Short Term Medical Enrollment Form - HealthSaver	Time Insurance Company	NEVADA

REQUESTED EFFECTIVE DATE

02	18	2010

Note: Effective date is assigned by Time Insurance Company. The effective date is the later of:

CERTIFICATE/POLICY NUMBER

9115382

1. The day after: a) the date this form is signed; b) the date this form is postmarked for mailing to Time Insurance Company; or c) the date we receive your enrollment request by electronic transmission in our home office, OR 2. If dates cannot be determined, the day we receive this form by mail. **The agent cannot assign an effective date different than this.**

APPLICANT'S NAME (Print last, first, middle)	GENDER	BIRTH DATE	SOCIAL SECURITY NUMBER
Silos, Frances, P	**F**	**04/02/1956**	**XXX-XX-7452**

STREET ADDRESS	STREET ADDRESS2	CITY, STATE, ZIP CODE
2432 Marlene Way		**Henderson, NV 89014**

SPOUSE'S NAME (if to be insured)	GENDER	BIRTH DATE	SOCIAL SECURITY NUMBER

CHILDREN (NAME) (if to be insured)	BIRTH DATE	NAME	BIRTH DATE	NAME	BIRTH DATE
1.		**2.**		**3.**	

Note: The plan cannot be issued if YES is answered to any questions. Under no circumstances can coverage become effective prior to the date this application is signed.

Answer the following questions completely and accurately.

1. Have/Are you, your spouse, or any person to be insured: **No**
   - been denied insurance due to any health reasons that are still present?
   - now pregnant, an expectant parent, in the process of adopting a child or undergoing infertility treatment?
   - over 300 pounds if male, or over 250 pounds if female?
2. For any of the following conditions within the last 5 years, have you or any person to be insured received any abnormal test results or medical or surgical treatment, or consulted a health care professional, or taken medication for: **No**
   - heart disorder including but not limited to heart attack or chest pain?
   - Emphysema?
   - Crohn's disease, ulcerative colitis or hepatitis?
   - AIDS or tested positive for HIV?
   - stroke?
   - kidney disorder, excluding kidney stones?
   - diabetes?
   - cancer or tumor?
   - alcoholism, chemical dependency, drug or alcohol abuse?

DEDUCTIBLE AMOUNT	LIFETIME MAXIMUM	PAYMENT OPTION AND LENGTH OF COVERAGE	RATE OF PAYMENT	TOTAL
$2,500	**$100,000**	**Monthly Payment - Coverage is needed for: up to 6 months**	**80/20**	**$174.07**

OPTIONAL RIDER *(Additional premium required)* I hereby select this optional benefit:
[ ] Substance Abuse Rider

The undersigned attests that the information above is true to the best of his/her knowledge. The undersigned realizes that any false, or inaccurate statement or misrepresentation in the enrollment form may result in claim denial or contract rescission. Any person who injures, defrauds, or deceives any insurer, files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. The undersigned understands that the plan applied for will not pay benefits for any expenses incurred on account of any condition which manifested itself before the effective date. The undersigned also understands that this is not a continuation of any previous medical plan, including any prior Short Term Medical plan. If I am self employed or an employee of an employer with 50 or fewer employees, I warrant premiums for this coverage are not: (1) Paid or reimbursed by my employer or, (2) To the best of my knowledge, treated as tax-deductible by my employer or me as related to an employer benefit plan (Internal Revenue Code sections 106, 125, 162 or 213).

PRIMARY PHYSICIAN'S NAME (IF ANY)	PRIMARY PHYSICIAN'S TELEPHONE NUMBER
Frances Silos APPLICANT'S SIGNATURE	**02/17/2010** TODAY'S DATE
(702)300-8342	**(702)300-8342**

DAY TELEPHONE NUMBER	EVENING TELEPHONE NUMBER

Form 28786

I have agreed to receive my policy and the company's "Notice of Privacy Practice" via the Internet.

EMAIL ADDRESS

Additional Benefit Option

[ ] Dental-Vision Discount Plan

Payment Information

Step 1: Select a Method of Payment **[X] Visa**

Important Reminders: The application fee is non-refundable.

