AID ASSOCIATION FOR LUTHERANS

MAJOR MEDICAL EXPENSE INSURANCE

- Benefits for specified medical expenses
- Precertification for inpatient and outpatient care or treatment
- Renewal at option of AAL

RENEWAL PROVISION

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 like health plans in your state.

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

NOTICE OF 10-DAY RIGHT TO RETURN AND 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 OR MAKE THIS CERTIFICATE VOID. WRITE TO US IMMEDIATELY IF ANY INFORMATION SHOWN ON IT IS NOT CORRECT OR IF DETAILS OF ANY MEDICAL HISTORY OR INFORMATION ABOUT OTHER COVERAGE HAVE 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.

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

W. R. Sherman — Secretary

R. L. Henderson — President

Aid Association for Lutherans

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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 the payment of the first premium. AAL will provide the benefits and rights of this certificate.

Payment of the first premium provides coverage through the end of the premium interval shown on page 3. That interval begins on the issue date. 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 consists 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 our 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.

2.2 Continued

A child born to you, your spouse, or a covered dependent child, while this certificate is in force, becomes a covered person at birth automatically. A child adopted while this certificate is in force becomes a covered person as of the date you become legally responsible for the child. Such coverage continues for 31 days without the need to provide evidence of insurability. For coverage to continue past the 31-day time period, you must send us a written request to add the child as a covered person and pay any additional premium due. If the request is not sent to AAL within this time period, coverage ends and evidence of insurability acceptable to AAL is required to add the child as a covered person.

If both parents have separate major medical certificates with AAL, the child 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 most recent page 3 begins under this certificate on the earliest of the following:

(1) At 12:01 a.m. on 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
(2) At 12:01 a.m. on the date that AAL receives payment of the first premium if paid after the certificate is issued.

Coverage for a child born to any covered person named on page 3 while this certificate is in force begins at birth. Coverage for an adopted child begins on the date you become legally responsible for the child. Such coverage continues for 31 days without the need to provide evidence of insurability. You must send us a written request to add the child as a covered person and pay any additional premium due for coverage to continue past the 31-day time period.

"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.

4.2 DUE TO NON-PAYMENT OF PREMIUM

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 reinstate coverage, section 10 describes how you can apply for reinstatement.

4.3 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 your 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. Proof that the child is still in this condition must be given to us as requested which will not be more than once per year.

4.4 AT OUR OPTION

AAL has the right not to renew all like health insurance certificates 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 coverage for a covered person if he or she is totally 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 total disability ends, but not for more than 12 months. Total disability must result from an injury or sickness that prevents a covered person from performing his or her regular occupation or employment for wage or profit.

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 covered person's coverage ends due to a change in eligibility, we will issue a new certificate to him or her, if we have one available for issue in the state in which he or she resides. The type of coverage issued will either be a Medicare supplement or another major medical certificate, as applicable. If major medical coverage is issued, the certificate would be one that contains the same or most similar benefits as this one. No certificate will be issued if: AAL does not have the type of coverage available that the covered person is eligible for at the time this coverage ends; or the covered person is insured for similar benefits under any other health insurance when this coverage ends.

The premium for a certificate issued to a covered person who is eligible for Medicare or to a child whose coverage ends due to a change in eligibility 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. The new certificate will be issued without regard to any changes in the covered person's health since the time coverage under this certificate began. Coverage under the new certificate 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 under this certificate for two types of expenses. They are: hospital, medical, and surgical expenses incurred by a covered person for medically necessary care and treatment of covered injury or sickness; and for the expenses incurred that are specified in this certificate as Additional Benefits. Benefits are paid only for expenses that are eligible for coverage under this certificate and meet the applicable requirements for benefits to be paid. Both types of expenses are subject to the deductible and copayment provisions.

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

6.2 DEDUCTIBLE

The basic deductible amount is shown on page 3.

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

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.

6.2 Continued

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 COPAYMENT

Each calendar year, benefits are payable on expenses incurred as follows, unless specified otherwise in section 6.

(1) AAL pays 80 percent of expenses covered under this certificate over the deductible amount and up to the coinsurance corridor amount. These amounts are shown on the most recent page 3.
(2) Expenses covered under the certificate above the deductible and the coinsurance corridor amount are paid by AAL at 100 percent, not to exceed 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 the total expenses being applied to meet the coinsurance corridor for all covered persons equals the total of two individual coinsurance corridor amounts. 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.

6.4 COVERED EXPENSE REQUIREMENTS

Covered expenses include only charges actually incurred for care or treatment of an injury or sickness. 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, infertility, sexual dysfunction, or any physical abnormality that does not cause medical problems.

