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.

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

This policy was delivered in Maryland and will be governed by the laws thereof.

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.

Signed for HCC Life Insurance Company.

RIGHT TO EXAMINE POLICY FOR 10 DAYS: If You are not satisfied, return this Policy to Us within 10 days after You have received it. The Insured shall notify Us of the cancellation in writing. All premiums, including all fees, will be refunded and Your coverage will be void.

SHORT TERM MEDICAL INSURANCE POLICY

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

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

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PART I – GENERAL DEFINITIONS

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

"Bereavement Counseling" means counseling provided to the Immediate Family or Family Caregiver of the Covered Person after the Covered Person's death to help in coping with the death of the Covered Person.

"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 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 incurred by a Covered Person before becoming eligible for benefits under this policy. This amount applies separately to each Covered Person and must be satisfied each Coverage Period.

"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.

"Domestic Partner" means an individual of the same or the opposite sex of the Insured who has completed the Domestic Partner Affidavit and satisfied the proof of common primary residence with the Insured and proof of financial interdependence between such individual and the Insured, as required within the Individual Application.

"Eligible Dependent" means:

1. The Insured's lawful spouse (the term "spouse" as used within the policy includes the Insured's Domestic Partner); and
2. The Insured's or the Insured's Domestic Partner's unmarried children who are:

    a. Less than age 25; or
    b. Age 25 or older if such child is mentally or physically incapacitated.

Dependent children may include stepchildren, foster children, legally adopted children, children of adopting parents pending finalization of adoption procedures, children for whom coverage has been court-ordered, grandchildren, and a minor for whom guardianship (other than a temporary guardianship of less than twelve (12) months duration) is granted by court or testamentary appointment, from the date of such appointment. A Dependent child will also include a dependent of the Insured as that term is used in 26 U.S.C. §§ 104, 105, and 106, and any regulations adopted under those sections. Dependent children (other than those for whom coverage has been court-ordered) must be primarily dependent on the Insured for principal support and maintenance.

"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 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.

"Experimental Treatment" means in Our discretion 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, unless specifically covered as part of the clinical trials benefit.
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 as determined in Our discretion, by reference to any one or more of the following: peer-reviewed English-language medical literature, consultation with physicians, 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.

"Family Caregiver" means a relative by blood, marriage, or adoption who lives with or is the primary caregiver of a Terminally Ill Covered Person.

"Family Counseling" means counseling given to the Immediate Family or Family Caregiver of a Terminally Ill Covered Person for the purpose of learning to care for the Covered Person his or her death.

“Home Health Care Agency” means an entity licensed by state or local law operated primarily to provide skilled nursing care, home health aid services 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.

"Hospice Care Program" means a coordinated, interdisciplinary program of hospice care services for meeting the special physical, psychological, spiritual, and social needs of Terminally Ill individuals and their families, by providing palliative and supportive medical, nursing, and other health services through home or inpatient care during the illness and bereavement to:

1. Individuals who have no reasonable prospect of cure as estimated by a physician; and
2. The immediate families or family caregivers of those individuals described above.

“Hospital” means an institution operated by law for the care and treatment of injured or sick persons; has organized facilities for diagnosis and surgery or has a contract with another hospital for these services; and has 24-hour nursing service. 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, grandparents, spouse, children, grandchildren, or siblings of a Covered Person, or any person residing with a Covered Person.

“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 as stated in the application and this policy, and whose coverage under this policy has become effective and has not terminated.

"Low Protein Modified Food Product" means a food product that is specially formulated to have less than one gram of protein per serving, and is intended to be used under the direction of a Doctor for the dietary treatment of an inherited metabolic disorder. A natural food that is naturally low in protein is not a Low Protein Modified Food Product.

"Medical Food" means a food that is intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation, and is formulated to be consumed or administered enterally under the direction of a Doctor.

"Medically Necessary" means the care, service or supply that a prudent Doctor would provide to a patient for the purpose of preventing, diagnosing or treating and Injury or a Sickness or its symptoms in a manner that the attending Doctor determines to be:
1. In accordance with generally accepted standards of medical practice;
2. Clinically appropriate in terms of type, frequency, extent, site and duration; and
3. Not primarily for the convenience of the patient or the Doctor.

"Mental and Nervous Disorder" means a mental illness or emotional disorder as determined by a Doctor.

"Morbid Obesity" means a body mass index that is:
1. Greater than 40 kilograms per meter squared; or
2. Equal to or greater than 35 kilograms per meter squared with a comorbid medical condition, including hypertension, a cardiopulmonary condition, sleep apnea, or diabetes.

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

"Partial Hospitalization" means the provision of medically directed intensive or intermediate short-term treatment to a Covered Person in a licensed or certified facility or program for Mental and Nervous Disorders or Substance Abuse, for a period of less than 24 hours but more than 4 hours in a day.

"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.

"Residential Crisis Services" means intensive mental health and support services that are:
1. Provided to a child or an adult with a mental illness who is experiencing or is at risk of a psychiatric crisis that would impair the individual's ability to function in the community;
2. Designed to prevent a psychiatric inpatient admission, provide an alternative to psychiatric inpatient admission, or shorten the length of inpatient stay;
3. Provided out of the individual's residence on a short-term basis in a community-based residential setting; and
4. Provided by entities that are licensed by the Department of Health and Mental Hygiene to provide residential crisis services.