Step 2: Authorization

- **When selecting the monthly payment option with MasterCard/VISA or Automatic Charge to a checking account:** I authorize Assurant Health to charge my account each month for the Short Term Medical policy listed above, until the end of the policy or until I request cancellation in writing. I understand I can request the charge be stopped if I notify Assurant Health seven days in advance of the charge occurring.

Card # **XXXXXXXXXXXX7502**	Exp. Date **07/2012**	Authorized Amount **$174.07**
ACCOUNT HOLDER'S SIGNATURE **Frances Silos**		DATE **02/17/2010**

AGENT NAME MARK HUSS	AGENT ID # 000H457R093001	APP SOURCE STMINETWADLINK

Assurant Health is the brand name for products underwritten and issued by Time Insurance Company. (September 2008)

Time Insurance Company
501 W. Michigan Street
Milwaukee, WI 53201-0624

SHORT TERM MEDICAL EXPENSE POLICY – FORM 135
OUTLINE OF COVERAGE

This outline of coverage provides a brief description of the important features of Your policy. This is not the insurance contract. The policy itself sets forth in detail the rights and obligations of both You and Your insurance company. It is important that You READ YOUR POLICY CAREFULLY!

MAJOR MEDICAL EXPENSE COVERAGE: The policy is designed to provide coverage for major Hospital, medical, and surgical expenses incurred as a result of Medically Necessary care for a covered Sickness or Injury during a Benefit Period.

AUTHORIZATION REQUIREMENT: To be eligible to receive the maximum benefits available read the Authorization Provisions section in the policy carefully. Authorization is required for all Hospital, Skilled Nursing Facility and inpatient rehabilitation admissions, outpatient or day surgeries, home health care, outpatient Physical Medicine visits and monthly rental or purchase of durable medical equipment that exceeds $500 and treatment of Severe Mental Illness and dental treatment performed in a health care facility or a rural clinic. Failure to follow the Authorization Provisions could result in no payment or a reduction in benefits.

PAYMENT OF BENEFITS: After the Deductible and/or any Copayment is satisfied, We will pay benefits for Covered Expenses at the Rate of Payment up to the Lifetime Maximum Benefit, or any other limitations as set forth in the policy, for each Insured during a Benefit Period. Benefits are subject to all the terms, limits, and conditions in the policy.

<table>
<tr><td colspan="4">COVERAGE INFORMATION</td></tr>
<tr><td colspan="2">Individual
Deductible
$2,500</td><td colspan="2">Family
Deductible
$0</td></tr>
<tr><td>Rate of Payment
80% of $20,000</td><td>Lifetime Maximum Benefit
$100,000</td><td>Benefit
Period
180 Days</td><td>Waiting Period for
Sickness
See Benefit Summary
Days</td></tr>
<tr><td colspan="2">Inpatient Hospital Services: See Benefit Summary
Outpatient Hospital Services: See Benefit Summary
Health Care Practitioner Services
Surgical: See Benefit Summary
Anesthesia: See Benefit Summary
Per Office Visit: See Benefit Summary
Reconstructive Surgery: See Benefit Summary</td><td colspan="2">Inpatient Rehabilitation: See Benefit Summary
Skilled Nursing Facility: See Benefit Summary
Home Health Care: See Benefit Summary
Outpatient Physical Medicine: See Benefit Summary
Ambulance: See Benefit Summary
X-ray and Lab: See Benefit Summary</td></tr>
<tr><td colspan="4">PREMIUM INFORMATION</td></tr>
<tr><td colspan="2">Premium Payment Mode Monthly Pay</td><td colspan="2">TOTAL MODAL PREMIUM AMOUNT: Initial Premium Due: $174.07 and Subsequent Premium Due: $149.07</td></tr>
</table>

BENEFIT PERIOD: The length of time the policy is in force. The policy is not renewable.

RATE OF PAYMENT: The amount We will pay for Covered Expense after You pay Your portion. You are responsible for any coinsurance balance. The Rate of Payment applies separately to each Insured during a Benefit Period. The payment of Covered Expense is subject to the Lifetime Maximum Benefit or any other maximum benefit for those services under the policy, whichever is less.

OTHER INSURANCE: Benefits that are otherwise payable under Our policy will be reduced if there is other insurance that also provides benefits for Covered Expenses. Our policy will not duplicate benefits.

