NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE NORTH CAROLINA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the North Carolina Life and Health Insurance Guaranty Association. The purpose of this Association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The North Carolina Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in North Carolina. You should not rely on coverage by the North Carolina Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The North Carolina Life and Health Insurance Guaranty Association
Post Office Box 10218
Raleigh, North Carolina 27605-0218

North Carolina Department of Insurance, Consumer Division
Post Office Box 26387
Raleigh, North Carolina 27611

The state law that provides for this safety-net coverage is called the North Carolina Life and Health Insurance Guaranty Association Act. On the back of this page is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Life and Health Guaranty Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are **not** protected by this Association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose Guaranty Association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy was issued by an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The Association also does **not** provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed the average rate specified in the law;
- dividends;
- experience or other credits given in connection with the administration of a policy by a group contract holder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- unallocated annuity contracts (which give rights to group contract holders, not individuals), unless they fund a government lottery or a benefit plan of an employer, association or union, except that allocated annuities issued to employee benefit plans protected by the Federal Pension Benefit Guaranty Corporation are not covered.

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Association is obligated to pay out: The Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one individual, the Association will pay a maximum of $300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. For any one group holder of an unallocated annuity contract, the Association will pay a maximum of $5,000,000.

TRUSTMARK INSURANCE COMPANY
400 Field Drive
Lake Forest, Illinois 60045
(Herein We, Us and Our)

MAJOR MEDICAL POLICY

This is Your Policy of Insurance (Policy) while You are Insured. This Policy is a legal contract between the Policyholder and Us. It is issued in consideration of Your application and the first Premium payment.

The Policy alone constitutes the agreement under which payments are made. We will pay the benefits set forth in the Policy if Your application has been accepted and premium has been timely paid. Benefit payment is governed by all the terms, conditions, exclusions and limitations of the Policy.

This Policy was issued on the basis that the information on Your application was correct and complete. I**f any information on the application was not correct or complete, write to Us within ten (10) days of receipt of this Policy. An error or omission may result in loss of coverage as of its effective date.**

Right to Examine: If You are not satisfied with this Policy, return it to Our home office or to Your agent within ten (10) days after the date You received it. The Policy will then be canceled and any premium paid will be refunded.

IMPORTANT NOTICE
PREEXISTING CONDITIONS WILL NOT BE COVERED DURING THE FIRST 12 MONTHS EXCEPT AS STATED IN THE "PRE-EXISTING CONDITION LIMITATION" PROVISION. YOU CAN FIND THE PAGE NUMBER FOR THE PROVISION IN THE TABLE OF CONTENTS.

IMPORTANT TERMINATION INFORMATION
Please read the "termination date" provision for termination information. You can find the page number for the provision in the table of contents.

EXCESS INSURANCE
This policy is not intended to be issued where other medical insurance exists. If other medical insurance does exist at the time of the claim then the amounts of benefit payable by such other medical insurance will become the deductible amount of this policy if such benefits exceed the deductible amount shown in the Schedule of Benefits.

IMPORTANT NOTICE FOR MASTECTOMY PATIENTS

Patients who undergo a mastectomy, and who elect breast reconstruction in connection with the mastectomy, are entitled to coverage for:

- reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas

in a manner determined in consultation with the attending physician and the patient. The coverage is subject to coinsurance and deductibles as provided in the schedule of benefits.

Please Read this Policy Carefully

J. Grover Thomas Jr.
President & Chief Executive Officer

Frank G. Gramm
Corporate Secretary & General Counsel

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TABLE OF CONTENTS

DEFINITIONS

Approved Transplant Services: Services and supplies which are related to a transplant procedure, approved in writing by Us, and include but are not limited to:

- Pre-transplant evaluation for the Medical Necessity of the transplant;
- Hospital charges;
- Physician charges; and
- Tissue typing and ancillary services.

Bone Mass Measurement: A scientifically proven radiologic, radiosotopic, or other procedure performed on a Qualified Individual to identify bone mass or to detect bone loss for the purpose of initiating or modifying treatment.

Brand Name: A Prescription Drug manufactured, marketed and sold under a trademark name.

Certification: A determination by an insurer or its designated Utilization Review Organization that an admission, availability of care, continued stay, or other designated service has been reviewed and, based on the information provided, satisfies the insurer's requirements for medically necessary services and supplies, appropriateness, health care setting, level of care and effectiveness.

Chemical Dependency: The pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces an impairment in personal, social or occupational functioning and which may, but need not, include a pattern of tolerance and withdrawal.

Complications of Pregnancy: A condition which: (a) is not part of a normal pregnancy; and (b) whose diagnosis is distinct from pregnancy but is adversely affected by or caused by pregnancy.

Complications of Pregnancy include: (1) nonelective caesarean section or ectopic pregnancy which is terminated; (2) spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible; (3) acute nephritis; (4) nephrosis; (5) cardiac decompensation; (6) missed abortion; (7) hyperemesis gravidarum; (8) eclampsia; (9) puerperal infection; (10) RH factor problems; (11) severe loss of blood requiring transfusions; and (12) similar medical and surgical conditions of comparable severity.

Complications of Pregnancy does not include: (1) false labor; (2) occasional spotting; (3) Physician prescribed rest during pregnancy; (4) morning sickness; (5) preeclampsia; and (6) similar conditions associated with the management of a difficult pregnancy but which are not a separate complication of pregnancy.

Compound Medication: A randomly prepared dosage form containing:

- At least one Federal Legend or State Restricted Drug; or
- Combined ingredients which require a prescription for the specific dosage or amount prescribed; and
- If a liquid, includes either: at least one solid that is weighed; or three measured liquids.

Copayment: The portion of the Covered Drug expense a Covered Person must pay for each prescription or authorized refill after the Drug Deductible has been met. The Copayment is shown on the Schedule. This amount does not apply toward the satisfaction of the Out-of-Pocket maximum.

Covered Person: A person listed on the Schedule as insured under this Certificate.

Deductible: The amount of Covered Charges a Covered Person must pay before We pay any benefits. The Deductible applies separately to each Covered Person each Year. This amount does not apply toward the satisfaction of the Out-of-Pocket Limit.

Dependent: A person who is:

(1) Your legally married spouse.

(2) Your unmarried natural or legally adopted children who are dependent upon You for support and maintenance and are under the age of 19.

(3) Your unmarried Foster Child who is under the age of 9.

(4) Your unmarried step children who are under the age of 19.

(5) Your unmarried natural, step or legally adopted children age 19 to age 24, but only if they are:

(a) Full-time students at an accredited educational institution; and

(b) Dependent upon You for support and maintenance.

A child age 19 to age 24 ceases to be a Dependent on the last day of the month in which the child fails to qualify as a full-time student, except for regularly scheduled vacation periods.

(6) Your unmarried child for whom a court has issued a medical support order which decrees that You must provide medical coverage.

Designated Facility: A facility which has an agreement with Us to render Approved Transplant Services. The facility may be outside a Covered Person's geographic area.

Drug Deductible: The amount of Covered Drug expense a Covered Person must pay before We pay any benefits. The Drug Deductible applies separately to each Covered Person each Year. The Drug Deductible is shown on the Schedule.

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, or by acute symptoms developing into a chronic medical condition that would lead the prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in any of the following:

(a) Placing the health of an individual, or with respect to a pregnant woman, the health of the woman or her unborn child in serious jeopardy;
(b) Serious impairment to bodily functions; or
(c) Serious dysfunction of any body organ or part.

Emergency Services: Health Care services and supplies furnished or required to screen for or treat an emergency medical condition until the condition is stabilized, including prehospital care and ancillary services routinely available to the emergency department.

Emergency Room Access Fee: A per visit amount that must be paid by the Covered Person for services rendered in the emergency room when the person is not Hospital confined. If the Covered Person is admitted as an inpatient directly from the emergency room then this fee will be waived. The Emergency Room Access Fee is in addition to the Deductible and is shown on the Schedule. This amount does not apply toward the satisfaction of the Out-of-Pocket Maximum. Any amounts incurred above the Emergency Room Access Fee are subject to Deductible and Insured Percent.

