INDEPENDENCE AMERICAN INSURANCE COMPANY

a Delaware Insurance Company

Administrative Office: 485 Madison Avenue, New York, NY 10022

Individual Health Insurance

Basic Policy

VALIDATION OF COVERAGE

Your Policy is validated by the attachment of this Validation of Coverage showing Your name and plan information.

Insured Person:	[INSURED NAME]
Dependent Coverage:	[SPOUSE][CHILD][CHILDREN]
[Case Number:]	[CASE NO.]
Insured Person's Effective Date:	[INSURED EFFECTIVE DATE]
Dependent Effective Date:	[DEPENDENT EFFECTIVE DATE]

The insurance coverage, benefits and the principal provisions that apply to the Insured Person named above are summarized in this Validation of Coverage, the Schedule of Benefits and this Policy.

10-DAY RIGHT TO RETURN THIS POLICY

If for any reason You are not satisfied with this Policy, You may return it to Us at Our Plan Administrator's office within 10 days after You receive it. We will refund any premium paid and Your coverage issued under this Policy will be deemed void, just as though coverage had not been issued.

IMPORTANT NOTICE

The application attached to this Policy must be carefully reviewed. If any information shown on the application for You or Your Dependents is not correct or is incomplete, or if any medical history has not been included, You must detail the inaccurate or omitted information, and send it to Us at Our Plan Administrator's office within 10 days of receipt of this Policy. The coverage under this Policy is issued on the basis that the answers to all questions and any other information requested in the application is correct and complete. **Omissions or misstatements in the application may cause Rescission or Reformation of coverage. Please see Section 7 – GENERAL PROVISIONS, subparagraph C. Correcting Omissions or Misstatements**.

THIS FACE PAGE SUPERCEDES AND REPLACES ANY AND ALL PREVIOUSLY ISSUED TO THE INSURED PERSON NAMED ABOVE

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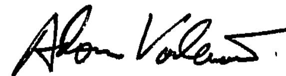

David Kettig
President

Adam C. Vandervoort
Secretary

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 false or deceptive statement is guilty of an insurance fraud.

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SCHEDULE OF BENEFITS

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MAXIMUM BENEFIT PER CALENDAR YEAR	$	50,000
CALENDAR YEAR DEDUCTIBLE(Per Covered Person)	$	1,000
(There is no Family Deductible)		
EMERGENCY ROOM DEDUCTIBLE (Per Visit, Per Covered Person)	$	75
(In addition to the Calendar Year Deductible Amount; Waived if admitted)		
DEDUCTIBLE FOR EACH HOSPITALIZATION NOT PRE-CERTIFIED	$	500
(In addition to the Calendar Deductible)		
COINSURANCE OF COVERED EXPENSES		50%
MAXIMUM OUT-OF-POCKET EXPENSE AFTER CALENDAR YEAR DEDUCTIBLE		
Per Calendar Year, Per Covered Person	$	5,000
100% for the remainder of the Calendar Year, Per Covered Person		
(There is no Family Maximum Out-of-Pocket Expense)		
HOSPITAL ROOM AND BOARD		Average semi-private rate
Intensive Care Unit		3 times the average semi-private rate
MENTAL/NERVOUS DISORDER/ALCOHOLISM/DRUG ADDICTION		
Lifetime Maximum Benefit per Covered Person	$	5,000
Calendar Year Maximum Inpatient Benefit per Covered Person	$	2,000
Calendar Year Maximum Outpatient Benefit per Covered Person	$	550
Covered Charge per Visit	$	50
LIFETIME MAXIMUM ORGAN TRANSPLANT BENEFIT	$	100,000
SPINAL MANIPULATION		
10 Visits/Calendar Year		
Covered Charge per Visit	$	25
OUTPATIENT PHYSICAL THERAPY		
20 Visits/Calendar Year		
Covered Charge per Visit	$	40
CHILD HEALTH SUPERVISION SERVICES		
Calendar Year Maximum Benefit, Per Covered Person		
Birth to Age 1	$	500*
*Includes a maximum benefit amount of $75.00 for hearing screening		
Age 1 through Age 8	$	150
OUTPATIENT PRESCRIPTION DRUGS		
Calendar Year Maximum Benefit, Per Covered Person	$	2,500
SPECIALTY CARE FACILITIES		
Calendar Year Maximum Benefit, Per Covered Person	$	5,000

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SECTION 1 - Dependents Acquired After Effective Date

Newborn Children: Coverage will be effective for a newborn Child of the Insured Person for 31 days following the moment of birth. Coverage shall continue beyond the 31-day period provided that the Insured Person meets the following requirements:

1. makes a written request for coverage, on forms approved by Us, within 31 days from the birth; and
2. makes the required premium payment, if applicable.

If the above requirements are not met and the Insured Person desires to provide future coverage under this Policy to the newborn, evidence of the newborn's insurability must be provided at no expense to Us and the newborn must meet Our then current underwriting guidelines. Coverage shall then take effect on the premium due date coincident with or next following the date on which We approve coverage.

Adopted Children: Coverage will be effective for adopted children of the Insured Person for 31days following placement in the custody of the Insured Person. Placement means the assumption by the Insured Person of the physical custody of the adopted Child. Coverage shall continue beyond the 31-day period provided that the Insured Person meets the following requirements:

1. makes written request for coverage, on forms approved by Us, within 31 days from placement; and
2. makes the required premium payment, if applicable.

If the above requirements are not met and the Insured Person desires to provide coverage under this Policy to an adopted Child, evidence of the adopted Child's insurability must be provided at no expense to Us and the adopted Child must meet Our then current underwriting guidelines. Coverage shall then take effect on the premium due date coincident with or next following the date on which We approve coverage and any applicable premium is paid.

Additional Dependents: An Insured Person may acquire additional Dependents while covered under this Policy. The insurance coverage with respect to such additional Dependents shall become effective on the premium due date coincident with or next following the date on which We approve coverage and any applicable premium is paid.

SECTION 2 – BENEFITS

Covered Charges

We will pay for Covered Charges under this Section for a Covered Person in connection with the treatment of an Injury or Sickness if the Charges are: (a) Medically Necessary; (b) Usual and Reasonable; (c) authorized by a Physician; (d) incurred while coverage under this Policy is in force; and (e) not excluded or limited by Section 3 – Exclusions and Limitations From Coverage. Covered Charges are subject to the Calendar Year Deductible(s) or Coinsurance Percentage(s), and the limitations and maximums specified in the Schedule of Benefits. **THE FOLLOWING COVERED CHARGES MAY BE SUBJECT TO SPECIFIC BENEFIT MAXIMUMS OR LIMITATIONS, AS SPECIFIED IN THE SCHEDULE OF BENEFITS. IT IS IMPORTANT THAT THE COVERED PERSON REVIEWS THE SCHEDULE OF BENEFITS FOR THE BENEFITS MAXIMUMS OR LIMITATIONS.**

A. Hospital In-Patient

Charges for Hospital Room and Board Charges and general nursing care furnished by the Hospital for confinement as an overnight bed patient in a Hospital. Charges for confinement in intensive care or cardiac care facilities in the Hospital equal to three (3) times the average semi-private room rate.

Charges for services and supplies furnished by the Hospital while confined, to include: operating rooms; recovery room; anesthesia; surgical dressings; central supplies; casts and splints; Prescription Drugs used in the Hospital; x-rays; laboratory services; and oxygen equipment and services.

Covered Charges do not include charges for personal and convenience items like telephone; radio; television; guest meals or cots; take-home drugs; or items not consumed or used while confined.

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B. Surgeon and Assistant Surgeon
Charges by Physicians for surgical procedures performed when confined as an overnight bed patient in a Hospital. If an assistant surgeon is Medically Necessary to assist in performing an operation, benefits are limited to twenty percent (20%) of the charges made by the surgeon performing the operation.

If two or more procedures are performed in the same operative session, the maximum payment shall be limited to:

a. if two or more procedures are performed through the same incision, payment shall be limited the amount payable for the procedure having the greater payment.
b. Payments shall be limited to the amount payable for the procedure having the greater payment plus one-half of the amount that would have otherwise been payable for the procedure having the lesser benefit.

C. Anesthesia Administration
Charges by an anesthesiologist for the administration of anesthesia while undergoing a covered surgical operation.

D. In-Hospital Physician's Visit
Charges for services of a licensed Physician while Hospital confined as an overnight bed patient.

E. Pathology
Charges for services of a licensed pathologist while Hospital confined as an overnight bed patient.

F. Radiology
Charges for services of a licensed radiologist while Hospital confined as a overnight bed patient.

G. Inpatient Mental/Nervous Disorders/Alcoholism/Drug Addiction
Charges for treatment of mental/nervous disorders/alcoholism/drug addiction on an inpatient basis, subject to the limits shown in the Policy Schedule. Inpatient and outpatient benefits combined may not exceed the Lifetime Maximum Benefit shown on the Policy Schedule.

H. Outpatient Mental/Nervous Disorders/Alcoholism/Drug Addiction
Charges for treatment of mental/nervous disorders/alcoholism/drug abuse on an outpatient basis, subject to the limits shown in the Policy Schedule. Inpatient and outpatient benefits combined may not exceed the Lifetime Maximum Benefit shown on the Policy Schedule.

I. Ambulance
Charges by a professional ambulance service for transportation to a Hospital or the necessary transfer from one Hospital to another.

J. Durable Medical Equipment
Charges for the lesser of the rental or purchase of Durable Medical Equipment due to Sickness or Bodily Injury. This equipment must be for temporary use only, for a period not to exceed six (6) months.

K. Mammography and Cytologic Screening
Charges for mammography screening for the presence of occult breast cancer,. Covered Charges include: (1) a baseline mammogram for women age thirty-five (35) to thirty-nine (39); (2) a mammogram every two (2) years for women age forty (40) to forty-nine (49), or an annually if determined by a Physician to have risk factors for breast cancer; and (3) an annual mammogram for women age fifty (50) or older.

Charges for cytologic screening for the presence of cervical cancer, in accordance with prevailing medical standards published by the American Academy of Pediatrics.

The total benefit for a screening mammography shall not exceed one hundred thirty percent of the Medicare Reimbursement Rate in this state for screening mammography. If there is more than one Medicare Reimbursement Rate in this state for screening mammography or a component of a screening mammography, the reimbursement limit shall be one hundred thirty percent of the lowest Medicare Reimbursement Rate in this state.

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L. Reconstructive Surgery Following Mastectomies
Charges for reconstructive surgery following a mastectomy, including:
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.

M. Organ Transplants
Charges for the following transplants only:
1. cornea;
2. heart;
3. combined heart and lung;
4. kidney;
5. pancreas;
6. bone marrow;
7. liver; and
8. lung, single and bi-lateral.

Covered Charges include: (a) initial testing and diagnosis; (b) immunosuppressant drug therapy before and after surgery; (c) complications due to surgery; (d) organ rejection or failure; and (e) repeat transplants of the same organ. Benefits are subject to the Maximum Benefit shown on the Policy Schedule.

Transplants must be precertified through the utilization review process before surgery, as explained in “Precertification of Benefits” below.

