

**OUTLINE OF COVERAGE
FOR POLICY FORM AS7008
HOME HEALTH CARE INSURANCE POLICY**

PARAGRAPH 1: Read Your Policy Carefully. This Outline of Coverage provides a very brief description of the important features of Your Policy. This is not the insurance contract and only the actual Policy provisions will control. The Policy itself sets forth, in detail, the rights and obligations of both You and the Company. It is, therefore, important that You **READ YOUR POLICY CAREFULLY**.

THE POLICY HAS LIMITED BENEFITS AND IS SUBJECT TO THE POLICY'S LIMITATIONS AND EXCLUSIONS, PER DAY, POLICY YEAR, AGGREGATE, LIFETIME, AND OTHER MAXIMUM BENEFIT AMOUNTS. READ YOUR POLICY CAREFULLY TO UNDERSTAND POLICY LIMITATIONS.

The capitalized terms used in this Outline of Coverage are defined in Your Policy or Rider.

THE POLICY DOES NOT PROVIDE LONG-TERM CARE INSURANCE COVERAGE.

PARAGRAPH 2: The Policy is designed to provide coverage in the form of a fixed daily benefit limited fixed indemnity benefit for covered home health care, subject to any limitations set forth in the Policy. Coverage is not provided for any benefits other than home health care, and home health care aide, and any additional indemnity benefit described below.

NOTICE: This is not a major medical insurance Policy. The Policy provides limited benefits. Benefits provided are supplemental and are not intended to cover all expenses. Benefits are paid in the amount stated on the Policy Schedule without regards to the cost of services rendered. The Policy does not provide expense reimbursement for charges based on provider's statement.

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE COVERAGE. If You are eligible for Medicare, review the Buyer's Guide to Health Insurance for People with Medicare available from the Company.

PLEASE READ YOUR POLICY CAREFULLY TO UNDERSTAND POLICY LIMITATIONS.

PARAGRAPH 3. BASE POLICY BENEFITS

HOME HEALTH CARE & HOME HEALTH CARE AIDE SERVICES BENEFITS

Nursing Care Services: We will pay \$75/150/200 per day for each day there is a charge for Nursing Care Services. Nursing Care Services for professional nursing care must be provided to You in Your Home by an individual who is qualified to provide Nursing Care Services, which includes the following: a registered professional nurse (RN); a licensed practical nurse (LPN); a licensed vocational nurse (LVN), and a certified or licensed hospice and palliative nurse (CHPN), who is practicing within the geographic area for which he or she is licensed or certified to practice. This benefit is subject to the Home Health Care & Home Health Care Aide Services Daily Maximum Aggregate Benefit amount of \$150/300/450, and the Home Health Care & Home Health Care Aide Services Maximum Benefit Period of 365 days (unless restored as provided in the Restoration of Benefits provision in the Policy), as shown on the Policy Schedule.

Physical Therapy: We will pay \$75/150/200 per day benefit, as shown on the Policy Schedule, for each day there is a charge for Physical Therapy. Physical Therapy must be provided to You in Your Home by a duly licensed physical therapist, practicing within the scope of his or her license in the geographic area for which he or she is licensed to practice. The physical therapist uses therapeutic exercise and other services that focus on improving:

1. posture;
2. locomotion;
3. strength;
4. endurance;
5. balance;
6. coordination;
7. joint mobility;
8. flexibility;

9. ADLs; and
10. alleviating pain.

This benefit is subject to the Home Health Care & Home Health Care Aide Services Daily Maximum Aggregate Benefit amount of \$150/300/450, and the Home Health Care & Home Health Care Aide Services Maximum Benefit Period of 365 days (unless restored as provided in the Restoration of Benefits provision in the Policy), as shown on the Policy Schedule.

Speech Pathology: We will pay \$75/150/200 per day benefit, as shown on the Policy Schedule, for each day there is a charge for Speech Pathology. Speech Pathology therapy must be provided to You in Your Home by a duly licensed speech pathologist therapist, practicing within the scope of his or her license in the geographic area for which he or she is licensed to practice. The speech pathologist therapist uses rehabilitative techniques to improve:

1. voice;
2. speech;
3. language, and
4. swallowing disorders.

