HCC Life Insurance Company

Caroline D Berg
15902 Mesa Verde
Houston, TX 77059

Thank you for purchasing coverage under STM Complete®, underwritten by HCC Life Insurance Company. This policy contains terms and limitations such as lifetime maximum and deductible amounts that you have selected, and exclusions for specific conditions or treatment including but not limited to a pre-existing condition exclusion. The policy does not pay for routine physicals or immunizations unless required under your state law. Hernia operations, gall bladder removal and other common surgical procedures are not covered for the first 6 months. Please read your policy carefully and, if not fully satisfied, you may request a full refund under the 10 day free look provision.

Patient Protection and Affordable Care Act ("PPACA"): This insurance is not subject to, and does not provide certain insurance benefits required by PPACA. In no event will HCC Life Insurance Company provide benefits in excess of those specified in the policy documents, and this insurance is not subject to guaranteed issuance or renewal. PPACA requires certain U.S. residents and citizens to obtain PPACA compliant insurance coverage. In certain circumstances penalties may be imposed on U.S. residents and citizens who do not maintain PPACA compliant insurance coverage. Consult your attorney or tax professional to determine if PPACA's requirements are applicable to you.

In this packet we have enclosed your payment receipt, personalized identification cards, and a copy of the Certificate of Insurance for your plan. Please keep your identification card with you at all times. In the event you need medical attention, present the identification card to your attending physician.

Please note that you need to notify us in advance (within 48 hours for emergencies) for any hospitalizations or surgeries. Notification may be completed by phoning us with details at 866-400-7102 or through Client Zone at http://www.hccmis.com/customerservice/

To file a claim, please submit the original, itemized bills to us along with your paid receipts and a completed Claimant's Statement and Authorization form. HCC Life Insurance Company offers to pay your provider directly but we will still require a Claimant's Statement from you. You may obtain a Claimant's Statement form by phoning us with the request or by visiting Client Zone at www.hcclifestm.com/services.

Should you wish to cancel, you may do so by sending a request to Orders@HCCMIS.com. Please note, if you are paying by monthly installments, we need to receive the request prior to your installment date. There are no refunds for single up-front payments unless you provide verification of other insurance (including the effective date).

There are several ways to contact us regarding your plan. You are welcome to phone us 24 hours a day, 7 days a week, or visit our website to obtain additional information or ask questions about your insurance. We are proud of our commitment to our customers and pleased to provide you with the protection of this insurance. Our staff is eager to serve you. Again, thank you for your enrollment in HCC Life STM.

Please contact HCC Life Insurance Company if you have any questions or concerns. You may reach HCC Life Insurance Company at 866-400-7102.

Payment Receipt

For Certificate: TX14003399
Paid By: Stuart Berg
Payment Type: MasterCard
Number: xxxxxxxxxxxx0095
Amount: $70.80
Date Paid: 10/2/2014

Credit Card Payments Only
Expiration Date: 9/17
Trans. Code: 508992830
Auth. Code: 620860

HCC Life Insurance Company

Covered Dependents:

Primary Insured:
Caroline D Berg
Certificate #: TX14003399

Effective Date: 10/3/2014

POSSESSION OF THIS CARD DOES NOT GUARANTEE COVERAGE

FOLD

- You are required to pre-certify all hospitalizations and surgeries. Failure to comply may result in a reduction of benefits.
- For pre-certification or general questions regarding Eligibility / Benefits / Claims, please call:

  1-800-605-2282 *or*
  1-317-262-2132

- Mail itemized bills including diagnosis to:

  HCCMIS Claims Department
  Box No. 2005
  Farmington Hills, MI
  48333-2005

- Claims may be submitted electronically using Payer ID: HCCMI

COVENTRY National Network

MMP Medical Management Programs, Inc.

HCC Life Insurance Company

Covered Dependents:

Primary Insured:
Caroline D Berg
Certificate #: TX14003399

Effective Date: 10/3/2014

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COVENTRY National Network

MMP Medical Management Programs, Inc.

Discount Pharmacy & Medical Savings Card
ALSO DENTAL, LAB & IMAGING DISCOUNTS & MORE!

VANTAGE AMERICA Solutions, Inc.
SAVINGS • BENEFITS • SERVICES

Save Money with your FREE Prescription Discount Card

Includes most prescription drugs

Your nationally recognized VantageAmerica Solutions Discount Pharmacy Card provides discounts on most FDA approved prescription drugs. There are no limited drug lists, no waiting periods and your card is active the moment you present it to the pharmacy.

Significant Savings

Savings average from 5%-15% off the cash price for brand drugs and average 15%-40% off the price of generic drugs. In the event a pharmacy's price is lower than our discounted price, you will always receive the lowest price available.

Use at almost any Pharmacy

Your VantageAmerica Solutions Discount Pharmacy Card is widely accepted at over 54,000 participating pharmacies across the United States, including most national and regional chains, pharmacy associations, and many local community pharmacies. If your community pharmacy is not enrolled, ask them to contact member services at 1-800-974-3454. We always welcome new participation.

Everyone can Save

This program applies to your entire family. Everyone deserves to save. All family members and friends are eligible for this program. Please present your card every time you need to fill a prescription to receive instant savings. There are absolutely no restrictions.

Pharmacy discounts are NOT insurance and are NOT intended as a substitute for insurance. The discount is only available at participating pharmacies.

For your convenience we have already activated your card and your savings will begin immediately. Please detach card below and present to your local pharmacy.

ADHV8-12-04

VANTAGE AMERICA Solutions, Inc.
SAVINGS • BENEFITS • SERVICES

Member ID: HCCMIS4575
Group ID: HCCMIS4110
BIN: 610210
PCN: PRX

PARAMOUNT Rx
Valid for entire family

Pharmacist Help Desk: 1-800-481-0605

Void where Prohibited by Law Process all transactions electronically

THIS IS NOT INSURANCE… DISCOUNT ONLY

ADHV9-12-04

Easy to Use!

Just present the attached card at a participating pharmacy the next time you or family members need to fill a prescription. You will also realize immediate savings of 15%-70% on Lab Testing,* 25%-80% on MRI and CT scans and 5%-30% on Diabetic Supplies. Additionally, you can save 10%-35% on Dental Care, 10%-30% on Vision Care and 15% on Hearing Equipment. Simply call the numbers on your card or visit the websites provided. Or, if you have questions or need assistance of any kind, call the Member Service Center at 1-800-975-3322 between the hours of 8:00 am and 5:00 pm (CST). One of our representatives will be happy to help you get the most from your complimentary VantageAmerica Solutions Discount Pharmacy Card.

Card NOT Valid in AK, MA, MN, MT, VT, and Canada

***Lab testing NOT available in MA, MD, NJ, NY and RI due to state restrictions.**

Disclosures:

a. The discount medical card program is NOT health insurance.
b. The plan provides discounts at certain health care providers for medical services.
c. The plan does not make payments directly to the providers of medical services.
d. The range of discounts for medical or ancillary services provided under the plan will vary depending on the type of provider and medical or ancillary services received.
e. The plan member is obligated to pay for all health care services but will receive a discount from those health care providers who have contracted with VantageAmerica Solutions, Inc., a discount medical plan organization.

Managed and Administered by:

VANTAGE AMERICA Solutions, Inc.
SAVINGS • BENEFITS • SERVICES

VantageAmerica Solutions, Inc.
1275 Milwaukee Avenue
Glenview, IL 60025
www.vantageamericasolutions.com

To find a provider refer below

PARAMOUNT Rx	Galaxy Health Network	Galaxy Health Network	Beltone
http://lookuprx.net	http://nea.mdlabtests.com	Group Code: GALAXY	www.Beltone.com
			REFERENCE # MC 50210
Pharmacy	**Lab Services***	**Imaging**	**Hearing**
1-800-974-3454	**1-877-849-5227**	**1-877-814-2461**	**1-800-235-8663**

UNI-CARE	EyeMed VISION CARE	Freedom Diabetic Program
http://www.lookupdentists.net	www.enrollwitheyemed.com	http://vantagediabeticplan.com
GROUP VAS804106	REFERENCE #9243999	
Dental	**Vision**	**Diabetic Supply**
1-800-308-0374	**1-866-939-3633**	**1-888-918-3782**

***Lab testing NOT available in MA, MD, NJ, NY, and RI due to state restrictions.**

PAYMENT MUST BE MADE AT SCHEDULING OR TIME OF SERVICE

THIS IS NOT INSURANCE!

fold here

HCC LIFE INSURANCE COMPANY
225 TownPark Drive, Suite 350
Kennesaw, Georgia 30144
866-400-7102

SHORT TERM MAJOR MEDICAL INSURANCE POLICY

HCC Life Insurance Company (hereinafter the Company, We, Our, or Us) agrees to pay the insurance benefits herein provided, subject to the terms and conditions of this policy. Benefits are payable in United States Dollars only.

This policy is issued to the Policyholder (hereinafter the Insured, You or Your) in consideration of the application and payment of premiums, to take effect as of the Effective Date. This policy will terminate as hereinafter provided.

The first premium is due on or before the Effective Date and future premiums are due as stated herein during the continuance of this policy.

All periods indicated herein begin and end at 12:01 A.M. Standard Time at the address of the Policyholder.

This policy is delivered in and is governed by the laws of Texas.

The benefits and provisions set forth on the following pages, riders or endorsements are a part of this policy as if recited over the parties' signatures.

NOTICE OF RIGHT TO EXAMINE POLICY FOR 10 DAYS: The Policyholder may return this Policy within 10 days of its delivery if, after examination of the Policy, the Policyholder is not satisfied with it for any reason. Upon return, the Company will refund all Premium paid. The Policy shall be void from the beginning and the parties shall be in the same position as if no policy had been issued. This provision does not apply to policies issued under the Single Up Front payment option.

Signed for HCC Life Insurance Company.

President

Corporate Secretary

LIMITED BENEFIT SHORT TERM MEDICAL INSURANCE

THIS POLICY A CONTRACT
BETWEEN THE POLICY HOLDER AND THE COMPANY
READ IT CAREFULLY

For service or complaints about this policy, please address any inquiries to the address shown above or call 866-400-7102.

IMPORTANT NOTICE

To obtain information or make a complaint:

You may call HCC Life Insurance Company's toll-free telephone number for information or to make a complaint at:

1-866-400-7102

You may write to HCC Life Insurance Company:
225 TownPark Drive, Suite 145
Kennesaw, GA 30144

You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights or complaints at:

1-800-252-3439

You may write the Texas Department of Insurance at:

P.O. Box 149104
Austin, TX 78714-9104
FAX #(512) 475-1771
Web : http://www.tdi.state.tx.us
Email :
ConsumerProtection@tdi.state.tx.us

PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your premium or about a claim you should contact the company first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

ATTACH THIS NOTICE TO YOUR POLICY: This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener informacion o para someter una queja:

Usted puede llamar al numero de telefono gratis de HCC Life Insurance Company para informacion o para someter una queja al:

1-866-400-7102

Used puede escribir a HCC Life Insurance Company:
225 TownPark Drive, Suite 145
Kennesaw, GA 30144

Puede comunicarse con el Departamento de Seguros de Texas para obtener informacion acerca de companias, coberturas, derechos o quejas al:

1-800-252-3439

Puede escribir al Departamento de Seguros de Texas:

P.O. Box 149104
Austin, TX 78714-9104
FAX #(512) 475-1771
Web : http://www.tdi.state.tx.us
Email :
ConsumerProtection@tdi.state.tx.us

DISPUTAS SOBRE PRIMAS O RECLAMOS: Si tiene una disputa concerniente a su prima o a un reclamo, debe comunicarse con la compania primero. Si no se resuelve la disputa, puede entonces comunicarse con el Departamento de Seguros de Texas.

