CELTIC INSURANCE COMPANY

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

MAJOR MEDICAL EXPENSE COVERAGE
Outline of Coverage for Policy Form 34368KS008
(Please retain this outline of coverage 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!

Major Medical Expense Coverage -- Policies of this type are designed to provide covered persons with coverage for the major costs of hospital, medical, and surgical care. The cost must be due to a covered illness or injury. Coverage is provided for daily hospital room and board, other hospital services, surgical services, anesthesia services, inpatient medical services, and out-of-hospital care. Coverage is subject to any deductible amounts, copayment provisions, or other limitations that may be set forth in the policy.

MAJOR MEDICAL EXPENSE BENEFITS

Deductible
The *deductible amount* means the amount of *covered expenses* that must be paid by all *covered Persons* before any benefits are payable.

Coinsurance Percentage
We will pay the applicable *coinsurance percentage* in excess of the applicable deductible for a service or supply that:

1. Qualifies as a *covered expense* under one or more benefit provisions; and
2. Is received while the *covered person's* insurance is in force under the *policy* if the charge for the service or supply qualifies as an *eligible expense*.

When the annual out-of-pocket maximum has been met, additional *covered expenses* will be payable at 100%.

The amount payable will be subject to:

1. Any specific benefit limits stated in the *policy*;
2. A determination of *eligible expenses*; and
3. Any reduction for expenses incurred at a *non-network provider*. Please refer to the information on the Schedule of Benefits.

Note: The bill *you* receive for services or supplies from a *non-network provider* may be significantly higher than the *eligible expenses* for those services or supplies. In addition to the *deductible amount* and *coinsurance percentage*, *you* are responsible for the difference between the *eligible expense* and the amount the provider bills *you* for the services or supplies. Any amount *you* are obligated to pay to the provider in excess of the *eligible expense* will not apply to *your deductible amount* or out-of-pocket maximum.

Network Availability
Your network is subject to change upon advance written notice. A *network* may not be available in all areas. If *you* move to an area where *we* are not offering access to a *network*, the *network* provisions of the *policy* will no longer apply. In that event, benefits will be calculated based on the *eligible expense*, subject to the *deductible amount* for *network providers*. *You* will be notified of any increase in premium.

Coverage Under Other Policy Provisions
Charges for services and supplies that qualify as *covered expenses* under one benefit provision will not qualify as *covered expenses* under any other benefit provision of this *policy.*

Ambulance Service Benefits
Covered expenses will include ambulance services for local transportation:

1. To the nearest *hospital* that can provide services appropriate to the *covered person's illness* or *injury*; or
2. To the nearest neonatal special care unit for newborn infants for treatment of *illnesses*, *injuries*, congenital birth defects, or complications of premature birth that require that level of care.

Benefits for air ambulance services are limited to:

1. Services requested by police or medical authorities at the site of an *emergency*; or
2. Those situations in which the *covered person* is in a location that cannot be reached by ground ambulance.

Exclusions:
No benefits will be paid for:

1. Expenses incurred for ambulance services covered by a local governmental or municipal body, unless otherwise required by law;
2. Non-*emergency* air ambulance;
3. Air ambulance:
    a. Outside of the 50 United States and the District of Columbia;
    b. From a country or territory outside of the United States to a location within the 50 United States or the District of Columbia; or
    c. From a location within the 50 United States or the District of Columbia to a country or territory outside of the United States; or
4. Ambulance services provided for a *covered person's* comfort or convenience.

Mental Health and Substance Abuse Expense Benefits
Covered expenses for mental health and substance abuse are included on a non-discriminatory basis for all *covered persons* for the diagnosis and *medically necessary* and active treatment of mental, emotional, and substance use disorders, as described in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders. *Deductible* and treatment limits for behavioral health expense benefits will be applied in the same manner as physical health service benefits.

Covered expenses are included on a non-discriminatory basis for individuals seeking diagnosis and treatment for mental health disorders following any type of assault or violent act, including rape or an assault with intent to commit rape when the diagnosis and treatment costs exceed the maximum compensation allowed by the state.

Inpatient, intermediate and outpatient mental health and substance abuse service expenses are covered, if *medically necessary* and may be subject to prior authorization. See the Schedule of Benefits for more information regarding services that require prior authorization and specific benefit, day or visit limits, if any. Medication management visits do not require prior authorization for *network providers*.

Inpatient mental health and substance abuse *covered expenses* include the following**:** 24 hour services, delivered in a psychiatric unit of a licensed general hospital, a psychiatric hospital, or a substance abuse facility, that provide evaluation and treatment for an acute psychiatric condition or substance use diagnosis, or both.

