
OHIO INDIVIDUAL BASIC INDEMNITY HEALTH INSURANCE POLICY

It is important that You understand the coverages being provided to You. Please read this Policy in its entirety.

TRIAL EXAMINATION PERIOD:

If You are not satisfied You may return this Policy to American Medical Security Life Insurance Company, P.O. Box 19032, Green Bay, WI 54307-9032, or its agent within 10 days from the date it is delivered to You. Notice given by mail and return of this policy by mail are effective on being postmarked, properly addressed and postage prepaid. The insurer must return all payments made for this policy after it receives notice of cancellation and the returned policy.

READ YOUR POLICY CAREFULLY:

This is a legal contract between the Policyholder and American Medical Security Life Insurance Company.

BY:

AMERICAN MEDICAL SECURITY LIFE INSURANCE COMPANY

**3100 AMS Boulevard
Green Bay, Wisconsin 54313**



President

TABLE OF CONTENTS

SCHEDULE OF BENEFITS	3
TERMINATION AND RENEWABILITY OF COVERAGE	7
Conversion of Medical Insurance.....	7
ADDING DEPENDENTS FOR COVERAGE	7
DEFINITIONS	8
MAJOR MEDICAL INSURANCE	13
Deductible	13
Coinsurance	13
Out-of-Pocket Expense Limit	13
Calendar Year Maximum	13
Covered Expenses.....	13
Pre-Certification	13
Ambulance	14
Biologically Based Mental Illness.....	14
Cancer Clinical Trials.....	14
Complications of Pregnancy	14
Doctor Visits in Hospital	14
Home Health Care	14
Hospice Care	15
Hospital	15
Mental Illness and Alcohol and Drug Abuse Care	15
Miscellaneous Expense	16
Newborn Care	16
Outpatient Surgical Facility	16
Preventive Care	16
Reconstructive Surgery Following Mastectomies.....	17
Skeletal Adjustment / Adjunctive Therapy / Vertebral Manipulation / Dislocation - Subluxation Services	17
Skilled Nursing Care Facility	17
Surgery.....	17
X-ray and Lab.....	18
Limitations and Exclusions.....	18
Prior Plan Extension of Coverage.....	19
Maximum Benefits Payable	19
Reduction of Benefits with Medicare.....	19
Coordination of Benefits.....	19
PREMIUMS	22
Payment of Premium.....	22
Grace Period.....	22
Premium Computation	22
Premium Rate Change	22
CLAIM PROVISIONS.....	23
Notice of Claim.....	23
Claim Form.....	23
Proof of Loss	23
Payment of Claim	23
Time of Payment of Claim	23
Assignment of Benefits	23
Physical Exam and Autopsy	23
Appeal Procedure	23
Legal Actions.....	24
Subrogation.....	25
Right of Reimbursement	25
Misrepresentation or Fraud.....	25
Right to Collect Needed Information.....	25

GENERAL PROVISIONS.....	26
Entire Contract; Changes.....	26
Incontestability	26
Choice of Service	26
Conformity with State and Federal Statutes	26
Workers' Compensation.....	26
Clerical Error; Misstatement of Age or Sex.....	26

SCHEDULE OF BENEFITS

PRECERTIFICATION PENALTY

Your failure to precertify any of the following services may result in a penalty: inpatient hospital admission; outpatient surgery; MRI; cat scan; any invasive diagnostic procedure. The penalty applies for services rendered by any hospital, doctor, or other health care provider. This penalty does not apply to satisfy any out-of-pocket expense limit.

Precertification penalty 10% of eligible charges up to a maximum of \$1,000 per confinement or occurrence including any related treatment, services, or supplies

MEDICAL INSURANCE

Benefit maximums per Insured Person:

Calendar year maximum \$50,000
Calendar year maximum - Skilled Nursing Care Facility, Home Health Care, and Hospice Care combined \$5,000
Calendar year maximum - Outpatient Prescription Drugs..... \$2,500
Lifetime maximum - Mental Illness and Alcohol and Drug Addiction \$5,000
Lifetime maximum - all Organ Transplants combined..... \$100,000
Lifetime maximum - all other conditions None

All covered expenses apply to the above calendar year maximum per Insured Person. Certain Covered Expenses are payable subject to the following benefit maximums. All of these maximums apply toward the above calendar year maximum.

Mental Illness and Alcohol and Drug Addiction Care (other than Biologically Based Mental Illness)

Inpatient..... \$2,000 combined aggregate maximum per calendar year
Outpatient..... \$550 combined aggregate maximum per calendar year
Outpatient..... \$50 eligible charge per visit

Outpatient Physical Therapy

Eligible charge..... \$40 per visit
Maximum visits per calendar year 20

Deductible and Coinsurance:

Insured Person deductible..... \$1,000 per calendar year
Family deductible..... None
Coinsurance after deductible..... 50%

Out-of-Pocket Expense Limit:

Per Insured Person..... \$5,000
Family None

Out-of-pocket expense limits do not include deductible and coinsurance amounts for prescription drugs, Mental Illness, alcohol and drug addiction care.

COVERED EXPENSES:

Doctor and professional fees-may be subject to benefit maximums in this schedule:

Doctor visit in office or at home	50% after deductible
Doctor visit in hospital.....	50% after deductible
Doctor visit in emergency room.....	50% after deductible
Surgery-primary, co-surgeon or assistant surgeon	50% after deductible
Anesthesiology	50% after deductible
Pathologist.....	50% after deductible
Radiologist.....	50% after deductible
Outpatient rehabilitation services	50% after deductible
Chemotherapy, radiation, infusion or inhalation therapy or kidney dialysis	50% after deductible
Durable medical equipment.....	50% after deductible
Injections.....	50% after deductible
Allergy vials.....	50% after deductible
Non-durable medical equipment or supplies	50% after deductible
Preventive Care	
Child wellness	50% after deductible
Calendar year maximum for birth to age one (includes a maximum benefit amount of \$75 for hearing screening)	\$500
Calendar year maximum for ages one through eight.....	\$150
Mammogram.....	50% after deductible
Maximum per visit	130% of the lowest Medicare reimbursement rate per mammogram at the time services are rendered
Limit for age 35-39.....	1 mammogram
Limit for ages 40-49.....	1 mammogram every 2 years or annually if woman has risk factors for breast cancer
Limit for ages 50-64.....	1 mammogram per calendar year
Routine pap smear	50% after deductible
Skeletal Adjustment / Adjunctive Therapy / Vertebral Manipulation / Dislocation-Subluxation Services	50% after deductible
Eligible charge.....	\$25 per visit
Maximum visits per calendar year	10

Hospital and facility charges-may be subject to benefit maximums in this schedule:

Inpatient and intensive care.....	50% after deductible per confinement
Outpatient care at a Hospital, Urgent Care Center, or Outpatient Surgical Facility	50% after deductible
Urgent Care Center	50% after deductible
Emergency room (this deductible is in addition to the Insured Person calendar year deductible - deductible waived if immediately confined)	50% after \$75 deductible
Outpatient lab tests at a Hospital, Urgent Care Center, or Outpatient Surgical Facility when no other facility services provided	50% after deductible
Outpatient x-rays at a Hospital, Urgent Care Center, or Outpatient Surgical Facility when no other facility services provided.....	50% after deductible
Skilled Nursing Care Facility.....	50% after deductible and subject to benefit maximums
Home health care	50% after deductible and subject to benefit maximums
Hospice care.....	50% after deductible and subject to benefit maximums
Inpatient Mental Illness and alcohol and drug abuse care	50% after deductible and subject to benefit maximums
Outpatient Mental Illness and alcohol and drug abuse care	50% after deductible and subject to benefit maximums
Biologically Based Mental Illness	50% after deductible
Chemotherapy, radiation, infusion or inhalation therapy, or kidney dialysis	50% after deductible
Ambulance-per transport	50% after deductible
Normal maternity and routine nursery care	None
Complications of Pregnancy.....	50% after deductible
Newborn well baby care	50% after deductible

Prescription drug benefit:

Each prescription or refill obtained at a pharmacy or by mail is covered for up to a maximum 34-day supply. A separate deductible/copay applies 50% after deductible

Each prescription for a controlled substance, whether obtained at a pharmacy or by mail, is covered for up to a maximum 34-day supply.

NOTE: Your prescription drug coinsurance amount does not apply to satisfy any out-of-pocket limit for your covered medical expenses.

Pre-existing Condition Limitation

Benefits for medical insurance are limited for any Pre-existing Condition that existed during the 6 months prior to the Insured Person's effective date. Coverage is not provided for any Pre-existing Condition until after the Insured Person has been:

1. continuously insured for 12 months under this Policy without any medical treatment for the condition; or
2. continuously insured for 12 months under this Policy.

