ASSURANT Health®

Assurant. On your terms.®

Short Term Medical

Temporary Insurance for Gaps in Health Coverage

30 - 180 Days

- Between Jobs
- Waiting for Employer Benefits
- Temporary or Seasonal Employees
- Newly Independent

Unexpected illnesses and accidents happen every day, and the resulting medical bills can be disastrous. Until you enroll in permanent coverage, safeguard your financial future with **Short Term Medical temporary insurance.** It provides the peace of mind and health care access you need at a price you can afford.

You can depend on Short Term Medical. Assurant Health marketed the first temporary insurance coverage in 1973 and has remained a leader ever since.

Time Insurance Company

Assurant Health is the brand name for products underwritten and issued by Time Insurance Company.

Choose Short Term Medical when you are

- between jobs
- looking for a lower-cost alternative to COBRA coverage*
- waiting for employer-sponsored benefits
- a temporary or seasonal employee
- newly independent

* To preserve your rights to guaranteed health insurance and coverage for pre-existing conditions, you may need to purchase up to 18 months of COBRA. You may forego these rights when you purchase a Short Term Medical plan or choose to go without insurance.

Who's eligible for Short Term Medical?

- Healthy individuals between the ages of 30 days and 64 years, 11 months who answer "no" to all questions.
- Dependent children under age 18* (age 24 if a full-time student) may be covered as dependents on a parent's plan

* For residents of CO, IA, ME, MN, MT, TX, UT, and VA: under the age of 25 regardless of student status.
* For residents of IN & TN: under the age of 24 regardless of student status.
* For residents of LA: under the age of 21 (age 23 if full-time student).
* For residents of ND: under the age of 22 (age 25 if full-time student).
* For residents of ID, NH & OK: under the age of 26 regardless of student status.
* For residents of SD: under the age of 19 (age 24 if full-time student).

Designing your plan

Your Short Term Medical plan design is based on three things:

- deductible
- length of time you need coverage
- coinsurance

Decide on the deductible right for you.

Consider the tradeoff when choosing:

- A lower deductible means you'll pay higher premiums (the amount you pay for your health coverage) but less out of pocket if you get sick or injured.
- A higher deductible means lower premiums but a greater initial sum out of pocket if you get sick or injured.

To decide how long you need health coverage, consider your needs.

If you pay by the month, simply stop paying when you secure permanent health insurance.

If you already know how long you'll need coverage, you can **save 20% on your premium** by making a single, up-front payment. Premium refunds are not available when making a single payment. Your payment is due when you enroll.

TelaDoc™*

Now you can have access to a national network of licensed physicians 24 hours a day, 365 days a year — by phone! TelaDoc is a convenient, cost-effective alternative for minor medical problems and a current solution for the health care issues of cost and access.

* Not available in OK.

Short Term Medical Benefits

With Short Term Medical, you get the following valuable benefits for unexpected illnesses and injuries. More details will appear in your enrollment kit. ***Coverage starts as early as the next day!***

Covered expenses are subject to your deductible and coinsurance unless otherwise noted.

PLAN FEATURES

Doctor Visits	• Covered for unexpected illness and injury • Choose your own doctors • Discounts for using network doctors — on average 20-35% off** • Teladoc™*
Hospital Benefits	• Inpatient and outpatient services covered • Discounts for using network facilities — on average 20-35% off**
Emergency Room Care	Covered
Ambulance	Service to nearest hospital able to treat condition
Outpatient Services	Covered
Prescription Drug Benefits	Covered
X-ray and Laboratory	Covered
Transplant Benefits	$100,000 including up to $10,000 in donor expenses
Extension of Benefits *(If you become ill or injured while covered by a Short Term Medical plan, your benefits may be extended.)*	• Continued coverage at no additional cost for up to 12 months if you are hospitalized* • $1,000 in benefits at no additional cost for up to 60 days if you have a non-disabling condition * *totally disabled in FL*
Deductible *(The amount you must pay before Assurant Health pays any benefits.)*	• $1,000, $2,500, $3,500, $5,000* • Families pay only ONE deductible per policy * *Options may vary by state.*
Coinsurance	100%/0%, 80%/20%, 50%/50%* * *Options may vary by state.*
Lifetime Maximum *(Maximum amount your plan will pay toward medical bills per covered person.)*	$2 million

* TelaDoc is not available in OK.
** Not applicable in RI.

Know What's Not Covered*

Knowing exactly what your health plan does and doesn't cover is important. To give you the best possible experience, we offer this summary of what is not covered. Complete details are included in your insurance contract.

- Treatment of a pre-existing condition, including those not inquired about on the enrollment form
- Routine care, examinations or immunizations
- Illness or injury that is self-inflicted or caused while engaged in a felony, under the influence of an illegal substance, driving under the influence, in military service, in a hazardous occupation or activity for which compensation is received, or while engaged in intercollegiate sports
- Vision or dental treatments, foot care or orthotics
- Expenses incurred outside the United States, its possessions and Canada
- Maternity,** genetics or fertility treatment or testing
- Custodial care or private nursing
- Cosmetic, experimental, investigational or not medically necessary treatment
- Treatment of mental illness or substance abuse

* Covered charges in excess of reasonable and customary amounts are not covered under this Short Term Medical plan.
Notice for NE residents: THIS PLAN DOES NOT PROVIDE BASIC COVERAGE FOR THE TREATMENT OF MENTAL HEALTH CONDITIONS AND ALCOHOLISM.
** Does not apply to MT residents.
Note: Depending on the state, an Outline of Coverage is available from the agent or insurer. Please refer to the Outline of Coverage for a description of the important features of the health benefit plan.