N. Child Health Supervision Services
Charges for child health supervision services from the moment of birth through age eight (8) years, subject to the maximums shown on the Policy Schedule. Services include periodic review of a child’s physical and emotional status performed by a Physician or by a health care professional under the supervision of a Physician. The review must include a history, complete physical examination, developmental assessment, anticipatory guidance, appropriate immunizations and laboratory tests, in accordance with the recommendations of the American Academy of Pediatrics.

O. Outpatient Prescription Drugs
Charges for outpatient Prescription Drugs and/or medicines, due to a Sickness or Bodily Injury, subject to the Maximum Benefit shown on the Policy Schedule.

P. Outpatient Physical Therapy
Charges for physical therapy on an outpatient basis, subject to the limits shown on the Policy Schedule.

Q. Spinal Manipulation
Charges for Spinal Manipulations, subject to the limits shown on the Policy Schedule.

R. Specialty Care Facilities
Charges for services provided in Specialty Care Facilities, subject to the Maximum shown on the Policy Schedule.

S. Emergency Room
Charges for Emergency Services provided in an emergency room for an Emergency Medical Condition, subject to satisfaction of the Emergency Room Deductible shown on the Policy Schedule, regardless if the Insured Person or emergency room Physician received prior approval. This deductible is in addition to the Cash Deductible Amount and applies to each emergency room visit. This deductible will not apply to the Cash Deductible Amount. We will waive the Emergency Room Deductible if the emergency room visit results in an admission to the Hospital for a covered stay.

T. Outpatient Medical Treatment
Charges for the following services and supplies:
1. use of radium or other radioactive materials;
2. chemotherapy;

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3. oxygen;
4. anesthetics and their administration;
5. artificial limbs, eyes, larynx, and other prosthetic devices;
6. diagnostic x-ray exam and laboratory test; or
7. services rendered by and in the physical presence of a Physician.

U. Freestanding Ambulatory Surgical Center

Services and supplies furnished by a Freestanding Ambulatory Surgical Center.

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SECTION 3 – EXCLUSIONS AND LIMITATIONS FROM COVERAGE

No benefits will be paid for charges:

1. For transportation, except local, to or from a Hospital, by professional ground ambulance service, except as provided in Section 2 - Benefits.
2. For normal childbirth, normal pregnancy or routine nursery care, elective cesarean section or voluntary induced abortion.
3. For fertility or infertility studies, diagnostic testing, advice, consultation, examination, medication, or for 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.
4. For replacement of artificial limbs and artificial eyes.
5. For blood or blood plasma which has been replaced.
6. For donation of any body organ by an Insured Person.
7. For services performed by a person who ordinarily resides in the Insured Person's home or is a Close Relative of the Insured Person.
8. For any cosmetic surgery, unless required to restore a body part that has been altered due to Bodily Injury, surgery or Sickness that occurred while insured by this Policy and for which benefits were paid under this Policy.
9. For custodial care.
10. Applied to a Deductible or Coinsurance.
11. For services or treatment: (a) not prescribed by a Physician; or (b) not shown as Covered Charges.
12. Due to Bodily Injury or Sickness arising out of, or in the course of, employment for wages or profit.
13. For charges incurred after insurance terminates.
14. For treatment or services that are experimental or investigational.
15. For eye refractions, eye glasses, or contact lens, including fittings and examinations, or eye surgery, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring), including, but not limited to radial keratotomy.
16. For treatment, services or supplies furnished by a department or agency of the United States government. This will not apply to a non-service connected Bodily Injury or Sickness of a veteran of the United States armed forces.
17. For services and supplies eligible for payment by a government or charitable program, except as required by law.
18. For hearing aids, including fittings and examinations.
19. That are not Medically Necessary for care or treatment of a Bodily Injury or Sickness.
20. That would not have been made if no insurance existed.
21. For recreational or educational therapy or vocational rehabilitation.
22. Except as allowed under covered charges subject to limitations, 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.
23. For which the Insured Person is not legally obliged to pay.
24. For treatment or services which are not generally accepted medical practices in the United States for a given Bodily Injury or Sickness.
25. For treatment of obesity, Morbid Obesity or for weight reduction purposes.
26. For Bodily Injury or Sickness due to participation in any assault, unlawful act, strike, civil disorder or riot.

27. For the treatment of sexual dysfunction or inadequacies, including, but not limited to, impotence and the implantation of a penile prosthesis.
28. For routine physical or premarital examinations except for: (a) Child Health Supervision Services; and (b) Mammography and Cytologic Screening.
29. For charges due to a Pre-Existing Condition until the date an Insured Person has been insured for twelve (12) consecutive months under this Policy. This exclusion does not apply to Federally Eligible Individuals.
30. For a private room in excess of Room and Board Charges.
31. In excess of Reasonable and Customary Charges.
32. For services or supplies prohibited by law.
33. For sex changes.
34. For sterilization and reversal of sterilization.
35. Resulting from any suicide, attempted suicide or intentionally self-inflicted Bodily Injury or Sickness while sane or insane unless such act is the result of an underlying medical condition.
36. For examination, treatment or surgery of the teeth, gums or direct supporting structure, except for repair or injury to sound natural teeth, (including their replacement) as a result of an accidental Bodily Injury which occurs while insured. Treatment must be given within ninety (90) days of the date of the accident.
37. For a Bodily Injury or Sickness caused by an act of war, whether or not declared.
38. For surrogate pregnancy.
39. 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.
40. For the treatment of complications arising from or connected in any way with a surgical or medical treatment or procedure not covered 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.
41. For foot care due to: (a) treatment of weak, strained or flat feet or instability or imbalance of the foot; or (b) treatment of corn, calluses of the free edge of toenails, except when necessitated for peripheral vascular disease or other Sicknesses of similar medical seriousness.
42. For contraceptives, infertility drugs or growth hormones.

SECTION 4 – ACCESSING AND ADMINISTERING YOUR BENEFITS

A. Managed Care

Health Care Coordination

Health Care Coordination is a program conducted by the case coordinator designated by Us which:

1. Identifies cases in which a Covered Person has a Sickness or Injury which is complicated, complex or which has the potential for catastrophic claims;
2. Assesses the appropriateness of the Covered Person's level of patient care and the setting in which it is received;
3. Develops, introduces and implements viable alternate treatment plans for such cases that maintain or enhance the quality of patient care; and
4. Maximizes benefits through implementation of the agreed upon alternate treatment plan.

The alternate treatment plan is a specific written plan developed by the case coordinator through discussion and agreement with the Covered Person or the Covered Person's legal guardian (if necessary), the Physician and Us. It includes:

1. Treatment plan objectives;
2. Course of treatment planned to accomplish such objectives;
3. Responsibility of each party (case coordinator, attending Physician and Covered Person and his family, if any) in implementing the plan; and
4. Estimated cost and savings.

If We agree with the case coordinator, the attending Physician and Covered Person on an alternate treatment plan, We may pay incurred Covered Charges at a higher percentage for treatment, services or supplies as specified in the alternate treatment plan. In the event the approved alternate treatment plan specifies services

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or supplies not considered as Covered Charges under the terms and provisions of this Policy, payment of benefits under this Policy for such treatment, services or supplies shall be contingent upon written approval by Us or Our authorized Plan Administrator. If such written approval is granted, payment of benefits under this Policy for such treatment, services or supplies shall be on the same basis as if such treatment, services or supplies were Covered Charges under the terms and provisions of this Policy.

No Covered Person is required, in any way whatsoever, to accept an alternate treatment plan recommended by the case coordinator.

Pre-Certification Program

The Pre-Certification Program is applicable to all Inpatient Confinements for Injury or Sickness, including Complications of Pregnancy and medical treatment and services as specified on the Schedule of Benefits.

The Pre-Certification penalty amount is specified in the Schedule of Benefits applicable to Covered Charges incurred in connection with an Inpatient Confinement or specific medical treatment and services when the Covered Person does **NOT** comply with Pre-Certification. The Pre-Certification penalty amount is in addition to the applicable Calendar Year Deductible, Copayments and Coinsurance. If the Covered Person complies with Pre-Certification, the Pre-Certification penalty amount will not apply.

Pre-Certification is a screening process using established medical criteria to determine whether the proposed length of stay and date of an Inpatient Confinement, the proposed treatment plan, or the proposed services or supplies are Medically Necessary and being provided in an appropriate setting. It may also include proposing alternative treatment plans and continued stay review.

This Policy requires Pre-Certification of all proposed Inpatient Confinements as defined by this Policy for more than 23 hours. Pre-Certification is also required of proposed medical treatment and services, as specified on the Schedule of Benefits.

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

Pre-Certification of Emergency Care

Inpatient Confinements for Emergency Care must be Pre-certified; however, the Insured Person or the Covered Person's Physician may notify the Pre-Certification service of the Emergency Inpatient Confinement within 48 hours of the Inpatient admission or as soon as reasonably possible and be in compliance with the Pre-Certification requirement. The attending Physician must verify that an Emergency condition existed.

If the Covered Person does not comply with Pre-Certification for Emergency Care, Covered Charges are subject to the Pre-Certification penalty amount specified in the Schedule of Benefits.

B. Subrogation/Right of Reimbursement

As a condition to receiving benefits under this Policy, Covered Person(s) agree to transfer to Us their right to recover damages to the extent of benefits paid by Us when an Injury or Sickness occurs through the act or omission of another person. If a Covered Person received payment from another person or entity on account of, due to, or arising out of an Injury or Sickness, the Covered Person agrees to reimburse Us to the full extent of Covered Charges paid. If a repayment agreement is required to be signed, all rights of recovery are transferred to Us regardless of whether it is actually signed. It is only necessary that the Injury or Sickness occur through the act or omission of another person or entity. Our rights of full recovery may be from any other person or entity, any liability or other insurance covering such other person or entity party, the Covered Person's own uninsured motorist insurance, underinsured motorist insurance, any medical payments, no-fault, workers compensation or school insurance coverages which are paid or payable. We may enforce Our reimbursement rights by requiring the Covered Person to assert a claim to any of the foregoing coverages to which the Covered Person may be entitled. Covered Person(s) shall provide all requested accident and insurance information to Us. We shall not be required to pay any portion of Covered Person's attorneys' fees or other costs associated with a claim/lawsuit.

C. Audit Expense Benefits

If a Covered Person discovers an error on any Claim submitted by a Provider or Facility for Covered Charges, We will pay the Insured Person a reward for those errors brought to Our attention in the amount of 50% of the reduction in Covered Charges, up to $1000 per Calendar Year, that results from the Covered Person's discovery. Proof of errors made by the Provider or Facility will be satisfied by comparing the final billing with the errors and subsequent itemized billing giving credit for such errors.

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The Provider or Facility must acknowledge such errors on a form acceptable to Us. **We reserve the right to determine the amount of the reduction in Covered Charges and the right to hold payment of the reward until the Provider or Facility acknowledges the accuracy of the Covered Person's discovery of the error**.

