QQLink

COMPREHENSIVE • AFFORDABLE • ECONOMICAL

Major Medical Plans

Underwritten and Administered by:

Comprehensive Plan

	In-Network		Out-of-Network	
Your Deductible and Doctor Office Co-pay Options Per Person Per Calendar Year	Deductible* $500 $1,000 $2,500	Physician Office Visit Co-pay $20 $30 Subject to Deductible and Coinsurance	Deductible* Double Selected In-Network Amount	Physician Office Visit Co-pay Subject to Deductible and Coinsurance
Your Benefit Amount	80% of $5,000		60% of $10,000	
Your Coinsurance	20% of $5,000		40% of $10,000	
Your Out-of-Pocket*	Deductible + $1,000		Double Deductible +$4,000	
Additional Dr. Office Visit Co-pays	In-office x-rays $10 Laboratory tests $5 Injections $5 Applied when provided on same day as office visit,by same physician. Not Applicable on $2,500 deductible.		Subject to Deductible and Coinsurance	
Preventive Medical Benefit	$100 per calendar year		$100 per calendar year	
Prescription Drugs	Retail Generic . . . . 100% in excess of $15 co-pay Formulary Brand . . . . 80% in excess of $25 co-pay Non-Formulary Brand . . . 70% in excess of $35 co-pay		Mail-Order Generic . . . . 100% in excess of $30 co-pay Formulary Brand . . . . 80% in excess of $50 co-pay Non-Formulary Brand . . . 70% in excess of $70 co-pay	
Emergency Room Co-pay for sickness In addition to deductible and Co-insurance	$75 (waived if hospitalized)		$75 (waived if hospitalized)	
Centers of Excellence Benefit	$1,000,000		Scheduled Benefit	
Life Insurance (Not available in GA, IA, KS, OH, OK, WV)	Life Primary Insured. . . . . $15,000 Spouse. . . . . $ 2,000 Child (6 mos. or older). . . . $ 1,000 Child (Less than 6 mos) . . . $ 500	AD&D $15,000 n/a n/a n/a	Life Primary Insured. . . . . $15,000 Spouse. . . . . $ 2,000 Child (6 mos. or older). . . . $ 1,000 Child (Less than 6 mos) . . . $ 500	AD&D $15,000 n/a n/a n/a
Lifetime Maximum	$5,000,000		$5,000,000	

*For single coverage only, for family coverage see Aggregate Deductible and Coinsurance Information on page 3.

Our Comprehensive Health plan is our most complete.

1. **Deductible –**
   You pay for your covered expenses up to your annual deductible amount. In-Network deductible options are: $500, $1,000, $2,500. For single coverage only. For family coverage see Aggregate Deductible and Coinsurance Information on page 3.
2. **Coinsurance –**
   After your deductible is reached, the company pays 80% of the next $5,000 of In-Network covered expenses.
3. **Out-of-Pocket Maximum –**
   Your In-Network out-of-pocket maximum is your deductible plus $1,000. After your out-of-pocket maximum is reached, your covered charges will be paid at 100%.

PLAN HIGHLIGHTS

- Doctor Office Visits Available
- Preventive Medical Benefit
- Prescription Drug Coverage Included*
- Lifetime maximum – $5,000,000 (for each covered person)
- Centers of Excellence Benefit – $1,000,000*

*Not available in all states.

Important Information:

- You maximize your benefits by using providers which are part of our Preferred Provider Organization (PPO) network. Benefits are reduced for other providers. See benefit chart above.
- Co-pays apply on certain benefits. See details above.

Initial 12-Month Rate:

To help control your costs, we will maintain your initial rate for medical benefits during the first 12 months of coverage. Exceptions that may affect your rate during the first 12 months are: 1) moving to a different location; 2) changing your benefits levels; 3) changing your optional coverage; and 4) administrative charge adjustments.

Affordable Plan

	In-Network	Out-of-Network
Your Deductible and Doctor Office Co-pay Options Per Person Per Calendar Year	Deductible* / Physician Office Visit Co-pay $500 / $25 $1,000 / $35 $2,500 / Subject to Deductible and Coinsurance	Deductible*: Double Selected In-Network Amount Physician Office Visit Co-pay: Subject to Deductible and Coinsurance
Your Benefit Amount	80% of $5,000	50% of $10,000
Your Coinsurance	20% of $5,000	50% of $10,000
Your Out-of-Pocket*	Deductible + $1,000	Double Deductible +$5,000
Pharmacy Advantage Plan	A Discount Prescription Plan offering preferred pricing on generic and brand name drugs through a network of over 54,000 participating pharmacies. A 100% co-pay remains after the discount is applied.	
Emergency Room Co-pay for sickness In addition to deductible and Co-insurance	$75 (waived if hospitalized)	$75 (waived if hospitalized)
Outpatient Surgical Facility Co-pay	$250 per visit	$500 per visit
Inpatient Hospital Co-pay	$500 per admission	$1,000 per admission
Centers of Excellence Benefit	$500,000	Scheduled Benefit
Life Insurance (Not available in GA, IA, KS, OH, OK, WV)	Life / AD&D Primary Insured. . . . . $15,000 / $15,000	Life / AD&D Primary Insured. . . . . $15,000 / $15,000
Lifetime Maximum	$2,000,000	$2,000,000

*For single coverage only, for family coverage see Aggregate Deductible and Coinsurance Information on page 3.