A different date may apply to You as specified in the Pre-existing Condition definition in Your Policy. This limitation does not apply to an Eligible Individual. This limitation does not apply to a newborn or adopted child who is insured on the date of birth or placement for adoption.

Maximum Allowable Charge

The maximum allowable charge for medical and hospital benefits is the portion of any charge for services or supplies which does not exceed an amount determined by us. You may be liable to pay the difference between the actual billed amount and the maximum allowable charge. The amount of the difference cannot apply to satisfy any deductible, copay, or coinsurance provision.

TERMINATION AND RENEWABILITY OF COVERAGE

We may only discontinue Your insurance based on the earliest of these dates:

1. You fail to pay premium according to the terms of this Policy or We do not receive Your timely premium payment, subject to the Grace Period provision. See the Premiums section in this Policy;
2. You perform an act or practice that constitutes fraud, or make an intentional misrepresentation of material fact under the terms of coverage;
3. We discontinue offering all health coverage in Your state, provided We give You at least 180 days advance written notice;
4. You no longer reside, live, or work in the network service area, if You are covered by a network plan; or
5. You move to a state or country where by law We are not authorized to do business.

Insurance for Your Dependents terminates:

1. for a spouse, on the date he or she is no longer an eligible Dependent because Your marriage has legally ended; or
2. for a child, on the date the child attains a limiting age as specified in the Policy definition of Dependent.

CONVERSION OF MEDICAL INSURANCE

If medical insurance ends for reasons stated below, You have the right to apply for a conversion plan or anything required under state law. You may only convert if You were insured by the Policy for at least three months and are no longer eligible for insurance because:

1. You are no longer an eligible Dependent because the Policyholder's marriage ends due to legal separation, annulment, dissolution or divorce. See the Policy definition of Dependent;
2. You are no longer an eligible Dependent because You have attained the limiting age. See the Policy definition of Dependent; or
3. the Policyholder dies.

You cannot convert if:

1. You are covered for benefits that are at least comparable to the group Policy under:
 - a. Title XVIII of the Social Security Act, as amended or superseded;
 - b. any act of congress or law under this or any other state of the United States that duplicates coverage offered under a. above;
 - c. any policy that duplicates coverage under a. above; or
 - d. any group sickness and accident insurance providing hospital, surgical, or medical expense coverage for other than specific disease or accident only.
2. We determine You have or are eligible for other coverage similar to the conversion plan, which together results in overinsurance. We use Our own standard for overinsurance to determine this; or
3. You are eligible for Medicare.

The conversion plan will continue to apply any Pre-existing Condition limitation of this Policy, as if insurance under the Policy were still in force.

Any benefits that are optional to the group medical insurance plan from which You are converting will not be included in the conversion plan.

HOW TO APPLY

You must apply to Us for the conversion plan within 31 days from the date the insurance ends under the Policy. If You did not receive notice of the conversion privilege at least 15 days prior to the expiration of the 31 days, You will be provided an additional period of time to apply for the conversion plan. The additional period ends 15 days after You receive notice of the conversion privilege.

We do not require evidence of insurability to convert. The conversion plan is effective on the day immediately following the date this insurance ends. If Your application and first quarterly premium is postmarked after the original 31 day conversion period, Your effective date for the conversion plan is the date of the application. The plan will be issued on the type of form then being issued by Us for conversion. The first quarterly premium must be paid with the application. Premiums are based on the type of coverage and Your age on the date You convert.

ADDING DEPENDENTS FOR COVERAGE

You may only add a newborn for coverage after the effective date of this Policy. You must notify Us within 31 days of the date of birth. You must pay any additional premium to Us within that time, or coverage for the child ends on the 31st day.

DEFINITIONS

Certain words used in this Policy have special meaning, and are explained below. They appear in this Policy beginning with a capital letter.

COMPLICATION OF PREGNANCY means conditions that are separate and distinct from the condition of pregnancy but which adversely affect or are adversely affected by the pregnancy and do not include ongoing management of a difficult or high risk pregnancy. Complications of Pregnancy include, but are not limited to:

1. acute nephritis; nephrosis; cardiac decompensation;
2. post-operative or post delivery complications such as peuperal infection, wound infection or damage to the bowel or bladder;
3. missed abortion;
4. ectopic pregnancy that is terminated;
5. spontaneous termination of pregnancy occurring during a term of gestation in which there is not viable birth (this does not include voluntary or elective abortion); or
6. non-elective cesarean section necessary to preserve the life or health of the mother due to complications listed in 1. above.

Complication of Pregnancy does not include:

1. false or premature labor;
2. occasional spotting;
3. physician-prescribed rest during the period of pregnancy;
4. morning sickness;
5. hyperemesis gravidarum;
6. pre-eclampsia and similar conditions associated with the management of a difficult pregnancy not constituting a distinct complication of pregnancy; or
7. cesarean sections that are performed for obstetrical indications, including but not limited to, repeat cesarean sections, failure to progress, cephalopelvic disporportion, fetal distress, or indications not related to a diagnosis listed above as a Complication of Pregnancy.

COVERED EXPENSE means an expense, fee or charge incurred by or on behalf of an Insured Person because of Injury or Sickness and for which the Insured Person is obligated to pay. The expense is incurred on the date the service is performed or the supply is received. Covered Expense must be incurred while this coverage is in force for the Insured Person, must be Medically Necessary, will not exceed the maximum allowable charge, is not excluded from coverage, and does not exceed any maximum amount payable.

CREDITABLE COVERAGE means, with respect to an Insured Person, coverage of the Insured Person under any of the following:

1. a Group Health Plan (including but not limited to a Government Plan or Church Plan as defined under the ERISA of 1974);
2. Health Insurance Coverage (either group or individual insurance);
3. Medicare part A or part B;
4. Medicaid;
5. military-sponsored health care;
6. a medical care program of the Indian Health Service or of an Indian tribal organization;
7. a State health benefits risk pool;
8. the Federal Employees Health Benefits Program (FEHBP);
9. a public health plan as defined under the federal regulations;
10. any health benefit plan under section 5(e) of the Peace Corps Act; or
11. State Children's Health Insurance Program (S-CHIP).

Creditable Coverage does not include any of the following:

1. coverage only for accident, or disability income insurance, or any combination thereof;
2. coverage issued as a supplement to liability insurance;
3. liability insurance, including general liability insurance and automobile liability insurance;
4. workers' compensation or similar insurance;
5. automobile medical payment insurance;
6. credit-only insurance;
7. coverage for on-site medical clinics; or

8. other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits.

Creditable Coverage does not include the following if offered separately:

1. limited scope vision or dental benefits;
2. benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or
3. such other similar, limited benefits as are specified in regulations.

Creditable Coverage does not include the following if offered as independent, noncoordinated benefits:

1. coverage only for a specified disease or illness; or
2. hospital indemnity or other fixed indemnity insurance.

Creditable Coverage does not include the following if offered as separate insurance policy:

1. Medicare supplemental insurance (as defined under section 1882(g)(1) of the Social Security Act);
2. coverage supplemental to military-sponsored health care; or
3. similar supplemental coverage under a group health plan.

DEPENDENT means Your lawful spouse and unmarried child who is not yet age 26.

A child means Your child by birth, by legal adoption, or by placement for adoption. Legal adoption means You assume legal obligation to support the child by legal custody of the child, regardless if the child is not yet physically placed in Your home. Placement for adoption means You have assumed a legal obligation for total or partial support of a child in anticipation of the adoption of the child. A child's placement for adoption with a person terminates upon the termination of that legal obligation.

A child means a stepchild if the child is residing in Your home and is chiefly supported by You.

A child means a foster child if the child is residing in Your home and for whom You are legally responsible.

A child means a child over whom You have legal guardianship if the child is chiefly supported by You and permanently resides in Your home.

An unmarried child who becomes age 26 or older while insured by the plan continues to be an eligible Dependent if the child is:

1. mentally or physically handicapped; and

2. not capable of self-sustaining employment; and
3. chiefly dependent on You for support and maintenance.

For purposes of this definition, chiefly dependent means that more than 50% financial support for the child is provided by You.

DOCTOR means the following legally qualified and licensed practitioners of the healing arts: a medical physician (M.D.), osteopath, optometrist, dentist, podiatrist, clinical psychologist with a doctoral degree in psychology, nurse midwife, midwife, and other types of health care professionals who We are compelled by applicable law to recognize as legally qualified to provide a covered service or treatment.

