JOHN DOE
JANUARY 01, 1993
H601866

AID ASSOCIATION FOR LUTHERANS

MAJOR MEDICAL EXPENSE INSURANCE

- Major medical expense insurance
- Benefits for specified medical expenses
- Participating - surplus refunds

This is a certificate of membership and major medical expense insurance with Aid Association for Lutherans (AAL). AAL will provide the benefits and rights of this certificate. The entire contract is defined in Section 1.2. A table of certificate provisions is shown on page 2. The benefits and covered persons are shown in the certificate schedule on page 3.

This certificate is issued in exchange for and on the basis of the application and the payment of the first premium.

GUARANTEED RENEWABLE
RATES MAY BE CHANGED BY CLASS

This certificate is guaranteed renewable by the timely payment of the premium at the rate in effect on each premium due date. It is renewable until the youngest adult covered person reaches age 65 or is eligible for Medicare, whichever occurs first.

RIGHT TO CANCEL CERTIFICATE

Please read this certificate carefully. It is a legal contract between you and AAL. If you are not satisfied with it, send it back to us or to your AAL representative within 10 days from the date you receive it. If you do, the certificate will be void from the beginning and any premium paid will be returned.

NOTICE CONCERNING STATEMENTS IN THE APPLICATION FOR THIS CERTIFICATE - PLEASE READ THE ATTACHED COPY OF YOUR APPLICATION. YOUR CERTIFICATE WAS ISSUED BASED ON STATEMENTS MADE IN IT. OMISSIONS OR MIS-STATEMENTS IN IT COULD CAUSE A CLAIM TO BE DENIED. WRITE TO AAL IF ANY INFORMATION SHOWN ON IT IS NOT CORRECT OR IF ANY MEDICAL HISTORY OR INFORMATION ABOUT OTHER COVERAGE HAS NOT BEEN INCLUDED.

PREEXISTING CONDITIONS LIMITATIONS

This certificate does not cover expenses resulting from preexisting conditions during the first two years coverage is in effect, unless they are disclosed in the application and not excluded from coverage by name or specific description. A preexisting condition is a sickness or injury that was diagnosed or treated within two years before the effective date of coverage, or for which symptoms were present during those two years that would cause a prudent person to seek diagnosis, care, or treatment. Also refer to section 12.1 in regard to incontestability.

Signed for Aid Association for Lutherans at the home office, 4321 North Ballard Road, Appleton, WI 54919.

W R Heerman — Secretary
R. L. Gunderson — President

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1. THE INSURANCE CONTRACT

1.1 GENERAL

This certificate, issued by Aid Association for Lutherans (AAL), is a legal contract providing major medical expense insurance. Any time you have questions or need service, you may contact your AAL representative or the home office.

Wherever the words "you" or "your" appear in this contract, they mean the insured person. The words "we," "us," or "our" mean AAL.

1.2 THE ENTIRE CONTRACT

The entire contract is made up of: this certificate including any benefit rider or amendment; the application; the AAL Articles of Incorporation and Bylaws; and any changes to the above. Any changes to the Articles of Incorporation and Bylaws made after the issue date cannot reduce the benefits which AAL promised as of the issue date.

No one but the president or secretary of AAL may change or waive any part of this contract.

All statements made in the application are treated as representations and not warranties. Only statements made in the application may be used to deny a claim or deny that this is a valid contract.

2. PERSONS ELIGIBLE FOR COVERAGE

2.1 WHEN THE CERTIFICATE IS ISSUED

Those eligible to be covered persons are:

(1) You;
(2) Your spouse; and
(3) Dependent children of you or your spouse who are not married and less than 20 years old. "Children" includes stepchildren and adopted children. If a dependent child is a full-time student and not married, he or she is eligible up to age 23.

Each person must be acceptable to AAL based on the rules in effect at the time of your application. A person covered by Medicare or any other plan with the same purpose as Medicare is not eligible. Covered persons are those so named on the certificate schedule found on the most recent page 3. You and your covered spouse, if any, are the adult covered persons.

2.2 AFTER THE CERTIFICATE HAS BEEN ISSUED

A child of yours born while this certificate is in force becomes a covered person at birth. Coverage for the child will continue, at no charge, to the first premium due date that occurs more than 31 days following birth. After that, any additional premium must be paid for coverage to continue. Within 31 days (90 days in Arkansas, 60 days in Washington, and 60 days in Wisconsin) following birth, you must send us a written request to add the child as a covered person. If the request is not sent to AAL within this period, evidence of insurability is required to add the child. If both parents have separate major medical certificates with AAL, the child will be covered under only one of them.