Intermediate mental health and substance abuse *covered expenses* include the following**:** Non-inpatient services that provide more intensive and extensive treatment interventions when outpatient services alone are not sufficient to meet the patient's needs. Intermediate care is based on *medical necessity*.

Outpatient mental health and substance abuse *covered expenses* include the following**:** Services provided in person in an ambulatory care setting. Outpatient services may be provided in a licensed *hospital*, a mental health or substance abuse clinic licensed by the appropriate state entity, a public community mental health center, a professional office or home–based services. Such services delivered in such offices or settings are to be rendered by a licensed mental health professional, a licensed physician who specializes in the practice of psychiatry, a licensed psychologist, a licensed independent clinical social worker, a licensed mental health counselor, or a licensed nurse mental health clinical specialist acting within the scope of his/her license.

Other *covered expenses* for mental health and substance abuse include:
1. Diagnosis and treatment of the following biologically based mental disorders: Schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder, delirium and dementia, affective disorders, eating disorders, post-traumatic stress disorder, substance abuse disorders, and autism;
2. For children and adolescents under the age of 19:

a. Treatment of non-biologically-based mental, behavioral, or emotional disorders which substantially interfere with or limit the functioning and social interactions of a child or adolescent. Benefits may be provided if the ongoing course of treatment is completed beyond age 19; and
b. Mandated benefits beyond age 19 may be covered even if coverage continues under other benefit contracts.

3. Adult substance abuse residential treatment;
4. Clinically managed detoxification services in a substance abuse facility;
5. Partial hospitalization;
6. Intensive Outpatient Programs (IOP); and
7. Day treatment.

Habilitation, Rehabilitation And Extended Care Facility Expense Benefits
Covered expenses include expenses incurred for *habilitation* or *rehabilitation* services or confinement in an *extended care facility*, subject to the following limitations:

1. *Covered expenses* available to a *covered person* while confined primarily to receive *habilitation* or *rehabilitation* are limited to those specified in this provision;
2. *Rehabilitation* services or confinement in a *rehabilitation facility* or *extended care facility* must begin within 14 days of a *hospital* stay of at least 3 consecutive days and be for treatment of, or *rehabilitation* related to, the same *illness* or *injury* that resulted in the *hospital* stay;
3. *Covered expenses* for *provider facility* services are limited to charges made by a *hospital*, *rehabilitation facility*, or *extended care facility* for:
    a. Daily room and board and nursing services;
    b. Diagnostic testing; and
    c. Drugs and medicines that are prescribed by a *physician*, must be filled by a licensed pharmacist, and are approved by the U.S. Food and Drug Administration;
4. *Covered expenses* for non-*provider facility* services are limited to charges incurred for the professional services of *rehabilitation medical practitioners.*

See the Schedule of Benefits for benefit levels or additional limits.

Care ceases to be *rehabilitation* upon *our* determination of any of the following:

1. The *covered person* has reached *maximum therapeutic benefit*;
2. Further treatment cannot restore bodily function beyond the level the *covered person* already possesses;
3. There is no measurable progress toward documented goals; and
4. Care is primarily *custodial care*.

Exclusion:
No benefits will be paid under these Habilitation, Rehabilitation and Extended Care Facility Expense Benefits for charges for services or confinement related to treatment or therapy for *mental disorders* or *substance abuse*.

Definition:
As used in this provision, *"provider facility"* means a *hospital, rehabilitation facility*, or *extended care facility*.

Home Health Care Expense Benefits
Covered expenses for *home health care* are limited to the following charges:

1. *Home health aide services*;
2. Services of a private duty registered nurse rendered on an outpatient basis;
3. Professional fees of a licensed respiratory, physical, occupational, or speech therapist required for *home health care;*

4. I.V. medication and pain medication;
5. Hemodialysis, and for the processing and administration of blood or blood components;
6. *Necessary medical supplies*; and
7. Rental of the *durable medical equipment* set forth below:
    a. I.V. stand and I.V. tubing;
    b. Infusion pump or cassette;
    c. Portable commode;
    d. Patient lift;
    e. Bili-lights, and
    f. Suction machine and suction catheters.

Charges under (4) and (7) are *covered expenses* to the extent they would have been *covered expenses* during an *inpatient hospital* stay.

At *our* option, *we* may authorize the purchase of the equipment in lieu of its rental if the rental price is projected to exceed the equipment purchase price, but only from a provider *we* authorize before the purchase. If the equipment is purchased, the *covered person* must return the equipment to *us* when it is no longer in use.

