LifeMap Assurance Company®
200 SW Market Street
P.O. Box 1271, M/S E8L
Portland, OR 97207-1271
(800) 756-4105

Short Term Medical Insurance
for Oregon Individuals and Families

This brochure is designed to give you a very brief description of the important features of the Policy. This is not the insurance contract and only the actual Policy provisions will govern. Please refer to the Policy for a detailed description of the rights and obligations of both you and LifeMap Assurance Company.

Short Term Medical Insurance

Short Term Medical Insurance is designed for people who have a temporary need for medical coverage and who are healthy. Short Term Medical Insurance gives you peace of mind by providing coverage for injuries and sudden-onset illnesses.

Short Term Medical Coverage is available from 30 to 90 Days

This Short Term Medical Policy is non-renewable.

Short Term Medical Insurance offers valuable medical protection on a short-term basis for people who are:

- Between jobs, laid off, or on strike.
- Waiting to be covered under a group medical plan.
- Waiting for issuance of an individual contract.
- Recent graduates.
- Starting a business.
- Taking time off from school.
- In need of temporary medical insurance.

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.

LifeMap Assurance Company
[200 SW Market Street
P.O. Box 1271, MS E-8L
Portland, OR 97207-1271
(800) 794-5390

FEDERAL DISCLOSURE AMENDMENT

to the

SHORT TERM MEDICAL INSURANCE
OUTLINE OF COVERAGE

It is agreed that the Outline of Coverage is amended effective ***January 1,2019***, or the effective date of the policy, whichever is later, as follows:

The not minimum essential coverage disclosure, on page one of the outline of coverage, is amended to read as follows:

This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your policy might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage.

ALL OTHER TERMS AND CONDITIONS REMAIN UNCHANGED.

LIFEMAP ASSURANCE COMPANY

Assistant Secretary, Lisa Murphy

President, Chris Blanton

SHORT TERM MEDICAL INSURANCE

OUTLINE OF COVERAGE

Read The Policy Carefully

This outline of coverage provides a very brief description of the important features of the Policy. Please note that this outline is not intended to be a part of the insurance contract. Only the actual Policy provisions are final and binding. The Policy itself sets forth in detail your rights and obligations as well as those of the insurance company. **PLEASE READ THE POLICY CAREFULLY**.

Major Medical Expense Coverage

Policies of this category are designed to provide, to persons insured, coverage for major hospital, medical and surgical expenses incurred as a result of a covered accident or illness. 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 the deductibles, copayment provisions and other limitations set forth in the Policy.

Eligibility

You are eligible for this Policy if you and any family members who apply for coverage:

- Are under age 65 and will remain under age 65 for the term of the policy. Dependent children must be unmarried and under age 26.
- Are not eligible for Medicare Benefits and will not be eligible for Medicare Benefits for the duration of the Policy.
- Are not pregnant. If any member of your family is pregnant, you may not apply for coverage until the pregnancy concludes.
- Are not covered under any other hospital or medical plan.

Temporary Coverage

Short Term Medical Insurance is designed to provide medical coverage on a temporary basis to fill a temporary need. It cannot be renewed and is not intended to replace permanent coverage. You may only apply for one new policy within a 12-month period.

Important Note: There is no continuous coverage between policies. Any condition which may have existed or occurred under one policy will be a pre-existing condition under the subsequent policy, and therefore, will not be covered under the subsequent policy.

Choice of Providers

This Policy does not contract with a network of providers. This means you may visit the physician or hospital of your choice. You are not limited to any provider networks or out-of-area service restrictions.

How the Policy Works

You choose the term of coverage - a minimum of 30 days up to the maximum policy term of 90 days.

You select the deductible amount - $500, $1000, $2500, $5000 or $7500 per member.

After the deductible is met, the policy pays the coinsurance amount you have selected - either 80% or 50% of the next $10,000 - and then 100% of the balance of covered expenses. We will not pay any amount of expenses which exceed usual and customary or reasonable charges as defined in the policy.

The policy maximum is $1,000,000 during the policy term per member.

