Case Number:

# Payment Authorization Form

| Primary applicant name: | Requested effective date: |
|---|---|
| Lala Meat | 06/05/2017 |

| Payment Frequency | Premium |
|---|---|
| MONTHLY | $81.73 |

**Payment Type**

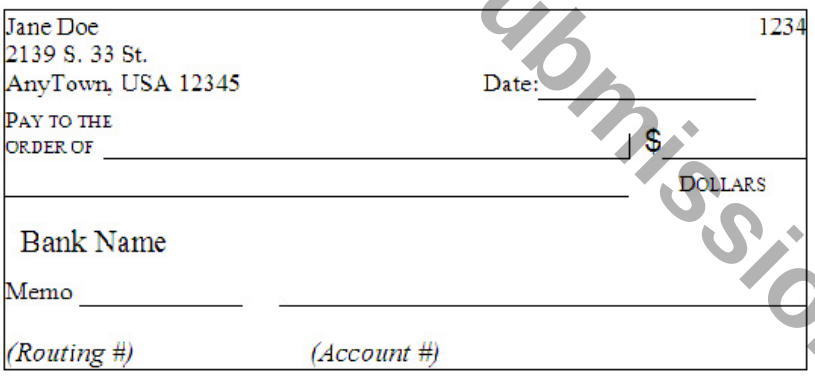
| | |
|---|---|
| ❑ Automatic Credit card payment<br>*(If elected, complete Section A and sign and date Section C)* | ❑ Automatic bank draft/ACH payment<br>*(If elected, complete Section B and sign and date Section C)* |

**A. Automatic credit card payment information and authorization**

| Card type<br>❑ MasterCard ❑ Visa ❑ Discover | Name—as it appears on the card | |
|---|---|---|
| Card Number | | Expiration date |

**B. Automatic bank draft/ACH payment information and authorization**

| Account type<br>❑ Checking ❑ Savings | Account holder name |
|---|---|
| Name of bank | Relationship to proposed insured |
| Routing number (from your check as shown below) | Account number (from your check as shown below) |






**C. Signatures**

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify the Ebix Health Administration Exchange, Inc. or its designated administrator in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted periodic payment dates fall on a weekend or holiday, I understand that the payment may be executed on the next business day. I understand that because this is an electronic transaction, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates. In the case of an ACH Transaction being rejected for Non-Sufficient Funds (NSF) I understand that the Ebix Health Administration Exchange, Inc. or its designated administrator may at its discretion attempt to process the charge again within 30 days, and agree to an additional $25.00 charge for each attempt returned NSF which will be initiated as a separate transaction from the authorized recurring payment. I acknowledge that the origination of ACH transactions to my account must comply with the provisions of U.S. law. I agree not to dispute this recurring billing with my bank so long as the transactions correspond to the terms indicated in this authorization form.

X_____ _____

Signature of account holder Date

Case Number:

# STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK

**485 Madison Avenue, New York, NY 10022**

## APPLICATION FOR INDIVIDUAL LIMITED SHORT TERM MEDICAL EXPENSE INSURANCE

### Applicant Information

| Applicant Name | Home Telephone | Work Telephone |
|---|---|---|
| Lala Meat | (123) 213-2311 | |

| Home Address | Billing Address |
|---|---|
| 123 Test St | |

| City | State | ZIP Code | City | State | ZIP Code |
|---|---|---|---|---|---|
| Next | IL | 60517 | | | |

| Marital Status | Gender | Date of Birth | Social Security Number |
|---|---|---|---|
| ☑ Single ☐ Married | ☐ Male ☑ Female | 11/11/1988 | ***-**-3123 |

E-mail Address: lalal+test@gmail.com

### Dependent Information, if applying for insurance coverage (please fill out completely) (attach separate sheet if more space is needed)

| Spouse Name (First, Middle, Last) | Date of Birth | Social Security Number | Gender |
|---|---|---|---|
| | | | ☐ M ☐ F |

| Dependent(s) Name (First, Middle, Last) | Date of Birth | Relationship | Gender |
|---|---|---|---|
| | | Child | ☐ M ☐ F |
| | | Child | ☐ M ☐ F |
| | | Child | ☐ M ☐ F |
| | | Child | ☐ M ☐ F |



### Medical Qualifying Questions

**Please answer the following medical questions for all individuals, including dependents, applying for coverage:**

Please be aware that any misstatements and omissions may be a material misrepresentation and a basis for rescission of your coverage. In the event of a rescission; (1) coverage will be void as of the Effective Date; (2) all premiums paid will be refunded; (3) any claims that have been submitted will be denied; (4) if any claims have been paid, the amount of claims paid will be deducted from any premium refund due.

