

**IMPORTANT INFORMATION ABOUT THE COVERAGE UNDER THE TEXAS LIFE,
ACCIDENT, HEALTH AND HOSPITAL SERVICE INSURANCE GUARANTY ASSOCIATION**

Texas law establishes a system, administered by the Texas Life, Accident, Health and Hospital Service Insurance Guaranty Association (the "Association"), to protect policyholders if their life or health insurance company fails to or cannot meet its contractual obligations. Only the policyholders of insurance companies which are members of the Association are eligible for this protection. However, even if a company is a member of the Association, protection is limited and policyholders must meet certain guidelines to qualify. (The law is found in the Texas Insurance Code, Article 21.28-D.)

**BECAUSE OF STATUTORY LIMITATIONS ON POLICYHOLDER PROTECTION, IT IS
POSSIBLE THAT THE ASSOCIATION MAY NOT COVER YOUR POLICY
OR MAY NOT COVER YOUR POLICY IN FULL.**

Eligibility for Protection by the Association

When an insurance company which is a member of the Association is designated as impaired by the Texas Commissioner of Insurance, the Association provides coverage to policyholders who are:

- residents of Texas at the time that their insurance company is impaired
- residents of other states, ONLY if the following conditions are met:
 - 1) The policyholder has a policy with a company based in Texas;
 - 2) The company has never held a license in the policyholder's state of residence;
 - 3) The policyholder's state of residence has a similar guaranty association; and
 - 4) The policyholder is **not eligible** for coverage by the guaranty association of the policyholder's state of residence.

Limits of Protection by the Association

Accident, Accident and Health, or Health Insurance:

- up to a total of \$200,000 for one or more policies for each individual covered.

Life Insurance:

- net cash surrender value up to a total of \$100,000 under one or more policies on any one life; or
- death benefits up to a total of \$300,000 under one or more policies on any one life.

Individual Annuities:

- net cash surrender amount up to a total of \$100,000 under one or more policies owned by one contractholder.

Group Annuities:

- net cash surrender amount up to \$100,000 in allocated benefits under one or more policies owned by one contractholder; or
- net cash surrender amount up to \$5,000,000 in unallocated benefits under one contractholder regardless of the number of contracts.

THE INSURANCE COMPANY AND ITS AGENTS ARE PROHIBITED BY LAW FROM USING THE EXISTENCE OF THE ASSOCIATION FOR THE PURPOSE OF SALES, SOLICITATION, OR INDUCEMENT TO PURCHASE ANY FORM OF INSURANCE.

When you are selecting an insurance company, you should not rely on coverage by the Association.

Texas Life, Accident, Health and Hospital Service
Insurance Guaranty Association 301 Congress,
Suite 500
Austin, Texas 78701
800-982-6362

Texas Department of Insurance
P.O. Box 149104
Austin, Texas 78714-9104

TRUSTMARK INSURANCE COMPANY (MUTUAL)

400 Field Drive
Lake Forest, Illinois 60045
(Herein We, Us and Our)

MAJOR MEDICAL EXPENSE COVERAGE

This is Your Certificate of Insurance (Certificate) while You are Insured. It explains the rights and benefits that are determined by the Master Policy (Policy). The Policy is a contract between the Policyholder and Us.

The Policy alone constitutes the agreement under which payments are made. We will pay the benefits set forth in this Certificate. Benefit payment is governed by all the terms, conditions and limitations of the Policy. The Policy may be amended at any time without Your consent or notice to You. Any such amendment will not affect a claim starting before the amendment takes effect.

A copy of the Policy is kept at Our home office. You may inspect it during regular business hours.

This Certificate was issued on the basis that the information on Your application is correct and complete. **If any information on the application is not correct or complete, write to Us within ten (10) days of receipt of this Certificate. An error or omission may result in loss of coverage as of its effective date.**

Right to Examine: If You are not satisfied with this Certificate, return it to Our home office or to Your agent within ten (10) days after the date You received it. The Certificate will then be canceled and any Premium paid will be refunded.

ITCTXCV40000

Please Read this Certificate Carefully



J. Grover Thomas Jr.
President & Chief Executive Officer



Frank G. Gramm
Corporate Secretary & General Counsel

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DEFINITIONS

Approved Transplant Services: Services and supplies which are related to a transplant procedure, approved in writing by Us, and include but are not limited to:

- Pre-transplant evaluation for the Medical Necessity of the transplant;
- Hospital charges;
- Physician charges; and
- Tissue typing and ancillary services.

Complications of Pregnancy: A condition which: (a) is not part of a normal pregnancy; and (b) whose diagnosis is distinct from pregnancy but is adversely affected by or caused by pregnancy.

Complications of Pregnancy include: (1) nonelective caesarean section or ectopic pregnancy which is terminated; (2) spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible; (3) acute nephritis; (4) nephrosis; (5) cardiac decompensation; (6) missed abortion; (7) hyperemesis gravidarum; (8) eclampsia; (9) puerperal infection; (10) RH factor problems; (11) severe loss of blood requiring transfusions; and (12) similar medical and surgical conditions of comparable severity.

Complications of Pregnancy does not include: (1) false labor; (2) occasional spotting; (3) Physician prescribed rest during pregnancy; (4) morning sickness; (5) preeclampsia; and (6) similar conditions associated with the management of a difficult pregnancy but which are not a separate Complication of Pregnancy.

Covered Person: A person listed on the Schedule as insured under this Certificate.

Deductible: The amount of Covered Charges a Covered Person must pay before We pay any benefits. This amount does not apply toward the satisfaction of the Out-of-Pocket Limit.

Dependent: A person who is:

- (1) Your legally married spouse.
- (2) Your unmarried natural or legally adopted children or Grandchildren who are under the age of 19.
- (3) Your step children who reside with You and are under the age of 19.
- (4) Your unmarried natural, stepchildren, Grandchildren or legally adopted children age 19 to age 24, but only if they are full-time students at an accredited educational institution.

A child age 19 to age 24 ceases to be a Dependent on the last day of the month in which the child fails to qualify as a full-time student, except for regularly scheduled vacation periods.
- (5) Your unmarried child for whom a court has issued a medical support order which decrees that You must provide medical coverage.
- (6) A child who is in Your custody pursuant to a temporary court order that grants You conservatorship of the child.

Designated Facility: A facility which has an agreement with Us to render Approved Transplant Services. The facility may be outside a Covered Person's geographic area.

