AID ASSOCIATION FOR LUTHERANS

MAJOR MEDICAL EXPENSE INSURANCE

- Benefits for specified medical expenses
- Precertification for hospitalization
- Second surgical opinion on selected procedures
- A deductible which is the greater of the basic deductible or the amount paid by other insurance

CONDITIONALLY RENEWABLE

This certificate is renewable until the first to occur of the following.

1) You reach age 65 or become eligible for Medicare. If your spouse is a covered person, this certificate is renewable until the younger adult covered person reaches age 65 or becomes eligible for Medicare.
2) Your premium is not paid before the end of the grace period.
3) We choose not to renew all health plans with the same form number in your state.
4) You become a covered person under other health insurance, that would result in overinsurance. Overinsurance is determined according to the standards on file with the South Carolina Insurance Commissioner.

See section 4 for more information on when coverage for each covered person ends.

BENEFITS WILL BE REDUCED IF COST CONTAINMENT PROCEDURES ARE NOT FOLLOWED.

Countersignature of Licensed Resident Agent

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 MISSTATEMENTS IN IT COULD CAUSE A CLAIM TO BE DENIED. WRITE TO US IMMEDIATELY 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 condition misrepresented or not revealed in the application and for which symptoms were present within two years before the effective date that would cause a prudent person to seek diagnosis, care, or treatment, or for which medical advice or treatment was recommended by or received from a doctor.

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

W. R. Heerman — Secretary

R. L. Henderson — President

AAL

FRATERNAL BENEFITS AND FINANCIAL SERVICES FOR LUTHERANS

TABLE OF CERTIFICATE PROVISIONS

1. THE INSURANCE CONTRACT

1.1 GENERAL

This certificate of membership and major medical expense insurance, is a legal contract issued by Aid Association for Lutherans (AAL). It is issued in exchange for and on the basis of the application and payment of the first premium. AAL will provide the benefits and rights of this certificate. 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.

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 underwriting 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

Any person eligible for coverage but not covered as of the issue date may be added later if: (1) You make a written application to add the person; (2) You pay any additional premium; and (3) 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.

A child born to you or your spouse (or a covered dependent child) while this certificate is in force becomes a covered person at birth. Evidence of insurability is not required. For coverage to continue, you must send us a written request to add the newborn as a covered person and pay any additional premium due within 31 days following birth. If the request is not sent to AAL within this period, evidence of insurability is required to add the newborn. If both parents have separate major medical certificates with AAL, the newborn will be eligible for coverage under only one of them. The newborn of a covered dependent child who is under age 18 is added as a covered person under this certificate. A covered dependent child who is 18 years old or older and has a baby, is issued a separate certificate with the newborn as a covered person.

3. WHEN COVERAGE FOR EACH COVERED PERSON BEGINS

Coverage for each covered person listed on the application begins 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.

4. WHEN COVERAGE FOR EACH COVERED PERSON ENDS

4.1 AT YOUR OPTION

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

If a premium is not paid when due, coverage for all covered persons ends on the last day of the 31-day grace period. 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; or
(2) The premium due date following the date the child is no longer chiefly dependent on you or your spouse for support and maintenance; or
(3) The date the child becomes eligible for Medicare; or
(4) The premium due date following the child's 23rd birthday; or
(5) The date of death.

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 you for support and maintenance, is not married, and is not eligible for Medicare. Proof of such 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.

4.3 OUR RIGHT TO NON-RENEW

AAL has the right not to renew this coverage if you become a covered person under other health insurance after this coverage is in effect and if other coverage results in overinsurance. Overinsurance is determined according to the standards on file with the South Carolina Insurance Commissioner. Any premium paid since you became overinsured will be refunded.

AAL also has the right not to renew all health insurance certificates with the same form number in your state. If we choose not to renew, it will not be effective until the next premium due date. A notice will be sent at least 30 days before the date coverage ends. Our decision not to renew would not be based upon any change in the physical or mental condition of any covered person.

We will continue benefits for a covered person if he or she is continuously disabled and is being treated for a covered injury or sickness when coverage ends. Covered expenses for that claim are subject to copayment, as described in section 6.4. Coverage for that person continues until the person's continuous disability ends, but not for more than 12 months.

