PLEASE NOTE: THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

Oregon

APPLICATION FOR FIXED INDEMNITY INSURANCE
GOLDEN RULE INSURANCE COMPANY
INDIANAPOLIS, IN 46278-1719

REASON FOR APPLICATION: ☐ New Application ☐ Benefit Change ☐ Add a Dependent ☐ Reinstatement

Policy Number ______ (for reinstatement, additions or benefit change)

Please list only those persons needing coverage. Please Print in Black Ink

Applicant(s) Information

Gender	Name (Last, First, M.I.)	Birth Date	MUST BE ACCURATE* Height	Weight
☐ Male ☐ Female	Primary (You)			
☐ Male ☐ Female	Spouse			
☐ Male ☐ Female	Child 1			
☐ Male ☐ Female	Child 2			
☐ Male ☐ Female	Child 3			
☐ Male ☐ Female	Child 4			
☐ Male ☐ Female	Child 5			

*Applicants must meet our height and weight guidelines to qualify for coverage.
If you need to list additional dependents, please use lined paper, sign and date it, and check this box.

Resident Physical Address (where you live and pay taxes). PO Boxes are not accepted.

Street (Include Apt.)	City	State	ZIP Code

Mailing Address (if different than Resident Address)

Street (Include Apt.)	City	State	ZIP Code

Explain why the mailing address is different than the resident physical address:______________________

Payor (if not you)

Name (Last, First, M.I.):	Relationship to Primary Relative Other (Specify):________		
Street (Include Apt.)	City	State	ZIP Code

Contact Information		
	Phone Number	Email
Primary (You)		
Spouse		
Payor (if not you)		

Your Beneficiary:________________________________ You will be the beneficiary for your spouse.
Name Relationship Age

Your Occupation:________________________________

Plan Selection

Requested Effective Date: ____/____/_____ *(See Statement of Understanding section)*

Plans *(Choose One)*	☐ Health ProtectorGuard Choice Value ☐ Health ProtectorGuard Select Plus ☐ Health ProtectorGuard Choice Plus ☐ Health ProtectorGuard Premier Plus ☐ Health ProtectorGuard Select Value

Initial Payment

Estimated Monthly Premium $ ______________

Monthly Network Fee + $ 3.25

Initial Monthly Payment with Application = $ ______________

If Quarterly, Initial Monthly Payment with Application x 3 = $ ______________

Application Questions

General Information		Yes	No
G1	**During the past 12 months, has any applicant smoked cigarettes or e-cigarettes or used tobacco in any form (including smokeless tobacco) or nicotine substitute?** If yes, select each person: Primary Spouse Child1 Child 2 Child 3 Child 4 Child 5	☐	☐
Medical History Information		**Yes**	**No**
M1	**Is any applicant currently pregnant, an expectant parent, in the process of adopting a child, or undergoing infertility treatment?** If yes, select each person: Primary Spouse Child1 Child 2 Child 3 Child 4 Child 5	☐	☐
M2	**During the past 12 months, has any applicant:**		
	a. Been bedridden or confined to a hospital? If yes, Who:______________ Details:______________ If yes, Who:______________ Details:______________ If yes, Who:______________ Details:______________	☐	☐
	b. Been confined to a nursing home, mental facility, inpatient rehabilitation, subacute facility, or hospice? If yes, select each person: Primary Spouse Child1 Child 2 Child 3 Child 4 Child 5	☐	☐
	c. Experienced recurrent breast tumors, unexplained tumors/growths, or abnormal pap smear without normal follow-up pap smear? If yes, select each person: Primary Spouse Child1 Child 2 Child 3 Child 4 Child 5	☐	☐