| | |
|---|---|
| ☐ Yes ☑ No | 1. Will any person to be covered be eligible for a government sponsored health insurance plan (Medicare or Medicaid)? |
| ☐ Yes ☑ No | 2. Are you or is any immediate family member (whether named or not named in this enrollment form) pregnant, an expectant parent, in the process of adopting a child, or undergoing fertility treatment? |
| ☐ Yes ☑ No | 3. Are you or any person applying for coverage currently over 300 pounds if male or 250 pounds if female OR has anyone to be insured undergone weight loss or bariatric surgery? |
| ☐ Yes ☑ No | 4. WITHIN THE LAST 5 YEARS, HAS ANY PERSON LISTED ON THIS APPLICATION RECEIVED ANY MEDICAL OR SURGICAL ADVICE, CONSULTATION OR TREATMENT, INCLUDING MEDICATION, FOR:<br>• Stem cell transplant<br>• Heart disorder, heart attack, coronary artery disease or circulatory system disorder (includes by-pass or stent surgery or carotid artery disease/surgery<br>• Stroke, seizures disorder or other neurological disorder<br>• Cancer or tumor OR taking medication to prevent recurrence of cancer or tumorous growth<br>• Paraplegia, quadriplegia or multiple sclerosis<br>• Emphysema, chronic bronchitis or COPD (chronic obstructive pulmonary disease)<br>• Insulin dependent diabetes<br>• Kidney disorder other than stones and/or liver disease<br>• Degenerative arthritis (degenerative disc disease, herniated disc, rheumatoid or psoriatic arthritis or degenerative joint disease)<br>• Alcohol or drug abuse or dependency OR chemical dependency |
| ☐ Yes ☑ No | 5. Have you or any person proposed for coverage been diagnosed or treated by a Medical Professional or Medically Diagnosed for Acquired Immune Deficiency Syndrome (AIDS), AIDS-related complex, or any other immune system disorder? Answer this question "no" if you have tested positive for HIV but have not developed symptoms of the disease AIDS |

**NOTE: IF "YES" IS ANSWERED TO ANY QUESTION 1 THROUGH 5, COVERAGE CANNOT BE ISSUED**

## REQUESTED COVERAGE INFORMATION (AS ELECTED):

| Effective Date | Coverage Length | Plan | Deductible | Coinsurance Percentage | Out of Pocket Maximum |
|---|---|---|---|---|---|
| 06/05/2017 | 90 Days | Secure Bridge | $7,500 | 50% | $10,000 |

Optional Benefits: None

Replacement Question: Is this plan intended to replace your current coverage? ☐ Yes ☑ No (If "Yes", then please see replacement disclosure notice for additional information)

## FRAUD WARNING

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement, or conceals information for the purpose of misleading may be guilty of insurance fraud and subject to criminal and/or civil penalty.

## ACCEPTANCE AND ACKNOWLEDGEMENT

I hereby apply for the coverage selected on this application form. I understand that the coverage shall not become effective until this application is accepted by the insurer and the initial premium is paid. I read this application carefully and represent that the information I provided is true, correct and complete. I understand that the insurer relied on my statements and my answers to the medical history questions and it is the basis for determining the issuance or denial of coverage. I understand that any misstatement or omission may result in the denial of benefits and/or the termination of coverage.

I agree and understand that coverage will not become effective for any applicant whose medical history changes prior to that person's Effective Date such that the applicant's answer would be "yes" to any of the medical history questions in this application and agree to immediately notify the insurer of any such changes. If such person is the Applicant, I understand that coverage is automatically declined for all persons applying on this application.

I understand that health insurance benefits are excluded for pre-existing conditions and this coverage will not pay benefits for a disease or physical condition that I or another applicant may now have or have had within 5 years of the application for coverage.

I understand that the producer who solicited this application and upon whose explanation of the benefits, limitations or exclusions I relied on was retained by me as my agent and is an independent contractor who has no right to alter the application, bind or approve coverage or alter any of the terms or conditions of the policy.

I understand that cancellation of this coverage within the 10 day right to return the policy period will result in a refund of premiums only. Any administrative fees or other fees that may apply will not be refunded.

I understand that this coverage for which I am applying is not Minimum Essential Coverage as defined by the Affordable Care Act of 2010 (ACA). Even if I have this coverage, I still may be subject to the federal tax assessed against individuals without Minimum Essential Coverage.

**AUTHORIZATION TO RELEASE INFORMATION**: I authorize any health care provider, doctor, medical professional, medical facility, insurance company, pharmacy benefit manager, person or organization to release any information regarding medical, dental, mental, alcohol or drug abuse history, treatment or benefits payable, including disability of employment related information concerning the patient, excluding genetic information, to the insurer or its administrator.



