



Payment Authorization Form

Primary applicant name Beberly Baez	Policy number 051731016
--	----------------------------

Payment Frequency	Initial Premium	Monthly Premium
MONTHLY	\$146.78	\$121.78

Payment Type	
<input checked="" type="checkbox"/> Automatic Credit card payment <i>(If elected, complete Section A and sign and date Section C)</i>	<input type="checkbox"/> Automatic bank draft/ACH payment <i>(If elected, complete Section B and sign and date Section C)</i>

A. Automatic credit card payment information and authorization		
Card type <input type="checkbox"/> MasterCard <input checked="" type="checkbox"/> Visa <input type="checkbox"/> Discover	Name—as it appears on the card Berberly Baez Reyes	Relationship to proposed insured Applicant
Card Number *****1947	Expiration date 2/2022	

B. Automatic bank draft/ACH payment information and authorization	
Account type <input type="checkbox"/> Checking <input type="checkbox"/> 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)

Jane Doe 2139 S. 33 St. AnyTown, USA 12345		1234
Date: _____		
PAY TO THE ORDER OF _____		\$ _____
		DOLLARS
Bank Name _____		
Memo _____		
(Routing #)	(Account #)	

C. Signatures	
<p>I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify The Loomis Company 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 I understand that because this is an electronic transaction, these funds may be withdrawn from my account as soon as the above noted periodic transaction dates.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 Loomis Company 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.</p> <p>If applicable, premium will be debited immediately following receipt of the form.</p>	
<u>X</u> <u>Beberly Baez</u> Signature of account holder	<u>03/18/2019</u> Date

INDEPENDENCE AMERICAN INSURANCE COMPANY
485 Madison Avenue, New York, NY 10022

APPLICATION FOR INDIVIDUAL LIMITED SHORT TERM MEDICAL EXPENSE INSURANCE

THIS IS NOT QUALIFYING HEALTH COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES. THE TERMINATION OR LOSS OF THIS POLICY DOES NOT ENTITLE YOU TO A SPECIAL ENROLLMENT PERIOD TO PURCHASE A HEALTH BENEFIT PLAN THAT QUALIFIES AS MINIMUM ESSENTIAL COVERAGE OUTSIDE OF AN OPEN ENROLLMENT PERIOD.

APPLICANT INFORMATION

Applicant's Name Beberly Baez			Home Telephone (863) 259-0698		Work Telephone
Home Address PO Box 210 keene			Billing Address		
City Keene	State TX	ZIP Code 76059	City	State	ZIP Code
Marital Status <input type="checkbox"/> Single <input checked="" type="checkbox"/> Married <input type="checkbox"/> Domestic Partner		Gender <input type="checkbox"/> Male <input checked="" type="checkbox"/> Female	Date of Birth 04/07/1986	Social Security Number (OPTIONAL)	
E-mail Address beberlyfernand23@ymail.com					

DEPENDENT INFORMATION, if applying for insurance coverage (please fill out completely)

Attach separate sheet if more space is needed

Spouse/Domestic Partner Name (First, Middle, Last) Fernand Ortiz	Date of Birth 07/08/1982	Social Security Number(OPTIONAL)	Gender <input checked="" type="checkbox"/> M <input type="checkbox"/> F
Dependent(s) Name (First, Middle, Last) & Relationship			Gender <input type="checkbox"/> M <input type="checkbox"/> F
			<input type="checkbox"/> M <input type="checkbox"/> F
			<input type="checkbox"/> M <input type="checkbox"/> F
			<input type="checkbox"/> M <input type="checkbox"/> F
			<input type="checkbox"/> M <input type="checkbox"/> F

REQUESTED COVERAGE INFORMATION (AS ELECTED):

Effective Date	Coverage Length	Plan Choice	Deductible	Coinsurance Percentage	Out of Pocket Maximum
03/19/2019	6 months	Connect Value	\$5,000	50%	\$10,000

Optional Developmental Delay Rider Y/N

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

Please be aware that any intentional misrepresentation of material fact may be 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.