An agency that is approved to provide *home health care* to those receiving Medicare benefits will be deemed to be a *home health care agency*.

Limitations:
Covered expenses for *home health aide services* will be limited to:
1. Seven visits per week; and
2. A calendar year maximum of 60 visits.

Each eight-hour period of *home health aide services* will be counted as one visit.

Covered expenses for outpatient private duty registered nurse services will be limited as follows:
1. Outpatient private duty registered nurse services will be limited to a lifetime maximum of 1,000 hours; and
2. Intermittent private duty registered nurse visits, not to exceed 4 hours each will be:
    a. Limited to $75 per visit; and
    b. Deemed to be 2 hours applied towards the hourly lifetime maximum above.

Exclusion:
No benefits will be payable for charges related to *respite care, custodial care,* or educational care.

Hospice Care Expense Benefits
This provision only applies to a *terminally ill covered person* receiving *medically necessary* care under a *hospice care program*.

The list of *covered expenses* in the Miscellaneous Medical Expense Benefits provision is expanded to include:
1. Room and board in a *hospice* while the *covered person* is an *inpatient;*
2. Occupational therapy;
3. Speech-language therapy;
4. The rental of medical equipment while the *terminally ill covered person* is in a *hospice care program* to the extent that these items would have been covered under the *policy* if the *covered person* had been confined in a *hospital;*
5. Medical, palliative, and supportive care, and the procedures necessary for pain control and acute and chronic symptom management;
6. Counseling the *covered person* regarding his or her *terminal illness;*

7. *Terminal illness counseling* of members of the *covered person's immediate family, and*
8. B*ereavement counseling*.

Exclusions And Limitations:
Any exclusion or limitation contained in the *policy* regarding:
1. An *injury* or *illness* arising out of, or in the course of, employment for wage or profit;
2. Medical necessity of services or supplies, to the extent such services or supplies are provided as part of a *hospice care program;* or
3. Expenses for other persons, to the extent those expenses are described above, will not be applied to this provision.

Benefits for *hospice inpatient* or outpatient care are available to a *terminally ill covered person* for one continuous period up to 180 days in a *covered person's* lifetime. For each day the *covered person* is confined in a *hospice,* benefits for room and board will not exceed:
1. For a *hospice* that is associated with a *hospital* or nursing home, the most common semiprivate room rate of the *hospital* or nursing home with which the *hospice* is associated; or
2. For any other *hospice,* the lesser of the billed charge or the most common semiprivate room rate applicable to a hospice associated with a *hospital* or nursing home.

Miscellaneous Medical Expense Benefits
Medical *covered expenses* are limited to charges:
1. Made by a *hospital* for:
    a. Daily room and board and nursing services, not to exceed the *hospital's* most common semi-private room rate;
    b. Daily room and board and nursing services while confined in an *intensive care unit*.
    c. *Inpatient* use of an operating, treatment, or recovery room;
    d. Outpatient use of an operating, treatment, or recovery room for *surgery;*
    e. Services and supplies, including drugs and medicines, that are routinely provided by the *hospital* to persons for use only while they are *inpatients; and*
    f. *Emergency* treatment of an *injury* or *illness*, even if confinement is not required.
2. For *surgery* in a *physician's* office or at an *outpatient surgical facility,* including services and supplies;
3. Made by a *physician* for professional services, including *surgery;*
4. Made by an assistant surgeon, limited to 20 percent of the *eligible expense* for the *surgical procedure;*
5. For the professional services of a *medical practitioner;*
6. For dressings, crutches, orthopedic splints, braces, casts, or other *necessary medical supplies.*
7. For diagnostic testing using radiologic, ultrasonographic, or laboratory services. Psychometric, behavioral and educational testing are not included;
8. For chemotherapy and radiation therapy or treatment;
9. For hemodialysis, and the charges by a *hospital* for processing and administration of blood or blood components;
10. For the cost and administration of an anesthetic;
11. For oxygen and its administration;
12. For *dental expenses* when a *covered person* suffers an *injury,* after the *covered person's effective date* of coverage, that results in:
    a. Damage to his or her natural teeth; and
    b. Expenses are incurred within six months of the accident or as part of a treatment plan that was prescribed by a *physician* and began within six months of the accident. *Injury* to the natural teeth will not include any injury as a result of chewing;
13. For reconstructive breast surgery charges as a result of a partial or total mastectomy for breast cancer. Coverage includes surgery and reconstruction of the diseased and non-diseased breast and prosthetic devices necessary to restore a symmetrical appearance and treatment in connection with other physical complications resulting from the mastectomy including lymphedemas;