Other eligible persons may be added after the certificate is issued if: you make a written application to add the person; you pay any additional premium; and AAL approves the person under our then current underwriting rules. An adopted child may be added as of the date you become legally responsible for the child.

3. WHEN COVERAGE FOR EACH COVERED PERSON BEGINS

Coverage begins for each covered person listed on the application on the earliest of the following:

(1) the date of application, if the first premium has been paid and all other conditions of the temporary insurance agreement have been met;
(2) the issue date (or effective date for persons added after the issue date) listed on page 3, if the first premium has been paid by that date; or
(3) the date that AAL receives payment of the first premium if paid after the certificate is issued.

"First premium" means the first full premium for the interval selected. Even if the first premium is paid, coverage will not take effect until any major medical insurance coverage that you have indicated to be replaced by this contract is no longer in effect.

4. WHEN COVERAGE FOR EACH COVERED PERSON ENDS

4.1 AT YOUR OPTION

Coverage for covered persons may be ended upon your written request.

Coverage for all covered persons ends if a premium is not paid when due. It will continue to the last day of the 31-day grace period following the date the premium was due. If this occurs, and you want to continue coverage, section 10 describes how you can apply for reinstatement.

4.2 DUE TO CHANGE IN ELIGIBILITY

Coverage for adults ends on the first to occur of:

(1) The date of death; or
(2) The date of eligibility for Medicare. Medicare means the Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965, all later amendments, and any successor programs: or
(3) The 65th birthday; or
(4) The first premium due date after notice of divorce is given to AAL. Your coverage under this certificate will remain in effect and your former spouse's will not. Your former spouse's coverage can continue under a new certificate issued through the conversion privilege. This is explained in section 5.

If your coverage ends due to your age, death, or eligibility for Medicare, your spouse, if then a covered person, will become the insured.

Coverage for each child ends on the first to occur of:

(1) The premium due date following the child's marriage;
(2) The premium due date following the date the child is no longer chiefly dependent on you or your spouse for support and maintenance;
(3) The date the child becomes eligible for Medicare; or
(4) The premium due date following the child's 23rd birthday.

Coverage may continue past a child's 23rd birthday if he or she is incapable of self-sustaining employment due to mental or physical handicap, is chiefly dependent on the insured for support and maintenance, is not married, and is not eligible for Medicare. Proof of incapacity must be given to us within 31 days of the premium due date following the child's 23rd birthday. (Within 60 days of the child's 23rd birthday in Florida.) Proof that the child is still in this condition must be given to us as requested.

Coverage may be converted as described in section 5.

5. CONVERSION PRIVILEGE

When a person is no longer eligible to be covered under this certificate, AAL will issue a new certificate to him or her, if possible. The type of coverage issued will either be a Medicare supplement or another major medical certificate, as applicable. The major medical certificate would be one that contains the same or most similar benefits as this one, that is available at that time. If the proper coverage is not available in your state when this coverage ends, no certificate will be issued.

The premium for a certificate issued to a covered person who is eligible for Medicare or a child will be based on the age, class and the table of premium rates in effect on the date of conversion. The premium for a certificate issued to an adult who is less than 65 and is not eligible for Medicare will be based on the original issue class and issue age.

Written request for conversion and the first premium must be received by AAL within 31 days after this coverage ends. The new certificate will be issued without regard to any health changes. Coverage will begin the day after this coverage ends. Any waiting periods set forth in the new certificate will be considered as being met to the extent they were met under this certificate.

6. BENEFITS

6.1 GENERAL

Coverage is provided for hospital, medical, and surgical expenses incurred by a covered person as a result of a covered injury or sickness. Benefits are payable for covered treatments, services, or supplies at the reasonable and customary level in the area where provided. Charges above the customary charges may be justified by the complexity of treatment.

Coverage for a newborn also includes expenses for: treatment of medically diagnosed congenital defects; treatment of birth abnormalities; and non-routine care required as a result of a premature birth. Routine newborn care is not covered unless the maternity benefit rider is indicated on the most recent certificate schedule found on page 3.