J-61301 (Rev. 7/2010)

Pre-existing condition information

Short Term Medical plans provide coverage for unexpected illnesses and injuries, meaning they do not cover pre-existing conditions. While the definition of "pre-existing condition" varies by state, in general it is a condition that has been diagnosed or treated, or for which you experienced signs or symptoms, during the 5 years immediately prior to the Short Term Medical effective date.*

If you need your insurance plan to cover treatment of an existing medical condition, consider extending your current plan to fill your gap in coverage. Employer-sponsored insurance can be extended under a government-regulated option called COBRA.

Because Short Term Medical is designed to cover the unexpected, it does not provide coverage for preventive care, physicals, dental care, or vision care.

*Please see pages 8-10 for your state's pre-existing definition.

Benefits are paid as follows:

FIRST	You pay the deductible.		
THEN	100%/0%	80%/20% coinsurance	50%/50% coinsurance
		You pay 20% of the next $10,000 in covered charges up to a maximum of $2,000.	You pay 50% of the next $10,000 in covered charges up to a maximum of $5,000.
THEREAFTER	Assurant Health pays 100% of remaining covered charges up to the plan maximum of $2 million for each covered person.		

When does coverage begin?

Your coverage will begin at 12:01 a.m. on your approved effective date, provided the enrollment form received is complete,* meets the requirements for acceptance, and includes the full initial premium. Your requested effective date must be within 45 days of the date you signed the enrollment form.

* Enrollment forms that do not meet eligibility requirements will be returned to the applicant or agent. Incomplete enrollment forms may be returned and/or re-dated by Assurant Health.

Two convenient payment options

Paying for your Short Term Medical plan is easy with these two convenient payment options:

- Single payment option: save 20% on your premium if you know the exact number of days you need coverage. The minimum plan duration you may apply for is 30 days, the maximum is 180 days. No refunds are available after the 10-day free look period.†
- Monthly payment option: ideal if you are unsure how long you'll need coverage. This "pay as you go" option gives you the flexibility to continue coverage for as long as you need—simply stop paying and discontinue the plan once you secure permanent insurance.

For FL, MD, MI, PA, VA and WI residents only

When you purchase Short Term Medical insurance, you are enrolled in Health Advocates Alliance, an association dedicated to the health and well-being of its members. Membership benefits include access to a 24-hour nurse helpline and discounts on vitamins and LensCrafters® purchases.

Premium refunds

If you are not 100 percent satisfied with the plan, simply call and cancel your coverage within 10 days of delivery for a premium refund. No questions asked! After the 10-day free look period, premiums are not refundable.† The one-time application fee is not refundable at any time.

†Not applicable to residents of FL, GA, ID, KS, KY, MI, OH, SC and TX.

J-61301 (Rev. 7/2010)

Reduce your medical costs*

You may be able to reduce your medical bills by using the doctors and hospitals participating in the PHCS Healthy Directions provider network. Simply call or go online to see if your doctor or hospital is part of PHCS Healthy Directions:

800.357.6847 • www.phcs.com

* Not applicable in RI.

TelaDoc™*

Now you can have access to a national network of licensed physicians 24 hours a day, 365 days a year — by phone! TelaDoc is a convenient, cost-effective alternative for minor medical problems and a current solution for the health care issues of cost and access.

* Not available in OK.

Purchasing an additional plan

When your plan expires, you may be eligible for another plan depending on how long you have been covered by Short Term Medical plans. Short Term Medical is temporary coverage. Plans cannot be renewed like permanent insurance. If you are issued a new Short Term Medical plan, the new plan will not provide benefits for any conditions or symptoms that existed during the previous plan.

Keep in mind that short term plans are not meant to be a substitute for permanent health insurance coverage. An Assurant Health Individual Medical plan may be a better option.

More solutions to suit your needs

- **Ideal companions — STM and HSA**
  Many of our STM plans, including all plans with 100% coinsurance and deductibles of $2,500 and higher are compatible with Health Savings Accounts (HSAs). That means you don't have to wait for an individual medical or group plan to build health expense savings the smart way. HSAs are completely portable – an HSA goes with you when you move to any qualified health plan.

- **Protection longer than six months**
  When your needs are longer than 180 days, Assurant Health has you covered. We have a portfolio of individual health plans with broad coverage options. Plans are designed with features that can help you save on your overall health care costs and on your premium. That makes it easier to find a plan with benefits that mean the most to you at a price you can afford.

More information is available at assuranthealth.com

J-61301 (Rev. 7/2010)

STATE NOTICES

CA Language Assistance Program (LAP) Notice

IMPORTANT: You can get an interpreter at no cost to talk to your doctor or health insurance company. To get an interpreter or to ask about written information in Spanish, first call your insurance company's phone number at 800-800-1212. Someone who speaks Spanish can help you. If you need more help, call the Department of Insurance Hotline at 800-927-4357.

IMPORTANTE: Puede obtener la ayuda de un intérprete sin costo alguno para hablar con su médico o con su compañía de seguros. Para obtener la ayuda de un interprete o preguntar sobre información escrita en español, primero llame al número de teléfono de su compañía de seguros al: 800-800-1212. Alguien que habla español puede ayudarle. Si necesita ayuda adicional, llame a la línea directa del Departamento de seguros al 800-927-4357.

CO

Colorado law requires carriers to make available a Colorado Health Benefit Plan Description Form, which is intended to facilitate comparison of health plans. The form must be provided automatically within three (3) business days to a potential policyholder who has expressed interest in a particular plan or who has selected the plan as a finalist from which the ultimate selection will be made. The carrier also must provide the form, upon oral or written request, within three (3) business days, to any person who is interested in coverage under or who is covered by a health benefit plan of the carrier.

We maintain an access plan for each network offered in Colorado. The access plan includes information regarding availability and accessibility of participating providers and our method of informing you of the plan's services and features. The access plan is available upon request by contacting us at 800-800-5453.