14. Acupuncture treatment on an outpatient basis only. See the Schedule of Benefits for benefit levels or additional limits;
15. For *medically necessary* services and supplies used in the treatment of diabetes*. Covered expenses* include, but are not limited to, equipment, and supplies, limited to hypodermic needles and supplies used exclusively with diabetes management and outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin using diabetes if prescribed by a health care professional legally authorized to prescribe such services and supplies under the law. Diabetes outpatient self-management training and education shall be provided by a certified, registered or licensed health care professional with expertise in diabetes. The coverage for outpatient self-management training and education will be covered only if ordered by a health care professional legally authorized to prescribe such services and the diabetic (1) is treated at a program approved by the American diabetes association; (2) is treated by a person certified by the national certification board for diabetes educators; or (3) is, as to nutritional education, treated by a licensed dietitian pursuant to a treatment plan authorized by such healthcare professional;
16. For *medically necessary manipulative therapy* treatment on an outpatient basis only. See the Schedule of Benefits for benefit levels or additional limits. *Covered expenses* are subject to all other terms and conditions of the *policy,* including deductible and *coinsurance percentage* provisions; and
17. For maternity care of the primary *covered person* or *spouse*: outpatient and inpatient pre- and post-partum care including exams, prenatal diagnosis of genetic disorder, laboratory and radiology diagnostic testing, health education, nutritional counseling, risk assessment, childbirth classes, and hospital stays for delivery or other *medically necessary* reasons less any applicable *deductible*, or *coinsurance*. An inpatient stay is covered for at least 48 hours following a vaginal delivery, and for at least 96 hours following a caesarean delivery. Other maternity benefits include *complications of pregnancy,* parent education, assistance, and training in breast or bottle feeding and the performance of any necessary and appropriate clinical tests; and
18. For the following types of tissue transplants:
    a. Cornea transplants;
    b. Artery or vein grafts;
    c. Heart valve grafts;
    d. Prosthetic tissue replacement, including joint replacements;
    e. Implantable prosthetic lenses, in connection with cataracts.
19. Coverage for the administration of general anesthesia and medical care facility charges for dental care provided to the following covered persons:
    a. a child five years of age and under; or
    b. a person who is severely disabled; or
    c. a person has a medical or behavioral condition which requires hospitalization or general anesthesia when dental care is provided;
20. 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; and
21. Diagnosis and treatment of cause of infertility, but does not include expenses for In vitro fertilization, in vivo fertilization or any other medically-aided insemination procedure.

Miscellaneous Outpatient Medical Services and Supplies Expense Benefits

Covered expenses for miscellaneous outpatient medical services and supplies are limited to charges:

1. For artificial eyes or larynx, breast prosthesis, or basic artificial limbs but not the replacement thereof, unless required by a physical change in the *covered person* and the item cannot be modified. If more than one prosthetic device can meet a *covered person's* functional needs, only the charge for the most cost effective prosthetic device will be considered a *covered expense*;

2. For one pair of foot orthotics per *covered person*;
3. For *medically necessary* genetic blood tests;
4. For *medically necessary* immunizations to prevent respiratory syncytial virus (RSV);
5. For two mastectomy bras per year if the *covered person* has undergone a covered mastectomy;
6. For rental of a standard hospital bed, a standard walker, a standard non-motorized wheelchair, a wheelchair cushion, and a ventilator;
7. For the cost of one Continuous Passive Motion (CPM) machine per *covered person* following a covered joint surgery;
8. For the cost of one wig per *covered person* necessitated by hair loss due to cancer treatments or traumatic burns. See the Schedule of Benefits for benefit levels or additional limits;
9. For occupational therapy following a covered treatment for traumatic hand injuries; and
10. For one pair of eyeglasses or contact lenses per *covered person* following a covered cataract surgery. See the Schedule of Benefits for benefit levels or additional limits.

Outpatient Prescription Drug Expense Benefits

Covered expenses in this benefit subsection are limited to charges from a licensed *pharmacy* for:

1. A *prescription drug; and*
2. Any drug that, under the applicable state law, may be dispensed only upon the written prescription of a *physician.*

NOTE – This will include coverage for a prescribed, orally administered anticancer medication used to kill or slow the growth of cancerous cells on a basis no less favorable than intravenously administered or injected cancer medications that are covered as medical benefits.

See the Schedule of Benefits for benefit levels or additional limits.