UNA ESTE AVISO A SU POLIZA: Este aviso es solo para proposito de informacion y no se convierte en parte o condicion del documento adjunto.

TABLE OF CONTENTS

NOTE: NO CONTINUOUS COVERAGE. This policy of insurance provides coverage for a short term duration only. It is not renewable.

Although this short term plan may be rewritten for new and completely separate Coverage Periods (as long as you meet the eligibility criteria described in the application), coverage does not continue from one policy to another. This means that a new application must be submitted, a new effective date is given, a new pre-existing condition exclusion period begins and a new deductible and out-of-pocket expense must be met. Any medical condition which may have occurred and/or existed under a prior policy will be treated as a pre-existing condition under the new policy.

PART I – GENERAL DEFINITIONS

"Accident" means a sudden, unforeseeable event that causes injury to one or more Covered Persons.

"Complications of Pregnancy" means:
1. Conditions requiring Inpatient treatment (when pregnancy is not terminated);
2. Whose diagnoses are distinct from pregnancy but are adversely affected or caused by pregnancy, such as hyperemesis gravidarum, preeclampsia, acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, Doctor prescribed rest during the period of pregnancy, morning sickness, and other similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and
3. Non-scheduled or emergency cesarean section, ectopic pregnancy that is terminated, and spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible.

"Congenital Condition" means a disease or other anomaly existing at or before birth, whether acquired during development or by heredity.

"Coverage Period" means the length of time which the Insured selected in the Insured's application and approved by us, not to exceed a/an six (6) month period commencing on the Effective Date. The Insured's Coverage Period is shown in the Schedule of Benefits.

"Covered Person" means an Insured and his eligible dependents for whom coverage is in effect under this policy, as described in Part II – Eligibility and Effective Date of Insurance Provisions and the Schedule of Benefits.

"Custodial or Convalescence Care" means any care that is provided to a Covered Person who is disabled and needs help to support the essential activities of daily living when the Covered Person is not under active and specific medical, surgical, or psychiatric treatment that will reduce the disability to the extent necessary for the person to perform the essentials of daily living on his own.

"Deductible" means the amount of covered expenses that must be paid by a Covered Person before benefits are payable under this policy. This amount applies separately to each Covered Person and must be satisfied as stated in the Schedule of Benefits.

"Doctor" means any duly licensed practitioner who is recognized by the law of the state in which treatment is received as qualified to perform the service for which claim is made.

"Eligible Dependent" means:
1. The Insured's lawful spouse under age 65; and
2. The Insured's unmarried children who are less than age 25.

Dependent children may include stepchildren, foster children, adopted children, children of adopting parents pending finalization of adoption procedures, , children who are medically certified as disabled and children for whom the Insured is required to insure under a medical support order issued under Chapter 154, Family Code, or enforceable by a court of this state.

Dependent children may also include a grandchild of the Insured who is less than age 25 and is a dependent on the Insured for federal income tax purposes at the time application for coverage is made. (Coverage for a grandchild may not be terminated solely because he or she is no longer a Dependent of the Insured for federal tax purposes).

"Durable Medical Equipment" means medical equipment that can withstand repeated use, is prescribed by a Doctor, and is appropriate for use in the home. Covered DME is limited to a standard basic Hospital bed, a portable toilet, and/or a standard basic wheel chair.

"Effective Date" means the date the Insured's (and Eligible Dependents' if applicable) coverage under this policy is effective.

"Emergency" means the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

"Experimental Treatment" means a treatment, drug, device, procedure, supply or service and related services (or any portion thereof, including the form, administration or dosage) for a particular diagnosis or condition when any one of the following exists:

1. The treatment, drug, device, procedure, supply or service is in any clinical trial or a Phase I, II or III trial.
2. The treatment, drug, device, procedure, supply or service is not yet fully approved or recognized (for other than experimental, investigational, research or clinical trial purposes) by the National Cancer Institute (NCI), Food & Drug Administration (FDA), or other pertinent governmental agency or professional organization.
3. The results are not proven through controlled clinical trials with results published in peer-reviewed English language medical journals, to be of greater safety and efficacy than conventional treatment, in both the short and long term.
4. The treatment, drug, device, procedure, supply or service is not generally accepted medical practice in the state where the Covered Person resides or as generally accepted throughout the United States by reference to any one or more of the following: peer-reviewed English-language medical literature, consultation with Doctors, authoritative medical compendia, the American Medical Association, or other pertinent professional organization or governmental agency.
5. The treatment, drug, device, procedure, supply or service is described as investigational, experimental, a study, or for research or the like in any consent, release or authorization which the Covered Person, or someone acting on his or her behalf, may be required to sign.

The fact that a procedure, service, supply, treatment, drug, or device may be the only hope for survival will not change the fact that it is otherwise experimental in nature.

"Extended Care Facility" means an institution, other than a Hospital, operated and licensed pursuant to law, that provides:

1. Permanent and full-time facilities for the continuous skilled nursing care of three (3) or more sick or injured persons on an Inpatient basis during the convalescent stage of their illnesses or injuries;
2. Full-time supervision of a Doctor;
3. Twenty-four (24) hour a day nursing service of one or more Nurses; and

4. Is not, other than incidentally, a rest home or a home for custodial care or for the aged. Extended Care Facility does not include an institution that primarily engages in the care and treatment of drug addiction or alcoholism.

"Home Health Care Agency" means an entity licensed by state or local law operated primarily to provide skilled nursing care and therapeutic services in an individual's home and:
1. Which maintains clinical records on each patient;
2. Whose services are under the supervision of a Doctor or a licensed graduate registered nurse (RN); and
3. Which maintains operational policies established by a professional group including at least one Doctor and one licensed graduate registered nurse (RN).

"Home Health Care Plan" means a program for continued care and treatment of an individual established and approved in writing by the individual's attending Doctor. As part of the plan, an attending Doctor must certify that proper treatment of the Injury or Sickness would require continued confinement in a Hospital in the absence of the services and supplies.

"Hospital" means a facility that is:
1. licensed as a hospital and operated pursuant to law; and
2. is primarily engaged in providing or operating (either on its premises or in facilities available to the hospital on a contractual prearranged basis and under the supervision of a staff of one or more duly licensed physicians), medical, diagnostic, and major surgery facilities for the medical care and treatment of sick or injured persons on an inpatient basis for which a charge is made; and
3. provides 24-hour nursing service by or under the supervision of a registered graduate professional nurse (RN); and
4. is an institution which maintains and operates a minimum of five beds; and
5. has x-ray and laboratory facilities either on the premises or available on a contractual prearranged basis; and
6. maintains permanent medical history records.

Hospital excludes any institution that is primarily a rest home, nursing home, convalescent home, a home for the aged, an alcoholism or drug addiction treatment facility, or a facility for treatment of mental disorders.

"Immediate Family" means the parents, spouse, children, or siblings of a Covered Person, or any person residing with a Covered Person.

"Incident" means all Sicknesses that exist simultaneously and which are due to the same or related causes are considered to be one Incident. Further, if a Sickness is due to causes which are the same as or related to the causes of a prior Sickness, the Sickness will be deemed to be a continuation of the prior Sickness and not a separate Incident. All Injuries due to the same Accident shall be deemed to be one Incident.

"Injury" means accidental bodily Injury of a Covered Person:
1. Caused by an Accident; and
2. That results in covered loss directly and independently of all other causes.

All Injuries sustained in one Accident, including all related conditions and recurring symptoms of the Injuries, will be considered one injury.

“Inpatient” means a person who incurs medical expenses for at least one day’s room and board from a Hospital.

“Insured” means a person who meets the eligibility requirements for an Insured in the Application and this policy, and whose coverage under this policy has become effective and has not terminated.

“Medically Necessary” means the care, service or supply is:
1. Prescribed by a Doctor for the diagnosis or treatment of an Injury or Sickness; and
2. Appropriate, according to conventional medical practice for the Injury or Sickness in the locality in which the care, service or supply, is given.

“Mental and Nervous Disorder” means a “biologically-based” mental disorder, including Schizophrenia, Schizoaffective disorder, Major depressive disorder, Bipolar disorder, Paranoia and other psychotic disorders, Obsessive-compulsive disorder, Panic disorder, Delirium and dementia, Affective disorders, and any other "biologically-based" mental disorders appearing in the most recent edition of the Diagnostic and Statistical Manual of the American Psychiatric Association (the "DSM").

“Outpatient” means a person who incurs medical expenses at Doctor’s offices and freestanding clinics, and at Hospitals when not admitted as an Inpatient.

“Regular and Customary Activities” means an Insured Person can carry on a substantial part of the standard and commonly practiced activities of a person in good health of the same sex and age. Activities performed while confined in a Hospital or other medical institution may not be used to meet this requirement.

“Routine Physical Exam” means examination of the physical body by a Doctor for preventive or informative purposes only, and not for the diagnosis or treatment of any condition.

“Sickness” means Sickness or disease of a Covered Person that:
1. Is treated by a Doctor while the person is covered under this policy; and
2. Results directly and independently of all other causes in loss covered by this policy.

“Substance Abuse” means the overindulgence in and dependence on a psychoactive leading to effects that are detrimental to the individual's physical health or mental health, or the welfare of others.

“Surgery or Surgical Procedure” means an invasive diagnostic procedure; or the treatment of Injury or Sickness by manual or instrumental operations performed by a Doctor while the patient is under general or local anesthesia.

“Total Disability” (or “Totally Disabled”) means the Insured is disabled and prevented from performing the material and substantial duties of his or her occupation. For Dependents, “Totally Disabled” means the inability to perform a majority of the normal activities of a person of like age in good health.

“Urgent Care Center” means a medical facility separate from a hospital emergency department where ambulatory patients can be treated on a walk-in basis without an appointment and

receive immediate, non-routine urgent care for an Injury or Sickness presented on an episodic basis.

"Usual and Customary" charges means the following:
1. A usual fee is defined as the charge made for a given service by a Doctor to the majority of his or her patients; and
2. A customary fee is one that is charged by the majority of Doctors within a community for the same services. All benefits are limited to Usual and Customary charges.

PART II – ELIGIBILITY AND EFFECTIVE DATE OF INSURANCE

An Insured must meet the following eligibility requirements:
1. Must be at least age 2 and under age 65;
2. Must not be pregnant, an expectant father, or planning on adopting;
3. Must not be covered under other hospital, major medical, group health or other medical insurance coverage;
4. Must not be a member of the armed forces of any country, state or international organization, other than on reserve duty for 30 days or less; and
5. Must submit an Application, and if required, provide satisfactory evidence of insurability to the Company.

The Insured's Dependents may apply for coverage under the Policy, if each such person:
1. Qualifies as an Eligible Dependent as defined in this Policy;
2. Is not pregnant, an expectant father, or planning on adopting;
3. Is not covered under other hospital, major medical, group health or other medical insurance coverage;
4. Is not a member of the armed forces of any country, state or international organization, other than on reserve duty for 30 days or less; and
5. Submits an Application, and if required, provides satisfactory evidence of insurability to the Company.