Emergency: An Injury or sudden onset of a medical condition, which manifests itself by acute symptoms, including severe pain, which is sufficiently severe that without immediate medical care the person could reasonably expect: (a) his life or health would be in serious jeopardy; (b) his bodily functions would be seriously impaired; or (c) a body organ or part would be seriously damaged. This would include childbirth.

Experimental/Investigational: A drug, device or medical treatment or procedure is considered experimental or investigational if:

- It has not been given approval for marketing by the United States Food and Drug Administration at the time it is furnished and such approval is required by law;
- Reliable evidence shows it is the subject of ongoing Phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment of diagnosis; or
- Reliable evidence shows that the consensus of opinion among experts is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence means only: published reports and articles in authoritative medical and scientific literature; written protocol or protocols by the treating facility or other facility studying substantially the same drug, device or medical treatment or procedure; or the written informed consent used by the treating facility or other facility studying substantially the same drug, device or medical treatment or procedure.

Family Member: You, Your spouse, or the parent, child, brother or sister of You or Your spouse.

Free Standing Surgical Center: A facility licensed as a free standing or ambulatory surgical center; which is operated solely for the purpose of providing outpatient surgical care.

Grandchild/Grandchildren: A child of your child, who is a dependent of Yours for federal income tax purposes.

Heritable Disease: An inherited disease that may result in mental or physical retardation or death.

Home Health Care: Treatment, services or supplies furnished in a Covered Person's home by a licensed or certified home health agency pursuant to a written plan prescribed by a Physician as Medically Necessary.

Hospice Care: A program of palliative and supportive care provided by a licensed or certified hospice. Hospice Care is available to a Covered Person and his immediate family upon a Physician's diagnosis of terminal illness.

Hospital: An institution licensed, accredited or certified by the State which: (a) provides 24-hour nursing service by registered nurses (RN); (b) mainly provides diagnostic and therapeutic care under the supervision of Physicians on an inpatient basis; and (c) maintains permanent surgical facilities.

A place, special ward, floor or other accommodation used for: custodial or educational care; rest; the aged; a nursing home; or an institution mainly rendering extended care or intermediate care will not be considered a Hospital.

Injury: Accidental bodily injury independent of disease, bodily infirmity or other cause.

Manipulative Treatment: The diagnosis, analysis and adjustment of spinal subluxation; and manipulative therapy and related treatment of the musculoskeletal structure for other than fractures and dislocation of the extremities.

Medically Necessary/Medical Necessity: A service, supply or drug that is necessary and appropriate for the diagnosis or treatment of a Sickness or Injury in accordance with generally accepted standards of medical practice in the United States at the time it is provided. When specifically applied to a confinement, it means that the diagnosis or treatment of symptoms or a condition cannot be safely provided on an outpatient basis.

A service, supply or drug shall not be considered as Medically Necessary if it:

- Is Experimental, Investigational or furnished in connection with medical research;
- Is provided solely for the convenience of the patient, the patient's family, Physician, Hospital or any other provider;
- Exceeds in scope, duration, or intensity that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment;
- Could have been omitted without adversely affecting the person's condition or the quality of medical care;
- Involves the use of a medical device, drug or substance not formally approved by the United States Food and Drug Administration; or

- Involves a service, supply or drug not considered reasonable and necessary by the Health Care Financing Administration Medicare coverage issues manual.

We retain the right to determine whether a service, supply or drug is Medically Necessary.

Medicare: Title XVIII of the Social Security Act of 1995, as amended. A person is considered to be eligible for Medicare on and after the date the person is first eligible for any Medicare coverage.

Mental Illness: Any condition or disease, regardless of its cause, listed in the most recent edition of the Diagnostic and Statistical Manual of Disorders of the American Psychiatric Association as a mental illness.

Non-Designated Facility: A facility which is not a Designated Facility.

Other Medical Expense Coverage: Any hospital or medical expense incurred policy or certificate, hospital or medical service plan and health maintenance organization subscriber contract, whether insured or uninsured, and regardless of where issued; or medical payments made pursuant to any national, state, or other governmental law of any country.

Physician: A licensed medical doctor; surgeon; osteopath; podiatrist; dentist; optometrist; chiropractor, or any practitioner of the healing arts acting within the scope of such license, who is not a Family Member.

Pre-existing Condition: During the 12 months prior to the Effective Date: a Sickness or Injury for which medical care, treatment, diagnosis or advice was received or recommended.

A Sickness or Injury fully disclosed on the application will not be considered a Pre-Existing Condition.

Series of Treatments: A planned, structured and organized program to promote chemical free status which may include different facilities or modalities. A Series of Treatments is complete when the Covered Person is discharged on medical advice from inpatient detoxification, inpatient rehabilitation/treatment, partial hospitalization or intensive outpatient or a series of these levels of treatments without a lapse in treatment or when the Covered Person fails to materially comply with the treatment program for a period of 30 days.

Sickness: Illness; disease; Complication of Pregnancy; and congenital defect, birth abnormality or prematurity of a covered newborn child.

Skilled Nursing Home: A licensed facility which: (a) operates within the scope of its license; (b) provides room and board accommodations at the patient's expense; (c) keeps a daily medical record of each patient; (d) routinely provides skilled nursing care under the direction of a Physician; and (e) provides skilled nursing care by, or under the supervision of, a registered nurse.

Skilled Nursing Home does not include: a rest home; a home for the aged; a place mainly for treating drug addiction, alcoholism or Mental Illness; or custodial or educational care facility.

Total Disability/Total Disabled: The confinement in a hospital due to Sickness or Injury or when you are unable to perform the substantial and material duties of any occupation for which you are or become qualified by reason of education, training, or experience and are not in fact engaged in employment for wage or profit. A Dependent is disabled when he is unable to perform substantially all of the normal activities of a person of like age and gender in good health.

Toxic Inhalant: A volatile chemical under Chapter 484, Health and Safety Code or abusable glue or aerosol paint under section 485.001, Health and Safety Code.

Usual and Customary Charge: The lesser of: (a) the actual charge; (b) the fee most often charged by the provider for the same service or supply; or (c) the fee most often charged in the same area by providers with similar training and experience for a comparable service or supply. "Area" means a metropolitan area, a county or a greater area if needed to find a cross-section of providers of a comparable service or supply.