This benefit is subject to the Home Health Care & Home Health Care Aide Services Daily Maximum Aggregate Benefit amount of \$150/300/450, and the Home Health Care & Home Health Care Aide Services Maximum Benefit Period of 365 days (unless restored as provided in the Restoration of Benefits provision in the Policy), as shown on the Policy Schedule.

Occupational Therapy: We will pay \$75/150/200 per day benefit, as shown on the Policy Schedule, for each day there is a charge for Occupational Therapy. Occupational Therapy must be provided to You in Your Home by a duly licensed occupational therapist, practicing within the scope of his or her license in the geographic area for which he or she is licensed to practice. The occupational therapist uses purposeful activities or assistive devices that focus on the following:

1. developing daily living skills;
2. strengthening and enhancing function;
3. coordination of fine motor skills; and
4. muscle and sensory stimulation.

This benefit is subject to the Home Health Care & Home Health Care Aide Services Daily Maximum Aggregate Benefit amount of \$150/300/450, and the Home Health Care & Home Health Care Aide Services Maximum Benefit Period of 365 days (unless restored as provided in the Restoration of Benefits provision in the Policy), as shown on the Policy Schedule.

Chemotherapy Specialist Services: We will pay \$60/120/200 per day benefit, as shown on the Policy Schedule, for each day there is a charge for Chemotherapy Specialist Services. Chemotherapy must be administered and monitored for treatment of Your cancer while in Your Home, by a duly licensed chemotherapy services specialist nurse, practicing within the scope of his or her license in the geographic area for which he or she is licensed to practice. This benefit is subject to the Home Health Care & Home Health Care Aide Services Daily Maximum Aggregate Benefit amount of \$150/300/450, and the Home Health Care & Home Health Care Aide Services Maximum Benefit Period of 365 days (unless restored as provided in the Restoration of Benefits provision in the Policy), as shown on the Policy Schedule.

Enterostomal Therapy: We will pay \$50/100/200 per day benefit, as shown on the Policy Schedule, for each day there is a charge for Enterostomal Therapy. Enterostomal Therapy must be provided to You in Your Home during the post-operative period following an ostomy (a surgically made opening that connects a portion of the intestine to the exterior (usually through the abdominal wall)) where Enterostomal Therapy is needed. Wound care that requires an enterostomal therapist is also considered Enterostomal Therapy. Enterostomal Therapy must be provided by a duly licensed enterostomal therapist (CETN), practicing within the scope of his or her license in the geographic area for which he or she is licensed to practice. This benefit is subject to the Home Health Care & Home Health Care Aide Services Daily Maximum Aggregate Benefit amount of \$150/300/450, and the Home Health Care & Home Health Care Aide Services Maximum Benefit Period of 365 days (unless restored as provided in the Restoration of Benefits provision in the Policy), as shown on the Policy Schedule.

Respiratory Therapy: We will pay \$50/100/200 per day benefit, as shown on the Policy Schedule, for each day there is a charge for Respiratory Therapy. Respiratory therapy must be provided to You in Your Home by a duly licensed respiratory therapist, practicing within the scope of his or her license in the geographic area for which he or she is licensed to practice, who:

1. teaches You about Your respiratory condition and how to manage it;
2. instructs You on how to use equipment, such as oxygen concentrators and related equipment, CPAP/BiPAP machines, nebulizers, and other respiratory assist devices;
3. teaches You breathing techniques to help reduce shortness of breath; and
4. participates in the development of a treatment plan.

Respiratory Therapy does NOT include watching or protecting a patient (examples include pulse oximetry monitoring, monitoring of respiratory status, seizure monitoring and observation of a person who is stable without cardiorespiratory compromise). This benefit is subject to the Home Health Care & Home Health Care Aide Services Daily Maximum Aggregate Benefit amount of \$150/300/450, and the Home Health Care & Home Health Care Aide Services Maximum

Benefit Period of 365 days (unless restored as provided in the Restoration of Benefits provision in the Policy), as shown on the Policy Schedule.