"Respite Care" means temporary care provided to the Terminally Ill Covered Person to relieve the Family Caregiver from the daily care of the Covered Person.

“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:
1. Alcohol abuse, a disease that is characterized by a pattern of pathological use of alcohol with repeated attempts to control its use, and with significant negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social; or
2. Drug abuse, a disease which is characterized by a pattern of pathological use of a drug with repeated attempts to control the use, and with significant negative consequences in at least one of the following areas of life: medical, legal, financial, or psycho-social.

“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.

"Terminally Ill" means a medical prognosis given by a physician that the Covered Person’s life expectancy is 6 months or less.

“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

Coverage will be effective for an Insured and his Eligible Dependent(s) as of the approved Effective Date, provided:

1. The Insured 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 Effective date;
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 an additional premium, if any 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 placed for adoption with the Insured while this policy is in force is covered for Injury and Sickness provided the Insured files a petition to adopt. 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 placement in the Insured's home if the Insured applies for coverage and pays any required premium within 31 days after the date of placement. However, coverage shall begin at the moment of birth if the petition for adoption, application for coverage and payment of an additional premium, if any 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.

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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, subject to the Extension of Benefits provision;
2. The end of the last period for which the last required premium payment was made for the Insured's or Covered Person's insurance, subject to the Grace Period provision;
3. The date a Covered Person receives the Coverage Period Maximum Benefit Amount;
4. 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. In such event, We will provide upon request a refund of pro-rata unearned premium for any period during which the Covered Person is not covered;
5. The premium due date that coincides with or next follows the date on which the Insured is no longer eligible;
6. For a Dependent spouse, the first day of the month following the date of divorce or legal separation from the Insured; or
7. 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 the Policy;
   C. Material misrepresentation, fraud, or omission of information on any application form, or in requesting the receipt of benefits under this Policy, subject to the Time Limit on Certain Defenses provision; 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.

If the Insured selected the Pay In Advance option in the Insured's Application and We received all required premium for the Coverage Period, premium will be reimbursed to the Insured for the period of time, if any, between the date coverage terminates in accordance with the above provisions 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 will also be paid for any Eligible Expenses incurred after the termination of insurance for a Covered Person until the earlier of:

1. The date when treatment for the Injury or Sickness is no longer required;
2. 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 twelve (12) months; or
3. The date the Coverage Period Maximum Benefit amount has been reached.

PART IV - PREMIUMS

1. Unless the Pay In Advance 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.

1. **Grace Period:** 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. This Policy will remain in force during such grace period.

2. **Reinstatement:** If the Policy lapses due to the Insured's nonpayment of premium within the grace period, the Policy may be reinstated. In order for reinstatement to be considered, the Insured must complete an application for reinstatement and submit the required premium to Us at our Home Office. The Policy will be reinstated upon approval of such application by Us, or lacking such approval, upon the forty-fifth (45^{th}) day following the date of such conditional receipt unless We have notified the Insured in writing of the disapproval of the application. The reinstated Policy shall cover only loss resulting from such Injury as may be sustained after the date of reinstatement and loss due to Sickness as may begin more than ten (10) days after such date. In all other respects, the Covered Person shall have the same rights under the Policy as they had under the Policy immediately before the due date of the defaulted premium, subject to any provisions endorsed hereon or attached thereto 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 sixty (60) days prior to the date of reinstatement.

3. This Policy does not share in the surplus earnings of the Company and no refund or assessment shall be made to the Policyholder, Insured, or Dependent of any excess or deficit earnings of the Company.

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 rate approved by the Maryland Health Services Cost Review Commission;
   - 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, 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. Prosthetic devices, components of prosthetic devices and repairs to prosthetic devices determined to be medically necessary as established under the Medicare coverage database. “Prosthetic devices” means an artificial device to replace, in whole or in part, a leg, an arm, or an eye. .
7. For all stages of reconstructive breast 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.
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 or derivatives including the cost of the actual blood or blood components or derivatives.
10. For oxygen and other gasses and their administration by or under the supervision of a Doctor.
11. For anesthetics and their administration by a Doctor, subject to a maximum of 20% of the benefit payable for the primary surgeon.
12. 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 three (3) 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.

13. Treatment of a Covered Person by a Home Health Care Agency, or a hospital with a valid certificate that is certified to provide home health care services, 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 payable up to the Maximum Allowable Charges for "Home Health Care" shown in "PART IX – SCHEDULE OF BENEFITS."
However, benefits will not be paid for charges made by a Home Health Care Agency for:
A. Any charges excluded under the Exclusions of this 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 inpatient benefits provided under any other provision of this 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 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.
18. Medical foods and low protein modified food products for the treatment of an inherited metabolic disease if the medical foods or low protein modified food products are prescribed as Medically Necessary under the direction of a Doctor. "Inherited metabolic disease" means a disease caused by an inherited abnormality of body chemistry and includes a disease for which the State of Maryland screens newborn babies. "Low protein modified food product" means a food product that is:
A. Specially formulated to have less than 1 gram of protein per serving; and
B. Intended to be used under the direction of a Doctor for dietary treatment of an inherited metabolic disease.