## SIGNATURE

| City | State | Day | Month | Year |
|---|---|---|---|---|
| Next | IL | | | |
| Applicant Signature | Spouse Signature if applying for coverage | | | |
| Applicant Name (print) | Spouse Name (if applying for coverage)(print) | | | |

**FOR PRODUCER USE ONLY**

Are you licensed in the state where the application was completed? ☑ Yes ❒ No

Are you currently appointed with Standard Security Life Insurance Company of New York in the state where the application was completed? ☑ Yes ❒ No

By signing below, the Producer understands that commissions cannot be paid unless appointed with Standard Security Life Insurance Company of New York.

| Producer Name | | Company | | |
|---|---|---|---|---|
| Address | | City | State | ZIP Code |
| Phone | Producer Number 0056671 | E-mail Address | | |
| Producer Signature | | | Date | |

# STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK

485 Madison Ave., New York, NY 10022
(Herein called We, Our, Us or the Company)

## SHORT TERM MEDICAL EXPENSE POLICY – SSL-ISTM-POL-IL-0913
## OUTLINE OF COVERAGE

**READ YOUR POLICY CAREFULLY!** This outline of coverage provides a very brief description of the important features of your Policy. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**



**NON-RENEWABLESHORT TERM MEDICAL EXPENSE POLICY**
Policies of this category are designed to provide, to the persons insured, coverage for hospital, medical and surgical expenses you incur as a result of a covered injury or sickness. Coverage is provided for daily hospital room and board, other hospital services, hospital out-patient services, surgical services, anesthesia services, and in-hospital medical services, subject to any deductibles, coinsurance provisions or other limitations which may be set forth in the Policy.

The policy covers the following covered expenses for a covered person in connection with the treatment of a injury or sickness if the expenses are: (a) medically necessary; (b) usual reasonable & customary; (c) authorized by a doctor; d) while coverage under the policy is in force, and (e) not excluded or limited by exclusions and limitations from coverage.

Covered Expenses means Expenses for treatments, services and supplies which a Doctor recommends (1) as Medically Necessary to treat a Sickness or Injury; (2) which are Usual, Reasonable and Customary; and (3) which do not exceed any amount payable under the terms of the Policy.

All covered expenses will first be applied to the deductible unless otherwise specified in the policy. Benefits are payable after the deductible [and any applicable co-payments as set forth in the policy [has][have] been satisfied and will be subject to the coinsurance percentage, coinsurance limits]and policy maximums. The deductible, coinsurance and [co-payments] will vary depending upon the plan you selected. [Procedures and services subject to a separate co-payment are shown on the policy's schedule of benefits.] The covered person has the freedom to use any provider.

## COVERED EXPENSES

### HOSPITAL COVERED EXPENSES

1. **Hospital Room, Board and General Nursing Care** while Confined in a Hospital, not to exceed the Maximum Benefit amount shown in the Schedule. If the Hospital does not provide semi-private rooms, the Hospital Benefit will be paid at 90% of the private room billed amount. In the event a private room is Medically Necessary due to a contagious disease, we will consider the cost of the private room as a Covered Expense.

2. **Intensive or Specialized Care Unit** provided four or more hours of nursing care is being provided each day, not to exceed the Maximum Benefit amount shown in the Schedule.

3. **Emergency Room Treatment** for services, supplies and treatment, not to exceed the Maximum Benefit amount shown in the Schedule.

4. **Inpatient Miscellaneous Medical Expense Services** for services and supplies provided on an inpatient basis in a Hospital, not to exceed the Maximum Benefit amount shown in the Schedule. Miscellaneous charges do not include charges for a telephone, radio, television, extra beds or cots, meals for guests, take home items, or other items of convenience.

5. **Inpatient Doctor Visits** for treatment provided by a Physician during a Hospital confinement, not to exceed the Maximum Benefit amount shown in the Schedule.

**B. COVERED EXPENSES FOR TREATMENT , SERVICES, OR SUPPLIES**

1. **Physician Office Visits** for treatment provided by a Physician in a Physician's office, not to exceed the Maximum Benefit amount shown in the Schedule. This benefit is not payable for treatment provided by a member of your Immediate Family.

2. **Ambulatory Surgical Center or Outpatient Hospital Surgery** for treatment or services in a state-approved freestanding Ambulatory Surgical Center that is not part of a Hospital, or a Hospital Outpatient Surgery Facility, not to exceed the Maximum Benefit amount shown in the Schedule.

3. **Surgeon Services** for Covered Expenses incurred from a Physician performing surgery in either an inpatient or outpatient setting, not to exceed the Maximum Benefit amount shown in the Schedule.

4. **Services** of a Physician administering anesthetics, not to exceed the Maximum Benefit amount for Surgery shown in the Schedule.

5. **Assistant Surgeon** services for a Physician assisting in the performance of a surgery, not to exceed the Maximum Benefit amount for Surgery shown in the Schedule.

