Time Insurance Company
501 West Michigan
Milwaukee, WI 53203

OUTLINE OF COVERAGE
FOR FORM 290.POL.TX
HOSPITAL CONFINEMENT AND OTHER FIXED INDEMNITY INSURANCE
REQUIRED OUTLINE OF COVERAGE

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 Your insurance company. It is, therefore, important that You READ YOUR POLICY CAREFULLY!

Hospital confinement and other fixed indemnity coverage is designed to provide You with a fixed daily benefit during periods of hospital confinement resulting and specified medical and surgical Events from a covered Injury or Sickness. Coverage is provided for the benefits outlined in Section 2. The benefits described in Section 2 may be limited by Section 3.

SECTION 1: GENERAL PROVISIONS:

NOTICE: This is not major medical insurance coverage. This plan provides fixed indemnity benefits for hospital confinement and specified medical and surgical Events. Fixed indemnity benefits are paid in the amount stated on the Benefit Schedule for the Covered Event without regard to the cost of services rendered. This plan does not provide expense reimbursement for charges based on Your health care provider's bill.

THIS IS NOT MEDICARE SUPPLEMENT INSURANCE COVERAGE.

THE PLAN HAS LIMITED BENEFITS AND ANNUAL MAXIMUMS. PLEASE READ YOUR POLICY CAREFULLY TO UNDERSTAND PLAN LIMITATIONS.

Conditionally Renewable Plan: Read the Termination Date provision carefully. We reserve the right to change premiums by class upon any renewal date after the initial 12 months coverage is in force.

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HOSPITAL-CONFINEMENT AND OTHER FIXED INDEMNITY PLAN: The plan is designed to provide only limited fixed indemnity benefits for hospital confinement and other specified medical Events. An Event is an observable and distinct occurrence in which medical treatment, services or supplies are provided to a Covered Person.

PAYMENT OF BENEFITS: We will pay Scheduled Benefits only for the Covered Events listed in the Hospital Confinement and Other Fixed Indemnity Benefits section of Your Policy. The Scheduled Benefit amount and the Maximum Benefit for eligible Covered Events listed in this section are shown in the Benefit Schedule. Refer to the exclusions section for occurrences for which benefits are not provided under this plan.

COVERED EVENT: A medical Event for which this plan provides a Scheduled Benefit and that meets all of the following requirements:

1. The treatment, services or supplies provided in connection with the Event are provided by a Health Care Practitioner, facility or supplier.
2. It is incurred by a Covered Person while coverage is in force under this plan as the result of a Sickness or an Injury or for preventive medicine services as specified in the Hospital Confinement and Other Fixed Indemnity Benefits section and the Benefit Schedule.
3. It is incurred for Events shown in the Hospital Confinement and Other Fixed Indemnity Benefits section and on the Benefit Schedule.
4. The occurrence includes treatment, services or supplies which are Medically Necessary.

SECTION 2: BENEFITS PROVIDED BY THIS PLAN:

Only the Covered Events described in the Hospital Confinement and Other Fixed Indemnity Benefits section of Your Policy are eligible for Scheduled Benefits. The Scheduled Benefit amount and the Maximum Benefit for eligible Covered Events are shown in the benefit schedule.

Maximum Lifetime Benefit:	$1,000,000 – All benefit payments apply to the Maximum Lifetime Benefit unless otherwise indicated.
Inpatient Hospital Confinement Benefits:	• Scheduled Benefit per day of a Confinement Period due to Sickness: $1000 • Scheduled Benefit per day of a Confinement Period due to Injury: $2000 • If treated for both a Sickness and an Injury during a