COVERED EXPENSES: Charges for services, treatment, or supplies prescribed by a Health Care Practitioner. Services must be received and charges must be incurred by You or Your Covered Dependents while the policy is in force.

Covered Expense must be Medically Necessary and does not include any charge in excess of the Reasonable and Customary Amount. Benefits are available from the first day Covered Expenses are incurred for an Injury that is sustained on or after the Effective Date of the coverage. Benefits are available for a Sickness that first manifests itself after any Waiting Period. A Sickness manifests itself if You receive medical treatment or consultation for it or have signs or symptoms of it.

REASONABLE AND CUSTOMARY AMOUNT: The lesser of: 1) The actual charge; or 2) What the provider would accept for the same service or supply in the absence of insurance; or 3) The reasonable amount as determined by Time Insurance Company, based on factors such as: a) the amount of resources expended to deliver the service or supply; or b) the amount charged for the same or comparable service or supply in a community similar to where the service or supply is furnished; or c) the costs incurred by providers in a community similar to where the service or supply is furnished and the amount by which such service or supply is commonly marked up by providers; or d) charging protocols and billing practices generally accepted by the medical community or specialty groups, including charging protocols and billing practices related to Medicare; or e) inflation trends by geographic region; or 4) Another schedule or method of deriving charges, as identified in the policy.

BENEFITS PROVIDED BY THE POLICY: Only the services and supplies listed in the policy will be considered Covered Expenses. The policy provides benefits for the following Covered Expenses:

- **Inpatient Hospital Services:** Room, board and routine nursing services that are provided to all inpatients while confined in a semi-private room, ward, coronary care or other intensive care unit in a Hospital. If You are in a private room, We will pay benefits based on the Hospital's most common daily charge for a semi-private room.

- **Outpatient Hospital Services:** Services performed in a Hospital's outpatient department or in a Free-Standing Ambulatory Surgical Facility.

- **Health Care Practitioner Services, Surgical and Anesthesia Services:** Surgical services, anesthesia services and Health Care Practitioner services (not including office visits). Health Care Practitioner services include any Medically Necessary exam associated with the use of covered prescription hormone replacement therapy or covered prescription contraceptive drugs or devices. Notwithstanding this policy's exclusion of dental treatment, general anesthesia services and associated care in a health care facility or a rural clinic are considered Covered Expenses when a Health Care Practitioner certifies that general anesthesia is required for dental treatment provided to a Covered Dependent child who: 1) has a physical, mental or medically compromising condition; or 2) has dental needs for which local anesthesia is ineffective because of an acute infection, an anatomic anomaly or an allergy; or 3) is extremely uncooperative, unmanageable or anxious; or 4) has sustained extensive orofacial and dental trauma to a degree that would require unconscious sedation. The dental procedure and the professional fee of the Health Care Practitioner for dental treatment are not covered.

- **Reconstructive Surgery:** Reconstructive surgery to restore function for conditions resulting from accidental Injury provided the Injury occurred while the Insured is covered under the policy. Reconstructive surgery that is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part if the trauma, infection or other diseases occurred or had their onset while the Insured was covered under the policy. Reconstructive surgery of the breast on which the mastectomy has been performed, reconstruction of the other breast to produce a symmetrical appearance, and coverage for physical complications in all stages of the mastectomy, including lymphedemas, because of Medically Necessary surgical removal f all or part of the breast. Reconstructive surgery because of congenital illness or anomaly of a Covered Dependent child, born while the policy is in force, that resulted in a functional defect.

- **Inpatient Rehabilitation Programs:** Inpatient rehabilitation includes, but is not limited to, physical, occupational and speech therapy provided on an inpatient basis in a facility that is accredited by the Joint Commission on Accreditation of Healthcare Organizations or the Commission on Accreditation of Rehabilitative Facilities when the confinement is in lieu of acute hospitalization.

- **Skilled Nursing Facility Care:** Care in a Skilled Nursing Facility when the confinement is in lieu of acute hospitalization or when admitted to the Skilled Nursing Facility within 14 days after a Hospital confinement of at least 3 days for the same condition. The maximum daily benefit for care in a Skilled Nursing Facility will not exceed: 1) one-half of the semi-private Hospital room rate for the Hospital confinement; or 2) one-half of the most common semi-private Hospital room rate for the area in which You live if You were not previously Hospital confined.