Application Questions *(continued)*			
	d. Experienced unexplained weight loss, fatigue, dizziness, or seizures? If yes, select each person: Primary Spouse Child1 Child 2 Child 3 Child 4 Child 5	☐	☐
	e. Experienced vascular insufficiency (circulatory problems), pulmonary hypertension, uncontrolled hypertension/high blood pressure, chest pains, irregular heartbeat or tachycardia? If yes, select each person: Primary Spouse Child1 Child 2 Child 3 Child 4 Child 5	☐	☐
	f. Received medical care from a member of the medical profession for a condition that has yet to be diagnosed? If yes, select each person: Primary Spouse Child1 Child 2 Child 3 Child 4 Child 5	☐	☐
	g. Been advised to undergo any test (except for HIV test), treatment, hospitalization, or surgery which has not yet been completed or for which results have not yet been received? If yes, select each person: Primary Spouse Child1 Child 2 Child 3 Child 4 Child 5	☐	☐
	h. Applied for, received, or currently receiving disability benefits from any insurance company, government, employer, or other source other than for maternity? If yes, select each person: Primary Spouse Child1 Child 2 Child 3 Child 4 Child 5	☐	☐
M3	**During the past 5 years, has any applicant been declined or rated up for life or health insurance?** If yes, select each person: Primary Spouse Child1 Child 2 Child 3 Child 4 Child 5	☐	☐
M4	**During the past 5 years, has any applicant been treated by a doctor or advised by a doctor to seek treatment for substance use disorder, drug or alcohol abuse or addiction?** If yes, select each person: Primary Spouse Child1 Child 2 Child 3 Child 4 Child 5	☐	☐
M5	**During the past 5 years, has any applicant been diagnosed with or received medical or surgical care from a member of the medical profession for any of the following:**		
	a. Disease or disorder of the heart or circulatory system, heart attack, cardiomyopathy, bypass/stent/angioplasty, atrial fibrillation, implant of pacemaker/defibrillator, Renal Hypertension, heart surgery (including valve replacement or correction), or congestive heart failure? If yes, select each person: Primary Spouse Child1 Child 2 Child 3 Child 4 Child 5	☐	☐
	b. Stroke/transient ischemic attack (TIA), thrombosis, embolism, or hemophilia? If yes, select each person: Primary Spouse Child1 Child 2 Child 3 Child 4 Child 5	☐	☐
	c. Chronic Obstructive Pulmonary Disease (COPD) or any chronic lung disease, emphysema, or pulmonary fibrosis? If yes, select each person: Primary Spouse Child1 Child 2 Child 3 Child 4 Child 5	☐	☐
	d. Diabetes (except gestational diabetes), organ transplant (or awaiting an organ transplant), bone marrow transplant, chronic kidney disease or disorder (not including stones), chronic liver disease including cirrhosis, Hepatitis B, or Hepatitis C? If yes, select each person: Primary Spouse Child1 Child 2 Child 3 Child 4 Child 5	☐	☐
	e. AIDS, HIV infection, or any AIDS related condition? If yes, select each person: Primary Spouse Child1 Child 2 Child 3 Child 4 Child 5	☐	☐
	f. Any cancer (excluding basal cell or squamous cell skin cancer), Carcinoma in Situ, leukemia, Hodgkin's or Non-Hodgkin's Lymphoma, Alzheimer's or Senile Dementia? If yes, select each person: Primary Spouse Child1 Child 2 Child 3 Child 4 Child 5	☐	☐
	g. Paralysis, Multiple Sclerosis, Muscular Dystrophy, Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's Disease), or Parkinson's? If yes, select each person: Primary Spouse Child1 Child 2 Child 3 Child 4 Child 5	☐	☐
	h. Crohn's Disease or Ulcerative Colitis? If yes, select each person: Primary Spouse Child1 Child 2 Child 3 Child 4 Child 5	☐	☐
	i. Systemic Lupus Erythematosus (SLE) or Cystic Fibrosis? If yes, select each person: Primary Spouse Child1 Child 2 Child 3 Child 4 Child 5	☐	☐
	j. Schizophrenia, Bipolar Mood Disorder, Mood (Affective) Disorder, or currently taking anti-psychotic medication prescribed by a medical professional? If yes, select each person: Primary Spouse Child1 Child 2 Child 3 Child 4 Child 5	☐	☐

Other Coverage Information		Yes	No
O1	**Does any applicant have or is any applicant currently applying for hospital or other fixed indemnity insurance?** If yes, Who:________ Company Name:________ Policy Number:________ If yes, Who:________ Company Name:________ Policy Number:________ If yes, Who:________ Company Name:________ Policy Number:________	☐	☐
O2	**Does any applicant intend to replace any existing coverage in force?** If yes, Who:________ Company Name:________ Policy Number:________ If yes, Who:________ Company Name:________ Policy Number:________ If yes, Who:________ Company Name:________ Policy Number:________	☐	☐

Statement of Understanding

I have read this application and represent that the information shown on it is true and complete. I understand and agree that:

(1) No insurance will become effective unless my application is approved and the appropriate premium is actually received by Golden Rule Insurance Company (GRIC) with this application.