This term does not include a natural food that is naturally low in protein. "Medial foods" means a food that is:
A. Intended for the dietarty treatment of a disease or condition for which nutritional requirements are established by medical evaluation; and
B. Formulated to be consumed or administered enterally under the direction of a Doctor.

19. Charges for breast cancer screening in accordance with the latest screening guidelines issued by the American Cancer Society. The Deductible does not apply to this benefit.
20. The following child wellness services for covered Dependent children, which shall not be subject to the Deductible:
    A. All visits for and costs of childhood and adolescent immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control;
    B. Visits for the collection of adequate samples, the first of which is to be collected before 2 weeks of age, for hereditary and metabolic newborn screening and follow-up between birth and 4 weeks of age;
    C. Universal hearing screening of newborns provided by a Hospital before discharge;
    D. All visits for and costs of age-appropriate screening tests for tuberculosis, anemia, lead toxicity, hearing, and vision as determined by the American Academy of Pediatrics;
    E. A physical examination, developmental assessment, and parental anticipatory guidance services at each of the above visits; and
    F. Any laboratory tests considered necessary by the Doctor as indicated by the services provided at each of the above visits.

    "Child wellness services" means preventive activities designed to protect children from morbidity and mortality and promote child development.
21. Orthopedic braces used to support a weak or deformed body member or to restrict or eliminate motion in a diseased or injured part of the body.
22. Medically Necessary and appropriate diabetes equipment, diabetes supplies and diabetes outpatient self-management training and education, including medical nutrition therapy, that the Insured's treating health care professional certifies as necessary for the treatment of insulin-using diabetes, noninsulin-using diabetes or elevated blood glucose levels induced by pregnancy. Upon certification by a health care professional, as noted, the diabetes outpatient self–management training and educational services, including medical nutrition therapy, shall be provided through a program supervised by an appropriately licensed, registered or certified health care provider whose scope of practice includes diabetes education management.
23. Bone mass measurement for the prevention, diagnosis, and treatment of osteoporosis as recommended by a Doctor for a Covered Person who is:
    A. An estrogen deficient individual at clinical risk for osteoporosis;
    B. An individual with a specific sign suggestive of spinal osteoporosis, including roentgenographic osteopenia or roentgenographic evidence suggestive of collapse, wedging, or ballooning of one or more thoracic or lumbar vertebral bodies, who is a candidate for therapeutic intervention or for an extensive diagnostic evaluation for metabolic bone disease;
    C. An individual receiving long-term glucocorticoid (steroid) therapy;
    D. An individual with primary hyperparathyroidism; or
    E. An individual being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.

    "Bone mass measurement" means a radiologic or radioisotopic procedure or other scientifically proven technology performed on a qualified individual for the purpose of identifying bone mass or detecting bone loss.
24. Medically recognized diagnostic examination for the detection of prostate cancer, including a digital rectal exam and a blood test called the prostate-specific antigen (PSA) test, as follows:
    A. For men who are between 40 and 75 years of age;

B. When used for the purpose of guiding patient management in monitoring the response to prostate cancer treatment;
C. When used for staging in determining the need for a bone scan in patients with prostate cancer; or
D. When used for male patients who are at high risk for prostate cancer.

25. General anesthesia and associated hospital or ambulatory facility charges in conjunction with dental care provided to a Covered Person who is:
A. 7 years of age or younger or is developmentally disabled;
B. An individual for whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual, or other medically compromising condition of the enrollee or insured; and
C. An individual for whom a superior result can be expected from dental care provided under general anesthesia; or
D. An extremely uncooperative, fearful, or uncommunicative child who is 17 years of age or younger with dental needs of such magnitude that treatment should not be delayed or deferred; and
E. An individual for whom lack of treatment can be expected to result in oral pain, infection, loss of teeth, or other increased oral or dental morbidity.

26. An annual Chlamydia screening test for women who are under the age of 20 if they are sexually active, women who are age 20 or older if they have multiple risk factors, and for men who have multiple risk factors. “Multiple risk factors” means having a prior history of a sexually transmitted disease, new or multiple sex partners, inconsistent use of barrier contraceptives, or cervical ectopy. “Chlamydia screening test” means any laboratory test that:
A. Specifically detects for infection by one or more agents of Chlamydia trachomatis; and
B. Is approved for this purpose by the Food and Drug Administration.

27. Human papillomavirus screening test in accordance with recommendations for cervical cytology screening developed by the American College of Obstetricians and Gynecologists. “Human papillomavirus screening test” means any laboratory test that:
A. Specifically detects for infection by one or more agents of the human papillomavirus; and
B. Is approved for this purpose by the federal Food and Drug Administration.

28. Coverage for inpatient hospitalization for 48 hours following a covered mastectomy. A Covered Person may request a shorter length of stay provided such Covered Person, in consultation with his or her attending Doctor, decides less time is needed for recovery.

