MAJOR MEDICAL POLICY

We promise to pay the benefits described in this policy, subject to its provisions. We issue this policy to you in consideration of your application and the payment of premiums.

Renewal May be Refused. Unless we refuse to renew this policy, you can renew it by paying your premium on time until the first of the month of your 65th birthday or until you become eligible for Medicare, whichever comes first. We can refuse to renew this policy on any policy anniversary as long as we refuse to renew all policies like this one in your state of residence. We will send you at least 31 days notice of our refusal to renew.

Premium Rates May Change. The premium shown on page 3 applies only to the first year this policy is in force. In subsequent years, we will charge renewal premiums according to our table of premiums in effect on the date your premium is due. We expect premiums to increase as age increases and as new premium tables become effective. Premiums also depend on your place of residence and may increase or decrease if you move. We may change our table of premiums from time to time. A change will be based on the expected claim experience on all policies similar to this one. The change will apply on a class basis to all policies like this one in your state of residence.

IMPORTANT NOTICE. Please read the copy of the application attached to this policy. Carefully check the application and write to us within ten (10) days if any information shown on it is not correct and complete, or if any past medical history has been left out of the application. This application is a part of the policy and the policy was issued on the basis that answers to all questions and the information shown on the application are correct and complete.

RIGHT TO CANCEL

You may cancel this policy by delivering or mailing a written notice or sending a telegram to MUTUAL SERVICE LIFE INSURANCE COMPANY, Two Pine Tree Drive, Arden Hills, MN 55112, and by returning the policy or contract before midnight of the tenth day after the date you receive the policy. Notice given by mail and return of the policy or contract by mail are effective on being postmarked, properly addressed and postage prepaid. MSI Insurance will return all payments made for this policy within ten days after it receives notice of cancellation and the returned policy.

President

Secretary

Registrar

MUTUAL SERVICE LIFE INSURANCE COMPANY

Mailing Address: Box 64035 - St. Paul, MN 55164
Home Office: Two Pine Tree Drive - Arden Hills, MN 55112

POLICY CONTENTS

Any Additional Benefits and Policy Amendments are as Provided by Rider

POLICY DATA

Read your policy carefully. It is a legal contract between you and us.

Policy Number

Insured

Policy Date

	Initial Annual Premium
Major Medical Benefit with Cost Containment Features	
Deductible Amount	
Additional Deductible (No pre-admission certification)	
Individual Out-of-Pocket Expense Limit	
Family Out-of-Pocket Expense Limit	
Maximum Benefit for Mental and Nervous Conditions	
Accidental Medical Expense Benefit	
Maternity Benefit Rider	

Initial Annual (Yearly)	**Initial Semi-Annual (Every 6 Months)**	**Initial Quarterly (Every 3 Months)**	**Initial Monthly**	**Initial Total Premium**

DEFINITIONS

The following words have special meanings. They are important to describing your rights and ours under this policy. Refer to these meanings as you read this policy.

1. **YOU** and **YOUR** mean the person who is the insured.

2. **WE, OUR, OURS** and **US** mean Mutual Service Life Insurance Company at its Home Office, Two Pine Tree Drive, Arden Hills, Minnesota 55112. Telephone (612) 631-7000.

3. **CALENDAR YEAR** means a 365-day period that starts on January 1 and ends on December 31, except that the first year begins on the policy date.

4. **COMPLICATION OF PREGNANCY** means (for pregnancy beginning while this policy is in force):

   - postpartum hemorrhage;
   - hypermesis gravidarum;
   - pre-eclampsia;
   - non-elective cesarean;
   - ectopic pregnancy which is terminated;
   - spontaneous termination of pregnancy when a viable birth is not possible, or;
   - a condition which is caused by pregnancy or diagnosed as distinct from pregnancy, such as:
     - — acute nephritis;
     - — cardiac decompensation;
     - — missed abortion;
     - — disease of the vascular hemopietic, nervous or endocrine systems; and
     - — a similar condition which cannot be classified as a distinct complication of pregnancy but which is related to management of a difficult pregnancy.

   does not mean:

   - occasional spotting;
   - false labor;
   - physician prescribed bed rest during the period of pregnancy or similar conditions associated with management of a difficult pregnancy.