Benefits are determined on a benefit year basis. A new benefit year begins each year on the anniversary of the issue date. Most covered expenses are subject to the deductible and the copayment percentage. The deductible, coinsurance corridor amount, maximum, and premiums are subject to change at the beginning of each benefit year. Such changes are based on changes in the average daily hospital charge in the ZIP code area where you live at that time. When changes are made, a new page 3 will be provided that you should attach to this certificate.

Each benefit year, copayment on covered expenses listed in section 6.4 is as follows:

(1) You pay for all covered expenses up to the deductible amount.
(2) After the deductible is met, you pay 20% of covered expenses up to the coinsurance corridor amount. AAL pays the remaining amount.
(3) Covered expenses above the deductible and the coinsurance corridor amount are paid by AAL at 100%, subject to the lifetime maximum. Each person reaches their lifetime maximum when the total of benefits paid by AAL for that covered person equals the lifetime maximum benefit amount.

6.2 THE DEDUCTIBLE

(1) On an Individual Basis

The deductible is shown on the most recent page 3. After one covered person incurs covered expenses equal to the deductible within a certificate year, the individual deductible for that person is met for that year. Once it has been met, benefits will be paid.

(2) On a Family Basis

When two covered persons each meet their annual deductible on the individual basis, the deductible has been met on the family basis. This means that no other covered persons have to meet their deductible during that benefit year, but benefits will be paid as if they had.

6.3 COVERED EXPENSE REQUIREMENTS

Covered expenses include only charges that:

(1) Are for medically necessary care and treatment of injury or sickness; and
(2) Are incurred while this coverage is in effect; and
(3) Are for such care and treatment at the reasonable and customary level in the area where provided.

The care and treatment must meet all of the following conditions:

(1) Be recognized as safe, appropriate, and proven effective by the medical community (the medical community includes the American Medical Association, the National Institutes of Health, the Public Health Service, the American Osteopathic Association, and the Food and Drug Administration); and
(2) Not be considered experimental or investigational by the medical community; and
(3) Be prescribed by a doctor; and
(4) Be provided within the United States, except if it is approved by us or it results from an injury that occurs, or a sickness that requires immediate treatment while on a trip outside of the United States; and
(5) Be available only by skilled medical professionals, and not be primarily of a custodial nature. Custodial care includes activities of daily living, such as help with eating, dressing, bathing, walking, taking medicine and getting in and out of bed.

An injury is an accidental bodily injury sustained by a covered person while this coverage is in effect. A sickness is any sickness or disease not excluded from coverage by name or specific description or as a preexisting condition. Injury or sickness does not include learning disabilities, mental retardation, developmental delays or disabilities or any physical abnormality that does not cause health problems.

When referred to in this certificate, a doctor means any person who is a legally qualified and licensed practitioner of the healing arts, practicing within the scope of his or her authority.

The date services were rendered or supplies furnished is considered the date incurred.

6.4 COVERED EXPENSES

Benefits are paid on the following covered expenses. We encourage you to contact us when you want to know if an expense not listed is covered.

(1) Hospital room and board at the medically necessary level of care. The hospital must be a lawfully operating institution for the care and treatment of injured or sick persons as resident bed patients. The institution must be one that:
    (a) has facilities or has access to facilities on a prearranged basis for diagnosis and treatment;

(b) is supervised by a staff of doctors;
(c) has 24-hour nursing care that is supervised by a registered graduate nurse always on duty; and
(d) is not used as a nursing home, a convalescent home, a rest home, a home for the aged, or a facility that provides primarily rehabilitation, education, or custodial care.

(2) Other hospital services and supplies, except for personal convenience and entertainment items.

(3) Necessary services and supplies provided by a licensed outpatient surgical facility. Services and supplies normally provided by a hospital are covered expenses. See section 6.5(3) for information on additional benefits paid for outpatient surgery.

(4) Room and board and necessary services and supplies provided by a skilled nursing facility, including extended care or rehabilitation facilities. Personal convenience and entertainment items are not covered. The facility must be a lawfully operating institution or part of one which is for the medically necessary care and treatment of resident bed patients. It must:
(a) be supervised by a doctor;
(b) provide 24 hour nursing care supervised by a registered graduate nurse;
(c) maintain clinical records on all patients;
(d) have procedures for administration of drugs and biologicals; and
(e) not be used as a rest home, a home for the aged, or a home or facility primarily used for the care and treatment of mental diseases or disorders, or custodial or educational care.