If a Covered Person receives less than 48 hours of inpatient hospitalization following a covered mastectomy, or undergoes a mastectomy on an outpatient basis, coverage will include:
A. One home visit scheduled to occur within 24 hours after discharge from the Hospital or Outpatient health care facility; and
B. An additional home visit if prescribed by the attending Doctor.

If a Covered Person remains in the Hospital for at least 48 hours, one home visit, to occur within 24 hours after discharge, will be covered, provided such visit is prescribed by the attending Doctor. “Mastectomy" means the surgical removal of all or part of a breast as a result of breast cancer.

29. Coverage for inpatient hospitalization for 48 hours following a covered testicle removal. A Covered Person may request a shorter length of stay provided such Covered Person, in consultation with his or her attending Doctor, decides less time is needed for recovery.

If a Covered Person receives less than 48 hours of inpatient hospitalization following a covered surgical removal of a testicle, or undergoes the surgical removal of a testicle on an outpatient basis, coverage will include:

A. One home visit scheduled to occur within 24 hours after discharge from the Hospital or Outpatient health care facility; and
B. An additional home visit if prescribed by the attending Doctor.

30. Habilitative services including occupational, physical, and speech therapy for the treatment of a child under the age of 19 years with a congenital or genetic birth defect, including but not limited to autism, autism spectrum disorders, and cerebral palsy. Habilitative services delivered through early intervention or school services are not covered. “Congenital of genetic birth defect” means a defect existing at or from birth, including a hereditary defect. This term includes, but is not limited to:
    A. Autism or an autism spectrum disorder; and
    B. Cerebral palsy.
31. A hair prosthesis, as prescribed by the attending Doctor, for a Covered Person whose hair loss results from chemotherapy or radiation treatment for cancer, as stated in the Schedule of Benefits.
32. Colorectal cancer screening in accordance with guidelines issued by the American Cancer Society.
33. Non-disposable hearing aids for a minor child prescribed, fitted, and dispensed by a licensed audiologist, as stated in the Schedule of Benefits. “Hearing aid” means a device that:
    A. Is of a design and circuitry to optimize audibility and listening skills in the environment commonly experienced by children; and
    B. Is nondisposable.
34. Medically Necessary surgical treatment of morbid obesity that is recognized by the National Institutes of Health (NIH) as effective for the long term reversal of morbid obesity and consistent with NIH guidelines. “Morbid obesity” means a body mass index that is:
    A. Greater than 40 kilograms per meter squared; or
    B. Equal to or greater than 35 kilograms per meter squared with a comorbid medical condition including hypertension, a cardiopulmonary condition, sleep apnea, or diabetes.

    “Body mass index” means a practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.
35. Medically Necessary Residential Crisis Services.
36. Amino acid-based elemental formula, regardless of delivery method, when certified as Medically Necessary by the ordering Doctor for the diagnosis and treatment of:
    A. Immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins;
    B. Severe food protein induced enterocolitis syndrome;
    C. Eosinophilic disorders, as evidenced by the results of a biopsy; and
    D. Impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.
37. Patient cost to a Covered Person who is a member in a Clinical Trial as a result of treatment provided for a life-threatening condition or prevention, early detection, and treatment studies on cancer. Covered patient costs include those incurred for drugs and devices that have been approved for sale by the FDA (whether or not for use in treating

the patient's particular condition), to the extent that the drugs or devices are not paid for by the manufacturer, distributor, or provider of that drug or device. The following conditions apply:

A. The treatment must be provided or the studies must be conducted in a Phase I, Phase II, Phase III, or Phase IV clinical trial for cancer; or the treatment must be provided in a Phase I, Phase II, Phase III, or Phase IV clinical trial for any another life-threatening condition;
B. The clinical trial must be approved by:
    a. one of the National Institutes of Health (NIH);
    b. an NIH cooperative group or an NIH center;
    c. the FDA in the form of an investigational new drug application;
    d. the federal Department of Veterans Affairs; or
    e. an institutional review board of an institution in the State which has a multiple project assurance contract approved by the Office of Protection from Research Risks of the National Institutes of Health;
C. The facility and personnel providing the treatment must be capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise;
D. There must be no clearly superior, non-investigational treatment alternative; and
E. The available clinical or preclinical data must provide a reasonable expectation that the treatment will be at least as effective as the non-investigational alternative.
F. The following are not considered “patient costs” and are not covered under this benefit:
    a. the cost of a drug or device that is investigational or that would otherwise meet the definition of an Experimental Treatment except that it is being used in a clinical trial;
    b. the cost of non-health care services that a patient may be required to receive as a result of the treatment being provided for purposes of the clinical trial;
    c. costs associated with managing the research associated with the clinical trial; or
    d. costs that would not be covered under this policy for non-investigational treatments.

38. The following services provided through a Hospice Care Program:
    A. Inpatient hospice care as stated in the Schedule of Benefits;
    B. Part time nursing care by or supervised by a registered graduate nurse;
    C. Counseling, including dietary counseling, for the terminally ill person;
    D. Family Counseling for the Immediate Family and the Family Caregiver before the death of the Terminally Ill Covered Person;
    E. Bereavement Counseling for the Immediate Family or Family Caregiver of the Covered Person as stated in the Schedule of Benefits;
    F. Respite Care as stated in the Schedule of Benefits:
    G. Medical supplies, equipment, and medication required to maintain the comfort and manage the pain of the Terminally Ill Covered Person.
39. Inpatient or outpatient expenses arising from orthodontics, oral surgery and otologic, audiological, and speech/language treatment involved in the management of the birth defect known as cleft lip or cleft palate or both.
40. An objective second opinion when required by a utilization review program under Maryland law.