5. **DATE** means a specified day of a month.

6. **DAY** means a 24-hour period that starts at 12:01 a.m.

7. **FREESTANDING CENTER** means a facility which provides ambulatory medical or surgical services. It is approved by the state to provide these services. It is not a hospital, a clinic, or a private office of a doctor.

8. **HOME HEALTH CARE** means care or treatment given or coordinated by a home health care agency under a plan of care which:

   - is established, approved in writing, and reviewed at least every 2 months by the attending physician, unless he or she decides that a longer time between reviews is enough; **and**
   - is initially approved, if the covered person was hospital confined immediately before home health care began, by the primary physician during the confinement.

   The plan of care must consist of one or more of the following:

   - part-time or intermittent home nursing care by or under the supervision of a Registered Nurse;

     or

   - part-time or intermittent home health aide services which:
     - — are medically necessary as part of the plan care; and
     - — are under the supervision of a Registered Nurse or medical social worker; and
     - — consist solely of caring for the covered person as a patient;

     or

   - physical, respiratory, occupational or speech therapy;

     or

   - the following, to the extent we would pay for them under the policy during hospital confinement:

— necessary physician-prescribed drugs and medical supplies; and

— necessary laboratory services by or on behalf of a hospital;

or

- nutrition counseling which is:

  — by or under the supervision of a registered dietician; and

  — medically necessary;

or

- services by a Registered Nurse, physician assistant, or medical social worker:

  — for evaluation of the need for home health care; and

  — for development of a plan for home health care; and

  — when approved or requested by the attending physician.

9. **HOME HEALTH CARE AGENCY** means:

   - a state-licensed or -approved agency; **or**

   - a Medicare-certified home health or rehabilitation agency.

10. **HOSPICE** means a health care program which provides a coordinated set of services rendered at home or in outpatient or institutional settings for individuals suffering from a disease or condition with a terminal prognosis.

11. **HOSPITAL** means:

    - an institution which:

      — is operating lawfully;

      — has facilities for resident patients;

      — mainly provides diagnostic, medical, and surgical treatment for a fee to persons with an injury or sickness or has this treatment available on a contractual pre-arranged basis;

      — has 24-hour nursing service; and

      — has a staff of at least one medical physician on call at any time;

      or

    - an institution which is approved by the Joint Committee on Accreditation of Hospitals.

    It is not a nursing home or an institution, or part of one, used mainly for convalescense, nursing, rest, or the aged.

    For treatment of mental and nervous disorders, alcoholism, and drug abuse in the State of Wisconsin, **HOSPITAL** means also:

    - a state-licensed special hospital; **or**

    - a state-licensed or -approved inpatient health care facility owned or operated by a state or county.

    For treatment of alcoholism in the State of Wisconsin, **HOSPITAL** means also a state-approved public or private treatment facility.

    For treatment of alcoholism in the state of South Dakota, **HOSPITAL** means also a state-approved residential primary treatment facility.

12. **INJURY** means an accidental bodily injury received by a covered person while this policy is in force.

13. **MEDICARE** means Title XVIII of the United States Social Security Act, as amended.

14. **NURSING HOME** means an institution, or part of one, which:

    - is operating lawfully;

    - provides room, board, and mainly skilled inpatient nursing care;

    - provides service under the full-time supervision of a physician, registered graduate nurse, or licensed practical nurse;

    - maintains adequate medical records; **and**

    - has at least one medical physician on call at all times.

    It is not an institution, or part of one, used mainly for rest or the aged.

15. **OUT OF POCKET EXPENSE** is:

    - the covered charges under this policy, less

- the portion of those charges that we pay under this policy and any other accident and health insurance or similar plan. The amount we pay includes what we would pay if claim were made under this policy or any other plan. The covered person must be obligated to pay the expenses.

Out-of-pocket expense does not include the deductibles or the 50% charge for outpatient treatment of mental and nervous conditions.

16. **PHYSICIAN** means a duly licensed physician acting within the scope of his or her own medical practice. It includes, but is not limited to, a certified psychologist, registered anesthetist, chiropractor, certified clinical social worker, nurse midwife and registered lay midwife.

