor Dependent Insured** on an **Emergency** basis including: a) **Emergency** room services and supplies; b) **Provider** services for surgery; c) x-ray and laboratory examinations; d) prescription drugs administered prior to discharge; e) surgical dressings, casts, splints, trusses, braces and crutches; and f) services for a registered nurse (R.N.).
10. EMERGENCY TRANSPORTATION TO HOSPITAL BY AMBULANCE: Transportation of an **Minor Dependent Insured** by either local ground ambulance or local air ambulance to the nearest **Hospital**. Expenses charged for air ambulance are not payable if such **Minor Dependent Insured's** medical condition was did not result in an **Inpatient** admission and **Confinement**
11. OUTPATIENT TREATMENT OF ACCIDENTAL INJURIES: Services **Provided** by a **Hospital**, an **Emergency Care Facility** or a **Provider** in connection with **Outpatient** treatment of **Injuries**.
11. OUTPATIENT PROVIDER OFFICE VISITS: Professional services **Provided** for a **Medically Necessary** visit for the purpose of evaluation, diagnosis and treatment of an **Injury** or **Sickness**.
12. OUTPATIENT PRESCRIPTIONS: **Prescription Drugs** filled at a **Participating Pharmacy**. Expenses for **Prescriptions** shall not exceed the amount of the cost of the least expensive drug, medicine or **Prescription Drug** that may be used to treat the **Minor Dependent Insured's** **Sickness** or **Injury**.
13. OUTPATIENT DIALYSIS: Services **Provided** at **Hospital** or other **Provider** in connection with dialysis.
14. HOME HEALTH CARE: Services specified in a **Home Health Care Plan**, up to the amount of the semi-private room rate for the same or related **Injury** or **Sickness** as the **Hospital** or **Skilled Nursing Home Confinement** and must begin thirty (30) days after discharge. Services are limited to a maximum of fifty (50) visits per **Minor Dependent Insured** per **Calendar Year**.
15. HOSPICE CARE: **Hospice Care** due to **Injuries** or **Sickness**, if: a) such **Hospice Care** is provided for which **expenses** were incurred by such **Minor Dependent Insured** for **Hospital Confinement**; b) the **Minor Dependent Insured's** **Provider** certifies the life expectancy of the **Minor Dependent Insured** is six (6) months or less; and c) the **Minor Dependent Insured's** **Provider** recommends a **Hospice Care** program.
16. MEDICAL EQUIPMENT: Medical Equipment and supplies **Provided** to an **Minor Dependent Insured** as a result of **Injury** or **Sickness**.

