

Group HI Plus Plans 1 and 2 |

Underwritten by CAIC



Features:

- **Guaranteed Issue—No Health Questions Asked!**
- **No pre-existing condition exclusion.**
- Benefits paid directly to you or to your assigned doctor or hospital.
- Supplements and pays regardless of any other insurance program.

Benefits:

Physician Office/Hospital Emergency Room Visit (per visit)	PLAN 1 \$50	PLAN 2 \$75
---	----------------------	----------------------

If you are injured in a covered accident or have treatment as the result of a covered sickness, benefits will be paid for each visit as shown for Physician's office charges and Emergency room charges. This benefit is limited to 6 visits (Plans 1 and 2) per calendar year.

Hospital Admission Benefit (per admission)	PLAN 1 \$500	PLAN 2 \$1,000
---	-----------------------	-------------------------

This benefit is payable when you are admitted to a hospital other than a recovery room and confined as a resident bed patient because of injuries received in a covered accident or because of a covered sickness. In order to receive this benefit for injuries received in a covered accident, you must be admitted to a hospital within 6 months of the date of the covered accident.

Daily Hospital Confinement Benefit (per day)	PLAN 1 \$400	PLAN 2 \$1,000
---	-----------------------	-------------------------

This benefit is payable for a maximum of 30 days when you are confined to a hospital as a resident bed patient as the result of injuries received in a covered accident or because of a covered sickness. In order to receive this benefit for injuries received in a covered accident, you must be confined to a hospital within 6 months of the date of the covered accident (\$12,000-Plan 1 or \$30,000-Plan 2 maximum per confinement).

Intensive Care Benefit (per day)	PLAN 1 \$500	PLAN 2 \$1,000
---	-----------------------	-------------------------

If you are confined in a hospital intensive care unit due to an injury received in a covered accident or because of a covered sickness, the daily benefit amount shown will be paid for a maximum of 30 days. In order to receive this benefit for a covered accident, you must be admitted to a hospital intensive care unit within 6 months of the date of the covered accident. This benefit pays in addition to the Daily Hospital Confinement Benefit (\$15,000-Plan 1 or \$30,000-Plan 2 maximum per confinement).

Surgical Benefit (up to)	PLAN 1 \$500	PLAN 2 \$2,000
---------------------------------	-----------------------	-------------------------

If surgery due to an injury received in a covered accident or because of a covered sickness is performed by a physician, we will pay the amount for the Surgical Operation shown opposite the procedure listed in the Schedule of Operations up to the maximum shown per surgical procedure. The surgery can be performed in a Hospital (on an inpatient or outpatient basis), in an Ambulatory Surgical Center, or in a Physician's office.

Anesthesia Benefit (up to)	PLAN 1 \$125	PLAN 2 \$500
-----------------------------------	-----------------------	-----------------------

When a surgical procedure is performed that is covered under the Surgical Benefit, we will pay for anesthesia administered by a physician in connection with such procedure. Benefits will be 25% of the amount paid under Surgical Benefit.

Ambulance Benefit (per accident)	PLAN 1 \$100	PLAN 1 \$200
---	-----------------------	-----------------------

If you require transportation to a hospital by a professional ambulance service within 90 days after a covered accident, we will pay the amount shown.

THIS IS NOT BASIC HEALTH INSURANCE OR MAJOR MEDICAL COVERAGE AND IS NOT DESIGNED AS A SUBSTITUTE FOR BASIC HEALTH INSURANCE OR MAJOR MEDICAL COVERAGE.

Group HI Plus Plans 1 and 2 | Underwritten by CAIC

Diagnostic Tests (up to)

PLAN 1 | \$1,250

PLAN 2 | \$2,500

We will pay the amount shown for the following diagnostic procedures performed on an outpatient basis because of a covered sickness or injuries received in a covered accident:

Magnetic Resonance Imaging (MRI) \$250/\$500

Computed Axial Tomography (CAT Scan) \$250 /\$500

X-ray \$50/\$100

We will pay no more than the amount shown per calendar year for each insured due to the above outpatient diagnostic procedures.

Outpatient Diagnostic Lab (per test)

PLAN 1 | \$75

PLAN 2 | \$75

We will pay the amount shown for tests performed in an Outpatient Lab because of a covered sickness or injuries received in a covered accident. We will pay no more than 3 tests per calendar year for each insured due to outpatient diagnostic lab procedures. Not paid in addition to Wellness Benefit.

Outpatient Accident Expense (per accident—up to)

PLAN 1 | \$500

PLAN 2 | \$1,000

If you are injured in a covered accident and receive treatment in an outpatient facility from a physician within one year after the accident, we will pay up to the amount shown for actual expenses related to: emergency room services and supplies; appliances; physician services.

Outpatient Facility Surgery Fee (per surgery)

PLAN 1 | \$100

PLAN 2 | \$100

We will pay an additional indemnity benefit (as shown) for Outpatient Surgery fees facility.

Wellness Benefit

PLAN 1 | \$50

PLAN 2 | \$100

We will pay the amount shown per calendar year when you visit a doctor and you are neither injured nor sick.

Well Baby Care

PLAN 1 | \$50

PLAN 2 | \$50

We will pay the amount shown per visit. Pays for up to 4 visits per calendar year per insured baby. (Our definition of a baby is a dependent child 12 months of age or younger.)

Group TermLife

PLAN 1 | \$5,000

PLAN 2 | \$10,000

Spouses covered at 50% and children covered at 25% of the amount shown.

PLAN 1 MONTHLY PREMIUMS		PLAN 1 WEEKLY PREMIUMS	
Member	\$90.39	Member	\$20.86
Member and Spouse	\$165.35	Member and Spouse	\$38.16
Member and Children	\$133.08	Member and Children	\$30.71
Member and Family	\$206.39	Member and Family	\$47.63
PLAN 2 MONTHLY PREMIUMS		PLAN 2 WEEKLY PREMIUMS	
Member	\$165.49	Member	\$38.19
Member and Spouse	\$315.76	Member and Spouse	\$72.87
Member and Children	\$245.68	Member and Children	\$56.70
Member and Family	\$392.65	Member and Family	\$90.61

Premiums include insurance and non-insurance products (breakout available upon request). Voluntary rates shown.

THIS IS NOT BASIC HEALTH INSURANCE OR MAJOR MEDICAL COVERAGE AND IS NOT DESIGNED AS A SUBSTITUTE FOR BASIC HEALTH INSURANCE OR MAJOR MEDICAL COVERAGE.