The services rendered by the Doctor must be within the scope and limitations of the Doctor's license. The Doctor cannot be a person who ordinarily resides in the Insured Person's home or be a close relative of the Insured Person or be the Insured Person's employer or partner.

ELIGIBLE INDIVIDUAL means a person:

1. who, as of the date when such person applied for coverage under this Policy, has an aggregate of 18 or more months of continuous Creditable Coverage;
2. whose most recent prior Creditable Coverage was under a Group Health Plan, governmental plan, or church plan, and such coverage was in effect for at least one full day; and
3. who is not eligible for coverage under a Group Health Plan, Medicare parts A or B, or Medicaid, and who does not have other Health Insurance Coverage in effect, including a conversion policy; and
4. whose most recent prior Creditable Coverage was under a Group Health Plan, and the Group Health Plan was not terminated for fraud or intentional misrepresentation of material fact; and
5. whose most recent prior Creditable Coverage was not terminated for nonpayment of premium by the individual; and
6. who, if eligible for continuation coverage under COBRA or a similar state program, elected and exhausted this coverage; and
7. who had no more than a 62 day lapse during all of which the person was not covered under any Creditable Coverage. This statement means the date of application for coverage under this Policy was not later than on the 63rd day following the date when the most recent prior Creditable Coverage ended.

EMERGENCY MEDICAL CONDITION means a condition that manifests itself by such acute symptoms of sufficient severity, including severe pain, that a prudent layperson with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

1. placing the health of the Insured Person or, with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy;
2. serious impairment to bodily functions; or
3. serious dysfunction of any bodily organ or part.

EMERGENCY SERVICES means:

1. a medical screening exam, as required by federal law, that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department, to evaluate an Emergency Medical Condition;
2. such further medical examination and treatment that are required by federal law to stabilize an Emergency Medical Condition and are within the capabilities of the staff and facilities available at the Hospital, including any trauma and burn center of the Hospital.

You may access prehospital Emergency Services by utilizing the 9-1-1 system and any other telephone access systems.

ENROLLMENT DATE means, with respect to an Insured Person covered under this Policy, the date of enrollment of the Insured Person in this Policy.

FAMILY MEMBER means any person related to an Insured Person, by blood or by marriage.

GROUP HEALTH PLAN means an employee welfare benefit plan to the extent that the plan provides medical care, and including items and services paid for as medical care, to employees or their Dependents directly or through insurance, reimbursement, or otherwise.

For purposes of this definition, medical care means amounts paid for:

1. the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;
2. transportation primarily for and essential to medical care referred to in section 1. above; and
3. insurance covering medical care referred to in sections 1. and 2. above.

HEALTH INSURANCE COVERAGE means benefits consisting of medical care (provided directly, through insurance or reimbursement, or other wise and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract or health maintenance organization contract offered by a health insurance issuer.

HOSPITAL means an institution operated pursuant to law for the care and treatment of sick and injured persons. It must: maintain organized facilities for medical, diagnostic and surgical care for patients who are Hospital Confined and for which a charge is made that the Insured Person is legally obligated to pay; maintain a staff of one or more duly licensed Doctors; provide 24-hour-a-day nursing care under supervision of a registered graduate professional nurse (R.N.); has surgical facilities on its premises or has a contract with another institution with a valid license to provide for surgical services; be legally operating in the jurisdiction where it is located.

An institution which provides for care and treatment of mentally ill or mentally retarded persons is not required to have major surgery facilities on its premises if it otherwise satisfies this definition of Hospital.

Except when provided elsewhere in this Policy, Hospital does not include an institution that is principally for: rest, nursing, long-term, extended, or custodial care; convalescence; care of the aged; alcoholics; drug addicts; or runaways. Also, it does not include services rendered at a military or veteran's hospital, soldier's home or any hospital that is contracted for or operated by the federal government or any of its agencies for members or former members of the Armed Forces, unless You are legally required to pay for the services.

HOSPITAL CONFINED means the Insured Person is admitted to the facility as an overnight bed patient for a minimum of 15 consecutive hours.

INJURY means a sudden, traumatic, accidental and unanticipated damage to the body, not of gradual onset. The cause must be external, physically violent, and immediately precede the damage.

INSURED PERSON means the Policyholder or Dependent who is insured by this Policy and for whom all due premiums have been paid.

MEDICALLY NECESSARY means a medical service that satisfies all of the following requirements as determined by Us:

1. must be consistent with the diagnosis and treatment of an Injury or Sickness;
2. must be consistent in type, frequency, and duration of treatment with scientifically based guidelines of national medical, research, or health care coverage organizations or governmental agencies that are accepted by the Policy;

3. must be known to be safe, effective, and appropriate by most Doctors when the medical service is provided;
4. cannot be provided primarily for the comfort or convenience of You or Your Dependent, a Family Member, or a health care provider;
5. is demonstrated through prevailing peer-reviewed medical literature to be either:
 - a. safe and effective for treating or diagnosing the Injury or Sickness for which its use is proposed; or
 - b. safe with promising efficacy:
 - i. for treating a life-threatening Injury or Sickness (for the purpose of this definition, the term life-threatening is used to describe Injuries or Sicknesses that are more likely than not to cause death within one year of the date of the request for treatment);
 - ii. in a clinically controlled research setting; and
 - iii. using a specific research protocol that meets standards equivalent to those defined by the National Institutes of Health; and
6. is rendered in the most cost-efficient manner and type of setting appropriate for the delivery of the medical service. This means there is no other similar or alternative medical service available at a lower cost.

The fact that a Doctor has performed or prescribed a procedure or treatment or the fact that it may be the only treatment for a particular Injury, Sickness, or mental health condition does not mean that it is Medically Necessary or a Covered Expense as defined in this Policy. The definition of Medically Necessary used in this Policy relates only to coverage and differs from the way in which a Doctor engaged in the practice of medicine may define Medically Necessary.

MEDICARE means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendment of 1965, as amended.

MENTAL ILLNESS is a mental and emotional condition due to nervous, psychoneurosis, psychosis and other mental and emotional sicknesses and disorders. Mental Illness also includes anorexia nervosa and bulimia, schizophrenia and depressive disorders (including, but not limited to, manic depression).

OUTPATIENT SURGICAL FACILITY means a licensed public or private medical facility that has an organized staff of Doctors, and permanent facilities equipped and operating primarily to perform surgery. The facility must provide continuous Doctor and registered professional nursing services whenever a patient is in the facility.

Outpatient Surgical Facility includes a facility that is operated by a Hospital that provides scheduled, non-emergency and outpatient surgical care. It does not include: a Hospital emergency room; trauma center; Doctor's office; or clinic.

POLICY means this individual insurance contract under which coverage is provided to You.

POLICYHOLDER means the person who applied for this coverage as identified on the cover of this Policy.

PRE-EXISTING CONDITION means:

1. a condition for which an Insured Person was given medical care, treatment, services, medication, diagnosis, diagnostic test or consultation prior to the Insured Person's effective date of coverage; or
2. a condition which produced symptoms prior to the Insured Person's effective date of coverage. These symptoms must be distinct and significant enough to establish onset or manifestation by one of the following tests:
 - a. the symptoms would allow one learned in medicine to make a diagnosis of the disorder; or
 - b. the symptoms would cause an ordinarily prudent person to seek medical diagnosis or treatment.

Genetic information shall not be treated as a Pre-existing Condition in the absence of a diagnosis of the condition related to such information.

This Policy will waive any time period applicable to a Pre-existing Condition limitation period for the period of time an individual was previously covered by Creditable Coverage. The Creditable Coverage must have been continuous to a date not greater than 63 days prior to an Insured Person's Enrollment Date under this Policy.

A pregnancy is not considered a Pre-existing Condition for an Eligible Individual.

The Pre-existing Condition limitation does not apply to:

1. a newborn child who is insured under this Policy within 31 days from the date of birth;
2. a child who is insured under this Policy within 31 days from the date adopted or placed for adoption before attaining 18 years of age; or
3. an Eligible Individual.

Coverage for Pre-existing Conditions is limited as described in the schedule of benefits.

PRIOR PLAN means the group medical coverage plan from which the Policyholder converted to this insurance.

RENEWAL DATE means the annual calendar year anniversary date of this Policy.

SICKNESS means a disorder of an Insured Person's bodily function or structure causing physical symptoms which, if not treated, would result in deterioration of the Insured Person's health.

SKILLED NURSING CARE FACILITY means a licensed and legally operated facility to care for and treat persons recovering from Injury or Sickness that provides:

1. permanent, full-time bed facilities for its residents;
2. continuous nursing services under the supervision of a registered nurse (R.N.) or Doctor;
3. continuous Doctor services; and
4. daily clinical records for its residents.