Our Affordable Health plan is the best fit for most.

1. **Deductible –**
   You pay for your covered expenses up to your annual deductible amount. In-Network deductible options are: $500, $1,000, $2,500. For single coverage only. For family coverage see Aggregate Deductible and Coinsurance Information on page 3.

2. **Coinsurance –**
   After your deductible is reached, the company pays 80% of the next $5,000 of In-Network covered expenses.

3. **Out-of-Pocket Maximum –**
   Your In-Network out-of-pocket maximum is your deductible plus $1,000. After your out-of-pocket maximum is reached, your covered charges will be paid at 100%.

PLAN HIGHLIGHTS

- Doctor Office Visits Available
- Discount Prescription Card Included*
- Lifetime maximum – $2,000,000 (for each covered person)
- Centers of Excellence Benefit – $500,000*

*Not available in all states.

Important Information:

- You maximize your benefits by using providers which are part of our Preferred Provider Organization (PPO) network. Benefits are reduced for other providers. See benefit chart above.
- Co-pays apply for certain benefits. See details above.

Initial 12-Month Rate:

To help control your costs, we will maintain your initial rate for medical benefits during the first 12 months of coverage. Exceptions that may affect your rate during the first 12 months are: 1) moving to a different location; 2) changing your benefits levels; 3) changing your optional coverage; and 4) administrative charge adjustments.

Economical Plan

	In-Network	Out-of-Network
Your Deductible Per Person Per Calendar Year	Deductible* $500 $1,000	Deductible* Double Selected In-Network Amount
Your Benefit Amount	80% of $5,000	50% of $10,000
Your Coinsurance	20% of $5,000	50% of $10,000
Your Out-of-Pocket*	Deductible + $1,000	Double Deductible +$5,000
Pharmacy Advantage Plan	A Discount Prescription Plan offering preferred pricing on generic and brand name drugs through a network of over 54,000 participating pharmacies. A 100% co-pay remains after the discount is applied.	
Emergency Room Co-pay for sickness In addition to deductible and Co-insurance	$75 (waived if hospitalized)	$75 (waived if hospitalized)
Outpatient Surgical Facility Co-pay	$250 per visit	$500 per visit
Inpatient Hospital Co-pay	$500 per admission	$1,000 per admission
Centers of Excellence Benefit	$500,000	Scheduled Benefit
Life Insurance (Not available in GA, IA, KS, OH, OK, WV)	Life / AD&D Primary Insured. $15,000 $15,000	Life / AD&D Primary Insured. $15,000 $15,000
Lifetime Maximum	$2,000,000	$2,000,000

*For single coverage only, for family coverage see Aggregate Deductible and Coinsurance Information below.

Our Economical Health plan covers all your basic needs.

1. **Deductible –**
   You pay for your covered expenses up to your annual deductible amount. In-Network deductible options are: $500 and $1,000. For single coverage only. For family coverage see Aggregate Deductible and Coinsurance Information below.
2. **Coinsurance –**
   After your deductible is reached, the company pays 80% of the next $5,000 of In-Network covered expenses.
3. **Out-of-Pocket Maximum –**
   Your In-Network out-of-pocket maximum is your deductible plus $1,000. After your out-of-pocket maximum is reached, your covered charges will be paid at 100%.

PLAN HIGHLIGHTS

- Discount Prescription Drug Included*
- Lifetime maximum – $2,000,000 (for each covered person)
- Centers of Excellence Benefit – $500,000*

*Not available in all states.

Important Information:

- You maximize your benefits by using providers which are part of our Preferred Provider Organization (PPO) network. Benefits are reduced for other providers. See benefit chart above.

Initial 12-Month Rate:

To help control your costs, we will maintain your initial rate for medical benefits during the first 12 months of coverage. Exceptions that may affect your rate during the first 12 months are: 1) moving to a different location; 2) changing your benefits levels; 3) changing your optional coverage; and 4) administrative charge adjustments.

LabOne: (For insured with a $1,000 deductible or lower)
This is an added cost containment program available on all three plans. LabOne is a fully accredited and certified laboratory offering significant savings over other labs. These savings are passed directly to you. LabOne does not replace existing lab benefits. You must ask your physician to send your lab work to LabOne.

AGGREGATE DEDUCTIBLE AND COINSURANCE

Each family member has his or her own individual deductible and coinsurance. However, a family has a maximum out-of-pocket expense up to three times the individual deductible and coinsurance amounts.

Optional Benefits

(May Vary by State)

Critical Payment Benefit*:

Provides a lump sum payment benefit for surviving a covered critical illness or surgery on the Primary Insured. You may choose a $10,000 or $25,000 lump sum payment to supplement your Major Medical coverage.