<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	1. Will any person to be covered be eligible for a government sponsored health insurance plan (Medicare or Medicaid)?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> 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?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<p>4. HAS ANY PERSON LISTED ON THIS APPLICATION RECEIVED AN ABNORMAL TEST REPORT, MEDICAL ADVICE, OR DIAGNOSIS, CARE OR TREATMENT RECOMMENDED OR RECEIVED WITHIN THE LAST 5 YEARS FOR A CONDITION LISTED BELOW?</p> <ul style="list-style-type: none"> a) Stem Cell Transplant b) Heart Disorder, Heart Attack, Coronary Artery Disease Or Circulatory System Disorder (Includes By-Pass, Stent Surgery or Carotid Artery Disease/Surgery) c) Stroke, Seizures Disorder or Other Neurological Disorder d) Cancer or Tumor or taking medication to prevent recurrence of Cancer or tumorous growth e) Paraplegia, Quadriplegia or Multiple Sclerosis f) Emphysema, Chronic Bronchitis or COPD (Chronic Obstructive Pulmonary Disease) g) Insulin Dependent Diabetes h) Kidney Disorder other than Kidney Stones and/or Liver Disease i) Degenerative Arthritis (Degenerative Disc Disease, Herniated Disc, Rheumatoid or Psoriatic Arthritis or Degenerative Joint Disease) j) Alcohol or Drug Abuse OR Chemical Dependency k) Blood/Bleeding Disorders including but not limited to: Hemophilia, Anemia, Aplastic, Sickle Cell, Thalassemia, Hemolytic, Hemorrhagic, Agranulocytosis, Pancytopenia, Thrombocytopenia, Von Willebrand Disease, Wegener's Granulomatosis, Rare Factor Deficiencies
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	5. Have you or any person proposed for coverage been diagnosed by a member of the medical profession as having AIDS and/or has any proposed insured received treatment from a member of the medical profession for AIDS
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	6. For the medical conditions listed above, are you or any person applying for coverage currently have a pending test(s), had testing performed and have not received results, or been advised by a medical professional to have treatment, testing, or surgery that has not been performed?
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	7. Is this plan intended to replace your current coverage?

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 to the best of my knowledge and belief. 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 Fraud or intentional material misstatement (such as an omission) may result in the denial of benefits and/or the termination of coverage. I understand that any intentional misrepresentation of a material fact 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 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 in writing within the 10 day right to return the policy period will result in a refund of premiums.

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.

SIGNATURE

City Keene	State TX	Day 18	Month 3	Year 2019
Applicant Signature <i>Beberly Baez</i>		Spouse/Domestic Partner Signature if applying for coverage <i>Fernand Ortiz</i>		
Applicant Name (print) Beberly Baez		Spouse/Domestic Partner Signature if applying for coverage (print) Fernand Ortiz		

FOR PRODUCER USE ONLY

Are you licensed in the state where the application was completed? ☒ Yes ☐ No

Are you currently appointed with INDEPENDENCE AMERICAN INSURANCE COMPANY in the state where the application was completed? ☒ Yes ☐ No

By signing below, the Producer understands that commissions cannot be paid unless appointed with INDEPENDENCE AMERICAN INSURANCE COMPANY.

Producer Name AMED GARCES		Company 1 NO AGENCY		
Address 1533 ALLIGATOR ST		City ST CLOUD	State FL	ZIP Code 34771
Phone	Producer Number 0059848	E-mail Address AHMEDGARCES@GMAIL.COM		
Producer Signature <i>AMED GARCES</i>				Date 03/18/2019

INDEPENDENCE AMERICAN INSURANCE COMPANY
485 Madison Avenue, New York, NY 10022
a Delaware Insurance Company

NOTICE TO CONSUMER

Coverage start date after January 1, 2019

This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your policy might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage.