OH

WARNING: IF YOU OR YOUR FAMILY MEMBERS ARE COVERED BY MORE THAN ONE HEALTH CARE PLAN, YOU MAY NOT BE ABLE TO COLLECT BENEFITS FROM BOTH PLANS. EACH PLAN MAY REQUIRE YOU TO FOLLOW ITS RULES OR USE SPECIFIC DOCTORS AND HOSPITALS, AND IT MAY BE IMPOSSIBLE TO COMPLY WITH BOTH PLANS AT THE SAME TIME. BEFORE YOU ENROLL IN THIS PLAN, READ ALL OF THE RULES VERY CAREFULLY AND COMPARE THEM WITH THE RULES OF ANY OTHER PLAN THAT COVERS YOU OR YOUR FAMILY.

NH

Your rates are guaranteed for the policy term
The premium you are quoted at the time of application will not change for the term of the policy. You can get a Short Term Medical plan for up to six months. If you purchase a plan for six months and pay monthly, the rate you are quoted when you apply is the same rate you'll pay each month the plan is in force.

Factors considered in the calculation of your premium
Our rating procedures are designed to treat you fairly and consistently with individuals similar to you. We comply with the guidelines set forth by your state. The premium rate you pay depends primarily on the specific benefit plan you have selected and your individual factors.
Factors include:
- Age of you and your spouse (if applicable)
- Number of dependents
- Geographic location
- Payment frequency (single payment or monthly payments)
- Length of coverage

Your coverage will not be terminated for filing claims
Our practice is not to terminate any covered person based on his or her claims experience. Policy termination will only occur when one of the following conditions exist:
- Non-payment of premium at the time it is due
- Evidence of fraud or an intentional misrepresentation of a material fact

Renewal provisions
Short Term Medical is a temporary coverage option, so plans cannot be renewed like permanent insurance. However, when your plan expires, you may apply for another plan if you have not had in total more than 540 days of short-term coverage within the preceding 24-month period.

Coverage for unexpected illness and injury
Because Short Term Medical protects you against the cost of unexpected illnesses or accidents, it does not provide coverage for any injuries or medical conditions that existed before the effective date of coverage. Please refer to your insurance policy for a full description of a pre-existing condition.

A full description of the policy exclusions, reductions and exceptions can be found in the insurance policy and on the state-specific supplements. This information is also available online at assuranthealth.com on the Short Term Medical page, or by viewing Plan Details when you get an online quote.

These practices reflect our commitment to provide you with the highest quality of coverage at an affordable premium, and are in compliance with the state of New Hampshire.

Pre-existing condition information

This pre-existing condition definition is used in AK, AL, AR, AZ, FL, GA, HI, IA, IN, KS, LA, MD, MN, NE, NV, OH, OK, OR, TN, VA, WA, WI, WV and WY. For all other states, see the definitions below.

PRE-EXISTING CONDITION: A medical condition due to sickness or injury:

1. For which the insured received medical treatment or advice from a provider within the 5-year period immediately preceding the effective date of coverage, regardless of whether the condition was diagnosed or not diagnosed; or
2. That produced signs or symptoms within the 5-year period immediately preceding the effective date of coverage. The signs or symptoms must have been significant enough to establish manifestation or onset by one of the following tests:
   a) The signs or symptoms would have allowed one learned in medicine to make a diagnosis of the disorder; or
   b) The signs or symptoms should have caused an ordinarily prudent person to seek diagnosis or treatment.

A pregnancy that exists on the day before your effective date will be considered a pre-existing condition.

CA

PRE-EXISTING CONDITION: A medical condition due to sickness or injury for which medical advice, diagnosis, care or treatment, including the use of prescription drugs, was recommended or received from a health care practitioner within the 6-month period immediately preceding the effective date of coverage.

CO

PRE-EXISTING CONDITION: A medical condition due to sickness or injury for which you received medical advice, diagnosis or care or for which treatment was recommended or received from a provider during the 12-month period immediately prior to your Short Term Medical effective date, regardless of whether the condition was diagnosed or not diagnosed.

DC

PRE-EXISTING CONDITION: A medical condition due to sickness or injury:

1. For which the insured received medical treatment or advice from a provider within the 5-year period immediately preceding the effective date of coverage, regardless of whether the condition was diagnosed or not diagnosed; or
2. That produced signs or symptoms within the 5-year period immediately preceding the effective date of coverage. The signs or symptoms must have been significant enough to establish manifestation or onset by one of the following tests:
   a. The signs or symptoms would have allowed one learned in medicine to make a diagnosis of the disorder; or
   b. The signs or symptoms should have caused a person to seek diagnosis or treatment.

A pregnancy that exists on the day before your effective date will be considered a pre-existing condition.

DE

PRE-EXISTING CONDITION: A medical condition due to sickness or injury for which the insured received medical treatment or advice from a provider within the 12-month period immediately preceding the effective date of coverage, regardless of whether the condition was diagnosed or not diagnosed.
A pregnancy that exists on the day before your effective date will be considered a pre-existing condition.

ID

PRE-EXISTING CONDITION: A medical condition due to sickness or injury and related complications:

1. A condition that would have caused an ordinarily prudent person to seek medical advice, diagnosis, care or treatment during the six (6) months immediately preceding the effective date of coverage;
2. For which medical advice, diagnosis, care or treatment was recommended or received from a provider within the 6-month period immediately preceding the effective date of coverage;

A pregnancy that exists on the effective date will be considered a pre-existing condition.