Why do you need this extra protection? Each year, millions of Americans suffer heart attacks or strokes, or develop some form of cancer. And survival rates are rising. The Critical Payment Benefit helps you manage your finances through a health crisis and recovery.

This benefit is paid regardless of any other insurance you may carry. The amount you receive depends on the Maximum Benefit at the time of application ($10,000 or $25,000), and the specific illness or surgery. Most, but not all, illnesses and surgeries pay the entire Maximum Benefit. If a partial benefit is paid, the remainder is available for another type of covered critical illness or surgery. Coverage ends after the Maximum Benefit is paid.

* Not available in GA

Schedule of Benefits:

Condition	Benefit
Life-Threatening Cancer	100%
Heart Attack	100%
Stroke (survived 30 days or longer)	100%
End Stage Renal Failure (including transplant)	100%
Major Organ Transplant (Heart, lung, liver or pancreas)	100%
Multiple Sclerosis (after 180 days)	100%
Blindness (in both eyes)	100%
Permanent Paralysis (of 180 days or longer)	100%
Loss of Two or More Limbs	100%
Alzheimer's Disease	50%
Coronary Artery Bypass Surgery	25%
Angioplasty	10%

For a list of definitions and exclusions and limitations see page 8.

Supplemental Accident Benefit:

$500 Benefit for charges incurred within 90 days of an accident.

- Benefits will be paid for covered charges as a result of an accidental bodily injury which occurs while the person is insured under this policy.
- The benefit will cover the following:
  a. Doctor
  b. Hospital
  c. Diagnostic x-ray or lab tests; and
  d. Registered Nurse (RN) or Licensed Practical Nurse (LPN)
- Charges must be incurred within ninety (90) days of the date of the Injury. The total amount of benefits paid will be the amount charged, but not more than the Maximum Payment shown on the Schedule of Benefits.
- Dental Expenses are not covered under this Benefit.

Family Protection Benefit**:

We understand the importance of protecting your family at all times. Based on age, the Primary Insured can increase his or her life benefit by the specific amounts shown below. These additional dollars will be beneficial to your family in their time of need.

Ages	Additional Term Life
0-49	$35,000
50-59	$25,000
60+	$15,000

** Not available in all states, see State Specific Benefits on QQLink.com

Covered Expenses

(May Vary by State)

1. Inpatient Hospital Confinement
   a. Hospital daily room and board up to the Usual and Customary semiprivate room charge of the Hospital.
   b. Intensive Care Unit Confinement not to exceed the Usual and Customary room charge of the Hospital for that unit. Benefits will not be paid for any other room charge during Intensive Care Confinement.
   c. Other Medically Necessary Hospital services and supplies.

2. Medical services and supplies furnished by an Outpatient department of a Hospital or an Ambulatory Surgical Facility.

3. Anesthetics and their administration.

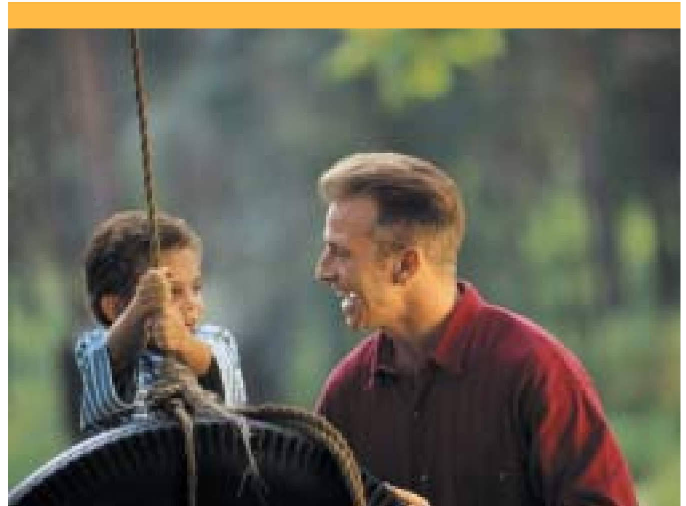
4. Medical services given by a Physician.

5. X-ray exams, lab tests and other diagnostic services.

6. X-ray and radiation therapy, cobalt and chemotherapy Treatment.

7. Local transportation to a local Hospital by a professional ground or air ambulance service. However, air ambulance is only covered if due to a life-threatening Injury or Sickness.

8. Medical supplies as follows:
   a. blood, plasma and derivatives;
   b. initial replacement of natural limbs and eyes when Loss occurs while insured under this Certificate;
   c. initial permanent lens immediately following cataract Surgery, except that replacements will not be covered;
   d. casts, splints, crutches and braces (except dental braces);
   e. rental or purchase or rental (whichever costs less, as determined by CGIC) of durable medical equipment and supplies; and
   f. oxygen.