Independence American Insurance Company
LIMITED BENEFIT SHORT TERM MEDICAL EXPENSE POLICY
IAIC-ISTM-POL-TX-0913
REQUIRED 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!**

This policy is designed to provide you with limited (state category of coverage: basic hospital expense, basic medical-surgical expense or disability income protection) coverage, but it provides benefit amounts which are less than those prescribed by the insurance regulatory authority of your state as minimum benefit amounts for this type of coverage. Coverage is provided for the benefits outlined in paragraph (3). The benefits described in paragraph (3) may be limited by paragraph (4).

BENEFITS

I. WHAT IS COVERED

Subject to the Hospital Preauthorization provision, if You or a Covered Dependent incurs Covered Expenses for medical treatment, supplies or services as a result of a Sickness or Injury which occurs while coverage is in force, and after satisfaction of the Deductible, We will pay the Coinsurance Percentage for Covered Expenses incurred in excess of the Deductible up to the maximum benefit amounts as shown in the Schedule. We will pay this amount for all Covered Expenses unless otherwise noted for a specific benefit or specified as limited or excluded in the Limitations and Exclusions provision.

Covered Expenses do not include Expenses which are in excess of the maximum amounts shown in the Schedule. Expenses in excess of the maximum amounts shown in the Schedule do not apply to the Deductible or the Coinsurance Limit.

After Covered Expenses for which benefits are payable at the Coinsurance Percentage have equaled the Coinsurance Limit for a Covered Person, We will pay Covered Expenses in excess of the Coinsurance Limit at the amount shown in the Schedule for each such person while coverage is in force, but not to exceed the Lifetime Maximum Amount payable for each Covered Person.

The Deductible, Coinsurance Percentage, Coinsurance Limit and Lifetime Maximum Amount are shown in Section I of the Schedule and apply to each Covered Person and for all benefits, unless otherwise stated for a specific benefit in Section II of the Schedule.

II. COVERED EXPENSES

Covered Expenses means the Usual, Reasonable and Customary charges for the following Medically Necessary services, supplies, or treatment prescribed or provided by a Physician for a covered Injury or Sickness while coverage is in force for a Covered Person. **Covered Expenses do not include Expenses which are in excess of the maximum amounts shown in the Schedule. Expenses in excess of the maximum amounts shown in the Schedule do not apply to the Deductible or the Coinsurance Limit.**

A. 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.
6. **Mastectomy** - Coverage for inpatient care for a minimum of:
 - a. 48 hours following a mastectomy; and
 - b. 24 hours following a lymph node dissection for the treatment of breast cancer.

We are not required to provide the minimum hours of coverage of inpatient care if your Physician determines that a shorter period of inpatient care is appropriate

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. . 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 circulatory blood. If chemotherapy is an integral part of the treatment involving bone marrow implementation, it is included in the definition.

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, pancreatography, 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. **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.
9. **Mammography, Pap Smear and Prostate Antigen Test** for: 1) one low-dose mammogram for the presence of occult breast cancer; 2) one annual cervical cytological screening for a female Covered Person and 3) one Prostate Antigen Test (PSA) for a male Covered Person at least 50 years of age and is asymptomatic or a male Covered Person at least 40 years of age that has a family history of prostate cancer or another prostate cancer risk factor. This benefit is not subject to satisfaction of the Deductible.
10. **Chemical Dependency –**
When received in connection with Chemical Dependency, including treatment in a Chemical Dependency Treatment Center.
11. **Craniofacial Abnormalities (CMJ) –** Coverage is provided for Medically Necessary diagnosis and treatment due to accident; trauma; congenital defect; development defect; or a pathology of the Craniomandibular Joint Dysfunction for a Covered Dependent child under the age of eighteen (18) years on the same basis as any other Injury or Sickness, for reconstructive surgery for craniofacial abnormalities for the purpose of improving the function or to create a normal appearance of an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease. Benefits include anesthesia and treatment in a hospital or other surgical facility for an insured when, as documented by the attending physician or dentist, such care is required due to a physical or mental condition.
12. **Temporomandibular Joint Dysfunction (TMJ) -** Treatment of temporomandibular, joint dysfunction, including the jaw, or craniomandibular joint dysfunction resulting from Injury, trauma, congenital defect, or developmental defect or pathology on the same basis as any other Injury. Benefits are not provided for dental services. Treatment, when under the order of the attending physician with concurrence of the attending dentist, will include that which is performed in a hospital or surgical center for an insured due to documented physical, mental, or medical reason.
13. **Diabetes –** Diabetes self-management training, equipment and supplies for a Qualified Covered Person. A Qualified Covered Person means an individual who has been diagnosed with:

- a. insulin dependent or non insulin dependent diabetes;
- b. elevated blood glucose levels induced by pregnancy; or
- c. another medical condition associated with elevated blood glucose levels.