The appropriate drug choice for a *covered person* is a determination that is best made by the *covered person* and his or her *physician.*

Notice And Proof Of Loss:

In order to obtain payment for *covered expenses* incurred at a *pharmacy* for *prescription orders,* a notice of claim and *proof of loss* must be submitted directly to *us.*

Exclusions And Limitations:

No benefits will be paid under this benefit subsection for expenses incurred:

1. For *prescription drugs* for the treatment of erectile dysfunction or any enhancement of sexual performance;
2. For immunization agents;
3. For medication that is to be taken by the *covered person,* in whole or in part, at the place where it is dispensed;
4. For medication received while the *covered person* is a patient at an institution that has a facility for dispensing pharmaceuticals;
5. For a refill dispensed more than 12 months from the date of a *physician's* order;
6. Due to a *covered person's* addiction to, or dependency on foods;
7. For more than the predetermined *managed drug limitations* assigned to certain drugs or classification of drugs;
8. For a *prescription order* that is available in over-the-counter form, or comprised of components that are available in over-the-counter form, and is therapeutically equivalent, except for over-the-counter products that are covered on the formulary;
9. For drugs labeled "Caution - limited by federal law to investigational use" or for investigational or experimental drugs;
10. For a *prescription drug* that contains an active ingredient(s) that is/are:

a. Available in and *therapeutically equivalent* to another covered *prescription drug;* or
b. A modified version of and *therapeutically equivalent* to another covered *prescription drug.* Such determinations may be made up to six times during a calendar year, and *we* may decide at any time to reinstate benefits for a *prescription drug* that was previously excluded under this paragraph;

11. For more than a 34-day supply when dispensed in any one prescription or refill, a 90-day supply when dispensed by mail order;
12. In excess of the cost of the generic equivalent, if any, regardless of whether the *physician* specifies name brand on the written prescription; and
13. For *prescription drugs* for any *covered person* who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. *Prescription drug* coverage may not be reinstated at a later date.

Pediatric Oral Expense Benefits

Covered expenses in this benefit subsection include the following for an *eligible child* under the age of 19 who is a *covered person*:

1. Diagnostic, preventive and restorative care;
2. Sealants (occlusal surface only. Teeth must be caries free. Not covered when placed over restoration.);
3. Oral surgery and reconstruction;
4. Endodontic and periodontic care;
5. Crown and fixed bridge;
6. Removable prosthetics; and
7. *Medically necessary* orthodontia, , including retainers (covered only for eligible children with cases of severe orthodontic abnormality caused by genetic deformity (such as cleft lip or cleft palate) or traumatic facial surgery resulting in serious health impairment to an insured child at the present time;
8. Cancer treatment (prophylaxis (preventive) extractions under the following circumstances: Organ transplant workup, intraoral radiation workup, heart valve replacement, immunodeficient states for which prophylactic extractions are medically justified, and potential life-threatening condition.);
9. Treatment of fractures;
10. Biopsies;
11. Emergency room services by a dentist;
12. Inpatient services;
13. Anesthesia and intravenous conscious sedation (limited to extensive or complex oral surgical services); and
14. Analgesia (nitrous oxide).

Visit limitations are as follows:

1. One Comprehensive exam per insured child, per dentist or dental group per lifetime. Only one exam per day per insured child, per dentist or dental group;
2. One diagnostic exam (including cleanings) every six months, beginning before age one;
3. Bitewing x-rays (Radiographs limited to $60 per date of service);
4. Full mouth x-rays once every three years;
5. Panoramic x-rays once every three years;
6. Fillings (silver amalgam or tooth colored composites) – total number of surfaces per tooth per material type are covered; not total number of restorations per tooth;
7. Fluoride, including fluoride varnishes, three times in a year ;
8. Root canals on baby teeth(pulpotomies only) one per tooth per lifetime; Root canals on permanent teeth, one tooth per lifetime;
9. Periodontal therapy four quadrants per twelve-month period, minimum 4 affected teeth/quadrant or four per 12 months, one to three affected teeth in quadrant;
10. Stainless steel crowns once per twenty four months;
11. Metal crowns only, Metal/porcelain crowns and porcelain crowns once per 60 months;
12. Space maintainers limited to one per year. Covered only when medically indicated due to premature loss of postier primary tooth. Re-cementation not covered within 6 months of initial placement;

13. One partial denture, replaced once within a five-year period (must replace 1 or more anterior teeth, or replaces 2 or more posterior teeth unilaterally or three or more posterior teeth, excluding 3rd molars; and;
14. One complete denture once every five years.