17. GASTRIC PACEMAKERS: **Gastric Pacemakers Provided** to an **Minor Dependent Insured** to treat **Gastroparesis**.
18. SKILLED NURSING HOME CARE: Daily room and board and miscellaneous charges for other services **Provided** for the same or related **Injury** or **Sickness** after a minimum of seven (7) consecutive days **Hospital Confinement**. Skilled Nursing Home Care must begin thirty (30) days after **Hospital** discharge and the **Minor Dependent Insured's Provider** must certify the need for **Skilled Nursing Home Confinement**, limited to a maximum of sixty (60) days in a twelve (12) month period.
19. SUPPLIES AND SERVICES ASSOCIATED WITH THE TREATMENT OF DIABETES: **Diabetes Equipment, Diabetes Supplies** and **Diabetes Self-Management Training**.
20. INHERITED METABOLIC DISORDERS: **Medical Foods**, metabolic supplements and gastric disorder formulas prescribed or ordered under the supervision of a **Provider**, as **Medically Necessary** for the treatment of an **Inherited Metabolic Disorder**.
21. MATERNITY AND NEWBORN CARE: The **Minor Dependent Insured's** routine pregnancy, including normal labor and delivery, cesarean section deliveries that are not performed on an emergency basis, and complications of pregnancy. Services for care and treatment of **Your** newborn child or adoptee.
22. SUBSTANCE ABUSE: Services **Provided** by a **Specialized Hospital** or a **Provider** for the treatment of **Substance Abuse**. This **Benefit** includes **Inpatient** and **Outpatient** rehabilitation services, and residential services.
23. HEARING AIDS: Services **Provided** to an **Minor Dependent Insured** for hearing aids that are **Medically Necessary**, up to \$1,400 per year, every three (3) years.
24. CRANIOFACIAL ANOMALY: Services **Provided** to an **Minor Dependent Insured** for the treatment and correction of a **Craniofacial Anomaly** and associated secondary conditions.
25. CHIROPRACTIC SERVICES: Diagnostic and treatment services **Provided** in connection with conservative management of neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain and improve function, limited to thirty (30) visits per **Calendar Year**.
26. TEMPROMANDIBULAR JOINT (TMJ) DISORDER: Services **Provided** by a **Provider** for **Medically Necessary** treatment of TMJ disorder caused by **Accident** or trauma, congenital defect, developmental defect, or a pathology.
27. INFERTILITY SERVICES: Services **Provided** to an **Minor Dependent Insured** to diagnose the underlying medical cause of infertility. All other infertility services are not covered under this **Policy**.
28. FAMILY PLANNING: Services and devices **Provided** to an **Minor Dependent Insured** for family planning services including: medical history, physical examination, related laboratory tests, medical supervision, information and counseling on contraception, implanted, injected and oral contraceptives, and surgical therapies.
29. DENTAL ANESTHESIA: Services **Provided** for general anesthesia and associated **Covered Expenses** for **Minor Dependent Insureds**: age seven (7) or under, diagnosed with a serious mental or physical condition, or with significant behavioral problems.
30. DENTAL SERVICES – ACCIDENT ONLY: Services **Provided** by a Hospital or **Provider** for the treatment of a fractured jaw or **Dental Injury** to **Sound Natural Teeth** when treatment sought within seventy-two (72) hours of injury.
31. PEDIATRIC DENTAL CARE: Services **Provided** for **Pediatric Dental Care** by a **Dentist** to an **Minor Dependent Insured**, up to age nineteen (19) for: **Emergency Room** Services; Preventive Pediatric Dental Care; Routine Pediatric Dental Care; Gum Therapy; and Prosthodontics.