If a covered person is pregnant on the date coverage ends, we will continue coverage for that pregnancy. Benefits are paid on expenses for that pregnancy, the same as they would have been paid if coverage was still in force.

5. CONVERSION PRIVILEGE

When a person is no longer covered due to a change in eligibility, AAL will issue a new certificate to him or her, if one is then currently being issued in your state. 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 then currently being issued in your state. If the proper coverage is not available in your state or the person is insured for similar benefits under any other health insurance 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 current age.

Written request for conversion and the first premium must be received by AAL within 31 days after this coverage ends. If coverage ends due to divorce, the former spouse must send us written request and the first premium within 60 days from the date of entry of a valid divorce decree or within 31 days after this coverage ends, whichever allows the greatest time period. 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. Reasonable and customary means the range of charges ordinarily made by providers in that geographic location for the same service or supply. Charges above those considered customary may be considered as covered expenses if they can be justified by complexity of treatment.

6.1 Continued

Coverage for a newborn consists of coverage of injury or sickness including: the care and treatment of medically diagnosed congenital defects and 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 certificate schedule found on page 3.

Benefits are determined on a calendar year basis. A new calendar year begins on January 1 each year.

6.2 DEDUCTIBLES

The deductible amount for covered expenses incurred by a covered person within any one calendar year is the greater of: (1) the basic deductible; and (2) the variable deductible. These deductibles are described below.

(1) Basic Deductible

This deductible amount is shown on page 3.

To meet this deductible on an individual basis, one covered person must incur covered expenses equal to the deductible within a calendar year. Once it has been met, benefits for that person will be paid on covered expenses greater than the deductible.

Covered expenses incurred during October, November, or December are applied to the deductible for the next calendar year if they were applied to the deductible for the previous year.

(2) Variable Deductible

This deductible is equal to the amount of hospital and medical expenses reimbursed by other medical expense coverage for the expenses covered under this certificate.

The amount of the variable deductible that is greater than the basic deductible will be disregarded to the extent necessary to provide payment for any covered expenses for which payment has not been made. The amount of benefits provided by this certificate plus the benefits provided by other medical expense coverage will be no more than 100 percent of actual covered charges.

If the insured or a covered person has other medical expense coverage that has a similar deductible provision and provides benefits for the same loss, the following conditions will apply:

(a) If AAL has not been given notice of the other medical expense coverage before the loss started, benefits under this certificate will be pro-rated based on the basic deductible. The pro-rating percent is found by dividing the benefits from this coverage plus the other coverage we were notified of, by the benefits from this coverage plus all other medical expense coverage. A premium refund will be made that goes back to the date of inception of the other medical expense coverage we did not know about. The refund will be based on premium paid that exceed the pro-rating percent.

6.2 continued

(b) If the insured has given us notice of all other medical expense coverage before the loss started, and we did not use our right to non-renew, the benefits of this certificate will be paid using the basic deductible.

Other medical expense coverage includes any other insurance or prepayment plan for confinements and medical services or supplies. Examples are: uninsured plans; individual hospital or medical insurance plans; individual and group hospital or medical services prepayment plans; motor vehicle plans; and group coverage through an employer, union or membership in an association. If the other coverage provides benefits on a service basis, then we assume the amount of those benefits are the amount the services rendered would have cost without such coverage.

The family deductible is met when two covered persons each meet their annual deductible on the individual basis. When this occurs, no other covered persons have to meet their deductible during that 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. Only the amount of charges that are reasonable and customary are covered, unless the additional amount can be justified by complexity of treatment.

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 or a sickness that occurs while on a trip outside of the United States and requires immediate treatment; 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.

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 COPAYMENT

Each calendar year, benefits are payable on expenses incurred as follows, unless specified otherwise in section 6.5.

(1) You are responsible for paying the amount of covered expenses up to the deductible amount and for paying any expenses incurred for care or treatment not covered under this certificate.

(2) After the deductible is met, you are responsible for paying 20 percent of covered expenses up to the coinsurance corridor amount shown on the most recent page 3. AAL pays the remaining 80 percent of covered expenses.

(3) Covered expenses above the deductible and the coinsurance corridor amount are paid by AAL at 100 percent, subject to the lifetime maximum of $2,000,000. Each person reaches their lifetime maximum when the total of benefits paid by AAL for that covered person equals the lifetime maximum benefit amount.