- **Home Health Care:** Home health care visits provided by a state licensed or Medicare certified home health agency. One visit consists of up to 4 hours of home health aide service within a 24-hour period.

- **Hospice Care:** A program of palliative and supportive services provided 24 hours per day, 7 days a week, in an

inpatient, outpatient or home setting by a state-licensed hospice when You have a terminal condition which would cause Your life expectancy to be 6 months or less as certified by a Health Care Practitioner. Bereavement support services for the Immediate Family, the primary caregiver and other persons with significant personal ties to the patient are also covered for a maximum of 15 visits or 6 months from the patient's date of death, whichever comes first.

- **Outpatient Physical Medicine Services:** Outpatient Physical Medicine includes, but is not limited to: physical, speech or occupational therapy; pulmonary or cardiac rehabilitation therapy; or adjustments and manipulations provided in the outpatient department of a Hospital, by a licensed or certified home health care agency or by a licensed therapist in Your home. One visit consists of up to 4 hours of therapy within a 24-hour period.

- **Ambulance Services:** Ambulance service for one trip to the nearest Hospital that is able to treat the Sickness or Injury.

- **X-ray and Laboratory Services:** X-ray, radioactive treatment and laboratory charges. This includes 1 cytologic screening test per Benefit Period for a covered female 18 years of age or older and 1 screening mammography exam per Benefit Period for a covered female, age 35 or over for a maximum benefit of $60.00.

- **Durable Medical Equipment and Supplies:** Rental, up to the purchase price, or purchase of a basic non-electric wheelchair, basic non-electric hospital bed or basic crutches; the initial permanent basic artificial limb or eye; oxygen and the equipment needed to administer oxygen; casts, orthopedic braces, splints, dressings and sutures; and external breast prosthesis needed because of Medically Necessary surgical removal of all or part of the breast provided the surgery was performed while the Insured was covered under the policy.

- **Blood Product Transfusions:** Whole blood, blood plasma and blood products if not replaced.

- **Temporomandibular Joint (TMJ) or Craniomandibular Joint (CMJ) Dysfunction:** Surgical and non-surgical treatment of temporomandibular or craniomandibular joint dysfunction, except for the treatment and services outlined in the policy. The combined maximum for all surgical and non-surgical treatment is limited to a 50% Rate of Payment of Covered Expenses.

- **Complications of Pregnancy:** The following complications arising from a pregnancy that began after the Effective Date of coverage and require inpatient confinement in a Hospital for medical treatment for the following conditions are covered on the same basis as any other covered Sickness: 1) acute nephritis, nephrosis, cardiac decompensation, missed abortion, or similar medically diagnosed conditions caused by Sickness or Injury not directly related to the pregnancy when the pregnancy is not terminated; and 2) nonelective caesarean section, ectopic pregnancy or spontaneous termination of pregnancy which results in termination of the pregnancy.

- **AIDS/HIV Services:** Treatment of AIDS, AIDS Related Complex (ARC) or related immunodeficiency disorders up to a maximum benefit of $10,000 for each Insured per Benefit Period.

- **Dietary Formulas:** A maximum of $2,500 per Benefit Period for enteral formulas and special food products for use at home that are prescribed by a Health Care Practitioner as medically necessary for the treatment of inherited metabolic diseases, characterized by deficient metabolism or malabsorption of amino acid, organic acid, carbohydrate or fat. A special food product is not a food that is naturally low in protein.

- **Diabetes Services:** Equipment, supplies, durable medical equipment, drugs and medicines that are approved by the FDA, outpatient self-management training, education and medical nutrition therapy, and other services that are prescribed by a Health Care Practitioner as Medically Necessary for the Insured's care and treatment of diabetes.