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<table>
<tr><td></td><td>Confinement Period, only the Injury benefit above will be paid.
• All Inpatient Hospital Confinement Benefits are limited to a Maximum Benefit of $200,000 per Calendar Year, per Covered Person.</td></tr>
<tr><td>Emergency Room and Urgent Care Facility Visit Benefits</td><td>• Scheduled Benefit per Emergency Room visit: $150
• Scheduled Benefit per Urgent Care visit: $150
• All Emergency Room Visits Benefits and Urgent Care Visit Benefits combined are limited to a Maximum Benefit of 1 visit per Calendar Year, per Covered Person.</td></tr>
<tr><td>Outpatient Medical Event Benefits:</td><td>All Outpatient Medical Event Benefits combined are limited to a Maximum Benefit of $1000 per Calendar Year, per Covered Person.
• Scheduled Benefits:
<table>
<tr><th>Outpatient Medical Event</th><th>Scheduled Benefit</th></tr>
<tr><td>Laboratory Service</td><td></td></tr>
<tr><td>Surgical Pathology</td><td>$100</td></tr>
<tr><td>All other laboratory services</td><td>$15</td></tr>
<tr><td></td><td></td></tr>
<tr><td>Radiology Services</td><td></td></tr>
<tr><td>Mammogram</td><td>$130</td></tr>
<tr><td>Computerized Tomography (CT) Scan</td><td>$300</td></tr>
<tr><td>Magnetic Resonance Imaging (MRI)</td><td>$450</td></tr>
<tr><td>Positron Emission Tomography (PET) Scan</td><td>$250</td></tr>
<tr><td>All other radiology services</td><td>$50</td></tr>
<tr><td></td><td></td></tr>
<tr><td>Physical Medicine</td><td></td></tr>
<tr><td>Physical Therapy (PT)</td><td>$25</td></tr>
<tr><td>Occupational Therapy (OT)</td><td>$25</td></tr>
<tr><td>Speech Therapy (ST)</td><td>$25</td></tr>
<tr><td></td><td></td></tr>
<tr><td>All Other Outpatient Events, not otherwise shown on this Benefit</td><td>$25</td></tr>
</table></td></tr>
</table>

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	Schedule:
Office Visit Benefits:	• Scheduled Benefit: $50 per Office Visit in a Health Care Practitioner's office. • Office Visit Benefits are limited to a Maximum Benefit of 2 visits per Calendar Year, per Covered Person.
Immunization and Allergy Immunotherapy Injection Benefits	• Scheduled Benefit per immunization: $10 • Scheduled Benefit per allergy immunotherapy injection: $10 • All Immunization and Allergy Immunotherapy Injection Benefits combined are limited to a Maximum Benefit of $100 per Calendar Year, per Covered Person.
Professional Ground or Air Ambulance Services Benefits:	• Scheduled Benefit per trip by ground ambulance: $100. • Scheduled Benefit per trip by air ambulance: $1000. • All Professional Ground or Air Ambulance Services Benefits combined are limited to a Maximum Benefit of 2 one-way trips per Calendar Year, per Covered Person.
Anesthesia Benefit	• Scheduled Benefit per Anesthesia event: $200 • All Anesthesia Benefits are limited to a Maximum Benefit of 1 Covered Event per Calendar Year, per Covered Person.
Surgical Services Benefits:	• The Scheduled Benefit for surgical Covered Events is the amount shown in the Surgical Schedule on the Benefit Schedule for the corresponding Surgical Event. • Two or more Surgical Events performed during the same operative session are considered one operation and the Surgical Services Benefit will be considered based on the event with the highest Scheduled Benefit shown in the Surgical Schedule. All Surgical Services Benefits are limited to a Maximum Benefit of $200,000 per Calendar Year, per Covered Person.

Inpatient Hospital Confinement Benefit:
We will pay the corresponding Scheduled Benefit amount for each day of Inpatient room and board during a Confinement Period under the orders of a physician for care of a Sickness or an Injury.

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When an Inpatient Hospital Confinement Benefit is payable, no other benefits are payable for the Covered Person under this plan for Events that occur during the same Confinement Period, except for eligible Surgical Services Benefits and/or Anesthesia Benefits.

Emergency Room Visit Benefits:
We will pay the corresponding Scheduled Benefit amount upon the occurrence of a visit to an Emergency Room during which a Covered Person receives Emergency Treatment.

When an Emergency Room Visit Benefit is payable, no other benefits are payable for the Covered Person under this plan for Events that occur during the same visit, except for eligible Surgical Services Benefits and/or Anesthesia Benefits. Benefits are limited to the Calendar Year Maximum Benefit shown on the Benefit Schedule.

Urgent Care Facility Visit Benefits:
We will pay the corresponding Scheduled Benefit amount upon the occurrence of a visit to an Urgent Care Facility during which a Covered Person receives Urgent Care treatment.

When an Urgent Care Facility Visit Benefit is payable, no other benefits are payable for the Covered Person under this plan for Events that occur during the same visit, except for eligible Surgical Services Benefits and/or Anesthesia Benefits. Benefits are limited to the Calendar Year Maximum Benefit shown on the Benefit Schedule.

Outpatient Medical Event Benefits:
We will pay the corresponding Scheduled Benefit amount upon occurrence of an Event wherein the Covered Person receives Outpatient treatment of a Sickness or Injury or preventive medicine services as recommended by the United States Preventive Services Task Force.
Those Covered Events for which benefit is considered under any other provision of this plan are not considered for benefits under this provision.