41. Medically Necessary treatment of treatable Mental and Nervous Disorders and Substance Abuse (including coverage of psychological and neuropsychological testing), as determined by a Doctor, subject to the amount stated in the Schedule of Benefits. The copayment of the daily cost for methadone maintenance treatment will not exceed 50%.

42. Inpatient hospitalization services for a Covered Person, who is a mother, and her newborn child for a minimum of:
    A. Forty-eight (48) hours of inpatient hospitalization care after and uncomplicated vaginal delivery; and
    B. Ninety-six (96) hours of inpatient hospitalization care after and uncomplicated cesarean section.

    Coverage will also include a home visit, if prescribed by the attending Doctor, to such Covered Person and her newborn child who do remain in the Hospital for at least the length of time shown in A or B above.

    The Covered Person, who is a mother, may request a shorter length of stay if she decides, in consultation with her attending Doctor, that less time is needed for recovery.

    If the Covered Person and her newborn child have a shorter Hospital stay than provided under A and B above, coverage will include:
    A. One (1) home visit scheduled to occur within twenty-four (24) hours after Hospital discharge; and
    B. An additional home visit if prescribed by the attending Doctor.

    A “home visit” must be:
    A. Provided in accordance with generally accepted standards of nursing practice for home care of a mother and newborn child;
    B. Provided by a registered nurse with at least one (1) year of experience in maternal and child health nursing or community health nursing with an emphasis on maternal and child health; and
    C. Include any services by the attending Doctor.

    If a Covered Person , who is a mother, is required to remain hospitalized after childbirth for medical reasons and the mother requests that the newborn remain in the Hospital, the hospitalization of the newborn will be covered up to four (4) days. A home visits will not be subject to the Deductible or Coinsurance.

43. Outpatient expenses arising from in vitro fertilization procedures performed on the Covered Person if:
    A. The Covered Person’s oocytes are fertilized with the Covered Person’s spouses sperm;The Covered Person and the Covered Person’s spouse have a history of infertility for at least two (2) years duration; or infertility in association with any of the following medical conditions:
        a. Endometriosis;
        b. Exposure in utero to diethylstilbestrol (commonly known as DES);
        c. Blockage of, or surgical removal of, one or both fallopian tubes (lateral or bilateral salpingectomy); or
        d. Abnormal male factors (including oligospermia) contributing to the infertility.

B. The Covered Person has been unable to attain a successful pregnancy through a less costly infertility treatment for which coverage is available under the Policy; and

C. The in vitro fertilization procedures are performed at medical facilities that conform to the American College of Obstetricians and Gynecologists guidelines for in vitro fertilization clinics or the American Fertility Society minimal standards for programs of in vitro fertilization.

Such coverage is limited to three (3) in vitro fertilization attempts per live birth, not to exceed a Maximum Lifetime Benefit of $100,000.

43. Diagnostic or surgical procedures involving a bone or joint of the face, neck, or head if, under the accepted standards of the profession of the Doctor rendering the service, the procedure is Medically Necessary to treat a condition caused by a congenital deformity, Sickness, or Injury. Coverage does not include intraoral prosthetic devices.

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 condition for which a Covered Person received medical treatment, diagnosis, care or advice within the sixty-month period immediately preceding such person's Effective Date are excluded for the first 12 months of coverage hereunder. Conditions revealed on the application will not be considered pre-existing conditions, unless excluded by a signed Exclusionary Rider, HCCL STMM MD EXC. 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. 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, except as expressly covered under this Policy.
3. Routine pre-natal care, pregnancy, childbirth, and postnatal care, except as expressly covered under this Policy. (This exclusion does not apply to "Complications of Pregnancy" as defined.)
4. Charges which are not incurred by a Covered Person during his/her Coverage Period, subject to the Extension of Benefits provision.
5. Treatment, services or supplies, which are not administered by or under the supervision of a Doctor.
6. Treatment, services or supplies which are not Medically Necessary as defined.
7. Treatment, services or supplies provided at no cost to the Covered Person, except for reimbursement to the Maryland Department of Health and Mental Hygiene for services paid for or provided by the Maryland Department of Health and Mental Hygiene that are otherwise covered under this Policy.
8. Charges which exceed Usual and Customary charge as defined.
9. Telephone consultations or failure to keep a scheduled appointment.
10. Consultations and/or treatment provided over the Internet.
11. Surgeries, treatments, services or supplies which are deemed to be Experimental Treatment, except as expressly covered under this Policy.
12. All charges Incurred while confined primarily to receive Custodial or Convalescence Care.
13. Weight modification or surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass surgery, except as expressly covered under this policy.
14. Modifications of the physical body in order to improve the psychological, mental or emotional well-being of the Covered Person, including sex-change surgery.
15. Surgeries, treatments, services or supplies for cosmetic or aesthetic reasons, except for reconstructive surgery which is expressly covered under this policy. The attending Doctor will determine whether a surgery is cosmetic or Medically Necessary with respect to a covered loss caused by an Injury or Sickness.
16. Any drug, treatment or procedure that either promotes or prevents conception including but not limited to: artificial insemination, treatment for infertility, except as expressly covered under this Policy or impotency, sterilization or reversal of sterilization.
17. Any drug, treatment or procedure that either promotes, enhances or corrects impotency or sexual dysfunction, except as expressly covered under this Policy.
18. Abortions, except in connection with covered Complications of Pregnancy or if the life of the expectant mother would be at risk.
19. Dental treatment, except for dental treatment that is expressly covered under this policy.