Diabetes equipment and supplies includes:

- a. blood glucose monitors, including those designed to be used by or adapted for the legally blind;
 - b. test strips specified for use with a corresponding glucose monitor;
 - c. lancets and lancet devices;
 - d. visual reading strips and urine testing strips and tablets which test for glucose, ketones and protein;
 - e. insulin and insulin analog preparations;
 - f. injection aids, including devices used to assist with insulin injection and needleless systems;
 - g. insulin syringes;
 - h. biohazard disposal containers;
 - i. insulin pumps, both external and implantable, and associated appurtenances, which include: (i) insulin infusion devices; (ii) batteries; (iii) skin preparation items; (iv) adhesive supplies; (v) infusion sets; (vi) insulin cartridges; (vi) durable and disposable devices to assist in the injection of insulin; and (vii) other required disposable supplies;
 - j. repairs and necessary maintenance of insulin pumps not otherwise provided for under a manufacturer's warranty or purchase agreement, and rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which shall exceed the purchase price of a similar replacement pump;
 - k. prescription medications which bear the legend "Caution: Federal Law prohibits dispensing without a prescription" and medications available without a prescription for controlling the blood sugar level;
 - l. podiatric appliances, including up to two pairs of therapeutic footwear per year, for the prevention of complications associated with diabetes;
 - m. glucagon emergency kits; and
 - n. any new or improved diabetes supplies, including improved insulin or other prescription drugs, as approved by the U.S. Food and Drug Administration and determined by the Physician as appropriate.
14. A Physician or provider who is licensed, registered, or certified in the state of Texas and who is acting within the scope of practice authorized by the practitioner's or providers' license registration or certification to provide such training must provide diabetes self-management training. Self-management training includes:
- a. Training provided to a Qualified Covered Person after the initial diagnosis of diabetes in the care and management of that condition, including nutrition counseling and proper use of diabetes equipment and supplies;
 - b. Additional training authorized on the diagnosis of a Physician or other health care practitioner of a significant change in the Qualified

- Insured Person's symptoms or condition that requires changes in the Qualified Insured Person's self-management regime; and
- c. Periodic or episodic continuing education training when prescribed by an appropriate health care practitioner as warranted by the development of new techniques and treatments for diabetes.
 - d. Coverage for diabetes self-management training provided to a Qualified Covered Person will include coverage for the following if provided on the order of a Physician, including the written order of a health care practitioner practicing under protocols jointly developed with a Physician:
 - e. A diabetes self-management training program recognized by the American Diabetes Association;
 - f. Diabetes self-management training given by a multidisciplinary team:
 - g. the non-physician members of which are coordinated by (1) a diabetes educator who is certified by the National Certification Board for Diabetes Educators; or (2) a person who has completed at least 24 hours of continuing education that meets guidelines established by the Texas Board of Health and that includes a combination of diabetes-related educational principles and behavioral strategies;
 - h. that consists of at least a licensed dietitian and a registered nurse and may include a pharmacist and a social worker; and
 - i. each member of which, other than a social worker, has recent didactic and experiential preparation in diabetes clinical and educational issues as determined by the member's licensing agency.
 - j. Diabetes self-management training provided by a diabetes education certified by the National Certification Board for Diabetes Educators; or
 - k. Diabetes self-management training in which one or more of the following components are provided:
 - l. The nutrition counseling component provided by a licensed dietitian.
 - m. The pharmaceutical component provided by a pharmacist.
 - n. Any component of the training provided by a Physician assistant or registered nurse, except that the Physician assistant or registered nurse may not be paid for providing a nutrition counseling or pharmaceutical component unless a licensed dietitian or pharmacist is unavailable to provide that component; or
 - o. Any component of the training provided by a Physician.
 - p. A person may not provide a component of a diabetes self-management training unless the subject matter of the component is within the scope of the person's practice and meets the education requirements.