- **Severe Mental Illness:** Covered Expenses incurred for the Medically Necessary treatment of schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, panic disorder and obsessive-compulsive disorder will be considered up to :1) a maximum of 40 days of inpatient services in a Hospital per Benefit Period; and 2) a maximum of 40 outpatient visits per Benefit Period, excluding visits for the management of medication. Partial hospitalization services may be covered in lieu of or in combination with inpatient services. Two visits for partial hospitalization, respite care or a combination of the two may be substituted for each 1 day of inpatient services in a Hospital that are not used by the Insured. The total combined maximum per Benefit Period for inpatient and partial hospitalization is limited to the equivalent of 40 days of inpatient services in a Hospital. Charges incurred for psychosocial rehabilitation or for custodial care received on an inpatient basis are not covered:

PRE-EXISTING CONDITIONS LIMITATION: No benefits will be provided during the term of the policy for any Pre-Existing Condition. A Pre-Existing Condition is a medical condition due to Sickness or Injury for which the Insured received medical treatment or advice from a provider within the 5-year period immediately preceding the Effective Date of coverage, regardless of whether the condition was diagnosed or not diagnosed; or that produced signs or symptoms

within the 5-year period immediately preceding the Effective Date of coverage. The signs or symptoms must have been significant enough to establish manifestation or onset by one of the following tests: 1) The signs or symptoms would have allowed one learned in medicine to make a diagnosis of the disorder; or 2) The signs or symptoms should have caused an ordinarily prudent person to seek diagnosis or treatment. A pregnancy that existed on the day before Your Effective Date of coverage is also considered a Pre-Existing Condition.

WAITING PERIOD LIMITATION: We will not pay benefits during the term of the policy for charges incurred due to a Sickness that manifests itself before any Waiting Period. Benefits are available from the first day Covered Expenses are incurred for an Injury that is sustained on or after the Effective Date of Your coverage.

EXCLUSIONS: The policy does not cover any of the following:

- Conditions for which claims were submitted under a prior Short Term Medical policy or certificate issued by Us that provided coverage that ended within 90 days before the Effective Date of the policy.
- Intentionally self-inflicted Sickness or Injury, whether sane or insane.
- Free services of a federal, veteran's, state or municipal Hospital.
- Sickness or Injury to the extent that benefits are paid by Medicare or any other government law or program, except Medicaid (Medi-Cal in California); or medical coverage under any automobile or no fault insurance.
- Sickness or Injury eligible for benefits under worker's compensation, employers' liability or similar laws even when You do not file a claim for benefits.
- Treatment of Sickness or Injury caused by or contributed to by: 1) War or any act of war; or 2) Participation in the military service of any country. Any premium paid for a time not covered will be returned pro-rata.
- Dental treatment unless a Hospital stay is required due to Injury from an accidental blow to the mouth causing trauma to sound, natural teeth, the gums or supporting structures of the teeth. A sound, natural tooth has no decay and has never had a filling, root canal therapy or crown. Inpatient Hospital care must be the least expensive setting needed to produce a professionally adequate result and the Hospital charges only are Covered Expense. The treatment must be received while the policy is in force.
- Treatment of temporomandibular or craniomandibular joint dysfunction, except as provided in the policy.
- Expense incurred that is not for treatment of Sickness or Injury. This includes, but is not limited to, charges for:

    1. Eyeglasses, contact lenses, eye exams, eye refraction or eye surgery for correction of refraction error; vision therapy; or artificial hearing devices.
    2. Preventive treatment including, but not limited to, routine physical exams and immunizations, unless otherwise noted as a Covered Expense in the policy or a rider to the policy.
    3. Normal pregnancy or childbirth; routine well baby care, including Hospital nursery charges at birth.
    4. Elective abortion, elective caesarean section, or any condition not included as a Covered Expense under the Complications of Pregnancy provision in the Benefits section of the policy.
    5. Infertility diagnosis and treatment for males and females including, but not limited to, drugs and medications, artificial insemination, in-vitro fertilization and reversal of sterilization.
    6. Genetic testing or counseling including, but not limited to, amniocentesis and chorionic villi testing.
    7. Sex transformation; treatment of sexual function, dysfunction or inadequacy; or treatment to enhance sexual performance or desire.
    8. Treatment and medication to stimulate growth and growth hormones for any purpose.
    9. Treatment, services or supplies to address quality of life or lifestyle concerns including, but not limited to: smoking cessation; snoring or sleep disorders; the treatment or prevention of hair loss; change in skin pigmentation; or cognitive enhancement.
    10. Sterilization and drugs or devices used directly or indirectly to promote or prevent conception, unless otherwise noted as a Covered Expense in the policy or a rider to the policy.
    11. Weight reduction or weight control programs or treatment; or surgery for weight control, obesity or morbid obesity.
    12. All treatments for varicose veins.
    13. Therapy or treatment for learning disorders or disabilities or developmental delays.
    14. Sales tax or gross receipt tax; provider administrative expenses including, but not limited to, charges for claim filing, contacting utilization review organizations, or case management fees.
    15. Travel, transportation or living expenses.