IL

PRE-EXISTING CONDITION: A medical condition due to sickness or injury:

1. For which the insured received medical treatment or advice from a provider within the 2-year period immediately preceding the effective date of coverage, regardless of whether the condition was diagnosed or not diagnosed; or
2. That produced signs or symptoms within the 1-year period immediately preceding the effective date of coverage. The signs or symptoms must have been significant enough to establish manifestation or onset by one of the following tests:
   a) The signs or symptoms would have allowed one learned in medicine to make a diagnosis of the disorder; or
   b) The signs or symptoms should have caused an ordinarily prudent person to seek diagnosis or treatment.

A pregnancy that exists on the day before your effective date will be considered a pre-existing condition.

KY

PRE-EXISTING CONDITION: A sickness or an injury and related complications if during the 5 year period immediately prior to your effective date you received medical treatment, diagnosis, consultation, or took prescription drugs for the condition. Genetic information in the absence of a diagnosis of a condition related to such information will not be considered a pre-existing condition. A pregnancy that exists on the day before your effective date will be considered a pre-existing condition.

ME

PRE-EXISTING CONDITION: A medical condition due to sickness or injury:

1. For which the insured received medical advice, diagnosis, care or treatment from a provider within the 12-month period immediately preceding the effective date of coverage, regardless of whether the condition was diagnosed or not diagnosed; or
2. That produced signs or symptoms within the 12-month period immediately preceding the effective date of coverage that would caused an ordinarily prudent person to seek medical advice, diagnosis, care or treatment.

A pregnancy that exists on the day before your effective date will be considered a pre-existing condition.

MI

PRE-EXISTING CONDITION: A medical condition due to sickness or injury:

1. For which the insured received medical advice, diagnosis or care or for which treatment was recommended or received from a provider within the 5-year period immediately preceding the effective date of coverage, regardless of whether the condition was diagnosed or not diagnosed; or
2. That produced signs or symptoms within the 5-year period immediately preceding the effective date of coverage. The signs or symptoms must have been significant enough to establish manifestation or onset by one of the following tests:
   a) The signs or symptoms would have allowed one learned in medicine to make a diagnosis of the disorder; or
   b) The signs or symptoms should have caused an ordinarily prudent person to seek diagnosis or treatment.

A pregnancy that exists on the day before your effective date will be considered a pre-existing condition.

MO

PRE-EXISTING CONDITION: A medical condition due to sickness or injury:

1. For which the insured received medical treatment or advice from a provider within the 5-year period immediately preceding the effective date of coverage, regardless of whether the condition was diagnosed or not diagnosed; or
2. That produced signs or symptoms within the 5-year period immediately preceding the effective date of coverage, when such signs or symptoms should have caused an ordinarily prudent person to seek diagnosis or treatment.

A pregnancy that exists on the day before your effective date will be considered a pre-existing condition.

MS

PRE-EXISTING CONDITION: A medical condition due to sickness or injury:

1. For which medical advice, care or treatment was recommended or received from a provider within the 12-month period immediately preceding the effective date of coverage, regardless of whether the condition was diagnosed or not diagnosed; or
2. That would have caused an ordinarily prudent person to seek medical advice, diagnosis, care or treatment within the 12-month period immediately preceding the effective date of coverage.

A pregnancy that exists on the day before your effective date will be considered a pre-existing condition.

MT

PRE-EXISTING CONDITION: A medical condition due to sickness or injury:

For which the insured received medical advice or treatment was recommended by or received from a provider of health care services within the 5-year period immediately preceding the effective date of coverage.

NC

PRE-EXISTING CONDITION: A medical condition due to sickness or injury for which medical advice, diagnosis, care, or treatment was received or recommended within the 1-year period immediately preceding the effective date of the insured's coverage, regardless of whether the condition was diagnosed or not diagnosed.

ND

PRE-EXISTING CONDITION: A medical condition due to sickness or injury for which the insured received medical treatment or advice from a provider within the 2-year period immediately preceding the effective date of coverage, regardless of whether the condition was diagnosed or not diagnosed. A pregnancy that exists on the day before Your effective date will be considered a pre-existing condition.

NH

PRE-EXISTING CONDITION: A medical condition due to sickness or injury for which the insured received medical treatment or advice from a provider within the 2-year period immediately preceding the effective date of coverage, regardless of whether the condition was diagnosed or not diagnosed. A pregnancy that exists on the day before your effective date will be considered a pre-existing condition.

PA

PRE-EXISTING CONDITION: A medical condition due to sickness or injury for which the insured received medical treatment or advice from a provider within the 5-year period immediately preceding the effective date of coverage, regardless of whether the condition was diagnosed or not diagnosed.

RI

PRE-EXISTING CONDITION: A medical condition due to sickness or injury:

1. For which the insured received medical treatment or advice from a provider within the 12-month period immediately preceding the effective date of coverage, regardless of whether the condition was diagnosed or not diagnosed; or
2. That produced signs or symptoms within the 12-month period immediately preceding the effective date of coverage. The signs or symptoms must have been significant enough to establish manifestation or onset by one of the following tests:
   a. The signs or symptoms would have allowed one learned in medicine to make a diagnosis of the disorder; or
   b. The signs or symptoms should have caused an ordinarily prudent person to seek diagnosis or treatment.

A pregnancy that exists on the day before your effective date will be considered a pre-existing condition.

SC

PRE-EXISTING CONDITION: A medical condition due to sickness or injury: For which medical advice or treatment was received or recommended from a provider within the 1-year period immediately preceding the effective date of coverage, regardless of whether the condition was diagnosed or not diagnosed.

SD

PRE-EXISTING CONDITION: A medical condition due to sickness or injury:

1. For which the insured received medical advice, diagnosis, care, or treatment was recommended or received during the 12-month period immediately preceding the effective date of coverage; or
2. Which would have caused an ordinarily prudent person to seek medical advice, diagnosis, care or treatment during the 12-month period immediately preceding the effective date of coverage. A pregnancy that exists on your effective date will be considered a pre-existing condition.