Pediatric Vision Expense Benefits
Covered expenses in this benefit subsection include the following for an *eligible child* under the age of 19 who is a *covered person*:

1. Routine vision screening (eye exams), including dilation and with refraction as needed when provided by ophthalmologists and optometrists, including dilation;
2. Up to three pairs of prescription lenses or three contacts per 365 day period, including polycarbonate lenses and scratch resistant coating;
3. Three pairs of frames per 365 day period. Standard frames will include a minimum of a one-year warranty ; and
4. Low vision optical devices including low vision services, and an aid allowance with follow-up care when pre-authorized.

Covered expenses do not include:

1. Visual therapy; or
2. Two pair of glasses as a substitute for bifocals.

Preventive Care Expense Benefits
Covered expenses are expanded to include the charges incurred by a *covered person* for the following preventive health services if appropriate for that *covered person* in accordance with the following recommendations and guidelines:

1. Evidence based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force;
2. Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to an individual;
3. Evidence-informed preventive care and screenings for infants, children, and adolescents, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration (for example, prostate exams for men); and
4. Additional preventive care and screenings not included in (1) above, in accordance with comprehensive guidelines supported by the Health Resources and Services Administration for women. (For example, mammograms and pap smears.)

Benefits for preventive health services listed in this provision, except under the administration of reasonable medical management techniques discussed in the next paragraph, are exempt from any deductibles and coinsurance provisions under the *policy* when the services are provided by a *network provider.*

Benefits for *covered expenses* for preventive care expense benefits may include the use of reasonable medical management techniques authorized by federal law to promote the use of high value preventive services from *network providers*. Reasonable medical management techniques may result in the application of deductibles and coinsurance provisions to services when a *covered person* chooses not to use a high value service that is otherwise exempt from deductibles and coinsurance provisions when received from a *network provider*.

As new recommendations and guidelines are issued, those services will be considered *covered expenses* when required by the United States Secretary of Health and Human Services, but not earlier than one year after the recommendation or guideline is issued.

Newborns' And Mothers' Health Protection Act Statement Of Rights

If expenses for *hospital* confinement in connection with childbirth are otherwise included as *covered expenses*, *we* will not limit the number of days for these expenses to less than that stated in this provision.

Under federal law, health insurance issuers generally may not restrict benefits otherwise provided for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a delivery by cesarean section. However, *we* may provide benefits for *covered expenses* incurred for a shorter stay if the attending provider (e.g., *your physician*, nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

The level of benefits and out-of-pocket costs for any later part of the 48-hour or 96-hour stay will not be less favorable to the mother or newborn than any earlier part of the stay. *We* do not require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours or 96 hours.

Note: This provision does not amend the *policy* to restrict any terms, limits, or conditions that may otherwise apply to *covered expenses* for childbirth.

Transplant Service Expense Benefits
Covered expenses for transplant expenses:
If *we* determine that a *covered person* is an appropriate candidate for a *listed transplant,* Medical Benefits *covered expenses* will be provided for:

1. Pre-transplant evaluation;
2. Pre-transplant harvesting;
3. Pre-transplant stabilization, meaning an *inpatient* stay to medically stabilize a *covered person* to prepare for a later transplant, whether or not the transplant occurs;
4. High dose chemotherapy;
5. Peripheral stem cell collection;
6. The transplant itself, not including the acquisition cost for the organ or bone marrow except at a *Center of Excellence* and
7. Post transplant follow-up.

Transplant Donor Expenses:
We will cover the medical expenses incurred by a live donor as if they were medical expenses of the *covered person* if:

1. They would otherwise be considered *covered expenses* under the *policy;*
2. The *covered person* received an organ or bone marrow of the live donor; and
3. The transplant was a *listed transplant.*

Ancillary "Center Of Excellence" Benefits:
A *covered person* may obtain services in connection with a *listed transplant* from any *physician*. However, if a *listed transplant* is performed in a *Center of Excellence:*

1. *Covered expenses* for the *listed transplant* will include the acquisition cost of the organ or bone marrow; and
2. *We* will pay a maximum of $10,000 per lifetime for the following services:
    a. Transportation for the *covered person,* any live donor, and the *immediate family* to accompany the *covered person* to and from the *Center of Excellence.*
    b. Lodging at or near the *Center of Excellence* for any live donor and the *immediate family* accompanying the *covered person* while the *covered person* is confined in the *Center of Excellence. We* will pay the costs directly for transportation and lodging, however, *you* must make the arrangements.