17. **POLICY ANNIVERSARY** means the first day of any year as measured from the policy date. It has the same month and day as the policy date.

18. **PRE-ADMISSION CERTIFICATION** means the review process which examines all hospital admissions to determine the length of stay necessary for the care of the patient.

    Pre-admission certification requires that any hospital admission of a covered person must be approved in order for you to limit your deductible amount to the deductible amount shown on page 3.

    It is your responsibility to have your physician obtain prior approval for any hospital confinement.

    We will provide instructional material to you with your policy. It will include a telephone number your physician can use when requesting certification, and will describe the information that is needed to evaluate the certification request.

    In most cases, a pre-admission certification request made by your physician is reviewed and a determination is made by PreCare during your physician's initial phone call to PreCare.

    Approval must be obtained for the following types of admissions.

    NON-EMERGENCY. Elective hospital treatment that is scheduled several days in advance, usually at a time that is convenient for both you and your physician.

    Have your physician request approval prior to the admission or as soon as reasonably possible thereafter.

    URGENT. Hospital treatment that requires immediate treatment, but is not considered a life threatening situation.

    Have your physician request approval prior to the admission or as soon as reasonably possible thereafter.

    EMERGENCY. Hospital treatment required for potentially life threatening situations.

    Have your physician request approval within 24 hours of the admission or as soon as reasonably possible thereafter.

    Pre-admission certification does not guarantee either the payment of benefits under this plan or the amount of benefits. Eligibility for, and payment of benefits are subject to all the terms of the policy. Certification is intended solely for the purpose of determining the amount of covered charges payable by you and us.

    Each time you do not pre-certify a hospital admission; a hospital admission is not approved when it is submitted for approval; or you incur costs for an unapproved hospital stay following an approved hospital stay, you must pay an additional deductible as shown on page 3. The number of additional deductibles that you pay may be limited by law or regulation in your state of residence.

19. **REASONABLE AND CUSTOMARY CHARGE** means the prevailing charge in the area for like services or supplies, in the absence of insurance. Like services are those which have the same nature and duration, require the same skills and are done with similar training and experience. Like supplies are those which are the same or almost the same.

20. **SICKNESS** means a sickness or disease of a covered person, including a covered newborn's congenital defects, birth abnormalities, and premature birth, which manifests itself while this policy is in force.

21. **TOTAL DISABILITY** is a disability:

    - which results from injury or sickness; **and**
    - which prevents the person from engaging in the normal activities of a person of the same age and in good health; **and**
    - which is certified by a physician; **and**
    - during which the person does not engage in any gainful occupation.

ELIGIBLE AND COVERED PERSONS

22. **Eligible Persons.** Persons eligible to be covered are:

    - you;
    - your spouse, if under age 65;

- any of your unmarried dependent children, if under age 20; and

- any of your unmarried children age 20 and over but under age 23, if:

  — a full-time student; and

  — dependent on you, or — in the case of your dissolution of marriage — on you and your former spouse, for major financial support.

We include as your children any stepchild, child for whom you are the legal guardian or adopted child. Coverage for an adopted child begins from the date the adopted child becomes the legal obligation of the insured. We will not apply any pre-existing condition to an adopted child if the insured's legal obligation to that child occurs after the date of this policy.

23. **Covered Persons.** Each eligible person named in the application is a covered person from the policy date.

    If an eligible person is not named in the application, he or she can still become covered. An eligible person will be a covered person when:

    - you make written application for that person;

    - we receive satisfactory proof of insurability;

    - any increase in premium is paid; and

    - we send you written acceptance of the application.

    A child who is born to you or to a covered child, while this policy is in force, will be covered for 60 consecutive days from the birth without notice to us of the birth. The newborn will then cease to be covered unless:

    - within 60 days after the date of birth, we receive written request, at the Home Office, to add the newborn; and

    - any increase in premium from the date of birth is paid;

TERMINATION OF A COVERED PERSON'S INSURANCE

24. **Your Insurance.** You will cease to be a covered person on the earliest of:

    - the date this policy terminates;

    - the date you become eligible for any coverage under Medicare; **or**

    - the first of the month of your 65th birthday.