A stay must begin within 14 days after discharge from a hospital and be recommended by a doctor for the same or a related condition. The doctor must certify that the covered person needs and receives daily medical services or care, which can only be provided in an extended care facility on an inpatient basis. At least once a month the doctor must recertify the need for continued confinement.

A maximum of 100 days coverage is provided for stays for the same or related conditions. Stays are considered separate when: the later stay begins after complete recovery from the condition causing the earlier stay; the later stay results from conditions unrelated to the cause for the earlier stay; or the covered person resumes full, normal activities for an uninterrupted period of at least 14 days between stays.

(5) Services of a doctor for medical care including diagnostic tests, surgical opinions, and surgery. Second opinions and in some cases third opinions, may be covered to a greater extent if the procedure is one listed on the most recent page 3.1. See section 6.5(2) for information on this additional benefit.

(6) Surgery and related expenses. Benefits are paid for such expenses as described in the other provisions of this section.

Coverage does not include expenses related to the following types of surgery: breast reconstruction surgery, unless done in connection with a mastectomy or lumpectomy on that breast; transsexual surgery; surgery to correct sexual dysfunction; or surgery related to treatment of infertility.

(7) Anesthesia and its administration.

(8) Skilled nursing care provided by: a nurse practitioner (NP); a registered nurse (RN); a licensed practical nurse (LPN); or a licensed vocational nurse (LVN). The care must be ordered and supervised by a doctor and must be services that can only be provided by a nurse. The cost of nursing care is limited per day to the amount of the average daily hospital charge found on the most recent page 3.

(9) Services of a licensed physical, respiratory, or speech therapist. The services must be ordered and supervised by a doctor for treatment of a covered injury or sickness and for rehabilitation or restoration of a function lost as a result of a covered injury or sickness.

(10) Professional ambulance service to the nearest qualified hospital by the mode of transportation that is medically required.

(11) X-ray and laboratory examinations.

(12) Medical supplies and equipment, including the following: surgical dressings, casts, splints, trusses; blood and blood derivatives; prosthetic appliances including artificial limbs and eyes; arm, leg, back, and neck braces; orthopedic shoes when they are part of leg braces; and oxygen equipment, hospital beds, wheelchairs, and other similar durable medical equipment for home use.

Medical supplies and equipment are limited to items designed exclusively for medical use and purpose. Items that have a general use or benefit, or are used for personal hygiene or convenience are not covered, such as air conditioners, humidifiers, physical fitness equipment, whirlpools, common first aid supplies, or nonallergenic bedding.

(13) Expenses resulting from complications of pregnancy. Such expenses are the only expenses related to pregnancy that are covered unless the maternity benefit rider is indicated on the most recent page 3. Complications include ectopic pregnancy, eclampsia, bleeding that requires blood transfusion, and the covered person's first Caesarean section delivery. To be eligible for payment, the pregnancy from which the complications arise from must have begun after this coverage was in effect. The amount of expenses covered is the difference between the reasonable and customary costs of normal childbirth in the area where delivery occurs and the total cost of the delivery with complications.

Complications do not include care or treatment of the following conditions during pregnancy: false labor; occasional spotting; rest prescribed by a doctor; morning sickness; and similar conditions related to the management of a difficult pregnancy but not classified as a complication of pregnancy.

Other expenses related to pregnancy and conception which are not covered include: normal pregnancy and childbirth; miscarriage; incomplete abortion; missed abortion; any Caesarean section deliveries after the covered person's first one; and any treatment directed specifically at inducing or allowing pregnancy to occur, such as artificial insemination and in vitro fertilization.

(14) Psychiatric care and counseling. This includes treatment for mental, nervous, or emotional disease or disorder. Coverage is limited to 60 days of inpatient care per benefit year. Care must be provided in a hospital or licensed facility specializing in such treatment. Payment on covered expenses for outpatient care is limited to $1500 per benefit year.

(15) Treatment of alcoholism and drug or substance abuse. Coverage is limited to 30 days of inpatient care per benefit year. Care must be provided in a hospital or licensed facility specializing in such treatment. Payment on covered expenses for outpatient care is limited to $500 per benefit year.