(2) If coverage is issued, the coverage will not be a continuation of any prior coverage.

(3) Incorrect or incomplete information in this application may result in voidance of coverage and claim denial.

(4) The information provided in this application, and any supplement or amendments to it, will be made a part of any policy or policies that may be issued.

(5) For an application sent by any electronic means, insurance, if approved, will be effective the later of:
   (a) The requested effective date; or
   (b) The day after receipt by GRIC.

(6) For a mailed application, insurance, if approved, will be effective the later of:
   (a) The requested effective date; or
   (b) The day after the **postmark date** affixed by the U.S. Postal Service. If mailed and not postmarked by the U.S. Postal Service or if the postmark is not legible, the effective date will be the later of:
      (i) The requested effective date; or
      (ii) The day received by GRIC.

(7) The producer is only authorized to submit the application and initial premium and may not change or waive any right or requirement.

(8) I must notify GRIC of any medical conditions or treatment arising between the date of this application and the effective date of my coverage.

(9) I represent that I have made such investigations as are necessary to assure the truth and accuracy of all statements made in this application regarding all applicants.

(10) If GRIC rejects this application, under no circumstances will any benefits be payable. Receipt of money, cashing of my check, or charging my credit card by GRIC does not constitute approval of my application or create GRIC coverage.

(11) I assign any benefits payable directly to the hospital or health care provider providing the service unless I revoke my assignment by providing written notice of such revocation to GRIC before proof of loss is received by us.

(12) I have received a Notice of Privacy Practices and a Conditional Receipt or Conditions Prior to Coverage.

(13) I have received a copy of the Outline of Coverage and Disclosure Notice.

(14) **THIS PRODUCT PROVIDES LIMITED BENEFITS. THIS IS NOT MAJOR MEDICAL OR COMPREHENSIVE HEALTH INSURANCE, AND IT DOES NOT PROVIDE THE MANDATED COVERAGE NECESSARY TO AVOID PENALTY UNDER THE AFFORDABLE CARE ACT.**

(15) There will be no benefits for any loss resulting from an illness during the first 5 days of coverage, following the person's effective date of coverage. If a wellness benefit is included, there will be no wellness benefit for the first 6 months of coverage, following the person's effective date of coverage.

(16) There will be no benefits for any loss incurred during a person's first 12 months of coverage due to a preexisting condition.

Signature Information

	Signature	Date Signed
Primary Applicant (or Parent/Legal Guardian if Primary Applicant is a minor)		
Spouse (if applying)		

Important Notes:

- **"Postmark date" means the date of the postmark as affixed by the U.S. Postal Service.**
- **No application will be accepted if received by Golden Rule more than 15 days after the date signed.**
- **Altered applications will not be accepted.**

HPG-AP-166-SI-GRI-36

Mail completed application and initial premium to:
Golden Rule Insurance Company
PO Box 31370
Salt Lake City, UT 84131-0370

Payment

Initial Payment Method With Application – Select One Below

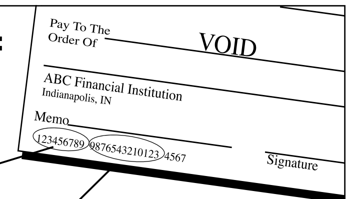
☐ **EFT** — Complete EFT Authorization below Initial Payment
☐ **Credit Card** — Complete Credit Card Authorization below
☐ **Check** — Made payable to Golden Rule Insurance Company

Ongoing Payments – Select One Below

☐ Monthly EFT
☐ Monthly Credit Card
☐ Quarterly EFT
☐ Quarterly Credit Card
☐ Semi-Annual EFT
☐ Semi-Annual Credit Card
☐ Annual EFT
☐ Annual Credit Card

Electronic Funds Transfer (EFT) and Credit Card payments will be collected at the time of application. If Initial Payment is EFT, Ongoing Payment must be EFT. If you choose Check as your Initial Payment Method, please mail your check with your completed application - checks are deposited upon receipt. Premium will be verified and may be adjusted up or down during the processing of your application.