20. 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 except as expressly covered under this policy.
21. Eye surgery, including radial keratotomy, when the primary purpose is to correct nearsightedness, farsightedness or astigmatism.
22. Treatment for cataracts.
23. 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.
24. Injuries or Sicknesses resulting from participation in interscholastic, intercollegiate or organized competitive sports.
25. Willfully self-inflicted Injury or Sickness.
26. Immunizations and Routine Physical Exams, except as expressly covered under this Policy.
27. Speech, vocational, occupational, biofeedback, acupuncture, recreational, sleep or music therapy, holistic care of any nature, massage and kinestherapy, except as expressly covered under this Policy.
28. Any services performed or supplies provided by a member of the Insured's Immediate Family.
29. Orthoptics and visual eye training.
30. Services or supplies which are not included as Eligible Expenses as described herein.
31. 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.
32. Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Doctor, except as expressly covered under this Policy.
33. Treatment of sleep disorders, unless determined by a Doctor to be due to a Mental and Nervous Disorder.
34. Hypnotherapy when used to treat conditions that are not determined by a Doctor to be a Mental and Nervous Disorder, and biofeedback, and non-medical self-care or self-help programs.
35. Any services or supplies in connection with cigarette smoking cessation.
36. Exercise programs, whether or not prescribed or recommended by a Doctor.
37. Treatment required as a result of complications or consequences of a treatment or condition not covered under this policy.
38. Charges for travel or accommodations, except as expressly provided for local ambulance.
39. Organ or Tissue Transplants or related services.
40. 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.
41. Services received or supplies purchased outside the United States, its territories or possessions, or Canada.
42. 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 or except as expressly covered under this Policy.

43. Spinal manipulation or adjustment.
44. Sclerotherapy for veins of the extremities.
45. Expenses for a Covered Person for the following:
    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.
46. Treatment or diagnosis of allergies, except for emergency treatment of allergic reactions.
47. Treatment, medication or hormones to stimulate growth, or treatment of learning disorders, disabilities, developmental delays or deficiencies, including therapy (unless such learning disorders, disabilities, developmental delays or deficiencies are determined by a Doctor to be due to a Mental and Nervous Disorder or except as expressly covered under this Policy).
48. Joint replacement or other treatment of joints, spine, bones or connective tissue including tendons, ligaments and cartilage, unless related to a covered Injury.
49. Expenses resulting from a declared or undeclared war or the Covered Person's commission of or attempt to commit a felony..
50. 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.
51. Payment of any claim, bill, or other demand or request for payment for health care services that the appropriate regulatory board determines were provided as a result of a prohibited referral. A “prohibited referral” means a referral prohibited under the laws of the State of Maryland.

PART VII - CLAIM PROVISIONS

Notice of Claim: Written notice of claim must be given within 31 days after a covered loss begins or as soon as is reasonably possible. The notice must be given to the Company. 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 of giving notice of claim, 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.

Proof of Loss: Written proof of loss must be given to the Company 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 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.

Our share of the recovery amount will be reduced by Our share of the Covered Person's court cost and attorney's fee.

Other Insurance: If a Covered Person is entitled to coverage under another plan providing similar coverage, We will consider benefits under this policy only after benefits are paid under all other plans. We will not pay an amount in excess of the amount that would have been paid if the Covered Person did not have another plan providing similar coverage. "Another plan providing similar coverage" will not include:

1. An individually underwritten and issued, guaranteed renewable, specified disease policy or intensive care policy, that does not provide benefits on an expense-incurred basis; or
2. Medical assistance under Maryland law for which the Covered Person is eligible.

Appeals Process

An appeal process is available for all adverse health care treatment decisions.

"Adverse determination" or "adverse health care treatment decision" means a health care treatment decision made by a health plan denying in whole or in part payment for or provision of otherwise covered services requested by or on behalf of an enrollee.

"Health care treatment decision" means a decision regarding diagnosis, care or treatment when medical services are provided by a health plan, or a benefits decision involving determinations regarding medically necessary health care, preexisting condition determinations and determinations regarding experimental or investigational services.

The Covered Person has the right to request that we review the decision through the appeal process. The appeal may be requested by the Covered Person or the Covered Person's representative. References to the Covered Person under this section mean the Covered Person or the Covered Person's authorized representative (i.e., the provider or the authorized representative may pursue the Covered Person's rights and shall receive all notices and benefit determinations). For each step in this process, there are specified time frames for filing an appeal or grievance and for notifying the Covered Person of the decision

To submit the appeal by telephone contact:

Brad Long at 1-800-447-0460.