Experimental/Investigational: A drug, device or medical treatment or procedure is considered experimental or investigational if:

- It has not been given approval for marketing by the United States Food and Drug Administration at the time it is furnished and such approval is required by law;

- Reliable evidence shows it is the subject of ongoing Phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment of diagnosis; or

- Reliable evidence shows that the consensus of opinion among experts is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence means only: published reports and articles in authoritative medical and scientific literature; written protocol or protocols by the treating facility or other facility studying substantially the same drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or other facility studying substantially the same drug, device or medical treatment or procedure.

Family Member: You, Your spouse, or the parent, child, brother or sister of You or Your spouse.

Federal Legend Drug: Any drug or medicine which must bear the legend: "Caution: Federal Law prohibits dispensing without a prescription."

Free Standing Surgical Center: A facility licensed as a free standing or ambulatory surgical center; which is operated solely for the purpose of providing outpatient surgical care.

Generic: A Prescription Drug manufactured, marketed and sold under a generic name which is medically equivalent to a Brand Name as determined by the federal Food and Drug Administration.

Grievance: A written complaint submitted by a Covered Person about any of the following:

- Our decisions, policies, or actions related to availability, delivery, or quality of health care services.
- Claims payment or handling; or reimbursement for services.
- The contractual relationship between a Covered Person and Us.
- The outcome of an appeal of a noncertification.

Health Care Services: Those services provided for the diagnosis prevention, treatment, cure or relief of a health condition, illness, injury, or disease.

Home Health Care: Treatment, services or supplies furnished in a Covered Person's home by a licensed or certified home health agency pursuant to a written plan prescribed by a Physician as Medically Necessary.

Hospice Care: A program of palliative and supportive care provided by a licensed or certified hospice. Hospice Care is available to a Covered Person and his immediate family upon a Physician's diagnosis of terminal illness.

Hospital: An institution licensed, accredited or certified by the State which: (a) is accredited by the Joint Commission on Accreditation of Hospitals; (b) provides 24-hour nursing service by registered nurses (RN); (c) mainly provides diagnostic and therapeutic care under the supervision of Physicians on an inpatient basis; and (d) maintains permanent surgical facilities.

A place, special ward, floor or other accommodation used for: custodial or educational care; rest; the aged; a nursing home; or an institution mainly rendering extended care or intermediate care will not be considered a Hospital.

"Hospital" also includes state tax-supported institutions, which are not required to maintain surgical facilities.

Injury: Accidental bodily injury independent of disease, bodily infirmity or other cause.

Insured Percent: The portion of Covered Charges that We will pay after the Deductible has been met.

Low-dose Screening Mammography: A radiologic procedure for the early detection of breast cancer provided to an asymptomatic woman using equipment dedicated specifically for mammography, including a physician's interpretation of the results of the procedure.

Mastectomy: The surgical removal of all or part of a breast as a result of breast cancer or breast disease.

Maintenance Drugs: Prescription Drugs taken on a regular, routine or long term basis for care and treatment of chronic conditions only. The following are examples of chronic conditions for which maintenance drugs are taken: high blood pressure, arthritis, heart conditions and diabetes.

Manipulative Treatment: The diagnosis, analysis and adjustment of spinal subluxation; and manipulative therapy and related treatment of the musculoskeletal structure for other than fractures and dislocation of the extremities.

Medically Necessary/Medical Necessity: Services, or supplies that are:

- Provided for the diagnosis, treatment, cure or relief of a health condition, illness, injury or disease; and not for experimental, investigational or cosmetic purposes.
- Necessary and appropriate for the diagnosis, treatment, cure, or relief of a health condition, illness, injury, disease or its symptoms.
- Within generally accepted standards of medical practice care in the community.
- Not solely for the convenience of the insured, the insured's family or the provider.

We retain the right to determine whether a service, supply or drug is Medically Necessary by comparing the cost-effectiveness of alternative services, supplies or drugs.

Medicare: Title XVIII of the Social Security Act of 1995, as amended. A person is considered to be eligible for Medicare on and after the date the person is first eligible for any Medicare coverage.

Mental Illness: Any condition or disease, regardless of its cause, listed in the most recent edition of the Diagnostic and Statistical Manual of Disorders of the American Psychiatric Association as a mental illness.

Noncertification: A determination by Us or Our designated Utilization Review Organization that an admission, availability of care, continued stay, or other Health Care Service has been reviewed and, based upon the information provided, does not meet Our requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service is therefore denied, reduced or terminated. It is not a decision based solely on the basis that the Health Benefit Plan does not provide benefits for the Health Care Service in question, if the exclusion of the specific service requested is specifically stated in this policy.

Non-Designated Facility: A facility which is not a Designated Facility.

Non-Participating Pharmacy: A licensed pharmacy which is not a Participating Pharmacy.

Other Medical Expense Coverage: Any hospital or medical expense incurred policy or certificate, hospital or medical service plan and health maintenance organization subscriber contract, whether insured or uninsured, and regardless of where issued; or medical payments made pursuant to any national, state, or other governmental law of any country.

Outpatient Contraceptive Services: Consultations, examinations, procedures and medical services provided on an outpatient basis and related to the use of contraceptive methods to prevent pregnancy.

Participating Pharmacy: A licensed pharmacy which has contracted to participate in the prescription drug program. A Participating Pharmacy may either be a retail pharmacy vendor or a mail-order vendor.

Physician: A licensed medical doctor; surgeon; osteopath; podiatrist; dentist; optometrist; or chiropractor, acting within the scope of such license, who is not a Family Member.

Pre-existing Condition: During the 12 months prior to the Effective Date: (a) a Sickness or Injury for which medical care, treatment, diagnosis or advice was received or recommended; or (b) the existence of symptoms which would cause a reasonable person to seek medical care, treatment, diagnosis or advice.

A Sickness or Injury fully disclosed on the application will not be considered a Pre-Existing Condition.

Prescribed Contraceptive Drugs or Devices: Drugs or devices that prevent pregnancy and that are approved by the United States Drug Administration (USDA) for use a s contraceptives and obtained under a prescription written by a health care provider authorized to prescribe medications under the laws of the State.

Prescription Drug(s): Drugs and medicines which are:

- Prescribed in writing by a Physician;
- Legally available only by prescription; and
- Are one of the following:
    - Federal Legend Drug;
    - State Restricted Drug; or
    - Compounded Medication.

Prostate-Specific Antigen (PSA) Tests or Equivalent Tests for the Presence of Prostate Cancer: A Serological test for determining the presence of prostate cytoplasmic protein (PSA) and the generation of antibodies to it, as a novel marker for prostatic disease.

Qualified Individuals: Any one or more of the following:

a. An individual who is estrogen-deficient and at clinical risk of osteoporosis or low bone mass.
b. An individual with radiographic osteopenia anywhere in the skeleton.
c. An individual who is receiving long-term glucocorticoid (steroid) therapy.
d. An individual with primary hyperparathyroidism.
e. An individual who is being monitored to assess the response to or efficacy of commonly accepted osteoporosis drug therapies.
f. An individual who has a history of low-trauma fractures.
g. An individual with other conditions or on medical therapies known to cause osteoporosis or low bone mass.

Routine Physical Examination: A visit to a Physician's office which is not prompted by Sickness or Injury.

Sickness: Illness; disease: complication of pregnancy; and congenital defect, birth abnormality or prematurity of a covered newborn child.

Skilled Nursing Home: A licensed facility which: (a) operates within the scope of its license; (b) provides room and board accommodations at the patient's expense; © keeps a daily medical record of each patient; (d) routinely provides skilled nursing care under the direction of a Physician; and (e) provides skilled nursing care by, or under the supervision of, a registered nurse.