Medical Social Worker Services: We will pay \$100/200/300 per day benefit, as shown on the Policy Schedule, for each day there is a charge for Medical Social Worker Services. Medical Social Worker Services must be provided to You in Your Home by a duly licensed medical social worker, practicing within the scope of his or her license in the geographic area for which he or she is licensed to practice. The purpose of the medical social worker's Home visit is to:

1. assist the Physician and other health professionals in understanding the social and emotional factors related to Your health problems;
2. participate in the development of a treatment plan; and
3. assess and ensure use of appropriate community resources.

This benefit is subject to the Home Health Care & Home Health Care Aide Services Daily Maximum Aggregate Benefit amount of \$150/300/450, and the Home Health Care & Home Health Care Aide Services Maximum Benefit Period of 365 days (unless restored as provided in the Restoration of Benefits provision in the Policy), as shown on the Policy Schedule.

Home Health Care Aide Services: We will pay \$40/80/120 per day benefit, as shown on the Policy Schedule, for each day there is a charge for Home Health Care Aide Services. Home Health Care Aide Services must be provided to You in Your Home by a Home Health Care Aide. Only one (1) benefit is payable per a 24-hour period, regardless of the amount of Home Health Care Aide Services provided on such day. This benefit is subject to the Home Health Care & Home Health Care Aide Services Daily Maximum Aggregate Benefit amount of \$150/300/450, and the Home Health Care & Home Health Care Aide Services Maximum Benefit Period of 60 days (unless restored as provided in the Restoration of Benefits provision in the Policy), as shown on the Policy Schedule.

HOMEMAKER SERVICES BENEFITS

We will pay this per day benefit, as shown on the Policy Schedule, for each day there is a charge for Homemaker Services. To be eligible for this benefit, You must also be eligible for Home Health Care & Home Health Care Aide Services under the Policy. Homemaker Services may be provided by any individual, including Immediate Family members, and do not require professional certification. Only one (1) benefit is payable per a 24-hour period, regardless of the amount of Homemaker Services provided on such day. This benefit is subject to the per day Homemaker Services Benefit and Policy Maximum as shown on the Policy Schedule (unless restored as provided in the Restoration of Benefits provision in the Policy). Before the per day benefit can be paid for Homemaker Services, a Physician must certify that You:

1. have Loss of Functional Capacity;
2. have Cognitive Impairment; or
3. are Terminally Ill.

RESTORATION OF BENEFITS

If You have received the Home Health Care & Home Health Care Aide and/or Homemaker Services Benefits under the Policy and have exhausted the Maximum Benefit Period and/or Policy Maximum of one or both of these benefits, but have recovered sufficiently to no longer require these services. We will restore Your Maximum Benefit Period and/or Policy Maximum to its full original Maximum Benefit Period and/or Policy Maximum each time the following conditions are met:

1. You have not received these services in Your Home for a period of 180 consecutive days; and
2. Your Physician must certify that You have sufficiently recovered and no longer require any services and that You have not been advised by a Physician to obtain such services.

There is no limit to the number of times Your Maximum Benefit Period and/or Policy Maximum may be restored.

PRESCRIPTION DRUG BENEFITS

Subject to the \$10 per-prescription Generic Drug or \$25 per-prescription Brand Name Drug and \$300/600/900 Policy Year Maximum amount, We will pay this per-prescription benefit for each Prescription Order for a Generic Drug or Brand Name Drug that is filled for You through a retail or mail-order Pharmacy for:

1. Prescription Drugs that are fully approved and prescribed for the specified indications by the FDA for marketing in the United States and can be obtained only with a Prescription Order from Your duly licensed health care practitioner;
2. Prescription Drugs in dosages, dosage forms, dosage regimens, and durations of treatment that are prescribed by Your duly licensed health care practitioner for sickness or injury; and
3. Prescription Drugs that are within the quantity, supply, or other limits that are appropriate for a Prescription Drug.

