CELTIC INSURANCE COMPANY
233 South Wacker Drive, Suite 700, Chicago, Illinois 60606-6393

INDIVIDUAL MAJOR MEDICAL EXPENSE COVERAGE
I5-555-00229-KS

OUTLINE OF COVERAGE

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

Individual Major Medical Expense Coverage - This *policy* provides, to the *insured person*, coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital medical services, out of hospital care and prosthetic appliance, subject to any deductibles, coinsurance, co-payment provisions, or other limitations which may be set forth in the *policy*.

The *policy* is underwritten by *us*, Celtic Insurance Company. *We* will pay *benefits* to *you*, the *insured person*, for covered loss due to *sickness, bodily injury* or *complication of pregnancy* as outlined in this *policy*. *Benefits* are subject to *policy* definitions, provisions, limitations and exceptions.

GUARANTEED RENEWABLE EXCEPT FOR SPECIFIED REASONS: This *policy* is renewable at the option of the *insured person*. Celtic may only non renew this coverage for one of the following reasons:

- The *insured person* fails to make any required premium payment, subject to the grace period provision;
- The *insured person* has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the *policy;* or
- *We* discontinue coverage for all *insured persons* in your state.

TEN DAY RIGHT TO RETURN POLICY: Please read your *policy* carefully. If you are not satisfied, return this *policy* to Celtic or to *our* agent within 10 days after *you* receive it. All premiums paid will be refunded, less any *benefits* paid, and the *policy* will be considered null and void from the effective date.

CONSIDERATION: *We* issued this *policy* in consideration of the application and the payment of the first premium. Coverage will not become effective if premium payment is not honored when first presented by Celtic. A copy of *your* application is attached, and is made a part of the *policy*.

PLEASE SEE THE ATTACHED PREMIUM RATE INFORMATION.

____
Agent name and date (please print)

____
Agent signature

BENEFITS PROVIDED BY THE POLICY

- **INPATIENT HOSPITAL CHARGES** for room, board and nursing services *incurred* by an *insured person* while *hospital confined* up to the average semi-private *room and board* charge in that *hospital.* This includes *inpatient hospital services* and supplies *medically necessary* for the treatment of the *insured person* while *hospital confined.* For *intensive care,* the maximum *eligible expense* is four times the average semi-private room charge.

- **INPATIENT OR OUTPATIENT SURGICAL CHARGES** made by a *physician* for surgical services.

    - Assistant Surgeon - The *eligible expense* for required services of an assistant surgeon, when *medically appropriate,* are paid at 20% of the *eligible expense* allowed for the primary surgeon's charges. If there are two or more co-surgeons, the combined coverage for all surgeon and assistant surgeon charges will be limited to 120% of the *reasonable and customary charge* for a single surgeon.
    - Multiple Surgeries - When two or more surgical procedures are performed in the same operative session, 50% of the *reasonable and customary* allowance is considered eligible for the subsequent surgeries.
    - Anesthesia Charges - *Eligible expenses* are limited to the anesthesia *reasonable and customary charge* for the surgery(s) performed regardless of the number of *providers* administering the anesthesia.

- **OUTPATIENT HOSPITAL CHARGES** for surgical facilities, *emergency room,* laboratory, radiology, diagnostic testing, pre-admission and other outpatient ancillary services.

- **OBSERVATION UNIT CHARGES** in a *hospital* facility are covered up to half the semi-private *room and board* charge or up to $250.00 per occurrence in an outpatient facility.

- **OUTPATIENT MEDICAL SERVICE CHARGES** for the following medical services:

    - Nonsurgical professional services by a *physician* or *nurse*;
    - Outpatient services for non-routine laboratory and x-ray used for diagnosis or treatment;
    - Tubal ligations and vasectomies performed as *outpatient surgery.* If a tubal ligation performed while *hospital confine*d due to a covered *pregnancy,* then those charges will be considered as *eligible expenses;*
    - Ambulance Charges - Ground or air transportation in an ambulance to a *hospital,* required as a result of a *medical emergency,* up to $5,000.00 per *calendar year*;
    - Coverage for the administration of general anesthesia and medical care facility charges for dental care provided to the following covered persons:
        - a child five years of age and under; or
        - a person who is severely disabled; or
        - a person has a medical or behavioral condition which requires hospitalization or general anesthesia when dental care is provided; and
    - Coverage for services related to diagnosis, treatment and management of osteoporosis when such services are provided by a medical *provider* licensed to practice medicine and surgery in Kansas, for *insured person's* with a condition or medical history for which bone mass measurement is medically necessary for such individual.