B. WELLNESS AND SCREENING BENEFITS

1. ADULT WELLNESS AND PREVENTIVE CARE: Services for evidence-based items or services that have a rating of "A" or "B" in the current list of the United States Preventive Services Task Force .. **Adult Wellness Preventive Care Provided** by a **Participating Provider** is not subject to the **Calendar Year Deductible** or the **Minor Dependent Insured Coinsurance Percentage**. **Adult Wellness Preventive Care** services **Provided** by a **Non-Participating Provider** are subject to the applicable deductibles and coinsurance.. If the **Adult Wellness Preventive Care** services are billed separately from an office visit, or if the primary purpose of the office visit was not for the delivery of such **Adult Wellness Preventive Care** services, **We** will impose any applicable deductibles or coinsurance with respect to the office visit.
2. CHILDHOOD WELLNESS AND PREVENTIVE CARE: Services for evidence-based items or services that are Provided, a rating of "A" or "B" by the United States Preventive Services Task Force (USPSTF). **Child Wellness Preventive Care** also includes preventive care and screenings in the guidelines of the Health Resources and Services Administration, American Academy of Pediatrics (AAP) and Bright Futures. **Childhood Wellness Preventive Care Provided** by a **Participating Provider** are not subject to the **Calendar Year Deductible** or the **Minor Dependent Insured Coinsurance Percentage**. **Childhood Wellness Preventive Care** services **Provided** by a **Non-Participating Provider** are subject to the applicable deductibles and coinsurance with the exception of **Benefits** for screening tests for hearing loss for children age twenty-four (24) months and younger. If the **Childhood Wellness Preventive Care** services are billed separately from an office visit, or if the primary purpose of the office visit was not for the delivery of such **Childhood Wellness Preventive Care** services, **We** will impose any applicable deductibles or coinsurance with respect to the office visit.
3. IMMUNIZATIONS: Routine immunizations as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC) received by a **Participating Provider** are not subject to the **Calendar Year Deductible** or the **Minor Dependent Insured Coinsurance Percentage**. Immunizations **Provided** by a **Non-Participating Provider** are subject all applicable deductibles. If the immunizations are billed separately from an office visit, or if the primary purpose of the office visit was not for the delivery of such immunizations, then **We** may impose any applicable deductibles or coinsurance with respect to the office visit. Immunization **Benefits** do not include charges for immunizations for occupational hazards or international travel, except as recommended by the CDC.
4. MAMMOGRAPHY SCREENING: For female **Minor Dependent Insureds** thirty-five (35) to thirty-nine (39) years of age, a single baseline **Mammogram** to detect the presence of occult breast cancer and **Mammograms** for female **Minor Dependent Insureds** with a family history of breast cancer upon recommendation of a **Provider**. Mammography **Benefits** for female **Minor Dependent Insureds** ages forty (40) and over are covered under the ADULT WELLNESS PREVENTIVE CARE provision.
5. PROSTATE CANCER SCREENING: Services **Provided** during an annual physical examination for the detection of prostate cancer, and a prostate-specific antigen test used for the detection of prostate cancer for each male **Minor Dependent Insured** over forty (40). The prostate cancer screening shall consist of a prostate-specific antigen blood test and a digital rectal examination.
6. COLORECTAL CANCER SCREENING: Screening **Provided** to **Minor Dependent Insureds** under age fifty (50) who are **High Risk for Colorectal Cancer**. Colorectal cancer screening for **Minor Dependent Insureds** over fifty (50) covered but ADULT WELLNESS AND PREVENTIVE CARE provision.
7. ROUTINE ANNUAL PHYSICAL EXAMINATION: Services **Provided** to **Minor Dependent Insureds** ages twenty-two (22) and up for necessary annual physical exam visit, by a **Participating Provider** no more than once in a 12 month period.
8. HEARING EXAMINATION: Services **Provided** by a **Hospital** or **Provider** for one **Hearing Examination** per adult **Minor Dependent Insured** per **Calendar Year**.
9. VISION EXAMINATION: One **Vision Examination** per **Minor Dependent Insured**, up to age twenty (20), per **Calendar Year** and one **Vision Examination** per **Minor Dependent Insured** age twenty (20) and over every two (2) years. **Vision Materials** prescribed by **Providers** will be Provided, subject to certain limitations and exclusions in the **Policy**.

C. LIMITATIONS, EXCLUSIONS AND NON-WAIVER

LIMITATIONS

• **[Minor Dependent Insureds** have the right to obtain **Prescriptions** from the pharmacy of their choice. However, if an **Minor Dependent Insured**: (i) uses a **Non-Participating Pharmacy** to fill a **Prescription**; or (ii) does not present his/her correct ID card when the **Prescription** is filled at a **Participating Pharmacy**, then such **Minor Dependent Insured** must pay the applicable pharmacy in full and file a claim form with the **Company** for reimbursement unless a **Non-Participating Pharmacy** accepts assignment of **Benefits**. In the event an **Minor Dependent Insured** must pay the applicable pharmacy in full, the **Minor Dependent Insured** will be reimbursed by the **Company** at the discounted or negotiated rate for such **Prescription** that would have been paid to a **Participating Pharmacy** by the **Company** under the **Policy** if the **Minor Dependent Insured** had used a **Participating Pharmacy** and properly presented the correct ID card at the time the **Prescription** was filled;][•Pre-authorization may be required by the **Company** prior to the time that **Prescriptions** for certain **Prescription Drugs** are filled;]•If as the result of an **Emergency Sickness** or an **Emergency Injury** services are rendered for an **Minor Dependent Insured** by a **Non-Participating Provider** when a **Participating Provider** was not reasonably available in connection with either (i) on an **Outpatient** basis in the emergency room of a **Hospital** or (ii) an **Emergency Inpatient** admission to a **Hospital**, then the **Covered Expenses** incurred will be reimbursed by **Us** as if such **Non-Participating Provider** were a **Participating Provider** up to the point when the **Minor Dependent Insured** can be safely transferred to a **Participating Provider**. If the **Minor Dependent Insured** refuses or is unwilling to be transferred to the care of a **Participating Provider** after such **Minor Dependent Insured** can be safely transferred, then reimbursement shall thereafter be reduced to the **Company's Insurance Percentage for Non-Participating Providers**; • **Sickness and Injury Benefits** and **Wellness and Screening Benefits** under the **Policy** for any **Minor Dependent Insured** who is eligible for or has coverage under **Medicare**, and/or amendments thereto, regardless of whether such **Minor Dependent Insured** is enrolled in **Medicare**, shall be limited to only the **Usual and Customary** charges for services, supplies, care or treatment covered under the **Policy** that are not or would not have been payable or reimbursable by **Medicare** and/or its amendments (assuming such enrollment), subject to all provisions, limitations, exclusions, reductions and maximum benefits set forth in the **Policy**.