Year: The calendar period beginning each January 1 and ending the following December 31. The first Year shall begin on the Effective Date.

You or Your: The Insured named on the Schedule.

All male terms will include the female terms, unless stated otherwise.

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CONDITIONS OF INSURANCE

ELIGIBILITY

- **INSURED** - You are eligible for coverage when You complete a valid application, provide evidence of insurability and pay the Initial Premium.
- **DEPENDENT** - A Dependent is eligible for coverage on the later of:
 - The date You become eligible for insurance; or
 - The date You acquire the Dependent.

A Dependent is deemed to be acquired as follows:

- **Spouse:** On the date of the marriage.
- **Natural Child:** On the date of birth.
- **Adopted Child:** On the date the child is placed in Your custody or the date You are a party in a suit in which You seek adoption of the child, if earlier.
- **Step Child:** On the date the Insured marries the step child's natural parent.
- **Custody due to court order:** On the date of the court order.
- **Grandchild:** On the date the child is Your dependent for federal income tax purposes.

If an eligible person does not meet Our underwriting standards, We may:

- Refuse to insure that person;
- Insure that person but exclude a specific disease or physical condition from coverage; or
- Make a surcharge for that person's coverage.

EFFECTIVE DATE

- **INSURED** - Coverage will start at 12:00 a.m. standard time at Your residence, on the Effective Date shown on the Schedule.
- **DEPENDENT**
- **Newborn:** Coverage for a newborn is effective from the moment of birth. For coverage to continue:
 1. We must receive written notice of the newborn within 45 days of the birth or before the end of the period for which Premium has been paid if later, and
 2. You must pay any additional Premium within 31 days of receiving a notice of the amount due.If notification of a newborn is received late, insurance will be effective only if an application for coverage is accepted by Us and Premium is paid.
- **Other Than A Newborn:** You must complete and sign an application which includes Your Dependents. If accepted by Us, an Effective Date will be assigned as follows:
 - The date Your insurance is effective for Dependents eligible on that date and for whom coverage is applied for;
 - For Dependents eligible on or first acquired after Your Effective Date; coverage will be effective on the date We assign.

- For Dependents who the Insured is required to provide coverage by court or administrative order, coverage will be effective on the date of application. If the Insured fails to apply for coverage, the custodial parent or child support agency with a duty to collect or enforce support for the child may apply for coverage on behalf of the child and will be supplied with all information or documents, necessary to file claims or continue coverage on behalf of the Dependent, without the approval of the Insured.

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TERMINATION DATE

- **INSURED**

Coverage will terminate at 12:00 a.m. standard time at Your home on the earliest of:

- The date coverage is terminated by Us for all certificate holders in Your state.
- The date the Policy terminates.
- The date We receive Your written request to have Your insurance terminated.
- The end of the period for which Premium is paid, subject to the Grace Period.
- The date of Your death.
- The date You become eligible for Medicare.

At least 30 days prior written notice will be given to You if We terminate Your coverage for any reason, except for nonpayment of premium.

- **DEPENDENT**

Dependent coverage will terminate at 12:00 a.m. standard time at Your home at the earliest of:

- The premium due date following the date a Dependent ceases to be a Dependent as defined.
- The end of the period for which Premium for Dependent coverage is paid.
- The date Your coverage terminates, subject to any Continuation Of Coverage.
- The date We receive Your written request to terminate Dependent coverage, unless a court or administrative order is still in effect or the Dependent is not enrolled in comparable health insurance coverage. Proof that the court order is not in effect or existence of comparable coverage must be provided.
- The date the Dependent becomes eligible for Medicare.

CONTINUATION FOR INCAPACITATED CHILDREN

Dependent children, insured herein, that reach the limiting age and are incapable of self-sustaining employment due to mental or physical handicap may continue to be covered regardless of age. The Dependent must be chiefly dependent on You for support and maintenance.

You must claim handicap status within 31 days of such child attaining the limiting age. We will require proof of handicap as often as necessary, but not more than once a year.

Coverage for a handicapped child will end on the earliest of:

- The date the Dependent marries;
- The date the Dependent obtains self-sustaining employment;
- The date the Dependent ceases to be handicapped;
- The date the Dependent ceases to be chiefly dependent upon You for support and maintenance;
- Sixty (60) days after a written request for proof of disability, if proof is not provided within such 60 days;
- The date You refuse to allow Us to examine the Dependent; or
- The date coverage would otherwise terminate.

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CONTINUATION/CONVERSION

A Dependent whose coverage terminates shall have the right to conversion or continuation under the Certificate as outlined below. In order to be eligible for this option, the Dependent, must have been continuously covered under the Certificate for at least three consecutive months prior to termination.

There is no right of conversion or continuation if:

- Coverage terminated for all certificate holders in Your state.
- The termination of coverage occurred because You failed to pay any required premium or this coverage was replaced by similar group coverage within 31 days of the termination;
- The Dependent is or could be covered by Medicare;
- The Dependent has similar benefits under another group or individual plan whether insured or uninsured;
- The Dependent is eligible for similar benefits under another group plan whether insured or uninsured; or
- Similar benefits are provided for or available to the Dependent under any state or federal law.

Written application and payment of the first premium must be made within 31 days after the date coverage terminates.

No evidence of Insurability is required. Each Dependent may select one of the following options:

Option 1: A conversion policy providing similar coverage and benefits as provided under this certificate. If this option is selected, lifetime maximums shall be computed from the initial effective date of this certificate; or

Option 2: A conversion policy with lesser coverage and benefits. If this option is selected, the benefits and premium will be provided in accordance with the minimum standards for conversion policies.

A conversion policy will be effective on the day after termination of coverage. A Dependent will be given credit for any satisfaction of waiting periods or limitations for any Preexisting Condition.

Option 3: Continuation of coverage under the group plan. If this option is selected, continuation will be permitted for a maximum of six months. The premium rate will be 102% of the group premium. The premium will be payable in advance to Us on a monthly basis. Continuation may not terminate until the earliest of:

- Six months after the date the continuation election is made;
- The date the Dependent fails to make timely premium payments;
- The date on which the Dependent is or could be covered by Medicare;
- The date on which the Dependent is covered for similar benefits under another group or individual policy;
- The date on which the Dependent is eligible for similar benefits under another group plan;

Additional Continuation/Conversion for Certain Dependents

If coverage terminates as the result of death or divorce, a Dependent's coverage can continue. The Dependent must have been covered under this certificate for at least one year, unless the Dependent is a child under one year of age. Continuation does not require evidence of insurability. Continuation is not available if:

- The policy terminates; or
- The Dependent fails to make any timely premium payments.