A Skilled Nursing Care Facility is not a facility or home primarily for:

1. care of the aged;
2. treatment of alcoholism and other drug addictions;
3. treatment of mental and nervous disorders or the mentally handicapped;
4. rest, or for educational or custodial purposes;
5. community-based re-entry, transitional, or residential living.

URGENT CARE CENTER means a facility providing medical and surgical care on an outpatient basis for Emergency Services.

WE, US, OUR means the insurance company identified in this Policy.

YOU, YOUR means any Insured Person, unless the Policy language specifically refers only to the Policyholder or only to the Dependent.

MAJOR MEDICAL INSURANCE

Covered Expenses are payable by this Policy as described in this Policy.

DEDUCTIBLE

Each Insured Person is required to satisfy a deductible before this Policy pays any benefits. The deductible amount is applied each calendar year. Only Covered Expenses are applied to satisfy the deductible. The individual deductible amount is shown in the schedule of benefits.

COINSURANCE

After the deductible is satisfied, this Policy pays benefits at coinsurance levels for Covered Expenses incurred during the rest of the same calendar year. Coinsurance means the Policy pays a portion of Your Covered Expenses. The coinsurance levels are shown in the schedule of benefits.

OUT-OF-POCKET EXPENSE LIMIT

This Policy limits out-of-pocket expenses for You, or for each of Your insured family members. Out-of-pocket expenses means Covered Expenses applied to satisfy deductible and coinsurance. The out-of-pocket limit is shown in the schedule of benefits.

CALENDAR YEAR MAXIMUM

The total amount of medical benefits We will pay for any one Insured Person per calendar year while covered by this Policy is shown in the schedule of benefits as the calendar year maximum.

COVERED EXPENSES

IMPORTANT: Covered Expenses as described in this Policy must be Medically Necessary, not in excess of the maximum allowable charge as described in the schedule of benefits, are subject to the limitations and exclusions, and all other applicable terms and conditions of coverage. Benefit payments begin only after the major medical insurance deductible is satisfied as shown in the schedule of benefits.

PRECERTIFICATION

Certain medical treatment or services require Our precertification. Your medical insurance identification card indicates when this is required.

Precertification allows Us to determine if a proposed treatment or service is Medically Necessary and is covered by this Policy. Our determination is based on the information available to Us at the time of Your request.

Although We may precertify a treatment or service, it does not guarantee that the benefits will be paid. Actual benefit payment may differ based on the information submitted to Us with the claim for benefits, subject to the terms, conditions and provisions of this Policy in effect as of the date when the treatment or service was rendered.

You, Your Doctor, a Hospital, or other health care provider on Your behalf, must precertify the service or treatment with Us, in writing or by telephone, at least 72 hours prior to the date when the treatment or service is rendered.

Your ID card gives the toll-free telephone number to contact Us. We require the following information:

1. patient information including name, birth date, insured and group numbers from Your ID card;
2. diagnosis with related symptoms and their duration;
3. results of any physical exam, lab tests and x-rays;
4. treatment plan;
5. Doctor information;
6. name, address and phone number of facility providing the services;
7. proposed admission date and number of inpatient days required, if applicable; and
8. date of proposed surgery or other procedure, if applicable.

You, Your Doctor, Hospital or other health care provider who precertified for You on your behalf, will be notified by Us of Our precertification decision.

If any treatment or service must be continued beyond what We originally precertify, We require precertification at least 24 hours before the date when the treatment or service continues.

PRECERTIFICATION PENALTY

When certain treatments or services are not precertified by Us, Your benefits may be reduced by a precertification penalty. The treatments and services, and the precertification penalty amount, are shown in the schedule of benefits.

If You receive any of the treatments or services for an Emergency Medical Condition, We must be notified by phone by You, Your Doctor, a Hospital, or other health care provider on Your behalf. The notice is required within 48 hours but in no event not later than the end of the next business day following the date You receive the treatments or services. If We are not notified within the specified time, the penalty may apply.

AMBULANCE

Emergency transportation to the nearest Hospital by a professional ambulance service is a Covered Expense. Subject to Our prior approval, when an Injury or Sickness requires special care not available at a local Hospital, the benefit covers ambulance transfer to the nearest Hospital that can provide the Medically Necessary care.

BIOLOGICALLY BASED MENTAL ILLNESS

We will provide benefits for Biologically Based Mental Illness on the same basis as We pay for treatment of a Sickness.

Benefits for the diagnosis and treatment of Biologically Based Mental Illnesses are provided if both of the following apply:

1. the Biologically Based Mental Illness is clinically diagnosed by an Ohio licensed Doctor, psychologist, professional clinical counselor, professional counselor, independent social worker, or a clinical nurse specialist whose nursing specialty is mental health; and
2. the prescribed treatment is not experimental or investigational, having proven its clinical effectiveness in accordance with generally accepted medical standards.

We may require You to obtain authorization prior to treatment.

For purposes of this provision, the following definition applies:

BIOLOGICALLY BASED MENTAL ILLNESS means schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, and panic disorder, as these terms are defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

CANCER CLINICAL TRIALS

We will provide benefits for Routine Patient Care administered to You when participating in any stage of an Eligible Cancer Clinical Trial on the same basis as We pay for treatment of a Sickness. Benefits for Routine Patient Care will only be provided if the care would be considered a covered expense if You were not participating in a clinical trial.

For purposes of this provision, the following definitions apply:

ELIGIBLE CANCER CLINICAL TRIAL means a cancer clinical trial that meets all of the following criteria:

1. a purpose of the trial is to test whether the intervention potentially improves Your health outcomes;
2. the treatment provided as part of the trial is given with the intention of improving Your health outcomes;

3. the trial has a therapeutic intent and is not designed exclusively to test toxicity or disease pathophysiology;
4. the trial does one of the following:
 - a. tests how to administer a health care service, item, or drug for the treatment of cancer;
 - b. tests responses to a health care service, item or drug for the treatment of cancer;
 - c. compares the effectiveness of a health care service, item, or drug for the treatment of cancer with that of other health care services, items, or drugs for the treatment of cancer;
 - d. studies new uses of a health care service, item, or drug for the treatment of cancer;
5. the trial is approved by one of the following entities:
 - a. the National Institutes of Health or one of its cooperative groups or centers under the United States Department of Health and Human Services;
 - b. the United States Food and Drug Administration;
 - c. the United States Department of Defense;
 - d. the United States Department of Veterans' Affairs.

ROUTINE PATIENT CARE means all health care services consistent with the coverage provided in the health benefit plan or public employee benefit plan for the treatment of cancer, including the type and frequency of any diagnostic modality, that is typically covered for a cancer patient who is not enrolled in a cancer clinical trial, and that was not necessitated solely because of the trial.

COMPLICATIONS OF PREGNANCY

The benefit provides coverage for Complications of Pregnancy, payable on the same basis as any covered Sickness. Benefits are only payable for charges incurred after the onset of the Complication of Pregnancy.

Pregnancy includes resulting childbirth.

Covered expenses for Complications of Pregnancy include expenses that would have been incurred if there had been a normal delivery without complications.

DOCTOR VISITS IN HOSPITAL

When You are Hospital Confined, this benefit pays for Medically Necessary Doctor visits other than those directly related to surgery.

HOME HEALTH CARE

Home health care is a Covered Expense under this Policy. Care must begin within 14 days after discharge from a Hospital or Skilled Nursing Care Facility confinement. Your Doctor must certify the care as Medically Necessary, instead of Hospital confinement or confinement in a Skilled Nursing Care Facility.

The home health care services and supplies are covered when provided on a part-time basis at Your home. They must be rendered by a licensed provider who is not a Family Member, and are provided upon an established home health care plan.

The calendar year maximum amount payable for the Skilled Nursing Care Facility, Home Health Care, and Hospice Care combined is shown in the schedule of benefits.

An established home health care plan includes:

1. care by or under supervision of a registered or licensed vocational nurse;
2. physical, occupational, respiratory or speech therapy;
3. medical social work, nutrition and home health aide services;
4. medical appliances and equipment, and lab services. These items are Covered Expenses when payable if You were otherwise confined.

Up to four consecutive hours of home health care is considered as one home care visit in any 24-hour period.

HOSPICE CARE

Hospice care is a Covered Expense when provided in lieu of all other care to treat a terminal Sickness. A terminal Sickness means You have six months or less to live.

The calendar year maximum amount payable for the Skilled Nursing Care Facility, Home Health Care and Hospice Care combined is shown in the schedule of benefits.