Covered Expenses

Covered expenses are charges for services or supplies prescribed by a physician for treatment of an illness or injury covered by your policy. The charges must be incurred for medically necessary care while the policy is in effect. **A covered expense is incurred on the date a service is rendered or received and may not exceed the usual and customary or reasonable charge as defined by the policy.**

Subject to the exclusions, limitations and conditions described in the policy, the following services and supplies will be considered covered expenses:

- Hospital room, board, and general nursing care, limited to the hospital's average semi-private room charge, unless confined in a coronary or intensive care unit.
- Other hospital services including emergency room, outpatient and ambulatory surgical center charges.
- Skilled nursing facility room, board, and general nursing care, limited to the facility's average semi-private room charge, up to a maximum of 100 days (other limitations apply; see your policy for complete description of benefit).
- Physician services for diagnosis, treatment, and surgery.
- X-rays, radioactive treatment, and laboratory tests.
- Breast and pelvic exams, mammograms, and Pap smear exams (if such exams are related to an annual women's examination).
- Prostate cancer screening exams.
- Colorectal cancer screening exams.
- Anesthesia and oxygen and their administration.
- Private nursing care by R.N. or L.P.N. in the home (limitations apply).
- Licensed ambulance service, limited to two trips per illness or injury (other limitations apply; see your policy for complete description of benefit).
- Physical, occupational, speech and audiological therapy, up to 30 sessions (other limitations apply).
- Home health care (up to 40 visits) when prescribed by a physician and rendered by a licensed home health agency (see your policy for complete description of benefit).
- Rental (up to purchase price) of wheel chair, hospital type bed, or other durable medical equipment unique to medical care or treatment.
- Prosthetic and Orthotic Devices that are medically necessary to restore or maintain the ability to complete activities of daily living or essential job-related activities and that are not solely for comfort or convenience.
- Blood and blood products, administration of blood, and blood processing.
- Drugs which require the written prescription of a physician (pre-existing limitations and deductibles apply).
- Non-prescription elemental enteral formula for home use if the formula is medically necessary for the treatment of severe intestinal malabsorption (see your policy for complete description of benefit).
- Organ transplants, including heart, kidney, liver and bone marrow transplants, up to a maximum of $250,000 (other limitations apply; see your policy for complete description of benefit).
- Kidney disease.
- AIDS, including AIDS, AIDS Related Complex (ARC) or related immuno deficiency disorders.
- Casts, splints, crutches, orthopedic braces, colostomy bags, catheters, syringes, dressings, and initial contact lens following cataract surgery performed while covered under the policy.

Extension of Benefits While Hospitalized
If a member is confined to a hospital on the expiration date of this policy, that member's coverage under the policy will continue without payment of additional premium.

Coverage will continue:

1. until the date the member is discharged from the hospital; or
2. until the date on which the applicable benefit maximums are reached, whichever occurs first.

Limited Pregnancy Benefit
Covered expenses with respect to the pregnancy benefit are limited to services and supplies that are:

1. Provided in direct connection with the treatment of an involuntary complication of pregnancy. The term "involuntary complication of pregnancy" includes, but is not limited to:
   a. toxemia of pregnancy;
   b. ectopic pregnancy;
   c. nephritis or pyelitis of pregnancy;
   d. puerperal infection;
   e. surgery due to spontaneous termination of pregnancy (miscarriage or missed abortion); or
   f. non-elective cesarean section. All other charges made in connection with pregnancy or childbirth are excluded; and
2. Incurred while the member is insured under the policy.

Limited Alcoholism Benefit
The policy will consider services rendered by a facility or other provider licensed to treat alcoholism as covered expenses. Benefits for treatment of alcoholism are limited to a maximum of $4,500 during the policy term.

Exclusions

The policy does not cover:

- **Pre-existing conditions** (see the definition below in the section titled “Pre-Existing Conditions”).
- Illness or injury incurred in the course of any employment for wage or profit or for which benefits are available under Workers’ Compensation or similar law.
- Illness or injury covered by Medicare.
- Hospital confinement for medical observation or diagnostic exams.
- Eye refractions and eyeglasses.
- Well baby care.
- Immunizations.
- Hearing tests and hearing aids.
- Routine physical exams, tests or screening procedures (certain exceptions apply).
- Treatment of drug abuse or drug addiction. However, medical treatment of Injuries or Illnesses caused by a Member’s use of controlled substances will be considered a Covered Expense subject to any Exclusions or Limitations shown in this Policy.
- Organ transplant or complications resulting from or related to an organ transplant, except as specifically provided in your policy.
- Treatment of intentional self-inflicted injury.