25. **Spouse's Insurance.** Your spouse will cease to be a covered person on the earliest of:

    - the date this policy terminates;

    - the date he or she becomes eligible for any coverage under Medicare; **or**

    - the last day of the premium period during which he or she ceases to be an eligible person (see the RIGHT OF CONVERSION and RIGHT OF CONTINUATION sections). This does not apply to your spouse who ceases to be an eligible person due to dissolution of marriage, unless proper notice of the right of conversion is given.

      The spouse must receive the notice at least 30 days before he or she will cease to be an eligible person.

      The notice is proper if it has:

      — a statement of the right of conversion;

      — the premiums for the new policy; and

      — the time, place, and manner in which the premiums must be paid.

26. **Children's Insurance.** A child will cease to be a covered person on the earliest of:

    - the date this policy terminates;

    - the date he or she becomes eligible for any coverage under Medicare; **or**

    - the last day of the premium period during which he or she ceased to be an eligible person (see the RIGHT OF CONVERSION and RIGHT OF CONTINUATION sections). This does not apply to a child who is:

      — incapable of self-sustaining employment due to mental retardation or physical handicap; and

      — dependent on you, or — in the case of your dissolution of marriage — on you or your former spouse, for major financial support.

Within 60 days before any covered dependent child reaches the age where he or she ceases to be a covered person, we may ask you whether that child is a disabled or dependent person. If we do not receive proof of disability or dependence within 60 days after we ask for it, we will terminate that child's coverage when he or she attains the age where coverage ceases.

If we do not ask you for any proof of disability or dependence of a covered child, the coverage will continue until the date this policy terminates; the date the incapacity or dependency ends (see Right of Conversion and Right of Continuation sections); or the last day of the period for which required premium for the child is paid.

27. **Absence of Successor Insured(s).** In the event of your death while this policy is in force:

    - if you have no covered spouse or covered children, this policy will terminate on the last day of the period for which premium was paid.

RIGHT OF CONTINUATION

28. **Extension of Benefits.** When a person ceases to be a covered person for a reason other than nonpayment of premium, we will pay the benefits of this policy as though it were still in force. The person must have been totally disabled when he or she ceased to be a covered person. We will pay only those charges incurred as a result of the injury or sickness that caused the total disability.

    This extension will end for charges incurred on or after the earlier of:

    - the date it would have ended had the person stayed a covered person; **or**
    - one year after the date the person ceases to be a covered person.

29. **Former Spouse and Children.** Upon your dissolution of marriage, this policy will be continued for your former spouse and children if:

    - your decree of dissolution of marriage states that you must continue to provide this policy's coverage for these persons; and
    - you pay any required premium on time to us.

    This continuation will end on the earlier of:

    - for your former spouse and children, the date you or your former spouse remarries; or
    - for each child, the date his or her insurance would have ended had your dissolution of marriage not occurred.

    See RIGHT OF CONVERSION sections for conversion of coverage when continuation of policy coverage under decree of dissolution of marriage expires.

30. **Successor Insured(s).** In the event of your death, or you and your spouse's death, while this policy is in force:

    - if your spouse or children are covered persons, this policy may be kept in force by them by paying the required premium within 90 days of receiving a notice of right of continuation.
    - if the successor insured(s) does (do) not pay the required premium as described above, we will send a written notice of cancellation to the successor insured's last known address at least 30 days before we cancel the policy. See RIGHT OF CONVERSION sections.

RIGHT OF CONVERSION

31. **Persons Who Can Convert.** These persons have the right of conversion:

    - you and your spouse when you cease to be a covered person due to age or eligibility for Medicare, if we then issue a Medicare supplement policy for conversion by persons in your then state of residence; **and**
    - your spouse who ceases to be a covered person due to dissolution of marriage and receives the proper notice described in section 25; **and**
    - any of your children who ceases to be a covered person because:
        - — he or she ceases to be an eligible person;
        - — continuation under section 26 ends due to the end of incapacity or dependency; or
        - — you and any successor insured are deceased.