9. Coverage is provided for prosthetic devices or reconstructive surgery following the surgical procedure mastectomy. The coverage for prosthetic devises and reconstructive Surgery is subject to the same Deducible and Coinsurance Percentage applicable to the mastectomy and all other terms and conditions of this Certificate. Breast reconstruction in connection with a covered mastectomy will include:
   a. Reconstruction of the breast on which the mastectomy has been performed.;
   b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
   c. prosthesis and physical complications from all stages of mastectomy, including lymphadema in a manner determined in consultation with the attending Physician and the Insured Person.

For purposes of this provision, "mastectomy" means the removal of all or part of the breast for Medically Necessary reasons as determined by a Physician.

Covered Expenses Subject to Limitations

(May Vary by State)

Mental & Nervous Disorders:

The plans pay 50% of covered expenses not to exceed a maximum benefit of $2,000 per Calendar Year for inpatient expenses. The plans allow $20 per physician's office visit not to exceed a maximum of $550 for a Calendar Year.

Spinal Manipulation:

The plans pay up to $15 a day for spinal manipulation with a $300 maximum benefit per insured person per calendar year, or a $600 maximum benefit per insured family per Calendar Year. In addition, x-ray charges are payable to a $75 maximum benefit per insured person per Calendar Year or a $150 maximum benefit per family per Calendar Year.

Hospice Benefit:

If hospitalized, the plan pays up to $200 a day for room and board not to exceed a lifetime maximum of $10,000. CGI allows $100 a day for outpatient hospice care not to exceed a lifetime maximum of $3,500. The plan pays for hospice care and services provided by a hospice care program or provider approved by CGI.

Occupational, Speech and Physical Therapy:

The plans pay up to $50 of covered expenses per visit, with a maximum of $1,250 each Calendar Year (includes occupational, speech and physical therapy, and for related diagnostic testing). These services must be performed by licensed occupational, speech and physical therapists under the supervision of a physician.

Home Health Care:

Home health care is limited to 40 visits per Calendar Year. Such care must be a part of a written Home Health Care plan of care and prescribed by a physician in place of hospital confinement.

Sterilization:

Benefits will be paid for sterilization not to exceed a lifetime maximum benefit of $350 of covered expense per insured person.

Treatment for Allergies:

Benefits will be paid for allergy testing and allergy injections, up to a maximum benefit of $500 of covered expenses per Calendar Year. The maximum benefit payable for the insured family combined is $1,000 of covered expenses per Calendar Year.

Growth Disorder:

Benefits will be paid for treatment of growth disorder or abnormally short stature up to a lifetime maximum benefit of $25,000 of covered expense.

Repair or Injury to Teeth:

Benefits will be paid for repair of injury to sound natural teeth (including their replacement) as a result of an injury which occurs while the person is insured. Treatment must be provided within 90 days of the date of the injury.

Cosmetic Surgery/Treatment:

Benefits will be paid for Cosmetic Surgery/Treatment only if required to restore a part of the body which has been altered as a result of the following events or conditions that occurred while the insured person was insured by this Certificate and for which benefits were paid in accordance with the terms of this Certificate:

1. accidental bodily injury,
2 surgery; or
3. disease that was first diagnosed while the Insured Person was insured by this Certificate.

Treatment of TMJ and CMD:

Benefits will be paid for Surgery of the jaw or any treatment of temporomandibular joint (TMJ) disorder and craniomandibular disorder (CMD) up to a Lifetime Maximum benefit of $2,500 of Covered Expenses per Insured Person. This limitation does not apply to Treatment of jaw fractures or removal of tumors of the jaw.

All Covered Expenses Subject To Limitations are subject to the Deductibles and Coinsurance Percentages shown on the Schedule of Benefits.

Personal Healthcare Management Benefits

(May Vary by State)

THE FOLLOWING SPECIALIZED SERVICES HELP YOU MAXIMIZE THE VALUE OF YOUR PLAN.

Dedicated Service Representatives for Fast Answers:
When you call, you'll be speaking with a Customer Service Representative who understands your needs and who can access your file promptly to provide you with the answers you need.

24-7 Medical and Benefit Support:
Call 1-877-575-4207 ANY TIME, ANY DAY for instant access to your medical plan.

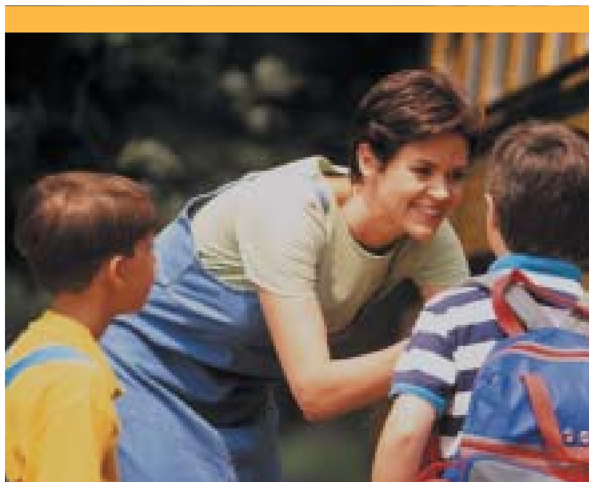
- Assistance in finding the physician, specialty or medical provider you need
- Locate preferred providers near you
- Receive advice on maximizing your benefits
- Initiate inpatient pre-certification
- Receive general medical information. Should you need information for a specific medical condition, a medical professional will provide useful information.