- **OUTPATIENT MEDICAL SUPPLY CHARGES** for the following medical supplies:

    - *Prescription drugs*;
    - Blood, blood plasma and oxygen;

- Initial artificial limbs or eyes needed to replace natural limbs or eyes that are lost while an *insured person's* coverage is in force;
- Casts, splints, surgical dressings, crutches, the rental of wheel chairs, *hospital* beds, and other *durable medical equipment.* The rental fees cannot exceed the purchase price;
- Diabetic equipment and supplies including insulin, syringes and any additional medically necessary items prescribed by a physician;
- Coverage for diabetes outpatient self-management training and education including medical nutrition therapy when prescribed by a *physician* or healthcare professional legally authorized to prescribe such services. The *insured person* must be treated in accordance with an approved program, by a person certified by the National Certification Board for Diabetes Educators, or in the case of nutrition therapy, by a licensed dietitian;
- Chemotherapy, *specialty drugs*, and biotech medications administered parenterally in an outpatient setting. These medications must be precertified. *Celtic* determines the *eligible expense* to be 75% of the *Prescription Benefit Manager's* charge for these medications;
- Coverage for the following immunizations for *dependent* children age 0 to 72 months (deductible, coinsurance and copayment amounts do not apply to this benefit):
  - 5 doses of vaccine against diphtheria, pertussis and tetanus;
  - 4 doses of vaccine against polio, Haemophilus B (Hib);
  - 3 doses of vaccine against Hepatitis B;
  - 2 doses of vaccine against measles, mumps and rubella;
  - 1 dose of varicella virus (chicken pox) vaccine; or
  - other such vaccines and dosages as may be prescribed by the secretary of health and environment; and
- Initial prosthetic devices required as a result of mastectomy.

- **HEALTH SCREENING CHARGES:**

  - Mammogram - Coverage for screening by low-dose mammography as recommended by a physician. The recommended frequencies are as follows:
    - one baseline mammogram for an *insured person* age 35 through 39;
    - one mammogram per *calendar year* for an *insured person* age 40 and over;;
  - Cytology - Cervix - Coverage for cytologic screening when performed at the direction of a physician;
  - Prostate Cancer - Coverage for prostate cancer screening, including a prostate-specific antigen (PSA) blood test and a digital rectal examination. Coverage will be provided according to the following guidelines:
    - one screening per *calendar year* for an *insured person* age 40 to 50 years of age who is symptomatic or in a high risk category; and
    - one screening per *calendar year* for an *insured person* age 50 and over.*and.*
  - Colorectal cancer screening with colonoscopy or fecal occult blood testing for:
    - an *insured person* age 50 or over every three years; or
    - an *insured person* age 30 or older who may be classified as high risk for colorectal cancer, because the *insured person* or a first-degree family member has a history of colorectal cancer.

- **RECONSTRUCTIVE BREAST SURGERY** charges for reconstructive breast surgery as a result of a partial or total mastectomy performed while an insured person's coverage is in force. Coverage includes:

- all stages of reconstructive breast surgery performed on a non-diseased breast to establish symmetry with a diseased breast when reconstructive surgery on the diseased breast is performed;
- Prostheses; and
- Treatment of physical complications for all stages of mastectomy including lymphedemas.

- **HUMAN ORGAN AND TRANSPLANT CHARGES** for *medically necessary, non-experimental* human *organ transplants. Eligible expenses* for *transplants* include all *transplantrelated expenses* such as pre-*transplant* testing; chemotherapy or radiation therapy when supported by *transplant* procedures; *prescription drugs* and medications, including those administered to mobilize stem cells for *transplants*; and inpatient hospitalization and outpatient services up to one year post *transplant. Eligible expenses* do not include storage charges *incurred* beyond 60 days of the removal of an *organ. Benefits* are available for a maximum of two *transplant* procedures per lifetime.

  Certified non-*experimental transplant* procedures can be performed by either a *transplant network provider* or by a *non-transplant-network provider*. If a *transplant network provider* is used, *benefits* are payable up to the amount of negotiated charges within the network. Travel and lodging expenses related to the covered *transplant* will be reimbursed up to a maximum of $2500.00.