- Cosmetic treatment or reconstructive or plastic surgery that is primarily a cosmetic procedure, including medical or surgical complications arising therefrom, except as provided in the Benefits section of the policy.
- Treatment of Mental Illness 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, unless otherwise noted as a Covered Expense in the policy or a rider to the policy.
- Treatment, repair or removal of tonsils or adenoids, except on an Emergency basis.
- Treatment or services rendered by, or supplies purchased from, a member of Your Immediate Family or an employer.
- Treatment or services required due to accidental Injury sustained in operating a motor vehicle while the Insured's blood alcohol level, as defined by law, exceeds that level permitted by law or otherwise violates legal standards for a person operating a motor vehicle in the state where the Injury occurred. This exclusion applies whether or not the Injury occurred in connection with an incident involving the operation of a motor vehicle, and whether or not the Insured is charged with any violation in connection with the accident.
- Treatment or services required due to Injury received while engaging in any hazardous occupation or other activity, including the following: Participating, instructing, demonstrating, guiding or accompanying others in parachute jumping, hang-gliding, bungee jumping, flight in an aircraft other than a regularly scheduled flight by an airline, racing any motorized or non-motorized vehicle, rock or mountain climbing, professional or semi-professional contact sports of any kind. Also excluded are treatment and services required due to Injury received while practicing, exercising, undergoing conditioning or physical preparation for any such activity.
- Treatment or services required due to Injury received while engaging in any hazardous occupation or other activity for which compensation is received, including the following: Participating, instructing, demonstrating, guiding or accompanying others in skiing and horse riding. Also excluded are treatment and services required due to Injury received while practicing, exercising, undergoing conditioning or physical preparation for any such compensated activity.
- Treatment or services required due to Injury sustained while participating in any interscholastic or inter-collegiate sport, contest or competition or while practicing, exercising, undergoing conditioning or physical preparation for any such sport, contest or competition.
- Treatment or services required for Sickness or Injury resulting from consumption, abuse or overdose of alcoholic beverages or any illegal or controlled substance.
- Expense incurred due to Sickness or Injury of which a contributing cause was the Insured's voluntary attempt to commit, participation in or commission of a felony, whether or not charged, or as a consequence of the Insured's being under the influence of illegal narcotics or non-prescribed controlled substances.
- Custodial Care; respite care; rest care; or supportive care.
- Expenses incurred outside of the United States or its possessions or Canada.
- Expenses incurred for Experimental or Investigational Treatment.
- Private duty nursing services rendered during Hospital confinement and charges for standby Health Care Practitioners.
- Dental braces, dental appliances, corrective shoes, repairs to or replacement of prosthetic devices, or orthotics, except as provided in the Benefits section of the policy.
- Inpatient treatment of chronic pain disorders; biofeedback; repair of diastasis recti; orthognathic surgery; non-medical self-care or self-help programs.
- Reduction mammoplasty or revision of breast surgery for capsular contraction or replacement of prosthesis, except as provided in the Benefits section.
- Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) and related immunodeficiency disorders, except as provided in the Benefits section of the policy.
- The first $2,500 or 50%, whichever is the lesser amount, of an otherwise Covered Expense not authorized in accordance with the Authorization Provisions section of the policy.