The family coinsurance corridor is met when two covered persons each meet their coinsurance corridor amount. When this occurs, no other covered persons have to meet their coinsurance corridor amount during that year, but benefits will be paid as if they had.

6.5 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.

All non-emergency hospital stays must be certified by calling the hospital review program shown on page 3.2 of this certificate and on your health insurance identification card. Hospital stays resulting from complications of pregnancy do not have to be certified. You or your docfor must call the hospital review program to obtain certification of the hospitalization prior to admission. Review of this certification may be necessary while you are hospitalized, if your doctor wants to extend the hospital stay. The hospital review program must be notified of an emergency admission within 24 hours of admission or the next working day. This certification is a way to help control and manage your health care costs.

If your entire hospital stay is certified, benefits are provided as described in section 6.4. If you do not have the entire hospital stay certified, or you remain hospitalized longer than the number of days that have been certified by the hospital review program, covered expenses will be reduced by 5 percent. This reduction applies to all expenses for that confinement, including related expenses. Related expenses are those expenses incurred from the date of admission through the date of discharge.

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 one or more doctors;

(c) has 24-hour nursing care that is provided by or under the supervision of a registered graduate nurse; 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.

6.5 continued

(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 and custodial and intermediate care 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 provided by or under the supervision of 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 educational or custodial 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 more than 6 months after the earlier stay; or the later stay results from conditions unrelated to the cause for the earlier stay.

(5) Services of a doctor for medical care including diagnostic tests, surgical opinions, and surgery.
(a) If your doctor recommends one of the non-emergency surgical procedures listed on page 3.1, you or your doctor must call the second surgical opinion program. The telephone number is shown on page 3.2 of this certificate and on your health insurance identification card. An authorized person from the program will discuss the recommendation for surgery with your doctor and decide if a second opinion should be obtained.

If you or your doctor do not call before you obtain a second opinion or you do not obtain a second opinion when one is recommended, the amount of covered expenses for that surgery and any related expenses will be reduced by 5 percent. Related expenses for surgery performed as an inpatient are those incurred from the date of admission through the date of discharge. If the surgery is performed as an outpatient or in a doctor's office, related expenses are those incurred on the day of surgery.

When a second opinion is approved through the second surgical opinion program, the full cost of obtaining the second opinion is paid by AAL. The deductible does not have to be met. If the second opinion agrees with the first, expenses for that surgery and any related expenses will be covered as described in section 6.4.

When the second opinion does not agree with the first, the full cost of obtaining a third opinion is paid by AAL. The deductible does not have to be met. This must be handled through the second surgical opinion program also. If the third opinion confirms the need for surgery, expenses for the surgery, including related expenses, are covered as described in section 6.4.

If the third opinion does not confirm the need for surgery or you do not obtain a third opinion, but the surgery is still performed, the covered expenses for that surgery, and any related expenses, will be reduced by 5 percent.

6.5 continued

(b) If the type of surgery your doctor recommends is not on the list shown on page 3.1, the cost of a second opinion is subject to the deductible and is covered as described in section 6.4.

The second (or third) opinion must be given by a duly licensed doctor who is qualified by training and has experience in performing such surgery. The doctor must perform the examination in person and not perform the surgery or be in practice with the doctor who gave the first opinion. The list of surgical procedures on page 3.1 is subject to change. You will be notified of changes as they occur.

(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 received by an RN, LPN, or LVN must be ordered and supervised by a doctor and must be services that can only be provided by a nurse.

(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) Care in connection with the detection and correction of structural imbalance, distortion, subluxation or misalignment of the body are covered expenses. Coverage includes manipulation, spinal adjustment, ultrasound treatment, and all other modalities to treat the above listed conditions. Covered expenses are limited to $1,000 per person in a calendar year.

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

(12) X-ray and laboratory examinations.

(13) 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.

6.5 continued

(14) 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. The amount of covered expenses is the total expenses incurred for that pregnancy, less the expenses that are attributed to normal pregnancy and childbirth. The expenses for normal pregnancy and childbirth are the reasonable and customary costs normally incurred in connection with a vaginal delivery in the area where the delivery occurs.