Office Visit Benefits:
We will pay the corresponding Scheduled Benefit amount upon the occurrence of an Office Visit for a Covered Person during which any of the following are rendered in a Health Care Practitioner's office:

1. Professional services that are provided by or under the direction of a Health Care

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Practitioner for a Sickness or an Injury for:
a. Measuring height, weight and blood pressure.
b. Obtaining a health history.
c. Performing a physical examination.
d. Making a medical decision.
e. Explaining treatment options.
f. Developing a treatment plan.
g. Instructions for management of the condition.

2. Professional services that are provided by or under the direction of a Health Care Practitioner for preventive medicine services for:
a. Measuring height, weight and blood pressure.
b. Obtaining a health history.
c. Performing a routine physical examination.
d. Explaining risk reduction behavior.
e. Preventive medicine services as recommended by the United States Preventive Services Task Force.

Allergy Immunotherapy Injection Benefits:
We will pay the corresponding Scheduled Benefit amount upon an occurrence of an allergy immunotherapy injection for a Covered Person.

Immunization Benefits:
We will pay the corresponding Scheduled Benefit amount for each immunization received by a Covered Person as recommended by the United States Preventive Services Task Force or the Advisory Committee on Immunization Practices on the date the immunization is rendered.

Professional Ground or Air Ambulance Services Benefits:
We will pay the corresponding Scheduled Benefit when professional ground or air transportation in an ambulance is obtained by a Covered Person who needs Emergency Treatment for a Sickness or an Injury.

Anesthesia Benefits:
We will pay the corresponding Scheduled Benefit when a Covered Person is administered anesthesia as part of a Covered Event.

Surgical Services Benefits:
We will pay the corresponding Scheduled Benefit when the Covered Person obtains

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surgical treatment as shown on the Surgical Schedule.

When a Surgical Services Benefit is payable, no other benefits are payable for the Covered Person under this plan for Events that occur during the same surgical Event, except for eligible Anesthesia Benefits.

Two or more surgical procedures performed during the same operative session are considered one operation and benefits will be considered based on the procedure with the highest Scheduled Benefit shown in the Surgical Schedule. If a surgical procedure is performed that is not specifically named in the Surgical Schedule, benefits will be considered under the benefit level for Surgical Event – Not Otherwise Listed.

SECTION 3: LIMITATIONS AND EXCLUSIONS:

PRE-EXISTING CONDITIONS LIMITATION: We will not pay benefits for Events that result from or are related to a Pre-Existing Condition, or its complications, until the Covered Person has been continuously insured under this plan for 12 months. After this period, benefits will be available for Events resulting from or related to a Pre-Existing Condition, or its complications, provided that the Covered Event occurs while this plan is in force. Pregnancy that exists on the Covered Person's Effective Date will be considered a Pre-Existing Condition under this plan.

EXCLUSIONS: This plan provides benefits only for Covered Events identified in the Hospital Confinement and Other Fixed Indemnity Benefits section. We will not pay benefits for claims resulting, whether directly or indirectly, from Events or loss related to or resulting from any of the following:

1. A Sickness or Injury that is the result ofa work-related condition that is eligible for benefits under worker's compensation, employers' liability or similar laws even when the Covered Person does not file a claim for benefits. This exclusion will not apply to a Covered Person who is not required to have coverage under any workers' compensation, employers' liability or similar law and does not have such coverage. However, the Covered Person must receive services in accordance with the Hospital Confinement and Other Fixed Indemnity Benefits section.

2. War or any act of war, whether declared or undeclared.

3. Participation in the military service of any country or international organization.

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4. Treatment, services or supplies that:
   a. Is not part of a specifically listed Covered Event shown on the Benefit Schedule.
   b. Is due to complications of a non-covered service.
   c. Is incurred before the Covered Person's Effective Date or after the termination date of coverage, except as provided under the Extension of Benefits provision in the Other Provisions section.

5. Glasses; contact lenses; vision therapy, exercise or training; surgery including any complications arising therefrom to correct visual acuity including, but not limited to, lasik and other laser surgery, radial keratotomy services or surgery to correct astigmatism, nearsightedness (myopia) and/or farsightedness (presbyopia); vision care that is routine.

7. Hearing care that is routine; any artificial hearing device, cochlear implant, auditory prostheses or other electrical, digital, mechanical or surgical means of enhancing, creating or restoring auditory comprehension.

8. Treatment for foot conditions including, but not limited to:
   a. Flat foot conditions.
   b. Foot supportive devices, including orthotics and corrective shoes.
   c. Foot subluxation treatment.
   d. Corns; bunions; calluses; toenails; fallen arches; weak feet; chronic foot strain; or symptomatic complaints of the feet.
   e. Hygienic foot care that is routine.