- Transplants.
- Services or supplies for foot care, including care of corns, bunions or calluses, except capsular or bone surgery.
- Complications resulting from leaving an Inpatient or Outpatient facility against the advice of Your Health Care Practitioner; complications of any condition that existed prior to the Effective Date; or treatment for an excluded service or procedure.
- Treatment, services or supplies rendered or received when coverage under the policy is not in effect.
- Any amount in excess of the Reasonable and Customary Amount, as determined by Us under the policy.
- Prophylactic treatment or services. Prophylactic means any surgery or other procedure performed to prevent a disease process from becoming evident in the organ or tissue at a later date.
- Treatment, services or supplies that are not Medically Necessary as determined by Us under the policy.
- Treatment, services or supplies that are prescribed, provided or furnished in a manner primarily for the convenience of the Insured or Health Care Practitioner.
- Drugs and medicines, except as covered in the Benefits section.
- Treatment, services or supplies not described in the Benefits section of the policy.
- Charges for reproductive or sexual treatment including, but not limited to: Normal pregnancy or childbirth; routine well baby care, including Hospital nursery charges at birth; abortion, except as otherwise covered in the Complications of Pregnancy provision; infertility diagnosis and treatment for males and females including, but not limited to, drugs and medications, artificial insemination, in-vitro fertilization and reversal of sterilization; sterilization and drugs or devices used directly or indirectly to promote or prevent conception; genetic testing or counseling including, but not limited to, amniocentesis and chorionic villi testing; and treatment of sexual dysfunction or inadequacy.

RENEWABILITY PROVISION: The policy is not renewable. Coverage is in force only for the Benefit Period You selected which is shown on page one.

PREMIUM: The first page shows the total premium for the coverage You selected. The premium amount will not change while the policy is in force.

MARK HUSS	02/17/2010
Licensed Agent's Signature	Date

Time Insurance Company
501 W. Michigan Street
Milwaukee, WI 53201-0624

OPTIONAL SUBSTANCE ABUSE BENEFITS FOR NEVADA RESIDENTS

The consideration for this Rider is the additional premium shown in the Benefit Summary. The policy or certificate to which this Rider is attached is amended as follows.

The policy is revised to include Covered Expenses for the treatment of Substance Abuse, as described below, if elected by the Insured in the space provided at the end of this Rider. These benefits are applicable to Nevada residents only, and are subject to all other policy terms, limits, and conditions, except to the extent specifically modified by this Rider.

SUBSTANCE ABUSE BENEFITS
If elected by the Insured, as indicated in the Benefit Election section of this Rider, the following benefit is added to and becomes a part of the Benefits section in the policy:

22. **Substance Abuse Benefits**: Covered Expenses are for services prescribed by a Health Care Practitioner as Medically Necessary for the treatment of Substance Abuse and are limited to:
    a. A maximum benefit of $1,500 per Benefit Period for treatment for withdrawal from the physiological effect of alcohol or drugs; and
    b. A maximum benefit of $9,000 per Benefit Period for inpatient treatment in a facility for the treatment of abuse of alcohol or drugs; and
    c. A maximum benefit of $2,500 per Benefit Period for outpatient treatment or counseling for an Insured who is not admitted to a facility on an inpatient basis for the treatment of abuse of alcohol or drugs

    Covered Expenses for the treatment of Substance Abuse must be received at:

    a. A facility for alcohol and drug abuse treatment as certified by the Nevada Department of Human Resources; or
    b. A Hospital or other facility that provides a program for the treatment of alcohol or drug abuse as part of its accredited activities and is both licensed by the Nevada Department of Human Resources and accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

The Authorization Provisions section of the policy is amended to add:

- Substance Abuse Treatment: Call at least 7 business days prior to receiving any services.

Exclusions 10 and 17, found in the Exclusions section of the policy, are deleted only to the extent that they conflict with the benefits provided in this Rider.

BENEFIT ELECTION
For an additional premium, this optional Rider may be added to the policy. The Insured's desire to include the benefits of this optional Rider in the policy or to waive such benefits must be indicated below. The optional benefits provided by this Rider are effective only to the extent that the Insured elects this Rider as indicated below.

_ Yes, the Insured hereby elects the optional coverage provided by this Rider.

X No, the Insured hereby declines the optional coverage provided by this Rider.

Frances Silos _____ 02/17/2010

Insured's Signature Date

This Rider applies only to Insureds and any Covered Dependents who reside in the State of Nevada. Nothing contained in this Rider will be held to vary, alter, waive or extend any of the terms, conditions, agreements or limitations of the policy or certificate other than as stated above.

If elected, the Effective Date of this Rider is the Effective Date of the policy or certificate to which it is attached.