Benefits are only paid for expenses for care and treatment eligible for coverage under this certificate and meet all of the following requirements:

(1) The care and treatment must be medically necessary. It is medically necessary only if according to generally accepted medical practice in the United States, the type and level of care and treatment cannot be omitted without adversely affecting the patient's medical condition.

(2) The insured or covered person is legally obligated to pay the charges.

(3) The expenses are incurred by a covered person for a loss that began while coverage for that person is in effect.

(4) The charges for care, treatment, services, or supplies are 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. Only the amount of charges that are reasonable and customary are covered.

6.4 Continued

(5) The care and treatment must be recognized as safe, appropriate, and proven effective by the medical community in the United States. It must not be considered experimental or investigational 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.

(6) The care and treatment must be prescribed by a doctor. 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.

(7) The care and treatment must 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 traveling outside of the United States and requires immediate treatment.

(8) The care and treatment must be available only by skilled medical professionals.

(9) The care and treatment must not be custodial care. Custodial care includes assistance with activities of daily living, such as help with eating, dressing, bathing, walking, taking medicine, and getting in and out of bed.

(10) The expenses must not be excluded or limited under this certificate.

6.5 TYPES OF EXPENSES ELIGIBLE FOR COVERAGE

The following types of expenses are eligible for coverage under this certificate. 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 duly licensed and operating within the scope of such license.

The hospital must be a lawfully operating institution which is licensed or approved as a hospital by the responsible state agency. It must provide care and treatment of injured or sick persons as resident bed patients and:

(a) have facilities or access to facilities on a prearranged basis for diagnosis and treatment;

(b) be supervised by a staff of one or more doctors;

(c) have 24-hour nursing care that is provided by or under the supervision of a registered graduate nurse always on duty; and

(d) not be 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) Outpatient care, treatment, services, and supplies. The outpatient facility must be duly licensed and operating within the scope of such license.

6.5 Continued

(4) Room and board and necessary services and supplies for skilled nursing care 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. A skilled nursing facility is 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 covered person must need and receive daily medical services or care, which can only be provided in an extended care facility on an inpatient basis. The doctor must certify that the covered person needs and is receiving daily medical service 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.

When multiple surgeries are performed at the same operative session, the following limitations apply:

(a) If the procedures are performed through the same incision or in the same operative field, the benefits payable will not exceed the reasonable and customary cost of the most costly procedure performed.

(b) If the procedures are performed in separate operative fields and through separate incisions, the benefits payable will be the sum of: the reasonable and customary cost of the major procedure; plus one-half of the reasonable and customary cost for each of any lesser procedure.

(c) When bilateral, similar procedures are performed in separate operative fields, the benefits payable will be: the reasonable and customary cost of the first procedure; plus one-half of the reasonable and customary cost of the second procedure.

The amount payable includes the fee for surgery and for the period of follow-up care. Charges for the services of an assistant surgeon are limited to 25 percent of the reasonable and customary charges for the surgeon.

(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 or complications due to any of these: breast reconstruction surgery, unless done in connection with a mastectomy or lumpectomy on that breast; transsexual surgery; surgery where the primary purpose is to correct sexual dysfunction; or surgery related to treatment of infertility.

(7) Anesthesia and its administration.

(8) Skilled nursing care provided in a facility licensed to provide medical treatment by: a nurse practitioner (NP); a registered nurse (RN); a licensed practical nurse (LPN); or a licensed vocational nurse (LVN). The care received from an RN, LPN, or LVN must be ordered and supervised by a doctor and must be medical services that can only be provided by a licensed 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. Expenses eligible for coverage 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 and includes up to two days confinement in a hospital.

To be eligible for payment, the complications 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 non-elective Caesarean section delivery.

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:

(a) Care and treatment of mental, nervous, or emotional diseases or disorders, and;

(b) Psychiatric care and counseling for the treatment of physical or organic sickness.

Coverage for such treatment is limited to 30 days of inpatient care per calendar year. Payment for outpatient care for such treatment is limited to $1,000 per person in a calendar year. Care for inpatient and outpatient treatment must be provided in a hospital or licensed facility specializing in such treatment to be eligible for coverage.

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

(17) Prescription drugs, which means drugs and medicines that: can only be obtained by written prescription of a doctor; are identified by a prescription number; are dispensed by a licensed pharmacist; and 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 eligible for coverage 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. Donor related expenses are included in coverage for transplants. Expenses for transplants of mechanical or nonhuman organs are not covered.

6.5 Continued

(19) Temporomandibular joint disorders (TMJ). Treatment for TMJ disorders is eligible for coverage, 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 is not covered, such as crowns, bridges, extractions, and orthodontic treatment.

(20) Home health care. Home health care means treatment of sickness or injury provided in the home or another location that is not a facility licensed to provide medical treatment. Home health care coverage is provided only for:

(a) Visits by a registered nurse, a licensed practical nurse, or a licensed vocational nurse, to provide skilled nursing care that can only be provided by a licensed nurse.