    Once the right of continuation in section 29 ends for your children and former spouse, we will send your former spouse and children a notice of conversion as described in section 25. Your children and your former spouse have the right of conversion without providing evidence of insurability if they apply to us within 60 days following the notice of right of conversion. Only the unexpired pre-existing conditions limitations of this policy will apply to your children and former spouse who elect to exercise a conversion right.

32. **To Convert.** A person described in section 31 has the right to a new major medical policy. To convert, he or she must apply in writing for the policy and pay its first premium within 30 days after ceasing to be a covered person.

The conversion date will be the day after the date coverage ends under this policy.

33. **Conditions for Conversion.** The conversion is subject to these conditions:

- The new policy will be similar in type and amount of benefits to this policy.
- The new policy will be the one we are then using for conversions.
- The new policy will be issued on the same premium class as this policy. We will base premiums for the new policy on the covered person's age and risk class at the conversion date and on our premium rates in effect then.
- The new policy can include only those special premium rates and exclusions that are in this policy for the covered person.
- Benefits payable for a loss under the new policy will be reduced by those paid under this policy for the same loss.
- The policy date of the new policy will be the conversion date.
- The policy will contain the minimum benefits of a Minnesota Qualified Plan I, II or III. (Minnesota insureds only).

BENEFITS

34. **Benefits Payable.** We will share with you the payment of the covered charges that a covered person incurs in a calendar year according to the following situations:

1. You pre-certify a hospital confinement that may have occurred during the calendar year. See the definitions section of the policy for a full explanation of the pre-admission certification review program.

   a. **YOU PAY:**

   the deductible amount shown on page 3 or described in Section 35 of the policy; and

   20% of the next $5,000 of covered charges.

   b. **WE PAY:**

   80% of the first $5,000 of covered charges incurred after you have paid the deductible shown on page 3 or described in Section 35 of the policy.

2. You do not pre-certify a hospital admission; a hospital admission is not approved when it is submitted for approval; or you incur costs for an unapproved hospital stay following an approved hospital stay: in any calendar year.

   a. **YOU PAY:**

   the deductible amount shown on page 3 or described in Section 35 of the policy; and

   the additional deductible amount shown on page 3 for each hospital confinement that is not pre-certified. The amount of additional deductibles that you pay may be limited by law in your state of residence; and

   20% of the next $5,000 of covered charges.

   b. **WE PAY:**

   80% of the first $5,000 of covered charges incurred after you have paid both the deductible amount shown on page 3 or described in Section 35 of the policy and the additional deductible shown on page 3 for each hospital confinement not pre-certified.

3. You incur charges that are covered charges under this policy that do not involve a hospital admission or pre-admission certification.

   a. **YOU PAY:**

   the deductible amount shown on page 3 of the policy or described in Section 35 of the policy; and

   20% of the next $5,000 of covered charges.

   b. **WE PAY:**

   80% of the first $5,000 of covered charges incurred after you have paid the deductible amount shown on page 3 or described in Section 35 of the policy.

We will pay 100% of all subsequent covered charges for an individual covered person in this policy, within a calendar year, up to the Major Medical Benefit Limit shown on page 3, when that covered person's out of pocket expenses reach the individual out of pocket expense limit shown on page 3.

We will pay 100% of all subsequent covered charges

for all covered persons in this policy, within a calendar year, up to the Major Medical Benefit Limit shown on page 3, when the aggregate out of pocket expenses for all covered persons reach the Family Out of Pocket Expense Limit shown on page 3.

The Major Medical Benefit Limit applies to each covered person in this policy.

Out of pocket expenses do not include any deductibles, or the 50% charge for treatment of mental and nervous conditions.

The most we will pay per person is the lifetime maximum shown on page 3. This maximum applies even though a break in coverage under the policy may have occurred.

35. **Deductible.** The deductible is the amount of covered charges which a covered person must incur before we will begin to pay benefits for that person. The deductible applies each calendar year to each covered person.

For covered charges resulting from one accident involving two or more covered persons, only one of the persons must satisfy the deductible.