☐ **ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION – ONLY IF PAYING BY EFT:**



I (we) hereby authorize Golden Rule Insurance Company to initiate debit entries to the account indicated below. I also authorize the named financial institution to debit the same to such account.

I agree this authorization will remain in effect until you actually receive written notification of its termination from me.

Type of Account: ☐ Checking ☐ Savings

Nine-digit Routing No. ________ Account No. ________

Financial Institution's Name ________________________

Address ________________________

City, State, ZIP ________________________

Draft On ____________ ____________
Day Date Signed
Only select a draft date between the 1st and 28th of the month.

In Tennessee and Texas, drafts may only be scheduled on 1) the premium due date; or 2) up to 10 days after the due date.

X________________________
Authorized Account Signature

☐ **CREDIT CARD AUTHORIZATION – ONLY IF PAYING BY CREDIT CARD:**

I authorize Golden Rule Insurance Company to bill my American Express/MasterCard/Visa account.
If quarterly billing requested, the Initial Payment will be for three months.

Type of Card: ☐ MasterCard ☐ Visa ☐ American Express Exp. Date: ____ ____
Month Year

Billing ZIP Code: ________ Card Number: ________

X________________________
Signature of Authorized User

Charge On ____________
Day
Only select a charge date between the 1st and 28th of the month.

NOTE: Some card issuers/financial institutions charge cash advance fees on insurance payments.

Final Authorizations

Producer Statement – Review the completed application before signing below.

Each question on the application was completed by the applicant(s). The applicant has received a Notice of Privacy Practices and a Conditional Receipt or Conditions Prior to Coverage.

X ______________________________ X ______________________________

Signature of Licensed Producer | Print Full Name

Producer Number

Authorization to Obtain and Disclose Nonmedical Information

I authorize Golden Rule Insurance Company's (GRIC) New Business and Medical History Review departments to obtain information that they need to underwrite or verify my application for insurance. Any employer, insurance company, government agency, consumer-reporting agency, or MIB, Inc., formerly known as Medical Information Bureau (MIB) having information about my occupation(s), avocations, driving history, criminal history, or prior insurance coverage for my family or me is authorized to give it to GRIC's New Business and Medical History Review departments.

GRIC may also release this information about my family or me to the MIB or any member company for the purposes described in GRIC's Notice of Privacy Practices.

I (we) have received GRIC's Notice of Privacy Practices.

This authorization shall remain valid for 30 months from the date below.

I (we) understand the following: A photocopy of this authorization is as valid as the original. I (we) or my (our) authorized representative may obtain a copy of this authorization by writing to GRIC. I (we) may request revocation of this authorization by writing to GRIC, as explained in GRIC's Notice of Privacy Practices. GRIC may condition enrollment in its health plan or eligibility for benefits on my (our) refusal to sign this authorization. The information that is used or disclosed in accordance with this authorization may be redisclosed by the receiving entity and may no longer be protected by federal or state privacy laws.

I have read the above: Authorization to Obtain and Disclose Nonmedical Information.

Signed X ___/___/___ X ______________________________

Date | Signature of Primary Applicant (You)

X ______________________________

Signature of Spouse (If to be covered)

051F-G-0816

Authorization to Obtain and Disclose Health Information

I authorize Golden Rule Insurance Company's (GRIC) New Business and Medical History Review departments to obtain health information that they need to underwrite or verify my application for insurance. Any health care provider, pharmacy benefit manager, consumer-reporting agency, MIB, Inc., formerly known as Medical Information Bureau (MIB), or insurance company having any information as to a diagnosis, the treatment, or prognosis of any physical or mental conditions about my family or me is authorized to give it to GRIC's New Business and Medical History Review departments.

This includes information related to substance use or abuse.

I understand any existing or future requests I have made or may make to restrict my protected health information do not and will not apply to this authorization, unless I revoke this authorization.

GRIC may release this information about my family or me to the MIB or any member company for the purposes described in GRIC's Notice of Privacy Practices.

I (we) have received GRIC's Notice of Privacy Practices.

This authorization shall remain valid for 30 months from the date below.

I (we) understand the following:

- A photocopy of this authorization is as valid as the original;
- I (we) or my (our) authorized representative may obtain a copy of this authorization by writing to GRIC;
- I (we) may request revocation of this authorization as described in GRIC's Notice of Privacy Practices;
- GRIC may condition enrollment in its health plan or eligibility for benefits on my (our) refusal to sign this authorization;
- The information that is used or disclosed in accordance with this authorization may be redisclosed by the receiving entity and may no longer be protected by federal or state privacy laws regulating health insurers.