The Pre-Existing Conditions Limitation does not apply to the Prescription Drug Benefit.

Prescription Drug Limitations and Exclusions: We will not pay benefits for—

1. drugs or medicines obtained from sources outside of the United States;
2. vitamins and/or vitamin combinations even if they are prescribed by a duly licensed health care practitioner;
3. any prescription products, drugs, or medicines in the following categories, whether or not prescribed by a duly licensed health care practitioner:
 - a. herbal or homeopathic medicines or products;
 - b. minerals;
 - c. appetite suppressants;
 - d. dietary or nutritional substances or dietary supplements;
 - e. nutraceuticals; or
 - f. medical foods;
4. drugs or medicines dispensed at or by a hospital, an emergency room, a free-standing facility, an urgent care facility, a health care practitioner's office, or other inpatient or outpatient setting for take Home by You;
5. drugs or medicines prescribed for treatment of a condition that is specifically excluded under the Policy;
6. drugs, medicines, or supplies that are illegal under federal law, such as marijuana, even if they are prescribed for medical use in a state;
7. duplicate prescriptions, replacement of lost, stolen, destroyed, spilled, or damaged prescriptions;
8. any administration for drug injections or any other drugs or medicines obtained other than through a Pharmacy with a Prescription Order;
9. Prescription Drug refills more than the number specified on the Prescription Order;
10. Prescription Drugs refilled more frequently than the prescribed dosage indicates; or
11. Prescription Drug that is filled on or after the date this insurance coverage terminates.

PARAGRAPH 4: LIMITATIONS AND EXCLUSIONS

Pre-Existing Conditions Limitation: This Policy and any attached benefit rider(s) do not cover Pre-Existing Conditions whether disclosed in the application or not, for the first six (6) months beginning on the date You become insured under the Policy. This Pre-Existing Conditions Limitation provision does not apply to the Prescription Drug Benefits.

Conditions specifically named or described as excluded in any part of the Policy are never covered.

This Policy does not cover any loss caused or contributed to by:

1. simple rest care, hotel or retirement home expense, or other expense which is related to Your Home;
2. declared or undeclared war or act thereof;
3. charges that You would not legally be obligated to pay in the absence of this insurance; or
4. alcoholism or drug addiction.

PARAGRAPH 5: OPTIONAL BENEFIT RIDER(S) (available for an additional premium):

AMBULANCE BENEFIT RIDER:

We will pay Ambulance benefit amount of \$200 per each one-way trip if a professional Ambulance service provides transportation for Emergency Care. Ambulance services also includes Ambulance transportation from one medical facility to another medical facility when health care services are provided during the duration of such transportation. This benefit is limited 4 one-way trips per Policy Year, and a Lifetime Maximum amount of \$2,500.

Ambulance transportation is not covered if provided solely for You, or Your family or health care provider's convenience.

EXCLUSIONS

This Rider does not pay benefits:

1. due to not having a charge or legal obligation to pay;
2. if the benefit would not routinely be paid in the absence of insurance;
3. due to You being under the influence of an excitant, depressant, hallucinogen, narcotic, or any other drug or intoxicant, including those prescribed by a Physician that are misused;
4. due to You engaging in an illegal activity or occupation;
5. due to You intentionally self-inflicting a bodily injury;
6. due to You committing or attempting suicide, while sane or insane;
7. due to You being exposed to war or any act of war, declared or undeclared;
8. due to You actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Army Reserve; or

9. due to participating in a felony, riot or insurrections.

ACCIDENT EXPENSE BENEFIT RIDER:

Benefits for Covered Accidents are payable if diagnosed and treated by a duly licensed health care practitioner in a Hospital Emergency Room, Urgent Care Facility, or Physician's office, subject to the conditions, limitations and exclusions in this Rider, and the Maximum Amount Per Each Covered Accident in the amount of \$1,250/2,500, and the Accident Expense Lifetime Maximum amount of \$10,000.