EXCLUSIONS

Coverage under the **Policy** is limited as provided by the definitions, limitations, exclusions, and terms contained in each and every Section of the **Policy**. In addition, the **Policy** does not provide coverage for expenses charged to an **Minor Dependent Insured** or any payment obligation for **Us** under the **Policy** for any of the following, all of which are excluded from coverage:

- the amount of any professional fees or other medical expenses or charges for treatments, care, procedures, services or supplies which do not constitute **Covered Expenses**; • **Covered Expenses** incurred before the **Policy Issue Date**; • the amount of any professional fees or other medical expenses contained on a billing statement to an **Minor Dependent Insured** which exceed the amount of the **Maximum Allowable Charge**; • any professional fees or other medical expenses for treatments, care, procedures, services or supplies which are not specifically enumerated in the **SICKNESS AND INJURY BENEFITS**, or **WELLNESS AND SCREENING BENEFITS** Sections of this **Policy** and any optional coverage rider attached hereto; • **Covered Expenses You or Your** covered family members are not required to pay, which are covered by other insurance, or that would not have been billed if no insurance existed; • any professional fees or expenses for which the **Minor Dependent Insured** and/or any covered family member are not legally liable for payment; • any professional fees or expenses for which the **Minor Dependent Insured** and/or any covered family member were once legally liable for payment, but from which liability the **Minor Dependent Insured** and/or family member were released; • treatment of the teeth, the surrounding tissue or structure, including the gums and tooth sockets. This exclusion does not apply to treatment: (a) due to **Injury** to natural teeth (treatment must be **Provided** within ninety (90) days of the date of the **Injury**); (b) for malignant tumors, or (c) which are otherwise **Provided** for in the **SICKNESS AND INJURY BENEFITS** section of this **Policy**; • **Injury** or **Sickness** due to any act of war (whether declared or undeclared); • services provided by any state or Federal government agency, including the Veterans Administration unless, by law, an **Minor Dependent Insured** must pay for such services;