Exclusions *(cont.)*

- Elective sterilization, family planning, birth control drugs or devices, artificial insemination, in vitro fertilization, diagnosis or treatment of infertility, reversal of sterilization, or genetic testing or counseling.
- Cosmetic surgery (certain exceptions apply).
- Services or supplies not reasonably intended for treatment of illness or injury or which are not medically necessary (as defined in your policy).
- Acupuncture, massage, or massage therapy.
- Private duty nursing for hospital or skilled nursing facility inpatients.
- Mental, emotional or nervous disorders, or counseling of any type, or treatment of learning disorders or disabilities.
- Any condition caused by or arising out of service in the armed forces of any country, or from war or any act of war, or from participation in a felony, riot, or insurrection.
- Sexual dysfunction or inadequacy procedures and any resulting complications.
- Services provided by an immediate family member.
- Treatment for obesity or weight control, including surgery and any resulting complications.
- Charges incurred after your policy ends, except as stated in your policy (see section titled "Extension of Benefits While Hospitalized" for brief description).
- Charges which exceed usual and customary or reasonable (as defined in your policy).
- Services rendered by governmental agencies or facilities, except as provided by law.
- Dental exams, treatment, or orthodontics.
- Services or supplies to change the position of the bone of the upper or lower jaw (certain exceptions apply).
- Services or supplies that are experimental or investigational (see your policy for complete details).
- Confinement in a health facility for custodial or maintenance care, rest, or to change a patient's environment.
- Pregnancy or childbirth, except complications of pregnancy as stated in your policy.
- Treatment of alcoholism, except as stated in your policy.
- Charges which are reimbursed due to third party liability or motor vehicle coverage (see your policy for complete details).

Pre-Existing Conditions

There is no coverage for pre-existing conditions under this Policy. Pre-existing condition means an illness or injury for which a member received any medical diagnosis, advice, treatment, service, supply, or drug prescription during the 5-year period immediately preceding the effective date of your policy. A condition is also pre-existing if, during the 5-year period immediately preceding the effective date of your policy, symptoms existed which would cause a prudent person to seek diagnosis, advice, care, or treatment.

Accidental Death Benefit

How This Benefit Works

We will pay the benefit shown below if all of the following conditions are met:

1. The member's death results from an accidental bodily injury (as defined in your policy):
2. The accidental bodily injury occurs while insured under the policy; and
3. The death occurs within 365 days after the date of the accidental bodily injury.

Once satisfactory proof of death by accidental bodily injury has been submitted, we will provide the following benefit:

For the Primary Insured (age 18 or older)	$25,000
For the Covered Spouse or Covered Domestic Partner (State Certified or Non State Certified)	$25,000
For the Covered Dependent Child (and Primary Insured under age 18)	$ 5,000

Exclusions

The policy does not cover accidental death resulting from injury caused by, or occurring as the result of:

- Suicide, intentionally self-inflicted injury, or any attempt to injure oneself, while sane or insane;
- Active participation in a violent disorder or riot. "Active participation" does not include being at the scene of a violent disorder or riot during the performance of official duties;
- Insurrection, war or any act of war, whether declared or undeclared;
- Injury suffered while serving in the armed forces of any country;
- Committing or attempting to commit an assault or felony;
- Any illness or pregnancy existing at the time of the accident;
- Voluntary use or consumption of any poison, chemical compound or drug, except a prescription drug used or consumed in accordance with the directions of the prescribing physician;
- Heart attack (including but not limited to myocardial infarction) or stroke (including but not limited to cerebral infarction);
- Diagnostic test, medical or surgical treatment; or
- Bodily infirmity or disease from bacterial or viral infections, other than infection caused from an injury sustained while insured under this benefit.

How to Apply for Short Term Medical Insurance

Please refer to the eligibility section of this brochure to be sure you meet the eligibility requirements.

- Complete the application in full. Missing information may cause your effective date to be delayed. If you have more than four children, please attach a separate list.
- Select the Policy Term (the number of days this Policy will be in effect). The minimum term is 30 days; the maximum term is 90 days.
- Calculate the premium for the Policy Term, coinsurance, and deductible amount you select. (Refer to the following rate calculation pages.) Unless an adult is included in the Policy, each child will require his or her own individual Policy.
- If applying by mail, payment must be made for the full Policy Term and policy fee. If the payment received is inadequate, the policy term (the number of days the policy will be in effect) will be shortened.
- You may also apply online at www.LifeMapCo.com. If you apply online you must pay in full.
- A grace period will apply to payment of premiums (except the initial premium). This grace period means that if you pay your premiums within 10 days after they are due, your coverage remains continuously in force. If you do not, your coverage is terminated and the termination date will be revised to coincide with the amount of coverage provided by the amount of premium received.
- This policy does not terminate if you become covered by a group or other insurance plan during the Policy Term.
- Sign and return to us the application and the "Authorization for Use and Disclosure of Protected Health Information".
- If your application is approved, the policy effective date will be 12:00 a.m. on the **later** of the day after online application is submitted, the date you request, or the day after the postmark date stamped on the application envelope. If there is no postmark, the Policy Effective Date is the later of the date the application is received by us or the date you requested.
- If you answered "Yes" to any of the questions numbered 1 through 4 on the application, **this policy cannot be issued.**
- If you have any questions please call 1 (800) 756-4105.
- Send the application, the authorization and your check or money order for the full payment amount (made payable to LifeMap Assurance Company) to:

  LifeMap Assurance Company
  P.O. Box 1271, MS E8L
  Portland, OR 97207-1271

- Keep this brochure for your records.