I have retained a copy of this authorization.

052F-G-0816

I have read the above: Authorization to Obtain and Disclose Health Information.

Signed X ___/___/___ X ______________________________

Date | Signature of Primary Applicant (You)

X ______________________________

Signature of Spouse (If to be covered)

OREGON INDIVIDUAL FIXED INDEMNITY INSURANCE POLICY DISCLOSURE STATEMENT

This fixed indemnity insurance policy is underwritten by Golden Rule Insurance Company, 7440 Woodland Drive, Indianapolis, Indiana 46278-1719.

NOTICE: This disclosure statement answers questions consumers often ask about health insurance coverage and costs. It highlights some of the important issues that frequently affect consumers. It is intended for your use whether you are purchasing health insurance for the first time or whether you are replacing your existing coverage.

Are you considering replacing your current coverage?
Before you replace your current policy with another, you should review both policies in order to determine whether replacement is in your best interests. The new coverage may be different in important respects. You should be aware of these differences, whether they are temporary or permanent.

Are you considering adding to your current coverage?
Before you add new coverage to your current coverage, you should review both policies to ensure that you are not purchasing unnecessary coverage. If you obtained your current policy from another agent or a representative of another company, be sure to ask that agent or representative any questions you may have about that policy and the need for additional coverage.

Questions? Ask for help.
If you have any questions that are not answered by this disclosure statement, be sure to ask your broker.

Read your policy!
If you purchase Golden Rule's fixed indemnity insurance policy, read your policy carefully as soon as you receive it. Because it is an individual policy, you will have an opportunity to send it back and obtain a premium refund.

Fill out your application carefully!
Be sure to fill out all portions of your application completely and truthfully. If misstatements are made or information about your health is omitted from the application, we may void the policy or deny your claims. If your age is misstated, the amounts payable on claims may be reduced.

The policy available through Golden Rule Insurance Company includes: A fixed dollar amount per day and/or calendar year maximum for: ambulance services; hospital emergency room, inpatient doctor visits, inpatient hospital confinement, intensive care unit, office visit/urgent care, oral chemotherapy, outpatient chemotherapy and/or radiation (non-oral); outpatient diagnostic imaging services, outpatient facility, outpatient laboratory and x-ray, outpatient prescription drug, second surgical opinion, surgical services and wellness.

We hope this disclosure statement will help you with your insurance purchase. However, please note that this disclosure statement is not intended to be a part of the policy and that only the actual policy issued by us is final and binding.

The above 'Oregon Individual Fixed Indemnity Insurance Disclosure Statement' was delivered to me on:

______________________ ______________________________

Date Applicant's Signature

UnitedHealthcare
Golden Rule
Insurance Company

Golden Rule Insurance Company
7440 Woodland Drive
Indianapolis, IN 46278-1719
For Inquiries: (800) 657-8205

In this outline, "you" or "your" will refer to the person whom this outline has been prepared for, and "we," "our," or "us" will refer to Golden Rule Insurance Company, a stock company.

Fixed Indemnity Coverage
Outline of Coverage for Policy Form HPG2-GRI-36
(Please retain this outline for your records)

Read Your Policy Carefully -- This outline sets forth a brief description of the important aspects of your policy. This is not the insurance contract. Only the actual policy will control. The policy sets forth in detail your and our rights and obligations. For this reason, it is important that you READ YOUR POLICY CAREFULLY!

Fixed Indemnity Coverage -- Plans of this type are designed to pay a specific benefit amount for a loss for ambulance, emergency care, hospitalization, office visits/urgent care, oral chemotherapy, outpatient chemotherapy and/or radiation (non-oral), outpatient prescription drugs (if included in your plan), outpatient services, second surgical opinion, surgery services, and wellness. Coverage is subject to the provisions or other limitations that may be set forth in the policy.

Indemnity Benefits

The applicable benefit amount is payable as set forth in the policy for the following benefits:

A. For a licensed professional ground or air ambulance service used to transport a covered person to a hospital or emergency care facility due to an illness or injury. The ambulance benefit is limited to emergency transportation to a hospital or transportation between hospitals during a period of hospital confinement when a higher level of care is medically necessary.