Continuation ends at the earliest of:

- Three years after the date the continuation election is made;
- The date the Covered Person fails to make timely premium payments;
- The date on which the Covered Person is eligible for similar benefits under another group plan;
- The Policy is canceled.

The Dependent must notify Us within 15 days of death or divorce. We will provide written notice of the right to continue coverage within 5 working days and will send the election form and instruction for premium payment. Within 60 days of death or divorce, the Dependent must give written notice to Us of the desire to exercise the right to continuation or the option expires. Coverage remains in effect for 60 days, provided premium is paid.

Any Dependent qualifying for continuation of coverage under this provision may elect a converted policy instead of such continuation. If a Dependent has elected continuation under this provision, the Dependent will have the option of a conversion policy at the end of continuation. All conversion provisions described in Option 1 & 2 will apply.

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EXTENSION OF BENEFITS

If a Covered Person is Totally Disabled on the date the Policy terminates or coverage is terminated for all Certificate holders in Your state, We will extend that Covered Person's benefits.

Extension applies only during the period of Total Disability. Benefits will be paid as if coverage had remained in effect.

Extension of Benefits will end at the earliest of:

- The date Total Disability ends;
- Three (3) months from the date coverage otherwise ended; or
- The date You become eligible for Other Medical Expense Coverage.

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BENEFIT PROVISIONS

Benefits are only payable for incurred Covered Charges which are Medically Necessary and provided by or under the direction of a Physician. After the Deductible, We will pay the Insured Percent for Covered Charges, Transplant Benefits, Preventive Benefits, and Routine Physical Examinations subject to:

1. The Usual and Customary Charge as established by Us;
2. Definitions, limitations, exclusions, benefit maximums and other provisions of the Certificate; and
3. The Cost Containment Procedures.

A Covered Charge is considered incurred on the date the service is rendered or the supply is furnished.

DEDUCTIBLE

The Deductible applies separately to each Covered Person each Year. A separate Deductible must be met for a covered newborn child. The Individual Deductible is shown on the Schedule.

FAMILY MAXIMUM: All Covered Persons under this Certificate need only satisfy a set number of Deductibles each Year. Once that happens, any remaining Deductible amounts are considered satisfied for that Year. The Family Maximum Deductible is shown on the Schedule.

COMMON ACCIDENT: If two or more Covered Persons are injured in the same accident, only one Deductible will be applied to the Covered Charges for that accident in the Year the accident occurs.

INSURED PERCENT AND OUT-OF-POCKET MAXIMUMS

The Insured Percent is the portion of Covered Charges that We will pay after the Deductible has been met. The Insured Percent may vary for certain Covered Charges. The Insured Percents are shown on the Schedule.

The Individual Out-of-Pocket Maximum is the amount of Covered Charges that You must pay each Year for each Covered Person. Once the Individual Out-of-Pocket Maximum has been paid, Covered Charges are payable at 100 percent for that Covered Person for the remainder of the Year. The Individual Out-of-Pocket Maximum is shown on the Schedule.

The Family Out-of-Pocket Maximum is the total amount of Covered Charges that You must pay each Year for all Covered Persons. Once the Family Out-of-Pocket Maximum has been paid, Covered Charges are payable at 100 percent for all Covered Persons for the remainder of the Year. The Family Out-of-Pocket Maximum is shown on the Schedule.

Out-of-Pocket amounts paid for the following will not apply toward the Out-of-Pocket Maximum:

1. Any applicable Deductible(s);
2. Covered Charges incurred for the treatment of Mental Illness;
3. The portion of a Covered Charge in excess of the Usual and Customary Charge;
4. Any expense which is not a Covered Charge;
5. Any benefit reduction or penalty for failure to use the Cost Containment Procedures;
6. Any benefit reduction or penalty for failure to obtain prior authorization for Approved Transplant Services; or
7. Any benefit reduction or penalty for use of a Non-Designated Transplant Facility.

MAXIMUM BENEFIT AMOUNTS

LIFETIME MAXIMUM: The Lifetime Maximum is the maximum amount of benefits We will pay on behalf of any Covered Person over the lifetime of that person for all Covered Charges. This includes any amounts paid under any conversion policy issued as a result of this Certificate. At no time, will total benefits available exceed the Lifetime Maximum shown on the Schedule.

SEPARATE COVERED CHARGE MAXIMUMS: Covered Charges for treatment of a certain Sickness or Injury are subject to Separate Benefit Maximums. These maximums are shown on the Schedule. Benefits paid pursuant to a Separate Benefit Maximum are included in the Lifetime Maximum.

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COVERED CHARGES

- Inpatient Hospital charges for:
 1. Room, board and general nursing care for each day of confinement, up to the most common semi-private (two bed) room rate at the Hospital where confined. If a Hospital has only private rooms, benefits will not exceed the most common semi-private room rate in the area.
 2. Confinement in an intensive care or coronary care unit.
 3. Other Medically Necessary services and supplies furnished by a Hospital for inpatient medical care.
- Physician charges for:
 1. Home, office and inpatient visits.
 2. Surgery.
 3. Dental treatment or surgery for Injury, except chewing injuries, to sound natural permanent teeth, within 6 months of the accident.
 4. Radiologist or pathologist services for interpretation of x-rays and laboratory tests necessary for diagnosis and treatment.
- Outpatient medical care charges furnished at:
 1. A Free Standing Surgical Center; or
 2. The outpatient department of a Hospital.
- Charges for:
 1. Anesthetics and its administration;
 2. Professional local ambulance service to or from the nearest Hospital with available facilities to treat the Covered Person.
 3. X-rays, except dental x-rays, and laboratory tests for diagnosis or treatment.
 4. X-ray and radioactive isotope therapy.
 5. Dental x-rays necessary for the removal of a cyst or tumor.