Skilled Nursing Home does not include: a rest home; a home for the aged; a place mainly for treating drug addiction, alcoholism or mental illness; or custodial or educational care facility.

Stabilize: To provide medical care that is appropriate to prevent a material deterioration of the Covered Person's condition within reasonable medical probability, in accordance with the HCFA (Health Care Financing Administration) interpretative guidelines, policies and regulations pertaining to responsibilities of Hospitals in emergency cases (as provided under the Emergency Medical Treatment and Labor Act, section 1867 of the Social Security Act, 42 U.S.C. 1395dd), including medically necessary services and supplies to maintain stabilization until the covered Person is transferred.

State Restricted Drug: Any drug or medicine which is legally available only by prescription under applicable State law.

Usual and Customary Charge: The lesser of: (a) the actual charge; (b) the fee most often charged by the provider for the same service or supply; or © the fee most often charged in the same area by providers with similar training and experience for a comparable service or supply. "Area" means a metropolitan area, a county or a greater area if needed to find a cross-section of providers of a comparable service or supply.

Woman at Risk of breast Cancer: A Woman is at Risk for breast Cancer if any one or more of the following is true: (a) the woman has a personal history of breast cancer; (b) the woman has a history of biopsy-proven benign disease; (c) the woman's mother, sister, or daughter has or has had breast cancer; or (d) the woman has not given birth prior to the age of 30.

Year: The calendar period beginning each January 1 and ending the following December 31. The first Year shall begin on the Effective Date.

You or Your: The Insured named on the Schedule.

All male terms will include the female, unless stated otherwise.

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CONDITIONS OF INSURANCE

ELIGIBILITY

- **INSURED** - You are eligible for coverage when You complete a valid application, provide evidence of insurability, pay the Total Initial Premium, and meet Our underwriting standards.

- **DEPENDENT** - A Dependent is eligible for coverage on the later of:

    - The date You become eligible for insurance; or
    - The date You acquire the Dependent.

    A Dependent is deemed to be acquired as follows:

    - **Spouse:** On the date of the marriage.
    - **Natural Child:** On the date of birth.
    - **Adopted Child:** On the date the child is placed in Your custody or the date You are legally or financially responsible for the child, if earlier.
    - **Step Child:** On the date the Insured marries the step child's natural parent.
    - **Foster Child:** On the date the child is placed in Your home. A foster child will be treated the same as a newborn Natural Child.

- MINOR CHILD WHO IS THE SUBJECT OF AN ADMINISTRATIVE OR COURT ORDER - Upon completion of enrollment from by either You, the custodial parent, guardian, or any other appointed representative for the minor child, and payment of any required premium.

If an eligible person does not meet Our underwriting standards, We may:

- Refuse to insure that person;
- Insure that person but exclude a specific disease or physical condition from coverage; or
- Make a surcharge for that person's coverage.

EFFECTIVE DATE

- **INSURED** - Coverage will start at 12:00 a.m. standard time at Your residence, on the Effective Date shown on the Schedule.

- **DEPENDENT**

    - **Newborn:** Coverage for a newborn is effective from the moment of birth. If the addition of a newborn to Your coverage results in a change in premium:

        1. We must receive written notice of the newborn within 45 days of the birth or before the end of the period for which Premium has been paid if later, and

        2. You must pay any additional Premium within 31 days of receiving a notice of the amount due.

        If notification of a newborn is received late, insurance will be effective only if an application for coverage is accepted by Us and Premium is paid.

- **Other Than A Newborn:** You must complete and sign an application which includes Your Dependents. If accepted by Us, an Effective Date will be assigned as follows:

    - The date Your insurance is effective for Dependents eligible on that date and for whom coverage is applied for;

    - For Dependents eligible on or first acquired after Your Effective Date; coverage will be effective on the date We assign.

    - On the date of placement in the adoptive/foster home.

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TERMINATION DATE

- **INSURED**

  Coverage will terminate at 12:00 a.m. standard time at Your home on the earliest of:

  - The date coverage is terminated by Us for all Policy holders in Your state.
  - The date We receive Your written request to have Your insurance terminated.
  - The end of the period for which Premium is paid, subject to the Grace Period.
  - The date of Your death.
  - The date We refuse to renew Your coverage because of fraud or intentional misrepresentation of a material fact under the terms of coverage.

At least 30 days prior written notice will be given to You if We terminate Your coverage for any reason, except for nonpayment of premium.

- **DEPENDENT**

  Dependent coverage will terminate at 12:00 a.m. standard time at Your home at the earliest of:

  - The premium due date following the date a Dependent ceases to be a Dependent as defined.
  - The end of the period for which Premium for Dependent coverage is paid.
  - The date Your coverage terminates, subject to any Continuation Of Coverage.
  - The date We receive Your written request to terminate Dependent coverage.

CONTINUATION FOR DEPENDENTS

If You die or become eligible for Medicare and voluntarily terminate Your coverage, Your Dependents whose coverage was in effect on the date of Your death, or the date You became eligible for Medicare, may continue coverage under this Policy. We should be notified of this election within 31 days of Your date of death, or within 31 days of Your Medicare eligibility. Benefits will be paid to the Dependent or a legal guardian, if the Dependent is a minor.

CONTINUATION FOR INCAPACITATED CHILDREN

Dependent children, insured herein, that reach the limiting age and are incapable of self-sustaining employment due to mental or physical handicap may continue to be covered regardless of age. The Dependent must be chiefly dependent on You for support and maintenance.

You must claim handicap status within 31 days of such child attaining the limiting age. We will require proof of handicap as often as necessary, but not more than once a year.

Coverage for a handicapped child will end on the earliest of:

- The date the Dependent marries;
- The date the Dependent obtains self-sustaining employment;
- The date the Dependent ceases to be handicapped;
- The date the Dependent ceases to be chiefly dependent upon You for support and maintenance;
- Sixty (60) days after a written request for proof of disability, if proof is not provided within such 60 days; or
- The date coverage would otherwise terminate.

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CONVERSION

If coverage ends due to divorce or attainment of the limiting age, the Dependent may elect to convert to individual coverage.

Notice of this election must be received by us within 60 days of the event. No evidence of insurability will be required. Premium for the conversion policy must be paid within 31 days after the election is made. Premium will be based on our rates in effect at the time of conversion.

Benefits under the Conversion policy will not be greater than those provided under this Policy.

Conversion is not available if:

- The Dependent has been covered by this Policy for less than 3 months;
- The Dependent is eligible for Medicare; or
- The Dependent is eligible for Other Medical Expense Coverage.

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EXTENSION OF BENEFITS

If a Covered Person is Hospital confined on the date the Policy terminates or coverage is terminated for all Policy holders in Your state, We will extend that Covered Person's benefits.

Extension applies only during Hospital confinement. Benefits will be paid as if coverage had remained in effect.

Extension of Benefits will end at the earliest of:

- The date Hospital confinement ends;
- Ninety (90) days from the date coverage otherwise ended; or
- The date You become eligible for Other Medical Expense Coverage.

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BENEFIT PROVISIONS

Benefits are only payable for incurred Covered Charges which are Medically Necessary and provided by or under the direction of a Physician. After the Deductible, We will pay the Insured Percent for Covered Charges, Transplant Benefits, and Wellness Benefits subject to:

1. The Usual and Customary Charge as established by Us;
2. Definitions, limitations, exclusions, benefit maximums and other provisions of the Certificate; and
3. The Cost Containment Procedures.

A Covered Charge is considered incurred on the date the service is rendered or the supply is furnished.

DEDUCTIBLE

The Deductible applies separately to each Covered Person each Year. A separate Deductible must be met for a covered newborn child. The Individual Deductible is shown on the Schedule.

FAMILY MAXIMUM: All Covered Persons under this Certificate need only satisfy a set number of Deductibles each Year. Once that happens, any remaining Deductible amounts are considered satisfied for that Year. The Family Maximum Deductible is shown on the Schedule.