Coverage will be effective for an Insured and his Eligible Dependent(s) as of the approved Effective Date, provided:
1. The Insured and his/her Dependent(s) meets the eligibility requirements set forth in the Application and this policy;
2. The Insured's Application is approved by Us;
3. The first premium payment is received on or before the date the Insured's Application is approved by Us;
4. The Insured is not confined at home or in a Hospital or medical institution as of the Effective date; and
5. The Insured is engaging in his Regular and Customary Activities as of the Effective date.

If the Insured is not engaged in his Regular and Customary Activities or is confined in a Hospital or medical institution on the Effective Date, coverage will begin the first day he can engage in his Regular and Customary Activities and is not confined in a Hospital or medical institution.

The Company will require satisfactory evidence of insurability for each Insured and Eligible Dependent.

Newborn Child Coverage: A child of the Insured born while this policy is in force is covered for Injury and Sickness (including necessary care and treatment of congenital defects, birth

abnormality and premature birth), as well as routine newborn care for the first 31 days. The child is covered from the moment of birth until the 31st day of age. A notice of birth together with additional premium must be submitted to us within 31 days of the birth in order to continue coverage for Injury and Sickness beyond the initial 31-day period.

Adopted Children Coverage: A minor child who is adopted by the Insured or for whom the Insured is a party to a suit in which the Insured seeks to adopt such child while this policy is in force is covered for Injury and Sickness. The coverage of such child will be the same as provided for other members of the Insured's family. Such child shall be covered from the date of adoption or the date the Insured becomes a party to a suit to adopt the child. For coverage to continue beyond the initial 31-day period, the Insured must apply for coverage and pay any required premium within 31 days after the date of adoption or the date that the Insured becomes a party in a suit in which adoption is sought. However, coverage shall begin at the moment of birth if the petition for adoption, application for coverage and payment of premium occurs within 31 days after the child's birth. Such child's coverage will not be subject to any pre-existing conditions limitation provided by this policy. Coverage for such minor child will continue unless the petition for adoption is dismissed or denied. A child for which the Insured is a party in a suit in which the adoption of child is sought shall be deemed an adopted child.

PART III - TERMINATION OF INSURANCE

Coverage of a Covered Person under this policy shall automatically terminate on the earliest of the following dates:

1. The date the Coverage Period expires;
2. The first day of the month coinciding with or following the date other hospital, major medical, group health or other medical insurance coverage becomes effective for a Covered Person;
3. The end of the last period for which the last required premium payment was made for the Insured's or Covered Person's insurance;
4. The date a Covered Person receives the Coverage Period Maximum Benefit Amount;
5. The date the Covered Person enters the armed forces of any country, state or international organization, other than for reserve duty of 30 days or less;
6. The premium due date that coincides with or next follows the date on which the Insured is no longer eligible;
7. For a Dependent spouse, the first day of the month following the date of divorce or legal separation from the Insured; or
8. The date We specify that the Covered Person's insurance is terminated because of:
    A. Failure to provide any signed release, consent, assignment or other documents requested by Us;
    B. Failure to fully cooperate with Us in the administration of this policy;
    C. Material misrepresentation, fraud, or omission of information on any application form, or in requesting the receipt of benefits under this policy; or
    D. Misuse of the Covered Person's identification card.

At the death of an Insured, all rights and privileges as a Covered Person under this policy will transfer to the surviving Dependent spouse. The Dependent spouse will then be considered an Insured instead of a Dependent. In the event the Dependent spouse remarries, coverage under this policy for the Dependent Spouse and Dependent child(ren), if any, will end on the first day

of the month following the date of that marriage. If no surviving Dependent spouse, or at the death of a surviving Dependent spouse, all rights and privileges as a Covered Person under this policy will transfer to each Dependent child, if any, and he will be considered the Insured instead of a Dependent.

In the event of the Insured's divorce, the Insured's former spouse may apply for a Policy if the former spouse was insured at the time of the event. The spouse must apply within 60 days of the date his/her insurance terminated and pay the required Premium to avoid any lapse in coverage. If the Insured selected the Pay In Advance option in the Insured's Application, We received all required premium for the Coverage Period, and coverage terminates because other insurance is secured or due to divorce or legal separation, premium will be reimbursed to the Insured for the period of time, if any, between the later of: (1) the date coverage terminates in accordance with the above provisions or (2) the date we are notified of ineligibility, and the end of that Coverage Period.

Extension of Benefits
If a covered Bodily Injury or Sickness commences while this policy is in force as to a Covered Person, benefits otherwise payable under this policy for the Injury or Sickness causing the Total Disability will also be paid for any Eligible Expenses incurred after the termination of insurance for a Covered Person if, from the date of such termination to the date such expenses are incurred, the Covered Person is Totally Disabled by reason of such Injury or Sickness. Such benefits shall be payable only during the continuance of such disability until the earlier of:

1. The date the Total Disability ends;
2. The date when treatment for the Total Disability is no longer required;
3. The date following a time period equal to the Covered Person's Coverage Period, with a minimum of thirty (30) days not to exceed a maximum of ninety (90) days;
4. The date the Covered Person becomes eligible for any other group insurance plan providing coverage for the same conditions causing the Total Disability; or
5. The date the Coverage Period Maximum Benefit amount has been reached.

PART IV - PREMIUMS

1. Unless the Single Payment option has been chosen, premium due dates for an Insured will be on the Effective Date and then the same date of each following calendar month. If a month has fewer days than the scheduled premium due date, premium will be due on the last day of the month. All insurance shall be charged from and to the premium due date.

2. If any change or clerical error affects premiums, an equitable adjustment in premiums shall be made on the premium due date next following the date of the change or the discovery of the error. Any premium adjustment that involves collecting earned premiums, or returning unearned premium shall be limited to the six (6) months immediately preceding the date of determination that the adjustment in premium should be made.

3. Premiums shall be payable in advance to Us at Our Home Office.

4. If the Insured has not given written notice to Us that insurance is to be terminated prior to the premium due date, a grace period of thirty-one (31) days beginning from the premium due date will be allowed for any premium after the first premium. If the Insured fails to pay premium before the grace period expires all coverage shall lapse as of the premium due date.

5. This policy does not share in the surplus earnings of the Company and no refund or assessment shall be made to this policyholder, Insured, or Dependent of any excess or deficit earnings of the Company.

Reinstatement

If any renewal premium is not paid within the time granted the Insured for payment, a subsequent acceptance of premium by the Company or by any agent authorized by the Company to accept such premium, without requiring in connection therewith an application for reinstatement, shall reinstate the Policy. Provided, that if the Company or such agent requires an application for reinstatement and issues a conditional receipt for the premium tendered, the Policy will be reinstated upon approval of such application by the Company or, lacking such approval, upon the 45th day following the date of such conditional receipt unless the Company has previously notified the Insured in writing of its disapproval of such application.

The reinstated policy shall cover only loss resulting from such accidental injury as may be sustained after the date of reinstatement and loss due to such sickness as may begin more than 10 days after such date. In all other respects the Insured and the Company shall have the same rights as they had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached hereto in connection with the reinstatement. Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid, but not to any period more than 60 days prior to the date of reinstatement.

PART V – DESCRIPTION OF MEDICAL EXPENSES

Subject to the Deductible, Coinsurance and other limits set forth in PART X – SCHEDULE OF BENEFITS, the Company will pay the following expenses incurred while this insurance is in effect:

1. Charges made by a Hospital for:
   - A. Daily room and board and nursing services not to exceed the average semi-private room rate;
   - B. Daily room and board and nursing services in Intensive Care Unit;
   - C. Use of operating, treatment or recovery room;
   - D. Services and supplies which are routinely provided by the Hospital to persons for use while Inpatients;
   - E. Emergency treatment of an Injury, even if Hospital confinement is not required; and
   - F. Emergency treatment of a Sickness; however, an additional $250 Deductible will apply to emergency room charges unless the Covered Person is directly admitted to the Hospital as an Inpatient for further treatment of that Sickness.
2. For Surgery at an Outpatient surgical facility, including services and supplies.
3. For charges made by a Doctor for professional services, including Surgery. Charges for an assistant surgeon are covered up to 20% of the Usual and Customary charge of the

primary surgeon. (Standby availability will not be deemed to be a professional service and therefore is not covered).

4. For dressings, sutures, casts or other supplies which are Medically Necessary and administered by or under the supervision of a Doctor, but excluding nebulizers, oxygen tanks, diabetic supplies, other supplies for use or application at home, and all devices or supplies for repeat use at home, except Durable Medical Equipment as herein defined.
5. For diagnostic testing using radiology, ultrasonographic or laboratory services (psychometric, intelligence, behavioral and educational testing are not included).
6. For artificial limbs, eyes or larynx, breast prosthesis or basic functional artificial limbs, orthotic devices and professional services related to their fitting and use. The repair and replacement thereof is covered unless due to misuse or loss by the Covered Person.
7. For reconstructive surgery when the surgery is directly related to surgery which is covered under this policy, including reconstructive breast surgery and prosthetic devices incident to a Mastectomy. Coverage will also be extended to include surgery on a non-diseased breast to establish symmetry with the diseased breast. As used in this benefit:
   A. "Mastectomy" means the surgical removal of all or part of a breast as a result of breast cancer.
   B. "Reconstructive breast surgery" means surgery performed as a result of a mastectomy to reestablish symmetry between the two breasts and includes augmentation mammoplasty, reductive mammoplasty, and mastopexy.

   Coverage for a Medically Necessary mastectomy will include inpatient care for a Covered Person for a minimum of:
   A. 48 hours following a mastectomy; or
   B. 24 hours following a lymph node dissection for the treatment of breast cancer, unless the Covered Person and their Doctor agree that a shorter period of time is appropriate.
8. For radiation therapy or treatment and chemotherapy.
9. For hemodialysis and the charges by the Hospital for processing and administration of blood or blood components but not the cost of the actual blood or blood components.
10. For oxygen and other gasses and their administration by or under the supervision of a Doctor. For anesthetics and their administration by a Doctor, subject to a maximum of 20% of the benefit payable for the primary surgeon.
11. Extended Care Facility charges for room and board accommodations; if:
    A. The Insured is an Inpatient in that facility on the certification of the attending Doctor that the confinement is Medically Necessary;
    B. The confinement commences immediately following a period of at least fourteen () continuous days of Hospital confinement; and
    C. That confinement is for the same covered Injury or Sickness that was treated during the Covered Person's confinement in the Hospital.
12. Treatment of a Covered Person by a Home Health Care Agency under a Home Health Care Plan. Up to four (4) consecutive hours in a twenty-four (24) hour period of Home Health Care services shall be considered as one Home Health Care visit. Eligible Expenses for Home Health Care are the Maximum Allowable Charges made for the following:
    A. Part-time skilled nursing care;
    B. Physical therapy;
    C. Speech therapy;
    D. Medical supplies, drugs and medicines prescribed by a Doctor;

E. Laboratory services by or on behalf of the Hospital but only to the extent benefits for those services would have been paid under this policy had the Insured Person remained Hospitalized;
F. Occupational therapy; and
G. Respiratory therapy.

However, benefits will not be paid for charges made by a Home Health Care Agency for:

A. Any charges excluded under the Exclusions of the policy;
B. Full-time nursing care at home;
C. Meals delivered to the home;
D. Homemaker services;
E. Any services of an individual who ordinarily resides in the Insured's home or is a member of the Insured's immediate family; or
F. Any transportation services.