(16) Prescription drugs, which means drugs and medicines that:
(a) can only be obtained by written prescription of a doctor;
(b) are identified by a prescription number;
(c) are dispensed by a licensed pharmacist; and
(d) are approved as a prescription drug by the United States Food and Drug Administration (FDA) for the condition and use intended.

Prescription drugs do not include homeopathic medicines or products available over the counter, such as vitamins, enzymes, minerals and food supplements, except for insulin.

(17) Organ transplants. Expenses incurred for human organ or tissue transplant are covered when the procedure is not considered experimental or investigational, when it is performed in connection with a generally accepted, established and proven transplant procedure, and to the extent such expenses are not covered by other insurance or government programs. Transplants of mechanical or nonhuman organs are not covered expenses.

(18) Temporomandibular joint disorders (TMJ). Treatment for TMJ disorders is covered, including: the initial exam; diagnostic X-rays and study models; orthopedic repositioning appliance to realign the jaw; and follow-up visits to adjust the appliance. If surgery on the jaw, joint, or related structures apart from the teeth is required, surgical and related hospital expenses are covered. Any permanent work on the teeth in relation to TMJ treatment are not covered, such as crowns, bridges, extractions, and orthodontic treatment.

(19) Home health care. Benefits are paid for home health care when it takes the place of a stay in a hospital or skilled nursing facility. The maximum daily benefit provided for services required by a home health care plan is limited to the average daily hospital charge shown on the most recent page 3.

The covered person must be under the care of a doctor and have received the doctor's written approval for a plan of home health care. Once a month, the doctor must recertify the need for home health care to continue.

Coverage is provided for:
(a) Skilled nursing care as specified in number (8) of this section.
(b) Physical, respiratory, or speech therapy required to treat the condition requiring home health care.
(c) Medical supplies, prescription drugs, and laboratory services.

To qualify as a covered expense, home health care must be provided by a hospital or a public or private agency that:
(a) Is licensed to provide coordinated home health care.
(b) Has policies that are established by a professional group that includes at least one doctor and one nurse.
(c) Has services that are continuously supervised by a doctor or registered nurse.
(d) Maintains a complete medical record of each patient.
(e) Has an administrator.

(20) Hospice care. Benefits are paid for treatment provided by a licensed or certified hospice program or hospice facility. They are covered to the extent that such treatment qualifies as a covered expense under any other provision of this certificate.

6.5 ADDITIONAL BENEFITS

(1) Preventive credit. Each adult covered person is eligible for this credit on the anniversary of the issue date if he or she has not met the deductible within the preceding two benefit years. If you meet this requirement, AAL will pay up to the amount shown on the most recent page 3 toward the cost of a routine physical examination. The deductible does not have to be met.

Within 30 days of your examination, send the bill to AAL to receive the credit. If you do not take advantage of this credit when eligible, you do not get additional credit in the next benefit period. Only one credit per person is allowed every two years.

(2) Second and third surgical opinions. When your doctor recommends one of the selected surgical procedures listed on the most recent page 3.1 as treatment of an injury or sickness, AAL pays the complete cost of a second opinion from another doctor. The deductible does not have to be met. The second opinion includes costs for an examination and related tests and studies.

In order to qualify for this benefit, the second (or third) opinion must be given by a board-certified specialist who is not in practice with the doctor who gave the first opinion. The specialist must perform the examination in person and not perform the surgery.

If the second opinion confirms the need for surgery, the surgical and hospital expenses, and any preadmission tests done within 72 hours prior to surgery are covered at 90% copayment after the deductible is met instead of 80%. If the second opinion does not confirm the need for surgery but it is still performed, expenses are covered at 80% copayment.

When the second opinion does not agree with the first, coverage is provided for a third opinion. As with the second opinion, the third opinion for one of the selected procedures is covered in full for the same expenses. If the third opinion confirms the need for surgery, the surgical and hospital expenses and any preadmission tests done within 72 hours prior to surgery are covered at 90% copayment after the deductible is met instead of 80%. If the third opinion does not confirm the need for surgery but it is still performed, expenses will be covered at 80% copayment.

If the type of surgery your doctor recommends is not on the list, the cost of a second opinion is subject to the deductible and it is covered the same as the covered expenses in section 6.4. This list is subject to change. You will be notified if it does.

(3) Outpatient surgery. When one of the selected surgical procedures listed on the most recent page 3.1 is performed on an outpatient basis, AAL pays for the expenses at 90% copayment instead of 80%. The deductible must be met prior to payment being made. This list is subject to change. You will be notified if it does.