COMMON ACCIDENT: If two or more Covered Persons are injured in the same accident, only one Deductible will be applied to the Covered Charges for that accident in the Year the accident occurs.

INSURED PERCENT AND OUT-OF-POCKET MAXIMUMS

The Insured Percent is the portion of Covered Charges that We will pay after the Deductible has been met. The Insured Percent may vary for certain Covered Charges. The Insured Percents are shown on the Schedule.

The Individual Out-of-Pocket Maximum is the amount of Covered Charges that You must pay each Year for each Covered Person. Once the Individual Out-of-Pocket Maximum has been paid, Covered Charges are payable at 100 percent for that Covered Person for the remainder of the Year. The Individual Out-of-Pocket Maximum is shown on the Schedule.

The Family Out-of-Pocket Maximum is the total amount of Covered Charges that You must pay each Year for all Covered Persons. Once the Family Out-of-Pocket Maximum has been paid, Covered Charges are payable at 100 percent for all Covered Persons for the remainder of the Year. The Family Out-of-Pocket Maximum is shown on the Schedule.

Out-of-Pocket amounts paid for the following will not apply toward the Out-of-Pocket Maximum:

1. Any applicable Deductible(s);
2. Covered Charges incurred for the treatment of Mental Illness;
3. The portion of a Covered Charge in excess of the Usual and Customary Charge;
4. Any expense which is not a Covered Charge;
5. Any benefit reduction or penalty for failure to use the Cost Containment Procedures;
6. The Emergency Room Access Fee; or
7. Any amount paid by You for Prescription Drug Card and Mail Order Prescription Drug Benefit.

MAXIMUM BENEFIT AMOUNTS

LIFETIME MAXIMUM: The Lifetime Maximum is the maximum amount of benefits We will pay on behalf of any Covered Person over the lifetime of that person for all Covered Charges. This includes any amounts paid under any conversion policy issued as a result of this Certificate. At no time, will total benefits available exceed the Lifetime Maximum shown on the Schedule.

SEPARATE COVERED CHARGE MAXIMUMS: Covered Charges for treatment of a certain Sickness or Injury are subject to Separate Benefit Maximums. These maximums are shown on the Schedule. Benefits paid pursuant to a Separate Benefit Maximum are included in the Lifetime Maximum.

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COVERED CHARGES

- Inpatient Hospital charges for:

    1. Room, board and general nursing care for each day of confinement, up to the most common semi-private (two bed) room rate at the Hospital where confined. If a Hospital has only private rooms, benefits will not exceed the most common semi-private room rate in the area.

2. Confinement in an intensive care or coronary care unit.
3. Other Medically Necessary services and supplies furnished by a Hospital for inpatient medical care.

- Physician charges for:

1. Home, office and inpatient visits.
2. Surgery.
3. Dental treatment or surgery for Injury, except chewing injuries, to sound natural permanent teeth, within 6 months of the accident.
4. Radiologist or pathologist services for interpretation of x-rays and laboratory tests necessary for diagnosis and treatment.

- Outpatient medical care charges furnished at:

1. A Free Standing Surgical Center; or
2. The outpatient department of a Hospital.

- Charges for:

1. Anesthetics and its administration;
2. Professional local ambulance service to or from the nearest Hospital with available facilities to treat the Covered Person.
3. X-rays, except dental x-rays, and laboratory tests for diagnosis or treatment.
4. X-ray and radioactive isotope therapy.
5. Dental x-rays necessary for the removal of a cyst or tumor.

- Coverage for anesthesia, hospital or facility charges for services performed in a hospital or ambulatory surgical facility in connection with dental procedures for children below the age of nine years, persons with serious mental or physical conditions, and persons with significant behavioral problems provided that the provider certifies that because of the patient's age or condition or problem, hospitalization or general anesthesia is required in order to safely and effectively perform the procedures. This is subject to the same deductibles, coinsurance, network requirements, medical necessity provisions and other limitations same as other illness.

- Manipulative Treatment, heat treatments and ultrasound, subject to the Separate Benefit Maximum shown in the Schedule.

- Supply and Equipment charges for:

1. Blood and blood plasma.
2. Oxygen and rental equipment for its administration.
3. Original purchase of standard artificial limbs or eyes. Subsequent purchase only as needed due to: (a) growth of a child; or (b) progression of a Sickness or Injury.
4. Original purchase of casts, splints, non-dental braces or crutches and surgical dressings.
5. Rental of a wheelchair or hospital style bed or other durable medical equipment with the minimum features necessary for the circumstances. We may, at Our option, purchase such equipment. If purchased, the Covered Charge is limited to the purchase price and the cost of installation reduced by any amount paid for rental.
6. Heart pacemaker.
7. Intraocular lens implant or the first contact lenses or glasses following cataract surgery.

- Physical or speech therapy provided by a licensed therapist acting within the scope of that license who is not a Family Member.

- Private duty nursing care by a registered nurse (RN) or licensed practical nurse (LPN) who is not a Family Member, subject to the Separate Benefit Maximum shown on the Schedule.

- Inpatient and outpatient prescription drugs, insulin and supplies for insulin administration. A prescription drug which has been approved by the USDA for treatment of specific cancer(s) yet is not being prescribed for treatment of a different cancer will be considered for benefits if it has been proven effective and accepted for the treatment of the specific cancer type for which it has been prescribed in any one of the following established reference compendia: 1) The American Medical Association Drug Evaluations; 2) The American Hospital Formulary Service Drug Information or 3) The United States Pharmacopeia Drug Information. There will be no coverage for Experimental drugs or those which the USDA has determined are not indicated for treatment of the specific type(s) of cancer for which the drug has been prescribed.

- Coverage for Prescribed Contraceptive Drugs and Devices including: coverage for the insertion and removal of and any medically necessary examination associated with the use of the prescribed drug or device and Outpatient Contraceptive Services provided by a health care professional. Prescribed Contraceptive Drugs and Devices does not include:

  a. Prescription drug known as “RU-486" or any “equivalent drug product”.
  b. Prescription drug marketed under the name “Preven” or any “equivalent drug product”.

  This is subject to the same deductibles, coinsurance and other limitations as applies to other prescription drugs and devices.

- Inpatient and outpatient treatment of chemical abuse or dependency, subject to the Separate Benefit Maximum shown on the Schedule.

- Inpatient and outpatient treatment of Mental Illness, subject to the Separate Benefit Maximum shown on the Schedule.

- Reconstructive surgery:

  1. Related to or following surgery for Injury, trauma, infection or other disease; or
  2. For the correction of birth abnormalities or congenital defects of a newborn child.
  3. Following mastectomy as follows:

     a. reconstruction of the breast performed; site and creation of a new breast mound;
     b. coverage for all stages and revisions of reconstructive surgery performed on a nondiseased breast to establish a symmetry when reconstructive surgery on a diseased breast is performed;
     c. reconstruction of the nipple/areolar complex following a mastectomy, without regard to the lapse of time between the mastectomy and the reconstruction, subject to the approval of the treating physician; and
     d. augmentation mammoplasty, reduction mammoplasty and mastopexy of the nondiseased breast; and
     e. Prostheses and physical complications of all stages of mastectomy, including lymphedemas.

- Home Health Care within 14 days following confinement in a Hospital or Skilled Nursing Facility for which benefits are payable. The attending Physician must certify prior to the first visit, that:

  1. Confinement would otherwise be required; and
  2. A Family Member cannot provide the necessary care without undue hardship.

- Home Health Care benefits are subject to the Separate Benefit Maximum shown on the Schedule, and are limited to:

  1. Physician home visits.
  2. Nursing care by or under the supervision of a registered nurse (RN).
  3. Home health aide services of a medical or therapeutic nature.
  4. Physical or speech therapy.
  5. Nutrition counseling by a registered dietitian.
  6. Medical services, prescription drugs and supplies which would be covered if Confined.