The facility or agency providing hospice care must be licensed on its own or as part of another facility. It must operate under direction of a Doctor. It must meet standards of the National Hospice Organization or similar standards. It must also:

1. have a full-time administrator and an on-going quality assurance program;
2. keep clinical records of patients;
3. have a Doctor on call at all times;
4. provide nursing services at all times, supervised by a Doctor or registered nurse;
5. provide service by a licensed social services coordinator;
6. be furnished in a licensed facility or in Your home, and before the care begins, Your Doctor must certify the hospice care plan as Medically Necessary;
7. be agreed upon in writing by Your Doctor and the hospice agency; and
8. be to meet Your medical and social needs.

Covered Expenses include:

1. room and board at a hospice facility;
2. services and supplies at a facility or Your home;
3. part-time nursing care and home health aide services up to eight hours a day;
4. consultation and case management services by a Doctor;
5. physical therapy; and
6. medical supplies and prescribed drugs and medicines.

Covered Expenses do not include: private or special duty nursing; care not for pain control or to manage acute or chronic symptoms; funeral arrangements; any financial or legal counseling; companion, homemaker or housekeeping services; voluntary services that are otherwise free; and counseling by Your church pastor or minister.

HOSPITAL

Room and board charges for Hospital confinement are payable up to the Hospital's daily ward or semi-private room rate. The daily benefit payable for confinement in a Hospital with single-bed rooms only is the maximum allowable charge for a semi-private room in the geographic area. Confinement in an intensive care or coronary care room is only covered up to three times the Hospital's average semi-private room rate not in excess of the maximum allowable charge.

Coverage is provided for miscellaneous services and supplies rendered by the Hospital on its own behalf. This coverage includes charges for radiology, pathology, x-ray exams and lab tests made by a Doctor for services rendered while You are Hospital Confined. These charges include x-ray, radon, radium and radioactive isotope therapy. The charges are covered under the Hospital Benefit, whether billed directly by the Hospital or separately by the Doctor.

Outpatient services rendered by the Hospital are payable by this Policy. These include services and supplies for:

1. pre-admission testing that is performed within seven days before Hospital confinement, and the tests are acceptable to the Hospital, in lieu of tests while Hospital Confined. The testing is covered even if the results are negative, no bed is available, or the Doctor prescribes other treatment;
2. Emergency Services for accidental Injury, or for treatment of a sudden and unexpected medical condition including, but not limited to, a heart attack, cardiovascular accident, poisoning, loss of consciousness or breathing;
3. chemotherapy, inhalation therapy, or radiation therapy ordered by Your Doctor and is regularly scheduled at the Hospital outpatient facility; or
4. non-emergency surgery ordered by Your Doctor.

MENTAL ILLNESS AND ALCOHOL AND DRUG ABUSE CARE

The maximum amounts payable for Mental Illness and alcohol and drug abuse care are shown in the schedule of benefits.

MISCELLANEOUS EXPENSE

These items are payable as Covered Expenses by this Policy:

1. Doctor home and office calls;
2. drugs and medicines which by law require written prescription by a Doctor and are dispensed by a licensed pharmacy, but do not include routine injection of drugs or immunizations. See the schedule of benefits for the calendar year maximum on outpatient prescription drugs;
3. services of a licensed, qualified physical therapist who is not a Family Member or who does not reside with the Insured Person. The services are covered only when ordered by the Insured Person's attending physician, are Medically Necessary, and are rendered for acute, traumatic Injury or functional defect when the Insured Person is not Hospital Confined. The limits on outpatient physical therapy are shown on the schedule of benefits;
4. oxygen and rental of equipment for its administration, including IPPB (Intermittent Positive Pressure Breathing) equipment;
5. devices implanted by surgery into a body cavity, to aid function of an internal organ, but only subject to prior approval by Us;
6. rental (but not repairs) of a non-motorized wheelchair, hospital bed, or other durable medical equipment, the benefit not to exceed the total purchase price of the item. The item is only covered if it is needed for therapeutic use and: can withstand repeated use; is normally used only for medical reasons; and is not of general use except to treat an Injury or Sickness;
7. first-time replacement of a natural limb or eye lost while You are insured by this Policy, or replacement due to pathological change. The replacement cost is a Covered Expense only when You incur the expense while insured by this Policy;
8. first-time replacement of natural teeth lost because of Injury that happens while You are insured by this Policy. The replacement cost is a Covered Expense only if incurred within six months of the accident;
9. casts other than impressions, surgical dressings, trusses, splints and braces (other than orthodontic braces and splints to the teeth), and crutches when prescribed or ordered by a Doctor;
10. these supplies prescribed by Your Doctor: catheters; colostomy bags, rings and belts; flotation pads; needles and syringes;
11. initial contact lenses or eyeglasses after cataract surgery if prescribed by Your Doctor and the surgery is performed while You are insured under this Policy;
12. Urgent Care Center treatment for accidental Injury or for Sickness.

NEWBORN CARE

If You, the Policyholder, have family coverage in force on the date a child is born to You, Covered Expenses are only payable for sick baby care. It is important that You carefully read the Adding Dependents for Coverage section in this Policy. Your failure to follow procedures may result in denial of benefits for the newborn child.

Sick baby care includes charges for the following:

1. Injury and Sickness;
2. Medically Necessary care to treat diagnosed birth defects and abnormalities;
3. surgery to repair or restore a body part to normal function; and
4. plastic or cosmetic surgery, but it is limited only to the following:
 - a. reconstruction because of Injury, infection, or other disease of a body part; or
 - b. correction of a functional defect caused by congenital disease or anomaly.
5. orthodontic and oral surgery treatment for cleft lip and cleft palate.

OUTPATIENT SURGICAL FACILITY

If You have surgery done at an Outpatient Surgical Facility, those charges are Covered Expenses. Coverage is provided for miscellaneous services and supplies rendered by the facility on its own behalf. This includes charges made by a Doctor for services rendered while You are at the facility, for x-rays and lab tests, and for radiology and pathology. The charges are covered by this benefit, whether billed directly by the facility or separately by the Doctor.

PREVENTIVE CARE

For purposes of this provision, the following definition applies:

PREVENTIVE CARE means services rendered for child wellness, mammograms and pap smears.

Covered Expenses for Preventive Care are payable, on an outpatient basis only, for the following services:

1. Doctor charges; and
2. diagnostic x-ray and lab charges.

Covered Expenses are payable for each Insured Person up to the calendar year maximum benefit amount shown in the schedule of benefits for the child wellness benefit.

Covered Expenses for Preventive Care benefits are payable subject to the deductible and coinsurance as shown in the schedule of benefits.

The benefits under this section are not subject to the Medically Necessary limitations.

RECONSTRUCTIVE SURGERY FOLLOWING MASTECTOMIES

Coverage will be provided in a manner determined in consultation with the attending physician and the patient for any covered person who is receiving benefits in connection with a mastectomy, who elect breast reconstruction for:

1. reconstruction of the breast on which the mastectomy has been performed;
2. surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Coverage is subject to any applicable deductibles, copayments, plan maximums and coinsurance.

SKELETAL ADJUSTMENT / ADJUNCTIVE THERAPY / VERTEBRAL MANIPULATION / DISLOCATION -SUBLUXATION SERVICES

Covered Expenses include charges for therapeutic restoration of an abnormal function of the nerve system by manipulation and treatment of structures of the human body. Covered charges include but are not limited to manipulation and treatment for structural imbalance, distortion, dislocation, misplacement, or subluxation of vertebrae of the spinal column. This benefit is payable up to the eligible charge per visit and up to the maximum number of visits per calendar year as shown on the schedule of benefits.

SKILLED NURSING CARE FACILITY

Benefits are payable when You are confined to a Skilled Nursing Care Facility because of a covered Injury or Sickness. Benefits include Covered Expenses that are Medically Necessary while You are confined in a Skilled Nursing Care Facility.

Your condition must require skilled nursing care. Confinement in the Skilled Nursing Care Facility must be Medically Necessary and You must continue to be under a Doctor's care while confined.

The calendar year maximum amount payable for the Skilled Nursing Care Facility, Home Health Care, and Hospice Care combined is shown on the schedule of benefits.

SURGERY

Doctor surgery charges are payable wherever performed. Doctor charges for post-operative care are included with the amount payable for the surgery. This benefit covers services rendered by an assistant surgeon, but payment for the surgical procedure is limited to 20% of all Covered Expenses made by the surgeon performing the operation. Charges to administer anesthesia are also covered by this benefit.