6. **Surgeon's Assistant** services for an assistant to the Physician performing the surgery, not to exceed the Maximum Benefit amount for Surgery shown in the Schedule.

7. **Complications of Pregnancy.** Treatment for Complications of Pregnancy on the same basis as any other Sickness.

8. **Cosmetic or Reconstructive Surgery (except Breast Reconstructive Surgery)**, not to exceed the Maximum Benefit amount for Surgery shown in the Schedule, for cosmetic or reconstructive surgery and complications of cosmetic procedures when services and treatment are:
   1. Incidental to or follows a covered Injury or Sickness occurring while this coverage is in force; or
   2. Performed due to a congenital defect or birth anomaly of a Covered Person born while this coverage is in force.

9. **Breast Reconstructive Surgery** for a female Covered Person who undergoes a covered mastectomy surgery while such persons coverage under this Policy is in force. Benefits payable, not to exceed the Maximum Benefit amount for Surgery shown in the Schedule include:
   1. Reconstructive surgery of the breast on which the mastectomy has been performed;
   2. Surgery and reconstruction of the other breast for the purpose of obtaining a symmetrical appearance; and
   3. Prostheses and for treatment for physical complications related to the mastectomy.

10. **Ambulance Services** for local licensed ground ambulance service, or air ambulance service within the 48 contiguous states, to the nearest Hospital qualified to treat the covered Injury or Sickness, not to exceed the Maximum Benefit amount shown in the Schedule. Such service must be Medically Necessary due to a sudden and unexpected Injury or Sickness that involves a life-threatening element.

11. **Prescription Medication** when prescribed on an inpatient basis for a covered Injury or Sickness. Outpatient Prescription Medication as shown on the Schedule of Benefits.

12. **Dental Treatment** for treatment or care required as a result of a covered Injury to a tooth that is natural, free of disease, and vital where the major portion of the tooth is present regardless of fillings or caps.

13. **AIDS** for the treatment of Acquired Immune Deficiency Syndrome (AIDS) or any complication or condition caused by, resulting from or related to AIDS or HIV, not to exceed the Maximum Benefit amount shown in the Schedule.

14. **Knee Injury or Disorder** The knee consists of the bones, muscles, cartilage, ligaments, membranes and menisci of the anterior aspect of the leg at the articulation of the femur and tibia. Coverage does not include charges incurred to diagnose or treat an injury or disorder of the knee including surgery in excess of the maximum benefit amount shown in the Schedule.

15. **Gallbladder Surgery** includes cholecystectomy and any type of surgical procedure to diagnose or treat a disorder of the gallbladder, including any condition related to or caused by a gallstone(s) in the bile duct. Surgery includes the pre-operative and post-operative visits, testing, the services of the surgeon, assistance surgeon, anesthesiologist, radiologist, pathologist, the Hospital or outpatient facility charges, and any other charges related to the surgery or complications there from, not to exceed the maximum benefit shown in the Schedule.

16. **Organ or Tissue Transplants** including bone marrow transplants, not to exceed the Maximum Benefit amount shown in the Schedule. This benefit shall include all expenses related to the transplant before the transplant is performed, for the procurement of the donor organ or tissue, including the Hospital expenses of the donor, and for follow-up care, including any complications while this coverage is in force.

    Covered Expenses do not include organ or tissue transplants which:
    1. Are animal-to-human transplants;
    2. Use artificial or mechanical organs;
    3. Are Experimental or Investigative; or
    4. Are not generally accepted by the medical community as an effective treatment for a covered Injury or Sickness.

    "Bone marrow transplant" means human blood precursor cells administered to a patient to restore normal hematological and immunological functions following ablative therapy with curative intent. Human blood precursor cells may be obtained from the patient in an autologous transplant or from a medically acceptable related or unrelated donor, and may be derived from bone marrow, circulatory blood, or a combination of bone marrow and circulator blood. If chemotherapy is an integral part of the treatment involving bone marrow implementation, it is included in the definition.

17. **General anesthesia** and associated Hospital or Ambulatory Surgical Center services in conjunction with dental care provided to Insured Persons age 6 or younger with medical conditions that require hospitalization and for disabled individuals.

## C. OUTPATIENT MISCELLANEOUS MEDICAL EXPENSE SERVICES

Outpatient Miscellaneous Medical Expenses as listed below are payable up to the Maximum Benefit amount shown in the Schedule for all services combined.

1. **Blood or Blood Plasma** and their administration, if not replaced.

2. **Artificial limbs or eyes.**

3. **Casts, non-dental splints, trusses, crutches, or non-orthodontic braces.**

4. **Equipment Rental** for a wheelchair, hospital-type bed or similar durable medical equipment. At our option, benefits may be available for purchase of such equipment, payable in monthly installments, while Your coverage remains in force under the Policy.

5. **Oxygen** for oxygen and rental of equipment for the administration of oxygen, not to exceed the purchase price of such equipment.