9. Dental treatment; dental care that is routine; bridges, crowns, caps, dentures, dental implants or other dental prostheses; dental braces or dental appliances; extraction of teeth; orthodontic treatment; odontogenic cysts; any other treatment or complications of the teeth and gum tissue, except as otherwise covered for a Dental Injury.

10. Treatment of Temporomandibular Joint Dysfunction and Craniomandibular Joint Dysfunction; any appliance, medical or surgical treatment for malocclusion (teeth that do not fit together properly which creates a bite problem), protrusion or recession of the mandible (a large chin which causes an underbite or a small chin which causes an overbite), maxillary or mandibular hyperplasia (excess growth of the upper or lower jaw) or maxillary or mandibular hypoplasia (undergrowth of

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the upper or lower jaw).

11. Treatment of Behavioral Health 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, including, but not limited to, drugs and medicines for Inpatient or Outpatient treatment of Behavioral Health or Substance Abuse.

12. Any treatment, services, supplies, diagnosis, drugs, medications or regimen, whether medical or surgical, for purposes of controlling the Covered Person's weight or related to obesity or morbid obesity, whether or not weight reduction is Medically Necessary or appropriate or regardless of potential benefits for co-morbid conditions; weight reduction or weight control surgery, treatment or programs; any type of gastric bypass surgery; suction lipectomy; physical fitness programs, exercise equipment or exercise therapy, including health club membership visits or services; nutritional counseling.

13. Organ, tissue or cellular material donation by a Covered Person, including administrative visits for registry, computer search for donor matches, preliminary donor typing, donor counseling, donor identification and donor activation.

14. Chemical peels, reconstructive or plastic surgery that does not alleviate a functional impairment and other confinement or treatment visits that are primarily for a Cosmetic Service as determined by Us.

15. Capsular contraction, augmentation or reduction mammoplasty, except for all stages and revisions of reconstruction of the breast following a Medically Necessary mastectomy for treatment of cancer, including reconstruction of the other breast to produce a symmetrical appearance and treatment of lymphedemas.

16. Removal or replacement of a prosthesis; Durable Medical Equipment or Personal Medical Equipment, except for external breast prostheses following a Medically Necessary mastectomy for treatment of cancer and services are received in accordance with the Hospital Confinement and Other Fixed Indemnity Benefits section.

17. Prophylactic treatment, services or surgery including, but not limited to,

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prophylactic mastectomy or any other treatment, services or surgery performed to prevent a disease process from becoming evident in the organ or tissue at a later date.

18. Treatment, services, and supplies for:
    a. Home Health Care.
    b. Hospice care.
    c. Skilled Nursing Facility care; Inpatient rehabilitation services.
    d. Custodial Care; respite care; rest care; supportive care; homemaker services.
    e. Phone, facsimile, internet or e-mail consultations; compressed digital interactive video, audio or clinical data transmission using computer imaging by way of still-image capture and store forward; other Telemedicine Services or Telehealth Services that facilitates access to a Health Care Practitioner.
    f. Treatment, services or supplies that are furnished primarily for the personal comfort or convenience of the Covered Person, Covered Person's family, a Health Care Practitioner or provider.
    g. Treatment or services provided by a standby Health Care Practitioner.
    h. Treatment or services provided by a masseur, masseuse or massage therapist; massage therapy; a rolfer.

19. Treatment, services, and supplies for growth hormone therapy, including growth hormone medication and its derivatives or other drugs used to stimulate, promote or delay growth or to delay puberty to allow for increased growth.

20. Treatment, services, and supplies related to the following conditions, regardless of underlying causes: sex transformation; gender dysphoric disorder; gender reassignment; treatment of sexual function, dysfunction or inadequacy; treatment to enhance, restore or improve sexual energy, performance or desire.

21. Treatment, services, and supplies related to: maternity; pregnancy (except Complications of Pregnancy); routine well newborn care at birth including nursery care; abortion.

22. Contraceptive procedures; contraceptive drugs or devices, not dispensed from a pharmacy, including, but not limited to, contraceptive patches, contraceptive vaginal rings, diaphragms, injectable contraceptives and contraceptive implants.

23. Treatment for or through use of:

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a. Genetic testing or counseling, genetic services and related procedures for screening purposes including, but not limited to, amniocentesis and chorionic villi testing.
b. Services, drugs or medicines used to treat males or females for an infertility diagnosis regardless of intended use including, but not limited to: artificial insemination; in vitro fertilization; reversal of reproductive sterilization; any treatment to promote conception.
c. Sterilization.
d. Cryopreservation of sperm or eggs.
e. Surrogate pregnancy.
f. Fetal surgery, treatment or services.
g. Umbilical cord stem cell or other blood component harvest and storage in the absence of a Sickness or an Injury.
h. Circumcision.