HIP DISLOCATION

We will pay the Hip Dislocation benefit amount of \$1,000/\$2,000 if You are diagnosed and treated within forty-eight (48) hours of the Covered Accident with a hip Dislocation.

KNEE DISLOCATION

We will pay the Knee Dislocation benefit amount of \$500/1,000 if You are diagnosed and treated within forty-eight (48) hours of the Covered Accident with a knee Dislocation.

HIP FRACTURE

We will pay the Hip Fracture benefit amount of \$1,250/2,500 if You are diagnosed and treated within forty-eight (48) hours of the Covered Accident with a hip Fracture.

SKULL FRACTURE

We will pay the Skull Fracture benefit amount of \$1,250/2,500 if You are diagnosed and treated within forty-eight (48) hours of the Covered Accident with a skull Fracture.

ALL OTHER FRACTURES

We will pay the All-Other Fracture benefit amount of \$250/500 if You are diagnosed and treated within forty-eight (48) hours of the Covered Accident with a Fracture that is not otherwise provided herein.

Limitation: No benefits are payable for any Fractured finger, toe, rib, coccyx, or chipped, Fractured or broken tooth.

KNEE LIGAMENT TEAR

We will pay the Knee Ligament Tear benefit amount of \$500/1,000 if You are diagnosed and treated within forty-eight (48) hours of the Covered Accident with a Knee Ligament Tear.

EXCLUSIONS

This Rider does not provide benefits due to You:

1. operating, learning to operate, or serving as a crew member of any aircraft;
2. officiating, coaching, practicing for, or participating in any semi-professional or professional competitive athletic contest for which any type of compensation or remuneration is received;
3. being exposed to war or any act of war, declared or undeclared;
4. actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Army Reserve;
5. participating in a felony, riot or insurrections;
6. being engaged in an illegal occupation;
7. intentionally self-inflicting an injury intentionally;
8. committing or attempting to commit suicide, while sane or insane;
9. being injured which arose out of or in the course of employment and which is payable or covered under any Workers' Compensation or Occupational Disease Act or Law; or
10. receiving injuries incurred outside the territorial limits of the United States or Canada unless such loss is incurred while You are on a trip of not more than sixty (60) days.

ACCIDENTAL DEATH & DISMEMBERMENT BENEFIT RIDER

ACCIDENTAL DEATH BENEFIT

If You are in a Covered Accident, which results in Your death within ninety (90) days after the date the Covered Accident, We will pay the Accidental Death benefit amount of \$10,000. However, this ninety (90) day period will be extended if You

were using any extraordinary life support system as a result of the Covered Accident, and such extraordinary life support system delayed Your death for more than ninety (90) days from the date of such Covered Accident. Your death must occur while this Rider is in force. Benefits will be paid to Your designated beneficiary. If You do not have a beneficiary, benefits will be paid to Your estate.

ACCIDENTAL DISMEMBERMENT BENEFIT

If You are in a Covered Accident, and within ninety (90) days of the Covered Accident and suffer a Complete Loss of Your hand, arm, foot, or leg (multiple); Your hand, arm, foot, or leg (single); Your finger or toe (multiple); Your finger or toe (single); Your sight, both eyes; or Your sight, one eye, We will pay the benefit amount for such accident dismemberment as follows:

Accidental Death	\$10,000
Loss of Sight, both eyes	\$ 5,000
Loss of Sight, one eye	\$ 2,500
Loss of Hand/arm/foot/leg (multiple)	\$ 5,000
Loss of Hand/arm/foot/leg (single)	\$ 2,500
Loss of Finger or toe (multiple)	\$ 500
Loss of Finger or toe (single)	\$ 250

However, this ninety (90) day period will be extended if You were using any extraordinary life support system as a result of the Covered Accident, and such extraordinary life support system delayed Your Complete Loss for more than ninety (90) days from the date of such Covered Accident.