- Manipulative Treatment, heat treatments and ultrasound, subject to the Separate Benefit Maximum shown in the Schedule.
- Supply and Equipment charges for:
 1. Blood and blood plasma.
 2. Oxygen and rental equipment for its administration.
 3. Original purchase of standard artificial limbs or eyes. Subsequent purchase only as needed due to: (a) growth of a child; or (b) progression of a Sickness or Injury.
 4. Original purchase of casts, splints, non-dental braces or crutches and surgical dressings.
 5. Rental of a wheelchair or hospital style bed or other durable medical equipment with the minimum features necessary for the circumstances. We may, at Our option, purchase such equipment. If purchased, the Covered Charge is limited to the purchase price and the cost of installation reduced by any amount paid for rental.
 6. Heart pacemaker.
 7. Intraocular lens implant or the first contact lenses or glasses following cataract surgery.
- Physical or speech therapy provided by a licensed therapist acting within the scope of that license who is not a Family Member.
- Private duty nursing care by a registered nurse (RN) or licensed practical nurse (LPN) who is not a Family Member, subject to the Separate Benefit Maximum shown on the Schedule.
- Inpatient and outpatient prescription drugs, insulin and supplies for insulin administration.
- Inpatient and outpatient treatment of chemical abuse or dependency, subject to the Separate Benefit Maximum shown on the Schedule.
- Inpatient and outpatient treatment of Mental Illness, subject to the Separate Benefit Maximum shown on the Schedule.
- Reconstructive surgery:
 1. Related to or following surgery for Injury, trauma, infection or other disease; or
 2. For the correction of birth abnormalities or congenital defects of a newborn child.
- Diagnostic and surgical treatment of the temporomandibular joint.
- Home Health Care within 14 days following confinement in a Hospital or Skilled Nursing Facility for which benefits are payable. The attending Physician must certify prior to the first visit, that:
 1. Confinement would otherwise be required; and
 2. A Family Member cannot provide the necessary care without undue hardship.
- Home Health Care benefits are subject to the Separate Benefit Maximum shown on the Schedule, and are limited to:
 1. Physician home visits.
 2. Nursing care by or under the supervision of a registered nurse (RN).
 3. Home health aide services of a medical or therapeutic nature.
 4. Physical or speech therapy.
 5. Nutrition counseling by a registered dietitian.
 6. Medical services, prescription drugs and supplies which would be covered if Confined.

Up to 4 hours of treatment or services in any 24-hour period will be considered as one Home Health Care visit. This includes time spent evaluating the need for or developing the home care plan.

No Home Health Care benefits are payable for: medical care not included in the written home care plan; services provided by a Family Member; homemaker services; services to aid in the normal activities of daily living; or services not listed above as a benefit.

Skilled Nursing Home charges for room, board and skilled nursing care, subject to the Separate Benefit Maximum shown on the Schedule, when such confinement:

1. Begins within 14 days following a Hospital confinement; and
2. Continues treatment of the Sickness or Injury which caused the Hospital confinement.

Inpatient and outpatient Hospice Care prescribed by a Physician, subject to the Separate Benefit Maximum shown on the Schedule. Hospice Care charges will not be considered under any other Covered Charge benefit.

ITCTXCM10000

TRANSPLANT BENEFITS

Benefits are payable only for Approved Transplant Services.

Transplant Benefits are subject to Pre-Treatment Certification.

No Transplant Benefits will be paid without prior authorization. You should contact Us when a transplant has been decided, but before the donor selection process begins, to establish available benefits.

Prior authorization means You must:

1. **Notify Us of the procedure to be performed;**
2. **Have the Physician submit a complete medical history, including current diagnosis, transplant protocol and informed consent; and**
3. **Have the Physician certify that the procedure is Medically Necessary and that alternative procedures, services or courses of treatment would not be effective.**

Expenses must be incurred during the transplant benefit period. The transplant benefit period begins 5 days before the date the transplant is performed and ends 12 months thereafter. During the transplant benefit period, if a second admission is required, and a retransplant occurs, a new transplant benefit period starts 5 days before the date the retransplant is performed and ends 12 months thereafter.

TRANSPLANTS

Transplants are limited to the following, subject to all Benefit Maximums shown on the Schedule:

A) Organ transplants

Benefits are payable only for human to human organ Transplants.

1. Cornea;
2. Heart;
3. Liver;
4. Kidney; and
5. Lung;

B) High Dose Chemotherapy (HDC);

C) Stem Cell Infusion (SCI);

D) Autologous Bone Marrow Transplant (ABMT(1)); and

E) Allogenic Bone Marrow Transplant (ABMT(2)).

Donor Expenses

Unless covered by Other Medical Expense Coverage, Approved Transplant Services are payable for an organ donor. Benefits payable for the donor will be charged to the recipient's claim and subject to the Lifetime Maximum shown on the Schedule.

Designated Facilities for Approved Transplant Services

A person who is authorized for a transplant procedure will be referred to a Designated Transplant Facility. If the person is denied the procedure by the Designated Transplant Facility, he will be referred to a second such facility for evaluation. If the person is denied the procedure at the second Designated Transplant Facility, no benefits will be paid for any services or supplies related to that procedure. This applies regardless of whether the procedure is performed at a third Designated Transplant Facility or at a Non- Designated Transplant Facility.

In addition to Approved Transplant Services, benefits will be paid, up to \$10,000 per procedure, subject to the Lifetime Maximum shown on the Schedule, for:

1. Reasonable and necessary travel, by the covered person and family member(s) accompanying him, to a Designated Transplant Facility over 50 miles away from the Covered Person's residence;
2. Reasonable and necessary lodging and meal expenses for family member(s) accompanying the covered person to the Designated Transplant Facility; and
3. Air ambulance or other emergency transportation to, but not from, a Designated Transplant Facility, when necessary and approved.

ITCXXCM10500

PREVENTIVE BENEFITS

1. For female Covered Persons, screening by low dose mammography for the presence of occult breast cancer at the following intervals:
 - One baseline mammogram between ages 35 and 39;
 - One mammogram every 2 years between ages 40 and 49, or more frequently if recommended by a Physician; and
 - An annual mammogram at age 50 and older.
2. One Papanicolaou (PAP) smear test per Year and associated office visit.

ROUTINE PHYSICAL EXAMINATION

For each Covered Person, one annual routine physical examination subject to the Separate Benefit Maximum shown on the Schedule.

ITCXXCM11000

COST CONTAINMENT PROCEDURES

REQUIRED OUTPATIENT SURGERY

Certain surgical procedures must be performed on an outpatient basis. If such surgery is performed on an inpatient basis, benefits will be reduced. This reduction is shown on the Schedule.