(b) Visits by a physical, occupational, respiratory, or speech therapist or audiologist to provide physical, occupational, respiratory, or speech therapy required to treat the condition requiring home health care.

(c) Medical supplies, prescription drugs, and laboratory services.

(d) Home health aide services. The aide must be under the supervision of a Registered Nurse or qualified therapist.

(e) Nutrition counseling by a nutritionist or dietitian.

(f) Medical social services.

For home health care to be eligible for coverage, the care must take the place of a stay in a hospital or skilled or intermediate 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, and that it takes the place of a stay in a hospital or skilled or intermediate nursing facility.

In addition, the home health care must be provided through a hospital or a public or private agency that: is licensed to provide coordinated home health care; has policies that are established by a professional group that includes at least one doctor and one nurse; has services that are continuously supervised by a doctor or registered nurse; maintains a complete medical record of each patient; and has an administrator.

Home health care coverage is provided for up to 100 home health care visits per covered person in a calendar year. Up to 4 consecutive hours of care or therapy in a 24 hour period is considered one visit.

(21) Hospice care. Benefits are paid for treatment provided by a licensed or certified hospice program or hospice facility. This covered person must have been diagnosed as terminally ill with a life expectancy of six months or less for benefits to be paid. Coverage is provided for:

(a) Skilled nursing care.

(b) Physical, occupational, respiratory, and speech therapy or audiology required to treat the condition requiring hospice care.

(c) Medical supplies, prescription drugs, and laboratory services.

6.5 Continued

(d) Home health aide services. The aide must be under the supervision of a Registered Nurse or qualified therapist.

(e) Nutrition counseling by a nutritionist or dietitian.

(f) Medical social services.

(g) Family counseling related to the member's terminal condition.

(h) Respite care, as a temporary relief for the provider of hospice care due to an unforeseen emergency or to the daily demands of caring for the person.

(i) Bereavement support services for the family of the deceased person during the 3 months after the death of the covered person. Payment for this benefit is limited to $500.

Any other expenses are covered to the same extent 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.

(23) Treatment of cleft lip and cleft palate for a newborn child born while this coverage is in effect. Care and treatment of cleft lip, cleft palate, or any condition or illness which is related to or developed as a result of cleft lip or cleft palate is eligible for coverage. Care and treatment includes the following, to the extent medically necessary:

(a) Oral and facial surgery, surgical management, and follow-up care by plastic surgeons and oral surgeons.

(b) Prosthetic treatment such as obturators, speech appliances, and feeding appliances.

(c) Medically necessary orthodontic treatment.

(d) Medically necessary prosthodontic treatment.

(e) Habilitative speech therapy.

(f) Otolaryngology treatment.

(g) Audiological assessments and treatment.

6.6 PRECERTIFICATION REQUIREMENTS

All hospital stays must be precertified by calling the hospital review program shown on page 3.1 of this certificate. This number is also found on your health insurance identification card. To precertify a non-emergency hospital stay, you (or your doctor) must contact the hospital review program at least 7 days prior to the date of admission. If your doctor wants to extend the hospital stay past the number of days that were already precertified, you or your doctor must contact the hospital review program. An extended stay review will be done to precertify the additional days. For emergency admissions, the hospital review program must be notified within 48 hours of admission to precertify the admission.

6.6 Continued

If you do not contact the hospital review program to have the hospital stay precertified, or you remain hospitalized longer than the number of days that have been precertified, expenses eligible for coverage will be reduced by $250.00. This reduction applies to each hospital admission that is not precertified through the hospital review program.

All outpatient non-emergency surgical or diagnostic procedures must be precertified if they meet one of the following requirements: the procedure requires a signed operative consent form authorizing the procedure to be done; or the surgeon's fee or cost of the procedure exceeds $500.00. To precertify the outpatient procedure, you (or your doctor) must call the outpatient review program shown on page 3.1 of this certificate at least 48 hours prior to the date the procedure is performed.

If you do not have the outpatient procedure precertified, expenses eligible for coverage will be reduced by $50.00. Emergency outpatient procedures do not have to be precertified.

The precertification process does not determine whether or not expenses are covered under this certificate. The process provides a preliminary review and assessment by AAL of the medical necessity, location of services, length of stay, and appropriateness of the proposed admission or procedure.

6.7 ADDITIONAL BENEFIT REQUIREMENTS

Additional benefits include only charges actually incurred for the expenses listed in the section that is entitled "Additional benefits eligible for coverage." In order to be eligible for benefits, the expenses must meet all of the following requirements:

(1) The insured or covered person is legally obligated to pay the charges.

(2) The expenses are incurred by a covered person for a loss that begins while coverage for that person is in effect.

