



P.O. Box 4884, Houston, Texas 77210-4884

**HOSPITAL INDEMNITY INSURANCE  
OUTLINE OF COVERAGE  
FORM H-0180**

**READ YOUR POLICY CAREFULLY.** This outline of coverage provides a very brief description of some 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 your insurance company. It is therefore, important that you **READ YOUR POLICY CAREFULLY!**

Hospital confinement indemnity coverage is designed to provide you with a fixed daily benefit during periods of hospital confinement resulting from a covered injury or sickness. Coverage is provided for the benefits outlined in the table below, subject to the limitations and exclusions described below.

<b>Calendar Year Policy Deductible</b> (per Covered Person with a maximum of 3 deductibles per policy)(Additional Outpatient Benefits Calendar Year Deductible does not apply to satisfaction of Calendar Year Policy Deductible)	<b>\$1,000 / \$2,500 / \$5,000</b>
<b>Lifetime Maximum</b> (per policy)	<b>\$5,000,000</b>

<b>Maximum Covered Benefits per Covered Person per Calendar Year</b>	<b>\$100,000</b>	<b>\$250,000</b>	<b>\$1,000,000</b>
Daily Indemnity Benefits as described below are limited to the Maximum Number of Days Per Covered Person Per Calendar Year indicated (for all benefits combined)	30	60	180

<b>HOSPITAL INDEMNITY BENEFITS</b>	<b>UNITS</b>		
	<b>1</b>	<b>2</b>	<b>3</b>
<b>Facility Fees</b>			
Daily Indemnity Benefit during Confinement in a Hospital (including Observation Unit stay for 24 hours or more) for:			
Alcohol and/or Substance Abuse Dependency	\$500	\$1,000	\$1,500
Mental Illness	\$500	\$1,000	\$1,500
Any Other Injury or Sickness	\$1,000	\$2,000	\$3,000
Daily Indemnity Benefit during Confinement in a Hospital's Intensive Care Unit (ICU) up to 20 days per Calendar Year	\$1,500	\$3,000	\$4,500
Daily Indemnity Benefit during Confinement in a Rehabilitation Facility or a Skilled Nursing Facility	\$500	\$1,000	\$1,500
Daily Indemnity Benefit for Outpatient Hospital or ambulatory surgical center services when surgery is performed	\$1,000	\$2,000	\$3,000

	Units		
	1	2	3
<b>Professional Services</b>			
Daily Indemnity Benefit for Outpatient Radiation or Chemotherapy	\$500	\$1,000	\$1,500
Other Inpatient Benefits: Physician Hospital Visit per visit	\$50	\$100	\$150
Surgical Indemnity Benefit for covered services when performed in a Hospital or in an ambulatory surgical center	Benefit per procedure as listed in the Fee Schedule (1 unit)		
Inpatient Pathologist/Radiologist Benefits for covered services	Benefit per procedure as listed in the Fee Schedule (1 unit)		
Anesthesia Indemnity Benefit for covered services	25% of surgical benefits payable equals one unit		
Emergency Ambulance Indemnity Benefit	\$250 per trip		

**Hospital, Rehabilitation Facility & Skilled Nursing Facility Benefits** for covered persons confined in such medical facilities for 24 or more consecutive hours are as shown in the above schedule.

**ADDITIONAL OUTPATIENT BENEFITS** (these benefits are payable for services performed on an outpatient basis only)

<b>Calendar Year Deductible</b> (Calendar Year Policy Deductible does not apply towards satisfaction of Calendar Year Deductible)	<b>\$500 per insured</b>		
<b>Aggregate Calendar Year Maximum</b>	<b>\$2,000</b>		
	<b>Units</b>		
	<b>1</b>	<b>2</b>	<b>3</b>
Outpatient Office Visit (fees per visit for office, outpatient clinic or emergency room)	\$25	\$50	\$75
Other Outpatient Services (per test)			
MRI, CAT Scan or Nuclear testing	\$175	\$350	\$525
Other diagnostic testing or X-rays	\$40	\$80	\$120
Laboratory testing	\$10	\$20	\$30
Injections	\$5	\$10	\$15
Generic Prescription (per prescription filled)	\$5	\$10	\$15
Brand Name Prescription (per prescription filled)	\$10	\$20	\$30
Well Care Maximum:	\$50 per visit up to \$150 per calendar year		

**GUARANTEED RENEWABLE TO AGE 65. THE COMPANY RESERVES THE RIGHT TO CHANGE PREMIUM RATES ON A CLASS BASIS.**

You have the right to renew this policy until the first premium due date on or after your 65th birthday.

We reserve the right, subject to 45 days prior written notice to You at Your last known address, to establish a new schedule of premium rates; such schedule of rates will be effective on the following premium due date for all or any class of Insured's covered by the policy. Premiums may also change due to attained age. Please read the Premium Rate Change provision carefully that is contained in the policy.

