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**OUTLINE OF COVERAGE**  
**LIMITED BENEFIT HEALTH COVERAGE**  
**HOSPITAL INDEMNITY AND**  
**RELATED BENEFITS**  
**Policy Form 93011**

THIS IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for People With Medicare available from the company.

**(1) BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES.**

This is a supplement to health insurance. It is not a substitute for hospital or medical expense insurance, a health maintenance organization (HMO) contract, or major medical expense insurance.

**(2) PLEASE READ YOUR POLICY CAREFULLY:**

This Outline of Coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

**(3) LIMITED BENEFIT HEALTH COVERAGE:**

Limited Benefit Health Coverage is designed to provide, to persons insured, limited or supplemental coverage. The policy benefits are outlined in Section 4 below; the benefits described in Section 4 may be limited by the limitations contained in Section 5.

**(4) BENEFITS PROVIDED UNDER THE POLICY:**

Benefit amounts are based on the benefit level you choose. The benefit levels are shown in the table below.

**HOSPITAL INDEMNITY BENEFIT:**

We will pay you the Hospital Indemnity Benefit amount for each day of your hospital stay due to an injury or sickness. Benefits are not payable beyond the maximum benefit period for any period of care.

If the policy terminates while you are hospitalized, we will continue to pay this benefit until the earlier of the initial date of discharge from the hospital (regardless of any hospital re-admission) or the date you reach the maximum benefit period.

**DURABLE MEDICAL EQUIPMENT BENEFIT:**

We will pay you the Durable Medical Equipment benefit amount for durable medical equipment expenses you incur due to an injury or sickness. This benefit is limited to one benefit per calendar year, and is subject to the lifetime maximum benefit amount.

**AMBULANCE BENEFIT:**

We will pay you the Ambulance Service Benefit amount if a licensed surface or air ambulance service transports you to or from a hospital due to injury or sickness. Any ambulance service must be necessary to protect your health and safety when other reasonable and customary travel methods are not available. This benefit is limited to one charge per period of care and is subject to the lifetime maximum benefit amount.

**EMERGENCY ROOM BENEFIT:**

We will pay you the Emergency Room benefit amount for services you receive in a hospital emergency room or hospital affiliated emergency care facility due to an Injury or Sickness. This benefit is payable only once per any period of care.

**PHYSICIAN BENEFIT:**

We will pay you \$25 per visit for follow up visits to a physician when the visit follows a hospital stay for which benefits are paid under the policy. The benefit is limited to three visits per calendar year and must be within 6 months of the hospital stay.

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### BENEFIT LEVELS:

| Benefit                                  | Gold  | Platinum  |
|--|---|---|
| <b>Hospital Indemnity Benefit</b>        | 31 Day Benefit Period (Daily Benefit amounts between {\$100-\$500})     | 90 Day Benefit Period (Daily Benefit amounts between {\$100-\$500})     |
| <b>Durable Medical Equipment Benefit</b> | \$300 Per Occurrence Per Calendar Year (\$2,500 Lifetime Max)           | \$400 Per Occurrence Per Calendar Year (\$2,500 Lifetime Max)           |
| <b>Ambulance Benefit</b>                 | \$150 Per occurrence (\$2,500 Lifetime Max)                             | \$200 Per occurrence (\$2,500 Lifetime Max)                             |
| <b>Emergency Room Benefit</b>            | \$200 Per Emergency room visit following a sickness, accident or injury | \$250 Per Emergency room visit following a sickness, accident or injury |
| <b>Physician Benefit</b>                 | \$25 Per visit, \$75 Calendar max                                       | \$25 Per visit, \$75 Calendar max                                       |

### (5) LIMITATIONS AND EXCLUSIONS:

#### PRE-EXISTING CONDITIONS:

No benefits are payable for any loss that begins within the first six (6) months after the effective date of your policy which is caused by a Pre-Existing Condition. A Pre-Existing Condition is a condition for which medical advice was given or treatment was recommended or provided by a physician within 6 months before the effective date of your policy.

The policy excludes benefits for care or expenses:

1. for treatment, services or supplies which:
  - are not prescribed by a physician as necessary to treat a sickness or injury; or
  - are received without charge or legal obligation to pay; or
  - would not routinely be paid in the absence of insurance; or
  - are received from any member of your immediate family; or
  - are received outside the United States; or
  - are incurred while this policy is not in force.
2. due to mental, nervous, psychotic or psychoneurotic illnesses or disorders.
3. resulting from war or an act of war, whether declared or undeclared, or resulting from service in the armed forces of any country.
4. resulting from committing or attempting to commit

an assault or felony or participating in a riot or civil commotion.

5. resulting from an attempted suicide or intentionally self-inflicted Injury while you are sane or insane.
6. for treatment provided in a U. S. government facility, where there is no charge to you.
7. for cosmetic surgery other than:
  - reconstructive surgery incidental to or following surgery resulting from trauma, infection, or other diseases of the involved part; or
  - reconstructive surgery because of a congenital disease or anomaly.
8. resulting from being legally intoxicated, as defined by the jurisdiction in which the Injury occurs.
9. resulting from your voluntary use of any drug, narcotic or controlled substance, unless as prescribed by your physician.

### (6) GUARANTEED RENEWABILITY OF THIS POLICY:

You have the right to continue your policy as long as you pay your premiums when due.

### (7) PREMIUM:

Total annual premium for your policy, including additional benefits purchased is \_\_\_\_\_.

We will not change the premium for your policy during your first year of coverage. Thereafter, we reserve the

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right to change premium rates for all policies of the same class. We will notify you at least 45 days before any premium change.

### **(8) OPTIONAL BENEFIT RIDER:**

There is an optional First Occurrence Cancer benefit offered with your policy for the payment of an additional premium. If you select this benefit, it will be included in your policy.

### **FIRST OCCURRENCE CANCER BENEFIT:**

We will pay you the First Occurrence Cancer benefit amount when you are diagnosed for the first time as having any internal cancer after the effective date of your policy and while the benefit rider is in force. We will pay this benefit even when cancer is not diagnosed until after death.

This benefit is not payable for skin cancer. This benefit is not available if you have been diagnosed with or treated for internal cancer before the effective date of coverage under your policy.

You may choose a First Occurrence Cancer Benefit Amount from \$1,000 to \$10,000.

THIS OUTLINE OF COVERAGE IS A BRIEF SUMMARY OF THE BENEFITS PROVIDED.

PLEASE CONSULT THE POLICY TO DETERMINE GOVERNING CONTRACTUAL PROVISIONS. PLEASE RETAIN THIS OUTLINE OF COVERAGE FOR YOUR RECORDS.