6. **Diagnostic Testing Services** for diagnostic tests including related professional fees, incurred on an outpatient basis. Diagnostic tests include x-rays, laboratory tests, electrocardiograms (EKGs), electroencephalograms (EEGs), nuclear medicine imaging, radioimmune assay, ultrasound/echography, computerized tomography (CT), magnetic resonance imaging (MRI), cholecystography, cytourethroscopy, endoscopy, duodenoscopy, hysterosalpingography, laparoscopy, myelography, pyelography, pancreatogrpahy, vasography, or venography.

7. **Therapy Services** for treatment provided by a physical therapist, inhalation therapist (respiratory), and speech therapist for diagnosis and Rehabilitative treatment. This benefit is not payable for treatment provided by a member of your Immediate Family.

8. **Multiple sclerosis preventive physical therapy**. Coverage is provided for Medically Necessary preventive physical therapy for a Covered Person diagnosed with multiple sclerosis. For the purposes of this section, "preventive physical therapy" means physical therapy that is prescribed by a Physician licensed to practice medicine in all of its branches for the purpose of treating parts of the body affected by multiple sclerosis, but only where the physical therapy includes reasonably defined goals, including, but not limited to, sustaining the level of function the person has achieved, with periodic evaluation of the efficacy of the physical therapy against those goals. The coverage required is be subject to the same deductible, coinsurance, waiting period, cost sharing limitation, treatment limitation, calendar year maximum, or other limitations as provided for other physical or rehabilitative therapy benefits covered by the Policy.

9. **Radiation Therapy and Chemotherapy Services** for therapeutic treatment of covered benign and malignant conditions, including charges for x-rays, radium, radioactive isotopes and chemotherapy drugs and supplies used in treatment.

10. **Clinical Breast Exam, Pap Smear and Prostate Antigen Test** for: 1) Clinical breast exam to check for lumps and other changes at least every 3 years for women at least 20 years of age but less than 40 years of age and annually for women 40 years of age or older. 2) one annual cervical cytological screening for a female Covered Person and 3) one Prostate Antigen Test (PSA) for a male Covered Person 50 years of age or older. This benefit is not subject to satisfaction of the Deductible.

11. Mammography Screening – Covered Expenses include the following screening services:

    - Low-dose mammography for all women over 35;
    - Baseline mammogram for women 35-39 and annual mammogram for women 40 years of age and older.
    - For women under 40 with a family history of breast cancer or other risk factors mammograms must be provided at an age and intervals considered medically necessary.
    - Coverage includes a comprehensive ultrasound screening of an entire breast or breasts when a mammogram demonstrates medical necessity as described.
    - Coverage includes a comprehensive ultrasound screening of an entire breast or breasts when a mammogram demonstrates medical necessity as described.
    - Coverage must be provided at no cost to the insured and shall not be applied to an annual or lifetime maximum benefit.

    When coverage is available through contracted providers and such a provider is not utilized, plan provisions specific to the use of those non-contracted providers must be applied without distinction to the coverage required and shall be at least as favorable as for other radiological examinations covered by the policy or contract.
    Covered Expenses are not subject to any cost-sharing provisions.

12. **Colorectal Cancer Screening –** Covered Expenses include benefits for colorectal cancer screening and fecal occult blood testing. Benefits are payable for testing once every 3-years for persons who are at least 50 years old. If a Covered Person is classified as high risk for colorectal cancer because such person (or a first degree family member) has a history of colorectal cancer, benefits are payable beginning at age 30. Covered Expenses are subject to the same dollar limits, Deductibles, Coinsurance, and Lifetime Maximum Benefit Amount as for any other diagnostic testing.

13. **Bone Mass Measurement –** Medically Necessary bone mass measurement and diagnosis and treatment of osteoporosis the same as any other illness.

14. **Amino acid-based elemental formulas** – coverage and reimbursement of amino acid-based elemental formulas, regardless of delivery method, for the diagnosis and treatment of i) eosinophilic disorders and (ii) short bowel syndrome when the prescribing Physician has issued a written order stating that the amino acid-based elemental formula is Medically Necessary.

15. **Vaccinations** are covered for the following:
    i. Human Papillomavirus Vaccine that is approved for marketing by the federal Food and Drug Administration.
    ii. Shingles Vaccine that is approved for marketing by the federal Food and Drug Administration if it is ordered by a Physician for a Covered Person who is 60 years of age or older.

16. **Autism Spectrum Disorder** - Benefits are payable for the Diagnosis and Treatment of Autism Spectrum Disorders for a Covered Person under 21 years of age.

This Benefit is subject to Copays, Deductibles or Coinsurance that apply to Sickness generally. This Benefit is subject to a maximum Calendar Year benefit of $36,000, but is not subject to any limits on the number of visits to a service provider. The maximum benefit is adjusted annually based on inflation.