SECTION 5 - TERMINATION OF INSURANCE

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Insured Person's Insurance

The Insured Person's insurance shall terminate on the earliest of the following dates:

1. The next premium due date after We receive Your written request to terminate Your coverage under this Policy;
2. The premium due date, if the premium then due is not paid by the end of the grace period;
3. The date the Insured Person has been determined by Us to have committed an act of fraud or made an intentional misrepresentation of material fact under the terms of this Policy;
4. The date the Insured Person reaches the Maximum Benefit while covered under this Policy as specified in the Schedule of Benefits;
5. The first date following 90 days advance written notice by Us to the Insured Person when We may lawfully discontinue offering coverage under this Policy in the state where this Policy was issued;
6. The first date following 180 days advance written notice by Us to the Insured Person when We may lawfully discontinue offering all health insurance coverage in the individual market in the state where this Policy was issued;
7. The date of Your death; or
8. The premium due date coinciding with or following the date of the termination of this Policy.

Dependent Insurance

The insurance coverage of a Dependent shall terminate on the earliest of the following dates:

1. The next premium due date after We receive Your written request to terminate coverage of the Dependent under this Policy;
2. With respect to the Insured Person's covered Dependent spouse, the premium due coinciding with or next following the date on which the Insured Person is divorced or legally separated from such spouse or such marriage was annulled.
3. The premium due date coinciding with or next following the date on which a Dependent Child marries or ceases to meet the definition of Dependent;
4. The date the Dependent has been determined by Us to have committed an act of fraud or made an intentional misrepresentation of material fact under the terms of this Policy;
5. The date the Dependent reaches the Maximum Benefit while covered under this Policy as specified in the Schedule of Benefits;
6. The first date following 90 days advance written notice by Us to the Insured Person when We may lawfully discontinue offering coverage under this Policy in the state where this Policy was issued; or
7. The first date following 180 days advance written notice by Us to the Insured Person when We may lawfully discontinue offering all health insurance coverage in the individual market in the state where this Policy was issued;
8. The date of the Dependent's death; or
9. The date of termination of the Insured Person's coverage under this Policy, unless the Dependent continues coverage pursuant to the Continuation of Coverage provision.

The attainment of the limiting age by a covered Dependent will not cause coverage to terminate while that person is and continues to be both incapable of self-sustaining employment by reason of mental or physical incapacity and Chiefly Dependent on You for support and maintenance.
"Chiefly Dependent" means the covered Dependent receives the majority of his/her financial support from You. If a covered Dependent is handicapped beyond the limiting age and You desire continued coverage for Your covered Dependent, You must provide written proof that the covered Dependent is Chiefly Dependent, at least 31 days prior to the date upon which the covered Dependent would otherwise reach the limiting age. Thereafter, We may request such proof no more frequently than annually. In the absence of such proof, We may terminate the coverage of such person after the attainment of the limiting age.

Continuation of Coverage

If coverage under this Policy terminates as the result of the death of the Insured Person, or the severance of the family relationship because of annulment or valid decree of divorce, a Dependent may continue coverage without providing evidence of insurability by making the required premium payments for issuance of his or her own Certificate. The eligible Dependent must submit a written request for this continuation of coverage within 31 days of the date on which coverage would otherwise terminate.

SECTION 6 - PREMIUM PAYMENT

A. Payment Of Premium

Premiums are payable to Us. No insurance agent, insurance broker or insurance consultant is authorized to accept any premium payment on Our behalf. The Insured Person must timely pay the monthly premium in order to maintain coverage under this Policy. The payment of any premium will not keep coverage under this Policy in force beyond the due date of the next premium, except as provided under B. the Grace Period below. If any premium is not received by Us before or at the end of the Grace Period, coverage for the Insured Person and Dependents will automatically end at the end of the period for which the last premium payment has been paid.

B. Grace Period

After payment of the first premium, We will allow a Grace Period of 31 days following a premium due date to pay subsequent monthly premiums. During this Grace Period, the Insured Person's coverage under this Policy will remain in force. No benefits are payable for expenses incurred during the Grace Period if the premium has not been received by the end of the Grace Period. If the Insured Person fails to pay the premium during the Grace Period, coverage under this Policy for the Insured Person and Dependents will automatically end at the end of the period for which the last premium payment has been paid. The Grace Period does not apply if coverage under this Policy terminates for reasons other than nonpayment of premium.

C. Premium Changes

We reserve the right to change premiums under this Policy on any premium due date by giving the Insured Person at least 31 days prior written notice.

If the Insured Person has selected an initial rate guarantee period when applying for coverage under this Policy, the premium will not change during the initial rate guarantee period except for the following reasons:

1. The addition or deletion of Dependents to or from the coverage under this Policy; or
2. A Covered Person enters into a new age rate-band; or
3. The Insured Person moves to a different location from where the Insured Person was located at the time they applied for coverage; or
4. The Insured Person requests that coverage under this Policy be modified to increase or decrease benefits from those selected when applying for coverage; or
5. Change in benefits as mandated by new state or federal statutes, rules or regulations which become effective after the Effective Date of coverage and affect Our liability under this Policy.

SECTION 7 - GENERAL PROVISIONS

A. Entire Contract

The entire contract is made up of: (a) this Policy; and (b) the applications of the Insured Persons. No agent or other individual, except Our President, Vice President, Secretary or Assistant Secretary can: (a) approve a change to this Policy; or (b) extend the time for payment of any premium. No change will be valid unless it is made: (a) by an Endorsement or Rider to this Policy; or (b) by an Amendment signed by Our President, Vice President, Secretary or Assistant Secretary. Any change made will be binding on each Covered Person and on any other individual(s) referred to in this Policy.

B. Contestability

In the absence of fraud, statements made by an Insured Person are representations and not warranties. After the Insured Person or a Dependent has been covered under this Policy for two consecutive years, only fraudulent misstatements in the application may be used to void Your coverage or a Dependent's coverage under this Policy or deny any Claim for loss incurred or disability starting after the 2-year period.

C. Correcting Omissions or Misstatements

If We determine that there was a misrepresentation or omission in the application for coverage, the true facts will be used to determine whether insurance is inforce or whether an adjustment of premiums and/or

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other benefits is required. If the age of any Covered Person has been misstated, an adjustment in premium or benefits, or both, will be made based on the true facts. No misstatement of age will continue insurance otherwise terminated or terminate insurance otherwise inforce.

Reformation. If We determine that there was a misrepresentation or omission in the application for coverage that caused Us to issue coverage without a specific condition Exclusion Endorsement, Rider or premium rate adjustment that would have been included had there been no misrepresentation or omission, We may reform Your insurance coverage by (1) issuing such Exclusion Endorsement or Rider and requiring that You execute it in order to maintain the Covered Person's coverage; or (2) adding a premium adjustment to Your coverage and requiring that You pay the additional premium retroactively to the Effective Date of the Covered Person's coverage. Once executed, the Exclusion Endorsement or Rider will apply to Your coverage beginning on the Effective Date of the Covered Person's coverage. Once the Exclusion Endorsement or Rider is applicable to Your coverage We may request a refund for Claims paid which would not have been eligible under the Exclusion Endorsement or Rider. If You do not accept the proposed Exclusion Endorsement Rider or remit the adjusted additional premium, We may rescind the Covered Person's coverage.

Rescission. If We determine that there was a misrepresentation or omission in the application for coverage that caused Us to issue coverage when coverage would not have been issued had there been no misrepresentation or omission, We may rescind coverage. If the misrepresentation or omission pertained to the Insured Person, coverage may be rescinded for the Insured Person and all Covered Dependents. If the misrepresentation or omission pertained to a Covered Dependent, coverage may be rescinded for that Dependent. Rescission causes coverage to be terminated back to the Effective Date as if the coverage was never issued.

Rescission will result in denial of all claims submitted. If rescission occurs, We will refund premiums received for any coverage We rescind within a reasonable time of the rescission; however, We will subtract total Claim payments for the person whose coverage We rescinded from this premium refund. If we have paid Claims in excess of the amount of premium We received for the person whose coverage We rescinded, We have the right to obtain a refund from the Insured Person.

D. Notice of Claim

Written notice of Claim must be given to Us: (a) within 20 days after the date on which the Claim was incurred; or (b) as soon as reasonably possible thereafter. Notice can be sent to Our authorized Plan Administrator or Our home office. The notice should include the Insured Person's name and Policy number.

E. Proof of Loss

Proof of loss is information and supporting documentation We need to determine the benefits payable under this Policy. It includes, but it is not limited to, medical history, medical records, accident reports and other information We request to make the determination. Written proof of loss must be given to Us or Our authorized Plan Administrator within 90 days of the date on which the Charges are incurred. If it was not possible for proof to be given within the 90 days, We will not deny the Charges provided proof is given as soon as reasonably possible. The date on which the Charges are incurred is the date on which the services or supplies were provided. If the Charges are for an Inpatient Confinement in a Facility, the Charges are incurred on the date of discharge. Notwithstanding the foregoing, proof must be sent no later than one year from the date on which the Charges are incurred unless the Covered Person is legally incapacitated.

Insured Persons are required to submit complete billings from providers using the standard HCFA-1500 form, UB-82, UB-92, standard superbill or similar billing format. Such billing must be completed in the entirety including, without limitation, the name of the Insured Person, name of patient, the CPT-4 procedures codes, the ICD-9 diagnosis codes, the date of service, the Charges and the name and address of Physician, Facility or other health care provider providing service. If the Covered Person is covered under a PPO Plan, and uses an In-Network Provider, the In-Network Provider may submit the Claim to Us.

Originals of all bills must be submitted to Us or Our authorized Plan Administrator unless they were previously submitted to another primary carrier under a Coordination of Benefits provision.

Claims for Covered Charges incurred for the purchase of Prescription Medications must show the following information:

1. Name of person for whom the drug was prescribed;
2. Prescription number;

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3. Name of the drug;
4. Cost of the drug;
5. Date of purchase;
6. Name of the doctor who prescribed the medication; and
7. Attending Physician statement indicating diagnosis at least once each year for continuing prescriptions.

NOTE: Cash register receipts and canceled checks cannot be accepted as proof of the cost of the drug for reimbursement.

Claims for all other Covered Charges must show the following:
1. Name of the Insured Person;
2. Name of the patient;
3. Date of the Charge or period of time covered by Charge;
4. Type of treatment or medical services; and
5. Name of the Physician prescribing treatment.

F. Time of Payment of Claims
Payments for Covered Charges will be paid subject to written proof of loss. Any balance unpaid at the end of liability will be paid on receipt of written proof of loss. Covered Charges paid by this Policy will be paid within 45 days following the date on which We or Our authorized Plan Administrator receives written proof of loss. Covered Charges for Claims payable under this Policy are overdue if not paid within 45 days after We, or Our Plan Administrator, receives proof of loss and necessary medical information or other information required by Us as essential to administer the provisions of this Policy including, but not limited to, the Coordination of Benefits and Subrogation Provisions. If such information is not supplied as to the entire Claim, the amount supported by reasonable proof is overdue if not paid within 45 days. Any part or all of the remainder of the Claim that is later supported by such proof is over due if not paid within 45 days.

