

**TIME INSURANCE COMPANY**

501 West Michigan  
Milwaukee, WI 53203

**SHORT TERM MEDICAL POLICY - FORM 135  
OUTLINE OF COVERAGE**

This outline of coverage provides a brief description of the important features of Your policy. This is not the insurance contract. The policy itself sets forth in detail the rights and obligations of both You and Your insurance company. It is important that You READ YOUR POLICY CAREFULLY!

**MAJOR MEDICAL EXPENSE COVERAGE:** The policy is designed to provide coverage for major Hospital, medical, and surgical expenses incurred as a result of Medically Necessary care for a covered Sickness or Injury during a Benefit Period.

**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.

<b>COVERAGE INFORMATION</b>				
Individual Deductible \$ _____	Family Deductible \$ _____	Copayment \$ _____	Prescription Drug Deductible \$ _____	Prescription Drug Copayment \$ _____
Rate of Payment ____ % of \$ _____	Lifetime Maximum Benefit \$ _____	Benefit Period _____ Days	Waiting Period for Sickness _____ Days	
Inpatient Hospital Services: _____ Outpatient Hospital Services: _____ Health Care Practitioner Services: Surgical: _____ Anesthesia: _____ Per Office Visit: _____ Reconstructive Surgery: _____		Inpatient Rehabilitation: _____ Skilled Nursing Facility: _____ Home Health Care: _____ Outpatient Physical Medicine: _____ Ambulance: _____ X-ray and Lab: _____ Prescription Drugs: _____		
<b>PREMIUM INFORMATION</b>				
Premium Payment Mode: _____ TOTAL MODAL PREMIUM AMOUNT: \$ _____				

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

**RATE OF PAYMENT:** The amount We will pay for Covered Expense after You pay Your portion. 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.

**OTHER INSURANCE:** Benefits that are otherwise payable under Our policy will be reduced if there is other insurance that also provides benefits for Covered Expenses. Our policy will not duplicate benefits.

**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.
- **Outpatient Hospital Services:** Services performed in a Hospital's outpatient department or in a Free-Standing Ambulatory Surgical Facility.
- **Health Care Practitioner Services, Surgical and Anesthesia Services:** Surgical services, anesthesia services and Health Care Practitioner services (not including office visits).
- **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 because of congenital illness or anomaly of a Covered Dependent child, born while the policy is in force, that resulted in a functional defect.
- **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.
- **Skilled Nursing Facility Care:** Care in a Skilled Nursing Facility when the confinement is in lieu of acute hospitalization or when admitted to the Skilled Nursing Facility within 14 days after a Hospital confinement of at least 3 days for the same condition. 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.
- **Home Health Care:** 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.

- **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 4 hours of therapy within a 24-hour period.
- **Ambulance Services:** Ambulance service for one trip to the nearest Hospital that is able to treat the Sickness or Injury.
- **X-ray and Laboratory Services:** X-ray, radioactive treatment and laboratory charges. Coverage for a pelvic examination, Pap smear and screening mammography exam for a covered female Insured as prescribed by You 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.
- **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:** The following complications arising from a pregnancy that began after the Effective Date of coverage are covered on the same basis as any other covered Sickness: 1) ectopic pregnancy; 2) spontaneous termination of pregnancy (miscarriage) that occurs before the 26th week of gestation; and 3) missed abortion. No benefits will be paid for: false labor; premature labor; high risk pregnancy or delivery; caesarean section delivery; occasional spotting; Health Care Practitioner prescribed rest; morning sickness; hyperemesis gravidarum; pre-eclampsia; placenta previa; or similar conditions that occur in a difficult pregnancy.
- **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 and are dispensed by a licensed pharmacy.
- **AIDS/HIV Services:** Treatment of AIDS, AIDS Related Complex (ARC) or related immunodeficiency.
- **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 and the maximum benefit for donor expenses is \$10,000.
- **Dietary Formula:** Coverage for nonprescription elemental enteral formula if Your Health Care Practitioner certifies that the formula is Medically Necessary for the treatment of severe intestinal malabsorption and that the formula comprises an essential source of nutrition.
- **Inform Errors of Metabolism Coverage:** Coverage for Medically Necessary diagnosis, treatment and monitoring of disorders that involve amino acid, carbohydrate and fat metabolism. Coverage includes, but is not limited to, quantification of metabolites in blood, urine or spinal fluid or enzyme or DNA confirmation in tissues; clinical visits; biochemical analysis; and Medical Foods used in the treatment of such disorders.