(3) The charges for care, treatment, services, or supplies are 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. Only the amount of charges that are reasonable and customary are covered.

(4) The care and treatment must be prescribed by a doctor. 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.

(5) The expenses must not be excluded or limited under this certificate.

6.8 ADDITIONAL BENEFITS ELIGIBLE FOR COVERAGE

(1) Routine mammograms. Expenses incurred for routine mammograms are eligible for coverage at the following intervals: one baseline mammogram for covered persons from 35 through 39 years old; one mammogram every 1 to 2 years for covered persons from 40 through 49 years old; and one mammogram every year for covered persons aged 50 or above.

6.9 OTHER INSURANCE

This provision applies when you are also covered under other valid coverage that we were not notified of until after a loss. The other coverage may provide benefits for the same loss on either a provision of service basis or on an expense incurred basis. If the benefits are provided on a provision of service basis, the amount deemed to be payable will be what the services would have cost in the absence of the plan.

The benefits payable under this provision will be limited to a prorated benefit amount. This benefit amount is determined by dividing the benefits payable from this certificate plus the benefits payable under other coverage we were notified of when you applied for this certificate, by the benefits payable from this certificate and all other coverage. Benefit payments from this plan when combined with the benefits paid from the other coverage shall not exceed 100 percent of the total eligible expenses incurred.

In addition, a portion of the last premium paid to AAL will be returned. The portion that will be returned is the portion that exceeds the pro-rata portion of the benefit payable. It is calculated by subtracting the pro-rata portion of the benefits payable from 100 percent and then multiplying the last premium paid to AAL by that percentage. An example is, if a claim payment is made for 70 percent of the eligible expenses incurred, 30 percent of the last premim paid will be refunded. The premium refund will be limited to the amount we would have paid if no other insurance was in effect, less the pro-rata claim payment.

Other valid coverage includes: hospital and medical expense insurance policies; health or welfare plan; automobile medical payments insurance; any medical services prepayment or indemnity arrangement; and coverage provided on an individual, family, or group basis through an employer, union, or membership in an association. It does not include any of the following: hospital indemnity plans providing coverage on a non-expense incurred basis; cancer or specified disease plans; or accident only plans.

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.

(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

7 Continued

(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, expenses for surgeries to eliminate the need for vision aids or hearing aids, or radial keratotomies.

(8) For treatment, care, or surgery dealing with the teeth or absence of teeth, or periodontal structures except when it is to treat cleft lip or cleft palate of a newborn covered child. Expenses incurred as a result of injury to natural teeth and for cleft lip and cleft palate are covered as provided in section 6.5.

(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.

(10) 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 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 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 from the time written proof of loss is required to be given.

8.9 BENEFIT APPEAL PROCEDURE

If you have a claim for benefits which is denied in whole or in part, you have the right to appeal the claim denial by sending us a written request for review. Mail your request to AAL in Appleton, Wisconsin 54919 and enclose any supporting material. Within 30 days of receiving your request, we will review your claim in detail and send you written notice of the results of the review.

9. PREMIUMS

9.1 PAYMENT OF PREMIUMS

The first premium is due on the issue date. To keep this certificate in effect, each premium must be paid to AAL when due. Premiums are due on the first day of each premium interval. Upon request, we will furnish a receipt for premium paid. This certificate will terminate when any premium is not paid in full when due or within the grace period.

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 premium on any premium due date. 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

The grace period is the 31-day period that follows a premium due date. If a premium is not paid on or before the due date, it may be paid during the 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. Evidence of insurability that is acceptable to AAL must be provided. 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: the date the application is approved; or the 45th day after the date of application, if not disapproved before then. This coverage will be reinstated if we accept a premium payment after the end of the grace period and do not require an application for reinstatement.

The reinstated certificate will cover only loss that results from: injury sustained after the date of reinstatement; and 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 TIME LIMIT ON CERTAIN DEFENSES

(1) MISSTATEMENTS IN THE APPLICATION

Coverage will be incontestable, as to statements made in the application, after two years from the date coverage begins 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) CONTESTABILITY BASED ON APPLICATION FOR PRIOR COVERAGE

The application for the AAL major medical certificate that was in effect immediately before this certificate was issued shall be considered the application for this certificate for the purpose of contesting coverage under this certificate, if this certificate was issued to you:

12.1 Continued

(a) after AAL chose not to renew your major medical certificate which was in effect immediately before this certificate was issued; and

(b) AAL did not require an application or evidence of insurability for the issue of this certificate.

In such case, the two year period described in paragraph (1) above shall begin to run from the date coverage began under your AAL major medical certificate that was in effect immediately before this certificate was issued.

(3) 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 inpatient and outpatient care or treatment
- Renewal at option of AAL