Benefit reduction will be waived if:

- Your Physician provides evidence, satisfactory to Us, that confinement is Medically Necessary; or
- Appropriate outpatient facilities, as determined by Us, are not available within 50 miles of the Covered Person's residence.

Surgical procedures which must be performed on an outpatient basis are:

- Adenoidectomy

- Arthroscopy and cartilage removal
- Breast biopsy
- Carpal tunnel
- Cataract removal
- Cystometrogram
- Dilatation and Curettage (D&C)
- Endoscopic procedures, including but not limited to:
 - Colonoscopy
 - Cystoscopy
 - E.R.C.P.
 - Esophagoscopy
 - Gastroscopy
 - Laparoscopy
- Examination under anesthesia
- Excisions:
 - Exostosis excision
 - Ganglion excision
 - Hammertoe excision
 - Neuroma or Morton's neuroma excision
- Eye muscle surgery
- Hemorrhoidectomy
- Hernia:
 - Inguinal hernia
 - Umbilical hernia repair
- Hydrocelectomy
- Palmer fasciectomy
- Pilonidal sinus
- Simple fistulectomy
- Tonsillectomy
- Tympanostomy with insertion of ventilatory tube

Other surgical procedures may be required to be performed on an outpatient basis. You will be notified of such additional requirement as part of the Pre-Treatment Certification process.

PRE-TREATMENT CERTIFICATION

Pre-treatment Certification (Certification) requires You, Your representative or Your Physician to notify our review agency of all Hospital admissions, including inpatient surgery.

Certification is a review process to determine the Medical Necessity of a Hospital admission or proposed surgery. A determination as to the necessary length of a Hospital stay is also made. You or Your Physician may, at any time prior to discharge, request a reevaluation or extension of the number of Hospital days certified.

If Certification is not completed, benefits will be reduced. The reduction is shown on the Schedule.

Certification will be valid for 60 days for the requesting Physician and the named Hospital. A change in Physician or Hospital will require a new Certification.

How to Certify: To certify a Hospital admission or surgery, call the telephone number on Your identification card. Be prepared to give the following information:

- Insured's name, social security number and Certificate Number.
- Patient's name and date of birth.
- Hospital name and address.
- Physician's name and telephone number.
- The diagnosis (what is wrong).
- The treatment (what will be done and when).

It is Your responsibility to ensure that proper Certification is made. We recommend that You follow-up with the attending Physician to ensure that all medical information is provided.

If We do not agree with the Medical Necessity of any treatment, we will pay 100% of the Usual and Customary charge for a second opinion, subject to the annual deductible. If the second opinion does not confirm the Medical Necessity of the treatment, no benefits will be payable for any expense related to the Hospital confinement, including surgical expenses.

When to Call: For routine elective admission or surgery, You must call at least 2 business days before You are admitted to the Hospital.

Emergency admission: An Emergency admission must be called in within 48 hours of the admission or the next business day if a weekend or holiday is involved.

Transplants: a transplant procedure must be called in before the transplant benefit period begins.

If it is not reasonably possible to make the Certification call within the times provided, payment will not be reduced if the call is made as soon as is reasonably possible.

Certification does not guarantee that proposed Hospital admissions or surgeries are covered under the Certificate. Please read the coverage provisions carefully.

ITCXXCO40000

EXCLUSIONS AND LIMITATIONS

Benefits will not be paid for any expenses arising from or in connection with:

- Treatment, services or supplies which are not listed as Covered Charges.
- Treatment, services or supplies which are incurred when coverage is not in effect.
- Charges in excess of the Usual and Customary Charge.
- Treatment, services or supplies which:
 - Are not Medically Necessary or recognized by Us as effective;
 - Are not prescribed by a Physician as necessary to treat a Sickness or Injury;
 - We determine to be Experimental or Investigational in nature;
 - Are received without charge or legal obligation to pay;
 - Would not routinely be paid in the absence of insurance;
 - Are received outside of the 50 United States and the District of Columbia, except as specifically stated; or
 - Are received while incarcerated by legal authorities of any state or country for any reason.
- Routine physical examinations; x-ray; laboratory tests; and immunizations not related to diagnosis or treatment of a Sickness or Injury, except as specifically stated.
- Dental treatment or surgery, except as specifically stated.
- Temporomandibular joint dysfunction syndrome (TMJ); except for diagnosis of TMJ and surgery to the temporomandibular joint.
- Cosmetic surgery or procedures and related care or complications arising therefrom; except for specifically stated reconstructive surgery.
- Routine eye or hearing examinations; radial keratotomy or other surgery to correct errors of refraction; eyeglasses or contact lenses, except as specifically stated; any type of external appliances used to improve visual acuity and their fittings; and vision therapy.
- Routine hearing examinations, hearing aids or fitting thereof.

- Treatment, services or supplies for which the Covered Person receives, or is eligible to receive, Workers' Compensation, Occupational Disease Act or similar benefits.
- Normal pregnancy or childbirth.
- Nursery or well baby care or circumcision for a Dependent child following birth.
- Artificial insemination; in vitro fertilization and fertility testing or treatment.
- Sterilization procedures or procedures to reverse sterilization.
- Treatment, services or supplies to change gender and related care or complications arising therefrom.
- Custodial care or rest.
- Injury sustained while traveling in any type of aircraft, except as a fare-paying passenger in a scheduled or chartered flight operated by a commercial airline.
- Military or naval service of any country.
- War or act of war, declared or undeclared.
- Suicide, attempted suicide, or intentionally self-inflicted Injury, while sane.
- A Covered Person engaging in civil disturbance or an illegal occupation.
- A Covered Person's commission of, or attempt to commit, a felony or act which would be considered a felony if prosecuted.
- Covered Person's use of intoxicating or hallucinogenic drugs or medicine, unless taken on the advice of, and in accordance with the direction of, a Physician.
- Over-the-counter drugs or medicine, even if prescribed by a Physician.

ITCTXEX20000

PRE-EXISTING CONDITION LIMITATION

Expenses that result from care or treatment of a Pre-existing Condition will not be considered as Covered Charges for the 12 months following the Covered Person's Effective Date of coverage.

ITCXXEX20500

TRAVEL OUTSIDE OF THE UNITED STATES

No benefits are payable for any medical care, treatment, services or supplies received outside of the United States, except for Emergency treatment. Benefits are limited to Injury or Sickness which first occurs during the initial 180 days of travel. No benefits are payable for any Injury or Sickness that occurs during travel for the 180 day period following the Effective Date of coverage for a Covered Person.