The deductible amount is the larger of:

- the minimum deductible amount shown on page 3; **or**
- the amount or value of benefits provided by any other accident and health insurance or similar plan, including auto insurance and Medicare, for charges which are covered charges under this policy. The benefits provided include those that would be provided if claim were made under the other insurance or plan; **and**
- the additional deductible shown on page 3 if preadmission certification is not complied with.

If any amount or value of benefits provided by other accident and health insurance is used to satisfy our deductible, we will increase the maximum benefit of this policy by $3 for each $1 paid by the other coverage which exceeds our cash deductible. This increased benefit applies for each person who satisfies our deductible in this manner.

When 3 covered persons have each satisfied his or her deductible in a calendar year, the other covered persons do not have to satisfy theirs in that year. However, the remaining covered persons' charges incurred prior to the satisfaction of the 3rd deductible are not payable.

Covered charges that satisfy all or part of the deductible in the last 3 months of a calendar year reduce the deductible for the next calendar year.

Covered charges satisfy the deductible in the order incurred.

36. **Covered Charges.** The charges shown below are covered charges if they:

- are incurred as a result of injury or sickness; **and**
- are necessary for treatment of the injury or sickness; **and**
- are prescribed by a physician; **and**
- are incurred while this policy is in force; **and**
- are not excluded under section 37.

Charges in excess of a maximum shown below are not covered charges.

We view a charge to be incurred on the date the service is performed or the supply is purchased.

We will pay 80% of the covered charges listed below, except that we will pay 50% instead of 80% of the charges for treatment of mental and nervous conditions (see item n of Section 36).

a. charges made by a hospital or hospice for room, board, and general nursing care received while confined in a semiprivate room, a ward, or an intensive care unit. If confinement is in a private room, we will pay 80% of the hospital's most common daily charge for a semiprivate room.

b. charges made by a hospital for miscellaneous medical services and supplies.

c. charges made by a physician for medical care, including diagnostic tests, second surgical opinions, and surgery. Charges made by a physician for a third surgical opinion will be covered if the first two opinions conflict.

d. charges for emergency transportation by a licensed ambulance to and from the nearest hospital qualified to treat the covered person's injury or sickness.

e. charges for private duty nursing care in a hospital by a graduate registered nurse,

licensed practical nurse, or licensed vocational nurse.

f. charges for drugs and medicines which:

- are bought for or by a covered person while hospital confined.
- when not confined, if they can be bought only on a physician's written prescription

When you purchase **generic** drugs or medicines on your physician's prescription, we will pay 100% of those charges after your deductible has been satisfied.

g. charges for home health care visits by members of a home health care agency, up to:

- 40 visits in any 12-month period; **and**
- a weekly maximum of the usual and customary weekly charges for care in a nursing home.

The charges must not be covered elsewhere under this policy.

We will view 4 hours or less per day as one visit.

The attending physician must certify that:

- confinement in a hospital or nursing home would be required if home health care were not provided; **and**
- necessary care and treatment are not available from the covered person's spouse, child, parent, grandparent, brother, sister, their spouses, or another person living with the covered person without causing undue hardship.

h. charges for:

- rental (not to exceed the purchase price) or purchase (if the Home Office gives prior approval) of a wheelchair, special hospital bed or other mechanical equipment of functional necessity for life support, or without which, would require hospitalization.
- lab or X-ray exams.
- treatment by X-ray, radioactive therapy, physiotherapy, or speech therapy.
- original purchase and fitting of protheses to replace natural parts of the body lost while this policy is in force.
- blood or blood plasma and the administration of it.
- oxygen and the rental of oxygen equipment.
- heart pacemakers.
- anesthetic and the administration of it.

i. charges for dialysis.

j. medically approved and accepted organ transplants or donor-related services received while an in-patient or an out-patient of a hospital.

k. charges made by a nursing home for room, board, and floor nursing, up to:

- the first 120 days of each period of confinement; **and**
- a daily maximum at one half the most common semiprivate room daily rate of the hospital where last confined.