Exclusions:

No benefits will be paid under these Transplant Expense Benefits for charges:

1. For search and testing in order to locate a suitable donor;
2. For a prophylactic bone marrow harvest or peripheral blood stem cell collection when no *listed transplant* occurs;
3. For animal to human transplants;
4. For artificial or mechanical devices designed to replace a human organ temporarily or permanently;
5. For procurement or transportation of the organ or tissue, unless expressly provided for in this provision;
6. To keep a donor alive for the transplant operation;
7. For a live donor where the live donor is receiving a transplanted organ to replace the donated organ;
8. Related to transplants not included under this provision as a *listed transplant; and*
9. For a *listed transplant* under study in an ongoing phase I or II clinical trial as set forth in the United States Food and Drug Administration (*USFDA*) regulation, regardless of whether the trial is subject to *USFDA* oversight.

Limitations on Transplant Expenses Benefits:
In addition to the exclusions and limitations specified elsewhere in this section:

1. *Covered expenses* for *listed transplants* will be limited to two transplants during any 10- year period for each *covered person*;
2. If a designated *Center of Excellence* is not used, *covered expenses* for a *listed transplant* will be limited to a maximum for all expenses associated with the transplant. See the Schedule of Benefits for benefit levels or additional limits; and

If a designated *Center of Excellence* is not used, the acquisition cost for the organ or bone marrow is not covered.

GENERAL LIMITATIONS AND EXCLUSIONS

No benefits will be paid for:

1. Any service or supply that would be provided without cost to *you* or *your* covered *dependent* in the absence of insurance covering the charge;
2. Expenses/surcharges imposed on *you* or *your* covered *dependent* by a provider, including a *hospital*, but that are actually the responsibility of the provider to pay;
3. Any services performed by a member of a *covered person's immediate family; and*
4. Any services not identified and included as *covered expenses* under the *policy*. *You* will be fully responsible for payment for any services that are not *covered expenses.*

Even if not specifically excluded by this *policy,* no benefit will be paid for a service or supply unless it is:

1. Administered or ordered by a *physician;* and
2. *Medically necessary* to the diagnosis or treatment of an *injury* or *illness,* or covered under the Preventive Care Expense Benefits provision.

Covered expenses will not include, and no benefits will be paid for any charges that are incurred:

1. For services or supplies that are provided prior to the *effective date* or after the termination date of this *policy*, except as expressly provided for under the Benefits After Coverage Terminates clause in this *policy's* Termination section;
2. For any portion of the charges that are in excess of the *eligible expense;*
3. For weight modification, or for surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass *surgery*;
4. For breast reduction or augmentation;
5. For modification of the physical body in order to improve the psychological, mental, or emotional well-being of the *covered person,* such as sex-change *surgery*;
6. For vasectomies, and reversal of sterilization and vasectomies;

7. For abortion unless the life of the mother would be endangered if the fetus were carried to term.
8. For treatment of malocclusions, disorders of the temporomandibular joint, or craniomandibular disorders, except as described in *covered expenses* of the Medical Benefits provision;
9. For expenses for television, telephone, or expenses for other persons;
10. For marriage, family, or child counseling for the treatment of premarital, marriage, family, or child relationship dysfunctions;
11. For telephone consultations or for failure to keep a scheduled appointment;
12. For *hospital* room and board and nursing services 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;
13. For stand-by availability of a *medical practitioner* when no treatment is rendered;
14. For *dental expenses,* including braces for any medical or dental condition, *surgery* and treatment for oral *surgery*, except as expressly provided for under Medical Benefits;
15. For *cosmetic treatment*, except for *reconstructive surgery* that is incidental to or follows *surgery* or an *injury* that was covered under the *policy* or is performed to correct a birth defect in a child who has been a *covered person* from its birth until the date *surgery* is performed;
16. For diagnosis or treatment of learning disabilities, attitudinal disorders, or disciplinary problems.
17. For diagnosis or treatment of nicotine addiction, except as otherwise covered under the Preventive Care Expense Benefits provision of this *policy*;
18. For charges related to, or in preparation for, tissue or organ transplants, except as expressly provided for under the Transplant Expense Benefits;
19. For high dose chemotherapy prior to, in conjunction with, or supported by *ABMT/BMT*, except as specifically provided under the Transplant Expense Benefits;
20. For eye refractive *surgery,* when the primary purpose is to correct nearsightedness, farsightedness, or astigmatism;
21. While confined primarily to receive *rehabilitation, custodial care,* educational care, or nursing services unless expressly provided for by the *policy*;
22. For vocational or recreational therapy, vocational *rehabilitation*, outpatient speech therapy, or occupational therapy, except as expressly provided for in this *policy*;
23. For alternative or complementary medicine using non-orthodox therapeutic practices that do not follow conventional medicine. These include, but are not limited to, wilderness therapy, outdoor therapy, boot camp, equine therapy, and similar programs;
24. For eyeglasses, contact lenses, hearing aids, eye refraction, visual therapy, or for any examination or fitting related to these devices, except as specifically provided under the *policy*;
25. For maternity expenses due to *pregnancy* of an *eligible child* except for *complications of pregnancy*;
26. For *experimental or investigational treatment(s)* or *unproven services.* The fact that an *experimental or investigational treatment* or *unproven service* 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* or *unproven service* for the treatment of that particular condition;
27. For 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;
28. As a result of an *injury* or *illness* arising out of, or in the course of, employment for wage or profit, if the *covered person* is insured, or is required to be insured, by workers' compensation insurance pursuant to applicable state or federal law. If *you* enter into a settlement that waives a *covered person's* right to recover future medical benefits under a workers' compensation law or insurance plan, this exclusion will still apply. In the event that the workers' compensation insurance carrier denies coverage for a *covered person's w*orkers' compensation claim, this exclusion will still apply unless that denial is appealed to the proper governmental agency and the denial is upheld by that agency;
29. As a result of:
    a. Intentionally self-inflicted bodily harm whether the *covered person* is sane or insane;
    b. An *injury* or *illness* caused by any act of declared or undeclared war;