Hospital confinement for Emergency treatment is limited to 30 days per trip for each Covered Person.

Pre-Treatment Certification of Hospital admission is not required when so confined outside of the United States.

The term "United States" means the 50 states and the District of Columbia. It does not include territories or possessions such as Puerto Rico or Guam.

ITCXXEX21000

PREMIUM PROVISIONS

PAYMENT OF PREMIUM

All premium, charges or fees (hereinafter "Premium") must be paid to Us at Our home office. All Premium is payable in advance.

We reserve the right to change the method of Premium payment selected with proper notice to You.

DUE DATE

The first Premium is due on the Effective Date of coverage. Subsequent Premium is due on the premium payment date shown on the Schedule. Failure to pay Premium when due shall result in termination of coverage on such due date subject to the Grace Period.

RETURNED OR DISHONORED PAYMENT

If a payment for any Premium is dishonored for insufficient funds, a reasonable service charge may be debited to You. A dishonored payment shall be considered a failure to pay Premium. A rejected debit to Your bank account or credit card shall be considered a failure to pay Premium.

If Your selected method of payment is dishonored as described, You will need to submit Premium in a method acceptable to Us prior to the end of the grace period.

GRACE PERIOD

If written notice of termination has not been received from You, a Grace Period of 31 days will be allowed for each Premium payment after the first Premium. If any Premium is unpaid at the end of the Grace Period, coverage shall automatically terminate on the last day for which Premium has been paid.

REINSTATEMENT

If coverage ends for failure to pay Premium, You may request a reinstatement. Such request must be in writing and submitted within 90 days from the date coverage ended and is subject to Our approval. If approved by Us, reinstated coverage will become effective on the date We assign. Credit will be given for waiting periods satisfied prior to the date coverage ended.

PREMIUM ADJUSTMENT

Premium rates may be adjusted from time to time as determined necessary by Us. No rate adjustment will take effect until:

- The end of any rate guarantee period; and
- At least 31 days prior written notice is given to You.

The rate guarantee and notice period shall not apply to any rate adjustment due to:

- Your request for a change in benefits or coverage;
- A change in any Premium tax law;
- A change in Federal or State law or regulation which affects the benefits or provisions of the Certificate;
- A misstatement of age, sex, or residence of any Covered Person; or
- A change in the residence of any Covered Person.

When coverage ends for a Covered Person, any resulting change in Premium will be made on the next premium Due Date.

A pro rata adjustment of Premium will be made if coverage ends due to Medicare eligibility.

ITCXXPP40000

CLAIMS PAYMENT PROVISIONS

NOTICE OF CLAIM

We must receive written notice of claim within 30 days after a covered loss starts or as soon thereafter as reasonably possible. Notice should include Your name and Certificate Number. Notice may be provided by the custodial parent or child support agency with a duty to collect or enforce support for the child.

CLAIM FORMS

When We receive the notice of claim, We will send You forms for filing a Proof of Loss. If these forms are not sent to You or the custodial parent or child support agency with a duty to collect or enforce support for the child within 15 days, the Proof of Loss requirement may be met by giving Us a written statement of the nature and extent of the loss within the time limit stated in the Proof of Loss section.

PROOF OF LOSS

Written Proof of Loss must be completed and returned to Us within 90 days or as soon thereafter as reasonably possible. Except for absence of legal capacity, no claim for benefits will be accepted after one year from the date treatment was completed.

FORGIVENESS OF OUT-OF-POCKET MAXIMUMS AND/OR DEDUCTIBLE

If any provider intentionally does not collect (forgives) any Covered Charge amount, benefits payable will be recalculated as follows:

- The amount accepted by the provider as payment in full will be considered the actual fee (i.e. the reported charge less any forgiven amount).
- The adjusted charge will be reduced by the applicable Deductible.
- The corresponding Insured Percent will be applied to the result.

Any resulting overpayment will be billed to You without prejudicing any other right or remedy available to Us at law or in equity.

PAYMENT OF CLAIMS

Benefits will be paid to You, unless assigned to the provider. In the case of a Dependent child in the legal custody of a person other than You, payment may be made directly to the custodian or child support agency with a duty to collect or enforce support for the child, at Our discretion or as required by law. Any unpaid Premium that is due may be deducted from a claim. Payment will be made not more than 60 days after receipt of a valid written proof of loss. Payment of benefits will discharge Us from all liability to You and Your beneficiary.

Benefits will be paid to the Texas Department of Human Services for actual costs of medical expenses paid on behalf of a Covered Person by the Texas Department of Human Services. Benefits so paid will, in no event, exceed benefits otherwise payable to You.

Benefits will be paid to the Texas Department of Human Services on behalf of Your child if:

- You are a possessory conservator of the child under a court order issued by a court in the State of Texas or if you are not entitled to possession of or access to the child and You are required by court order or court approved agreement to pay child support;
- The Texas Department of Human Services is paying benefits on behalf of the child; and
- We are notified in writing through an attachment to the claim for benefits when the claim is first submitted to us that the benefits must be paid directly to the Texas Department of Human Services.

PAYMENT ERROR

Any benefit paid in error may be recovered from the person receiving the incorrect payment or from You. At Our option, We may offset the overpayment against future benefit payments. The acceptance of Premium or paying other benefits shall not constitute a waiver of Our rights under this section. Recovery or offset shall be in addition to any other remedies available to Us at law or in equity.

FRAUDULENT CLAIM SUBMISSION

If any Covered Person knowingly submits or participates in the submission of a claim for benefits which contains false or misleading information that would have the effect of increasing the benefit payable, We shall have the right to rescind that Covered Person's coverage to the date the fraud was perpetrated. Such rescission is without prejudice to any other right or remedy available to Us at law or in equity.

APPEAL OF DENIED CLAIMS

If a claim for benefits is wholly or partially denied, You will be sent a written notice of the decision. This notice will:

- Give the specific reason(s) for the denial;
- Make specific reference to the provisions on which the denial is based; and
- Provide an explanation of the review procedure.

On any denied claim, You or Your representative may appeal to Us for a full and fair review. You may:

- Request a review in writing within 60 days of receipt of a claim denial; and
- Submit issues and comments in writing.