Each period of confinement in the nursing home must start within 14 consecutive days right after a hospital confinement of at least 3 consecutive days. (This coverage is not available for North Dakota insureds.)

l. charges made by a freestanding center for medical care.

m. charges for treatment of alcoholism, drug addiction or chemical dependency:

- up to 73 days of treatment in any calendar year in a hospital or a state-approved or -licensed residential treatment program; **or**
- up to 130 hours of treatment in any calendar year in a state-approved or -licensed nonresidential treatment program.

n. charges for treatment of mental and nervous conditions:

- while confined in a hospital; or
- by a physician while not confined in a hospital. After the deductible has been satisfied, we will pay 50%, instead of 80%, of the charges, not to exceed charges for 2 hours every week.

The most we will pay per person while covered under this policy is the maximum benefit shown on page 3 for mental and nervous conditions. This maximum exists within the lifetime maximum shown on page 3. It applies even though a break in coverage under the policy may have occurred.

o. overcharges on your hospital bill. You are requested to review your bill and look for charges for items or services you did not receive. If the health care provider agrees with the error, we will pay you 50% of the difference between the original and revised hospital bills, for amounts that exceed the deductible, up to a maximum amount of $500.

p. charges for special dietary treatment for phenylketonuria when recommended by a physician.

EXCLUSIONS

37. **Excluded Charges.** Covered charges do not include:

a. charges for tests and check-up exams which are not needed for medical treatment.

b. charges which are more than the reasonable and customary charges.

c. charges for which payment is not required.

d. routine pregnancy exams including ultra sound tests and stress tests.

e. charges caused by pregnancy and childbirth, except for complications of pregnancy for a pregnancy that began while a covered person.

f. charges for elected abortion unless the covered person's life is in danger if the fetus is carried to term.

g. charges for routine well-baby care.

h. charges for care, treatment, or service performed by you or your spouse or your or your spouse's brother, sister, parent or child.

i. charges for cosmetic or reconstructive surgery unless:

- it is incidental to or follows surgery caused by injury or sickness of the involved body part.
- it is done because of a congenital disease or birth abnormality of a covered newborn dependent child.
- it is done because of a disorder of a normal bodily function.

j. charges for:

- treatment of injury or sickness covered by a workers' compensation or similar law.
- injury or sickness caused by war or any act of war, declared or undeclared.
- injury or sickness occurring or starting while the covered person is on full-time active duty with the armed forces of any country. If we receive written proof, we will give back the part of any premium which applies to the covered person's term of full-time active duty.

k. charges for rest cure or custodial care.

l. charges for dental X-rays or any treatment of the teeth, surrounding tissue or structure, including the gums and tooth sockets. This exclusion does not apply to treatment resulting from injury to natural teeth and received within one year after the injury.

m. charges due to tests for, fitting of, or purchase of corrective lenses or hearing aids.

n. charges covered by Medicare, Dependents Medical Care Act or any medical care plan of any government, except Medical Assistance, to the extent the covered person is or could be covered.

o. charges caused by any intentionally self-inflicted injury.

p. charges for the following unless you receive prior approval from us:

- procedures not commonly accepted in the physician's profession.

- experimental treatment, services, or supplies.

- treatment, services, or supplies that are mainly educational or research in nature.

q. charges for treatment of tonsilitis, charges for tonsillectomies, adenoidectomies or elective sterilization, unless incurred more than six months after having become a covered person.

r. charges for or on account of male impotency, in vitro fertilization, artificial insemination, surgical reversal of elective sterilization or fertility drugs. These charges are excluded without regard to the success of the procedure.

s. charges for treatment of alcoholism, drug addiction, chemical dependency, or mental and nervous conditions, except as described in items m. and n. of section 36.

t. charges to which the maximum benefit for mental and nervous conditions applies.

u. enrollment in a health, athletic or similar club; or weight loss or similar program.

v. purchase or rental of supplies of common household use, such as: exercise cycles, air purifiers, central or unit air conditioners, water purifiers, allergenic pillows or mattresses or waterbeds.

w. purchase or rental of motorized transportation equipment, escalators or elevators, saunas or swimming pools.

PREMIUM AND REINSTATEMENT

38. **Payment of Premium.** Premiums must be paid on time to keep this policy in force. The amount of the initial premium payment is shown on page 3. Renewal premiums will be charged according to our table of premiums in effect on the date your premium is due.