Refunds

If you are not satisfied with our Short Term Medical Insurance Policy, you may return the policy within 10 days of delivery for a full refund of premium. After that time, refunds are not available. Coverage will continue for the full period you selected.

Please note: The Policy fee of $20 is non-refundable.

Please read your Policy carefully and keep it available for future reference.

THIS PAGE INTENTIONALLY LEFT BLANK

LifeMap Assurance Company®
100 SW Market Street
P.O. Box 1271, MS E-8L
Portland, OR 97207-1271
(800) 756-4105

Oregon Short Term Medical Application Checklist

Please review the following checklist before submitting your application

---

- Please confirm that the application and rate page you are using has a 1/2019 in the lower right corner. If not, contact our Customer Service Department at 1(800) 756-4105.

- On the Application have you:
  - ☐ Indicated your requested effective date?
  - ☐ Completed all personal information, including mailing address and e-mail?
  - ☐ Selected a deductible amount?
  - ☐ Selected a Policy Term (30 – 90 days)?
  - ☐ Selected a coinsurance amount (rate of payment)?
  - ☐ Entered the total premium due (total the daily rate of each member to calculate)?
  - ☐ Answered all qualifying questions on page 1?
  - ☐ Signed and dated the application?

- With your completed, signed and dated Application, please return to LifeMap:
  - ☐ The Authorization for Use and Disclosure of Protected Health Information
  - ☐ Your check or money order for full premium due plus the $20.00 application fee

- Please keep for your records:
  - ☐ The Outline of Coverage
  - ☐ Federal Disclosure Amendment
  - ☐ The Fraud Notice
  - ☐ Notice of Privacy Practices

Please note: missing information or inadequate premium may cause a delay or denial of your application for coverage.

THIS PAGE INTENTIONALLY LEFT BLANK

LifeMap®

Application for Short Term Medical Insurance

Non-Renewable

LifeMap Assurance Company®
200 SW Market Street
P.O. Box 1271, M/S E8L
Portland, OR 97207-1271
(800) 756-4105

Home Office Use Only
Policy #
Eff. Date
Term Date
Check #

Note: Coverage begins at 12:00 a.m. on the **later** of the day **after** online application is submitted, the date you request, or the postmark date stamped on the application envelope. If there is no postmark, the Policy Effective Date is the later of the date the application is received by us or the date you requested.

- If applying by mail, coverage will take effect only upon receipt of full premium. Cash is not accepted. Please do not staple or tape your payment to this application.
- If applying online, coverage will only take effect upon receipt of full premium. Automatic payments by credit card or electronic check are available.

Please complete all information on this page and on page 2, missing information may cause your effective date to be delayed.

Primary Insured's Name (Last, First, Middle)	☐ M ☐ F	Social Security Number	**Requested Effective Date**
Date of Birth (mm/dd/yyyy)	☐ Married or Domestic Partner ☐ Divorced ☐ Single		Telephone Number ( )
Home Address (Street, City, State and Zip)		Email Address	

Additional Family Members to be enrolled: May include your Spouse or Domestic Partner (State Certified or Non State Certified) and Dependent Children under the age of 26.

Name (Last, First, M.I.)	Social Security Number	Birth Date	Sex	Relationship To You
			☐ M ☐ F	
			☐ M ☐ F	
			☐ M ☐ F	
			☐ M ☐ F	

List names as they should appear on your identification card. If enrolling additional family members, please attach a separate sheet including all of the information requested above.

Individual Deductible Amount	**Policy Term (30 – 90 Days)**	**Total Premium** $
☐ $500 ☐ $1000 ☐ $2,500 ☐ $5,000 ☐ $7,500	**Number of Days** _____	**Policy Fee +** $ **20.00**
Coinsurance Amount After Deductible ☐ 80% to $10,000 ☐ 50% to $10,000		**Total Due** $

Application for
Short Term Medical Insurance
Non-Renewable

LifeMap Assurance Company®
200 SW Market Street
P.O. Box 1271, M/S E8L
Portland, OR 97207-1271
(800) 756-4105

1. Are you, or any person to be insured, age 65 or older?	☐ YES ☐ NO **If YES, this policy cannot be issued.**
2. Are you, or any person to be insured, eligible for Medicare now or will become eligible at any time during the duration of the policy?	☐ YES ☐ NO **If YES, this policy cannot be issued.**
3. Do you, or any person to be insured, now have any hospital, major medical, group health or medical insurance coverage that will not terminate prior to the beginning of this policy?	☐ YES ☐ NO **If YES, this policy cannot be issued.**
4. Are you, or any family member, now pregnant?	☐ YES ☐ NO **If YES, this policy cannot be issued.**
5. How did you learn about LifeMap? ☐ Radio Ad ☐ Agent ☐ Employer ☐ Friend/Family ☐ Online ☐ Community Event ☐Other_____	