This benefit covers charges to obtain a second surgical opinion. If the second opinion differs from Your Doctor's opinion, the benefit also covers charges for a third opinion. The Doctor giving the opinion must be a specialist for Your condition, not be financially

associated with Your Doctor, and not perform the surgery.

When multiple surgical procedures are done at the same time, Covered Expenses include the maximum allowable charge for the first or major procedure, and one-half of the maximum allowable charge for each additional procedure. No benefit is payable for incidental surgical procedures, such as an appendectomy performed during gall bladder surgery.

Surgery includes an endoscopic procedure, treatment of fracture and reduction of a dislocation.

Covered charges under this surgery benefit include:

1. heart valve replacement;
2. implantable prosthetic lenses for cataracts;
3. prosthetic bypass; or
4. replacement vessels.

The Surgery Benefit covers transplant surgery for a recipient who is covered under this Policy, but only subject to prior approval by Us. Covered transplant surgeries are:

1. heart;
2. heart and lung;
3. lung;
4. liver;
5. kidney;
6. bone marrow;
7. pancreas; and
8. cornea.

No other organ transplants are covered.

If the organ is donated from a living person, this benefit will pay for Covered Expenses incurred by that donor, but only if that person has no coverage for this type of expense under any type of insurance or government program. Covered Expense does not include transplant of an artificial organ.

The charges covered under these organ transplants are the initial testing and diagnosis; immunosuppressant drug therapy, before and after surgery; complications resulting from surgery organ rejection/failure; and repeat transplants of the same organ.

ORAL SURGERY

Benefits for oral surgery are limited to these procedures only:

1. excision of tumors and cysts of the jaw, cheeks, lips, tongue, roof and floor of the mouth when the conditions require a pathological exam;

2. surgery required to correct accidental injury of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
 3. reduction of fractures and dislocation of the jaw;
 4. external incision and drainage of cellulitis;
 5. incision of accessory sinuses, salivary glands or ducts; and
 6. frenectomy, which is cutting the midline tongue tissue.
5. experimental or investigational treatments or services unless otherwise stated in the Policy;

X-RAY AND LAB

Charges are covered for x-ray and diagnostic lab procedures performed while You are not Hospital Confined. Included are charges for radiology and pathology to interpret the tests or studies. This benefit covers x-ray, radium, and radioactive isotope therapy when You are not Hospital Confined.

The above procedures and therapy must be ordered by Your Doctor.

LIMITATIONS AND EXCLUSIONS

Policy benefits are subject to limitations and exclusions described below. This Policy does not cover:

1. services, treatment, and supplies that are:
 - a. not Medically Necessary;
 - b. not prescribed by a Doctor or for services, treatment or supplies not shown as covered;
 - c. furnished by a department or agency of the United State government. This exclusion will not apply to a non-service connected Sickness of a veteran of the United States Armed Forces who does not have a service connected Sickness;
 - d. eligible for payment by a government or charitable program, except as required by law;
 - e. charged in excess of the maximum allowable charge;
 - f. provided free of charge if You did not have this insurance;
 - g. provided for which the Insured Person is not legally obliged to pay, and
 - h. rendered after Your insurance is terminated;
2. Sickness arising out of, or in the course of employment for wages or profit.
3. Injury and Sickness that results from participation in any assault, unlawful act, strike, civil disorder or riot; caused by an act of war, whether declared or undeclared;
4. charges resulting from any suicide, attempted suicide or intentionally self-inflicted Injury or Sickness while sane or insane unless such act is the result of an underlying medical condition;

6. for any cosmetic surgery, except as stated in the plan or required to restore a part of the body that has been altered as a result of an accidental Injury or Sickness;
7. blood or blood plasma which has been replaced;
8. recreational or educational therapy or vocational therapy;
9. custodial care; services by a Family Member or by someone who ordinarily resides with You or by Your employer or partner;
10. for examination, treatment or surgery of the teeth, gums or direct supporting structure, except for repair of Injury to sound natural teeth (including their replacement), as a result of an accidental bodily Injury. Treatment must be given within ninety (90) days of the date of the accident;
11. for surgery of the jaw or for any treatment of temporomandibular joint (TMJ) disorder; treatment of jaw fractures and removal of tumors of the jaw will not be subject to this exclusion;
12. charges due to a Pre-existing Condition. This limitation relates only to conditions treated during the six months immediately preceding the effective date of insurance under this Policy. Benefits will be paid for charges incurred after the end of the period of twelve (12) consecutive months while the person is insured under this Policy. This exclusion does not apply to Eligible Individuals;
13. eye refractions, eye glasses or contact lens including fitting or examinations; eye surgery, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring), including but not limited to radial keratotomy; hearing exams, hearing aids and their fitting;
14. sex change operations and complications from that surgery; fertility or infertility studies, diagnostic testing, advice, consultation, examination, medication, or any treatment related to or connected in any way with the restoration or enhancement of fertility or the inability to conceive or conception by artificial means, including, but not limited to, in-vitro fertilization or embryo transfer; elective abortion; voluntary sterilization; reversal procedures of sterilization; contraceptives, infertility drugs, and growth hormones;
15. treatment of obesity, morbid obesity or for weight reduction purposes;
16. normal childbirth, normal pregnancy or routine nursery care (except as provided in the Schedule of Benefits); elective cesarean section or voluntarily induced abortion;

17. treatment for speech or occupational therapy and related diagnostic testing if the therapy or testing is in connection with or related in any way to the treatment of a learning disability, speech impediment, or developmental delay even though therapy is recommended due to organic dysfunction, including, but not limited to, congenital deformity or birth trauma, except as allowed under covered charges;
18. treatment of weak, strained or flat feet; treatment of instability or imbalance of the feet; treatment of corns, calluses or toenails, except when necessitated for peripheral vascular disease or other Sicknesses of similar medical seriousness;
19. charges for transportation, except local, to or from a Hospital, by professional ground ambulance services;
20. surrogate pregnancy;
21. services or supplies prohibited by law;
22. treatment of complications arising from or connected in any way with a surgical or medical treatment or procedure that is not a Covered Expense under the terms of this Policy, whether or not the Insured Person was insured under this Policy at the time the non-covered treatment or procedure was performed;
23. routine physical or premarital examinations except as may be covered under the child wellness benefit; mammograms and pap smears are covered;
24. replacement of artificial limbs and eyes;
25. treatment or services which are not generally accepted medical practices in the United States for a given Sickness;
26. treatment of sexual dysfunction or inadequacies, including, but not limited to, impotence and the implantation of a penile prosthesis;
27. a private room in excess of the average semi-private room and board rate; and
28. donation of any body organ by an Insured Person.

PRIOR PLAN EXTENSION OF COVERAGE

This coverage will reduce its benefits payable by any amount that continues to be payable by the Prior Plan under any extension of benefits.

MAXIMUM BENEFITS PAYABLE

During the first year You are insured by this coverage, this insurance together with any benefits payable by the Prior Plan will not exceed the total benefits payable as if the Prior Plan was still in force.

REDUCTION OF BENEFITS WITH MEDICARE

If You are enrolled in Medicare Part B, We will reduce payment for medical Covered Expenses by the amount that is paid by Medicare.

COORDINATION OF BENEFITS

Coordination of Benefits is the procedure used to pay health care expenses when a person is covered by more than one plan. This plan follows rules established by law to decide which plan pays first and how much the other plan must pay. The objective is to make sure the combined payments of all plans are no more than the total Allowable Expenses.

Allowable Expenses means the cost of a Medically Necessary health care service, including deductible, coinsurance, and copayments, that is covered by this plan. An expense or service, or any portion of an expense or service, that is not covered by this plan is not an Allowable Expense. For example, an Allowable Expense does not include any amount over the maximum allowable charge.

When You or Your Family Members are covered by another group or individual plan in addition to this one, We will follow the rules outlined in this Coordination of Benefits provision of Your Policy to determine which plan is primary and which is secondary. You must submit all bills first to the primary plan. The primary plan must pay its full benefits as if You had no other coverage. If the primary plan denies the claim or does not pay the full bill, You may then submit the balance to the secondary plan.

PLANS THAT DO NOT COORDINATE

This plan will provide benefits without regard to benefits paid by the following kinds of coverage:

1. Medicaid;
2. group hospital indemnity plans that pay less than \$100 per day;
3. school accident coverage; or
4. some supplemental sickness and accident policies.

HOW THIS PLAN PAYS AS PRIMARY

When We are primary, We will pay the full benefit allowed by Your Policy as if You had no other coverage.