TX

PRE-EXISTING CONDITION: A disease, illness, condition or an injury and related complications:

1. For which medical advice, diagnosis, care or treatment was sought, received or recommended from a provider or prescription drugs were prescribed within the 5-year period immediately preceding the Insured's Effective Date of coverage; or
2. That produced signs or symptoms within the 5-year period immediately preceding the Insured's Effective Date of coverage which would have caused an ordinarily prudent person to seek diagnosis or treatment.

UT

PRE-EXISTING CONDITION: A medical condition due to sickness or injury:

1. For which medical treatment or advice was received or recommended from a provider within the 5-year period immediately preceding the insured's effective date of coverage, regardless of whether the condition was diagnosed or not diagnosed; or
2. That produced signs or symptoms within the 5-year period immediately preceding the insured's effective date of coverage which would have caused an ordinarily prudent person to seek diagnosis, care, or treatment.

A pregnancy that exists on the day before your effective date will be considered a pre-existing condition.

If you have questions about Assurant Health or Short Term Medical, call 1.800.800.5453.

This brochure provides a brief description of the important features of this plan. For specific costs and for the details of the coverage, including exclusions and reduction or limitations, and the terms under which the policy may be continued in force, contact your agent or Assurant Health.This is not the insurance policy. The actual plan sets forth in detail the rights and obligations of both you and your insurance company. State mandated benefits, if applicable, are incorporated in your plan.

135/136/137/135.001.TX/135.001.TX.A

TIME INSURANCE COMPANY
501 West Michigan
Milwaukee, WI 53203
A Stock Company

TIME INSURANCE COMPANY
SHORT TERM MEDICAL EXPENSE POLICY
OUTLINE OF COVERAGE
FOR WASHINGTON RESIDENTS

Read Your Policy Carefully - This outline of coverage provides a very brief description of the important features of Your policy. This is not the insurance contract, and the actually 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!

SHORT TERM DURATION MEDICAL EXPENSE COVERAGE: The policy is designed to provide coverage for hospital, medical, and surgical expenses incurred as a result of Medically Necessary care for a covered Sickness, Mental Illness or Injury during a Benefit Period. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services, anesthesia services, in-hospital medical services and out of hospital care subject to any deductibles, coinsurance or co-payment provisions, or other limitations which may be set forth in the policy. Covered Expenses will be based on what We determine to be the Reasonable and Customary Amount.

AUTHORIZATION REQUIREMENT: To be eligible to receive the maximum benefits available read the Authorization Provisions section in the policy carefully. Authorization is required for all Hospital, Skilled Nursing Facility and inpatient rehabilitation admissions, outpatient or day surgeries, transplants, home health care, outpatient Physical Medicine visits and monthly rental or purchase of durable medical equipment that exceeds $500. Failure to follow the Authorization Provisions could result in no payment or a reduction in benefits.

PAYMENT OF BENEFITS: After the Deductible and/or any Copayment is satisfied, We will pay benefits for Covered Expenses at the Rate of Payment up to the Lifetime Maximum Benefit, or any other limitations as set forth in the policy, for each Insured during a Benefit Period. Benefits are subject to all the terms, limits and conditions in the policy.

COVERAGE INFORMATION				
Deductible Individual: $_____ Family: $ _____	Out of Pocket Limit Individual: $_____ Family: $ _____	Copayment $_____	Prescription Drug Deductible $_____	Prescription Drug Copayment $_____
Rate of Payment: _____ % of the Reasonable and Customary Amount until the Out-of-Pocket Limit is satisfied, 100% of the Reasonable and Customary Amount thereafter.	Lifetime Maximum Benefit $_____	Benefit Period _____ Days	Waiting Period for Sickness _____ Days	

Inpatient Hospital Services: _____	Inpatient Rehabilitation: _____
Outpatient Hospital Services: _____	Skilled Nursing Facility: _____
Health Care Practitioner Services:	Home Health Care: _____
Surgical: _____	Outpatient Physical Medicine: _____
Anesthesia: _____	Ambulance: _____
Per Office Visit: _____	X-ray and Lab: _____
Reconstructive Surgery: _____	Prescription Drugs: _____

BENEFIT PERIOD: The length of time the policy is in force. The policy is not renewable.

RATE OF PAYMENT: The amount We will pay of the Reasonable and Customary Amount for a Covered Expense, after You pay Your Deductible. You are responsible for any coinsurance balance. The Rate of Payment applies separately to each Insured during a Benefit Period. The payment of Covered Expense is subject to the Lifetime Maximum Benefit or any other maximum benefit for those services under the policy, whichever is less.

COVERED EXPENSES: Charges for services, treatment or supplies prescribed by a Health Care Practitioner. Services must be received and charges must be incurred by You or Your Covered Dependents while the policy is in force. Covered Expense must be Medically Necessary and does not include any charge in excess of the Reasonable and Customary Amount. Benefits are available from the first day Covered Expenses are incurred for an Injury that is sustained on or after the Effective Date of the coverage. Benefits are available for a Sickness that first manifests itself after any Waiting Period. A Sickness manifests itself if You receive medical treatment or consultation for it or have signs or symptoms of it.

REASONABLE AND CUSTOMARY AMOUNT: The lesser of: 1) The actual charge; or 2) What the provider would accept for the same service or supply in the absence of insurance; or 3) The reasonable amount as determined by Time Insurance Company, based on factors such as: a) the amount of resources expended to deliver the service or supply; or b) the amount charged for the same or comparable service or supply in a community similar to where the service or supply is furnished; or c) the costs incurred by providers in a community similar to where the service or supply is furnished and the amount by which such service or supply is commonly marked up by providers; or d) charging protocols and billing practices generally accepted by the medical community or specialty groups, including charging protocols and billing practices related to Medicare; or e) inflation trends by geographic region; or 4) Another schedule or method of deriving charges, as identified in the policy.