G. Payment of Claims
Covered Charges will be payable to the Insured Person unless they are assigned to a Physician, Facility or other health care provider. Any notice of assignment of benefits must be in writing and mailed to Us or Our authorized Plan Administrator. Notice of the assignment of benefits received from a Physician, Facility or other health care provider will be sufficient to cause Covered Charges to be paid to such Physician, Facility or other health care provider. You may revoke an assignment of benefits at any time by providing written notice of such revocation to Us or Our authorized Plan Administrator. Any such written revocation of an assignment of benefits shall be valid as to both You and the Physician, Facility or other health care provider.

H. Allocation of Covered Charges
We reserve the right to allocate the Calendar Year Deductible or Daily Deductible to any Covered Charge and to apportion the benefits to the Covered Person and any assignees. Such allocation and apportionment by Us shall be conclusive. The Covered Person or any assignee cannot change this, nor can they direct which claims can be used to satisfy the Calendar Year Deductible or Daily Deductible requirements.

I. Administrative Appeals of a Claim Decision
If the Covered Person or the Covered Person's provider would like additional information or have any complaints concerning the basis upon which payment was made, they may contact Our Customer Service Department at 1-866-429-0608. We will address the Covered Person's concerns and will attempt to resolve them satisfactorily. If We are unable to resolve a concern over the phone, We will request submission of the concern in writing to pursue a formal grievance.

J. Recovery of Overpayments
We reserve the right to deduct from any future benefits payable under this Policy the amount of any payment that has been made:

1. In error; or
2. pursuant to a misstatement contained in a proof of loss; or
3. pursuant to fraud or misrepresentation made to obtain coverage under this Policy within 2 years after the Effective Date; or
4. with respect to an ineligible person; or
5. pursuant to a Claim for which benefits are recoverable under any Policy or act of law providing coverage for occupational Injury or disease to the extent that such benefits are recovered.

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Such deduction may be against any future Claim for benefits under this Policy made by a Covered Person if Claim payments previously were made with respect to such Covered Person.

K. Fraud or Misrepresentation

No payments will be made for Claims involving fraud or misrepresentation. If benefits are paid for a Claim involving fraud or misrepresentation We will be entitled to a refund from the Insured Person or the Covered Person's provider.

L. Other Insurance With This Insurer

If a Covered Person is covered under more than one major medical policy with Us comparable to this Policy, only one policy chosen by the Covered Person, his beneficiary or his estate, as the case may be, will be effective. We will refund all premiums paid, less the amount of Claims paid, for the coverage under all the other major medical policies for the term during which duplicate coverage was provided.

M. Conformity with Federal and State Laws

Any provision of this Policy which is in conflict with Federal laws or any applicable state law, is hereby amended to meet the minimum requirements of the law.

N. Physical Examination

We have the right, at Our own expense, to have a Covered Person examined as often as is reasonable while a Claim is pending.

O. Workers' Compensation

This Policy is not in lieu of and does not affect any requirements for coverage by Workers' Compensation insurance.

P. Waiver Of Rights

If We fail to enforce any provision of this Policy, such failure will not affect Our right to do so at a later date; nor will it affect Our right to enforce any other provision of this Policy. Any waiver of rights must be in writing and signed by Our President, Vice President Secretary or Assistant Secretary or an individual authorized by them to agree to such waiver.

Q. Required Information

The Insured Person agrees to provide to Us any information or data that we reasonably request for the proper administration of this Policy including; but not limited to, information pertaining to medical history, medical records, the names of all health care providers from whom the Covered Person has received treatment or services, marriage license, documentation of adoption or placement for adoption, documentation of legal custody of a Dependent, student status information, and treating provider statements.

R. Effective Date

No insurance under this Policy shall become effective until notice in writing is given to the Insured Person by Us. Issuance of a Policy with a Validation of Coverage will be deemed proper notification, provided premium due has been paid in accordance with the terms of this Policy.

S. Cancellation by the Insured. Noncancellation by the Insured

You may cancel this Policy at any time by written notice delivered or mailed to Us. Your cancellation will take effect when We receive it or on a later date if specified in Your notice. We will return promptly the unearned portion of any premium paid. We will calculate the earned portion by use of the short-rate table last filed by Us with the Ohio Insurance Department. Your cancellation will not prejudice any claim originating before the effective date of cancellation.

T. Legal Actions

No legal action may be brought to recover on this Policy within sixty (60) days after written proof of loss has been given as required by this Policy. No such action may be brought after three (3) years from the time written proof of loss is required to be given.

U. Grievance Process

Internal Review Process

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1. If We make a decision that the Insured Person wishes to appeal, a written request must be sent to Us within sixty (60) days of the date of written notice of Our decision. The appeal shall be addressed to Independence American Insurance Company, 485 Madison Ave., New York, New York 10022
2. The Insured Person's written request must provide:
   (a) The policy number, name of the Insured, and a written statement of the reasons for the appeal and facts of the matter; and
   (b) Copies of any evidence or other supporting documentation.
3. (a) Within forty-five (45) days after the date of receipt of a timely-filed request for reconsideration, We must provide written notice to the Insured Person that:
      (i) The decision has been reversed or modified;
      (ii) The decision has been reaffirmed; or
      (iii) Additional information is requested from the Policyholder (which will include any information from third parties, such as health care Providers).
   (b) Within thirty (30) days after the requested information is received, We must notify the Insured Person as provided in (i) or (ii) herein.
   (c) If the Insured Person does not provide the information requested within sixty (60) days of the requesting date, We will reconsider the decision based on the information in the file.

You may contact the Ohio Department of Insurance at 2100 Stella Court, Columbus, Ohio 43215-1067; (614) 644-2658, after you have completed the above Internal Review Process.

External Review Process

An Insured Person or their Authorized Person, have the opportunity to file an external review with Us within 60 days of receipt of denial if We have denied, reduced or terminated coverage for what would be a Covered Charge except that We have determined that the Covered Charge is not Medically Necessary, the Covered Charge, plus an ancillary services and follow-up care will cost the Insured Person more than $500.00 if the Covered Charge is not covered by Us and the Insured Person has completed the internal review process.

An external review must be requested in writing, except if the Covered Person has a condition that requires an expedited review, the review may be requested orally or by electronic means. When an oral or electronic request for review is made, written confirmation of the request must be submitted to Us no later than five (5) days after the request is made.

For an expedited review, the Covered Person's Provider must certify that the Covered Person's condition could, in the absence of immediate medical attention, result in any of the following:
(1) Placing the health of the Covered Person or, with respect to a pregnant woman, the health of the Covered Person or the unborn child, in serious jeopardy;
(2) Serious impairment to bodily functions;
(3) Serious dysfunction of any bodily organ or part; or
(4) a terminal condition that, according to the current diagnosis of the insured's physician, has a high probability of causing death within two years.

External Review Procedure

The procedures used in conducting an external review shall include all of the following:
(1) The review shall be conducted by an Independent Review Organization assigned by the Superintendent of Insurance;
(2) Neither the Clinical Peer nor any health care facility with which the Clinical Peer is affiliated shall have any professional, familial, or financial affiliation with any of the following:
   (a) Us, any of Our officers, directors, or managerial employees of Ours;
   (b) The Covered Person, the Covered Person's Provider, or the practice group of the Covered Person's Provider;
   (c) The health care facility at which the health care service requested by the Covered Person would be provided; or
   (d) The development or manufacture of the principle drug, device, procedure, or therapy proposed for the Covered Person.

We shall provide to the Independent Review Organization conducting the review a copy of those records in Our possession that are relevant to the Covered Person's medical condition and the review. At the request

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of the Independent Review Organization, We, the Covered Person, the Provider, or health care facility rendering the services shall provide any additional information the Independent Review Organization requests to complete the review. A request for additional information may be made in writing, orally, or by electronic means. The Independent Review Organization shall submit the request to the Covered Person and Us. If a request is submitted orally or by electronic means to the Covered Person or Us, not later than five (5) days after the request is submitted, the Independent Review Organization shall provide written confirmation of the request. If the review was initiated by a Provider or health care facility, a copy of the request shall be submitted to the Provider or health care facility.

An Independent Review Organization is not required to make a decision if it has not received any requested information that it considers necessary to complete a review. An Independent Review Organization that does not make a decision for this reason shall notify the Covered Person and Us that a decision is not being made. The notice may be made in writing, orally, or by electronic means. An oral or electronic notice shall be confirmed in writing not later than five (5) days after the oral or electronic notice is made. If the review was initiated by the Provider or health care facility, a copy of the notice shall be submitted to the Provider or health care facility.

We may elect to cover the service requested and terminate the review. We shall notify the Covered Person and all other parties involved with the decision by mail, or with the consent or approval of the Covered Person, by electronic means.

In making its decision, an Independent Review Organization conducting the review shall take into account all of the following:

(1) Information submitted by Us, the Covered Person, the Covered Person's Provider, and the health care facility rendering the service, including the following: (a) the Covered Person's medical records; and (b) the standards, criteria, and clinical rational used by Us to make Our decision.

(2) Findings, studies, research, and other relevant documents of government agencies and nationally recognized organizations, including the National Institutes of Health, National Cancer Institute, the National Academy of Sciences, the United States Food and Drug Administration, the Health Care Financing Administration of the United States Department of Health and Human Services, and the agency for Health Care Policy and Research; and

(3) Relevant findings in peer-reviewed medical or scientific literature, published opinions of nationally recognized medical experts, and clinical guidelines adopted by relevant national medical societies.

Expedited Review

In the case of an expedited review, the Independent Review Organization shall issue a written decision not later than seven (7) days after the filing of the request for review. In all other cases, the Independent Review Organization shall issue a written decision not later than thirty (30) days after the filing of the request. The Independent Review Organization shall send a copy of its decision to Us and the Covered Person. If the Covered Person's Provider or the health care facility rendering the service requested the review, the Independent Review Organization shall also send a copy of its decision to the Covered Person's Provider or the health care facility.

The Independent Review Organization's decision shall include a description of the Covered Person's condition and the principle reasons for the decision and an explanation of the clinical rational for the decision. The Independent Review Organization shall base its decision on the information submitted. In making its decision, the Independent Review Organization shall consider safety, efficacy, appropriateness, and cost-effectiveness.

We shall provide any coverage determined by the Independent Review Organization's decision to be Medically Necessary, subject to the other terms, limitations, and conditions of this Policy.

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SECTION 8 - DEFINITIONS

The capitalized terms used herein shall be defined as follows:

Alcoholism or Drug Addiction means any use of alcohol or a controlled substance that produces a pattern of pathological use causing impairment in social or occupational functioning or which produces physiological dependency evidenced by physical tolerance or withdrawal.

Adverse Determination means a determination by a health insuring corporation or its designee Utilization Review Organization that an admission, availability of care, continued stay or other health care service covered under the contract has been reviewed and based upon the information provided, the health care service does not meet the health insuring corporation's requirements for benefit payment, and is therefore denied, reduced, or terminated.

Authorized Person means a parent, guardian, or other person authorized to act on behalf of a Covered Person with respect to health care decisions.

Bodily Injury means an accidental injury that results directly and independently of all other causes in a loss or expense that is covered under this Policy. A reaggravation of a prior condition is not a new Bodily Injury within this definition.

Calendar Year. A period of one year that starts on January 1 and ends on December 31.

Calendar Year Deductible. The amount(s) of Covered Charges as specified in the Schedule of Benefits which each Covered Person must first incur each Calendar Year before this Policy will begin payment for Covered Charges.