I understand that:

1) if my application for coverage is accepted, the Policy Effective Date will be the later of the day after online application is submitted, the date you request, or the postmark date stamped on the application envelope. If there is no postmark, the Policy Effective Date is the later of the date the application is received by us or the date you requested.
2) if my application for coverage is not accepted, any premium I paid will be promptly refunded;
3) this is not a continuation of any previous medical plan, including any prior Short Term Medical Plan;
4) this Policy is not renewable; and
5) this insurance will not cover Pre-Existing Conditions. Pre-Existing Conditions are defined as any illness or injury for which any medical diagnosis, advice, treatment, service, supply or drug prescription has been received, or for which symptoms have been shown, during the 5 years immediately preceding the Policy Effective Date of this coverage.

I acknowledge and understand LifeMap Assurance Company (LifeMap) may request or disclose health information about me or my dependents (persons who are listed for benefit coverage on the enrollment form) from time to time for the purpose of facilitating health care treatment, payment or for the purpose of business operations necessary to administer health care benefits; or as required by law.

Health information requested or disclosed may be related to treatment or services performed by:

1) a physician, dentist, pharmacist or other physical or behavioral health care practitioner;
2) a clinic, hospital, long-term care or other medical facility;
3) any other institution providing care, treatment, consultation, pharmaceuticals or supplies, or
4) an insurance carrier or group health plan.

LifeMap Assurance Company®
200 SW Market Street
P.O. Box 1271, M/S E8L
Portland, OR 97207-1271
(800) 756-4105

Health information requested or disclosed may include, but is not limited to: claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes).

Disclosure: If you have a broker or agent, they may receive bonuses, commissions, administrative service fees or other compensation, including non-cash compensation, from LifeMap. Incentives may be based on any of several factors, the products you buy, your broker or agent's volume of business with LifeMap and the other services your agent or broker provides to you. These incentives may have a direct or indirect impact on your rates. For more information, please contact your broker or agent.

Please Note: Short Term Medical Insurance is an individual insurance plan and cannot be purchased by employers for their employees.

I represent that each of the above statements and answers are complete and true to the best of my knowledge and belief. I understand that if I have made intentionally false or misleading statements or answers on behalf of myself or any family members that all entitlements to benefits are void and the contract may be canceled or modified retroactively to its effective date. I acknowledge that I have read the Fraud Notices attached to this form.

▶ _____ _____
Primary Insured's Signature Parent's or Guardian's Signature

▶ _____ _____ _____
Date Signed LifeMap Producer Number Licensed Producer's Name / Agency (Please Print)

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.

THIS PAGE INTENTIONALLY LEFT BLANK

LifeMap Assurance Company®
200 SW Market Street
P.O. Box 1271, MS E-8L
Portland, OR 97207-1271
(800) 756-4105

Authorization for Use and Disclosure of Protected Health Information

I authorize any physician, health care provider, hospital, insurance or reinsurance company, or other insurance information exchange to disclose to LifeMap Assurance Company (LifeMap) or its representatives health information (including alcohol, chemical dependency, mental health treatment, genetic testing or HIV treatment) pertaining to me and/or my eligible dependents. I acknowledge and understand that this information will only be used for the purpose of determining enrollment in the health plan and eligibility for benefits or payment of claims. Health information may include claims records, correspondence, medical records, billing statements, diagnostic imaging reports, laboratory reports, dental records, or hospital records (including nursing records and progress notes).

If I choose to not sign this authorization, LifeMap may be unable to enroll my family or me in the health plan or to pay claims that were incurred while we had insurance coverage with LifeMap.

I may cancel this authorization at any time by sending a written request to LifeMap. Cancellation of this authorization will not affect any action LifeMap took before it received this request. If I do not revoke this authorization, it will automatically expire when I am no longer covered under this policy and all claims arising from the policy have been settled, or in 24 months from the date below, whichever comes first. A photocopy of this authorization is as valid as the original.

Federal law requires LifeMap to tell me that if the party to whom LifeMap discloses my personal information shares it with anyone else, some state and federal laws may no longer protect it. This excludes alcohol and drug abuse records, which are protected by federal confidentiality rules (42 CFR, part 2). Federal law prohibits redisclosure of this information without specific written authorization.