B. For each day a covered person receives services for hospital emergency room care.

C. For each visit by a doctor while a covered person is inpatient in a hospital.

D. For each day a covered person is hospital confined as an inpatient under the orders of a doctor. The day before a covered person is discharged is the covered person's last inpatient day.

E. For each day a covered person is confined in an intensive care unit as an inpatient under the orders of a doctor.

F. For each office visit when a covered person receives services rendered in a doctor's office while the covered person is not an inpatient. For each visit a covered person receives urgent care in an urgent care center.

   For this benefit to be payable, office and/or urgent care visits must relate to a covered illness or injury. Office and/or urgent care visits are limited only to those that do not relate solely to alternative treatments, including acupressure, acupuncture, aroma therapy, hypnotism,

massage therapy, rolfing, and other forms of alternative treatment as defined by the National Center for Complementary and Integrative Health of the National Institutes of Health.

G. For each month a covered person receives oral chemotherapy medication for the treatment of cancer while the covered person is not inpatient.

H. For each day a covered person receives chemotherapy medication (non-oral) or radiation therapy for the treatment of cancer while the covered person is not inpatient.

I. For each outpatient diagnostic imaging service received by a covered person. Outpatient diagnostic imaging services consist of the following:

1. Angiogram, arteriogram, and thallium stress test.
2. Electroencephalogram (EEG).
3. Myelogram.
4. Positron Emission Tomography (PET) scan.
5. Magnetic Resonance Imaging (MRI).
6. Computed Tomography (CT) scan.

J. For each day a covered person has outpatient surgery in an outpatient surgical facility while not in a period of hospital confinement.

K. For each outpatient laboratory test or X-ray received by a covered person that is not a routine screening examination or preventive testing.

L. For each fill a covered person receives for an outpatient prescription drug prescribed by a doctor and dispensed at a licensed pharmacy, while the covered person is not an inpatient if your plan includes outpatient prescription drug.

M. For each day when a covered person obtains a second surgical opinion from another doctor prior to the surgical procedure.

This benefit is only payable provided the doctors providing the second surgical opinion:

1. Are not affiliated with each other or with the original doctor who will perform the surgery;
2. Are not financially associated with the original doctor; and
3. Do not assist in the surgery.

N. For each day a covered person receives services from a surgeon, assistant surgeon, or anesthesiologist for inpatient or outpatient surgery as prescribed by a doctor.

Surgeries may be performed in a hospital inpatient setting, an outpatient surgical facility, or a doctor's office/clinic.

If multiple surgical procedures occur on the same day, we will pay one benefit amount, which will be the largest applicable surgery services (inpatient and outpatient) benefit amount that is shown on the Data Page for the surgery.

O. For each day a covered person undergoes any of the following routine screening examinations or preventive testing:

1. Annual physical examination;
2. Routine gynecological examination including pap smear;
3. Immunizations, other than a flu shot;

4. Routine non-surgical cancer screening tests such as mammography or digital rectal examination; or
5. Blood screenings including but not limited to prostate-specific antigen testing.

Services must be recommended by or received under the supervision of a doctor.

Amount Payable

Amount Payable: The applicable specified benefit amount will be paid which results from a loss while a covered person's insurance is in force subject to all terms, conditions, limitations, exclusions, waiting periods and benefit maximum limits under the policy.

What Is Not Covered

This is not major medical insurance.

The policy does not pay benefits for any loss caused by, resulting from, for, or relating to any of the following:

A. A loss occurring before the policy effective date, after termination of the policy, or during any time that coverage is not in force.

B. Intentionally self-inflicted bodily harm (whether the covered person is sane or insane).

C. Any act of declared or undeclared war.

D. Active service in the armed forces of any country, or related auxiliaries including the National Guard or military reserve.

E. The covered person taking part in a riot.

F. The covered person's commission or attempt to commit a felony, whether or not charged.

G. Cosmetic treatment, including hospital confinement for such services.

H. Pregnancy or childbirth (except for complications of pregnancy).

I. Hospital confinement for the first Friday or Saturday of an inpatient stay that begins on one of those days, unless it is an emergency or medically necessary inpatient surgery is scheduled for the day after the date of admission.

J. Hospital confinement primarily to receive rehabilitation, custodial care, educational care, or nursing services (unless expressly provided for by this policy).