The expenses covered at 90% include charges from your doctor, the anesthesiologist, and the outpatient facility on the day of surgery. Any preadmission testing done within 72 hours of surgery is also covered at 90%.

7. EXCLUSIONS AND LIMITATIONS

This certificate does not cover:

(1) Preexisting conditions during the first two years coverage is in effect, unless they are disclosed in the application and not excluded from coverage by name or specific description.

(2) Care or treatment for which payment has been provided by Medicare or any similar law or program of the government (except Medicaid), workers' compensation, employer's liability, occupational disease or similar law, or under a motor vehicle no-fault plan; care, treatment, or services performed by a member of the covered person's immediate family (you, your spouse, or a child, parent, brother or sister of yours or your spouse's); and services for which no charge is normally made in the absence of insurance.

(3) Expenses which result from war or an act of war, declared or not.

(4) Reconstructive surgery to correct a condition that existed when coverage was issued and all cosmetic surgery. However, AAL will not deny benefits for reconstructive surgery:

(a) Due to injury, trauma, infection or other disease of the involved part of the body that occurs while this coverage is in effect; or
(b) To correct a congenital defect of a covered child born to you or your spouse while this certificate is in effect.

(5) Glasses, contact lenses, hearing aids and examinations, testing or fitting of them, expenses for surgeries to eliminate the need for vision aids or hearing aids, or radial keratotomies.

(6) Treatment, care, or surgery dealing with the teeth or absence of teeth, or periodontal structures. Expenses incurred as a result of injury to natural teeth are covered; however, the injury must have occurred while coverage is in effect and treatment must begin within 12 months of the date of injury.

(7) Mental, nervous, or emotional disease or disorder, except as provided in section 6.4(14).

(8) Alcoholism and drug or substance abuse, except as provided in section 6.4(15).

(9) Pregnancy, unless the maternity benefit rider is indicated on the most recent page 3. Complications of pregnancy are covered as provided in section 6.4(13).

(10) Expenses of a stay in a skilled nursing facility unless the stay begins within 14 days after discharge from a hospital for the same or related condition. Coverage is limited to 100 days per stay as provided in section 6.4(4).

(11) The cost of nursing care that is greater per day than the average daily hospital charge in your area.

(12) Intentionally self-inflicted injuries.

8. CLAIMS

8.1 NOTICE OF CLAIMS

Written notice of claim must be given as soon as reasonably possible. The notice shall be given to us at our home office located at 4321 North Ballard Road, Appleton WI 54919. Notice should include your name and the certificate number. Help may be obtained through an AAL district representative.

8.2 CLAIM FORMS

When we receive the notice of claim, we will send you forms for filing proof of loss. If you do not receive these forms within 10 days, you may meet the proof of loss requirements by giving us a written statement of the nature and extent of the loss within the time limit stated in section 8.3.

8.3 PROOF OF LOSS

Written proof of loss must be given within 90 days after such loss. If it was not reasonably possible to give written proof in the time required, we won't reduce or deny the claim for this reason, if the proof is filed as soon as reasonably possible. In any event, the proof must be given no later than 1 year (15 months in Hawaii) from time proof is otherwise required, unless you were legally incapacitated.

8.4 TIME OF PAYMENT OF CLAIMS

Benefits for loss covered by this certificate will be processed as soon as we receive proper written proof.

8.5 PAYMENT OF CLAIMS

Benefits will be paid to you or the provider of services upon your written request. Any benefits unpaid at your death will be paid to your estate.

If benefits are payable to your estate or to a covered person who cannot give a valid release, AAL may pay up to $1,000 of benefits to a person related to you by blood or marriage whom we consider to be entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

8.6 LIEN ON RECOVERY FROM THIRD PARTIES

If you claim benefits under this contract for any condition or injury for which a third party may be liable, AAL will pay any such benefits on the condition that you agree in writing: (1) to reimburse AAL to the extent of benefits AAL has provided as soon as you have collected damages or a settlement award from the third party or its insurance carrier; and (2) to provide AAL with a lien, to the extent of benefits provided by AAL. This lien may be filed with the person whose act caused the condition or injuries, his or her agent or the court.