15. **Colorectal Cancer Screening** – A medically recognized screening examination for the detection of colorectal cancer for males age 50 or older and at normal risk for developing colon cancer. This includes:
 - a. a fecal blood test performed annually; and
 - b. a flexible sigmoidoscopy performed every five years; or
 - c. a colonoscopy performed every 10 years.
16. **Brain Injury** – Cognitive rehabilitation therapy, cognitive communication therapy, neurocognitive therapy and rehabilitation, neurobehavioral, neurophysiological, neuropsychological, and psychophysiological testing or treatment, neurofeedback therapy, remediation, post-acute transition services, or community reintegration services necessary as a result of and related to an acquired brain injury.
17. **Serious Mental Illness** – Coverage is provided under the Policy in connection with a Serious Mental Illness if received:
 - a. while Confined in a Hospital; or
 - b. on a group or individual outpatient basis at the following facilities in lieu of a Hospital Confinement, as certified by the Physician
 - c. Psychiatric Day Treatment Facility. The facility must be accredited by the Program of Psychiatric Facilities, or its successor, of the Joint Commission on Accreditation of Hospitals. Treatment must be for not more than eight hours in any 24 hour period.
 - d. Residential treatment center for children and adolescents. The facility must be accredited as a residential treatment center by the Council on Accreditation, the Joint Commission on Accreditation of Hospitals, or the American Association of Psychiatric Services for Children.
 - e. A crisis stabilization unit.
18. **Telemedicine** – Coverage is provided for services through Telemedicine. Telemedicine means the use of interactive audio, video, or other electronic media to deliver health care. The term includes the use of electronic media for diagnosis, consultation, treatment, transfer of medical data, and medical education. The term does not include services performed using a telephone or facsimile machine.
19. **Osteoporosis** – Bone mass measurement to determine a risk of osteoporosis and fractures associated with osteoporosis for a Qualified Covered Person. Qualified Covered Person means:
 - a. a postmenopausal woman who is not receiving estrogen replacement therapy;
 - b. an individual with (1) vertebral abnormalities; (2) primary hyperparathyroidis; or (3) a history of bone fractures; and

- c. an individual who is: (1) receiving long-term glucocorticoid (steroid) therapy; or (2) being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.
20. **Child Hearing Test** – A screening test for hearing loss for a newborn child through the age of 30 days and the necessary diagnostic follow-up care related to the screening test for a newborn child through age 24 months.
21. **Phenylketonuria (PKU)** – Coverage for the formulas necessary for the treatment of PKU or other heritable diseases to the same extent as for drugs available only on the orders of a Physician.

"Heritable disease" means an inherited disease that may result in mental or physical retardation or death. "Phenylketonuria" means an inherited condition that may cause severe mental retardation if not treated.

22. **Atherosclerosis and Abnormal Artery Screening Test** for each Covered Person who is:
- a. A male older than 45 years of age and younger than 76 years of age; or
 - b. A female older than 55 years of age and younger than 76 years of age; and who:
 - a. is diabetic; or
 - b. has a risk of developing coronary heart disease, based on a score derived using the Framingham Heart Study coronary prediction algorithm, that is intermediate or higher.

This test must be performed by a laboratory that is certified by a national organization recognized by the commissioner by rule in: 1) computed tomography (CT) scanning measuring coronary artery calcification or 2) ultrasonography measuring carotid intima-media thickness and plaque.