To be eligible for payment, the pregnancy from which the complications arise from must have begun after this coverage was in effect. Complications include: miscarriage; incomplete abortion; missed abortion; ectopic pregnancy; eclampsia; bleeding that requires blood transfusion; and the covered person's first Caesarean section delivery. Any Caesarean section deliveries after the first are covered only if the Maternity Expense Benefit Rider is issued or if the Caesarean section delivery is a result of a complication of that pregnancy. Hospital stays resulting from complications of pregnancy do not have to be certified through the hospital review program.

Complications do not include care or treatment of the following conditions during pregnancy: false labor; occasional spotting; rest prescribed by a doctor; morning sickness; similar conditions related to the management of a difficult pregnancy but not classified as a complication of pregnancy; and any treatment directed specifically at inducing or allowing pregnancy to occur, such as artificial insemination and in vitro fertilization.

(15) Psychiatric care and counseling. This includes treatment for mental, nervous, or emotional disease or disorder. Coverage is limited to 30 days of inpatient care per calendar 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 $1,000 per person in a calendar year.

(16) Treatment of alcoholism and drug or substance abuse. Coverage is limited to 30 days of inpatient care per calendar 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 person in a calendar year.

(17) 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.

(18) 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.

6.5 continued

(19) 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.

(20) 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 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.

(21) 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.

(22) Expenses incurred as a result of injury to natural teeth are covered. The injury must have occurred while coverage is in effect and treatment must begin within 12 months of the date of injury.

7. EXCLUSIONS

This certificate does not cover expenses incurred:

(1) Due to 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) For care or treatment to the extent benefits have been provided by Medicare or any similar law or program of the government (except Medicaid), workers' compensation, employer's liability, or occupational disease or similar law.

(3) For 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).

(4) In excess of what is normally charged in the absence of insurance.

7 continued

(5) As a result of injury due to a war or an act of war, whether declared or not.

(6) For 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 (or a covered dependent child) while this certificate is in effect.

(7) For glasses, contact lenses, hearing aids and examinations, testing or fitting of them.

(8) For 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 as provided in section 6.5(22).

(9) Due to pregnancy, unless the maternity benefit rider is indicated on the most recent page 3. Complications of pregnancy are covered as provided in section 6.5(14).

(10) For 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 6.5(4).

(11) Due to 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 in 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

:fits will be paid to you or the provider of services upon your written request. Any ben..its 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 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.

8.7 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. Premiums already paid, as well as future premiums, will be adjusted. Any premium due and unpaid may be deducted from a claim payment made under this certificate. Any overpayment will be returned.

8.8 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

8.9 LIEN ON RECOVERY FROM THIRD PARTIES

When benefits are paid for a covered person under the terms of this contract, the insurer shall be subrogated (unless otherwise prohibited by law), to the rights of recovery of such covered person against any person who might be acknowledgedly liable or found legally liable by a Court of competent jurisdiction for the injury or sickness that necessitated the hospitalization or the medical or the surgical treatment for which the benefits were paid. Such subrogation rights shall extend only to the recovery by the insurer of the benefits it has paid for such hospitalization and treatment and the insurer shall pay fees and costs associated with such recovery.

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

:iums may be paid at annual, quarterly, or monthly intervals. The monthly interval is only :le 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 premium on any premium due date. You will be notified of any change at least 31 days before it becomes effective. Changes are based on the ages of covered persons, as of their last birthday. 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; coinsurance corridor amount; smoking habits; age; health at issue; the time since issue; and underwriting risk class at issue.

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. The grace period does not apply if we deliver or mail, to your last address shown in our records, written notice of our intent not to renew this certificate.

10. REINSTATEMENT

Your coverage ends if a premium is not paid before the end of the grace period. If your coverage ends, you may apply for reinstatement by completing an application and paying the premium due. A payment accepted for reinstatement can only be applied to pay a premium that has not already been paid. The payment may only be applied to cover a period of time that is not more than 60 days prior to the date of reinstatement. Coverage 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.

This coverage will be reinstated without an application if we accept a premium payment 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.

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

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.
Coverage will be incontestable, as to statements made in the application, after two years from the effective date of coverage for each benefit for each covered person, except for any claim for a loss that occurred during these 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
- Precertification for hospitalization
- Second surgical opinion on selected procedures
- A deductible which is the greater of the basic deductible or the amount paid by other insurance

AAL
Fraternal Benefits And Financial Security For Lutherans