Charge. The billed amount for a treatment, service or supply rendered to a Covered Person. Such Charge shall be considered to have been incurred on the date the treatment, service or supply was provided.

Child.

1. An Insured Person's natural child;
2. An Insured Person's lawfully adopted child;
3. A child placed for adoption with an Insured Person;
4. A child for whom the Insured Person has been appointed legal guardian by a court of competent jurisdiction and who resides with and who is dependent upon the Insured Person in a conventional parent-child relationship; or
5. A child of the Insured Person for whom the Insured Person is obligated to provide medical child support pursuant to a Qualified Medical Support Order, provided that the requirement for qualifications of the order as outlined in this Policy are met.

Claim. A HCFA 1500 or UB92, or any replacement form published by the U.S. Department of Health and Human Services or Centers for Medicare and Medicaid Services, that establishes a demand by or on behalf of a Covered Person for the payment of benefits under this Policy and contains all the required data elements as required by state law. In the absence of state law as are required to process the Claim.

Clinical Peer means a Physician when an evaluation is to be made of the clinical appropriateness of health care services provided by a Physician. If an evaluation is to be made of the clinical appropriateness of health care services provided by a Provider who is not a Physician, "Clinical Peer" means either a Physician or a Provider holding the same license as the Provider who provided the health care services.

Close Relative. The Insured Person's spouse or the parent, brother, sister, Child or grandparent of the Insured Person or of the Insured Person's spouse.

Coinsurance/Coinsurance Percentage. The sharing of health care expenses between Us and the Covered Person. The Coinsurance percentage, as specified in the Schedule of Benefits, is the percentage of Covered Charges for which We are responsible after payment by the Covered Person of any applicable Calendar Year Deductibles, as specified in the Schedule of Benefits.

Complications of Pregnancy means a condition that is distinct from pregnancy, but is adversely affected by the pregnancy. Examples of such conditions include: acute nephritis; nephrosis; cardiac decompensation; missed abortion; and conditions of comparable severity. It also includes conditions such

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as emergency non-elective cesarean section; ectopic pregnancy; hyperemesis gravidarum; and spontaneous abortion occurring when a viable birth is not possible. It does not include: false labor; occasional spotting; Physician-prescribed rest during pregnancy; morning sickness;; pre-eclampsia; or other conditions related to a difficult pregnancy.

Confined/Confinement. Registered as an Inpatient in a Facility, on the order of a Physician, for Medically Necessary treatment.

Covered Charges: Covered Charges are the Charges for services and supplies that are eligible for reimbursement under this Policy. In order for a Charge to be a Covered Charge, it must be all of the following:

1. Listed as Covered Charges under SECTION 2 – BENEFITS; and
2. Be Medically Necessary; and
3. Be the Usual and Reasonable Charge for such service or supply; and
4. Be authorized or ordered by a Physician; and
5. Be incurred while coverage under this Policy is in force; and
6. Not be excluded by this Policy.

Covered Person. The Insured Person and/or his or her Dependent who: (a) has applied for coverage; (b) meets the eligibility rules set forth in this Policy; (c) is approved for coverage by Us; and (d) for whom all applicable premiums are paid, and is therefore insured.

Custodial Care. Any care, regardless of whether it is prescribed by a Physician, that is provided to a Covered Person who is disabled to support the essential activities of daily living.

Dependent. An Insured Person's:
1. Lawful spouse of the opposite gender under age 64 years;
2. Unmarried Child who is primarily dependent upon the Insured Person for support and maintenance and is:
   a. Less than 19 years of age; or
   b. Between 19 and 25 years of age; provided however, that the Child is dependent upon the Insured Person for support and maintenance and a full-time student actively attending an accredited college, vocational or high school. Full-time, as used in this definition, means actively attending at least 12 hours of classes a week or, if less, attending the minimum hours of class the school considers as full-time status;

Doctor. See definition for Physician.

Durable Medical Equipment means equipment that meets all of the following criteria:
1. It can withstand repeated use;
2. It is primarily and customarily used to serve a medical purpose, rather than being primarily for comfort or convenience;
3. It is not customarily useful to a person, in the absence of a Sickness or a Bodily Injury;
4. It is appropriate for home use;
5. It is related to the Insured Person's physical disorder; and
6. It is certified in writing by a Physician as being Medically Necessary.

Effective Date. The date, as assigned by Us and shown on Your Validation of Coverage, on which coverage becomes effective under this Policy.

Emergency Medical Condition means a medical condition that manifests itself by such acute symptoms of sufficient severity, including severe pain, that a prudent layperson with an average knowledge of health and medicine could reasonably expect that the absence of immediate medical attention could result in any of the following:
1. Placing the health of the individual 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 the following:

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1. A medical screening examination, 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; or
2. Such additional medical examination and treatment that is 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.

In the event that You encounter an Emergency Medical Condition, You should use the 9-1-1 emergency telephone operating system or Your local telephone access system utilized to access pre-Hospital Emergency Services.

Federally Eligible Individual means an eligible individual as defined in 45 Code of Federal Regulations (CFR) 148.103.

Freestanding Ambulatory Surgical Center means a legally operated institution which meets all of these requirements:
1. it has permanent operating rooms;
2. it has at least one (1) recovery room;
3. it has all necessary equipment for use before, during and after surgery;
4. it is supervised by an organized medical staff, including registered nurses (R.N.s) available for care in an operating or recovery room;
5. It has a contract with at least one (1) nearby Hospital for immediate acceptance of patients who require Hospital care following care in the Freestanding Ambulatory Surgical Center;
6. It is other than: (a) a private office or clinic of one (1) or more Physicians; or (b) part of a Hospital; and
7. It requires that admission and discharge take plan within the same working day.

Facility. A Hospital, Hospice, Rehabilitation Facility, Residential Treatment Program, Ambulatory Surgical Center or Skilled Nursing Facility.

Home Health Care Agency. A public or private agency or organization that specializes in providing medical care and treatment in the home under the supervision of a Physician or Nurse. Such provider must meet all of these requirements:

1. it operates pursuant to law;
2. it mainly provides skilled Nursing and other therapeutic services in the Covered Person's home;
3. it maintains a complete medical record on each person served; and
4. it has a full-time administrator.

Hospice. An agency which:
1. is licensed and operates pursuant to law;
2. provides a hospice care program of palliative, supportive and interdisciplinary team services;
3. provides a continuum of Inpatient care, home care and follow-up bereavement services on a 24-hour, 7-day-a-week basis, for Covered Persons who:
   a. are in the terminal stage of Sickness; and
   b. are expected to die within 6 months.

Hospice Care Program. A plan for palliative and supportive medical, nursing and other health services to terminally ill persons and members of their families in a Hospice or in the home. The Insured Person's Physician must certify that proper care and treatment would otherwise require Confinement in a Hospital or Skilled Nursing Facility.

Hospital. An institution that meets fully every one of the following tests:
1. it provides medical and surgical facilities for the treatment and care of injuries or sick persons on an Inpatient basis;
2. it is under supervision of a staff of Physicians;
3. it provides 24-hour a day nursing service by Registered Nurses (R.N.s);
4. it is duly licensed as a Hospital, except that this requirement will not apply in the case of a state tax-supported or charitable institution;
5. is approved as a Hospital by the Joint Commission on the Accreditation of Health Care Organizations or the American Osteopathic Association;
6. is not, other than incidentally, a place for rest, a place for the aged, a nursing home or custodial or training type institution, or an institution that is supported in whole or in part by a federal government fund.

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The requirement of surgical facilities shall not apply to a Hospital specializing in the care and treatment of mentally ill patients. Hospital shall also mean, where appropriate:

1. for the purpose of Chemical Dependency treatment, a facility or institution which provides a program for the treatment of Chemical Dependency pursuant to a written treatment plan approved and monitored by a Physician, which facility is also:

    a. accredited as such a facility by the Joint Commission on the Accreditation of Health Care Organizations;
    b. affiliated with a Hospital, as defined above, under contractual agreement with an established system for patient referral; or
    c. a state agency; or
    d. licensed, certified or approved as a Chemical Dependency treatment program or center by any state agency having legal authority to so license, certify or approve.

Independent Review Organization means an entity that conducts independent external reviews of adverse determinations.

Injury. Bodily injury resulting directly from an accident and independently of all other causes occurring while a Covered Person's coverage is in force under this Policy. It does not include an intentional, self-inflicted Injury.

Inpatient and Outpatient. The terms "Inpatient" and "Outpatient" refer either to the setting in which medical care is given or to a Covered Person who is receiving care in that setting.

When the terms describe the setting in which medical care is given:
1. "Inpatient" means therapeutic services which are available on a 24-hour basis to a Covered Person while Confined in a Hospital or other treatment Facility, as a registered bed patient;
2. "Outpatient" means therapeutic services are furnished to Covered Persons while not Confined.

When the terms refers to a Covered Person who is receiving medical care:
1. "Inpatient" means a Covered Person who is Confined in a Hospital as a registered bed patient for a period of 23 consecutive hours or longer upon the advice of a Physician for the purpose of other than Custodial or Convalescence Care;
2. "Outpatient" means a Covered Person who is not so Confined.

Insured/Insured Person. The Insured Person is named on the Validation of Coverage.

Lifetime Maximum Benefit For All Benefits While Covered Under this Policy. The Maximum Benefit, as specified in the Schedule of Benefits, payable for all Covered Charges combined for each Covered Person while covered under this Policy under any and all plans selected by the Insured Person. No benefits will be paid for Charges incurred by a Covered Person after the Covered Person's coverage under this Policy terminates, except as may be provided under any extended benefits provision, if applicable.

Maximum Calendar Year Benefit: The Calendar Year Maximum Benefit payable under this Policy for each Covered Person for Covered Charges incurred for certain treatment and services is specified on the Schedule of Benefits. When a Covered Person reaches the Maximum Calendar Year Benefit while covered under this Policy, no further Charges incurred after such date for the specific treatment and services in which the Maximum Benefit is reached will be considered Covered Charges for the remainder of that Calendar Year for that Covered Person.

Medically Necessary. Treatment, services or supplies provided for a Sickness or Injury which:
1. have been established as safe and effective;
2. are furnished in accordance with generally accepted professional standards to treat a Sickness or Injury;
3. are determined by Us to be:
    a. rendered for the treatment or diagnosis of an Injury or Sickness, including premature birth, congenital defects and birth defects;
    b. appropriate for the symptoms, consistent with the diagnosis;
    c. are otherwise in accordance with generally accepted medical practice and professionally recognized standards;
    d. not mainly for the convenience of the Covered Person, his or her Physician or other providers;

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e. not in excess (in scope, duration or intensity) of that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment.
f. services and supplies that are necessary for the therapeutic treatment of an Injury or Sickness; and

4. when applied to Confinement in a Hospital, the Covered Person:
   a. must be Confined as an Inpatient due to the nature of treatment, services or supplies rendered or due to his or her condition;
   b. cannot receive safe and adequate care through Outpatient treatment.

Treatment, services or supplies are not automatically deemed Medically Necessary based solely on the fact that they were prescribed, ordered or recommended by a Physician or any other health care practitioner.