23. **Routine Patient Costs incurred by a Qualified Individuals who participates in an Approved Clinical Trial.** A Qualified Individual who wishes to participate in an Approved Clinical Trial if covered under a Preferred Provider Benefit Plan must use an In-Network Provider in Your Network Provider Organization if an In-Network Provider is participating in the trial and the In-Network Provider accepts the Qualified Individual as a participant in the trial. However, if the Approved Clinical Trial is either conducted outside the state in which the Qualified Individual resides by an Out-of-Network Provider or there is no In-Network Provider conducting the Approved Clinical Trial and accepting the Qualified Individual in the individual's state of residence, then Routine Patient Costs will be covered as if provided by an In-Network Provider.

For the purpose of this benefit, the following definitions apply:

Approved Clinical Trial means a phase I, phase II, phase III, or phase IV Clinical Trial that is (1) conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and (2) is one of the following:

a. Federally funded trials

The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

- 1) The National Institutes of Health.
- 2) The Centers for Disease Control and Prevention.
- 3) The Agency for Health Care Research and Quality.
- 4) The Centers for Medicare & Medicaid Services.
- 5) A bona fide Clinical Trial Cooperative group or center of any of the entities described in clauses 1) through 4) above or the Department of Defense or the Department of Veterans Affairs.
- 6) A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
- 7) Any of the following in clauses a. – c. below if the following conditions are met: The study or investigation has been reviewed and approved through a system of peer review that the Secretary determines to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
 - a. The Department of Veterans Affairs
 - b. The Department of Defense
 - c. The Department of Energy; or

b. The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration; or

c. The study or investigation is a drug trial that is exempt from the investigational new drug application requirements.

Life-threatening Condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Qualified Individual means a Covered Person who meets the following conditions:

- a. The individual is eligible to participate in an approved Clinical Trial according to the trial protocol with respect to treatment of cancer or other life-threatening diseases or conditions.

b. Either:

- 1) The referring health care Provider has concluded that the Insured Person's participation in the Clinical Trial would be appropriate based upon the Insured Person meeting the conditions described in paragraph a. above; or
- 2) The Insured Person provides medical and scientific information establishing that participation in such trial would be appropriate based upon the Insured Person meeting the conditions described in paragraph a. above.

Routine Patient Costs means all items and services that are typically covered by the Policy for a Qualified Individual who is not enrolled in a Clinical Trial. Routine patient costs do not include:

- a. The investigational item, device, or service, itself;
- b. Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
- c. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

24. Childhood Immunizations – Coverage is provided for immunizations for a Covered Child from birth through the date of the Child's sixth birthday coverage for:

- diphtheria;
- haemophilus influenzae type b;
- hepatitis B;
- measles;
- mumps;
- pertussis;
- polio;
- rubella;
- tetanus;
- varicella; and
- any other immunization that is required for the child by law.

25.A medically recognized diagnostic examination for the early detection of cervical cancer for a female Covered Person 18 years of age or older. Covered Charges include a conventional pap smear screening or a screening using liquid-based cytology methods, as approved by the United States Food and Drug Administration, alone or in combination with a test approved by the United States Food and Drug Administration for the detection of the human papillomavirus.

26. Prosthetic and Orthotic Devices – Coverage is provided for:

The initial purchase of a functional prosthetic device including the professional services related to the fitting and use of the device. and

The repair or replacement of a functional prosthetic device in the event of (i) a pathologic change to the affected post-surgical appendage or site; or (ii) if the Insured Person's functional prosthetic device no longer functions properly due to circumstances other than abuse, misuse, or use in a fashion other than as intended by the manufacturer