Benefits for Home Health Care are in lieu of any similar benefits provided under any other provision of the policy.

14. Local Ambulance transport necessarily incurred in connection with Injury, and Local Ambulance transport necessarily incurred in connection with Sickness resulting in Inpatient hospitalization.
15. Dental treatment and dental surgery necessary to restore or replace natural teeth lost or damaged as a result of an Injury covered under this policy.
16. Medically Necessary rental of Durable Medical Equipment (limited to a standard basic hospital bed, a portable toilet, and/or a standard basic wheelchair) up to the purchase prices, not including expenses for customization and only for the portion of the cost equivalent to the Coverage Period.
17. Physical Therapy if prescribed by a Doctor who is not affiliated with the Physical Therapy practice, necessarily incurred to continue recovery from a covered Injury or Sickness.

Pre-Authorization Requirements

1. All hospitalizations, other Inpatient care, and Surgeries or Surgical Procedures must be Pre-authorized.

To comply with the Pre-authorization requirements, the Covered Person must:

A. Contact the Company at the telephone number contained in the Insured's policy as soon as possible before the expense is to be incurred; and
B. Comply with the instructions of the Company and submit any information or documents they require; and
C. Notify all Doctors, Hospitals and other providers that this insurance contains Pre-authorization requirements and ask them to fully cooperate with the Company**.**

2. If the Covered Person complies with the Pre-authorization requirements, and the expenses are Pre-authorized, the Company will pay Eligible Medical Expenses subject to all terms, conditions, provisions and exclusions described in this policy. If the Covered Person does not comply with the Pre-authorization requirements or if the expenses are not Pre-authorized:
   A. Eligible Medical Expenses will be reduced by 50%; and
   B. The Deductible will be subtracted from the remaining amount; and
   C. The Coinsurance will be applied.
3. Emergency Pre-authorization: In the event of an emergency Hospital admission, Pre-authorization must be made within 48 hours after the admission, or as soon as is reasonably possible.
4. Pre-authorization Does Not Guarantee Benefits – The fact that expenses are Pre-authorized does not guarantee either payment of benefits or the amount of benefits.

Eligibility for and payment of benefits are subject to all the terms, conditions, provisions and exclusions herein.

5. Concurrent Review – For Inpatient stays of any kind, the Company will Pre-authorize a limited number of days of confinement. Additional days of Inpatient confinement may later be Pre-authorized if a Covered Person receives prior approval.

State Mandated Benefits.

The following benefits are mandated by applicable state law. All benefits will be subject to any inside benefit limitations set forth below, as well as the Coverage Period Maximum Benefit amounts shown on the Schedule of Benefits.

1. **Colorectal Cancer Screenings** - Coverage shall be provided for a medically recognized screening examination for the detection of colorectal cancer for each Covered Person who is 50 years of age or older and at normal risk for developing colon cancer. Benefits shall include:
   A. A fecal occult blood test performed annually and a flexible sigmoidoscopy performed every 5 years; or
   B. A colonoscopy performed every 10 years.

2. **Diabetic Supplies/Equipment and Self-Management Education** – Coverage shall be provided for equipment, supplies and related services for the treatment of Type I, Type II and gestational diabetes when recommended or prescribed by a Doctor for a Covered Person or the caretaker of a Covered Person:
   A. Visual reading and urine testing strips and tablets which test for glucose, ketones and protein;
   B. Insulin pumps, both external and implantable, and associated appurtenances, which include: (a) batteries; (b) skin preparation items; (c) adhesive supplies; (d) infusion sets; (e) insulin cartridges; (f) durable and disposable devices to assist in the injection of insulin; and (g) other required disposable supplies;
   C. Insulin infusion devices;
   D. Podiatric appliances, including up to two pairs of therapeutic footwear, for prevention of complications associated with diabetes;
   E. Blood glucose monitors, including noninvasive glucose monitors and blood glucose monitors for the legally blind;
   F. Lancets and lancet devices;
   G. Test strips for glucose monitors;
   H. Insulin and insulin analog preparations;
   I. Injection aids, including devices used to assist with insulin injection and needleless systems;
   J. Glucagon emergency kits;
   K. Insulin syringes;
   L. Prescriptive and nonprescriptive oral agents for controlling blood sugar;
   M. Biohazard disposal containers;
   N. Repairs and necessary maintenance of insulin pumps not otherwise provided for under a manufacturer's warranty or purchase agreement, and rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which shall exceed the purchase price of similar replacement pump; and
   O. prescription drugs (bears the legend "Caution: Federal law prohibits dispensing without a prescription") and medications available without a prescription for controlling the blood sugar level.

Coverage shall also include diabetes self-management training prescribed by a Doctor, including Medically Necessary medical nutrition therapy relating to diet, caloric intake and diabetes management (excluding programs whose only purpose is weight reduction) only if that therapy is provided by a licensed health care professional with specialized training in diabetes management, including a licensed registered dietician or a licensed certified nutritionist, and that is limited to the following:

A. Visits upon the diagnosis of diabetes;
B. Medically Necessary changes in a Covered Person's self-management based on a Doctor's diagnosis representing a significant change in the Covered Person's symptoms or condition; and
C. Visits for Medically Necessary re-education or refresher training.

Coverage shall also be provided for:

A. Office visits and consultations with Doctors and practitioners for monitoring and treatment of diabetes, including office visits and consultations with appropriate specialists;
B. Immunizations required by Insurance Code Article 21.53F, Coverage for Childhood Immunizations;
C. Immunizations for influenza and pneumococcus;
D. Inpatient services, and Doctor and practitioner services when the Covered Person is confined to a Hospital, rehabilitation facility, or a skilled nursing facility; and
E. Inpatient and outpatient laboratory and diagnostic imaging services.

3. **Prostate Screening Tests** – Coverage shall be provided for an annual medically recognized diagnostic examination for the detection of prostate cancer for male Covered Persons as follows:
   A. A physical examination for the detection of prostate cancer; and
   B. A prostate-specific antigen test used for the detection of prostate cancer for each male Covered Person who is:
      a. At least 50 years of age and asymptomatic; or
      b. At least 40 years of age with a family history of prostate cancer or another prostate cancer risk factor.

4. **Telehealth Services and Telemedicine Medical Services –** Coverage shall be provided for telehealth services and telemedicine medical services.

5. **Cranio Facial Abnormalities of a Child** – Coverage shall be provided for reconstructive surgery for craniofacial abnormalities for a child who is younger than 19 years of age. As used here, "reconstructive surgery for craniofacial abnormalities" means surgery to improve the function of, or to attempt to create a normal appearance of an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease.

6. **Acquired Brain Injury** – Coverage shall be provided for cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing or treatment, neurofeedback therapy, remediation, post-acute transition services, and community reintegration services, including outpatient day treatment services, or other post-acute care treatment services, if such services are necessary as a result of and related to an acquired brain injury.

For purposes here, the following definitions shall apply:

Acquired brain injury – A neurological insult to the brain, which is not hereditary, congenital or degenerative. The injury to the brain has occurred after birth and results in a change in neuronal activity, which results in the impairment of physical functioning, sensory processing, cognition or psychosocial behavior.

Cognitive communication therapy – Services designated to address modalities of comprehension and expression, including understanding, reading, writing, and verbal expression of information.

Cognitive rehabilitation therapy – Services designed to address therapeutic cognitive activities, based on an assessment and understanding of the individual's brain-behavioral deficits.

Community reintegration services – Services that facilitate the continuum of care as an affected individual transitions into the community.

Neurobehavioral testing – An evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status, and premorbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the individual, family, or others.

Neurobehavioral treatment – Interventions that focus on behavior and the variables that control behavior.

Neurocognitive rehabilitation – Services designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.

Neurocognitive therapy – Services designed to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities.

Neurofeedback therapy –Services that utilize operant conditioning learning procedure based on electroenephalography (EEG) parameters, and which are designed to result in improved mental performance and behavior, and stabilized mood.

Neurophysiological testing – An evaluation of the functions of the nervous system.

Neurophysiological treatment – Interventions that focus on the functions of the nervous system.

Neuropsychological testing – The administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral, and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning.

Neuropsychological treatment – Interventions designed to improve or minimize deficits in behavioral and cognitive processes.

Outpatient day treatment services – Structured services provided to address in deficits in physiological, behavioral, and/or cognitive functions. Such services may be delivered in setting that include transitional residential, community integration, or non-residential treatment settings.

Post-acute care treatment services – Services provided after acute confinement and/or treatment that are based on an assessment of the individual's physical, behavior, or cognitive functional deficits, which include a treatment goal of achieving functional changes by reinforcing, strengthening, or re-establishing previously learned patterns of behavior and/or establishing new patterns of cognitive activity or compensatory mechanisms.

Post-acute transition services – Services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.

Psychophysiological testing – An evaluation of the interrelationships between the nervous system and other bodily organs and behavior.

Psychophysiological treatment – Interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors.

Remediation – The process(es) of restoring or improving a specific function.

7. **Hearing Screening Tests** – Coverage shall be provided for screening tests for hearing loss from birth through the date the child is 30 days old, including any necessary diagnostic follow-up care related to the screening test from birth through the date the child is 24 months old. (This covered charge is not subject to any Deductible, but is subject to payment of any applicable coinsurance).

8. **Mammography Exam** – Coverage shall be provided for mammography screening, subject to the same terms and conditions as a Sickness covered under the policy (including the application of deductible amounts, benefit percentages, and benefit maximums),for a Covered Person age 35 and over.

9. **Childhood Immunizations** – Coverage shall be provided from birth through the date of a Dependent child's sixth birthday coverage for immunization against: (1) diphtheria; (2) haemophilus influenza type b; (3) hepatitis B; (4) measles; (5) mumps; (6) pertussis; (7) polio; (8) rubella; (9) tetanus; (10) varicella; and (11) any other immunization that is required for the child by law. Coverage for childhood immunizations shall not be subject to any Deductible, coinsurance or co-payment.

10. **Papillomavirus and Cervical Cancer Testing** – Coverage shall be provided for an annual medically recognized diagnostic examination for the early detection of cervical cancer for female Covered Persons age 18 and older. Coverage includes a conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the United States Food and Drug Administration, alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus.

A screening test must be performed in accordance with the guidelines adopted by the American College of Obstetricians and Gynecologists or another similar national organization of medical professionals.

11. **Cardiovascular Disease** – Coverage shall be provided for each Covered Person who is: (1) a male older than 45 years of age and younger than 76 years of age; or (2) a female older than 55 years of age and younger than 76 years of age; and who:
    A. Is diabetic; or
    B. Has a risk of developing coronary heart disease, based on a score derived using the Framingham Heart Study coronary prediction algorithm, that is intermediate or higher.

    Coverage shall be for up to $200 for one of the following noninvasive screening tests for atherosclerosis and abnormal artery structure and function every five years, performed by a laboratory that is certified by a national organization:
    A. Computed tomography (CT) scanning measuring coronary artery calcification; or
    B. Ultrasonography measuring carotid intima-media thickness and plaque.