Up to 4 hours of treatment or services in any 24-hour period will be considered as one Home Health Care visit. This includes time spent evaluating the need for or developing the home care plan.

No Home Health Care benefits are payable for: medical care not included in the written home care plan; services provided by a Family Member; homemaker services; services to aid in the normal activities of daily living; or services not listed above as a benefit.

- Skilled Nursing Home charges for room, board and skilled nursing care, subject to the Separate Benefit Maximum shown on the Schedule, when such confinement:

  1. Begins within 14 days following a Hospital confinement; and
  2. Continues treatment of the Sickness or Injury which caused the Hospital confinement.

- Inpatient and outpatient Hospice Care prescribed by a Physician, subject to the Separate Benefit Maximum shown on the Schedule. Hospice Care charges will not be considered under any other Covered Charge benefit.

- Procedures involving any bone or joint of the jaw, face, or head. Procedures must be Medically Necessary to treat a condition which prevents normal functioning of the particular bone or joint involved. The condition must be caused by congenital deformity, disease or traumatic injury.

  For the treatment of conditions of the jaw, temporomandibular joint dysfunction (TMJ), authorized therapeutic procedures, shall include splinting and use of intraoral prosthetic appliances to reposition he bones. For these therapeutic procedures and for procedures involved in any other nonsurgical treatment of TMJ, benefits are subject to the Separate Benefit Maximum shown on the Schedule.

  No benefits will be provided for orthodontic braces, crowns, bridges, dentures, treatment for periodontal disease, dental root form implants, or root canals.

- Mammograms. For female Covered Persons screening by low dose mammography for the presence of occult breast cancer at the following intervals: (1) one or more mammograms a year, as recommended by a physician for any Woman at Risk for Breast Cancer; (2) one baseline mammogram between ages 35 and 39; (3) one mammogram every 2 years between ages 40 and 49, or more frequently if recommended by a Physician; and (4) an annual mammogram at age 50 or older;

- Papanicolaou smear test (PAP). One test per Year, or more frequently if recommended by a Physician, and associated office visit. This includes the examination, the laboratory fee and the physician's interpretation of the laboratory results.

- Prostate-Specific Antigen (PSA) Test or equivalent test for the presence of prostate cancer when recommended by a Physician.

- Medically Necessary and appropriate services for diabetes outpatient self-management training and educational services, supplies, medications, and laboratory procedures used to treat diabetes. Diabetes outpatient self-management training and educational services must be provided by a Physician or a health care professional designated by the Physician.

- For newborn, adopted or foster child(ren), treatment of congenital defects or anomalies which include but are not limited to all necessary treatment and care needed by individuals born with cleft lip of cleft palate for those occurrences beginning with the moment of the child's birth, provided the coverage was in force when the birth, adoption or placement occurred.

- Coverage for Qualified Individual for scientifically approved Bone Mass Measurement for the diagnosis of osteoporosis or low bone mass subject to deductibles, coinsurance as provided in the Schedule of Benefits. Bone Mass Measurement will be covered if at least 23 months have elapsed since the last Bone Mass Measurement performed, except if the follow-up measurement is medically necessary including but not limited to:

(1) Monitoring beneficiaries on long term glucocorticoid therapy of more than three months.
(2) Allowing for central Bone Mass Measurement to determine the effectiveness of adding an additional treatment regimen for a Qualified Individual who is proven to have low bone mass so long as the Bone Mass Measurement is performed 12 to 18 months from the start date of the additional regimen.

This coverage is not provided to non Qualified Individuals.

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TRANSPLANT BENEFITS

Benefits are payable only for Approved Transplant Services.

Transplant Benefits are subject to Pre-Treatment Certification.
No Transplant Benefits will be paid without prior authorization. You should contact Us when a transplant has been decided, but before the donor selection process begins, to establish available benefits.

Prior authorization means You must:

1. **Notify Us of the procedure to be performed;**
2. **Have the Physician submit a complete medical history, including current diagnosis, transplant protocol and informed consent; and**
3. **Have the Physician certify that the procedure is Medically Necessary and that alternative procedures, services or courses of treatment would not be effective.**

You will be notified of the determination within 10 business days after the receipt of Your request and medical documentation necessary to determine if there is a coverage.

Expenses must be incurred during the transplant benefit period. The transplant benefit period begins 5 days before the date the transplant is performed and ends 12 months thereafter. During the transplant benefit period, if a second admission is required, and a retransplant occurs, a new transplant benefit period starts 5 days before the date the retransplant is performed and ends 12 months thereafter.

TRANSPLANTS

Transplants are limited to the following, subject to all Benefit Maximums shown on the Schedule:

A) Organ transplants

Benefits are payable only for human to human organ Transplants.

1. Cornea;
2. Heart;
3. Liver;
4. Kidney; and
5. Lung;

B) High Dose Chemotherapy (HDC);

C) Stem Cell Infusion (SCI);

D) Autologous Bone Marrow Transplant (ABMT(1)); and

E) Allogenic Bone Marrow Transplant (ABMT(2)).

Donor Expenses:

Unless covered by Other Medical Expense Coverage, Approved Transplant Services are payable for an organ donor. Benefits payable for the donor will be charged to the recipient's claim and subject to the Lifetime Maximum shown on the Schedule.

Designated Facilities for Approved Transplant Services

A person who is authorized for a transplant procedure will be referred to a Designated Transplant Facility. If the person is denied the procedure by the Designated Transplant Facility, he will be referred to a second such facility for evaluation. If the person is denied the procedure at the second Designated Transplant Facility, no benefits will be paid for any services or supplies related to that procedure. This applies regardless of whether the procedure is performed at a third Designated Transplant Facility or at a Non- Designated Transplant Facility.

In addition to Approved Transplant Services, benefits will be paid, up to $10,000 per procedure, subject to the Lifetime Maximum shown on the Schedule, for:

In addition to Approved Transplant Services, benefits will be paid, up to $10,000 per procedure, subject to the Lifetime Maximum shown on the Schedule, for:

1. Reasonable and necessary travel, by the covered person and family member(s) accompanying him, to a Designated Transplant Facility over 50 miles away from the Covered Person's residence;
2. Reasonable and necessary lodging and meal expenses for family member(s) accompanying the Covered Person to the Designated Transplant Facility; and
3. Air ambulance or other emergency transportation to, but not from, a Designated Transplant Facility, when necessary and approved.

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WELLNESS BENEFIT

For the benefit maximums and a listing of the services covered under this benefit, see the Separate Benefit Maximum shown on the Schedule.

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PRESCRIPTION DRUG CARD BENEFIT

COVERED DRUGS

Drugs which will be considered Covered Drugs are:

- Prescription Drugs and authorized refills.
- Disposable blood/urine/glucose/acetone testing agents (Chemstrips, Acetest tablets, Clinitest tablets, Diastix Strips and Tes-Tape).
- Disposable insulin needles and syringes.

BENEFITS

Payment for any Covered Drug is subject to payment of any applicable Drug Deductible and Copayment, as shown on the Schedule, which does not apply toward the Deductible, as defined in the Definitions section. Payment is also subject to definitions, limitations, exclusions and maximum benefits and other provisions of this Policy.

If the Covered Person elects to purchase a Brand Name or if the Physician has specified "dispense as written" (DAW), benefits will be payable for the Brand Name, as shown on the Schedule.

A) PRESCRIPTION DRUGS

Benefits are payable only for Covered Drugs purchased on an outpatient basis. A maximum 34 day supply will be covered for each Covered Drug.

Participating Pharmacy: When purchasing a Covered Drug from a Participating Pharmacy:

- Present Your identification card to the pharmacist at the time of purchase.
- If the Drug Deductible has not been met, the Covered Person must pay for the entire cost of the Covered Drug.
- If the Drug Deductible has been met, the Covered Person must pay the Copayment for the Covered Drug.
- If Your identification card is not presented at the time of purchase, the Covered Person must pay for the entire cost of the Covered Drug. A claim form must then be submitted to Us. You will be reimbursed at the negotiated rate that would have been paid to a Participating Pharmacy for the cost of the Covered Drug minus any applicable Drug Deductible and Copayment.