We will make a decision no more than 60 days after receipt of the request, except in special circumstances, but in no case more than 120 days after the request for review is received. The written decision will include specific references to the provision(s) on which the decision is based.

PHYSICAL EXAMINATIONS

We have the right, at Our expense, to have a Covered Person examined as often as reasonably necessary while a claim on that Covered Person is pending.

ITCTXCP40000

GENERAL PROVISIONS

STATEMENTS IN THE APPLICATION

All statements made in Your application, in the absence of fraud, are considered to be representations and not warranties. No statement made by You shall be used to contest coverage or reduce benefits unless: (a) the statement is contained in an application; and (b) a copy of the statement is furnished to You.

After a Covered Person's coverage has been in effect for 2 years, during the lifetime of that person, only material misstatements in the application may be used to void coverage or deny any claim.

MISSTATEMENT OF AGE

If the age of a Covered Person is misstated such that coverage is provided for which the person is not otherwise eligible at the correct age, the misapplied coverage shall be rescinded and any applicable Premium refunded.

If the age of a Covered Person is misstated such that the person is eligible for coverage at the correct age, premium will be adjusted. Any additional Premium due must be paid within 31 days of receiving a notice of the amount due.

CLERICAL ERROR

If a clerical error is made so that an otherwise eligible person's coverage does not become effective, coverage may be in effect if: (a) the person makes a written request for coverage on a form We approve; and (b) any premium not paid because of the error is paid in full from the effective date of coverage. Company reserves the right to limit retroactive coverage to two months preceding the date the error was reported.

If a clerical error is made so that the coverage is in effect for a person who is not eligible, an adjustment will be made to correct the error. Any Premium refund will be reduced by any payment made for claims. If claims paid exceed the Premium refund, the Insured shall reimburse Company for the overpayment.

LEGAL ACTIONS

No legal action may be brought against Us within 60 days after written Proof of Loss has been sent to Us. No such action may be brought more than 3 years from the time written Proof of Loss is required to be given.

ITCTXGP40000

COORDINATION OF BENEFITS

DEFINITIONS

Allowable Expense: The necessary, reasonable and customary item of expense for health care when the expense is considered a covered charge, at least in part, by one or more of the Plans. When a Plan provides benefits by services, reasonable cash value of each service will be treated as both an Allowable Expense and a benefit paid.

Coordination of Benefits: Taking other Plans into account when We pay benefits.

Plan: Any plan, including this one, that provides benefits or services for medical expenses on a group basis. "Plan" includes group and blanket insurance and self-insured and prepaid plans. It includes government plans, plans required or provided by statute (except Medicaid), and no fault insurance (when allowed by law). "Plan" shall be treated separately for that part of a plan which reserves the right to coordinate with benefits or services of other plans and that part which does not.

Primary Plan: The Plan that, according to the rules for the Order of Benefit Determination, pays benefits before all other Plans.

Year: The Calendar Year, or any part of it, during which a person claiming benefits is covered under this Plan.

BENEFIT COORDINATION

Benefits will be adjusted so that the total payment under all Plans is no more than 100 percent of the Covered Person's Allowable Expense. In no event will total benefits paid exceed the total payable in the absence of coordination.

If a Covered Person's benefits paid under this Plan are reduced due to coordination, each benefit will be reduced proportionately. The amount of the reduction will be applied as a benefit credit to pay any portion of the Covered Person's Allowable Expense not covered by any Plan. This credit applies only to charges incurred during the same Year as the credit.

Only the amount of any benefit actually paid will be charged against any applicable benefit maximum.

THE ORDER OF BENEFIT DETERMINATION

1. When this is the Primary Plan, We will pay benefits as if there were no other Plans.
2. When a person is covered by a Plan without a coordination provision, the Plan without the provision will be the Primary Plan.
3. When a person is covered by more than one Plan with a coordination provision, the order of benefit payment is as follows:
 - **Non-dependent/Dependent.** A Plan which covers a person other than as a
 - Dependent will pay before a Plan which covers that person as a Dependent.

- **Dependent Child/Parents Not Separated or Divorced.** For a Dependent child, the Plan of the parent whose birthday occurs first in the Calendar Year will pay benefits first. If both parents have the same birthday, the Plan which has covered the Dependent child for the longer period will pay first.

If the other Plan uses gender to determine which Plan pays first, We will also use that basis.

- **Dependent Child/Separated or Divorced Parents.** If two or more Plans cover a person as a Dependent of separated or divorced parents, benefits for the child are determined in the following order:

A. The Plan of the parent who has responsibility for providing insurance as determined by a court order, and the Plan has actual knowledge of the court order;

B. The Plan of the parent with custody of the child;

C. The Plan of the spouse of the parent with custody; and

- The Plan of the parent without custody of the child.

- **Dependent Child/Joint Custody.** If the joint custody court decree does not specifically state which parent is responsible for the child's medical expenses, the rules as shown for Dependent Child/Parents Not Separated or Divorced shall apply.

- **Continuation/Non-continuation.** The Plan covering the person as an employee, member or subscriber will pay benefits first.

4. When an order of payment is not established by the above, the Plan which has covered the person for the longer period of time will pay first.

RIGHT TO EXCHANGE INFORMATION

We may release to, or obtain from, any other insurance company, organization or person information necessary for coordination. This will not require the consent of, or notice to You or any claimant. You are required to give Us information necessary for coordination.

RIGHT TO MAKE PAYMENTS TO ANOTHER PLAN

Coordination may result in payments made by another Plan which should have been made by Us. We have the right to pay such other Plan all amounts it paid which would otherwise have been paid by Us. Amounts so paid will be treated as benefits paid under this Plan. We will be discharged from liability to the extent of such payments.

RIGHT TO RECEIVE PAYMENTS

Coordination may result in overpayments by Us. We have the right to recover any excess amounts paid from any person, insurance company or other organization to whom, or for whom, payments were made.

ITCTXCB40000

LIMITED RIGHT OF REIMBURSEMENT

If a Covered Person incurs medical expenses for Covered Charges that occurred due to the negligence of a third party, We will not provide any benefits unless and until the Covered Person, or his legal representative, agrees in writing:

1. To reimburse Us from any and all damages collected whether by action at law, settlement or otherwise, all benefits paid for the same medical expenses; and
2. To assign to Us, the right to recover from that third party, or its insurer, to the extent of the benefits paid under this Plan.

ITCXXLR40000