Only the highest single benefit will be payable per Covered Accident. Benefits will be paid only once per Covered Accident. If death and loss of finger, toe, hand, foot, or eyesight result from the same Covered Accident, only the Accidental Death Benefit will be paid. This benefit is subject to the Accidental Dismemberment Lifetime Maximum amount of \$10,000.

EXCLUSIONS

This Rider does not provide benefits due to You:

1. operating, learning to operate, or serving as a crew member of any aircraft;
2. officiating, coaching, practicing for, or participating in any semi-professional or professional competitive athletic contest for which any type of compensation or remuneration is received;
3. being exposed to war or any act of war, declared or undeclared;
4. actively serving in any of the armed forces, or units auxiliary thereto, including the National Guard or Army Reserve;
5. participating in a felony, riot or insurrections;
6. being engaged in an illegal occupation;
7. intentionally self-inflicting an injury intentionally;
8. committing or attempting to commit suicide, while sane or insane;
9. being injured which arose out of or in the course of employment and which is payable or covered under any Workers' Compensation or Occupational Disease Act or Law; or
10. receiving injuries incurred outside the territorial limits of the United States or Canada unless such loss is incurred while You are on a trip of not more than sixty (60) days.

HOME MEDICAL EQUIPMENT BENEFIT RIDER

If Your Physician or Your duly licensed health care provider prescribes or orders Home Medical Equipment while You are receiving Home Health Care Services and/or Home Health Care Aide benefits under the Home Health Care Insurance Policy for which this Rider is attached, and You purchase or enter into a rental agreement for such Home Medical Equipment, We will pay the Home Medical Equipment benefit. This benefit is subject to the Home Medical Equipment per item amount of \$100 and Lifetime Maximum amount of \$500 for this benefit Rider.

Limitations:

1. Home Medical Equipment is limited to the following Durable Medical Equipment:
Mobility Assistance: Wheelchairs; walkers, rollators, canes, crutches or similar walking aids.
Transfer Aids: Gait/transfer belts; transfer benches; transfer boards; transfer mats.
Bathroom Safety: Shower chairs; elevated toilet seats; commode chairs.
Home Accommodations: hospital beds; patient lifts; trapezes.
Personal Medical Equipment: braces (arm, leg, back and neck).

2. Home Medical Equipment must be the most appropriate model that adequately meets Your medical need, as measured by Medicare guidelines.
3. Replacement of Home Medical Equipment will only be covered for a material change in clinical status or customary wear and tear; duplicates are never a covered benefit.
4. Total benefits for rented Home Medical Equipment shall not exceed the benefit for purchase of that same equipment.

Unused benefits in one Policy Year are not carried forward to any future Policy Year.

ROUTINE ANNUAL PHYSICAL EXAMINATION BENEFIT RIDER

Subject to a 12-Month Waiting Period

If You undergo a Routine Annual Physical Examination, We will pay a Routine Annual Physical Examination Benefit amount of \$150. This benefit is limited to one (1) Routine Annual Physical Examination per Policy Year, and payable only after the 12-month Waiting Period is satisfied.

PARAGRAPH 6: RENEWABILITY

Guaranteed Renewable. You have the right to renew the Policy as long as You live if You pay the correct premium when due or within the Grace Period. At no time while You continue Your Policy in force, may We place any restrictive riders on Your coverage.

PARAGRAPH 7: PREMIUM

We retain the right to change the premium on the Policy. Premiums are based on Your attained age. The premium will change if a new table of rates is applicable to the Policy. The change in the table of rates will apply to all covered persons in the same class on the date of the change. We will give You advance written notice as required by Your state prior to any premium change.

The total annual premium for this insurance coverage that You applied for is:

Home Health Care Insurance Policy \$ _____

Routine Annual Physical Examination Benefit \$ _____
Rider

Accidental Death & Dismemberment Benefit \$ _____
Rider

Home Medical Equipment Benefit Rider \$ _____

Accident Expense Benefit Rider \$ _____

Ambulance Benefit Rider \$ _____

TOTAL: \$ _____