12. **Clinical Trials** – Coverage shall be provided for routine patient care costs to a Covered Person in connection with a phase I, phase II, phase III, or phase IV clinical trial if the clinical trial is conducted in relation to the prevention, detection, or treatment of a life-threatening disease or condition and is approved by:
    A. The Centers for Disease Control and Prevention of the United States Department of Health and Human Services;
    B. The National Institutes of Health;
    C. The United States Food and Drug Administration;
    D. The United States Department of Defense;
    E. The United States Department of Veterans Affairs; or
    F. An institutional review board of an institution in this state that has an agreement with the Office for Human Research Protections of the United States Department of Health and Human Services.

    As used here, “routine patient care costs” means the costs of any Medically Necessary health care service for which benefits are provided under a health benefit plan, without regard to whether the Covered Person is participating in a clinical trial. Routine patient care costs do not include:
    A. The cost of an investigational new drug or device that is not approved for any indication by the United States Food and Drug Administration, including a drug or device that is the subject of the clinical trial;
    B. The cost of a service that is not a health care service, regardless of whether the service is required in connection with participation in a clinical trial;
    C. The cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
    D. A cost associated with managing a clinical trial; or
    E. The cost of a health care service that is specifically excluded from coverage under this Policy.

    Coverage shall not be provided for:
    A. Services that are a part of the subject matter of the clinical trial and that are customarily paid for by the research institution conducting the clinical trial; or
    B. Services provided outside this state.

The Company is not required to reimburse the research institution conducting the clinical trial for the cost of routine patient care provided through the research institution unless the research institution, and each health care professional providing routine patient care through the research institution, agrees to accept reimbursement under this Policy, at the rates that are established under this Policy, as payment in full for the routine patient care provided in connection with the clinical trial.

PART VI – EXCLUSIONS

Charges for the following treatments and/or services and/or supplies and/or conditions are excluded from coverage:

1. Pre-existing Conditions – Charges resulting directly or indirectly from a pre-existing condition are excluded from coverage hereunder. A pre-existing condition is a condition: (1) for which medical advice, diagnosis, care, or treatment (includes receiving services and supplies, consultations, diagnostic tests or prescription medicines) was recommended or received within the 60 months immediately preceding the Effective Date; or (2) that had manifested itself in such a manner that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment (includes receiving services and supplies, consultations, diagnostic tests or prescription medicines) within the 12 months immediately preceding such person's Effective Date. This exclusion does not apply to a newborn or newly adopted child who is added to coverage under this policy in accordance with PART II – ELIGIBILITY AND EFFECTIVE DATE OF INSURANCE.
2. Waiting Period – If coverage was purchased within 3 days of the Covered Person's Effective Date, then in respect to Sickness, Covered Persons will only be entitled to receive benefits for Sicknesses that begin, by occurrence of symptoms and/or receipt of treatment, at least 72 hours following the Covered Person's Effective Date of coverage under this policy.
3. Outpatient Prescription Drugs, medications, vitamins, and mineral or food supplements including pre-natal vitamins, or any over-the-counter medicines, whether or not ordered by a Doctor.
4. Routine pre-natal care, Pregnancy, childbirth, and postnatal care. (This exclusion does not apply to "Complications of Pregnancy" as defined.)
5. Alcoholism.
6. Substance abuse.
7. Charges which are not incurred by a Covered Person during his/her Coverage Period.
8. Treatment, services or supplies, which are not administered by or under the supervision of a Doctor.
9. Treatment, services or supplies which are not Medically Necessary as defined.
10. Treatment, services or supplies provided at no cost to the Covered Person.
11. Charges which exceed Usual and Customary charge as defined.
12. Telephone consultations or failure to keep a scheduled appointment.
13. Consultations and/or treatment provided over the Internet.
14. Surgeries, treatments, services or supplies which are deemed to be Experimental Treatment.
15. All charges Incurred while confined primarily to receive Custodial or Convalescence Care.
16. Weight modification or surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass surgery.

17. Modifications of the physical body in order to improve the psychological, mental or emotional well-being of the Covered Person, such as sex-change surgery.
18. Surgeries, treatments, services or supplies for cosmetic or aesthetic reasons, except for reconstructive surgery which is expressly covered under this policy.
19. Any drug, treatment or procedure that either promotes or prevents conception including but not limited to: artificial insemination, treatment for infertility or impotency, sterilization or reversal of sterilization.
20. Any drug, treatment or procedure that either promotes, enhances or corrects impotency or sexual dysfunction.
21. Abortions, except in connection with covered Complications of Pregnancy or if the life of the expectant mother would be at risk.
22. Dental treatment, except for dental treatment that is expressly covered under this policy.
23. Eyeglasses, contact lenses, hearing aids, hearing implants, eye refraction, visual therapy, and any examination or fitting related to these devices, and all vision and hearing tests and examinations.
24. Eye surgery, such as radial keratotomy, when the primary purpose is to correct nearsightedness, farsightedness or astigmatism.
25. Treatment for cataracts.
26. Treatment of the temporomandibular joint.
27. Injuries resulting from participation in any form of skydiving, scuba diving, auto racing, bungee jumping, hang or ultra light gliding, parasailing, sail planing, flying in an aircraft (other than as a passenger on a commercial airline), rodeo contests or as a result of participating in any professional, semi-professional or other non-recreational sports including boating, motorcycling, skiing, riding all-terrain vehicles or dirt-bikes, snowmobiling or go-carting.
28. Injuries or Sicknesses resulting from participation in interscholastic, intercollegiate or organized competitive sports.
29. Injury resulting from being under the influence of or due wholly or partly to the effects of alcohol or drugs, other than drugs taken in accordance with treatment prescribed by a Doctor, but not for the treatment of Substance Abuse.
30. Willfully self-inflicted Injury or Sickness.
31. Venereal disease, including all sexually transmitted diseases and conditions.
32. Immunizations and Routine Physical Exams.
33. Services received for any condition caused by a Covered Person's commission of or attempt to commit a felony or to which a contributing cause was the Covered Person being engaged in an illegal occupation.
34. Speech, vocational, occupational, biofeedback, acupuncture, recreational, sleep or music therapy, holistic care of any nature, massage and kinestherapy.
35. Any services performed or supplies provided by a member of the Insured's Immediate Family.
36. Orthoptics and visual eye training.
37. Services or supplies which are not included as Eligible Expenses as described herein.
38. Care, treatment or supplies for the feet: orthopedic shoes, orthopedic prescription devices to be attached to or placed in shoes, treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions, and treatment of corns, calluses or toenails.
39. Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Doctor.
40. Treatment of sleep disorders.

41. Hypnotherapy when used to treat conditions that are not recognized as Mental or Nervous Disorders by the American Psychiatric Association, and biofeedback, and non-medical self-care or self-help programs.
42. Any services or supplies in connection with cigarette smoking cessation.
43. Exercise programs, whether or not prescribed or recommended by a Doctor.
44. Treatment required as a result of complications or consequences of a treatment or condition not covered under this policy.
45. Charges for travel or accommodations, except as expressly provided for local ambulance.
46. Treatment incurred as a result of exposure to non-medical nuclear radiation and/or radioactive material(s).
47. Organ or Tissue Transplants or related services.
48. Treatment for acne, moles, skin tags, diseases of sebaceous glands, seborrhea, sebaceous cyst, unspecified disease of sebaceous glands, hypertrophic and atrophic conditions of skin, nevus.
49. Services received or supplies purchased outside the United States, its territories or possessions, or Canada.
50. Treatment for or related to any congenital condition, except as it relates to a newborn or adopted child added as a Covered Person to this policy.
51. Spinal manipulation or adjustment.
52. Sclerotherapy for veins of the extremities.
53. Expenses during the first 6 months after the Effective Date of coverage for a Covered Person for the following (subject to all other coverage provisions, including but not limited to the Pre-existing Condition exclusion):
    A. Total or partial hysterectomy, unless it is Medically Necessary due to a diagnosis of carcinoma;
    B. Tonsillectomy;
    C. Adenoidectomy;
    D. Repair of deviated nasal septum or any type of surgery involving the sinus;
    E. Myringotomy;
    F. Tympanotomy;
    G. Herniorraphy; or
    H. Cholecystectomy.
54. Chronic fatigue or pain disorders.
55. Treatment or diagnosis of allergies, except for emergency treatment of allergic reactions.
56. Treatment, medication or hormones to stimulate growth, or treatment of learning disorders, disabilities, developmental delays or deficiencies, including therapy.
57. Kidney or end stage renal disease.
58. Joint replacement or other treatment of joints, spine, bones or connective tissue including tendons, ligaments and cartilage, unless related to a covered Injury.
59. Expenses resulting from a declared or undeclared war, or from voluntary participation in a riot or insurrection.
60. Expenses incurred by a Covered Person while on active duty in the armed forces. Upon written notice to Us of entry into such active duty, the unused premium will be returned to the Covered Person on a pro-rated basis.

PART VII – NON-DUPLICATION OF BENEFITS

The Insured may have other valid coverage (with another insurer) which applies to a loss covered by this policy. Other valid coverage may reduce the benefits payable under this policy.

The benefits payable under this policy will not be reduced by other valid coverage if the Insured has notified us in writing that the Insured does have other valid coverage. The Insured must notify us before a loss begins.

The benefits payable under this policy will be reduced by other valid coverage if the Insured has not notified us in writing (before the loss begins) that the Insured does have other valid coverage. The amount of the reduced benefits payable under this policy will be determined by applying the formula below:

ADD: The amount which would have been payable under this policy.

PLUS: The total of the like amounts under all other valid coverages on the same loss of which we have had notice.

DIVIDED BY: The total like amounts under all valid coverage for such loss.
When the Insured's benefits are reduced due to other valid coverage, we will return part of the last premium which the Insured paid prior to the commencement of a loss covered under this policy. The proportion we will use to determine the Insured's premium refund will be the same proportion we use to determine the benefit reduction in the formula above.
When the Insured's other valid coverage is written on a provision of service basis, the "like amount" of such other coverage will mean the dollar amount which the services the Insured received would have cost the Insured if the Insured did not have the other coverage.

"Other Valid Coverage" – means any of the following which provides benefits or services for medical expenses:
1. Individual or family insurance or subscriber contracts.
2. Any group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice, or individual practice coverage.
3. Any federal, state or local governmental programs, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time.)

PART VIII - CLAIM PROVISIONS

Notice of Claim: Written notice of claim must be given within 31 days after a covered loss begins (60 days in Kentucky; six months in Montana) or as soon as is reasonably possible. The notice must be given to the Company named on the Schedule of Benefits. Notice should include information that identifies the claimant and this policy.

Claim Forms: When the Company receives notice of claim, forms for filing proof of loss will be sent to the claimant. If claim forms are not supplied within 15 days, a claimant can give proof as follows:
1. In writing;
2. Setting forth the nature and extent of the loss; and
3. Within the time stated in the Proof of Loss provision.

(If the Insured resides in Georgia, the reference to 15 days is changed to 10 working days.)

Proof of Loss: Written proof of loss must be given to the Company named on the Schedule of Benefits within 90 days after the loss begins. We will not deny nor reduce any claim if it was not reasonably possible to give proof of loss in the time required. In any event, proof must be given to the Company within one year after it is due unless the Insured is legally incapable of doing so.

Time of Payment of Claim: Benefits for loss covered by this policy will be paid as soon as we receive proper written proof of such loss.

Payment of Claims: All benefits will be paid to the Insured, if living, unless an Assignment of Benefits has been requested by the Insured. Any other benefits due and unpaid at the Insured's death will be paid to the Insured's estate. If a benefit is to be paid to the Insured's estate, or to an Insured or beneficiary who is not competent to give a valid release, the Company may pay up to $1,000.00 of such benefit to one of the Insured's relatives who is deemed by the Company to be justly entitled to it. Such payment, made in good faith, fully discharges the Company to the extent of the payment.