Payments made for any care, treatment, intervention, service, or item, the provision of which was for the treatment of a health condition not diagnosed as an autism spectrum disorder, shall not be applied toward the maximum Calendar Year benefit.

For the purposes of this Benefit the following definitions apply:

**Autism spectrum disorders** means pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, including autism, Asperger's disorder, and pervasive developmental disorder not otherwise specified.

**Diagnosis of autism spectrum disorders** means one or more tests, evaluations, or assessments to diagnose whether an individual has autism spectrum disorder that is prescribed, performed, or ordered by

(A) a physician licensed to practice medicine in all its branches or

(B) a licensed clinical psychologist with expertise in diagnosing autism spectrum disorders.

**Medically necessary** means any care, treatment, intervention, service or item which will or is reasonably expected to do any of the following:

(i) prevent the onset of an illness, condition, injury, disease or disability;

(ii) reduce or ameliorate the physical, mental or developmental effects of an illness, condition, injury, disease or disability; or
(iii) assist to achieve or maintain maximum functional activity in performing daily activities.

Treatment for autism spectrum disorders shall include the following care prescribed, provided, or ordered for an individual diagnosed with an autism spectrum disorder by
(A) a physician licensed to practice medicine in all its branches or
(B) a certified, registered, or licensed health care professional with expertise in treating effects of autism spectrum disorders when the care is determined to be medically necessary and ordered by a physician licensed to practice medicine in all its branches:

(1) Psychiatric care, meaning direct, consultative, or diagnostic services provided by a licensed psychiatrist.
(2) Psychological care, meaning direct or consultative services provided by a licensed psychologist.
(3) Habilitative or rehabilitative care, meaning professional, counseling, and guidance services and treatment programs, including applied behavior analysis, that are intended to develop, maintain, and restore the functioning of an individual. Applied behavior analysis means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relations between environment and behavior.
(4)Therapeutic care, including behavioral, speech, occupational, and physical therapies that provide treatment in the following areas:
(i) self care and feeding,
(ii) pragmatic, receptive, and expressive language,
(iii) cognitive functioning,
(iv) applied behavior analysis, intervention, and modification,
(v) motor planning, and (vi) sensory processing.

The Policy contains certain exclusions and limitations as described. **EXCEPT AS SPECIFICALLY PROVIDED FOR IN THE POLICY AS SPECIFIED IN SECTION 4 – BENEFITS**, Expenses for any services, supplies, and treatment as described below will not be considered as a Covered Expense in the Policy and no benefits will be payable for such Expenses. The Policy does not provide any benefits for the following expenses:

1. Expenses for the treatment of Preexisting Conditions, as defined in the Preexisting Conditions Limitation provision;
2. Expenses incurred prior to the Effective Date of a Covered Person's coverage or incurred after the Expiration Date, regardless of when the condition originated, except in accordance with the Extension of Benefits provision;
3. Expenses to treat complications resulting from treatment, drugs, supplies, devices, procedures or conditions which are not covered under the Policy;
4. Expenses incurred for Experimental or Investigational services or treatment or unproven services or treatment;
5. Expenses for purposes to be educational;
6. Amounts in excess of the Usual, Reasonable and Customary charges made for covered services or supplies;
7. Expenses You or Your Covered Dependent are not required to pay, or which would not have been billed, if no insurance existed;
8. Expenses to the extent that they are paid or payable under another insurance or medical prepayment plan;