INSURED'S NAME: (Please print) _____ **DOB:** _____

INSURED'S SIGNATURE*: _____ **DATE:** _____

*If signature by a personal representative of the Insured, please complete the following:

Personal Representative's Name: _____

Relationship to Insured: ☐ Parent ☐ Legal Guardian* ☐ Holder of Power of Attorney*

*Please attach legal documentation if you are the Legal Guardian or Holder of Power of Attorney.

Please send my records to:

LifeMap Assurance Company
200 SW Market Street
P.O. Box 1271, MS E-8L
Portland, OR 97207-1271

_____ **(initials)** I specifically give authorization to my provider to FAX my medical information to LifeMap.
Medical Records can be faxed to LifeMap at 1 (855) 207-1205

THIS AUTHORIZATION MAY NOT BE USED FOR PSYCHOTHERAPY NOTES
(Notes recorded and separately maintained by a mental health professional documenting or analyzing the contents of conversation during a counseling session.)

THIS PAGE INTENTIONALLY LEFT BLANK

LifeMap Assurance Company®
200 SW Market Street
P.O. Box 1271, M/S E8L
Portland, OR 97207
(800) 756-4105

NOTICE OF PRIVACY PRACTICES

THE FOLLOWING NOTICE APPLIES TO ALL SHORT TERM MEDICAL, VISION, AND DENTAL POLICIES.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

We, at LifeMap Assurance Company (LifeMap), know you value your privacy. That is why we are committed to the confidentiality and security of your personal information. We maintain physical, administrative and technical safeguards to protect against unauthorized access, use, or disclosure of your personal information.

We collect personal information, such as your name, contact information, and health information, from you, your health care providers, and other insurers that provide you coverage. We are required by law to maintain the privacy of this information and to explain our legal duties and privacy practices. We are also required by law to notify affected individuals following a breach of unsecured protected health information. We provide the protections and apply the practices described in this notice to all personal information that we maintain, including to personal information of former members who are no longer covered by us. We hope this notice will clarify our responsibilities to you and give you an understanding of your rights. We are required to abide by the notice that is currently in effect. This notice is in effect as of August 7, 2013.

Your Rights

You may exercise the following rights by calling our Customer Service department or writing our Privacy Official. See “Contacting Us” at the end of this notice.

Inspection and Copies. You have the right to request an inspection or copies of protected health information that we maintain about you in a “designated record set” except psychotherapy notes and information that we compiled in anticipation of, or for use in, a civil, criminal, or administrative proceeding. A “designated record set” is a group of records that is used to administer your health benefits, including enrollment information and claims. We may limit the information that you can inspect or copy if we have reason to believe that is necessary to protect you or another person from harm. If we limit your right to inspect or copy, you can ask for a review of that decision.

Amendment. If you believe that protected health information we maintain about you in a designated record set is inaccurate or incomplete, you have the right to request an amendment to correct or complete the information. You must submit your request in writing and explain the reason for the amendment. If the amendment is made, we will make reasonable efforts to inform others, including people you identify, that the information has been amended and we will use our best efforts to include the amendment with any future disclosure. We may decline to amend information under certain circumstances. This is likely to occur if we did not create the original record. If we decline to amend the information, you have the right to submit a statement of disagreement. You should know that we are allowed to attach a rebuttal statement in response to your statement of disagreement.

LifeMap Assurance Company®
200 SW Market Street
P.O. Box 1271, M/S E8L
Portland, OR 97207
(800) 756-4105

Notice. You have the right to receive a paper copy of this notice upon request.

Accounting. You have the right to request a list of certain disclosures of protected health information. The list will not include disclosures made for treatment, payment, or health care operations. It also will not include disclosures made pursuant to an authorization, made more than six years before the date of the request, incidental disclosures, disclosures made for national security or intelligence, or disclosures made to a correctional facility. The list will include the date of any accountable disclosure, to whom that disclosure was made, a brief description of the information disclosed, and the purpose for that disclosure (provided this information is known to us). We will supply this list free of charge once a year at your request. If you request an accounting more than once in a 12-month period, we may charge a reasonable fee.

Special Handling. You have the right to request restrictions on our use or disclosure of protected health information in addition to the restrictions imposed by law. We are not required to agree to your request and we may be unable to do so. If we do agree, we will comply with your request except in the case of emergency. You also have the right to request that we communicate with you in confidence with respect to communications you believe may endanger you. We will make every effort to accommodate your request if it is reasonable and you provide an alternate means to communicate. You should know that redirecting communication may not prevent others on your policy from discovering that you sought medical care. Accumulated deductibles and co-payment information may reveal that you obtained services. In addition, historic claims reports may include services that were obtained during the time communications were redirected.