• **Covered Expenses** that are payable under any motor vehicle no fault law insurance policy or certificate; • charges that are payable or reimbursable by either: a) a plan or program of any governmental agency (except Medicaid), or b) **Medicare** Part A, Part B and/or Part D (If the applicable **Minor Dependent Insured** does not enroll in **Medicare**, **We** will estimate the charges that would have been paid if such enrollment had occurred); • drugs or medication not used for a Food and Drug Administration (FDA) approved use or indication, unless used for the treatment of cancer or HIV; • administration of experimental drugs or substances or investigational use or experimental use of **Prescription Drugs** except for any **Prescription Drug** prescribed to treat a covered chronic, disabling, life-threatening **Sickness** or **Injury**, but only if the investigational or experimental drug in question: a) has been approved by the FDA for at least one indication; and b) is recognized for treatment of the indication for which the drug is prescribed in: 1) a standard drug reference compendia; or 2) substantially accepted peer-reviewed medical literature. c) drugs labeled "Caution – limited by Federal law to investigational use"; • experimental procedures or treatment methods not approved by the American Medical Association or other appropriate medical society; • any **Injury** or **Sickness** covered by any Workers' Compensation insurance coverage, or similar coverage underwritten in connection with any Occupational Disease Law, or Employer's Liability Law, regardless of whether you file a claim for benefits thereunder; • eyeglasses, contact lenses, radial keratotomy, lasik surgery, hearing aids and exams for their prescription or fitting, except as **Provided** for in the SICKNESS AND INJURY BENEFITS and WELLNESS AND SCREENING BENEFITS sections of this **Policy**; • any damage or harm to the physical structure of the body of an **Minor Dependent Insured** occurring while the **Minor Dependent Insured** is intoxicated or under the influence of alcohol or any drug, narcotic or hallucinogens unless administered via a prescription and on the advice of a **Provider**, and taken in accordance with the limits of such advice. An **Minor Dependent Insured** is conclusively determined to be intoxicated by drug or alcohol if (ii) a chemical test administered in the jurisdiction where either the **Accident** occurred or the **Minor Dependent Insured** was medically treated is at or above the legal limit set by that jurisdiction or (ii) the level of alcohol was such that a person's coordination, ability to reason, was impaired, regardless of the legal limit set by that jurisdiction; • intentionally self-inflicted **Injury**, suicide or any suicide attempt while sane or insane; • serving in one of the branches of the armed forces of any foreign country or any international authority; • voluntary abortions, abortifacients or any other drug or device that terminates a pregnancy; • services **Provided** by **You** or a **Provider** who is a member of an **Minor Dependent Insured's** family; • any loss to which a contributing cause was the **Minor Dependent Insured's** being engaged in or attempting to engage in an illegal occupation or illegal activity; • participation in aviation, except as fare-paying passenger traveling on a regular scheduled commercial airline flight; • cosmetic surgery or reconstructive procedures, except for **Medically Necessary** cosmetic surgery or reconstructive procedures performed under the following circumstances: (i) where such cosmetic surgery is incidental to or following surgery resulting from trauma or infection; (ii) to correct a normal bodily function; or (iii) such cosmetic surgery constitutes **Breast Reconstruction** that is incident to a **Mastectomy**; provided any of the above occurred while the **Minor Dependent Insured** was covered under this **Policy**; • Charges for breast reduction or augmentation or complications arising from these procedures; • **Prescription Drugs** or other medicines and products used for cosmetic purposes or indications; • reversal or attempted reversal of a previous elective attempt to induce or facilitate sterilization; • fertility hormone therapy and/or fertility devices for any type fertility therapy, artificial insemination or any other direct conception; • any operation or treatment performed, **Prescription** or medication prescribed in connection with sex transformations or any type of sexual or erectile dysfunction, including complications arising from any such operation or treatment; • infertility services, including the treatment of male and female infertility; • appetite suppressants, including but not limited to, anorectics or any other drugs used for the purpose of weight control, or services, or treatments; • **Prescriptions**, treatment or services for behavioral or learning disorders, Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD); • any professional fees or other medical expenses incurred as the result of an **Injury** which was caused or contributed by an **Minor Dependent Insured** racing any land or water vehicle; • any professional fees or other medical expenses incurred for the diagnosis, care or treatment of **Serious Mental Illness** and **Substance Abuse** except as **Provided** for in the SICKNESS AND INJURY BENEFITS section of this **Policy**; • **Outpatient Prescription Drugs** that are dispensed by a **Provider**, **Hospital** or other state-licensed facility; • **Prescription Drugs** produced from blood, blood plasma and blood products, derivatives, Hemofil M, Factor VIII, and synthetic blood products, or immunization agents, biological or allergy sera, hematinics, blood or blood products administered on an **Outpatient** basis; • level one controlled substances; • **Prescription Drugs** used to treat or cure hair loss or baldness; • compounded **Prescription Drugs**; • fluoride products; • allergy kits intended for future emergency