Enhanced PPO Referral Service:
Whether you are home or travelling, one convenient number (877-575-4207) connects you with customer service representatives who work closely with you to locate and direct you to a PPO provider.

Using a PPO provider is your best way to keep more money in your pocket:

- Lower co-payment for you
- Protection from charges above reasonable and customary amounts
- Gives you the comfort of knowing that your PPO benefits travel with you while you are vacationing or away from home
- When you obtain medical services from a Travel PPO provider, covered charges will be paid in accordance with in-network benefits as outlined in your plan

Non-Network Negotiation Service:
If there is no provider within our network who performs the service you require, we will help locate a non-network provider and attempt to negotiate the cost with this provider to help save you money. Our purpose is to eliminate or reduce any balance billing you will receive from these providers. We will be your advocate with these medical providers!



Case Management – Special Care for Special Cases:
For catastrophic illness and injuries and certain other medical conditions, a registered nurse Case Manager will work with you and your doctor to coordinate your treatment plan, to facilitate quality care and maximize your benefits.

"Building Blocks" High Risk Pregnancy Program:
Our Registered Nurse Maternity Specialists help identify pregnancy risks, answer questions and provide valuable information and support. If you are a high risk mother, we offer a personal case manager to work with you and your doctor. This service is available, even if you do not have maternity coverage with us.

Cancer Case Management Program:
Our Registered Nurse Oncology Case Managers answer questions, provide educational information and discuss treatment options with you. In addition, the Case Manager maintains contact with you and your physicians to assist in coordinating your care and maximizing your medical benefits.

Disease Management Early Identification Program:
We know that if you manage certain conditions when they are first identified, you may lead a more productive life. Our Registered Nurse Case Managers provide support to you and your doctor to help manage these conditions and lower your future medical costs.

Critical Payment Definitions & Exclusions and Limitations

(May Vary by State)

Definitions of Specific Covered Illnesses and Surgeries:

Alzheimer's Disease: A clinically established diagnosis of Alzheimer's Disease (pre-senile dementia) by a psychiatrist or neurologist, resulting in the inability to independently perform three or more of the following activities of daily living: bathing, dressing, toileting, eating and taking medication.

Angioplasty: The undergoing of balloon angioplasty, endarterectomy or laser treatment to correct narrowing or blockage of one or more coronary arteries. Must be recommended by a cardiologist.

Blindness: Permanent and uncorrectable loss of sight in both Eyes such that the corrected visual acuity is worse than 20/200 or field of vision less than twenty (20) degrees in both eyes. Must be certified by an ophthalmologist.

Coronary Artery Bypass Surgery: Undergoing open heart surgery to correct narrowing or blockage of one or more of the coronary arteries using either the saphenous vein or internal mammary artery graph. It does not include procedures such as angioplasty, laser relief, stints or other non-surgical procedures.

End Stage Renal Failure: The chronic irreversible failure of the function of both kidneys, necessitating renal dialysis at least weekly or resulting in kidney transplantation.

Heart Attack: Myocardial infarction. The death of a portion of the heart muscle (myocardium) resulting from the blockage of one or more coronary arteries. The diagnosis must include all of the following: EKG findings consistent with myocardial infarction; elevation of cardiac enzymes above generally accepted laboratory levels of normal (in the case of creatine phosphokinase, a CPK-MB measurement must be used); and confirming imaging studies such as thallium scans, MUGA scans, or stress echocardiograms.

Life-Threatening Cancer: A disease identified by the presence of malignant cells or a malignant tumor characterized by the uncontrolled and abnormal growth and spread of invasive malignant cells. Life-Threatening Cancer includes leukemia. The following are not covered under this insurance: pre-malignant conditions, conditions with malignant potential, pre-leukemic conditions, benign tumors, or polyps; basal cell carcinoma and squamous cell carcinoma of the skin; Stage I Hodgkin's Disease; Stage A prostate cancer; melanoma that is diagnosed as Clark's Level I or II or Breslow less than 0.75 mm; and carcinoma in situ, that is in the natural or normal place without having invaded neighboring tissue.

Loss of Limbs: The total and permanent loss of the use of two or more limbs as a result of the severance of an arm above the elbow or a leg above the knee.

Major Organ Transplant Surgery: Undergoing surgery as a recipient of a transplant of a human heart, lung or lungs, liver or pancreas.

Multiple Sclerosis: The unequivocal diagnosis of Multiple Sclerosis made by a qualified neurologist. The claimant must exhibit at least moderate neurological abnormalities that have existed for a period of at least 180 consecutive days and be evidenced by the progressive demyelination of the white matter of the brain and spinal cord resulting in neurologic dysfunction such as tremor, nystagmus and disturbances of speech.

Permanent Paralysis: The permanent and complete cessation of function of any two or more limbs as a result of injury or Sickness continuing for a period of at least 180 consecutive days and diagnosed by a neurologist.