24. Spinal and other adjustments, manipulations, subluxation treatment and/or services.

25. Treatment for: behavior modification or behavioral (conduct) problems; learning disabilities; developmental delays; attention deficit disorders; hyperactivity; educational testing, training or materials, except for Outpatient diabetes self-management training and education for treatment of a Covered Person with diabetes; memory improvement; cognitive enhancement or training; vocational or work hardening programs; transitional living.

26. Treatment for or through use of:
a. Non-medical items, self-care or self-help programs.
b. Aroma therapy.
c. Meditation or relaxation therapy.
d. Naturopathic medicine.
e. Treatment of hyperhidrosis (excessive sweating).
f. Acupuncture; biofeedback; neurotherapy; electrical stimulation.
g. Inpatient treatment of chronic pain disorders.
h. Treatment of spider veins .
i. Family or marriage counseling.
j. Applied behavior therapy treatment for autistic spectrum disorders.
k. Smoking deterrence or cessation.
l. Snoring or sleep disorders.

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m. Change in skin coloring or pigmentation.
n. Stress management.

27. A Sickness or Injury resulting from abuse or overdose of any illegal or controlled substance, except when administered in accordance with the advice of the Covered Person's Health Care Practitioner.

28. Treatment of a Sickness or an Injury when a contributing cause of the condition was the Covered Person's voluntary attempt to commit or participation in or commission of a felony, whether or not charged, or as a consequence of the Covered Person being under the influence of any illegal or non-prescribed controlled substance while committing a felony.

29. Services ordered, directed or performed by a Health Care Practitioner or supplies purchased from a Medical Supply Provider who is a Covered Person, an Immediate Family Member, employer of a Covered Person or a person who ordinarily resides with a Covered Person.

30. Any amount in excess of the Maximum Lifetime Benefit or any other Maximum Benefit limitation for covered Scheduled Benefits.

31. Treatment that does not meet the definition of a Covered Event in this plan including, but not limited to, treatment that is not Medically Necessary.

32. Treatment, services and supplies for Experimental or Investigational Services.

33. Treatment incurred outside of the United States, including drugs or medicines obtained from pharmacy provider sources outside the United States.

34. Sickness or Injury caused or aggravated by suicide, attempted suicide or self-inflicted Sickness or Injury.

35. Vitamins and/or vitamin combinations even if they are prescribed by a Health Care Practitioner.

36. Drugs or medicines: administered or dispensed at or by a rest home, sanitarium, extended care facility, convalescent care facility, Skilled Nursing Facility or similar institution; dispensed at or by a Hospital, an Emergency Room, a Free-Standing

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Facility, an Urgent Care Facility, a Health Care Practitioner's office or other Inpatient or Outpatient setting for take home by the Covered Person.

SECTION 4: RENEWABILITY PROVISION:

This Policy will terminate at 12:01 a.m. local time at the Policyholder's state of residence on the earliest of the following dates:

1. The date We receive a request in writing or by telephone to terminate this plan or on a later date that is requested by the Policyholder for termination.
2. The date We receive a request in writing or by telephone to terminate coverage for a Covered Dependent or on a later date that is requested by the Policyholder for termination of a Covered Dependent.
3. The date this plan lapses for nonpayment of premium per the Grace Period provision in the Premium Provisions section.
4. The date there is fraud or material misrepresentation made by or with the knowledge of any Covered Person applying for this coverage or filing a claim for benefits.
5. The date all plans the same as this one are non-renewed in the state in which this Policy was issued or the state in which the Policyholder presently resides.
6. The date We terminate or nonrenew all individual market hospital-indemnity insurance plans in the state in which this Policy was issued or the state in which You presently reside. We will give You advance notice, as required by state law, of the termination of Your coverage.
7. The date the Policyholder moves to a state where We do not provide insurance under a plan with the same plan design as this Policy, We reserve the right to terminate this coverage.
8. For a Dependent, the date a Covered Dependent no longer meets the Dependent definition in this plan. We will pay benefits to the end of the time for which We have accepted premiums.

Delay or failure to report termination of any insurance will not continue the insurance in force beyond the date it would have terminated according to this Policy.

The premium may be increased upon renewal.

SECTION 5: PREMIUM:

PREMIUM INFORMATION

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Initial Annual Premium: ________________
Initial Premium Payment Mode: _______________
INITIAL MODAL PREMIUM AMOUNT: $________________

____ ______________________________

Licensed Agent's Signature Date

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