Complaints. You have the right to submit a complaint if you believe we have violated your privacy rights. To submit a complaint, write to: LifeMap, Privacy Office, P.O. Box 1271, Mailstop E12P, Portland, OR 97207 or call our Customer Service department at the phone number provided at the end of this notice. You also have the right to submit a complaint to the Secretary of the U.S. Department of Health & Human Services. Be assured that we will not retaliate against you for submitting a complaint.

Permitted Uses and Disclosures

To administer health benefits, we collect, use and disclose protected health information for a variety of purposes:

Treatment. We may disclose protected health information to a health care provider in order for the provider to treat you. We may also use or disclose protected health information to support a provider's activities to furnish preventive health, early detection, and case management programs.

Payment. We may use or disclose protected health information for payment purposes, including to adjudicate claims, issue Explanation of Benefits, or coordinate benefits with other entities responsible for paying your claims.

Health Care Operations. We may use or disclose protected health information to facilitate operations, including underwriting, customer service, and detection or prevention of fraud or abuse. We may not, however, use or disclose genetic information for underwriting purposes.

Business Associates. Occasionally, we contract with business associates to perform insurance-related functions on our behalf. We may disclose protected health information to these business

associates in order to allow them to perform these functions. They also may collect, use or disclose protected health information on our behalf. We contractually obligate our business associates and they are required by law to provide the same privacy protections that we provide.

Employers and Other Plan Sponsors. If you are enrolled in an employer-sponsored group health plan (or a group health plan sponsored by another entity), we may disclose protected health information to the group health plan or plan sponsor to facilitate administration of the plan. For example, we supply enrollment lists to employers so that premiums can be paid appropriately.

As Permitted or Required by Law. We use or disclose protected health information as permitted or required by law. For example, some laws permit or require us to disclose protected health information for workers' compensation programs or to certain government agencies, such as the Food and Drug Administration.

Public Health Activities. We may disclose protected health information to: (a) public health agencies for the prevention and control of disease; (b) coroners or medical examiners as necessary for fulfillment of their duties; (c) agencies that engage in the procurement, banking, or transportation of organs or tissue to facilitate such donation and transplantation services; (d) researchers to conduct medical research or research intended to improve the health care system; and (e) third parties as necessary to avert a serious threat to the health or safety of a person.

Health Oversight. We may disclose protected health information to health oversight agencies. These agencies are authorized by law to conduct audits; perform inspections and investigations; license health care providers, insurers and facilities; to enforce regulatory requirements; and to investigate healthcare fraud. These agencies include: State Commissioner of Insurance, State Board of Medicine, the U.S. Department of Health and Human Services, and the FBI.

Legal Proceedings. We may disclose protected health information in the course of a judicial or administrative proceeding, and in response to a court order, subpoena, discovery request, or other lawful process.

Law Enforcement. We may disclose protected health information to law enforcement officials in response to an administrative subpoena, a warrant, or an administrative request intended to identify or locate a suspect, victim, or witness. We also may disclose protected health information for the purpose of reporting a crime on our premises.

Military and National Security. We may disclose protected health information to armed forces personnel for military activities and to authorized federal officials for national security and intelligence activities.

Correctional Institution. If you are an inmate, we may disclose protected health information to your correctional institution for treatment purposes or to ensure the safety of yourself and others.

You. We may disclose your protected health information to you at your request, to inform you about the status of your claims, or for other purposes. For example, we may use protected health information to provide information about treatment alternatives or other health related benefits or services that may be of interest to you. This may include enhancements to your health plan and health related products or services available only to health plan members that add value to, but are not a part of, your benefit plan.

LifeMap Assurance Company®
200 SW Market Street
P.O. Box 1271, M/S E8L
Portland, OR 97207
(800) 756-4105

Others Involved in Your Health Care. We may disclose protected health information to personal representatives such as appointed guardians, executors, conservators, and in many cases parents of minor children, as well as to attorneys in fact when a valid power of attorney exists. In addition, if you give us verbal permission or if your permission can be implied (for example, while you are unconscious during an emergency), we may disclose protected health information to family members or others who call on your behalf. This permission is valid only for a limited time. If you want to authorize on-going disclosures to family members or friends, you must submit written authorization.

Authorizations. You may give us written authorization to use protected health information or disclose protected health information about yourself to anyone for any purpose. An authorization remains valid for two years unless the authorization states otherwise or you revoke it. You may revoke an authorization at any time by submitting a written revocation (see "Contacting Us," below), but a revocation will not affect any use or disclosure permitted by the authorization while it was in effect. An authorization is required for us to use or disclose your protected health information for purposes other than those described in this notice. In particular, we need your written authorization to use or disclose psychotherapy notes, except in limited circumstances such as when the disclosure is required by law. We also must obtain your written authorization to sell information about you to a third party or when we receive financial compensation to use or disclose your protected health information to send you communications about products and services.