To submit the appeal by mail, submit to:

Mr. Brad Long
Assistant Vice President, Compliance
HCC Life Insurance Company
225 Town Park Drive, Suite 350
Kennesaw, Georgia 30144

Any request for review should include the:

1. Covered Person's ID number
2. Patient's name
3. Covered Person's name
4. Nature of the appeal and any other information that may be helpful for the review

If within 5 working days after the filing date of a grievance, We do not have sufficient information to complete Our internal grievance process, We shall:

1. Notify the Covered Person or health care provider who filed the grievance on the Covered Person's behalf We may not proceed with reviewing the grievance unless additional information is provided; and

2. Assist the Covered Person and health care provider in gathering the necessary information without further delay.

The Company shall issue a final written decision to the Covered Person and, if applicable, to the Covered Person's health care provider, within 30 working days after receiving an appeal request. However, we may have an extension not to exceed 30 working days with the Covered Persons' written approval. A complaint may be filed with the Maryland Commissioner of Insurance if a grievance decision is not made within the 30 working days. Written notice of an adverse decision is required to be sent to the Covered Person within 5 working days after the decision has been made.

The final written decision issued shall:

1. State in detail in clear, understandable language the specific factual bases for Our decision;
2. Reference the specific criteria and standards, including interpretive guidelines, on which the decision was based, and will not solely use generalized terms such as "experimental procedure not covered," "cosmetic procedure not covered," "service included under another procedure," or "not medically necessary";
3. State the name, business address, and business telephone number of Our designated employee or representative who has responsibility for Our internal grievance;
4. Give written details of Our internal grievance process and procedures; and
5. Include the following information:
    a. That the Covered Person or the Covered Person's health care provider on behalf of the Covered Person has a right to file a complaint with the Commissioner within 30 working days after receipt of Our grievance decision;
    b. That a complaint may be filed without first filing a grievance if the Covered Person or a the Covered Person's health care provider filing a grievance on behalf of the Covered Person can demonstrate a compelling reason to do so as determined by the Commissioner;
    c. The Commissioner's address, telephone number, and facsimile number;
    d. A statement that the Health Advocacy Unit is available to assist the Covered Person in both mediating and filing a grievance under the carrier's internal grievance process; and
    e. The address, telephone number, facsimile number, and electronic mail address of the Health Advocacy Unit.

<u>Retrospective Denial Appeals Process</u>

The Covered Person or the Covered Person's health care provider on behalf of the Covered Person may file a grievance within 180 days after the Covered Person receives an adverse decision on the first appeal, providing the information in the same manner outlined under the Appeals Procedure above.

The Company shall issue a final written decision to the Covered Person and, if applicable, to the Covered Person's health care provider, within 45 working days after receiving the appeal

request. However, we may have an extension not to exceed 30 working days with the Covered Persons' written approval. A complaint may be filed with the Maryland Commissioner of Insurance if a grievance decision is not made within the 45 working days. Written notice is required to be issued within 5 working days after the grievance decision has been made.

Expedited Appeals:
The Covered Person has the right to an expedited review if a delay would seriously jeopardize the Covered Person's life or health or ability to regain maximum function. An expedited appeal can be initiated by the Covered Person, or the provider acting on his or her behalf.

An expedited review will be handled by an appropriate clinical peer(s) not involved in the initial decision. Expedited review shall be provided for all requests for admissions, availability of care, continued stay or health care services for a Covered Person. We will communicate the decision by phone to the Covered Person and the Covered Person's provider as soon as possible, taking into account the medical circumstances, but no later than 24 hours after receiving the request. A complaint may be filed with the Maryland Commissioner of Insurance if a grievance decision is not made within the 24-hour time period. Written notice must be provided by Us within 1 day of the date the decision has been orally communicated to the member or the Covered Person's health care provider. The Covered Person may then request all information that was relevant to the review.

Written final notice of an adverse decision will contain the same information as such notice provided during the "Appeals Process" described above.

Written final notice of a grievance decision will:

1. State in detail in clear, understandable language the specific factual bases for Our decision;
2. Reference the specific criteria and standards, including interpretive guidelines, on which the decision was based, and will not solely use generalized terms such as "experimental procedure not covered," "cosmetic procedure not covered," "service included under another procedure," or "not medically necessary";
3. State the name, business address, and business telephone number of Our designated employee or representative who has responsibility for Our internal grievance;
4. Include the following information:
    a. That the Covered Person has a right to file a complaint with the Commissioner within 30 working days after receipt of a Our grievance decision; and
    b. The Maryland Commissioner of Insurance's address, telephone number, and facsimile number.

Complaint Procedure:
The Covered Person or the Covered Person's authorized representative has the right to file a complaint with the Maryland Insurance Administration within 30 working days after receipt of a grievance decision. Such complaint may be filed without first filing a grievance if the Covered Person or the Covered Person's authorized representative can demonstrate a compelling reason to do so as determined by the Commissioner in the State of Maryland.