Non-Participating Pharmacy: When purchasing a Covered Drug from a Non-Participating Pharmacy:

- The Covered Person will have to pay the Non-Participating Pharmacy for the entire cost of the Covered Drug and then submit a claim form to Us for reimbursement. You will be reimbursed at the negotiated rate that would have been paid to a Participating Pharmacy for the cost of the Covered Drug minus any applicable Drug Deductible and Copayment.

PRESCRIPTION DRUG CARD EXCLUSIONS

No Prescription Drug Card benefits are payable for:

- Refills in excess of the number specified by the Physician; or any drug or medicine dispensed more than one year after the date on the prescription;
- Covered Drugs administered while confined in a Hospital or while an inpatient in a hospice, rest home, nursing home or other institution;
- Any over-the-counter drugs or medicines, except as specifically stated.
- Any drug for which there is no charge;
- Any drug labeled “Caution: Limited by Federal Law to Investigational Use” or Experimental drugs;
- Any type of equipment or device used to render drugs effective, except as specifically stated.
- Tretinoin, all dosage forms (e.g. Retin-A), except for the treatment of Acne Vulgaris;
- Charges for the administration or injection of any drug;
- Vitamins, cosmetics and dietary supplements;
- Immunization agents, biological sera, blood/blood plasma or oxygen, including its administration;
- Contraceptives, contraceptive materials or devices or infertility drugs, except as specifically stated in this Policy; and
- Hypodermic syringes and/or needles, injectables or any prescription directing administration or injection, other than insulin.

PRESCRIPTION DRUG CARD LIMITATIONS

No Prescription Drug Card benefits are payable for the following Prescription Drugs. Benefits for these Prescription Drugs are payable as Covered Charges:

- Didanosine (Videx);
- Growth Hormones;
- Levonorgestrel (Norplant);
- Minoxidil (Rogaine) for the treatment of alopecia;
- Zidovudine (Retrovir);
- Azidothymidine (AZT); and
- Viagra.

Other Prescription Drugs may only be payable as Covered Charges under this Policy. You will be notified of this requirement: by the Participating Pharmacy at the time of purchase; or by Us when a claim is made for Prescription Drugs purchased at a Non-Participating Pharmacy.

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COST CONTAINMENT PROCEDURES

REQUIRED OUTPATIENT SURGERY

Certain surgical procedures must be performed on an outpatient basis. If such surgery is performed on an inpatient basis, benefits will be reduced. This reduction is shown on the Schedule.

Benefit reduction will be waived if:

- Your Physician provides evidence, satisfactory to Us, that confinement is Medically Necessary; or
- Appropriate outpatient facilities, as determined by Us, are not available within 50 miles of the Covered Person's residence.

Surgical procedures which must be performed on an outpatient basis are:

- Adenoidectomy
- Arthroscopy and cartilage removal
- Breast biopsy
- Carpal tunnel
- Cataract removal
- Cystometrogram
- Dilatation and Curettage (D&C)
- Endoscopic procedures, including but not limited to:
  - Colonoscopy
  - Cystoscopy
  - E.R.C.P.
  - Esophagoscopy
  - Gastroscopy
  - Laparoscopy
- Examination under anesthesia

- Excisions:
  - Exostosis excision
  - Ganglion excision
  - Hammertoe excision
  - Neuroma or Morton's neuroma excision
- Eye muscle surgery
- Hemorrhoidectomy
- Hernia:
  - Inguinal hernia
  - Umbilical hernia repair
- Hydrocelectomy
- Palmer fasciectomy
- Pilonidal sinus
- Simple fistulectomy
- Tonsillectomy
- Tympanostomy with insertion of ventilatory tube

Other surgical procedures may be required to be performed on an outpatient basis. You will be notified of such additional requirement as part of the Pre-Treatment Certification process.

PRE-TREATMENT CERTIFICATION

Pre-treatment Certification (Certification) requires You, Your representative or Your Physician to notify our review agency of all Hospital admissions, including inpatient surgery by using the toll free number provided on your Identification Card.

Certification is a review process to determine the Medical Necessity of a Hospital admission or proposed surgery. A determination as to the necessary length of a Hospital stay is also made. Concurrent Review is a review conducted during a Covered Person's hospital stay or course of treatment. You or Your Physician may, at any time prior to discharge, request a reevaluation or extension of the number of Hospital days certified.

Retrospective review is a review of Medically Necessary services and supplies that is conducted after the services have been provided, but not the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding, or adjudication for payment. Retrospective review determinations will be provided to You within 30 days of receipt of all the necessary information. Written notice of noncertification will be provided to You and Your provider within 5 business days after the determination is made.

Noncertification does not become effective until notice is provided to You. If the Company or its review agency however, determines that the services, supplies or other items are covered, including utilization review determinations, We shall not subsequently retract the determination after the services, supplies or other items have been provided, or reduce payments for such, unless the determination was based upon a material misrepresentation on Your part or on the part of Your Provider.

If Certification is not completed, benefits will be reduced. The reduction is shown on the Schedule.

Certification will be valid for 60 days for the requesting Physician and the named Hospital. A change in Physician or Hospital will require a new Certification.

How to Certify: To certify a Hospital admission or surgery, call the telephone number on Your identification card. Be prepared to give the following information:

- Insured's name, social security number and Policy Number.
- Patient's name and date of birth.
- Hospital name and address.
- Physician's name and telephone number.
- The diagnosis (what is wrong).
- The treatment (what will be done and when).

It is Your responsibility to ensure that proper Certification is made. We recommend that You follow-up with the attending Physician to ensure that all medical information, including pertinent clinical information necessary to make a determination is provided to Us. You will be notified of the determination within 3 business days of receipt of all necessary information. Certification will be communicated to the provider and written confirmation will be sent to You.

If We do not agree with the Medical Necessity of any treatment, we will pay 100% of the Usual and Customary charge for a second opinion, subject to the annual deductible. If the second opinion does not confirm the Medical Necessity of the treatment, no benefits will be payable for any expense related to the Hospital confinement, including surgical expenses.

When to Call: For routine elective admission or surgery, You must call at least 2 business days before You are admitted to the Hospital.

Emergency admission: You are covered for emergency medical conditions and may receive medical services to treat an emergency medical condition without prior authorization, until the condition is stabilized. Both the Emergency Department and Us, shall make a good faith effort to communicate with each other in a timely fashion to expedite post-evaluation or post-stabilization services in order to avoid material deterioration of the Covered Person's condition within a reasonable clinical confidence, or with respect to a pregnant woman, to avoid material deterioration of the condition of the unborn child within a reasonable clinical confidence.

Transplants: a transplant procedure must be called in before the transplant benefit period begins.

If it is not reasonably possible to make the Certification call within the times provided, payment will not be reduced if the call is made as soon as is reasonably possible.

Upon request, You may be provided with any of the following:

- An explanation of the utilization review criteria and treatment protocol for specific conditions (in writing if requested).
- Reasons for denying a requested treatment, including the reasons for the denial and an explanation of the Utilization Review criteria or treatment protocol on which the denial is based.
- The procedures and medically based criteria for determining whether a specified procedure, test or treatment is Experimental.

Please read the coverage provisions carefully.

APPEALS PROCEDURE

As a participant in the Certification procedures, You have the right to request an appeal when You are dissatisfied with a decision by either the Review agency or Our claims administration. This appeal procedure is voluntary on Your part and maybe initiated by You or Your representative which may either be a relative or any other representative including Your provider.