**EXCLUSIONS AND LIMITATIONS**

With respect to all of the benefits provided under the policy, no benefits will be payable as the result of: any service, supplies or treatment that is not a Covered Service described in Section 3 hereof; suicide or any attempt thereat, while sane or insane; any intentionally self-inflicted Injury or Sickness; rest care; cosmetic surgery or care or treatment solely for cosmetic purposes, or complications there from. This exclusion does not apply to cosmetic surgery resulting from an Injury if initial treatment of the Covered Person is begun within 12 months of the date of the Injury; immunization shots and routine examinations such as: health exams; periodic check-ups; pre-marital exams; and routine physicals, except as otherwise covered under the Policy; routine newborn care, including routine nursery charges; voluntary abortion, except with respect to You or Your covered Dependent

spouse where such person's life would be endangered if the fetus were carried to term or where medical complications have arisen from an abortion; pregnancy of a Dependent child, unless required by law; a Covered Person's participation in a riot, civil commotion, civil disobedience, or unlawful assembly. This does not include a loss which occurs while acting in a lawful manner within the scope of authority; a Covered Person committing, attempting to commit, or taking part in a felony, or engaging in an illegal occupation; a Covered Person's participation in a contest of speed in power driven vehicles, parachuting, parasailing, bungee-jumping, or hang gliding; air travel, except: (i) as a fare-paying passenger on a commercial airline on a regularly scheduled route; or (ii) as a passenger for transportation only and not as a pilot or crew member; any Injury occurring directly or indirectly as a result of the voluntary use of alcohol, drugs, narcotics or hallucinogens unless taken on the written advice of a Physician except for treatment of Alcohol and/or Substance Abuse Dependency as provided in the policy; sex changes; any dental care, treatment or service to the teeth, gums or mouth; experimental treatments or surgery; the reversal of tubal ligation and vasectomies; artificial insemination, in vitro fertilization, and test tube fertilization, including any related testing, medications, or Physician's services, unless required by law; treatment of exogenous obesity or weight control; an act of war, whether declared or undeclared, or while performing police duty as a member of any military or naval organization. This exclusion includes Injury sustained or Sickness contracted while in the service of any military, naval or air force of any country engaged in war. We will refund the pro rata unearned premium for any such period the Covered Person is not covered; Injury or Sickness arising out of and in the course of any occupation for compensation, wage or profit. Expenses which are payable under Occupational Disease Law or similar law, whether or not application for such benefits have been made; any service, supplies or treatment that is not Medically Necessary; any facility charges for treatment at a Hospital in excess of the indemnity amount specified in the Schedule of Benefits; pregnancy, childbirth or voluntary abortion, except for complications of pregnancy as defined; Pre-Existing Conditions; and any service or treatment rendered outside the territorial limits of the United States of America.

**Pre-Existing Condition** means a condition for which medical treatment was rendered or recommended by a Physician or for which drugs or medicine was prescribed within 12 months prior to a Covered Person's Effective Date. A condition shall no longer be considered a Pre-Existing Condition after the date a person has been covered under this policy for 12 consecutive months.

**TERMINATION OF A COVERED PERSON'S INSURANCE**

An insured persons insurance will cease on the earliest of: (a) the date of lapse at the end of the grace period for non-payment of premium; (b) the first day of the month following the date the covered person attains the Limiting Age; or (c) the date the policy terminates.

The insurance on a Dependent will cease on the earliest of: (a) the date the Insured's coverage terminates; (b) the first day of the month following the date the dependent attains the limiting age for Dependents; (c) the end of the last period for which premium payment has been made to Us, subject to the Grace Period; (d) the first day of the month following the date the dependent no longer meets the definition of dependent, as defined in the policy; (e) the date the policy is modified so as to exclude dependent coverage; or (f) the date the policy terminates.

We shall have the right to terminate the coverage of any covered person who submits a fraudulent claim under the policy.

If we accept a premium for coverage for a covered person after the date on which the policy provides that a covered person will cease to be covered, the coverage for that covered person will continue in force until the end of the period for which such premium has been accepted.

**THIRTY DAY FREE LOOK**

You have thirty (30) days after receiving the policy, and if you are not satisfied for any reason, you may return it to the company for a full refund of all premiums paid. Mail the policy with your written request for cancellation to us at our Home Office. We will promptly refund the premium paid and the insurance will be void.

Received \$ _____ for ____ month's premium with application for:
If for any reason policy is not issued, payment is to be refunded. Insurance is not effective until policy applied for has been issued. If you do not receive the policy in 30 days, please write the company.
Authorized Representative _____ Date _____

**Important Notice:** This Outline of Coverage provides general information about the policy. It is not a contract. Only the actual policy provisions issued by the company will control.