The Maryland Insurance Administration may be contacted by mail at the following address:

Maryland Insurance Administration
Attn: Consumer Complaint Investigation
Life and Health/Appeals and Grievance

200 St. Paul Place, Suite 2700
Baltimore, MD 21202

The Maryland Insurance Administration may be contacted by telephone or facsimile as follows:

Phone: (410) 468-2000 or 1-800-492-6116
FAX: (410) 468-2270 or (410) 468-2260 (Life and Health/Appeals and Grievance)

The Maryland Health Education and Advocacy Unit is available to assist the Covered Person or the Covered Person's authorized representative in both mediating and filing a grievance under the Company's internal grievance process.

The Health Education and Advocacy Unit may be contacted as follows:

Phone: (410) 528-1840
FAX: (410) 576-6571
Toll Free: 1-877-261-8807
E-mail: http://www.oag.state.md.us/Consumer/heau.htm

"Adverse decision" means a utilization review determination by a private review agent, Us, or a health care provider acting on behalf of Us:

1. A proposed or delivered health care service which would otherwise be covered under the Covered Person's contract is not or was not medically necessary, appropriate, or efficient; and
2. May result in noncoverage of the health care service.

An "adverse decision" does not include a decision concerning a person's status as a Covered Person.

"Compelling reason" includes showing that the potential delay in receipt of a health care service until after the Covered Person or the Covered Person's health care provider exhausts the internal grievance process and obtains a final decision under the grievance process could result in loss of life, serious impairment to a bodily function, serious dysfunction of a bodily organ, or the member remaining seriously mentally ill with symptoms that cause the member to be in danger to self or others.
In a case involving a retrospective denial, there is no compelling reason to allow a Covered Person or a Covered Person's health care provider to file a complaint without first exhausting the internal grievance process of a carrier.

"Emergency case" means a case involving an adverse decision for which an expedited review is required under Maryland law.

"Filing date" means the earlier of:

1. 5 days after the date of mailing; or
2. The date of receipt.

"Grievance" means a protest filed by a Covered Person or a health care provider on behalf of a Covered Person with Us through Our internal grievance process regarding an adverse decision concerning the member.

"Grievance decision" means a final determination by Us that arises from a grievance filed with Us under Our internal grievance process regarding an adverse decision concerning a member.

”Health care provider" means:

1. An individual who is:
    a. Licensed or otherwise authorized in Maryland to provide health care services in the ordinary course of business or practice of a profession, and
    b. A treating provider of a Covered Person; or
2. A hospital, as defined within Maryland law.

PART VIII – GENERAL PROVISIONS

Entire Contract; Changes: This policy, including any endorsements, riders and applications copies of which are attached hereto, constitute the entire contract of insurance. No change in this policy shall be valid until approved by an executive officer of the Company and unless such approval be endorsed hereon or attached hereto. No agent has authority to change this policy or to waive any of its provisions.

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.

Time Limit on Certain Defenses: After two years from the date of issue of this policy no misstatements, except fraudulent misstatements, made by the Insured in the application for this Policy shall be used to void this Policy or to deny a claim for loss incurred or disability (as defined in this Policy) after the expiration of such two-year period.

No claim for loss incurred or disability (as defined in this Policy) commencing after one (1) month – twelve (12) months from the date of issue of this policy shall be reduced or denied on the ground that a disease or physical condition not excluded from coverage by name or specific description effective on the date of loss had existed prior to the effective date of coverage of this Policy.

Misstatement of Age: If the age of any Covered Person is incorrectly stated, all amounts payable under this Policy shall be such as the premium paid would have purchased at the correct age. 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. If the age of the Covered Person is misstated and, according to the correct age of the insured, the coverage provided by this Policy would not have become effective or would have ceased before the acceptance of a premium for this Policy, Our liability is limited to the refund, on request, of the premiums paid for the period not covered by this Policy.

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.

PART IX – SCHEDULE OF BENEFITS

INSURED INFORMATION:

Name:

Policy Effective Date:

COVERAGE PERIOD:

ELIGIBILE DEPENDENTS COVERED

COVERAGE AND BENEFIT AMOUNTS:

Deductible	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 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	The rate approved by the Maryland Health Services Cost Review Commission, 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 and Substance Abuse	Outpatient Treatment: 80% of Eligible Expenses for the first 5 visits in a Benefit Period; 65% of Eligible Expenses for the

	6th through 30th visit in a Benefit Period; and 50% of Eligible Expenses for all subsequent visits in a Benefit Period.Partial Hospitalization: Maximum 60 days of Partial Hospitalization. Inpatient Treatment: Covered to the same extent as any other Sickness under this Policy.
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
Hair Prosthesis for cancer patient receiving chemotherapy or radiation	$350 Maximum
Hearing Aids for Dependent children	$1,400 per hearing aid for each hearing-impaired ear.
Hospice Care: Inpatient: Respite Care: Bereavement Counseling:	 Up to 30 days of inpatient care. Up to 14 days of Respite Care. Bereavement Counseling for up to 6 months following the Covered Person's death, or 15 visits, whichever occurs first.
All Other Eligible Medical Expenses	Usual and Customary charges
Overall Maximum Limit per Coverage Period	