BENEFITS PROVIDED BY THE POLICY: Only the services and supplies listed in the policy will be considered Covered Expenses. The policy provides benefits for the following Covered Expenses:

- **Inpatient Hospital Services:** Room, board and routine nursing services that are provided to all inpatients while confined in a semi-private room, ward, coronary care or other intensive care unit in a Hospital. If You are in a private room, We will pay benefits based on the Hospital's most common daily charge for a semi-private room. The maximum benefit is shown on page one. Upon the recommendation of a Health Care Practitioner, Covered Expenses will include home health care when provided in lieu of inpatient Hospital services, at equal or lesser cost. In order for home health care to be covered under this benefit, a Health Care Practitioner must certify that inpatient Hospital confinement would otherwise be required, and must approve a written treatment plan. Home health care will not be substituted for inpatient Hospital care without Your consent.

- **Outpatient Hospital Services:** Services performed in a Hospital's outpatient department or in a Free-Standing Ambulatory Surgical Facility. The maximum benefit is shown on page one.

- **Health Care Practitioner Services, Surgical and Anesthesia Services:** Surgical services, anesthesia services and Health Care Practitioner services (not including office visits). The maximum benefit is shown on page one. Office visits to a Health Care Practitioner are shown separately.

- **Reconstructive Surgery:** Reconstructive surgery to restore function for conditions resulting from accidental Injury provided the Injury occurred while the Insured is covered under the policy. Reconstructive surgery that is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part if the trauma, infection or other diseases occurred or had their onset while the Insured was covered under the policy.

Reconstructive surgery needed because of Medically Necessary surgical removal of all or part of the breast when such removal was done as the result of a condition that had its onset while the Insured was covered under the policy. In such case, reconstructive surgery includes reconstruction of the breast on which the mastectomy has been performed, and reconstruction of the other breast to produce a symmetrical appearance Reconstructive surgery because of congenital illness or anomaly of a Covered Dependent child, born while the policy is in force, that resulted in a functional defect. The maximum benefit is shown on page one.

- **Inpatient Rehabilitation Programs:** Inpatient rehabilitation includes, but is not limited to, physical, occupational and speech therapy provided on an inpatient basis in a facility that is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the Commission on Accreditation of Rehabilitative Facilities when the confinement is in lieu of acute hospitalization. The maximum benefit is shown on page one.

- **Skilled Nursing Facility Care:** Care in a Skilled Nursing Facility when the confinement is in lieu of acute hospitalization or for the same condition that required a Hospital confinement. The maximum daily benefit for care in a Skilled Nursing Facility will not exceed: 1) one-half of the semi-private Hospital room rate for the Hospital confinement; or 2) one-half of the most common semi-private Hospital room rate for the area in which You live if You were not previously Hospital confined. The maximum benefit is shown on page one.

- **Home Health Care:** Home health care that is provided as part of an alternative care arrangement as a substitute for inpatient Hospital care is covered separately under the Inpatient Hospital Services benefit. For all other home health care, Covered Expenses are for home health care visits provided by a state licensed or Medicare certified home health agency. One visit consists of up to 4 hours of home health aide service within a 24-hour period. The maximum benefit is shown on page one.

- **Outpatient Physical Medicine Services:** Outpatient Physical Medicine includes, but is not limited to: physical, speech or occupational therapy; pulmonary or cardiac rehabilitation therapy; or adjustments and manipulations provided in the outpatient department of a Hospital, by a licensed or certified home health care agency or by a licensed therapist in Your home. One visit consists of up to 3 hours of therapy within a 24-hour period. The maximum benefit is shown on page one.

- **Ambulance Services:** Ambulance service for one trip to the nearest Hospital that is able to treat the Sickness or Injury. The maximum benefit is shown on page one.

- **X-ray and Laboratory Services:** X-ray, radioactive treatment and laboratory charges. The maximum benefit is shown on page one. This includes diagnostic and screening mammography for a covered female, colorectal and prostate cancer screenings upon the recommendation of a Health Care Practitioner.

- **Durable Medical Equipment and Supplies:** Rental, up to the purchase price, or purchase of a basic non-electric wheelchair, basic non-electric hospital bed or basic crutches; the initial permanent basic artificial limb or eye; oxygen and the equipment needed to administer oxygen; casts, orthopedic braces, splints, dressings and sutures; and the initial external breast prosthesis needed because of Medically Necessary surgical removal of all or part of the breast provided the surgery was performed while the Insured was covered under the policy. There is up to a maximum benefit of $1,000.00 per Benefit Period for all of the items listed above combined.

- **Blood Product Transfusions:** Whole blood, blood plasma and blood products if not replaced.

- **Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction:** Surgical and non-surgical treatment of temporomandibular or craniomandibular joint dysfunction, except for the treatment and services outlined in the policy. The combined maximum for all surgical and non-surgical treatment is limited to $1,000.00 for each Insured per Benefit Period.

- **Complications of Pregnancy:** Sickness arising from a pregnancy for an Insured who is covered under this policy, for which diagnoses is distinct from the pregnancy but is adversely affected by the pregnancy or is caused by the pregnancy, except for heperemesis gravidarum or a non-emergency caesarean section delivery and similar conditions associated with the management of a difficult pregnancy not constituting a nosologically

distinct complication of pregnancy. Benefits are provided on the same basis as for any other covered Sickness.