  If a *non-transplant network provider* is used, *benefits* for certified, non-*experimental transplant* procedures will be reimbursed up to $100,000 per procedure. No charges for travel, lodging, *donor* search or *organ* procurement made outside of the *transplant network* will be considered *eligible expenses.*

- **INPATIENT OR OUTPATIENT REHABILITATION THERAPY CHARGES:**

  - *Eligible expenses* include confinement in a *rehabilitation facility* up to a maximum of 30 days per *calendar year*; and
  - Outpatient *rehabilitation therapy* up to a maximum of 30 visits per *calendar year.*

- **EXTENDED CARE AND SKILLED NURSING FACILITY CHARGES** up to 12 days of confinement per *calendar year* in an *extended care* or *skilled nursing facility*, but only if a *hospital confinement* would otherwise be needed.

- **HOME HEALTH CARE CHARGES** up to 30 visits per *calendar year*, by a *home health care agency*, but only if a *hospital* or *extended care facility* confinement would otherwise be needed;

- **HOSPICE SERVICE CHARGES** up to $5,000 per an *insured person's* lifetime for *hospice services* and supplies;

- **MANIPULATIVE THERAPY CHARGES** for manipulative therapy up to $500 in *eligible expenses* per *insured person* per *calendar year* regardless of the type of *physician* providing the care. Manipulative therapy includes diagnosis and non-surgical treatment of structural imbalance, distortion, dislocation, misplacement or subluxation of vertebrae or the spinal column.

- **ALCOHOLISM, DRUG ABUSE, NERVOUS OR MENTAL CONDITION CHARGES:** Treatment of alcoholism, drug abuse, nervous or mental conditions while confined in a medical care facility; treatment facility for drug abusers or alcoholics, community mental health center or clinic, or psychiatric hospital licensed by the state of Kansas up to 30 days.

After the *insured person's annual deductible* has been paid, outpatient treatment of alcoholism, drug abuse, nervous or mental conditions in the facilities listed above when confinement is not necessary for the treatment, or by a physician licensed or psychologist licensed to practice under the laws of the state of Kansas will be paid at 100%, subject to the lifetime maximum of $7,500.

- **PREVENTIVE CARE BENEFIT:** After coverage has been in force for 90 days, *eligible expenses* for medical services and supplies *incurred* for *preventive care* in an *asymptomatic individual* are covered at [100%], up to [$300] per *insured person* per *calendar year.* [The *annual deductible* does not apply to all *eligible expenses* for Preventive Care Benefits.]

  Preventive Care Benefits include, but are not limited to, charges for the following:

  - Annual physical examinations, including office visits;
  - Routine x-rays, labs and diagnostic tests;
  - Screening services such as pap smears, mammograms, colorectal cancer tests, bone mass measurement, cardiovascular and diabetes tests;
  - Immunizations; and
  - Routine eye exam up to $[50] per *calendar year.*

  Charges for medical supplies and services under this provision are not considered *eligible expenses* under any other section of this *policy*. *Preventive Care Benefits* in excess of the yearly maximum cannot be used to satisfy the *out-of-pocket maximum.*

EXCLUSIONS AND LIMITATIONS

Exclusions

Charges *incurred* for the following are not *eligible expenses*:

- Normal *pregnancy* and delivery, elective or repeat cesarean section unless the Optional Maternity Benefit Rider is attached;

- Elective abortion;

- *Sickness or bodily injury* as a result of:

  - Participation in a riot, felony or other illegal act;
  - Suicide or attempted suicide or self-inflicted *bodily injury* while sane or insane;
  - *Bodily injury, total disability* or death sustained while being intoxicated by and/or under the influence of alcohol, drugs or narcotics unless used as prescribed by a *physician*. Intoxication is defined and determined by the laws of the jurisdiction where the loss or the cause of the loss occurred. The alcohol intoxication exclusion applies only to the expenses resulting from an accident occurring while the *insured person* is operating a motorized vehicle; or
  - Any act of war, declared or undeclared, or service in the military forces of any country, including non-military units supporting such forces;

- Routine well-baby care, including newborn nursery charges, of a *dependent* child, unless required by state law. Well-baby care is defined as charges not related to a *sickness* or *bodily injury*;

- Diagnosis, treatment or surgical procedure relating to fertility or infertility;

- Tubal ligations or vasectomies performed while *hospital confined.* If a tubal ligation is performed during a *pregnancy* or *complication of pregnancy,* then those charges will be considered as *eligible expenses*. The reversal of a tubal ligation or vasectomy is not covered at any time;

- Treatment or surgery for exogenous, endogenous or morbid obesity;