8.7 PHYSICAL EXAMINATIONS

AAL, at its expense, has the right to have any covered person examined as often as reasonably necessary while a claim is pending or being paid.

8.8 MISSTATEMENT OF AGE, SEX, OR SMOKING HABITS

At time of issue, if a covered person's age, sex, or smoking habits were misstated, the premiums will be adjusted to the correct amount. Any premium due and unpaid may be deducted from a claim payment made under this certificate. Any overpayment will be returned.

8.9 LEGAL ACTIONS

No legal action may be brought to recover on this certificate until after 60 days from the date written proof of loss has been given. No such action may be brought after 3 years (5 years in Kansas, 6 years in South Carolina) from the time written proof of loss is required to be given.

9. PREMIUMS

9.1 PAYMENT OF PREMIUMS

The first premium is due on the issue date. After that, premiums are due on the first day of each premium interval. Upon request, we will furnish a receipt for premium paid.

If a premium is not paid when due or within the grace period (see section 9.4), the certificate will lapse.

9.2 PREMIUM INTERVAL

Premiums may be paid at annual, quarterly, or monthly intervals. The monthly interval is only available by automatic withdrawal from your checking account. Any other interval may be used as it is made available by AAL. You may change the premium interval at any time, unless premiums are being waived under the waiver of premium disability benefit rider. If you want to change to the annual interval, premiums must be paid to the certificate anniversary date.

9.3 CHANGES IN PREMIUM

AAL has the right to change the unit premium rate and the number of units on any premium due date. Any such change will be:

(1) Made without regard to a covered person's health or any prior claim payments made on behalf of a covered person; and
(2) Made only on a class basis. A class includes all covered persons residing in the same geographic area with the same benefit and any combination of: sex; deductible; smoking habits; age at issue; health at issue; the time since issue; and underwriting risk class at issue.

The number of units is based on the average daily hospital charge in the ZIP code area where you live.

9.4 GRACE PERIOD

If a premium is not paid on or before the due date, it may be paid during the following 31 day grace period. During the grace period, coverage will stay in effect. If a claim payment is made on expenses incurred during the grace period, the premium then due may be deducted from the payment.

10. REINSTATEMENT

Your coverage will lapse if a premium is not paid before the end of the grace period. If your coverage lapses, you may apply for reinstatement by completing an application and paying the premium due. It will be reinstated on the earlier of:

(1) The date the application is approved; or
(2) The 45th day (30th day in New Mexico) after the date of application, if not disapproved before then.

AAL may reinstate this certificate without an application if a premium payment is accepted after the end of the grace period.

The reinstated certificate will cover only loss that results from:
(1) Injury sustained after the date of reinstatement; and
(2) Sickness that first manifests itself after the date of reinstatement.

In all other respects, your rights and those of AAL will remain the same, subject to any provisions noted on or attached to the reinstated certificate.

The incontestability provision will operate anew from the date of reinstatement only as to statements made in the application for reinstatement.

11. SURPLUS REFUNDS

This is a participating certificate. It will share in the divisible surplus, if any, as determined and apportioned each year by the AAL Board of Directors.

12. GENERAL

12.1 INCONTESTABILITY

(1) Misstatements in the application.
After this certificate has been in effect for two years, AAL cannot contest it on the basis of statements made in the application, except for any claim for a loss that occurred during the two years or for fraudulent misstatements. If a different incontestability provision appears in any benefit rider, it applies to that rider only.

(2) Preexisting conditions
Unless a condition is excluded from coverage by name or specific description, no claim will be denied on the basis of preexistence after the first two years of coverage, even if the condition existed before coverage was in effect.

12.2 MAINTENANCE OF SOLVENCY

If the solvency of AAL ever becomes impaired, you may be required to make an extra payment. AAL's Board of Directors would determine a fair and just amount needed from each benefit member.

12.3 MEMBERSHIP

The applicant as shown in the application is a benefit member of AAL. This membership cannot be transferred. The privileges of membership are stated in AAL's Articles of Incorporation and Bylaws.

12.4 CONFORMITY WITH STATE STATUTES

If any part of this certificate is in conflict with the laws of the state in which you reside on the issue date, it is automatically amended to meet the minimum requirements of such laws.

- Major medical expense insurance
- Benefits for specified medical expenses
- Participating — surplus refunds

AAL

FRATERNAL BENEFITS
AND FINANCIAL SECURITY
FOR LUTHERANS