9. Charges that are eligible for payment by Medicare or any other government program except Medicaid;
10. Expenses for care in government institutions unless You or Your Covered Dependent are obligated to pay for such care;
11. Expenses for which benefits are paid or payable under workers' compensation or similar laws;
12. Medical expenses which are payable under any automobile insurance policy without regard to fault (does not apply in any state where prohibited);
13. 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 you on a pro-rated basis;
14. Expenses resulting from a declared or undeclared war, or from voluntary participation in a riot or insurrection;
15. Expenses incurred while engaging in an illegal occupation or during the commission, or the attempted commission, of a felony or assault;
16. Expenses for the treatment of normal pregnancy or childbirth, except for Complications of Pregnancy;
17. Charges for a Covered Dependent who is a newborn child not yet discharged from the Hospital, unless the charges are Medically Necessary to treat premature birth, congenital Injury or Sickness, or Sickness or Injury sustained during or after birth;
18. Expenses for voluntary termination of normal pregnancy, normal childbirth or elective cesarean section;
19. Expenses incurred for any drug, including birth control pills, implants, injections, supply, treatment device or procedure that prevents conception or childbirth;
20. Expenses for the diagnosis and treatment of infertility, including but not limited to any attempt to induce fertilization by any method, invitro fertilization, artificial insemination or similar procedures, whether the Covered Person is a donor, recipient or surrogate;
21. Expenses for sterilization or reversal of sterilization;
22. Expenses related to sex transformation or penile implants or sex dysfunction or inadequacies;
23. Expenses for physical exams or other services not needed for medical treatment, except as specifically covered;
24. Expenses for Prophylactic Treatment, including surgery or diagnostic testing, except as specifically covered;
25. Expenses for the treatment of mental illness or nervous disorders, including, but not limited to, neurosis, psychoneurosis, psychopathy, psychosis, attention deficit disorder, hyperactivity, or mental or emotional disease or disorder of any kind;
26. Expenses for the treatment of alcoholism or alcohol abuse, chemical dependency, substance use or drug addiction;
27. Expenses incurred in connection with programs, treatment, or procedures for tobacco use cessation;
28. Expenses resulting from suicide or attempted suicide or intentionally self-inflicted Injury, while sane or insane;
29. Expenses for dental treatment or care or orthodontia or other treatment involving the teeth or supporting structures, except as specifically covered;
30. Expenses incurred in the treatment by any method for jaw joint problems including temporomandibular joint dysfunction (TMJ), TMJ pain syndromes, craniomandibular disorders, myofacial pain dysfunction or other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the joint;
31. Expenses of radial keratotomy or correction of refractive error, eye refractions, vision therapy, routine vision exams to assess the initial need for, or changes to prescription eyeglasses or contact lenses, the purchase, fitting or adjustment of eyeglasses or contact lenses, or treatment of cataracts;
32. Expenses for routine hearing exams to assess the need for or change to hearing aids, or the purchase, fittings or adjustments of hearing aids;
33. Expenses for cosmetic or reconstructive procedures, services or supplies except as specifically covered;

34. Expenses for breast reduction or augmentation or complications arising from these procedures except as specifically covered in the Benefit section;
35. Outpatient Prescription, medications, vitamins, and mineral or food supplements, including pre-natal vitamins, or any over-the-counter medicines, whether or not ordered by a Doctor;
36. Expenses incurred in connection with any drug or other item used to treat hair loss;
37. Expenses incurred in the treatment of weak, strained, flat, unstable, or unbalanced feet, metatarsalgia, bunions, spurs, or the removal of corms, calluses or toenails, unless specifically for the treatment of a metabolic or peripheral vascular disease or for the prompt repair of an Injury sustained while coverage is in force for the Covered Person;
38. Expenses incurred in the treatment of acne, or varicose veins;
39. The Expenses of weight loss programs or diets;
40. Transportation Expenses, except as specifically covered;
41. Expenses for rest or recuperation cures or care in an extended care facility, convalescent nursing home, a facility providing rehabilitative treatment, Skilled Nursing Facility, or home for the aged, whether or not part of a Hospital;
42. Expenses for services or supplies for personal comfort or convenience, including homemaker services or supportive services focusing on activities of daily life that do not require the skills of qualified technical or professional personnel, including but not limited to bathing, dressing, feeding, routine skin care, bladder care and administration of oral medications or eye drops;
43. Expenses for services or supplies furnished or provided by a member of your Immediate Family;
44. Expenses for diagnosis or treatment of a sleeping disorder;
45. Expenses for the purchase of a noninvasive osteogenesis stimulator (bone stimulator);
46. Expenses for services or supplies of a common household use, such as exercise cycles, air or water purifiers, air conditioners, allergenic mattresses, and blood pressure kits;
47. Expenses for participating in interscholastic, intercollegiate or organized competitive sports;
48. Medical care, treatment, service or supplies received outside of the United States, Canada or its possessions;
49. Expenses for spinal manipulation or adjustment;
50. Expenses for private duty nursing services;
51. Expenses for the repair or maintenance of a wheelchair, hospital-type bed or similar durable mechanical equipment;
52. Expenses for orthotics, special shoes, spine and arch supports, heel wedges, sneakers or similar devices unless they are a permanent part of an orthopedic leg brace;
53. Expenses incurred in connection with the voluntary taking of a poison or inhaling gas;
54. Expenses incurred in connection with obesity treatment or weight reduction including all forms of intestinal and gastric bypass surgery, including the reversal of such surgery even if the Covered Person has other health conditions that might be helped by a reduction of obesity or weight;
55. Expenses for marital counseling or social counseling;
56. Expenses for acupuncture;
57. Expenses for a service or supply whose primary purpose is to provide a Covered Person with (1) training in the requirements of daily living; (2) instruction in scholastic skills such as reading and writing; (3) preparation for an occupation; (4) treatment of learning disabilities, developmental delays or dyslexia; or (5) development beyond a point where function has been demonstrably restored;
58. Expenses for replacement of artificial limbs or eyes;
59. Expenses for removal of breast implants; or
60. Expenses that do not meet the definition of or are not specifically identified under the Policy as Covered Expenses.