- **Prescription Drugs:** Drugs and medicines that are fully approved by the U.S. Food and Drug Administration, are received on an outpatient basis, require the written prescription of a Health Care Practitioner for treatment of a condition that is a Covered Expense under the policy (including Mental Illness) and are dispensed by a licensed pharmacy. Coverage for prescription drugs includes Medically Necessary equipment and supplies that are prescribed for the treatment of diabetes, including insulin, syringes, injection aids, blood glucose monitors and test strips, insulin pumps and infusion devices, oral agents for controlling blood sugar levels, glucagons emergency kits, and foot care appliances for prevention of complications associated with diabetes. The maximum benefit is shown on page one.

- **AIDS/HIV Services:** Treatment of AIDS, AIDS Related Complex (ARC) or related immunodeficiency disorders.

- **Transplantation Benefit:** Certain human organ/tissue transplants or replacements as listed in the policy and donor expenses provided that the transplant is the result of a Sickness or Injury that had its onset after the Effective Date of the policy. The maximum transplant benefit per Benefit Period is $100,000 for all transplants, combined transplants, and sequential transplants. Covered Expenses of a live donor will be considered up to the maximum lifetime transplant benefit amount that remains after the Insured's Covered Expenses under the transplantation benefit have been paid.

- **Diabetes Self-Management Training Benefit:** Outpatient self-management training and education, including medical nutrition therapy, as prescribed by a Health Care Practitioner.

- **Nutritional Formulas:** Nutritional formulas as Medically Necessary for the treatment of phenylketonuria, as administered under the direction of a Health Care Practitioner. The Pre-Existing Conditions Limitation does not apply to this benefit.

- **Mental Illness:** Medically Necessary treatment of Mental Illness, except for treatment through skilled nursing facility services, home health care, residential treatment and custodial care.
  Common Questions Regarding Mental Illness Benefits:
  1. **What are the steps that must be taken to have outpatient mental health services paid for by my plan?** ANSWER: Outpatient Hospital Services and Health Care Practitioner Services (office visits) for treatment of Mental Illness do not require preauthorization. However, other covered services, including inpatient procedures, Outpatient Surgery, and Inpatient Rehabilitation Programs, require preauthorization of medical appropriateness in accordance with the Authorization Provision section of Your policy.
  2. **What information about my mental condition will anyone other than my mental health provider see?** ANSWER: During verification of claims and processing, We may view Your claims and medical records including but not limited to diagnostic details, treatment codes, treatment plans including expected outcomes, and progress notes.
  3. **Do I have to pay a higher co-pay, deductible or other charges than I pay for my other covered medical services to get mental health services under this plan?** ANSWER: Mental Illness is treated like any other Sickness under this plan. Coinsurance, deductible and out-of-pocket costs will be the same as other covered general Sickness benefits under this plan.
  4. **What is the maximum number of medically necessary in-patient days and out-patient visits I can get each year under this plan?** ANSWER: Mental Illness is treated like any other Sickness under this plan; Mental Illness benefits are limited by the general contract terms the same as Sickness generally; Inpatient Rehabilitation Program benefits are limited to 30 days per Benefit Period.
  5. **What is the average number of outpatient visits this plan pays for people who have been provided mental health services?** ANSWER: 2008 is the first year that this plan pays for Mental Illness, therefore plan-specific information is not available at this time. However, other plans We offer average payment of between 11 to 20 visits per 12-month period for persons who use services for treatment of Mental Illness.
  6. **In which circumstances where I might need mental health services would I find them excluded or subject to restrictions or limitations other than medical necessity?** ANSWER:

Skilled nursing facility services, home health care, residential treatment, custodial care and when there is a diagnosed mental disorder related to sexual dysfunction or a sex change.

7. **What is this plan's most common goal in financing treatment in adults? In children?** ANSWER: For both adults and children, Our most common goal is to return the Insured Person to previous functioning.

PRE-EXISTING CONDITIONS LIMITATION: No benefits will be provided during the term of the policy for any Pre-Existing Condition. A Pre-Existing Condition is a medical condition due to Sickness or Injury for which the Insured received medical treatment or advice from a provider within the 5 year period immediately preceding the Effective Date of coverage, regardless of whether the condition was diagnosed or not diagnosed; or that produced signs or symptoms within the 5-year period immediately preceding the Effective Date of coverage. The signs or symptoms must have been significant enough to establish manifestation or onset by one of the following tests: 1) The signs or symptoms would have allowed one learned in medicine to make a diagnosis of the disorder; or 2) The signs or symptoms should have caused an ordinarily prudent person to seek diagnosis or treatment. A pregnancy that existed on the day before Your Effective Date of coverage is also considered a Pre-Existing Condition.

WAITING PERIOD LIMITATION: We will not pay benefits during the term of the policy for charges incurred due to a Sickness that manifests itself before any Waiting Period. Benefits are available from the first day Covered Expenses are incurred for an Injury that is sustained on or after the Effective Date of Your coverage.

EXCLUSIONS: The policy does not cover any of the following:

- Conditions for which claims were submitted under a prior Short Term Medical policy or certificate issued by Us that provided coverage that ended within 90 days before the Effective Date of the policy.

- Intentionally self-inflicted Sickness or Injury, whether sane or insane.

- Free services of a federal, veteran's, state or municipal Hospital.

- Sickness or Injury to the extent that benefits are paid by Medicare or any other government law or program, except Medicaid (Medi-Cal in California); or medical coverage under any automobile or no fault insurance.

- Sickness or Injury eligible for benefits under worker's compensation, employers' liability or similar laws even when You do not file a claim for benefits.

- Treatment of Sickness or Injury caused by: 1) War or any act of war; or 2) Participation in the military service of any country. Any premium paid for a time not covered will be returned pro-rata.

- Dental treatment unless a Hospital stay is required due to Injury from an accidental blow to the mouth causing trauma to sound, natural teeth, the gums or supporting structures of the teeth. A sound, natural tooth has no decay and has never had a filling, root canal therapy or crown. Inpatient Hospital care must be the least expensive setting needed to produce a professionally adequate result and the Hospital charges only are Covered Expense. The treatment must be received while the policy is in force.