- Smoking cessation or weight loss programs, except as covered under the Healthy Lifestyle Program;

- Acupuncture except for treatment of chronic pain;

- *Cosmetic surgery*; complications of *cosmetic surgery* or drugs prescribed for cosmetic purposes;

- Reconstructive surgery unless surgery is needed as a result of a bodily injury sustained while coverage is in force or, in a newborn child, to correct a functional defect resulting from a congenital abnormality or developmental anomaly. This exclusion does not include reconstructive breast surgery as listed in Section IV;

- Treatment or surgery for gender re-assignment (sex change);

- Repair or replacement of artificial limbs, artificial eyes or other prosthetic devices;

- Repair, replacement or maintenance to *durable medical equipment*;

- Eye refractions, vision therapy, glasses or fitting of glasses, contact lenses, or surgical or non-surgical treatment to correct refractive eye disorders or any treatment or procedure to correct vision loss. Routine eye exams are only covered under the Preventive Care Benefit

- Hearing aids, exams or fittings, or surgical or non surgical treatment to correct hearing loss;

- Orthognathic surgery; prevention or correction of teeth irregularities and/or malocclusion of jaws; dental implants, removal, replacement or treatment of or to teeth (including removal of impacted or unerupted teeth) or surrounding tissues; except:

  - Treatment of sound, natural teeth due to *bodily injury* that occurs while the *insured person's* coverage is in force and the *bodily injury* must not have been caused directly or indirectly by biting or chewing. All treatment must be completed within six (6) months of the date of *bodily injury*.

- Expenses resulting from or related to the procurement or donation of any *organ* in conjunction with a *transplant* for individuals not covered by this plan;

- Treatment or medication that is *experimental/investigational*; except coverage for a *prescription drug* for cancer treatment on the grounds the *prescription drug* has not been approved by the federal food and drug administration for that covered indication if the *prescription drug* is recognized for treatment of the indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature. The prescribing *physician* shall submit to the insurer documentation supporting the proposed off-label use or uses if requested by Celtic.

- [Birth control drugs, regardless of their intended use;]

- *Custodial care;*

- *Room and board* unless the *insured person* has an overnight stay. In the case where an *insured person* leaves a *hospital, psychiatric care* or *extended care facility* for visitation privileges, the *insured person* must return to sleep in the facility before midnight the same night;

- Any otherwise eligible expense for services for injuries of diseases related to your job to the extent you are covered or are required to be covered by the Workers' Compensation law. If you enter into a settlement giving up your right to recover future medical benefits under a Workers' Compensation law, the policy will not pay those medical benefits that would have been payable in absence of that settlement;

- Any otherwise *eligible expense* for which *you* are not financially responsible in the absence of this insurance;

- Any otherwise *eligible expense* for treatment provided by a *hospital* operated by a government body unless *you* are required to pay;

- Treatment received outside the United States:
  - except for a medical emergency while traveling for up to a maximum of (90) consecutive days.
  - if travel extends beyond 90 consecutive days, no coverage is provided for medical emergencies for the entire period of travel including the first 90 days.

- *Sickness* caused by a congenital defect, which affects a bodily function, unless the *sickness* begins while the *insured person's* coverage is in force;

- Services or supplies eligible for payment under either federal or state programs (except Medicaid). This exclusion applies whether or not *you* assert *your* rights to obtain this coverage or payment of these services;

- Complications of any treatment or surgery for an excluded service or procedure;

- Any amount in excess of the *reasonable and customary charge*;

Pre-existing Conditions Limitation

A *pre-existing condition* is a *sickness* or *bodily injury* for which an *insured person* received a diagnosis, medical advice, consultation or treatment from a *physician* during the 12 months prior to the effective date of coverage, or which, in the opinion of a *physician,* caused symptoms during the 12 months prior to the effective date that were obvious enough to cause an ordinarily prudent person to seek diagnosis, medical care or treatment.