Stroke: An acute cerebral vascular accident resulting in permanent neurological damage and resulting in paralysis or other measurable objective neurological deficit persisting for at least 30 days. The diagnosis must be based on confirmatory neuroimaging studies such as a CAT Scan or MRI. Stroke does not include Transient Ischemic Attacks (TIA) and attacks of Vertebrobasilar Ischemia.

Exclusions and Limitations of Critical Payment Benefit:

- There is a 90-day waiting period, during which no benefits are payable. Conditions diagnosed during the waiting period will not be covered at any time.
- When an Insured Person attains age 70, the applicable Maximum Benefit shown in the Schedule of Benefits is Reduced to 50% of the amount which would otherwise be payable. Benefits are paid based on the Maximum Benefit in effect on the Date of Diagnosis.
- No benefits are payable for illnesses or surgeries other than the Specified Critical Illnesses and Specified Surgeries as defined in the certificate or policy.
- No benefits are payable for a Preexisting Illness which occurs during the first 24 consecutive months of insurance.
- The benefits paid for any one Insured Person will not exceed the applicable Maximum Benefit, regardless of the number of Specified Critical Illnesses or Specified Surgeries.
- No benefits are payable if a claim results from any of the following: suicide or attempted suicide, while sane or insane; war or act of war, whether declared or not; participating in or contracting with the armed forces; misuse of alcohol or the use of or taking of any narcotic, barbiturate or any other drug unless taken or used as prescribed by a Doctor; an Insured Person intentionally causing a self-inflicted injury or participating in or attempting to participate in an illegal activity.

(May Vary by State)

Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act (HIPAA) requires that each health insurance issuer that offers health insurance coverage in the individual market (as defined by HIPAA) may not decline to offer coverage to, or deny enrollment of, an Eligible Individual and may not impose any preexisting illness exclusions with respect to such coverage. However, this requirement does not apply in states that have enacted "acceptable alternative mechanisms" under federal law.

Where required by state law, the insurance company will make available health insurance coverage to Eligible Individuals. Refer to your state-specific benefits for the type of coverage available to Eligible Individuals in your state.

Eligible Individuals

An Eligible Individual is a person:

1. who, as of the date on which the individual seeks coverage, has been insured under Creditable Coverage [as defined in Section 2701(c) of HIPAA] for at least eighteen (18) months and whose most recent period of coverage was under a group health plan (employer-sponsored plan), governmental plan, or church plan (or health insurance coverage offered in connection with any such plan); and
2. who is not eligible for coverage under:
   a. a group health plan (an employer-sponsored plan); or
   b. Part A or Part B of title XVIII of the Social Security Act (Medicare); or
   c. a state plan under title XIX of such Act (Medicaid or any successor program); and
3. does not have other health insurance coverage; and
4. whose most recent coverage was not terminated because of nonpayment of premiums or fraud; and
5. who is ineligible for COBRA or has elected and exhausted COBRA benefits (or continuation coverage under a similar state provision).

Creditable Coverage for "Eligible Individuals":

In general, Creditable Coverage [as defined in Section 2701(c) of HIPAA] is coverage under any of the following, provided there was no more than a sixty-three (63) day break in coverage during all of which time period the individual was not covered (a waiting period shall not be treated as a break in coverage):

1. A group health plan (an employer-sponsored plan);
2. Health insurance coverage;
3. Part A or Part B of title XVIII of the Social Security Act (Medicare);
4. Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under section 1928 (the program for distribution of pediatric vaccines);
5. Chapter 55 of title 10, United States Code (CHAMPUS);
6. A medical care program of the Indian Health Service or of a tribal organization;
7. A State health benefits risk pool;
8. A health plan offered under chapter 89 of title 5, United States Code (the Federal Employees Health Benefits Program);
9. A public health plan; or
10. A health benefit plan under section 5(e) of the Peace Corps Act [22 U.S.C. 2504(e)].

THE FOLLOWING APPLIES ONLY TO PERSONS WHO HAVE BEEN DETERMINED TO BE "ELIGIBLE INDIVIDUALS"

If timely application is made:

- No Preexisting Illness exclusion will apply.
- Coverage will be guaranteed issue (subject to plan eligibility requirements). The effective date of coverage will be the date the application is received or the first day following the termination of the person's prior coverage, whichever is later.

Preexisting Condition (may vary by state)

Preexisting Condition: Is a condition:

1. for which medical advice was given or Treatment was recommended by a Physician within a five-year period prior to the Effective Date of coverage for that Insured Person; or
2. which produced symptoms within a five-year period prior to the Effective Date of coverage for that Insured Person.

Preexisting Conditions are not covered during the first two years. After two years, benefits are payable unless specifically excluded from coverage. Conditions fully disclosed on the application and not excluded from coverage by name or specific description are covered, subject to the provisions of the Preexisting Certificate.