Medicare. Title XVIII – Health Insurance for the Aged and Disabled, of the United States Social Security Act of 1965, as then constituted or as later amended.

Medicare Reimbursement Rate. The reimbursement rate paid in this state under the Medicare program for screening mammography that does not include digitization or computer-aided detection, regardless of whether the actual benefit includes digitization or computer-aided detection.

Mental or Nervous Disorder. Any nervous, emotional and mental disease, illness, syndrome, or dysfunction, other than a behavior or conduct disorders, classified in the most recent edition of the *American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders* including, but not limited to neurosis, psychoneurosis, psychopathy, psychosis, and eating or panic disorder except for mental retardation. It also includes any nervous, emotional or nervous disorder that may be a manifestation of an organic condition, disease, illness, or syndrome, including organic mental syndrome associated with psychoactive substances (e.g., alcohol, cocaine, opiate, and others).

Morbid Obesity. Obesity of such degree as to interfere with normal activities, including but not limited to respiration.

Out-of-Pocket Maximum. The amount of Covered Charges that the Covered Person must pay each Calendar Year, as specified in the Schedule of Benefits excluding Calendar Year Deductible or Daily Deductible and Coinsurance.

Outpatient. See definition for Inpatient and Outpatient.

Physician or Doctor. A person who is licensed by the proper authorities of the state in which he or she practices and is operating within the scope of his or her license in rendering or prescribing treatment which gives rise to Covered Charge for which Claim is made; who is not the Insured Person or a Close Relative of the Insured Person by blood or marriage or who ordinarily does not reside in the household of such Insured Person.

Such duly licensed health care provider must act within the scope of his or her license and includes: (a) a Doctor of Medicine (M.D.); (b) a Doctor of Osteopathy (D.O.); (c) a Doctor of Podiatric Medicine (D.P.M.); (d) a Doctor of Dental Surgery (D.D.S); (e) a Doctor of Chiropractic (D.C.); (f) a Doctor of Optometry (O.D.); (g) a Psychiatrist (M.D.), (h) a Psychologist (PHD.) or (i) such other medical health care practitioners We recognize pursuant to applicable state law.

Plan Administrator. A third party administrator contracted by Us to perform the administration required under this Policy.

Policy. The contract providing the benefits described herein issued to the Policyholder.

Pregnancy. Being pregnant as confirmed by the results on an over-the-counter or Physician administered urine test, blood test, ultrasound, detection of fetal heartbeat, or an X-ray.

Pre-Certification/Pre-Certify. A screening process to determine if the proposed Inpatient Hospital Confinement and treatment plan are Medically Necessary. Pre-Certification is not pre-authorization or pre-approval of coverage and does not guarantee payment of benefits.

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Pre-Existing Conditions means any condition which manifested itself or which was the subject of medical advice or treatment by a health care provider during the six (6) month period immediately preceding the Effective Date of the Insured Person's coverage. Pregnancy is a Pre-Existing Condition when inception of the pregnancy preceded the Effective Date of the pregnant Insured Person's coverage regardless of whether the pregnant Insured Person knew of the pregnancy.

Prescription Medication. Any medical substance, remedy, vaccine, biological product, drug, pharmaceutical or chemical compound, other than an Specialty Medications, which can only be dispensed pursuant to a prescription and which is required to bear the following statement on the label: "Caution: Federal law prohibits dispensing without a prescription."

Room and Board Charges means the most common average semi-private Hospital room rate in the geographic area where service is provided.

Same Day Surgery Facility means a licensed public or private establishment with an organized staff of Physicians and permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures. It must provide continuous Physician services and registered professional nursing services whenever a patient is in the facility. It includes facilities operated by a Hospital which provide scheduled, non-emergency outpatient surgical care. It does not include a Hospital emergency room, trauma center, Physician's office, or clinic.

Semi-Private Rate. The Hospital's most common charge for a two-bed room.

Sickness. An illness, disease, or Complications of Pregnancy that causes loss while a Covered Person's coverage is in force under this Policy.

Skilled Nursing Facility. An institution meeting all of these requirements:

1. It operates pursuant to law and primarily provides room and board for people convalescing from Sickness or Injury;
2. It provides 24-hour nursing services for the full-time supervision of a Physician or Registered Nurse (RN);
3. It maintains adequate medical records;
4. It has the services of a Physician under an established agreement, if a Physician does not supervise the institution;
5. It is not: a rest home; or a nursing home; or a home for the aged; or a Free-standing Birthing Center; or a place primarily for the treatment of mental disease, drug addiction or alcoholism.

This term shall also apply to an institution which otherwise meets the required conditions, referring to itself as: a Skilled Nursing Facility; or a Convalescent Nursing Home; or any such other similar term.

Sound Natural Teeth. Teeth which are intact with a root, pulp, and have a maximum of two surfaces restored and/or decayed, and no missing tooth structure due to fracture.

Total Disability/Totally Disabled. The inability of the Covered Person to perform the normal substantial activities of his/her occupation if employed immediately prior to the onset of the disability, or of a person of like age and sex in good health if not so employed.

Specialty Care Facilities means a Skilled Nursing Facility, convalescent home, extended care facility, Home Health Care, and hospice services.

Spinal Manipulation means skeletal adjustment, adjunctive therapy, vertebral manipulation and dislocation-subluxation services.

Usual and Reasonable. Charges for services and supplies, which are the lesser of: (a) the Charge usually made for the service or supply by the Physician or Facility who furnished it; (b) the negotiated rate; and; (c) the reasonable Charge as determined by Us made for the same service or supply in the same geographic area.

We shall determine to what extent the Charge is reasonable, taking into account: (a) The complexity involved; (b) The degree of professional skill involved; (c) Data compiled and regularly updated from Our records or those of Our agents. We use and subscribe to a standard industry reference source that collects data for determining excessive fees and makes it available to its member companies. The data base used

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reflects the amounts Charged by providers for health care services based on the smallest geographic zip code areas generating a statistically credible charge distribution. This data is updated and published twice annually. The data is reflective of reported provider Charges from the lowest to the highest for each service or supply. The data is also adjusted periodically to reflect negotiated fee schedules with providers not included in the data base. We then use a specific representative percentile of that range of Charges; (d) The condition being treated; (e) Any medical complications or unusual circumstances; (f) The amounts the Physician or Facility routinely accepts as full payment from all payers after good faith collection efforts; and (g) other pertinent factors.

The Physician's or Facility's usual Charge must not exceed the usual Charge made by most providers of like service in the same geographic area. Area means the geographical area as determined by Us which is significant enough to establish a representative base of Charges for the treatment.

The following are examples of Charges that will not be considered Usual and Reasonable: (1) Pharmaceutical charges which exceed 200% of Average Wholesale Price or cost, which ever is less; (2) Unbundled Charges; and (3) Charges which industry standards recognize as included in the primary charge. When it is determined by this specific payment methodology that a Charge by a Physician or Facility is above the Usual and Reasonable amount, the Charge is not a Covered Charge.

Utilization Review (UR). A process used to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services, procedures, or settings.

Utilization Review Organization (URO). An entity that conducts UR other than a health carrier performing review for its own health plans.

We, Our, Us, The Company. Independence American Insurance Company, New York, New York.

You, Your. The person named on the Validation of Coverage as the Insured Person.

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INDEPENDENCE AMERICAN INSURANCE COMPANY

a Delaware Insurance Company

AMENDATORY ENDORSEMENT
FOR OHIO RESIDENTS ONLY

It is understood and agreed that the Policy to which this Amendatory Endorsement is attached is amended as follows:

A. **SECTION 3 – EXCLUSIONS AND LIMITATIONS OF COVERAGE**, the following is added to item 29 pertaining to Pre-existing condition:

29. For charges due to a Pre-Existing Condition until the date a Covered Person has been insured for twelve (12) consecutive months under this Policy. We will credit the time the Covered Person was covered by a plan of Creditable Coverage against this Pre-Existing Condition exclusion period if no more than 63 days elapsed between the termination of the Covered Person's prior Creditable Coverage and the Covered Person's Effective Date. This exclusion does not apply to Federally Eligible Individuals.

B. **SECTION 5 - TERMINATION OF COVERAGE**, the following is added:

Once an unmarried child has attained the limiting age for dependent children, We will cover the unmarried child until the child attains twenty-eight years of age if all of the following are true: (a) Your child is a natural child, stepchild, or adopted child; (b) The child is a resident of Ohio or a full-time student at an accredited public or private institution of higher education; (c) The child is not employed by an employer that offers any health benefit plan under which the child is eligible for coverage; (d) After having attained the limiting age, the child has been continuously covered under any health benefit plan; and (e) The child is not eligible for coverage under the Medicaid program established under Chapter 5111. of the Ohio Revised Code or the Medicare program established under Title XVIII of the "Social Security Act," 42 U.S.C. 1395.

C. **SECTION 7 – GENERAL PROVISIONS**, The first paragraph under External Review is deleted and replaced with:

A Covered Person or their Authorized Person, have the opportunity to file a request for an external review with Us at the address above within 180 days of receipt of denial if:

D. **SECTION 8 – DEFINITIONS,** the following changes are hereby made:

1. The **Sickness** definition is deleted and replaced with:

Sickness. An illness, disease, and Complications of Pregnancy that causes loss while a Covered Person's coverage is in force under the Policy.

Sickness includes the diagnosis and treatment of Biologically Based Mental Illness, if both of the following apply:

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

2. The following definitions are added:

Biologically Based Mental Illness. 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.

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Creditable Coverage. Coverage of an individual under any of the following:

1. a self-funded group health plan under the Employee Retirement Income Security Act of 1974;
2. group or individual health insurance coverage;
3. Part A or Part B of title XVIII of the Social Security Act;
4. Title XIX of the Social Security Act, other than benefits consisting solely of benefits under Section 1928;
5. Chapter 55 of title 10, United States Code;
6. a medical program of the Indian Health Service or of a tribal organization;
7. a state health benefit risk pool;
8. a health plan offered under chapter 89 of Title 5, United States Code;
9. a public health plan (as defined in federal regulations);
10. a health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e));
11. a State Children's Health Insurance Program (S-CHIP).

Prior benefits or coverage consisting solely of excepted benefits do not count towards, or contribute to, Your Creditable Coverage. Excepted benefits are those benefits not subject to Creditable Coverage requirements, not subject to Creditable Coverage requirements if offered separately, and not subject to Creditable Coverage requirements if offered as a separate insurance policy. Types of prior benefits or coverage that do not count towards Creditable Coverage include benefits received under one or more, or any combination, of the following:

1. coverage only for accident, or disability income insurance, or any combination thereof;
2. coverage issued as supplement to liability insurance;
3. liability insurance, including general liability insurance and automobile liability insurance;
4. worker's compensation or similar insurance;
5. automobile medical payment insurance;
6. credit-only insurance;
7. coverage for on-site medical clinics;
8. other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance benefits;
9. if offered separately, a limited scope dental or vision benefit;
10. if offered separately, benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof;
11. if offered separately, such other similar limited benefits as are specified in regulations;
12. limited scope dental or vision benefits;
13. benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof;
14. if offered as independent, non-coordinated benefits, coverage only for a specified disease or illness;
15. if offered as independent, non-coordinated benefits, hospital only or other fixed indemnity insurance;
16. if offered as a separate insurance policy, Medicare supplemental health insurance;
17. if offered as a separate insurance policy, coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code; and
18. if offered as a separate insurance policy, similar supplemental coverage provided to coverage under a group health plan.