HOW THIS PLAN PAYS AS SECONDARY

When We are secondary, the sum of the benefits payable under this plan and any other plans included under this provision will not exceed 100% of the Allowable Expenses. In no event will We pay more than We would have paid had We been primary.

We will pay only for health care expenses that are covered by this plan.

We will pay only if You have followed all of Our procedural requirements.

We will pay no more than the Allowable Expenses for the health care involved. If Our Allowable Expense is lower than the primary plan's, We will use the primary

plan's allowable expense. That may be less than the actual bill.

WHICH PLAN IS PRIMARY

To decide which plan is primary, We have to consider both the coordination provisions of this plan and the other plan and which member of Your family is involved in a claim. The primary plan will be determined by the first of the following that applies:

1. **Non-Coordinating Plan**
If the person is covered under another group plan that does not coordinate benefits, the other plan will always be primary.
2. **Employee, Member or Subscriber**
The plan that covers the person as an employee, member or subscriber (not as a Dependent) is the primary plan. Except, a plan covering the person as a Dependent is the primary plan and a plan covering the person as an employee, member or subscriber is the secondary plan when:
 - a. the person is a Medicare beneficiary;
 - b. Medicare is primary to the plan covering the person as the employee, member or subscriber; and
 - c. Medicare is secondary to the plan covering the person as a dependent.
3. **Children and the Birthday Rule (Not children of divorced or separated parents)**
When this plan and a spouse's plan cover the same child as a Dependent, We follow the birthday rule. The birthday rule is:
 - a. the plan of the parent with the first birthday in a calendar year is primary for the child. For example, if Your birthday is in January and Your spouse's birthday is in March, Your plan is primary;
 - b. if both parents have the same birthday, the plan that covered a parent longer is the primary plan and the plan that covered the other parent for a shorter time is secondary.
4. **Children (Parents Divorced or Separated)**
 - a. If the court decree makes one parent responsible for health care expenses, that parent's plan is primary.
 - b. If the court decree gives joint custody and does not mention health care expenses, We will follow the birthday rule.
 - c. If neither a. nor b. applies, the order of benefits will be:
 - i. the plan of the parent with custody of the child;
 - ii. the plan of the spouse of the parent with custody of the child;

iii. the plan of the parent not having custody of the child; and

iv. the plan of the spouse of the parent not having custody of the child.

5. **Laid Off or Retired Employee**
A plan that covers the person as an employee, who is not laid off or retired, or as a Dependent of that employee is primary to a plan that covers that person as a retired or laid off employee or as the retired or laid off employee's Dependent. If the other plan's coordination of benefit provision does not include this rule and as a result the plans do not agree to the order of benefits, this rule will be ignored.
6. **Continuation of Coverage**
If the person has continuation coverage under federal or state law and is also covered under another plan, the plan covering the person as an employee, member or subscriber or as the Dependent of the employee, member, subscriber is primary and the continuation of coverage plan is secondary.
7. **Length of Coverage**
A plan covering the person as an employee, member or subscriber for the longer period of time is primary to a plan that has covered the person for a shorter period of time. The time covered under a plan is measured from the person's first date of coverage under the plan, in spite of any benefit changes.
8. **Other Situations**
If none of the preceding rules determine the primary plan, the Allowable Expenses will be shared equally between the plans.

COORDINATION DISPUTES

If You believe that We have not paid a claim properly, You should first attempt to resolve the problem by contacting Us. If You are still not satisfied and You are an Ohio resident, You may call the Ohio Department of Insurance at (614) 644-2673 or (800) 686-1526 for instructions on filing a consumer complaint. If You are a non-Ohio resident, You may call Your state Department of Insurance for instructions on filing a consumer complaint.

RIGHT TO NECESSARY INFORMATION

We may require information to apply coordination of benefits. To do this, We reserve the right to release or obtain from any insurance company, organization, or person any information We need, without Your consent. At Our request, You will furnish Us with the information We need.

FACILITY OF PAYMENT

If another plan pays benefits, but this plan would have been primary according to the Which Plan is Primary section in the Policy, this plan will make the proper benefit adjustment. We reserve the right to pay the amount We determine to be warranted. The amount We pay is then considered a benefit payment by this plan. We are fully discharged from liability under this plan to the extent of that payment.

RIGHT OF RECOVERY

We reserve the right to recover any amount of benefit for an allowable expense under this plan if the amount We pay exceeds the amount We are required to pay under the Coordination of Benefits provision in the Policy. We also reserve the right to recover any amount of benefit that was paid in error. This right applies to Us against any person to, for, or with respect to whom Our payment was made and any other insurance company or organization that, according to this section, owes benefits for the same allowable expense under the other plan. We alone will determine against whom this right applies.

PREMIUMS

PAYMENT OF PREMIUM

The first premium is due on the effective date. Each premium thereafter is due on the first day of each coverage month. Premiums are payable to the date of termination.

A premium is considered due and payable on its due date. If prior to a due date We receive written notice that insurance will terminate prior to the due date, then no premium is due on such date.

Premiums are payable directly to Us at the address shown on the billing statement. Payment to any person or entity not authorized and approved by Us in writing will not be payment to Us.

A check is not a payment until it is honored by the bank. Payment received by Us more than ten days after the due date is subject to a \$10 late charge. We reserve the right to return a check issued against insufficient funds without resorting to a second deposit attempt.

GRACE PERIOD

We allow a grace period of 31 days from the premium due date in which to pay each premium due after the first. Insurance remains in force until the end of the grace period and then automatically terminates, unless We receive a written request for earlier termination and We receive the request before the end of the 31 days.

Premiums for insurance in effect during the grace period are due and payable to Us.

PREMIUM COMPUTATION

Premium charge or credit due to increase or decrease in insurance becomes effective on the first of the month on or after the date of change, or on the date of change. We will make the adjustment retroactive for up to a maximum period of 60 days.

If premiums are due Us or We owe a refund in premiums because of clerical error in the information We receive, We will make an adjustment.

PREMIUM RATE CHANGE

We reserve the right to change the table of premium rates every three months.

The premium rates that apply are based on the rates in effect when the insurance first becomes effective under this Policy. We have the right to change the premium rates on any premium due date. We will provide the Policyholder with a minimum of 20 days advance written notice before the change in premium goes into effect.

CLAIM PROVISIONS

NOTICE OF CLAIM

Written notice of claim must be sent to Us within 20 days after a claim is incurred. The written notice must identify the name of the Insured Person who incurred the claim, and the person's mailing address.

CLAIM FORM

We will provide You with necessary claim forms when We receive notice of claim. We will provide You with a claim form within 15 days from the date We receive Your request. If We do not provide a claim form, the Proof of Loss requirement below can be satisfied if proper notice of claim is submitted to Us.

PROOF OF LOSS

An Insured Person who incurs charges that are Covered Expenses under this Policy must submit proof of loss to Us. A loss means a claim that is payable by this Policy, or that applies to a deductible.

The proof of loss must be submitted to Us in writing. It must be sent to Us within 90 days after the date of admission for Hospital confinement. For other Covered Expenses, proof must be sent to Us within 90 days from the date the charges are incurred. No claim will be reduced or denied by Us if it was not reasonably possible for You to submit the proof within 90 days.

In any event, the proof must be submitted to Us within one year from the date written proof of loss is required to be submitted under this provision. We will not honor the claim for payment after the one year is expired, unless You were not legally able to provide the proof within one year.

PAYMENT OF CLAIM

We may pay benefits directly to the provider of services. After We make an authorized payment of benefits, We are discharged from paying further benefits to the extent of the payment. If You want payment made to You, You must notify Us on or before We receive Your proof of loss.

If any benefits are payable to the Insured Person's estate, or to a person who is a minor or otherwise is not competent to give a valid release, We may pay such benefits up to an amount not exceeding \$1,000 to a Family Member of such person, who We deem to be equitably entitled to the benefits.

Any payment We make in good faith under this provision fully discharges Us to the extent of Our payment.

TIME OF PAYMENT OF CLAIM

All other benefit payments due under this Policy are payable immediately upon receipt of written proof of loss subject to time review constraints under state law. There may be a delay in payment if We need to investigate a claim to determine proof of loss.

ASSIGNMENT OF BENEFITS

You may not assign benefits under this Policy.

PHYSICAL EXAM AND AUTOPSY

We have the right to have You examined, at Our expense, pending payment of claim. We also have the right, at Our expense, to have an autopsy performed at Your death, unless forbidden by law.

APPEAL PROCEDURE

For purposes of this provision, the following definition applies:

AUTHORIZED REPRESENTATIVE means an individual designated in writing by You to act on Your behalf.