K. Operating a taxi or any other passenger transportation services for wage, compensation, or profit.

L. As a result of any injury sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following:

   1. Professional or semi-professional sports; intercollegiate sports (not including intramural sports);
   2. Parachute jumping; hang-gliding; skydiving; bungee jumping; parakiting;
   3. Racing or speed testing any motorized vehicle or conveyance;
   4. Racing or speed testing any non-motorized vehicle or conveyance (if the covered person is paid to participate or to instruct);
   5. Scuba/skin diving (when diving 60 or more feet in depth);

6. Rodeo sports; horseback riding (if the covered person is paid to participate or to instruct);
7. Rock or mountain climbing (if the covered person is paid to participate or to instruct); or
8. Skiing (if the covered person is paid to participate or to instruct).

M. As a result of any injury sustained while operating, riding in, or descending from any type of non-commercial aircraft if the covered person is a pilot, officer, or member of the crew of such aircraft or is giving or receiving any kind of training or instructions or otherwise has any duties that require him or her to be aboard the aircraft.

N. Fees/surcharges imposed on you or your covered dependent by a provider (including a hospital) but which are actually the responsibility of the provider to pay.

O. Services incurred during the waiting period.

P. Services performed by a member of the covered person's immediate family.

Q. Services or supplies that are not administered or ordered by a doctor, or are not medically necessary to the diagnosis or treatment of an illness or injury.

R. Routine well-baby care of a newborn infant while inpatient, except as expressly provided for by the policy.

S. Any loss sustained while the covered person is incarcerated in a state or federal prison or other detention facility.

T. Any loss related to the treatment of mental disorders, substance abuse, or for court ordered treatment programs for substance abuse.

U. Any loss related to performance of an abortion (unless the life of the mother would be endangered if the fetus were carried to term).

V. Any loss related to any examination or fitting related to eyeglasses, contact lenses, hearing aids, eye refraction, or visual therapy.

W. Any services rendered outside of the United States, except for services rendered for emergency treatment of a covered person.

X. Any loss for dental expenses, unless a covered person sustains an injury, due to an accident, after the covered person's effective date, which results in:

   1. Damage to his or her natural teeth (injury to the natural teeth will not include any injury as a result of chewing); and
   2. The services resulting in the dental expense are received within six months of the accident or as part of a treatment plan which was prescribed by a doctor and was begun within six months of the accident.

Y. Experimental or investigational treatment(s). The fact that an experimental or investigational treatment is the only available treatment for a particular condition will not result in benefits if the procedure is considered to be an experimental or investigational treatment for the treatment of that particular condition.

PREEXISTING CONDITIONS: We will not pay benefits under the policy for a loss which manifests due to, results from, is caused or otherwise contributed to by, a preexisting condition, or complications resulting from a preexisting condition. The preexisting condition limitation will not apply longer than 12 months after a covered person's applicable effective date under this policy.

"Preexisting condition" means an illness, injury or condition:

A. For which medical advice, diagnosis, care, or treatment was recommended to or received by a covered person within 12 months immediately preceding the effective date the covered person became insured under this policy; or

B. That manifested symptoms which would cause an ordinarily prudent person to seek diagnosis or treatment within the 12 months immediately preceding the applicable effective date the covered person became insured under this policy.

Term of Coverage and Renewability

The policy term begins as of the effective date of the policy. You may keep the policy in force, subject to the Termination provisions in the policy, by paying us the required premium as it comes due. However, we may cancel the policy if there is a fraud or misrepresentation made by or with the knowledge of a covered person in filing a claim.

If the policy is other than a primary insured only plan, it may be continued after your death or after your 65th birthday by your spouse or eligible child if a covered person.

Premium

From time to time, we may change the rate table used for this policy form. Other than rate changes due to covered person changes and/or benefit changes, rates for the policy will not change during the initial 12 months following the policy effective date. On each premium's due date, the premium will be based on the rate table in effect in the state where the policy was issued. After the initial 12 months following the policy effective date, the age, sex, and tobacco class of covered persons and type and level of benefits on the premium due date are some of the factors that could be used in determining your premium rates. At least 31 days written notice of any plan to take an action or make a change permitted by this clause will be mailed to you at your last address as shown in our records. We will make no change in your premium solely because of claims made under this policy or a change in a covered person's health.