This Amendatory Endorsement is subject to all provisions of the Policy which are not in conflict with the provisions of this Amendatory Endorsement. Nothing in this Amendatory Endorsement will be held to vary, alter, waive, or extend any of the terms, conditions, provisions, agreements, or limitations of the Policy other than stated above.

IN WITNESS WHEREOF, the Insurance Company has caused this Amendatory Endorsement to be signed by its President and Secretary.

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INDEPENDENCE AMERICAN INSURANCE COMPANY

David Kettig
President

Adam C. Vandervoort
Secretary

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

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

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

Coverage is *NOT* provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus
Insurance companies or their agents are required by law to give or send you this notice. *However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.*

The Ohio Life and Health Insurance Guaranty Association
1840 MacKenzie Drive
Columbus, Ohio 43220

Ohio Department of Insurance
50 W. Town Street
Third Floor, Suite 300
Columbus, Ohio 43215

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

COVERAGE

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

EXCLUSIONS FROM COVERAGE

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

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);

- the insurer was not authorized to do business in that state;
- their policy was issued by a medical, health or dental care corporation, an HMO, a fraternal benefit society, a mutual protective association or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

This association also does **not** provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate guarantees that exceed an average rate;
- dividends;
- credits given in connection with the administration of a policy by a group contractholder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them).

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the Association is obligated to pay out: The association cannot pay more than what the insurance company would owe under a group policy or contract. Also, for any one insured life, the association will pay a maximum of $300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall $300,000 limit, the association will not pay more than $100,000 in cash surrender values, $100,000 in health insurance benefits, $100,000 in present value of annuities, or $300,000 in life insurance death benefits – again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages.

Note to benefit plan trustees or other holders of unallocated annuities (GICs, DACs, Etc.) covered by the act: for unallocated annuities that fund governmental retirement plans under §§401(k), 403(b) or 457 of the Internal Revenue Code, the limit is $100,000 in present value of annuity benefits including net cash surrender and net cash withdrawal per participating individual. In no event shall the association be liable to spend more than $300,000 in the aggregate per individual; for covered unallocated annuities that fund other plans, a special limit of $1,000,000 applies to each contractholder, regardless of the number of contracts held with the same company or number of persons covered. In all cases, of course, the contract limits also apply.

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GRIEVANCE PROCESS

Please read this notice carefully. This notice contains important information about how to appeal decisions made by your insurer.

Definitions

1. **Authorized Person** means a parent, guardian, or other person authorized to act on behalf of a Covered Person with respect to health care decisions.

2. **Adverse Determination** means a determination by a health insuring corporation or its designee Utilization Review Organization that an admission, availability of care, continued stay or other health care service covered under the contract has been reviewed and based upon the information provided, the health care service does not meet the health insuring corporation's requirements for benefit payment, and is therefore denied, reduced, or terminated.

3. **Clinical Peer** means a Physician when an evaluation is to be made of the clinical appropriateness of health care services provided by a Physician. If an evaluation is to be made of the clinical appropriateness of health care services provided by a Provider who is not a Physician, "Clinical Peer" means either a Physician or a Provider holding the same license as the Provider who provided the health care services.

4. **Independent Review Organization** means an entity that conducts independent external reviews of adverse determinations.

5. **Utilization Review (UR)** means a process used to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services, procedures, or settings.

6. **Utilization Review Organization (URO)** means an entity that conducts UR other than a health carrier performing review for its own health plans.

Levels of Review

Mediation

After the exhaustion of the Company's appeals procedures, the parties will, in good faith, attempt to settle any dispute arising out of or related in any manner to the Policy that remains by mediation in accordance with the Insurance Dispute Resolution Program, as amended, and shall be conducted by the American Arbitration Association according to its Commercial Rules of Arbitration.

External Review Process

A Covered Person or their Authorized Person, have the opportunity to file an external review.

An external review must be requested in writing, except if the Covered Person has a condition that requires an expedited review, the review may be requested orally or by electronic means. When an oral or electronic request for review is made, written confirmation of the request must be submitted to Us no later than five (5) days after the request is made.

For an expedited review, the Covered Person's Provider must certify that the Covered Person's condition could, in the absence of immediate medical attention, result in any of the following:

(1) Placing the health of the Covered Person or, with respect to a pregnant woman, the health of the Covered Person or the unborn child, in serious jeopardy;
(2) Serious impairment to bodily functions; or
(3) Serious dysfunction of any bodily organ or part.

External Review Procedure

The procedures used in conducting an external review shall include all of the following:

(1) The review shall be conducted by an Independent Review Organization assigned by the Superintendent of Insurance;
(2) Neither the Clinical Peer nor any health care facility with which the Clinical Peer is affiliated shall have any professional, familial, or financial affiliation with any of the following:
    (a) Us, any of Our officers, directors, or managerial employees of Ours;

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(b) The Covered Person, the Covered Person's Provider, or the practice group of the Covered Person's Provider;
(c) The health care facility at which the health care service requested by the Covered Person would be provided; or
(d) The development or manufacture of the principle drug, device, procedure, or therapy proposed for the Covered Person.

We shall provide to the Independent Review Organization conducting the review a copy of those records in Our possession that are relevant to the Covered Person's medical condition and the review. At the request of the Independent Review Organization, We, the Covered Person, the Provider, or health care facility rendering the services shall provide any additional information the Independent Review Organization requests to complete the review. A request for additional information may be made in writing, orally, or by electronic means. The Independent Review Organization shall submit the request to the Covered Person and Us. If a request is submitted orally or by electronic means to the Covered Person or Us, not later than five (5) days after the request is submitted, the Independent Review Organization shall provide written confirmation of the request. If the review was initiated by a Provider or health care facility, a copy of the request shall be submitted to the Provider or health care facility.

An Independent Review Organization is not required to make a decision if it has not received any requested information that it considers necessary to complete a review. An Independent Review Organization that does not make a decision for this reason shall notify the Covered Person and Us that a decision is not being made. The notice may be made in writing, orally, or by electronic means. An oral or electronic notice shall be confirmed in writing not later than five (5) days after the oral or electronic notice is made. If the review was initiated by the Provider or health care facility, a copy of the notice shall be submitted to the Provider or health care facility.

We may elect to cover the service requested and terminate the review. We shall notify the Covered Person and all other parties involved with the decision by mail, or with the consent or approval of the Covered Person, by electronic means.

In making its decision, an Independent Review Organization conducting the review shall take into account all of the following: (1) Information submitted by Us, the Covered Person, the Covered Person's Provider, and the health care facility rendering the service, including the following: (a) the Covered Person’s medical records; and (b) the standards, criteria, and clinical rational used by Us to make Our decision.

(2) Findings, studies, research, and other relevant documents of government agencies and nationally recognized organizations, including the National Institutes of Health, National Cancer Institute, the National Academy of Sciences, the United States Food and Drug Administration, the Health Care Financing Administration of the United States Department of Health and Human Services, and the agency for Health Care Policy and Research; and

(3) Relevant findings in peer-reviewed medical or scientific literature, published opinions of nationally recognized medical experts, and clinical guidelines adopted by relevant national medical societies.

Expedited Review
In the case of an expedited review, the Independent Review Organization shall issue a written decision not later than seven (7) days after the filing of the request for review. In all other cases, the Independent Review Organization shall issue a written decision not later than thirty (30) days after the filing of the request. The Independent Review Organization shall send a copy of its decision to Us and the Covered Person. If the Covered Person's Provider or the health care facility rendering the service requested the review, the Independent Review Organization shall also send a copy of its decision to the Covered Person's Provider or the health care facility.

The Independent Review Organization's decision shall include a description of the Covered Person's condition and the principle reasons for the decision and an explanation of the clinical rational for the decision. The Independent Review Organization shall base its decision on the information submitted. In making its decision, the Independent Review Organization shall consider safety, efficacy, appropriateness, and cost-effectiveness.

We shall provide any coverage determined by the Independent Review Organization's decision to be Medically Necessary, subject to the other terms, limitations, and conditions of the Policy.

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INDEPENDENCE AMERICAN INSURANCE COMPANY

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

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice describes how we protect personal health information we have about you which relates to our medical, dental, vision and prescription drug coverage. Protected Health Information ("PHI") is individually identifiable information about you. All of the following are examples of PHI: demographic information like your name, address and social security number; medical information that relates to your past, present or future physical or mental health that is collected, created or received from you, a health care provider, a health plan, employer or a health care clearinghouse; the providing of health care; or the past present or future payment for providing health care to you.

Our Legal Duty

We are required by applicable federal and state laws to maintain the privacy of your PHI. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your PHI. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect April 14, 2003 or the date coverage became effective for you, whichever is later, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all PHI that we maintain, including PHI we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and send the new notice to our Insureds at the time of change.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosures of Your PHI

In conducting our business we will create records regarding you and the insurance services we provide you. The main reasons for which we may use and may disclose your PHI are to evaluate and process any requests for medical coverage and claims for benefits you may make. The following describe these and other uses and disclosures, together with some examples:

Treatment: We may use or disclose your PHI to facilitate medical treatment by providers. For example, your PHI may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to treat you. We may request the services of a business associate to assist us in these activities.

Payment: We may use and disclose your PHI to facilitate payment of benefits under your insurance coverage. For example, we might disclose your PHI to determine your eligibility for benefits, to coordinate benefits, to examine medical necessity, to obtain payments and to issue explanations of benefits. We also may use your PHI to obtain payment from third parties that may be responsible for your premium payments, such as family members.

Health Care Operations: We may use and disclose your PHI as necessary, and as permitted by law, to operate our business. Health care operations include: (i) rating our risk and determining our premiums for your insurance; (ii) conducting quality assessment and improvement activities; (iii) conducting or arranging for medical review, legal services, audit services, fraud and abuse detection and compliance programs; and (iv) business planning and development.

On Your Authorization: You may give us written authorization to use your PHI or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosure permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your PHI for any reason except those described in this notice.

To Your Family and Friends: We may disclose your PHI to a family member, friend, or other person to the extent necessary to help with your health care or for payment of your health care. We may use or disclose your name, location and general condition or death to notify, or assist in the notification, of (including identifying or locating) a person involved in your care. Before we disclose your PHI to a person involved with your health care or payment for your health care, we will provide you with an opportunity to object to such uses or disclosures. If you are not present, or in the event of your incapacity or an emergency, we will disclose your PHI based on our professional judgment of whether the disclosure would be in your best interest.