**PRE-CERTIFICATION PROGRAM:** This plan requires a Precertification by a Professional Review Organization prior to in-patient Hospitalization or surgery. A Covered Person must call the Professional Review Organization:

1. For elective or non-emergency Hospitalization or surgery, at least 10-days prior to the date of proposed Hospitalization;
2. Within 48-hours of an emergency admission; or
3. Within 48-hours of delivery for complicated childbirth.

Non-compliance with the Pre-Admission Certification procedure will result in a **reduction in benefits of 50%,** unless the Covered Person is incapacitated and unable to contact us. However, the reduction will not be more than $500. In such cases, the Covered Person must contact us as soon as possible. You have been provided with information and procedures necessary for Pre-Admission Certification. You may obtain more information regarding Pre-Certification and its procedures from the Company

**PRE-EXISTING CONDITIONS LIMITATION -** We will not provide benefits for any loss caused by, or resulting from, a Pre-existing Condition. **"**Preexisting Conditions**"** means any medical condition or Sickness for which:

1. Medical advice, care, diagnosis, treatment, Consultation, or medication was recommended by or received from a Doctor within the 2-years immediately prior to a Covered Person's Effective Date of coverage; or
2. Symptoms existed within the 2-years immediately prior to the Covered Persons Effective Date of coverage which would cause a reasonable person to seek diagnosis, care or treatment.

"Consultation" means evaluation, diagnosis, or medical advice was given with or without the necessity of a personal examination or visit.

**PRE-CERTIFICATION OF CARE PROGRAM**

Pre-certification is required prior to each Inpatient confinement for an Injury or Illness. Pre-certification is also required prior to receiving Outpatient chemotherapy or radiation treatment.

If the Covered Person does not comply with the Pre-certification requirements, we will only pay 50% of the benefits which would otherwise have been payable for Covered Expenses for that confinement or treatment.

**TERMINATION OF YOUR INSURANCE**

Your insurance will automatically terminate on the earliest of the following dates:

1. The date that the Policy terminates;
2. The due date of a premium payment that is not paid when due, if such payment has not been made within 31-days following such premium due date;
3. The date that we determine fraudulent statements or an intentional material misrepresentation has been made by You or with Your knowledge in filing a claim for benefits;
4. The date that You enter full-time active duty in the armed forces of any country or international organization;
5. The date You become eligible for Medicare;
6. The earlier of: (1) the Expiration Date of Your coverage; or (2) 12-months from the Effective Date of Your insurance, whichever occurs first; or
7. Date of Your death.

**II. TERMINATION OF A COVERED DEPENDENT'S INSURANCE**

A Covered Dependent's insurance will automatically terminate on the earliest of the following dates:

1. The date that the Policy terminates;
2. The due date of a premium payment that is not paid when due, if such premium payment has not been made within 31-days following such premium due date;
3. The date that insurance under the Policy is discontinued;
4. The date that we determine fraud or intentional material misrepresentation has been made by You or a Covered Dependent or with Your or a Covered Dependent's knowledge in filing a claim for benefits;
5. The date that Your insurance terminates. However, if termination is due to Your death, a Covered Dependent may elect to continue coverage beyond the original Expiration Date by making written request for such coverage and by continuing payments toward the cost of that insurance. When such an election is made, Your Covered Dependent spouse will be considered the primary insured;
6. The date You or a Covered Dependent becomes eligible for Medicare;
7. The date the Covered Dependent ceases to be eligible. However if, upon attaining any limiting age, a Covered Dependent has a handicapped condition rendering such person incapable of earning his own living and is chiefly dependent upon You or other care providers for lifetime care and supervision because of a handicapped condition that occurred before attainment of the limiting age, benefits with respect to such person may be continued on a premium-paying basis during the continuance of such incapacity up to the end of the Coverage Period, provided that we receive written proof of such incapacity within 31-days after the date on which the Covered Dependent attains the limiting age. During continuance of insurance, We have the right to require due proof of the continuance of the incapacity and to have such dependent examined by Physicians designated by Us at any time during the term of coverage. The continuance of insurance as described will cease in the event of:
    a. The termination of the Policy or the earlier of: (i) the Expiration Date of Your coverage ; or (ii) [0-364 days] from the Effective Date of Your insurance, whichever occurs first.

**Premium Payments:** All premiums are paid to Us, or if We direct, to Our authorized administrator. The first premium is due on the Effective Date. Subsequent premiums are due monthly, in advance, on the anniversary date and month of the Effective Date. Except as otherwise provided herein, all such insurance will terminate on the premium due date, except as provided in the Grace Period provision, if premiums are not paid when due.

**Premium Changes**: We will determine the premium for each Covered Person. We have the right to change premium rates on any premium due date by giving You 60-days advance written notice of such change.