EXCLUSIONS, LIMITATIONS, REGULATIONS

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 determined by Us to be educational except for periodic or episodic continuing education training when prescribed by an appropriate health care practitioner as warranted by development of new techniques and treatment for diabetes;
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 act or 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, autism, hyperactivity, or mental or emotional disease or disorder of any kind without demonstrable organic disease;
25. Expenses for the treatment of alcoholism or alcohol abuse, chemical dependency, substance abuse or drug addiction;
27. Expenses incurred for loss sustained or contracted in consequence of the Covered Person being intoxicated or under the influence of any narcotic unless administered on the advice of a Physician. Intoxication shall be established conclusively by a blood alcohol level of .10 or the legal limit in the state where the incident occurred, whichever is less;
28. Expenses incurred in connection with programs, treatment, or procedures for tobacco use cessation;
29. Expenses resulting from suicide or attempted suicide or intentionally self-inflicted Injury, while sane or insane;
30. Expenses for dental treatment or care or orthodontia or other treatment involving the teeth or supporting structures, except as specifically covered;
31. Expenses incurred in the treatment by any method for jaw joint problems including temporomandibular joint dysfunction (TMJ), TMJ pain syndromes, craniomandibular disorders except for reconstructive surgery for a child who is younger than 18 years of age, 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;
32. 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;
 33. Expenses for routine hearing exams to assess the need for or change to hearing aids, or the purchase, fittings or adjustments of hearing aids except as specifically provided;
 34. Expenses for cosmetic or reconstructive procedures, services or supplies except as specifically covered;
 35. Expenses for breast reduction or augmentation or complications arising from these procedures except as specifically covered in the Benefit section;
 36. Outpatient Prescriptions, medications, vitamins, and mineral or food supplements, including pre-natal vitamins, or any over-the-counter medicines, whether or not ordered by a Doctor other than for the treatment of diabetes; unless shown as included in the Schedule of Benefits;
 37. Expenses incurred in connection with any drug or other item used to treat hair loss;
 38. Expenses incurred in the treatment of weak, strained, flat, unstable, or unbalanced feet, metatarsalgia, bunions, spurs, or the removal of corns, 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;
 39. Expenses incurred in the treatment of acne, or varicose veins;
 40. The Expenses of weight loss programs or diets;
 41. Transportation Expenses, except as specifically covered;
 42. 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;
 43. 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;
 44. Expenses for services or supplies furnished or provided by a member of your Immediate Family;
 45. Expenses for diagnosis or treatment of a sleeping disorder;
 46. Expenses incurred in the treatment of Injury or Sickness resulting from participation in skydiving, scuba diving, hang or ultralight gliding, riding an all-terrain vehicle such as a dirt bike, snowmobile or go-cart, racing with a motorcycle, boat or any form of aircraft, any participation in sports for pay or profit, or participation in rodeo contests;
 47. Expenses for the purchase of a noninvasive osteogenesis stimulator (bone stimulator);

48. 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;
49. Expenses for participating in interscholastic, intercollegiate or organized competitive sports;
50. Expenses for spinal manipulation or adjustment;
51. Expenses for private duty nursing services;
52. Expenses for the repair or maintenance of a wheelchair, hospital-type bed or similar durable medical equipment;
53. Expenses for orthotics except as specifically covered, special shoes, spine and arch supports, heel wedges, sneakers or similar devices unless they are a permanent part of an orthopedic leg brace except for the treatment of diabetes;
54. Expenses incurred in connection with the voluntary taking of a poison or inhaling gas;
55. 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;
56. Expenses for marital counseling or social counseling;
57. Expenses for acupuncture;
58. 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 unless the optional developmental delay rider is in effect;
59. Expenses for replacement of artificial limbs or eyes;
60. Expenses for removal of breast implants; or
61. Expenses that do not meet the definition of or are not specifically identified under the Policy as Covered Expenses.

PRE-EXISTING CONDITIONS LIMITATION - Preexisting condition means the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment within a five year period preceding the effective date of the coverage of the Covered Person or a condition for which medical advice or treatment was recommended by a Physician or received from a Physician within a five year period preceding the effective date of the coverage of the Covered Person.

HOSPITAL PREAUTHORIZATION

PRE-AUTHORIZATION OF CARE PROGRAM

Pre-authorization is required prior to each Inpatient confinement for an Injury or Illness. Pre-authorization is also required prior to receiving Outpatient chemotherapy or radiation treatment. If the Covered Person does not comply with the Pre-authorization requirements, we will only pay 50% of the benefits which would otherwise have been payable for Covered Expenses for that confinement or treatment unless the Covered Person is incapacitated and unable to contact us. In such cases, the Covered Person must contact us as soon as possible.