Benefits are paid for an *insured person's pre-existing condition* once coverage is in force for 12 continuous months after the effective date, unless specifically excluded from coverage under this *policy.*

Any treatment or service for an excluded *pre-existing condition*, including any *complications* or conditions resulting from treatment of a *pre-existing condition* are not *eligible expenses.*

Weekend Admissions Limitations

There is a restriction for non-emergency weekend admissions. If an *insured person* is *hospital confined* on a Friday, Saturday, or Sunday, *room and board* expenses will only be covered if the treatment or surgery is certified, as required, and is performed within 24 hours from the time *hospital confinement* begins

TERMINATION OF COVERAGE

Coverage Terminates

All coverage terminates for an *insured person* at 12:01 a.m. on the day following the date through which your premium has been paid if any of these circumstances occurs:

- The *insured person* gives prior written notice of termination;
- The *insured person* begins living outside the United States;
- The *insured person* fails to make any required premium payments, subject to the grace period provision;
- The *dependent* ceases to be eligible under the plan;
- We discontinue to offer a particular type of health insurance coverage in the individual market; or
- The *policy* is terminated.

If there are losses for charges *incurred* in connection with a disability or medical condition that began while coverage was in force, this *policy* does not provide *benefits* after the *insured person's* coverage terminates.

The Policy Is Terminated

The *policy* provides continuous coverage subject to the payment of monthly premiums and all other *policy* provisions. Celtic can terminate the *policy* on the first day of any month by giving at least 90 days prior written notice to the *primary insured person.* Celtic can modify any provision and can terminate any line of business, any class of eligible *insured persons*, or any plan or option.

In any case in which Celtic elects to discontinue offering all health insurance coverage in the individual market in Kansas, health insurance coverage may be discontinued by Celitc only if:

- Celtic provides notice to each covered *insured person* who is provided such *policy* providing hospital, medical or surgical expense benefits at least 90 days prior to the date of the discontinuation of such coverage;

- Celtic offers to each covered *insured person* who is provided such *policy* providing hospital, medical or surgical expense benefits the option to purchase any other individual policy providing hospital, medical or surgical expense benefits which is being sold by Celtic; and

- in exercising the option to discontinue coverage Celtic acts uniformly without regard to any health status-related factor of *insured person* or individuals who may become eligible for coverage under the *policy.*

If Celtic elects to discontinue offering any individual policies providing hospital, medical or surgical expense benefits in this state, such insurance coverage may be discontinued only if:

- Celtic provides notice to the commissioner and to each *insured person* of such discontinuation at least 180 days prior to the date of the expiration of such coverage; and

- Celtic is prohibited from the issuance of any individual policies providing hospital, medical or surgical expense benefits in the state during a five-year period beginning on the date of the discontinuation of the last individual *policy* providing hospital, medical or surgical expense benefits which is not renewed.

- **Cancellation by Primary Insured Person**

The *primary insured person* may cancel this *policy* at any time by giving written notice delivered or mailed to Celtic, effective upon receipt of such notice or on such later date as may be specified in such notice. In the event of cancellation or death of the *primary insured person*, Celtic will promptly return the unearned portion of any premium paid. The earned premium shall be computed on a pro-rata basis. Cancellation shall be without prejudice to any claim originating prior to the effective date of cancellation.

- **Conversion**

  When this coverage ends as a result of a *primary insured person's* death or dissolution of marriage or attainment of the limiting age by a *dependent*, *dependents*, if insured under the plan immediately prior to termination, may apply for a new *policy* issued on the same form as this *policy*, if approved in the state where they live. Proof of good health will not be required. A new *policy* will be issued subject to the following:

  - The *dependent* must notify Celtic in writing within 60 days of the date of the *primary insured person's* death or entry of a judgment of divorce or attainment of the limiting age by a *dependent*. Failure to provide such notice will result in the loss of coverage;
  - The first premium must be sent to *us* and received within 31 days after the *dependent* ceases to be an *insured person* or within 60 days after the entry of a judgment of divorce of the *primary insured person,* if later;
  - The premium will be based on the attained age and rating class applicable to the *insured person* for the *policy*;
  - The new *policy* will not provide *benefits* greater than those provided under this *policy*;
  - The effective date of the new *policy* will be the date coverage ends under this *policy*;
  - Any special provisions that apply to a *dependent* under this *policy* will also apply under the new *policy*; and
  - A new *policy* will not be issued if it would result in overinsurance under our usual underwriting guidelines.

- **Handicapped Child**

  Medical expense plan coverage can be continued for a child who is unable to earn his own living because of a handicapped condition and is principally dependent on the *primary insured person* or *other care providers* for total care and supervision. *Celtic* may request proof of such a handicap no earlier than two months prior to the date the child reaches the limiting age, or as reasonably required thereafter. Proof acceptable to *Celtic* must be furnished within 60 days.

  Celtic may, from time to time, at its own expense require proof that the handicap continues. It may also have the *dependent* examined by *physicians* chosen by *Celtic*.