- Treatment of temporomandibular or craniomandibular joint dysfunction, except as provided in the policy.

- Expense incurred that is not for treatment of Sickness or Injury. This includes, but is not limited to, charges for:
  1. Eyeglasses, contact lenses, eye exams, eye refraction or eye surgery for correction of refraction error; vision therapy; or artificial hearing devices.
  2. Preventive treatment including, but not limited to, routine physical exams and immunizations, unless otherwise noted as a Covered Expense in the policy or a rider to the policy.
  3. Normal pregnancy or childbirth; routine well baby care, including Hospital nursery charges at birth; or abortion, except as provided in the complications arising from pregnancy provision in the Benefits section of the policy.
  4. Infertility diagnosis and treatment for males and females including, but not limited to, drugs and medications, artificial insemination, in-vitro fertilization and reversal of sterilization.

5. Genetic testing or counseling including, but not limited to, amniocentesis and chorionic villi testing.
6. Sex transformation; treatment of sexual function, dysfunction or inadequacy; or treatment to enhance sexual performance or desire.
7. Treatment and medication to stimulate growth and growth hormones for any purpose.
8. Treatment, services or supplies to address quality of life or lifestyle concerns including, but not limited to: smoking cessation; snoring or sleep disorders; the treatment or prevention of hair loss; change in skin pigmentation; or cognitive enhancement.
9. Sterilization and drugs or devices used directly or indirectly to promote or prevent conception.
10. Weight reduction or weight control programs or treatment; or surgery for weight control, obesity or morbid obesity.
11. All treatments for varicose veins.
12. Therapy or treatment for learning disorders or disabilities or developmental delays, except for congenital anomalies of a Covered Dependent child.
13. Sales tax or gross receipt tax; provider administrative expenses including, but not limited to, charges for claim filing, contacting utilization review organizations, or case management fees.
14. Travel, transportation or living expenses.

- Cosmetic treatment or reconstructive or plastic surgery that is primarily a cosmetic procedure, including medical or surgical complications arising therefrom, except as provided in the Benefits section of the policy.

- Treatment of the following behavioral disorders: (a) Substance related disorders, including alcoholism and drug dependency; (b) life transition problems, currently referred to as "V" codes, and diagnostic codes 302 through 302.9 as found in the diagnostic and statistical manual of mental disorders, 4th edition, published by the American Psychiatric Association; (c) skilled nursing facility services, home health care, residential treatment, and custodial care for Mental Illness; and (d) court-ordered treatment of Mental Illness unless We determine the treatment to be medically necessary.

- Treatment, repair or removal of tonsils or adenoids, except on an Emergency basis.

- Treatment or services rendered by, or supplies purchased from, a member of Your Immediate Family or an employer.

- Treatment or services required due to Injury received while participating in flying, ballooning, hang-gliding, parachuting, or other aeronautic activities, except as a passenger on a commercial aircraft..

- Treatment or services required due to Injury sustained while participating in any interscholastic or inter-collegiate sport, contest or competition or while practicing, exercising, undergoing conditioning or physical preparation for any such sport, contest or competition.

- Expense incurred due to Sickness or Injury of which a contributing cause was the Insured's participation in a felony, riot or insurrection, or for which a contributing cause was the Insured's being engaged in an illegal occupation..

- Custodial Care; respite care; rest care; or supportive care, except as provided in the Benefits section.

- Expenses incurred outside of the United States or its possessions or Canada, except as authorized by Us.

- Expenses incurred for Experimental or Investigational Services.

- Private duty nursing services rendered during Hospital confinement and charges for standby Health Care Practitioners.

- Dental braces, dental appliances, corrective shoes, repairs to or replacement of prosthetic devices, or orthotics, except as provided in the Benefits section of the policy.

- Inpatient treatment of chronic pain disorders; biofeedback; repair of diastasis recti; orthognathic surgery; non-medical self-care or self-help programs.

- Reduction mammoplasty or revision of breast surgery for capsular contraction or replacement of prosthesis; except as provided in the Benefits section of the policy.

- The first $2,500 or 50%, whichever is the lesser amount, of an otherwise Covered Expense not authorized in accordance with the Authorization Provisions section of the policy.

- Transplants, except as covered in the Benefits section of the policy.

- Services or supplies for foot care, including care of corns, bunions or calluses, except capsular or bone surgery.

- Complications resulting from leaving an Inpatient or Outpatient facility against the advice of Your Health Care Practitioner; complications of any condition that existed prior to the Effective Date; or treatment for an excluded service or procedure.

- Treatment, services or supplies rendered or received when coverage under the policy is not in effect, except as provided under the Extension of Benefits provision.

- Any amount in excess of the Reasonable and Customary Amount, as determined by Us under the policy.

- Prophylactic treatment or services. Prophylactic means any surgery or other procedure performed to prevent a disease process from becoming evident in the organ or tissue at a later date.

- Treatment, services or supplies that are not Medically Necessary as determined by Us under the policy.

- Treatment, services or supplies that are prescribed, provided or furnished in a manner primarily for the convenience of the Insured or Health Care Practitioner.

- Drugs prescribed for treatment of a Sickness or an Injury that are not covered under the policy.

- Treatment, services or supplies not described in the Benefits section of the policy.

TERMINATION OF COVERAGE: The policy is not renewable. Coverage is in force only for the Benefit Period You selected as shown on page one, and coverage will terminate upon the expiration of the Benefit Period, except as provided in the Extension of Benefits provision of the policy.

PREMIUM INFORMATION	
Premium Payment Mode: _____	TOTAL MODAL PREMIUM AMOUNT: $_____

_____ _____

Licensed Agent's Signature Date