## FEE SCHEDULE SAMPLE

CPT	DESCRIPTION	BENEFIT 1 Unit	CPT	DESCRIPTION	BENEFIT 1 Unit
<b>SKIN</b>			<b>HEMIC/LYMPHATIC SYSTEM</b>		
11042	debride skin/tissue	\$34.53	38221	bone marrow biopsy	\$59.72
11100	biopsy, skin lesion	\$38.45	38230	bone marrow collection	\$262.71
12001	repair superficial wound(s)	\$80.79	38300	drainage of lymph node abscess	\$138.77
17000	destruction of premalignant lesion	\$41.47	38510	biopsy/removal, lymph nodes	\$326.16
17108	destruction of skin lesions	\$398.41	38745	remove armpit lymph nodes	\$669.30
<b>BREAST</b>			<b>DIGESTIVE SYSTEM</b>		
19102	Breast biopsy percut w/image	\$83.29	43239	upper gi endoscopy, biopsy	\$137.83
19301	partial mastectomy	\$488.15	43830	place gastrostomy tube	\$532.31
19303	simple mastectomy	\$757.00	44005	freeing of bowel adhesion	\$847.33
19307	Mastectomy, modified radical	\$899.93	44145	partial removal of colon	\$1,291.14
19342	delayed breast prosthesis	\$703.02	44970	laparoscopy, appendectomy	\$457.34
<b>MUSCULOSKELETAL SYSTEM</b>			45114	partial removal of rectum	\$1,399.68
22554	neck spine fusion	\$990.05	45378	diagnostic colonoscopy	\$173.42
22612	lumbar spine fusion	\$1,242.59	45380	colonoscopy and biopsy	\$208.35
23420	repair of shoulder	\$742.28	45385	lesion removal colonoscopy	\$247.24
23655	treat shoulder dislocation	\$286.48	47562	laparoscopic cholecystectomy	\$570.19
25605	treat fracture radius/ulna	\$430.90	49568	hernia repair w/mesh	\$212.12
26735	treat finger fracture, each	\$433.47	<b>URINARY SYSTEM</b>		
27130	total hip arthroplasty	\$1,117.29	50590	Lithotripsy, fragmenting of kidney stone	\$467.60
27447	total knee arthroplasty	\$1,195.13	52000	cystoscopy	\$104.30
28485	treat metatarsal fracture	\$402.36	52353	cystouretero w/lithotripsy	\$355.67
29826	shoulder arthroscopy/surgery	\$508.75	<b>GENITAL SYSTEM</b>		
29827	arthroscop rotator cuff repr	\$831.23	55700	biopsy of prostate	\$114.88
29848	wrist endoscopy/surgery	\$376.86	57260	repair of vagina	\$655.91
29881	knee arthroscopy/surgery	\$488.34	57288	repair bladder defect	\$573.11
<b>RESPIRATORY SYSTEM</b>			57454	biopsy/curett of cervix w/scope	\$108.13
30520	repair of nasal septum	\$456.45	58100	biopsy of uterus lining	\$69.48
31240	nasal/sinus endoscopy, surg	\$126.71	58150	total hysterectomy	\$788.78
31255	removal of ethmoid sinus	\$319.51	58262	vag hyst including tubes and ovaries	\$733.15
31624	diagnostic bronchoscope/lavage	\$117.66	58353	endometrial ablation, thermal	\$173.72
32655	thoracoscopy, surgical	\$781.60	59510	cesarean delivery	\$1,622.93
<b>CARDIOVASCULAR SYSTEM</b>			<b>NERVOUS SYSTEM</b>		
33208	insertion of heart pacemaker	\$451.31	61518	removal of brain lesion	\$2,162.14
33249	Insertion of pacing defibrillator	\$783.44	61548	removal of pituitary gland	\$1,219.40
33533	Coronary Artery Bypass, arterial, single	\$1,600.98	62270	spinal fluid tap, diagnostic	\$62.42
35301	rechanneling of artery	\$906.61	63020	neck spine disk surgery	\$902.31
36556	insert non-tunnel centrl venous cath	\$99.09	64721	carpal tunnel surgery	\$312.92
36558	insert tunneled centrl venous cath	\$230.38	<b>EYE/AUDITORY SYSTEM</b>		
36620	insertion catheter, artery	\$40.88	65220	remove foreign body from eye	\$32.49
92980	insert intracoronary stent (PTCA)	\$655.20	66821	after cataract laser surgery	\$219.98
93510	left heart catheterization	\$914.75	66984	cataract surg w/intraocular lens, 1 stage	\$561.97
			67113	repair retinal detach, complex	\$1,278.06