Important Information

(May Vary by State)

24-Hour Coverage for the Self-Employed

Benefits will be paid for covered charges resulting from an on-the-job injury or illness of an insured person who is (1) self-employed; and (2) exempt under any applicable state or federal workers' compensation statutes or any other similar laws. This coverage is not being sold as workers' compensation coverage nor is it intended to be a substitute for workers' compensation coverage. Self-employed is defined as an individual who works for himself or herself, such as a sole proprietor, partner, shareholder, farmer or independent contractor and who is exempt from state or federal workers' compensation statutes.

Hospital Preadmission Certification

Certification is required for all emergency and non-emergency hospitalizations. Certification is based on medical necessity and appropriateness of treatment location. To obtain certification, your doctor or other authorized representative must contact the precertification center at the telephone number shown on the back of your insurance identification card at least 72 hours before the scheduled hospitalization. For emergency admissions, the certification service must be contacted within 48 hours following admission.

A precertification penalty of $500 or 20% of covered charges, up to $1,000, whichever is greater, for each treatment will apply where precertification is required but not obtained. The penalty will apply before the deductible and coinsurance and will not be applied to the out-of-pocket maximum. Obtaining precertification does not assure that benefits will be paid for the hospitalization. The Insurance Company will make the final determination whether benefits are payable based on the terms of the Policy, following submission of the claim.

General Definitions

Coinsurance Percentage: The percentage of the Covered Expenses the Insured person must pay which is the difference between 100% and the Coinsurance Percentage stated in the Schedule of Benefits.

Copayment/Copay: Copayment or Copay refers to the payment that an insured Person must make to the health care provider each time a particular Treatment or service is provided.

Deductible: The amount of Covered Expenses the Insured person must pay each Calendar Year before this certificate pays major medical benefits.

Preferred Provider Organization (PPO): A organization that has contracted with Physicians, Hospitals, or other health care providers who have agreed to provide health care services at negotiated rates. CGIC contacts with the PPO to create a network plan.

Application Process and Important Information

1. Our preliminary questions will determine if you are eligible to apply for this coverage.
2. To apply, you must answer all questions on the application. YOU CAN HAVE YOUR QQLINK AGENT ASSIST YOU IN COMPLETING THE APPLICATION.
3. Once you have submitted the online application, you will receive a verification telephone call to make sure the application is completed correctly.
4. Your application will be reviewed by our underwriters to determine eligibility for the plan and its benefits. No insurance will become effective unless and until you receive written notice (via e-mail or US mail) of approval specifying the effective date of coverage.
5. Your certificate booklet/policy and ID card(s) will be available online or mailed to you, generally within two weeks following approval by the Home Office.

Should we reject the application, our only obligation will be the return of premium money. We reserve the right to rescind, cancel or terminate coverage for any individual who is found to have fraudulently misrepresented any answer or information during verification, the online insurance application or any other enrollment materials.

Exclusions and Limitations

(May Vary by State)

NO BENEFITS WILL BE PAID FOR CHARGES:

- For transportation, except local transportation to a local Hospital by a professional ground or air ambulance service. However, air ambulance is only covered if due to a life-threatening injury or sickness.
- For fertility or infertility studies, diagnostic testing, advice, consultation, examination, medication, or for and Treatment related to or connected in any way with the restoration or enhancement of fertility or the inability to conceive or conception by artificial means, including, but not limited to, in vitro fertilization or embryo transfer.
- For replacement of artificial limbs and artificial eyes.
- For blood or blood plasma which has been replaced.
- For donation of any body organ by an Insured Person.
- For services performed by a person who ordinarily resides in the Insured Person's home or is a member of the Insured Person's Immediate family or by the Insured person's employer or partner.
- For any Cosmetic Surgery/Treatment, unless required to restore a part of the body which has been altered as a result of the following events or conditions that occurred while the Insured Person was insured by this certificate and for which benefits were paid in accordance with the terms of this Certificate:
    a. accidental bodily injury;
    b. Surgery; or
    c. disease that was first diagnosed while the insured person was insured by this Certificate.
- For Custodial Care.
- Applied to a Deductible, Coinsurance Percentage, or Copayment amount under any benefit of this Certificate.
- For services or Treatment not prescribed by a Physician or for services or Treatment not shown as covered.
- For any Injury or Sickness that is subject to and paid or payable under any state or federal workers' compensation law or other similar statute or occupational disease law. If the Insured Person is denied benefits under any such law but an award is made at a later date, CGIC shall have the right to recover the cost of any claims paid. However, coverage is provided to the Insured Person for Covered Expenses incurred by the Insured Person due to Injury or Sickness arising out of or in the course of employment for wage or profit if the insured person is:
    a. self-employed; and
    b. exempt from under any state or federal workers' compensation statutes or other similar laws.
- For expenses incurred prior to the Effective Date of insurance or after the insurance terminates.
- For Treatment or services Experimental or Investigational in nature or for research.
- For services in a nursing or convalescent home or Extended Care Facility except as covered under an Extended Care Facility benefit provision.
- For eye refractions, eye glasses, or contact lens, including fittings and examinations, or eye Surgery, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring), including, but not limited to radial keratotomy.
- For Treatment, services or supplies furnished by a department or agency of the United States Government. This exclusion will not apply to a nonservice-connected Injury or Sickness, or a veteran of the United States armed forces who does not have a service-connected Injury or Sickness.
- For services and supplies eligible for payment by a governmental or charitable program, except as required by law.
- For hearing aids, including fittings and examinations.
- Which are not Medically Necessary to the care or Treatment of an Injury or Sickness.
- Which would not have been made if no insurance existed.
- For recreational or educational therapy or vocational rehabilitation.
- Except as allowed under Covered Expenses Subject To Limitations, for speech or occupational therapy and related diagnostic testing if the therapy or testing is in connection with or related in any way to the Treatment of a learning disability, speech impediment, or developmental delay even though therapy is recommended due to organic dysfunction, including, but not limited to, congenital deformity or birth trauma.
- For which the Insured Person is not legally obliged to pay.
- For Treatment or services which are not generally accepted medical practices in the United States for a given Injury or Sickness.
- For Treatment of obesity, morbid obesity or for weight reduction purposes.
- For Injury or Sickness that results from participation in any assault, strike, civil disorder or riot.
- For the Treatment of sexual dysfunction or inadequacies regardless of the reason, including, but not limited to, Impotence and the implantation of a penile prosthesis.