Physical Examination: At our expense, we may have a person claiming benefits examined as often as reasonably necessary while the claim is pending.

Legal Action: No legal action may be brought to recover on this policy before 60 days after written proof of loss has been furnished as required by this policy. No such action may be brought after three years (five years in Kansas, six years in South Carolina and the applicable statute of limitation in Florida) from the time written proof of loss is required to be furnished.

Third Party Liability: No benefits are payable for any Sickness, Injury, or other condition for which a third party may be liable or legally responsible by reason of negligence, an intentional act, or breach of any legal obligation on the part of such third party. Nevertheless, the Company will advance the benefits of this policy to the Insured subject to the following**:**

1. The Insured agrees to advise Us, in writing, within 60 days of any Covered Person's claim against the third party and to take such action, provide such information and assistance, and execute such paper as We may require to facilitate enforcement of the claim. The Insured and Covered Person also agree to take no action that may prejudice Our rights or interests under this policy. Failure to provide notice of a claim or to cooperate with Us, or actions that prejudice Our rights or interests, will be material breach of this policy and will result in the Insured being personally responsible for reimbursing Us.
2. We will automatically have a lien, to the extent of benefits advanced, upon any recovery that any Covered Person receives from the third party, the third party's insurer, or the third party's guarantor. Recovery may be by settlement, judgment or otherwise. The lien will be in the amount of benefits paid by Us under this policy for the treatment of the Sickness, disease, Injury or condition for which the third party is liable.

Payment to the Texas Department of Human Services: All benefits paid on behalf of the child or children under the policy must be paid to the Texas Department of Human Services whenever:

1. The Texas Department of Human Services is paying benefits under the Human Resources Code, Chapter 31, or Chapter 32, i.e. financial and medical assistance service programs administered pursuant to the Human Resources Code; and

2. The parent who is covered by this policy has possession or access to the child pursuant to a court order, or is not entitled to access or possession of the child and is required by the court to pay child support. We must receive at our home office written notice affixed to the insurance claim when the claim is first submitted stating that all benefits paid must be paid directly to the Texas Department of Human Services.

Benefits will not be reduced or denied because such benefits are covered by the Medical Assistance Act of 1967, as amended. Benefits will be paid to the Texas Department of Human Resources for the actual cost of medical expenses it pays through medical assistance for a person insured by this policy, if the Covered Person would otherwise be entitled to payment of benefits for such medical expenses. Benefits so paid, in no event, will exceed benefits otherwise payable under this policy. Any benefits payable for expenses not paid by such Department will be paid as provided in this policy.

Payment to Possessory or Managing Conservator of Dependent Child: For a minor child who otherwise qualifies as a Dependent of the Insured, benefits may be paid on behalf of the child to a person who is not the Insured if an order issued by a court of competent jurisdiction in this or any other state names such person the possessory or managing conservator of the child.

To be entitled to receive benefits, a possessory or managing conservator of a child must submit to us with the claim form, written notice that such person is the possessory or managing conservator of the child on whose behalf the claim is made and submit a certified copy of a court order establishing the person as the possessory or managing conservator. This will not apply in the case of any unpaid medical bill for which a valid assignment of benefits has been exercised or to claims submitted by the Insured where the Insured had paid any portion of a medical bill that would be covered under the terms of this policy.

PART IX – GENERAL PROVISIONS

Time Limit on Certain Defenses: The validity of coverage issued under this policy with respect to an Insured or his Eligible Dependents may not be contested after two years from this policy's effective date, except for nonpayment of premiums.

Misstatement of Age: If the age of any Covered Person is incorrectly stated, we will make a fair adjustment of the premiums, benefits or both. The adjustment will be based on the premiums and benefits that would have been payable had we known the correct information.

Not in Lieu of Workers' Compensation: This policy is not in lieu of and does not affect requirements for coverage under Workers' Compensation laws.

Pronouns: Whenever a personal pronoun in the masculine gender is used, it will be deemed to include the feminine also, unless the context clearly indicates to the contrary.

Entire Contract: This policy, riders, endorsements and the Policyholder's application, a copy of which is attached hereto, shall constitute the entire contract between the parties.
Authority, Amendment and Alteration: None of the terms of this policy may be modified, except by an agreement in writing signed by the President, a Vice President or the Secretary of the Company. The authority for this purpose cannot be delegated. This policy may be amended or changed at any time, subject to the laws of the jurisdiction in which it is delivered. No agent or person, other than as stated above, shall have the authority to change this policy or otherwise waive any requirements or provisions of this policy. No change in this policy shall be valid

unless evidenced by endorsement on this policy or by an amendment to this policy signed by Us.

Non-Renewability of Insurance: Insurance for an Insured and his Eligible Dependents, if any, does not renew and shall terminate at the end of the Coverage Period selected by the Insured and approved by Us, unless earlier terminated as provided in this policy.

Conformity with Law: If any provision of this policy is contrary to any law to which it is subject, this provision is hereby amended to conform thereto.

Change of Beneficiary: The right to change of beneficiary is reserved to the Insured and the consent of the beneficiary or beneficiaries shall not be requisite to surrender or assignment of this policy or to any change of beneficiary or beneficiaries, or to any other changes in this policy.

PART X – SCHEDULE OF BENEFITS

INSURED INFORMATION:

Name: Caroline D Berg

Policy Effective Date: 10/3/2014

COVERAGE PERIOD: 6 Months

ELIGIBILE DEPENDENTS COVERED

COVERAGE AND BENEFIT AMOUNTS:

Deductible	$1,000 per Covered Person per Coverage Period. Maximum of 3 Deductibles per family per Coverage Period. An additional Deductible of $250 per visit will be applied to charges for use of emergency room in the event of Sickness unless the Covered Person is directly admitted as an Inpatient for further treatment.
Coinsurance	During a Coverage Period, the Company will pay 50% of the next $5,000 of Eligible Expenses after the Deductible, then 100% of Eligible Expenses to the Overall Maximum Limit.
Urgent Care Center	For each visit, the Covered Person shall be responsible for a $50 co-payment, after which Coinsurance will apply. Not subject to Deductible
Hospital Room and Board	Average Semi-private room rate, including nursing services.
Local Ambulance	Injury: Usual and Customary charges to a Maximum of $250 per trip, when related to a covered Injury. Sickness: Usual and Customary charges to a maximum of $250 per trip, when covered Sickness results in hospitalization as Inpatient
Intensive Care Unit	Usual and Customary charges
Physical Therapy	$50 Maximum per visit per day
Mental and Nervous Disorders	Outpatient Treatment: $50 Maximum per visit, Maximum 10 visits per Coverage Period Inpatient Treatment: $100 Maximum per

	day, Maximum 31 days per Coverage Period
Home Health Care	Maximum 1 visit per day. Maximum of 40 visits during a Coverage Period
Extended Care Facility	Not to exceed a daily rate of $150 nor a maximum of 60 days
All Other Eligible Medical Expenses	Usual and Customary charges
Penalty for Failure to Pre-authorize	50% of Eligible Medical Expenses
Overall Maximum Limit per Coverage Period	$2,000,000

HCC Life Insurance Company
Short Term Medical Insurance Application

For use in TX

Please submit completed enrollment forms with payment to:
HCC Life Insurance Company
251 N. Illinois Street, Suite 600
Indianapolis, IN 46204

- Please complete this enrollment form entirely. Failure to provide complete information may delay processing.
- You may elect the Single Payment option for 6 to 11 months and the $5,000 and $7,500 deductible options by applying online or contacting us.

Personal Details
Please provide the following details for all individuals to be covered.

Name (First and Last)	Date of Birth	Gender	Contact Information		
Primary *Caroline D Berg*	*4/6/1987*	☐ Male ☒ Female	Address *15902 Mesa Verde*		
Spouse		☐ Male ☐ Female	City *Houston*	State *TX*	Zip *77059*
Child 1		☐ Male ☐ Female	Phone Number *(832)971-3718*		
Child 2		☐ Male ☐ Female	E-mail Address *caroline.berg.photo@gmail.com*		

Plan Options
Please check the boxes corresponding to your elections for a policy period deductible and coinsurance

Deductible ☐ $250 ☐ $500 ☒ $1,000 ☐ $2,500 ☐

Coinsurance ☐ 80% of $5,000 ☒ 50% of $5,000

Requested Effective Date *10* / *3* / *2014*

Payment Option
☒ Monthly – 6 month plan
☐ Monthly – 11 month plan
☐ Single Payment (please specify end date)
Specify End Date _____
Number of days _____

Eligibility Questions
Please answer the questions below as they apply to all family members applying for coverage.

1.	Will any applicant have other health insurance in force on the policy effective date or be eligible for Medicaid? Texas residents are not required to answer this question.	☐ Yes ☒ No
2.	Are you or any applicant: a. Now pregnant, an expectant father, in process of adoption, or undergoing infertility treatment? b. Over 300 pounds if male or over 250 pounds if female?	☐ Yes ☒ No
3.	Within the last 5 years has any applicant been diagnosed, treated, or taken medication for or experienced signs or symptoms of any of the following: cancer or tumor, stroke, heart disease including heart attack, chest pain or had heart surgery, COPD (chronic obstructive pulmonary disease) or emphysema, Crohn's disease, liver disorder, degenerative disc disease or herniation, rheumatoid arthritis, kidney disorder, diabetes, degenerative joint disease of the knee, alcohol abuse or chemical dependency, or any neurological disorder?	☐ Yes ☒ No
4.	Within the last 5 years has any applicant been treated by a physician or medical practitioner for Acquired Immune Deficiency Syndrome (AIDS) or tested positive for Human Immunodeficiency Virus (HIV)? Residents of WI do not need to disclose HIV test results.	☐ Yes ☒ No
5.	If you are not a US Citizen, do you expect to legally reside in the US for the duration of the policy?	☐ Yes ☐ No ☒ US citizen

If you have answered "Yes" to questions 2 through 4 or "No" to question 5 above, coverage cannot be issued. Thank you for your interest.

For product information or assistance with this enrollment form, please contact:

John Sullivan
281-333-4829
info@2mybenes.com

Rate Calculation

Use the rate table corresponding to your choice of plan option and coinsurance level to complete applicant rates below, then follow the calculation instructions.

			Monthly Payments	Single Up-front Payment
A	Applicant's Rate		A 59.23	A
B	Spouse's Rate		B 0	B
C	Per child 0 x # 0 =		C 0	C
D	A + B + C =		D 59.23	D
E	Zip Code Factor		E 1.1110	E
F	D x E = Monthly / Daily Premium Total (round to the nearest penny)		F $65.80	F
G	Number of Months to be Covered		n/a	G
H	F x G =		n/a	H
I	Administrative Fee* *Fee is $5 on each monthly payment after the first payment.		I $5.00	I
J	**Total Due**	**Monthly:** F + I= **Daily:** H + I =	J $70.80	J

Payment Information

Please provide complete payment information. Enrollment forms without payment cannot be processed.