c. The *covered person* taking part in a riot; or
d. The *covered person's* commission of a felony, whether or not charged;

30. For or related to *durable medical equipment* or for its fitting, implantation, adjustment, or removal, or for complications there from, except as expressly provided for under the Medical Benefits;
31. For any *illness* or *injury* incurred as a result of the *covered person* being intoxicated, as defined by applicable state law in the state in which the *loss* occurred, or under the influence of illegal narcotics or controlled substance unless administered or prescribed by a *physician*;
32. For or related to surrogate parenting;
33. For or related to treatment of hyperhidrosis (excessive sweating);
34. For fetal reduction surgery;
35. Except as specifically identified as a *covered expense* under the *policy*, expenses for alternative treatments, including acupressure, acupuncture, aroma therapy, hypnotism, massage therapy, rolfing, and other forms of alternative treatment as defined by the Office of Alternative Medicine of the National Institutes of Health;
36. As a result of any *injury* sustained during or due to participating, instructing, demonstrating, guiding, or accompanying others in any of the following: operating or riding on a motorcycle; professional or semi-professional sports; intercollegiate sports not including intramural sports; parachute jumping; hang-gliding; racing or speed testing any motorized vehicle or conveyance; racing or speed testing any non-motorized vehicle or conveyance, if the *covered person* is paid to participate or to instruct; scuba/skin diving when diving 60 or more feet in depth; skydiving; bungee jumping; rodeo sports; horseback riding, if the *covered person* is paid to participate or to instruct; rock or mountain climbing, if the *covered person* is paid to participate or to instruct; or skiing, if the *covered person* is paid to participate or to instruct;
37. As a result of any *injury* sustained while operating, riding in, or descending from any type of 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;
38. As a result of any *injury* sustained while at a *residential treatment facility;*
39. For prescription drugs for any *covered person* who enrolls in Medicare Part D as of the date of his or her enrollment in Medicare Part D. Prescription drug coverage may not be reinstated at a later date; and
40. For the following miscellaneous items: artificial Insemination except where required by federal or state law; biofeedback; care or complications resulting from non-*covered expenses*; chelating agents; domiciliary care; food and food supplements; routine foot care, foot orthotics or corrective shoes; health club memberships, unless otherwise covered; home test kits; care or services provided to a non-*member* biological parent; nutrition or dietary supplements; pre-marital lab work; processing fees; private duty nursing; rehabilitation services for the enhancement of job, athletic or recreational performance; routine or elective care outside the service area; sclerotherapy for varicose veins; treatment of spider veins; smoking cessation drugs, programs or services, except where required by federal or state law; transportation expenses, unless specifically described in this *policy*;
41. 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.

Limitation On Benefits For Services Provided By Medicare Opt-Out Practitioners
Benefits for *covered expenses* incurred by a Medicare-eligible individual for services and supplies provided by a *Medicare opt-out practitioner* will be determined as if the services and supplies had been provided by a *Medicare participating practitioner*. Benefits will be determined as if Medicare had, in fact, paid the benefits it would have paid if the services and supplies had been provided by a *Medicare participating practitioner*.

Premium Information

Policy Premium: _____

Designated Company Representative Information

Name: Nate Watters
Address: Celtic Insurance Company
Sears Tower
233 South Wacker Drive, Suite 700
Chicago, IL 60606-6393

Signature: 
_____

Date: _____