Medical Foods are foods that are formulated to be consumed or administered enterally under the supervision of a Health Care Practitioner that are specifically processed or formulated to be deficient in one or more of the nutrients present in typical nutritional counterparts and are for the medical and nutritional management of patients with limited capacity to metabolize ordinary foodstuffs or certain nutrients contained therein or have other specific nutrient requirements as established by medical evaluation. These Medical Foods must be essential to optimize Your growth, health and metabolic homeostasis.

**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 or contributed to 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.
  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 Mental Illness or Substance Abuse, whether organic or non-organic, chemical or non-chemical, biological or non-biological in origin and irrespective of cause, basis or inducement, unless otherwise noted as a Covered Expense in the policy or a rider to the policy.
  - 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 accidental Injury sustained in operating a motor vehicle while the Insured's blood alcohol level, as defined by law, exceeds that level permitted by law or otherwise violates legal standards for a person operating a motor vehicle in the state where the Injury occurred. This exclusion applies whether or not the Injury occurred in connection with an incident involving the operation of a motor vehicle, and whether or not the Insured is charged with any violation in connection with the accident.
  - Treatment or services required due to Injury received while engaging in any hazardous occupation or other activity, including the following: Participating, instructing, demonstrating, guiding or accompanying others in parachute jumping, hang-gliding, bungee jumping, flight in an aircraft other than a regularly scheduled flight by an airline, racing any motorized or non-motorized vehicle, rock or mountain climbing, professional or semi-professional contact sports of any kind. Also excluded are treatment and services required due to Injury received while practicing, exercising, undergoing conditioning or physical preparation for any such activity.
  - Treatment or services required due to Injury received while engaging in any hazardous occupation or other activity for which compensation is received, including the following: Participating, instructing, demonstrating, guiding or accompanying others in skiing and horse riding. Also excluded are treatment and services required due to Injury received while practicing, exercising, undergoing conditioning or physical preparation for any such compensated activity.
  - Treatment or services required due to Injury sustained while participating in any interscholastic or intercollegiate sport, contest or competition or while practicing, exercising, undergoing conditioning or physical preparation for any such sport, contest or competition.
  - Treatment or services required for Sickness or Injury resulting from consumption, abuse or overdose of alcoholic beverages or any illegal or controlled substance.

- Expense incurred due to Sickness or Injury of which a contributing cause was the Insured's voluntary attempt to commit, participation in or commission of a felony, whether or not charged, or as a consequence of the Insured's being under the influence of illegal narcotics or non-prescribed controlled substances.
- Custodial Care; respite care; rest care; or supportive care.
- Expenses incurred outside of the United States or its possessions or Canada.
- Expenses incurred for Experimental or Investigational Treatment.
- 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; reduction mammoplasty; revision of breast surgery for capsular contraction or replacement of prosthesis; orthognathic surgery; non-medical self-care or self-help programs.
- 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 and medicines, except as covered in the Benefits section.
- Treatment, services or supplies not described in the Benefits section of the policy.

**RENEWABILITY PROVISION:** The policy is not renewable. Coverage is in force only for the Benefit Period You selected which is shown on page one.

**PREMIUM:** The first page shows the total premium for the coverage You selected. The premium amount will not change while the policy is in force.

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Licensed Agent's Signature

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Date