If You or Your Authorized Representative disagree with a determination, You or Your Authorized Representative may ask to have it reviewed.

A written or verbal request should be made to Us within 60 calendar days of the date You or Your Authorized Representative receives Our determination. Appeal requests may include:

1. comments, documents, records, and other information relating to the determination; and
2. the ID numbers on Your insurance card.

Please state the reason(s) You or Your Authorized Representative disagrees with the determination and include all information that may support the appeal.

We will notify You or Your Authorized Representative of the decision within 60 days of Our receipt of the appeal request. If We deny Your first appeal, a second appeal may be requested using the same procedure as required for the first appeal. We will respond to the second appeal within 60 days of Our receipt of the second appeal request. This completion of the second appeal will exhaust the internal appeal process.

For non-medical issues, if You disagree with Our decision, You have the right to file a complaint with the Ohio Department of Insurance. For medical issues, You have the right to request a standard external review.

REQUEST FOR STANDARD EXTERNAL REVIEW

You may request a standard external review by an Independent Review Organization (IRO), accredited by the Ohio Department of Insurance if:

1. We deny, reduce, or terminate coverage for what would be a covered medical service because We determined that the medical service is not Medically Necessary; and
2. the proposed service will cost You more than five hundred dollars if We do not cover the service.

The request for a standard external review may only be made:

1. after all internal appeal processes have been exhausted; and

2. if the Ohio Superintendent of Insurance has not determined that the medical service is not a Covered Expense under the terms of the Policy;
 3. You request a review no later than 60 days after receipt of notification from the Ohio Superintendent of Insurance that determination requires resolution of a medical issue; and
 4. if You have not previously had an external review for the same denial of coverage and no new clinical information has been submitted to Us.
3. Your health care provider certifies that You have a terminal condition as described in 1. above and any of the following situations are applicable to You:
 - a. standard therapies have not been effective in improving the condition; or
 - b. standard therapies are not medically appropriate;
 - c. there is no standard therapy that is a Covered Expense by Us that is more beneficial than therapy described below:
 - i. Your health care provider recommends a medical service that the health care provider certifies, in writing, is likely to be more beneficial to You, in the health care provider's opinion, than standard therapies, or You have requested a therapy that has been found in a preponderance or peer-reviewed published studies to be associated with effective clinical outcomes for the same condition;
 - ii. You have been denied coverage by Us for a medical service recommended or requested by Your health care provider in i. above and You have exhausted Our internal review process; and
 - iii. the medical service for which coverage has been denied, would be a Covered Expense except for Our determination that the medical service is experimental or investigational.

The request for an external review must be in writing, except if the external review request is for a medical condition that requires expedited review, then the request may be made orally or by electronic means. See the Expedited External Review provision below.

The request must include written certification from Your health care provider rendering the proposed medical service, plus any ancillary service and follow-up care, will cost You more than five hundred dollars if We do not cover the medical service.

The request may be made by You, Your Authorized Representative, or the health care provider rendering the service, provided You give prior consent to the health care provider rendering the service. The written request may be sent directly to Us at the following address:

Appeals and Grievance Supervisor
 American Medical Security Life Insurance Company
 P.O. Box 13597
 Green Bay, WI 54307-3597
 (800) 232-5432

Upon receipt of Your request, We will promptly forward all information used in Our determination to the contracted IRO. If the IRO needs any additional information from Us, You, or the health care provider rendering the service, they will promptly request the information. If the requested information is not received, the IRO will terminate their review without a decision.

If all information is submitted timely, the IRO will make a determination within 30 days after receipt of the request for review. A written decision will be sent to You, Us, and, if requested, the health care provider rendering the medical service. The decision of the RIO is binding on Us.

STANDARD EXTERNAL REVIEW FOR TERMINAL CONDITIONS

You may request a standard external review by an Independent Review Organization (IRO), contracted by the Ohio Department of Insurance if:

1. You have a terminal condition that, according to the current diagnosis of Your health care provider, has a high probability of causing death within two years; and
2. You request a review no later than 60 days after receipt of notification from the Ohio Superintendent of Insurance that determination requires resolution of a medical issue; and

The IRO will render its decision within 30 days of receipt of the request for review; seven days in case of an expedited review. An expedited review will be allowed if the treating health care provider certifies that delay would cause the therapy or treatment to be significantly less effective. The decision of the IRO is binding on Us.

The cost of independent review is Our responsibility.

EXPEDITED EXTERNAL REVIEW

An expedited external review by an IRO will be conducted if You have an Emergency Medical Condition. The request may be made orally, in writing or by electronic means. If an oral or electronic request is made, written confirmation of the request must be submitted to Us no later than five days after the request was made.

We will forward to the IRO the information that is used in Our determination within one business day of receipt of the request. The IRO **is to** compete its review within 7 business days of receipt of the request for external review, provided all information necessary to make the decision is received.

LEGAL ACTIONS

You cannot bring an action at law or in equity to recover a claim from Us until more than 60 days after the date written proof of loss is made and the Appeal Procedure is completed. Such action cannot be made more than three years after the date written proof of loss is made.

SUBROGATION

You agree that We shall be subrogated to Your right to damages, to the extent of the benefits provided by this Policy, for Injury or Sickness that a third party is liable for or causes.

You assign to Us Your claim against a liable party to the extent of Our payments, and shall not prejudice Our subrogation rights. Entering into a settlement or compromise arrangement with a third party without Our prior written consent shall be deemed to prejudice Our rights. You shall promptly advise Us in writing whenever a claim against another party is made and shall further provide to Us such additional information as is reasonably requested by Us. You agree to fully cooperate in protecting Our rights against a third party.

RIGHT OF REIMBURSEMENT

You may receive benefits under this Policy, and may also recover losses from another source, including workers' compensation, uninsured, underinsured, no-fault or personal injury protection coverages. The recovery may be in the form of a settlement, judgment, or other payment.

You must reimburse Us from these recoveries in an amount up to the benefits paid by Us under this Policy. We have an automatic lien on any recovery.

MISREPRESENTATION OR FRAUD

Claims will be denied in whole or in part in the event of misrepresentation or fraud by You or Your representative.

RIGHT TO COLLECT NEEDED INFORMATION

You must cooperate with us when We are investigating a claim. When asked, You will assist Us by:

1. authorizing the release of medical information, including names of all providers from whom You received medical attention;
2. providing information about the circumstances of any Injury or accident; and
3. providing information about other insurance coverage and benefits.

Your failure to assist Us regarding any of the above items may result in Our denial of a claim or in rescission of Your coverage.

GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES

The entire contract of insurance consists of this Policy and the Policyholder application.

All statements made by the Policyholder, in the absence of fraud, are deemed representations and not warranties.

Only Our President, Vice-President or Secretary has the power to change this Policy. No other person has the authority to bind Us in any manner. No agent may accept risks, extend the time for payment of premium, alter or change coverage, or waive any provisions of this Policy. Any change in this Policy will be made by amendment signed by Us and attached to this Policy. A change may be made to this Policy at any time by Us without the consent of the Policyholder, any Insured Person, or beneficiary.

INCONTESTABILITY

After You are insured with Us for two years, We cannot contest the validity of Your insurance except for non-payment of premium or for fraud. No statement made by You can be contested by Us unless it is in a written form signed by You. A copy of the form must be given to You.

CHOICE OF SERVICE

You have the sole right to select a Hospital or Doctor, and a physician-patient relationship shall be maintained.

CONFORMITY WITH STATE AND FEDERAL STATUTES

If a Policy provision does not conform to applicable provisions of State or federal law, this Policy is hereby amended to comply with such law.

WORKERS' COMPENSATION

This Policy is not issued in lieu of, nor does it affect any requirement of, coverage under any Act or Law which provides benefits for any Injury or Sickness occurring during or arising from Your course of employment.

We will apply the Claims Right of Reimbursement provision for work related Injuries or Sickness even though:

1. benefits are in dispute or are made by means of settlement or compromise;
2. no final determination is made that Injury or Sickness was sustained in the course of or resulted from Your employment;
3. the amount due for medical or health care is not agreed upon or defined by You or the carrier; or
4. the medical or health care benefits are specifically excluded from settlement or compromise.

In consideration for insurance under this Policy, You hereby agree to notify Us of any claim You make. You agree to reimburse Us based on items 1. through 4. above.

CLERICAL ERROR; MISSTATEMENT OF AGE OR SEX

If Our records for Your age, sex or other information are in error or are missing, the proper amount of insurance for You will be in effect. An equitable premium adjustment will be made. We will make the adjustment retroactive up to a maximum period of 60 days. This applies whether the error was made by You or by Us.