Your Employer or Organization Sponsoring Your Health Plan: We may disclose Your PHI and the PHI of others enrolled in your group insurance plan to the employer or other organization that sponsors your group insurance plan to permit the plan administrator to perform plan administration functions. We may also disclose summary information about the enrollees in your group insurance plan to the plan administrator to use to obtain premium bids for the health insurance coverage offered through your group insurance plan or to decide whether to modify, amend or terminate your group insurance plan. The summary information we may disclose will summarize claims history, claims expenses, or types of claims experienced by the enrollees in your group insurance plan. The summary information will be stripped of demographic information about the enrollees in the group insurance plan, but the plan administrator may still be able to identify you or other participants in your group health plan from the summary information. We may also disclose enrollment and disenrollment information to either the plan administrator or plan sponsor of your group insurance plan.

Underwriting: We may receive your PHI for underwriting, premium rating or other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits. We will not use or further disclose this PHI for any other purpose, except as required by law, unless the contract of health insurance or health benefits is placed with us, or where we disclose such information to MIB Group, Inc., a non-profit membership organization of life and health insurance companies, which operates an information exchange on behalf of its members. In those cases, our use and disclosure of your PHI will only be as described in this notice.

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Public Benefit: We may use or disclose your PHI as authorized by law for the following purposes deemed in the public interest or benefit:

- as required by law;
- for public health activities, including disease and vital statistic reporting, child abuse reporting; FDA oversight, and to employers regarding work-related illness or injury;
- to report adult abuse, neglect, or domestic violence;
- to health oversight agencies;
- in response to court and administrative orders and other lawful processes;
- to law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- to coroners, medical examiners, and funeral directors;
- to organ procurement organizations;
- to avert a serious threat to health and safety;
- to the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- to correctional institutions regarding inmates; and
- as authorized by state worker's compensation laws.

Business Associates: Certain aspects and components of our business are preformed through contracts with outside persons or organizations. Examples of these outside persons and organizations include our duly appointed insurance agents, third party administrators, financial auditors, actuarial and underwriting services, reinsurers, legal services, enrollment and billing services, claim payment and medical management services and collection agencies. At times it may be necessary for us to provide your PHI to one or more of these outside persons or organizations who assist us with our payment or health care operations. In all cases, we require these business associates to appropriately safeguard the privacy of your information.

Individual Rights

Access: In most cases, you have the right to inspect and obtain a copy of the PHI that we maintain about you. To inspect and copy PHI, you must submit your request in writing using the "Contact Information" provided at the end of this Notice. To receive a copy of your PHI, you may be charged a fee for the costs of copying, mailing or other supplies associated with your request. However, certain types of PHI will not be made available for inspection and copying. This includes psychotherapy notes and PHI collected by us in connection with, or in reasonable anticipation of any claim or legal proceeding. In very limited circumstances we may deny your request to inspect and obtain a copy of your PHI. If we do, you may request that the denial be reviewed. The review will be conducted by an individual chosen by us who was not involved in the original decision to deny your request. We will comply with the outcome of that review.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your PHI for purposes other than for treatment, payment, health care operations or as otherwise authorized by you since April 14, 2003 or the date coverage became effective for you, whichever is later. For example, we would account for your PHI or demographic information we disclose during an audit by an insurance department or pursuant to a court order. You must make your request in writing using the "Contact Information" provided at the end of this Notice. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Restriction: You have the right to request a restriction or limitation on PHI we use or disclose about you for treatment, payment or health care operations, or that we disclose to someone who may be involved in your care or payment for your care, like a family member or friend. While we will consider your request, **we are not required to agree to it**. If we do agree to it, we will comply with your request. To request a restriction, you must make your request in writing using the "Contact Information" provided at the end of this Notice. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply (for example, disclosures to your spouse or parent). We will not agree to restrictions on PHI uses or disclosures that are legally required, or which are necessary to administer our business.

Confidential Communications: You have the right to request that we communicate with you about PHI in a certain way or at a certain location if you tell us that communication in another manner may endanger you. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing using the "Contact Information" provided at the end of this Notice and specify how or where you wish to be contacted. We will accommodate all reasonable requests.

Amendment: If you believe that your PHI is incorrect or that an important part of it is missing, you have the right to ask us to amend your PHI while it is kept by or for us. You must provide your request and your reason for the request in writing using the "Contact Information" provided at the end of this Notice. We may deny your request if it is not in writing or does not include a reason that supports the request. In addition, we may deny your request if you ask us to amend PHI that: (i) is accurate and complete; (ii) was not created by us, unless the person or entity that created the PHI is no longer available to make the amendment; (iii) is not part of the PHI kept by or for us; or (iv) is not part of the PHI which you would be permitted to inspect and copy.

Right to File a Complaint: If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, submit your complaint using the "Contact Information" provided at the end of this Notice. All complaints must be submitted in writing. **You will not be retaliated against for filing a complaint**.

Contact Information: If you have questions regarding this Notice or need further assistance regarding this Notice, please contact us at:

Privacy Officer
IHC Health Solutions
Post Office Box 37587; Phoenix, AZ 85069-7587
Phone: (602) 395-7043

SPECIMEN

Independence American Insurance Company
485 Madison Avenue
New York, New York 10022

PRIVACY NOTICE

Applicable to United States Personal Lines Policyholders
We value the trust of our policyholders and others with whom we do business. This privacy notice will provide you with our policy regarding the collection and protection of nonpublic personal information that is collected by us when our policyholders and former policyholders, seek to obtain, or obtain financial products and services primarily for personal, family or household purposes.

Categories of Nonpublic Personal Information We Collect
We may collect certain nonpublic financial and health information when underwriting, administering or servicing an insurance policy or in handling a claim. This information may be collected from our affiliates, independent insurance agents or brokers, the policyholder, the claimant, the claimant's employer or a financial institution. We may collect nonpublic personal information from persons who witnessed incidents, or persons retained by a claimant or by us in the administering or servicing a policy or handling a claim. The person retained could be a physician, attorney, accountant, appraiser or a representative from a repair shop or consumer reporting agency. Information that may be collected includes, but is not limited to, a policyholder's name, address, telephone number, social security number, policy number, premium and/or premium payment history, medical history, assets, income, claim history, and credit reports. We also may collect from a claimant the claimant's name, address, telephone number, social security number, medical history, employment history, claim number, date of loss, type of loss, cause of loss, claim status, and value of a claim.

Categories of Nonpublic Personal Information We May Disclose
Nonpublic personal information may be shared with affiliated and non-affiliated third parties in order to administer or service an insurance policy or a claim, and as otherwise permitted or required by law. Our affiliates include insurance companies, administrators, investment companies, brokers/dealers, and other providers of financial and medical products and services. Examples of unaffiliated third parties include an independent insurance agent or broker, persons or organizations retained to assist in the administration of policies and/or claims (such as appraisers, repair shops, claim adjusters and medical providers), insurance support organizations, reinsurers, companies we have joint marketing agreements with, and others as may be permitted or required by law. We sometimes must collect nonpublic personal health information to provide you a product or a service such as underwriting an insurance policy or evaluating a claim. We do not share this information for any other purposes except the following: administering your policy, account, or claim, as required or permitted by law, or as otherwise authorized by you.

Categories of Nonpublic Personal Information Usage
We use nonpublic personal information to underwrite, administer or service a policy, administer a claim or in connection with billing charges and as otherwise permitted by law. Nonaffiliated third parties that may receive or have access to our nonpublic personal information are not authorized to use such information for any marketing purposes except as permitted by law. They may not copy or disclose nonpublic personal information to any other party and may use it only for the purpose of performing their responsibilities to us or one of our policyholders, or claimants, and as otherwise permitted by law.

Security of Nonpublic Personal Information
We control access to nonpublic personal information to those who need access to provide products and services to policyholders and to others as permitted or required by law. We maintain physical, electronic, and procedural safeguards to protect against the misuse of nonpublic information under our control.

SPECIMEN

Modifications to our Privacy Policy – Additional Copies of Privacy Notice

We reserve the right to change our privacy policies in the future, which could include sharing nonpublic personal information with nonaffiliated third parties for purposes other than as stated in this Notice. We will provide you with a revised privacy notice before we do that. Requests for additional copies of the Privacy Notice may be submitted to the following office: IHC Health Solutions, Privacy Officer, P.O. Box 37587, Phoenix, AZ 85069.

Privacy Notices from Other Independence American Insurance Company and Independence Holding Company Affiliates

In addition to this Privacy Notice, Independence American Insurance Companies customers may receive separate privacy notices from other business units, companies, affiliates and subsidiaries of Independence American Insurance Company, or Independence Holding Company. The terms of this Privacy Notice do not modify, revise, or amend the terms of other privacy notices received from other business units, companies, affiliates or subsidiaries of Independence American Insurance Company, or Independence Holding Company.

Access To and Amending Personal Information:

You have the right to request access to the personal information that we record about you. Your right includes the right to know the source of the information and the identity of the persons, institution or types of institution to whom we have disclosed such information within 2 years prior to your request. Your right includes the right to view such information and copy it in person, or request that a copy of it be sent to you by mail (for which we may charge you a reasonable fee to cover our costs). Your right also includes the right to request corrections, amendments or deletions of any information in our possession. The procedures that you must follow to request access to or an amendment of your information as follows:

To obtain access to your information: You should submit a request in writing to IHC Health Solutions, Privacy Officer, P.O. Box 37587, Phoenix, AZ 85069-7587. The request should include your name, address, social security number, telephone number, and the recorded information to which you would like access. The request should state whether you would like access in person or a copy of the information sent to you by mail. Upon receipt of your request we will contact you within 30 business days to arrange to provide you with access in person or the copies that you have requested.

To correct, amend, or delete any of your information: You should submit a request in writing to IHC Health Solutions, Privacy Officer, P.O. Box 37587, Phoenix, AZ 85069-7587. The request should include your name, address, social security number, telephone number, the specific information in dispute, and the identity of the document or record that contains the disputed information. Upon receipt of your request, we will contact you within 30 business days to notify you either that we have made the correction, amendment or deletion, or that we refuse to do so and the reasons for the refusal, which you will have an opportunity to challenge.

Independence American Insurance Company
Privacy Officer
485 Madison Avenue
New York, New York 10022

IHC Health Solutions
Privacy Officer
P.O. Box 37587
Phoenix, AZ 85069-7587

SPECIMEN

INDEPENDENCE AMERICAN INSURANCE COMPANY

a Delaware Insurance Company

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

IMPORTANT NOTICE REGARDING HEALTH POLICIES PROVIDING COVERAGE FOR THE TREATMENT OF BREAST CANCER

This notice is being provided in accordance with the Women's Health and Cancer Rights Act of 1998. The law provides important benefits for breast cancer patients who elect breast reconstruction in connection with a mastectomy.

Any Covered Person who is receiving benefits under coverage offered by Independence American Insurance Company in connection with a mastectomy, performed on a person who has been diagnosed with breast cancer, and who elects breast reconstruction, the coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

1. Reconstruction surgery performed to reconstruct the breast on which the mastectomy was performed;
2. Surgery or reconstruction of the non-diseased breast for which mastectomy was not required in order to restore or achieve breast symmetry; and
3. Prosthetic devices and treatment of physical complications, including lymphedemas at all stages of the mastectomy.

The coverage is subject to all provisions of the Policy, including your Calendar Year Deductible or Daily Deductible, Coinsurance and any applicable Co-payments, as shown on Your Schedule of Benefits or any Amendments/Endorsements issued after the coverage Effective Dates.

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