☐ Check/Money Order (Single Up-Front Payment Only)
☒ MasterCard ☐ VISA
☐ Discover ☐ American Express

Credit Card Number	Exp Date
xxxxxxxxxxxx0095	9/2017

Name on Card: Stuart Berg

Phone # (832)971-3718

Billing Address (including city, state and zip)
15902 Mesa Verde
Houston, TX 77059

Check or Money Orders should be made payable, in US dollars, to HCC Life Insurance Company. If paying by credit card, I authorize HCC Life to debit my Discover, VISA, MasterCard or American Express account for the amount specified in the Rate Calculation section. If I have selected a monthly plan, I hereby request and authorize HCC Life to debit my Credit Card account for the proper installment amounts on the due dates of the installments. This authorization will remain in effect for the duration of the Coverage Period elected or until revoked by me in writing. Coverage purchased by credit card is subject to validation and acceptance by the credit card company.

Cardholder Signature	Date
Signed Electronically	10/2/2014

Authorization

I hereby request coverage under a policy underwritten by HCC Life Insurance Company. I understand this insurance contains a Pre-existing Condition exclusion, a Pre-authorization Penalty and other restrictions and exclusions. I agree that coverage will not become effective for me or any dependent whose medical status, prior to the effective date, has changed and therefore results in a "yes" answer to any of the medical questions on this application. If my medical status changes in this way, coverage will be declined for all individuals included on this application. I understand that if I have elected the Monthly Payment option, my credit card will be charged each month on the due date of the premium for 6 or 11 months, depending on the plan I have selected. I understand that I may terminate the scheduled payments by notifying HCC Life in writing at least one business day prior to the next scheduled payment date. I understand that this coverage is not renewable or extendable. I understand that the information contained herein is a summary of the coverage offered in the policy and that I may obtain a complete copy of the policy upon request to HCC Life. I understand that HCC Life, as underwriter of the plan, is solely liable for the coverage and benefits provided under the insurance. I understand and agree that the insurance agent/broker, if any, assisting with this application is a representative of the applicant. If signed by a representative of the applicant, the undersigned represents his/her capacity to so act. If signed as guardian or proxy of the applicant, the undersigned represents his/her capacity to so act. By acceptance of coverage and/or submission of any claim for benefits, the applicant ratifies the authority of the signer to so act and bind the applicant. Fraud Warning: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person submits an insurance application or statement of claim containing any materially false, incomplete or misleading information may be committing a crime and may be subject to civil or criminal penalties.

Applicant Signature	Date	Spouse Signature	Date
Signed Electronically	10/2/2014		

Signed by HCC Life Appointed Agent:	Plan Administrator Use Only:	
	PBC 612.110.04.12	Code: 236011-188

HCC LIFE INSURANCE COMPANY
225 TownPark Drive, Suite 350
Kennesaw, Georgia 30144
800-447-0460

Short Term Major Medical Expense Insurance

OUTLINE OF COVERAGE

READ YOUR POLICY CAREFULLY. This outline of coverage provides a very brief description of the important features of your Policy. This is not the insurance Policy 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.

Major Medical Expense Coverage — Policies of this category are designed to provide, to persons insured, coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services, and out of hospital care, subject to any deductibles, co-payment provisions, or other limitations which may be set forth in the policy.

Description of Coverage	
Benefits	The policy will pay benefits shown on the schedule of benefits subject to exclusions and limitations and other terms included in the policy.
Deductible	$1,000 per Covered Person per Coverage Period. Maximum of 3 Deductibles per family per Coverage Period. An additional Deductible of $250 per visit will be applied to charges for use of emergency room in the event of Sickness unless the Covered Person is directly admitted as an Inpatient for further treatment.
Coinsurance	During a Coverage Period, the Company will pay 50% % of the next $5,000 of Eligible Expenses after the Deductible, then 100% of Eligible Expenses to the Overall Maximum Limit.
Urgent Care Center	For each visit, the Covered Person shall be responsible for a $50 co-payment, after which Coinsurance will apply. Not subject to Deductible For each visit, the Covered Person shall be responsible for a $50 co-payment, after which Coinsurance will apply. Not subject to Deductible.
Hospital Room and Board	Average Semi-private room rate, including nursing services.
Local Ambulance	Injury: Usual and Customary charges to a Maximum of $250 per trip, when related to a covered Injury. Sickness: Usual and Customary charges to a maximum of $250 per trip, when covered Sickness results in hospitalization as Inpatient.
Intensive Care Unit	Usual and Customary charges.
Physical Therapy	$50 Maximum per visit per day.

Mental and Nervous Disorders	Outpatient Treatment: $50 Maximum per visit, Maximum 10 visits per Coverage Period. Inpatient Treatment: $100 Maximum per day, Maximum 31 days per Coverage Period.
Home Health Care	Maximum 1 visit per day. Maximum of 40 visits during a Coverage Period.
Extended Care Facility	Not to exceed a daily rate of $150 nor a maximum of 60 days.
All Other Eligible Medical Expenses	Usual and Customary charges.
Penalty for Failure to Pre-certify	50% of Eligible Medical Expenses.
Overall Maximum Limit per Coverage Period	$2,000,000
Exclusions and Limitations	1. Pre-existing Conditions – Charges resulting directly or indirectly from a pre-existing condition are excluded from coverage hereunder. A pre-existing condition is a condition: (1) for which medical advice, diagnosis, care, or treatment (includes receiving services and supplies, consultations, diagnostic tests or prescription medicines) was recommended or received within the 24 months immediately preceding the Effective Date; or (2) that had manifested itself in such a manner that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care, or treatment (includes receiving services and supplies, consultations, diagnostic tests or prescription medicines) within the 12 months immediately preceding such person's Effective Date. This exclusion does not apply to a newborn or newly adopted child who is added to coverage under this policy in accordance with PART II – ELIGIBILITY AND EFFECTIVE DATE OF INSURANCE.

	2. Waiting Period – If coverage was purchased within 3 days of the Covered Person's Effective Date, then in respect to Sickness, Covered Persons will only be entitled to receive benefits for Sicknesses that begin, by occurrence of symptoms and/or receipt of treatment, at least 72 hours following the Covered Person's Effective Date of coverage under this policy. 3. Outpatient Prescription Drugs, medications, vitamins, and mineral or food supplements including pre-natal vitamins, or any over-the-counter medicines, whether or not ordered by a Doctor. 4. Routine pre-natal care, Pregnancy, childbirth, and postnatal care. (This exclusion does not apply to "Complications of Pregnancy" as defined.) 5. Alcoholism. 6. Substance abuse. 7. Charges which are not incurred by a Covered Person during his/her Coverage Period. 8. Treatment, services or supplies, which are not administered by or under the supervision of a Doctor. 9. Treatment, services or supplies which are not Medically Necessary as defined.

	10. Treatment, services or supplies provided at no cost to the Covered Person. 11. Charges which exceed Usual and Customary charge as defined. 12. Telephone consultations or failure to keep a scheduled appointment. 13. Consultations and/or treatment provided over the Internet. 14. Surgeries, treatments, services or supplies which are deemed to be Experimental Treatment. 15. All charges Incurred while confined primarily to receive Custodial or Convalescence Care. 16. Weight modification or surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass surgery. 17. Modifications of the physical body in order to improve the psychological, mental or emotional well-being of the Covered Person, such as sex-change surgery. 18. Surgeries, treatments, services or supplies for cosmetic or aesthetic reasons, except for reconstructive surgery which is expressly covered under this policy. 19. Any drug, treatment or procedure that either promotes or prevents conception including but not limited to: artificial insemination, treatment for infertility or impotency, sterilization or reversal of sterilization. 20. Any drug, treatment or procedure that either promotes, enhances or corrects impotency or sexual dysfunction. 21. Abortions, except in connection with covered Complications of Pregnancy or if the life of the expectant mother would be at risk. 22. Dental treatment, except for dental treatment that is expressly covered under this policy. 23. Eyeglasses, contact lenses, hearing aids, hearing implants, eye refraction, visual therapy, and any examination or fitting related to these devices, and all vision and hearing tests and examinations. 24. Eye surgery, such as radial keratotomy, when the primary purpose is to correct nearsightedness, farsightedness or astigmatism. 25. Treatment for cataracts. 26. Treatment of the temporomandibular joint. 27. Injuries resulting from participation in any form of skydiving, scuba diving, auto racing, bungee jumping, hang or ultra light gliding, parasailing, sail planing, flying in an aircraft (other than as a passenger on a commercial airline), rodeo contests or as a result of participating in any professional, semi-professional or other non-recreational sports including boating, motorcycling, skiing, riding all-terrain vehicles or dirt-bikes, snowmobiling or go-carting. 28. Injuries or Sicknesses resulting from participation in interscholastic, intercollegiate or organized competitive sports. 29. Willfully self-inflicted Injury or Sickness. 30. Venereal disease, including all sexually transmitted diseases and conditions. 31. Immunizations and Routine Physical Exams. 32. Services received for any condition caused by a Covered Person's commission of or attempt to commit a felony or to which a contributing cause was the Covered Person being engaged in an

	illegal occupation. 33. Speech, vocational, occupational, biofeedback, acupuncture, recreational, sleep or music therapy, holistic care of any nature, massage and kinestherapy. 34. Any services performed or supplies provided by a member of the Insured's Immediate Family. 35. Orthoptics and visual eye training. 36. Services or supplies which are not included as Eligible Expenses as described herein. 37. Care, treatment or supplies for the feet: orthopedic shoes, orthopedic prescription devices to be attached to or placed in shoes, treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions, and treatment of corns, calluses or toenails. 38. Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Doctor. 39. Treatment of sleep disorders. 40. Hypnotherapy when used to treat conditions that are not recognized as Mental or Nervous Disorders by the American Psychiatric Association, and biofeedback, and non-medical self-care or self-help programs. 41. Any services or supplies in connection with cigarette smoking cessation. 42. Exercise programs, whether or not prescribed or recommended by a Doctor. 43. Treatment required as a result of complications or consequences of a treatment or condition not covered under this policy. 44. Charges for travel or accommodations, except as expressly provided for local ambulance. 45. Treatment incurred as a result of exposure to non-medical nuclear radiation and/or radioactive material(s). 46. Organ or Tissue Transplants or related services. 47. Treatment for acne, moles, skin tags, diseases of sebaceous glands, seborrhea, sebaceous cyst, unspecified disease of sebaceous glands, hypertrophic and atrophic conditions of skin, nevus. 48. Services received or supplies purchased outside the United States, its territories or possessions, or Canada. 49. Treatment for or related to any congenital condition, except as it relates to a newborn or adopted child added as a Covered Person to this policy. 50. Spinal manipulation or adjustment. 51. Sclerotherapy for veins of the extremities. 52. Expenses during the first 6 months after the Effective Date of coverage for a Covered Person for the following (subject to all other coverage provisions, including but not limited to the Pre-existing Condition exclusion): A. Total or partial hysterectomy, unless it is Medically Necessary due to a diagnosis of carcinoma; B. Tonsillectomy; C. Adenoidectomy;

	D. Repair of deviated nasal septum or any type of surgery involving the sinus; E. Myringotomy; F. Tympanotomy; G. Herniorraphy; or H. Cholecystectomy. 53. Chronic fatigue or pain disorders. 54. Treatment or diagnosis of allergies, except for emergency treatment of allergic reactions. 55. Treatment, medication or hormones to stimulate growth, or treatment of learning disorders, disabilities, developmental delays or deficiencies, including therapy. 56. Kidney or end stage renal disease. 57. Joint replacement or other treatment of joints, spine, bones or connective tissue including tendons, ligaments and cartilage, unless related to a covered Injury. 58. Expenses resulting from a declared or undeclared war, or from voluntary participation in a riot or insurrection. 59. Expenses incurred by a Covered Person while on active duty in the armed forces. Upon written notice to Us of entry into such active duty, the unused premium will be returned to the Covered Person on a pro-rated basis.
Renewal and Premium Changes	
Renewal	**NOTE: NO CONTINUOUS COVERAGE. This policy of insurance provides coverage for a short term duration only. It is not renewable.** Although this short term plan may be rewritten for new and completely separate Coverage Periods (as long as you meet the eligibility criteria described in the application), coverage does not continue from one policy to another. This means that a new application must be submitted, a new effective date is given, a new pre-existing condition exclusion period begins and a new deductible and out-of-pocket expense must be met. Any medical condition which may have occurred and/or existed under a prior policy will be treated as a pre-existing condition under the new policy.
Right to Change Premium	If any change or clerical error affects premiums, an equitable adjustment in premiums shall be made on the premium due date next following the date of the change or the discovery of the error. Any premium adjustment that involves collecting earned premiums, or returning unearned premium shall be limited to the six (6) months immediately preceding the date of determination that the adjustment in premium should be made.