treatment of possible future allergic reactions; • replacement of a prior filled prescription for **Prescription Drugs** that was covered and is replaced because the original prescription was lost, stolen or damaged; • **Prescription Drugs**, which have an over the counter equivalent that may be obtained without a **Prescription**, even though such **Prescription Drugs** were prescribed by a **Provider**; • any intentional misuse or abuse of **Prescription Drugs**, including **Prescription Drugs** purchased by an **Minor Dependent Insured** for consumption by someone other than such **Minor Dependent Insured**; • **Prescription Drugs** that are classified as anti-fungal medication used for treatment of onychomycosis; • **Prescription Drugs** that are classified as tobacco cessation products; • charges for blood, blood plasma, or derivatives that has been replaced; • Temporomandibular Joint Disorder (TMJ) and Craniomandibular Disorder (CMD), except as **Provided** for in the SICKNESS AND INJURY BENEFITS section of this **Policy**; • services or supplies for personal convenience, including custodial care or homemaker services; • treatment received outside of the United States; • bariatric surgery, including but not limited to, open vertical banded gastroplasty, laparoscopic vertical banded gastroplasty, open sleeve gastrectomy, laparoscopic sleeve gastrectomy, and open adjustable gastric banding; • any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations, except as **Provided** for in the **Benefit** entitled **Substance Abuse Services** section of this **Policy**; • any services for treatment of **Mental and Emotional Disorders** that have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain; • services for treatment of chronic mental conditions not subject to favorable modification according to generally accepted standards of medical practice; • services for developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders; developmental language disorders, or articulation disorders; • services for counseling for the following: for activities of an educational nature, for borderline intellectual functioning, for occupational problems and for any relation to consciousness raising; • services for vocational or religious counseling; • I.Q. testing; • services for occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline; • services for biofeedback are not covered for reasons other than pain management; • treatment for **Autism Spectrum Disorder** performed by the following: Sensory Integration, LOVAAS Therapy and Music Therapy; • non-medical ancillary services including, but not limited to, vocational rehabilitation, behavioral training, sleep therapy, employment counseling, driving safety, and services, training or educational therapy for learning disabilities, developmental delays, and mental retardation; • purchase or rental of **Durable Medical Equipment** and prosthetics are not covered when due to misuse, damage and replacement when lost; • miscellaneous charges while lodging, including but not limited to personal convenience items movies, wireless internet, telephone, radio, cleaning supplies and shipping charges; • routine foot care, except as **Provided** for in the SUPPLIES AND SERVICES ASSOCIATED WITH THE TREATMENT OF DIABETES section of the **Policy**.

NON-WAIVER

Expenses that are mistakenly applied by **Us** to the **Calendar Year Deductible** or erroneously paid by **Us** under any Section or provision of this **Policy** [including **Prescription Drugs**] shall not: • constitute a waiver of or modification to any conditions, terms, definitions or limitations contained in the **Policy**, specifically including, but not by way of limitation, the definitions of **Sickness** and **Injury**, as well as any exclusion, limitation and/or exclusionary riders which may be attached to the **Policy**, or otherwise operate to alter, amend, affect, abridge or modify the **Policy** to which it is attached; • create or establish coverage of any medical condition illness, disease or injury under the **Policy** or under any exclusion, limitation and/or exclusionary riders which may be attached to the **Policy**; or • affect, alter, amend, abridge, constitute or act as a waiver of the **Company's** ability to rely upon, assert and apply such terms, definitions, limitations or exclusions of the **Policy** or any amendments thereto.

D. RENEWABILITY

The **Policy** is guaranteed renewable, subject to the **Company's** right to adjust **Renewal Premiums** and discontinue or terminate the **Policy** as provided in the **Policy**. The **Initial Premium** for coverage of all **Minor Dependent Insureds** under the **Policy** is due and payable on or before the **Issue Date**. **Renewal Premiums** are due and payable in accordance with the terms set forth in the **Policy**. You may renew coverage under the **Policy**, as applicable, by timely payment of the proper amount of **Renewal Premium** when due or within the grace period.

You will be given a grace period of thirty-one (31) days following the premium due date to pay **Your** premium. The **Policy** will remain in effect during the grace period.

- E. RIGHT TO RETURN POLICY** - If **You** are not satisfied with the **Policy**, **You** may return it to **Us** within thirty (30) days after **You** receive it. **You** may return it to **Us** by mail or to the agent who sold it. **We** will then refund any premiums paid and the **Policy** will be voided as of the **Issue Date**.