Exclusions and Limitations

(May Vary by State)

- For routine physical or premarital examination (except as may be covered under the Preventative Medical Benefit, if included).
- For a private room in excess of the average semiprivate Room and Board rate.
- In excess of Usual and Customary expense.
- For services or supplies prohibited by law.
- For sex changes.
- For reversal of sterilization.
- For Treatment of controlled (as defined by the United States Food and Drug Administration) or prohibited substance abuse, including any conditions caused by, or related in any manner to, such abuse.
- Resulting from any suicide, attempted suicide or intentionally self-inflicted Injury or Sickness while sane or insane.
- For examination, Treatment or Surgery of the teeth, gums or direct supporting structure except for repair of Injury to sound natural teeth, (including their replacement) as the result of an accidental bodily injury which occurs while the person is insured. Treatment must be provided within 90 days of the date of the accident.
- For an Injury or Sickness caused by any act of war, whether or not declared.
- For surrogate pregnancy
- For the Treatment of complications arising from or connected in an way with a surgical or medical Treatment or procedure that is not a covered surgical or medical Treatment or procedure under the terms of this Certificate, whether or not the Insured Person was insured under this Certificate at the time the noncovered Treatment or procedure was performed.
- Services and supplies that are covered under an extension of group health benefits provision by a previous employer-related health plan, health insurance plan, or other coverage arrangement. Such services and supplies will not be covered by this Certificate until the extension of benefits under the prior plan ends.
- For Injury or Sickness that results either directly or indirectly from the Insured Person's participation in a hazardous activity.
- For Injury or Sickness that results either directly or indirectly from the Insured Person's being Intoxicated or being under the influence or alcohol, drugs, controlled substances, or any other substance capable of mental or physical impairment, unless it has been administered or prescribed on the advice of a Physician.
- For Injury or Sickness that results either directly or indirectly from the Insured Person's committing, attempting to commit, or participation in a felony.
- For pregnancy or prenatal care, except covered Complications of Pregnancy.
- For benefits if they are provided by Medicare or any government program (except Medicaid). Total benefits payable under this Certificate shall not exceed the unpaid portion of the Insured Person's Hospital, medical or surgical bills (otherwise covered under this certificate), after applying benefits from any government program; or the benefits set forth in this Certificate, whichever is less.
- For the following conditions during the first six months this Certificate is in Force unless such conditions are treated on an emergency basis:
  a. hernia;
  b. removal of adenoids and/or tonsils;
  c. varicose veins;
  d. hemorrhoids;
  e. middle ear disorders; or
  f. disorders of the reproductive organs.
- For routine newborn or well child care.
- For elective abortion.
- For genetic testing.
- For out-patient prescription drugs or medicine (unless Prescription Drug Benefit included).
- For alcoholism, drug Treatment or chemical dependency.
- For preexisting conditions.

Please Note:

- This is not an insurance certificate booklet. Not all policy provisions, exclusions and limitations are listed. The certificate booklet, which is issued upon approval of coverage, will contain a summary of the coverage with a complete list of covered charges, exclusions and limitations.
- State laws may require that the coverage described in this brochure or on the website may be changed. Please refer to your State Specific Benefits on QQLink.com for a description of these changes, if applicable.
- This plan is not being sold as an employment benefit plan, and the employer is not responsible, either directly or indirectly, for paying the premium or benefits; therefore, state small employer laws do not apply.
- No agent has the authority to change any benefits, to bind coverage with the insurance company, or to promise a specific effective date.

CONTINENTAL GENERAL INSURANCE COMPANY
A Subsidiary of Ceres Group, Inc.
8901 Indian Hills Drive, PO Box 247007, Omaha, NE 68124-7007
402-397-3200 • www.continentalgeneral.com

EPB-0001 (06/03/02)