IMPORTANT: In the event of any inconsistency between this Outline of Coverage and the Policy, the terms of the Policy will control.

IMPORTANT INFORMATION ABOUT COVERAGE UNDER THE TEXAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION (For insurers declared insolvent or impaired on or after September 1, 2011)

Texas law establishes a system to protect Texas policyholders if their life or health insurance company fails. The Texas Life and Health Insurance Guaranty Association ("the Association") administers this protection system. Only the policyholders of insurance companies that are members of the Association are eligible for this protection which is subject to the terms, limitations, and conditions of the Association law. (The law is found in the *Texas Insurance Code*, Chapter 463.)

It is possible that the Association may not protect all or part of your policy because of statutory limitations.

Eligibility for Protection by the Association

When a member insurance company is found to be insolvent and placed under an order of liquidation by a court or designated as impaired by the Texas Commissioner of Insurance, the Association provides coverage to policyholders who are:

- Residents of Texas **(regardless of where the policyholder lived when the policy was issued)**
- Residents of other states, ONLY if the following conditions are met:
    1. The policyholder has a policy with a company domiciled in Texas;
    2. The policyholder's state of residence has a similar guaranty association; and
    3. The policyholder is *not eligible* for coverage by the guaranty association of the policyholder's state of residence.

Limits of Protection by the Association

Accident, Accident and Health, or Health Insurance:

- For each individual covered under one or more policies: up to a total of $500,000 for basic hospital, medical-surgical, and major medical insurance, $300,000 for disability or long term care insurance, or $200,000 for other types of health insurance.

Life Insurance:

- Net cash surrender value or net cash withdrawal value up to a total of $100,000 under one or more policies on a single life; or
- Death benefits up to a total of $300,000 under one or more policies on a single life; or
- Total benefits up to a total of $5,000,000 to any owner of multiple non-group life policies.

Individual Annuities:

- Present value of benefits up to a total of $250,000 under one or more contracts on any one life. **Group Annuities:**
- Present value of allocated benefits up to a total of $250,000 on any one life; or
- Present value of unallocated benefits up to a total of $5,000,000 for one contractholder regardless of the number of contracts.

Aggregate Limit:

- $300,000 on any one life with the exception of the $500,000 health insurance limit, the $5,000,000 multiple owner life insurance limit, and the $5,000,000 unallocated group annuity limit.

These limits are applied for each insolvent insurance company.

Insurance companies and agents are prohibited by law from using the existence of the Association for the purpose of sales, solicitation, or inducement to purchase any form of insurance. When you are selecting an insurance company, you should not rely on Association coverage. For additional questions on Association protection or general information about an insurance company, please use the following contact information.

Texas Life and Health Insurance
Guaranty Association
515 Congress Avenue, Suite 1875
Austin, Texas 78701
800-982-6362 or www.txlifega.org

Texas Department of Insurance
P.O. Box 149104
Austin, Texas 78714-9104
800-252-3439 or www.tdi.texas.gov

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Our Privacy Promise

We will keep your medical information private. We will also give you this notice about our privacy practices, our legal duties and your rights concerning your medical information. We will follow the privacy practices that we describe in this notice while it is in effect. This notice took effect April 14, 2003, and will remain in effect until it is changed or replaced.

We reserve the right to change our privacy practices and the terms of this notice at any time, as long as the law allows. We reserve the right to make these changes effective for all medical information that we keep, including medical information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice accordingly and send the new notice to you prior to the effective date of the change.

You may request a copy of this notice at any time or view a copy on our Web site at www.hcclife.com.

Uses and Disclosures of Medical Information

Treatment, Payment, Health Care Operations

We may use and disclose your medical information for purposes of treatment, payment and health care operations. For example:

Treatment: We may disclose your medical information to a physician or other health care professional so they can treat you.

Payment: We may use and/or disclose your medical information for these and other related activities:

- To pay claims from physicians, hospitals and other health care professionals for covered services you received.
- To determine your eligibility for benefits.
- To coordinate those benefits.
- To determine medical necessity.
- To obtain premiums.
- To issue explanations of benefits to the named insured.

We may also disclose your medical information to a health care professional or entity that is bound by the federal Privacy Rules so they can obtain payment or engage in payment activities.

Health Care Operations: We may use and/or disclose your medical information in the normal course of our health care operations. This includes:

- Determining our risk and premiums for your health plan.
- Quality assessment and improvement activities.
- Reviewing the qualifications of health care professionals; evaluating practitioner and provider performance; conducting training programs; and accreditation, certification, licensing and credentialing activities.
- Medical review, legal services and auditing, including fraud and abuse detection and compliance programs.
- Business planning and development.
- Business management and general administrative activities, including management activities relating to privacy, customer service, internal grievances and creating de-identified information or a limited data set.

We may disclose your medical information to another entity, which has a relationship with you and is also bound by the federal Privacy Rules, for its health care operations relating to quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, or detecting or preventing health care fraud and abuse.

Your Authorization

You may give us written authorization to use your medical information or to disclose it to anyone for any purpose. You may revoke your authorization in writing at any time. However, this will not affect any uses and disclosures we made while your authorization was in effect. Without your written authorization, we will not use or disclose your medical information for any reason except those described in this notice.

Your Family and Friends

We may disclose your medical information to a family member, friend or other person to the extent necessary for them to assist with your health care, or with payment for your health care. We may also use or disclose your medical information to notify (or help notify, including identifying and locating) a family member, a personal representative or other person responsible for your care of your location, general condition or death.

Before we disclose your medical information to that person, we will give you a chance to object to us doing so. If you are not available, or if you are incapacitated or in an emergency situation, we will disclose your medical information based on our professional judgment of what would be in your best interest.

Your Employer or Organization Sponsoring Your Group Health Plan

We may disclose summary information about you to your employer or plan sponsor for two reasons. One is to get premium bids for the health insurance coverage offered

through your group health plan. The second is to decide whether to modify, amend or terminate your group health plan. The summary information we may disclose summarizes claims history, claims expenses or types of claims members of your group health plan have filed. The summary information will not include demographic information about the people in the group health plan, but your employer or plan sponsor may be able to identify you or others from the summary information.

Underwriting
We may receive your medical information for underwriting, premium rating or other activities necessary to create, renew or replace a contract of health insurance or health benefits. We will not use or further disclose this medical information for any other purpose (except as required by law) unless the contract of health insurance or health benefits is placed with us, in which case we will use and disclose your medical information as described in this notice.

Disaster Relief
We may use or disclose your medical information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Public Benefit
We may use or disclose your medical information as authorized by law for the following purposes that are in the public interest or benefit:

- As required by law.
- For public health activities, including disease and vital statistics reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury.
- To report adult abuse, neglect or domestic violence.
- To health oversight agencies.
- In response to court and administrative orders and other lawful processes.
- To law enforcement officials in response to subpoenas and other lawful processes concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies and to identify or locate a suspect or other person.
- To coroners, medical examiners and funeral directors.
- To organ procurement organizations.
- To avert a serious threat to health or safety.
- In connection with certain research activities.
- To the military and to federal officials for lawful intelligence, counterintelligence and national security activities.
- To correctional institutions regarding inmates.
- As authorized by state workers' compensation laws.

Health-Related Services
We may use your medical information to contact you about health-related benefits and services, or about treatment alternatives. We may disclose your medical information to a business associate to assist us in these activities.

Marketing
We may use or disclose your medical information to encourage you to purchase or use a product or service by face-to-face communication, or to provide you with promotional gifts of nominal value.

Individual Rights

Access
You have the right to inspect or get copies of your medical information, with some exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical to do so. To get your medical information, you must make a request in writing. If you request copies, we will charge you $0.50 for each page and for staff time to copy your medical information. We also will charge for postage if you want us to mail the copies to you. If you request another format, we will charge a cost-based fee for providing your medical information in that format. Contact us using the information listed at the end of this notice for a full explanation of our fees.

Disclosure Accounting
You have the right to request, in writing, to receive a list of instances in which we (or our business associates) disclosed your medical information for purposes other than treatment, payment and health care operations, or as authorized by you, or for certain other activities allowed by law, on or after April 14, 2003. We will provide you with the date on which we made each disclosure, the name of the person or entity to which we disclosed your medical information, a description of the medical information we disclosed and the reason for the disclosure. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for each additional request. Contact us using the information listed at the end of this notice for a full explanation of our fees.

Restriction
You have the right to request, in writing, that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement to additional restrictions must be in writing signed by a person authorized to make such an agreement for us. We will not be bound unless our agreement is in writing.

Confidential Communications
You have the right to request, in writing, that we communicate with you about your medical information by other means, or to other locations. You must state that you could be in danger if we do not communicate to you in confidence. We must accommodate your request if it is reasonable, if it specifies the other means or location, and if it permits us to continue to collect premiums and pay claims under your health plan. This includes sending explanations of benefits to the named insured of your health plan. We will not be bound to your confidential communications request unless our agreement is in writing.

Even though you requested that we communicate with you about your health care in confidence, an explanation of benefits issued to the named insured for health care that the named insured (or others covered by the health plan) received might contain sufficient information, such as deductible and out-of-pocket amounts, to reveal that you obtained health care for which we paid.

Amendment
You have the right to request, in writing, that we amend your medical information. Your request must explain why we should amend the information. We may deny your request if we did not create the information you want amended and the person or entity that did create it is available, or we may deny your request for certain other reasons. If we deny your request, we will send you a written explanation.

You may respond with a statement of disagreement that we will add to the information you wanted to amend. If we accept your request to amend the information, we will make reasonable efforts to inform others of the amendment, including people you name, and to include the changes in any future disclosures of that information.

Electronic Notice
If you are viewing this notice on our Web site or by electronic mail (e-mail), you may request this notice in written form by using the information listed at the end of this notice.

Questions and Complaints

If you want more information about our privacy practices, or if you have questions or concerns, please contact us using the information below.

If you think that we may have violated your privacy rights, or you disagree with a decision we made about your privacy rights, you may tell us using the contact information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with that address upon request.

We support your right to the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Information

HCC Life
Bradley T. Long, Privacy Officer
225 TownPark Drive, Suite 350
Kennesaw, GA 30144

(800) 447-0460 (telephone)
(770) 973-9854 (fax)