You may start an appeal procedure for the following reasons:

1. if You or a Dependent are denied Certification approval for a Hospital confinement or continuation of a confinement,
2. whenever You believe that a claim for You or Your Dependent was subject to an additional Deductible or paid at a lower Insured Percent in error.

For immediate review of a disapproval from the Review agency given prior to Your Hospital confinement, or for an extension of Your Hospital confinement days, You or Your Physician should first call the Review agency at the toll free number provided on the back of your Identification Card. If You do not receive a satisfactory answer within 3 business days from the time You submitted all the necessary information, You or Your Physician may then call our customer service department at the toll free number provided on the back of your Identification Card. Within 3 business days after receiving a request for a non-expedited appeal, You shall be provided with the name, address and telephone number of

the coordinator and information on how to submit written material. Written notification of the decision will be provided to You and Your Provider, within 30 days after the receipt of the request for an appeal.

An expedited appeal will be made available to You, if the non expedited appeal would reasonably appear to seriously jeopardize Your life and health or jeopardize Your ability to regain maximum function. The expedited review will be done in consultation with Your provider and a medical doctor designated by Us. The decision will be communicated to You, Your designated representative or Provider, in writing, by U.S. mail as soon as possible but not later than 4 days after receiving information justifying expedited review. If the expedited review is a concurrent review determination, You shall be covered for health care services until you have been notified of the determination. Expedited appeal is not available for retrospective reviews. In the case of non expedited appeals, please refer to the Second-Level Grievance Review procedure in the Notice of Grievance Procedure provided at the end of this Policy.

If you have received and explanation of benefits for a claim showing that benefits were paid at the lower Insured Percent, denied in full or an additional Deductible was applied and You disagree with the decision, You may call or send a written notice to Us, explaining the reason for Your objection and ask for a review, You will receive Our written decision, within 30 calendar days of Our receipt of Your appeal. If Our review will take longer than 30 days, we will inform You as to why additional time is needed and when You can expect final resolution.

The appeal process described in this section does not apply to Noncertifications rendered solely on the basis that We do not provide benefits for the health care service performed or being requested, as outlined in this Policy.

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EXCLUSIONS AND LIMITATIONS

Benefits will not be paid for any expenses arising from or in connection with:

- Treatment, services or supplies which are not listed as Covered Charges.
- Treatment, services or supplies which are incurred when coverage is not in effect.
- Charges in excess of the Usual and Customary Charge.
- Treatment, services or supplies which:
    - Are not Medically Necessary or recognized by Us as effective;
    - Are not prescribed by a Physician as necessary to treat a Sickness or Injury;
    - We determine to be Experimental or Investigational in nature;
    - Are received without charge or legal obligation to pay;
    - Would not routinely be paid in the absence of insurance;
    - Are received outside of the 50 United States and the District of Columbia, except as specifically stated; or
    - Are received while incarcerated by legal authorities of any state or country for any reason.
- Routine physical examinations; x-ray; laboratory tests; and immunizations not related to diagnosis or treatment of a Sickness or Injury, except as specifically stated in this policy.
- Dental treatment or surgery, except as specifically stated in this policy.
- Temporomandibular joint dysfunction syndrome (TMJ); except for surgery to the temporomandibular joint and as specifically stated in this policy.
- Cosmetic surgery or procedures and related care or complications arising therefrom; except for specifically stated reconstructive surgery in this policy.

- Routine eye or hearing examinations; radial keratotomy or other surgery to correct errors of refraction; eyeglasses or contact lenses, except as specifically stated; any type of external appliances used to improve visual acuity and their fittings; and vision therapy.

- Routine hearing examinations, hearing aids or fitting thereof.

- Treatment, services or supplies which are paid or payable under Workers' Compensation, Occupational Disease Act or similar benefits.

- Normal pregnancy or childbirth.

- Nursery or well baby care or circumcision for a Dependent child following birth.

- Artificial insemination; in vitro fertilization; fertility testing or treatment; and contraceptives, except as specifically stated in this policy.

- Sterilization procedures or procedures to reverse sterilization.

- Treatment, services or supplies to change gender and related care or complications arising therefrom.

- Custodial care or rest.

- Military or naval service of any country.

- War or act of war, declared or undeclared.

- Suicide, attempted suicide, or intentionally self-inflicted Injury, while sane or insane.

- A Covered Person engaging in civil disturbance or an illegal occupation.

- A Covered Person's commission of, or attempt to commit, a felony or act which would be considered a felony if prosecuted.

- A Covered Person's use of alcohol, or hallucinogenic drugs or medicine, unless taken on the advice of, and in accordance with the direction of, a Physician.

- Over-the-counter drugs or medicine, even if prescribed by a Physician.

- Charges paid by Medicare unless required by Federal Law.

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PRE-EXISTING CONDITION LIMITATION

Expenses that result from care or treatment of a Pre-existing Condition will not be considered as Covered Charges for the 12 months following the Covered Person's Effective Date of coverage.

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TRAVEL OUTSIDE OF THE UNITED STATES

No benefits are payable for any medical care, treatment, services or supplies received outside of the United States, except for Emergency treatment. Benefits are limited to Injury or Sickness which first occurs during the initial 180 days of travel. No benefits are payable for any Injury or Sickness that occurs during travel for the 180 day period following the Effective Date of coverage for a Covered Person.

Hospital confinement for Emergency treatment is limited to 30 days per trip for each Covered Person.

Pre-Treatment Certification of Hospital admission is not required when so confined outside of the United States.

The term "United States" means the 50 states and the District of Columbia. It does not include territories or possessions such as Puerto Rico or Guam.

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PREMIUM PROVISIONS

PAYMENT OF PREMIUM

All premium, charges or fees (hereinafter "Premium") must be paid to Us at Our home office. All Premium is payable in advance.

We reserve the right to change the method of Premium payment selected with proper notice to You.

DUE DATE

The first Premium is due on the Effective Date of coverage. Subsequent Premium is due on the premium payment date shown on the Schedule. Failure to pay Premium when due shall result in termination of coverage on such due date subject to the Grace Period.

RETURNED OR DISHONORED PAYMENT

If a payment for any Premium is dishonored for insufficient funds, a reasonable service charge may be debited to You. A dishonored payment shall be considered a failure to pay Premium. A rejected debit to Your bank account or credit card shall be considered a failure to pay Premium.

If Your selected method of payment is dishonored as described, You will need to submit Premium in a method acceptable to Us prior to the end of the grace period.

GRACE PERIOD

If written notice of termination has not been received from You, a Grace Period of 31 days will be allowed for each Premium payment after the first Premium. If any Premium is unpaid at the end of the Grace Period, coverage shall automatically terminate on the last day for which Premium has been paid.

REINSTATEMENT

If coverage ends for failure to pay Premium, You may request for reinstatement in writing and submitted within 45 days from the date coverage ended. If approved by Us, and we issue a conditional receipt for premium tendered, reinstated coverage will become effective on the date We assign, or lacking such approval, on the forty-fifth (45) day following the date of such conditional receipt unless We have previously notified You in writing of Our disapproval of such application. Credit will be given for waiting periods satisfied prior to the date coverage ended.

PREMIUM ADJUSTMENT

Premium rates may be adjusted at anytime during any subsequent year based upon at least 12 months of experience but not more frequently than once every 12 months. No rate adjustment will take effect until:

- The end of any rate guarantee period; and
- At least 45 days prior written notice is given to You.

The rate guarantee and notice period shall not apply to any rate adjustment due to:

- Your request for a change in benefits or coverage;
- A change in any Premium tax law;
- A change in Federal or State law or regulation which affects the benefits or provisions of the Certificate;
- A misstatement of age, sex, or residence of any Covered Person; or
- A change in the residence of any Covered Person.

When coverage ends for a Covered Person, any resulting change in Premium will be made on the next premium Due Date.

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CLAIMS PAYMENT PROVISIONS

NOTICE OF CLAIM

We must receive written notice of claim within 30 days after a covered loss starts or as soon thereafter as reasonably possible. Notice should include Your name and Certificate Number.