To request Pre-authorization, the Covered Person or the Covered Person's attending Physician must contact the designated Pre-authorization service at least 7 days prior to each non-Emergency Inpatient Confinement or receiving Outpatient chemotherapy or radiation treatment. Emergency Inpatient confinements must be Pre-authorized within 48 hours following the admission, or as soon as reasonably possible. The Pre-authorization service may be reached by writing or by telephone between 6 a.m. and 6 p.m. central time Monday through Friday on each day that is not a legal holiday and between 9 a.m. and noon central time on Saturday, Sunday, and legal holidays. The name of the designated Pre-authorization service and instructions for requesting Pre-authorization is provided to each Eligible Person.

A patient who is an inpatient in a health care facility will be provided a pre-authorization determination within 24 hours of the request by the Physician or Provider. The Pre-authorization service will then consult with the Covered Person's attending Physician. If the Pre-authorization service concurs with the Covered Person's attending Physician with the appropriateness of the setting and Medical Necessity of the proposed treatment plan, the Pre-authorization service will notify the Covered Person not later than the second working day of the request and the Covered Person will be deemed to have complied with the Pre-authorization requirement described herein.

The Pre-authorization service may also conduct a continued stay review for any ongoing Inpatient Confinement. The continued stay review is a process of monitoring a Covered Person's progress on a daily basis to determine if the Covered Person will be discharged within the Pre-authorized number of days and to determine the appropriate number of additional days of Inpatient confinement that may be required according to the Covered Person's condition and plan of treatment. Inpatient confinements will be monitored to assure that the Covered

Person will be discharged timely. The attending Physician and the facility's utilization review nurses will be contacted to determine the progress of the Covered Person and the need, if any, for an extension of the length of stay of the Inpatient confinement. If an extension of the Inpatient confinement is not Pre-authorized for all or part of the requested day(s), the Covered Person and the attending Physician will be notified no later than the third calendar day after the date the request is received by Us.

Benefits are not paid for days of Inpatient Confinement which extends beyond the number of days deemed by the Pre-authorization service to be Medically Necessary.

If the Pre-authorization service does not concur with the Covered Person's Physician, the Pre-authorization service will so notify the Covered Person in writing no later than the third calendar day after the date the request is received by Us and the Covered Person will be deemed as not in compliance with the Pre-authorization requirement described herein.

**PRE-AUTHORIZATION IS NOT A GUARANTEE OF PAYMENT.
PAYMENT OF BENEFITS WILL BE DETERMINED IN
ACCORDANCE WITH AND SUBJECT TO ALL THE TERMS,
CONDITIONS, LIMITATIONS AND EXCLUSIONS OF THE
POLICY.**

For the purposes of this Section Pre-authorization means a screening process using established medical criteria to determine if the proposed Inpatient confinement or proposed Outpatient chemotherapy or radiation treatment is Medically Necessary and appropriate for the treatment of a covered Injury or Illness. Pre-authorization is not pre-authorization or pre-approval of coverage and does not guarantee payment of Benefits.

TERMINATION OF INSURANCE

I. 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, subject to the grace period;
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 earlier of: (1) the Expiration Date of Your coverage; or (2) 6 months from the Effective Date of Your insurance, whichever occurs first; or
6. 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 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 Covered Person;
6. 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/her 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. The continuance of insurance as described will cease in the event of the termination of the Policy or the earlier of: (i) the Expiration Date of Your coverage; or (ii) ~~6 months~~ from the Effective Date of Your insurance, whichever occurs first.

RENEWABILITY – THIS POLICY IS A SHORT TERM LIMITED DURATION POLICY AND IS NONRENEWABLE.

PREMIUM

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.

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF HEALTH INSURANCE

According to your application, you intend to lapse or otherwise terminate existing health insurance and replace it with a policy to be issued by Independence American Insurance Company. Your new policy provides ten days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

- (1) Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim may have been payable under your present policy.
- (2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.
- (3) Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.
- (4) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied.