COMPANION LIFE INSURANCE COMPANY
7909 Parklane Road
COLUMBIA, SC 29223
Telephone (803) 735-1251

INDIVIDUAL SHORT-TERM HEALTH INSURANCE POLICY
POLICY FORM NO. STMP 5100 IND SC
OUTLINE OF COVERAGE

THIS IS NOT QUALIFYING HEALTH COVERAGE (“MINIMUM ESSENTIAL COVERAGE”) THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON’T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES

Read Your Policy Carefully
This Outline of Coverage briefly describes the important features of the Short-Term Policy. This is not the insurance Policy. Only the actual Policy provisions will control your Policy. The Policy itself sets forth in detail the rights and obligations of you and of Companion Life Insurance Company or its administrator. It is important that you read your Policy carefully.

Major Medical Expense Coverage
Policies of this category are designed to provide coverage to persons insured for major Hospital, medical and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily Hospital room and board, miscellaneous Hospital services, surgical services, anesthesia services, in-Hospital medical services and out-of-Hospital care subject to any Deductibles, Copayments or other limitations that may be set forth in the Policy.

Preauthorization Requirement
To make the most of your benefits, Companion Life has an approval process in place. We must give advance approval for all Hospital admissions and certain other specified services for you to receive maximum benefits.

Preauthorization means that a service is Medically Necessary for treatment of the patient’s condition. Preauthorization is not a guarantee or verification of benefits. Payment is subject to patient eligibility, Pre-existing Condition Limitations and all other limitations or exclusions of the Policy. Final benefit determination will be made when we process your claim.

Tell your Physician that your health insurance Policy requires advance Preauthorization. In-network Providers will be familiar with this requirement and will get the necessary approvals.

If you don’t use an In-network Provider, no benefits are provided. If you don’t get preapproval, then we may not pay benefits or pay only reduced benefits.

Benefit Description

Deductible – You Pay
$500, $1,000, $2,500 or $3,500
The Deductible does not apply to the Out-of-pocket Maximum

Benefit Percentage – We Pay
80%

Out-of-pocket Maximum – You Pay
$2,000 or $4,000
Covered Services will be paid at 100% of the Allowable Charges when you reach your Out-of-pocket Maximum.

The Out-of-pocket Maximum doesn’t include any Deductible; charges in excess of the Allowable Charge; amounts exceeding any Maximum Payments for benefits; or any expense not allowed according to any provisions of this Policy.

Benefit Period Maximum Payment – We Pay
$500,000, $750,000 or $1,000,000 All Covered Services (combined)
$10,000 Inpatient Rehabilitation
$500 Short-Term Therapy Physical Services
$500 Durable Medical Equipment, Prosthetic Devices, Orthotic Devices, Ostomy Supplies (combined)
$500 Ambulance
Covered Services

<table>
<thead>
<tr>
<th>Daily Hospital Room and Board</th>
<th>Semi-private room or Intensive Care Unit.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Covered Hospital Services</td>
<td>Ancillary Hospital services; Outpatient Hospital services; Outpatient Surgery; Emergency Medical Care; Outpatient diagnostic, X-ray and lab services; chemotherapy; inhalation therapy; physical therapy; radiation therapy.</td>
</tr>
<tr>
<td>Physician Services</td>
<td>Surgery; administration of anesthesia; daily Hospital medical care; Outpatient services; treatment of accidents; non-routine office visits.</td>
</tr>
<tr>
<td>Therapy Services</td>
<td>When Medically Necessary and ordered by a Physician.</td>
</tr>
<tr>
<td>Preventive Benefits</td>
<td>Pap Smear Screening, Prostate Screening and Laboratory Work and Colorectal Screening and Testing — according to the most recently published guidelines of the American Cancer Society. Preventive Mammography – 100% of Allowable Charges for any Member according to the most recently published guidelines of the American Cancer Society. A Contracting Mammography Provider must provide the services.</td>
</tr>
<tr>
<td>Other Covered Services</td>
<td>Dental services related to accidental injury; Prosthetic Appliances, Orthotic Devices and Durable Medical Equipment; oxygen and equipment for its use; Medical Supplies; ambulance service; blood and blood plasma.</td>
</tr>
</tbody>
</table>

Benefits are available when Covered Services are Medically Necessary.

For a complete Summary of Benefits, please refer to the Covered Services section of the Short-Term Policy.

Exclusions and Limitations of the Policy

Except as specifically provided in the Policy, no benefits will be provided for:

1. Treatment provided in a government Hospital that you are not legally responsible for; or for which benefits are provided under Medicare or other governmental programs (except Medicaid).
2. Any charges for services or supplies for which you are entitled to payment for benefits (whether or not you have applied for such payment or benefits) under any motor vehicle no-fault law.
3. Injuries or diseases paid by Workers' Compensation or settlement of a Workers' Compensation claim.
4. Separate charges for services provided by employees of Hospitals, laboratories or other institutions; for services or supplies performed or furnished by a member of the Member's immediate family; and for services for which a charge is normally not made in the absence of insurance.
5. Cosmetic Surgery except that Cosmetic Surgery does not include reconstructive Surgery incidental to or following Surgery resulting from trauma, infection or other diseases of the involved part.
6. Illness contracted or injury sustained as the result of: war or act of war (whether declared or undeclared); committing or attempting to commit a felony; participation in a riot or insurrection; service in the armed forces or an auxiliary unit; or engaging in an illegal occupation.
7. Rest cures and Custodial Care.
8. Transportation, except as shown in Covered Services.
9. Routine physical examinations, except as shown in Covered Services.
10. Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain or symptomatic complaints of the feet. This exclusion does not include corrective Surgery or treatment for metabolic or peripheral vascular disease.
11. Dental care or treatment.
12. Eyeglasses, except as shown in the Schedule of Benefits; contact lenses (except after cataract Surgery) and hearing aids and examination for their prescribing or fitting.
13. Normal pregnancy or childbirth.
14. Treatment, services or supplies received as a result of suicide, attempted suicide or intentionally self-inflicted injuries whether the patient was sane or insane.
15. Services, care or supplies used to detect and correct, by manual or mechanical means structural imbalance, distortion or subluxation in your body for purpose of removing nerve interference and its effects when this interference is the result of or related to distortion, misalignment or subluxation of, or in, the spinal column.

16. Being legally intoxicated or impaired by being under the influence of alcohol, any narcotic or drug, unless taken on the advice of a Physician.

17. Mental or emotional disorders.

Pre-Existing Conditions

THERE IS NO COVERAGE FOR PRE-EXISTING CONDITIONS, as defined in the policy. Benefits will not be provided during the term of this policy for any Pre-existing Condition.

A Pre-existing Condition is a condition for which: a) symptoms existed that would cause a reasonable person to seek diagnosis, care or treatment within a one-year period preceding the Effective Date of coverage; or b) medical advice or treatment was recommended by or received from a Physician within a five-year period preceding the Effective Date of coverage.

Renewability and Premiums
This is a non-renewable policy. You pay the premium for this Policy monthly.

Extension of Benefits
If you are in the Hospital, Skilled Nursing Facility or are Totally Disabled on the day coverage ends coverage may be extended under this Policy. Your coverage will continue while you remain Totally Disabled from the same or related cause until one of these occurs: 1) the date the hospitalization ends or the date of recovery from the Total Disability, whichever is later; or 2) the Policy maximums are met; or 3) a period of time no longer than this Policy Term following the termination date of coverage. We will pay benefits only for Covered Services as listed in this Policy that are related to the treatment of the disabling medical condition.

The terms Totally Disabled/Total Disability mean you are unable to perform the duties of your occupation and are under the care of a Physician. A child who is Totally Disabled is receiving ongoing medical care by a Physician and unable to perform the normal activities of a child in good health of the same age and sex.
Non-Discrimination Statement and Foreign Language Access

We do not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, sexual orientation or health status in our health plans, when we enroll members or provide benefits.

If you or someone you’re assisting is disabled and needs interpretation assistance, help is available at the contact number posted on our website or listed in the materials included with this notice (TDD: 711).

Free language interpretation support is available for those who cannot read or speak English by calling one of the appropriate numbers listed below.

If you think we have not provided these services or have discriminated in any way, you can file a grievance by emailing contact@hcrcompliance.com or by calling our Compliance area at 1-800-832-9686 or the U.S. Department of Health and Human Services, Office for Civil Rights at 1-800-368-1019 or 1-800-537-7697 (TDD).

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de este plan de salud, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-396-0183. (Spanish)

如果您，或是您正在协助的对象，有关于本健康计划方面的询问，您有权免费以您的母语得到协助和信息。请拨打1-844-396-0188。 (Chinese)

Nếu quý vị, hoặc là người mà quý vị đang giúp đỡ, có những câu hỏi quan tâm về chương trình sức khỏe này, quý vị sẽ được giúp đỡ với các thông tin bằng ngôn ngữ của quý vị miễn phí. Để nói chuyện với một thợ dịch viên, xin gọi 1-844-389-4838. (Vietnamese)

이 건강보험에 관하여 궁금한 사항 혹은 질문이 있으시면 1-844-396-0187로 연락해 주십시오. 귀하의 비용 부담없이 한어어로도 대화드립니다. (Korean)

Kung ikaw, o ang iyong tinutulungan, ay may mga katanungan tungkol sa planong pangkalusugang ito, may karapatan ka na makakuhang tulang at impormasyon sa iyong wika nang walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-844-389-4839. (Tagalog)

Если у Вас или лица, которому вы помогаете, имеются вопросы по поводу Вашего плана медицинского обслуживания, то Вы имеете право на бесплатное получение помощи и информации на русском языке. Для разговора с переводчиком позвоните по телефону 1-844-389-4840. (Russian)

إن كان لديك أو لدى شخص تساعدته أسئلة يتخصسي خطة الصحة هذه، فليس لديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون أية نكتة. للتحدث مع مرتجم اتصل ب 1896-396-8441 (Arabic)
Si ou menm oswa yon moun w ap ede gen kesyon konsèn plan sante sa a, se dwa w pou resëvwa asistans ak enfòmasyon nan lang ou pale a, san ou pa gen pou peye pou sa. Pou pale avèk yon entèpré, rele nan 1-844-398-6232. (French/Haitian Creole)

Si vous, ou quelqu'un que vous êtes en train d'aider, avez des questions à propos de ce plan médical, vous avez le droit d'obtenir gratuitement de l'aide et des informations dans votre langue. Pour parler à un interprète, appelez le 1-844-396-0190. (French)

Jeśli Ty lub osoba, której pomagasz, macie pytania odnośnie planu ubezpieczenia zdrowotnego, masz prawo do uzyskania bezpłatnej informacji i pomocy we własnym języku. Aby porozmawiać z tłumaczem, zadzwoń pod numer 1-844-396-0186. (Polish)

Se você, ou alguém a quem você está ajudando, tem perguntas sobre este plano de saúde, você tem o direito de obter ajuda e informação em seu idioma e sem custos. Para falar com um intérprete, ligue para 1-844-396-0182. (Portuguese)

Se tu o qualcuno che stai aiutando avete domande su questo piano sanitario, hai il diritto di ottenere aiuto e informazioni nella tua lingua gratuitamente. Per parlare con un interprete, puoi chiamare 1-844-396-0184. (Italian)

あなたの、またはあなたがお世話をされている方が、この健康保険についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-396-0185 までお電話ください。 (Japanese)

Falls Sie oder jemand, dem Sie helfen, Fragen zu diesem Krankenversicherungsplan haben bzw. hat, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-396-0191 an. (German)

آگر شما یا یکدیگر که به او کمک می کنید سوالاتی درباره این برنامه به‌خیال داشته باشید، حق این را دارید که کمک و اطلاعات به زبان خود را به طور رایگان دریافت کنید. برای صحبت کردن با متراکم، لطفاً با شماره 333-3984-4281 تماس حاصل نمایید. (Persian-Farsi)

Ni da doodago t’áá háída biká’ a mín wó’i-gi dií Béeso Æch’ágh naa’niligí háá’ida yi na’ idil kidgo, nihá’áhéro’i’ nihí ká’á’doo wolgo kwii ha’át’ishíj bi na’idokidigi doo bik’é’azlágóó. Ata’ halncè’ła’ bích’í’ ha deszizh ninizingo, koji’ béésh bee hólnc’ 1-844-516-6328. (Navajo)