Future Changes

We reserve the right to change our privacy practices and this notice at any time without advance notice. Before we make any material change in our privacy practices, we will change this notice and post the new notice on our website. We will provide a copy of the new notice (or information about the changes to our privacy practices and how to obtain the new notice) in our next annual mailing to members who are then covered by one of our health plans. The new notice will apply to all protected health information in our possession, including any information created or received before the revised notice became effective.

Contacting Us

You may reach us during regular business hours by calling us at (800) 794-5390. For more information about this notice or to file a written privacy-related complaint, you may write to: LifeMap Privacy Official, P.O. Box 1271, MS E12P, Portland, OR 97207.

LifeMap Assurance Company®
200 SW Market Street
P.O. Box 1271, M/S E8L
Portland, OR 97207
(800) 756-4105

Unless specific state language is provided below, the following fraud notice applies: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Arizona Residents: For your protection Arizona law requires the following statement to appear on this form. Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal and civil penalties.

California Residents: For your protection California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

District of Columbia Residents: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Florida Residents: Any person who, knowingly and with intent to injure, defraud, or deceive any employer or employee, insurance company, or self-insured program, files a statement of claim containing any false or misleading information is guilty of a felony of the third degree.

Hawaii Residents: For your protection, Hawaii law requires you to be informed that presenting a fraudulent claim for payment of a loss or benefit is a crime punishable by fines or imprisonment, or both.

Alabama, Arkansas, Louisiana, Maryland, New Mexico, Rhode Island, Texas and West Virginia Residents: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

New Jersey Residents: Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties.

New York Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Minnesota Residents: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

Ohio Residents: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Maine, Tennessee, Virginia and Washington Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

Alaska and Oregon Residents: Any person who knowingly provides false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company may be guilty of a crime. Penalties may include imprisonment, fines, and denial of insurance benefits.

Delaware, Idaho, Indiana and Oklahoma Residents: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, files a statement of claim containing any false, incomplete or misleading information is guilty of a felony.

THIS PAGE INTENTIONALLY LEFT BLANK

Instructions for Calculating Your Policy Premium and Total Payment

Please Note: Unless an adult is included in the Policy, each child will require his or her own individual Policy.

1. Determine your premium by choosing from the options below:
   A. Coinsurance Amount: 80/20% or 50/50% (Only one Coinsurance Amount may be selected)
   B. Individual Deductible Amount: $500, $1,000, $2,500, $5,000 or $7,500 (Only one Deductible Amount may be selected)
   C. Age and Gender of each individual to be covered
   D. Policy Term (Number of days of coverage you desire) Note: You may select from a minimum of 30 days up to a maximum of 90 days.
2. Refer to the OR daily rate charts. Find the daily rate of coverage for each individual you desire to insure by using the choices made in options A, B and C above.
3. Calculate the Total Daily Rate by adding the Daily Premium Rates for each member.
4. Multiply the Total Daily Rate by the Policy Term chosen in option D above. This equals your Total Premium.

Example

1. Coinsurance Amount: 80/20%

   Individual Deductible Amount: $500

   Term of Coverage: 60 days

2.

		Age	Daily Premium Rate
Primary Insured	☒ M ☐ F	36	$ 2.32
Additional Member 1	☐ M ☒ F	33	$ 3.22
Additional Member 2	☒ M ☐ F	16	$ 1.64
Additional Member 3	☒ M ☐ F	10	$ 1.64
Additional Member 4	☐ M ☒ F	7	$ 1.69
		Total Daily Rate	$ 10.51

3. Total Daily Rate = $10.51

4. Term of Coverage 60 days X Total Daily Rate $10.51 = $630.60 Total Premium

   Add $ 20.00 Policy Fee

   $650.60 Total Payment Due

Your Rate Calculation

1. Coinsurance Amount: _____%

   Individual Deductible Amount: $_____

   Term of Coverage: _____days

2.

		Age	Daily Premium Rate
Primary Insured	☐ M ☐ F		$
Additional Member 1	☐ M ☐ F		$
Additional Member 2	☐ M ☐ F		$
Additional Member 3	☐ M ☐ F		$
Additional Member 4	☐ M ☐ F		$
Additional Member 5	☐ M ☐ F		$
Additional Member 6	☐ M ☐ F		$
Additional Member 7	☐ M ☐ F		$
Additional Member 8	☐ M ☐ F		$
		Total Daily Rate	$

3. Total Daily Rate = $_____

4. Term of Coverage _____ Days X Total Daily Rate $_____ = $_____ Total Premium

   Add $ 20.00 Policy Fee

   $_____ Total Payment Due