CLAIM FORMS

When We receive the notice of claim, We will send You forms for filing a Proof of Loss. If these forms are not sent to You within 15 days, You will meet the Proof of Loss requirement by giving Us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss section.

PROOF OF LOSS

Written Proof of Loss must be completed and returned to Us within 90 days or as soon thereafter as reasonably possible. Except for absence of legal capacity, no claim for benefits will be accepted after one year from the date treatment was completed.

FORGIVENESS OF OUT-OF-POCKET MAXIMUMS AND/OR DEDUCTIBLE

If any provider intentionally does not collect (forgives) any Covered Charge amount, benefits payable will be recalculated as follows:

- The amount accepted by the provider as payment in full will be considered the actual fee (i.e. the reported charge less any forgiven amount).
- The adjusted charge will be reduced by the applicable Deductible.
- The corresponding Insured Percent will be applied to the result.

Any resulting overpayment will be billed to You without prejudicing any other right or remedy available to Us at law or in equity.

PAYMENT OF CLAIMS

Benefits will be paid to You, unless assigned to the provider. In the case of a Dependent child in the legal custody of a person other than You, payment may be made directly to the custodian, at Our discretion or as required by law. Any unpaid Premium that is due may be deducted from a claim. Payment of benefits will discharge Us from all liability to You and Your beneficiary.

PAYMENT ERROR

Any benefit paid in error may be recovered from the person receiving the incorrect payment or from You. At Our option, We may offset the overpayment against future benefit payments. The acceptance of Premium or paying other benefits shall not constitute a waiver of Our rights under this section. Recovery or offset shall be in addition to any other remedies available to Us at law or in equity.

FRAUDULENT CLAIM SUBMISSION

If any Covered Person knowingly submits or participates in the submission of a claim for benefits which contains false or misleading information that would have the effect of increasing the benefit payable, We shall have the right to rescind that Covered Person's coverage to the date the fraud was perpetrated. Such rescission is without prejudice to any other right or remedy available to Us at law or in equity.

PHYSICAL EXAMINATIONS

We have the right, at Our expense, to have a Covered Person examined as often as reasonably necessary while a claim on that Covered Person is pending.

ITKNCCP30000

GENERAL PROVISIONS

POLICY AMENDMENT AND ALTERATION

Company may amend the Policy at any time without Your consent or notice to You. Any such amendment will not affect a claim starting before the amendment take effect. Benefit changes made to the Policy will take effect on the date of the change or other date assigned by Company.

Company may amend or change the Policy at any time, without Your consent, and without the consent of any Insured, Covered Person or beneficiary, if required by law. Any amendment shall be without prejudice to any claim starting prior to the effective date of the amendment.

No person other than Company's President or Secretary has authority to waive, alter or amend any provision of the Policy. Any such waiver, alteration or amendment shall be in writing and signed by the President or Secretary.

No agent has authority, implied or express, to determine incurability, make any contract in the name of Company or waive, alter or amend any provision of the Policy.

ENTIRE CONTRACT; WAIVER; DISCRETION

The Policy, including any endorsements, riders and amendments, the Policy application and the Insured's application represent the entire contract. All provisions of the Policy shall apply separately to each Insured.

Failure by Company to enforce any Policy provision shall not waive, modify or render such provision unenforceable: at any other time; at any given time; or under any given set of circumstances, whether the circumstances are or are not the same.

Company has full, exclusive and discretionary authority to determine all questions arising in connection with the Policy, including its interpretation.

STATEMENTS IN THE APPLICATION

All statements made in Your application, in the absence of fraud, are considered to be representations and not warranties. No statement made by You shall be used to contest coverage or reduce benefits unless: (a) the statement is contained in an application; and (b) a copy of the statement is furnished to You.

After a Covered Person's coverage has been in effect for 2 years, during the lifetime of that person, no misstatements in the application may be used to void coverage or deny any claim.

Any increase in coverage or reinstatement of coverage, as requested by application from You, shall begin a new two-year contestable period for the amount of the increase or reinstated coverage from the effective date of such coverage

MISSTATEMENT OF AGE

If the age of a Covered Person is misstated such that coverage is provided for which the person is not otherwise eligible at the correct age, the misapplied coverage shall be rescinded and any applicable Premium refunded.

If the age of a Covered Person is misstated such that the person is eligible for coverage at the correct age, premium will be adjusted. Any additional Premium due must be paid within 31 days of receiving a notice of the amount due.

LEGAL ACTIONS

No legal action may be brought against Us within 60 days after written Proof of Loss has been sent to Us. No such action may be brought more than 3 years from the time written Proof of Loss is required to be given.

CONFORMITY WITH STATE STATUTES

Any provision of this Policy which, on its Effective Date, is in conflict with the laws of the State in which You reside on that date is amended to conform to the minimum requirements of such laws.

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NOTICE OF ANNUAL MEETINGS

Our annual meetings are held at Our home office at 2:30 p.m. on the first Thursday of March.

NON-PARTICIPATION

The Policy is non-participating. It does not share in the Company's profits or surplus earnings.

ITKXXNO300000

Notice of Grievance Procedures for North Carolina Residents

If you have any questions about any decisions related to your coverage with Trustmark Insurance Company (Trustmark), you may call us and a Customer Service Representative will assist you.

First Level Grievance Review: You, your medical provider, or your personal representative may submit a written request for a formal grievance review, if you have a complaint about any of the following:

- Trustmark's decisions, policies, or actions related to coverage of health care services.
- Claims payment or handling.
- The contractual relationship between a covered person and Trustmark.
- The outcome of an appeal on a denial of certification of an admission or continued stay.

Your written request should contain the issues and comments which are pertinent and should be sent to:

Trustmark Insurance Company
Grievance Review Board
PO Box 7950
Lake Forest, IL 60045-2581

All grievance procedures are voluntary and at any time you may seek the assistance of the Commissioner of Insurance at the following address:

Commissioner of Insurance
430 N. Salisbury Street
PO Box 26387
Raleigh, NC 27611
Telephone: 1-800-546-5664

Within 3 working days after receiving your written request for a review of your grievance (a first-level grievance review), we will send you the name, address and telephone number of the designated person coordinating the review of your grievance. You may submit written material for consideration by the first-level reviewer(s).

- Within 30 days after receiving your grievance, we will send you a written decision and, if applicable, a copy to your medical provider. The written decision will also contain a statement advising you of your right to, and how to, request a second-level grievance review.

Second Level Grievance Review: If you feel that the first-level grievance review decision, or utilization review appeal decision did not comply with the terms of your policy, you, your medical provider or your personal representative, on your behalf, may request a second -level grievance review.

- We will, within10 working days after receiving your second-level grievance review request, send you the name, address and telephone number of the designated person coordinating the review of your grievance.

- You have the right: (1) to request and receive from us all information relevant to the case; (2) attend the second-level grievance review; (3) present your case to the review board; (4) submit supporting materials before and at the review meeting; (5) ask questions of any member of the review board; (6) and be assisted or represented by a person of your choice, which person may be without limitation to: a medical provider, family member, employer representative, or attorney.

- The review panel will hold a meeting within 45 days after receiving your request for a second-level grievance review. You will be notified, in writing, at least 15 days before the review meeting date. Within 7 working days after completing the review, a written decision will be sent to you and, if applicable, to your medical provider. You have the right to full review whether or not you attend the review meeting.

An expedited second-level review will be made when the usual review time period would reasonably appear to seriously jeopardize the life or health or a covered person or jeopardize the person's ability to regain maximum function. Expedited second-level review is available whether or not the initial review was expedited. You may however, be required to provide documentation of the medical justification for the review. If you are eligible for an expedited second-level review, We may conduct a review proceeding by way of telephone call or by exchange of written information.

- We will send our written decision to You as soon as possible, but not later than 4 business days after receiving the necessary information justifying the expedited review.

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