    Starting on the policy date, payment is due in advance of the first day of each payment period. Premiums can be paid once a year, once every 6 months, or once every 3 months, as long as each payment is at least the minimum amount we allow. Premiums can also be paid monthly through an indirect arrangement with your bank, as described below. A change in the frequency of your payments is effective when we accept your payment at the new frequency.

    You can pay premiums directly to us in one of two ways. You can make your payment through one of our authorized agents, or you can send your payment to our Home Office. When sending your payment, please include your policy number. On request, we will furnish a receipt signed by one of our officers.

    Premiums can also be paid indirectly to us. You may be able to arrange with your bank and us to pay your premiums monthly by automatic withdrawal from your account. If a premium is not paid under an indirect arrangement, you must pay the premium directly to us before the end of the grace period. Otherwise the policy will lapse.

    If the indirect arrangement terminates, premiums are payable quarterly or as often as needed for the payment amount to be at least the minimum we require.

    If your age has been stated correctly and we accept premium that has been paid on time, but for a period after the last day you have the right to renew, this policy will stay in force to the end of that period.

39. **Grace Period and Unpaid Premiums.** After the first premium has been paid, a grace period of 31 days is allowed for late payment of premium. Your policy will remain in force during the grace period.

    If the premium is not paid when it is due or within the grace period, the policy will lapse.

    If any loss is incurred during the grace period, we may reduce the claim payment by the amount of due and unpaid premium.

    The grace period will not apply if, at least 31 days before the premium due date, we deliver or mail to your last address as shown in your records, a written notice of our intent not to renew this policy.

40. **Premium Refund at Death.** If you die while this policy is in force, we will refund to your estate any premium paid for the period after the policy month in which you die.

41. **Reinstatement.** Reinstating a lapsed policy puts it in force so that it provides coverage again. A reinstated policy covers only:

    - loss due to sickness that begins more than 10 days after the reinstatement date; or

    - loss due to injury which occurs after the reinstatement date.

    Except for the above, your rights and ours are the same as those before this policy lapsed, subject to any terms added to this policy with the reinstatement.

To reinstate this policy, contact our agent or us. If we accept premium without requiring an application, the policy is reinstated when we accept the premium. If we require an application and issue a receipt for the premium paid, the policy is reinstated on the date we approve the application. If you do not receive a notice that we approve or disapprove the application, it is approved on the 30th day after the date of our receipt of premium paid.

For misstatements made in the application for reinstatement, section 50 will apply from the date this policy is reinstated.

CLAIMS

42. **To Report a Claim.** We require written notice of any claim. You must give us this notice within 60 days after a covered charge is incurred or as soon as possible after that. In the notice, include your name and the policy number. You may send the notice to us at our Home Office or to an authorized agent.

43. **Claim Forms.** After receiving your written notice of claim, we will send you forms for filing proof of claim. If you do not receive these claim forms within 15 days after we receive your notice, you must still file a written proof of the claim as described below.

44. **Proof of Claim.** Proof of claim for a covered charge is information about:

    - when, where and how the injury or sickness occurred; **and**
    - the type of injury or sickness; **and**
    - the charges for which the claim is made.

    You must give written proof of claim to our Home Office. We must receive this proof within 90 days after the covered charge is incurred.

    If it is not reasonably possible for you to give us proof within the 90 days, your claim is still valid. However, you must give us proof as soon as you reasonably can. Except in the case of legal incapacity, you must give proof within one year after the 90-day deadline.

45. **Time Payment of Claim.** If benefits are payable, we will pay them as soon as we receive written proof of claim.

    If any payment for claims is not paid within 30 days after we receive written proof of loss, we will include interest at 9% per year from the 31st day after written proof of loss is received.

46. **Persons to Receive Payment of Claims.** All benefits will be paid to you, if living. Any benefits unpaid at your death will be paid to your estate. However, we may pay up to $1,000 of benefits to any of your relatives who we feel are justly entitled to it if:

    - you are not competent to give a valid release; **or**
    - the benefit is payable to your estate.

    If we make payment in good faith, we will not be liable to anyone for the amount we pay.

47. **Physical Examination and Autopsy.** At our expense we can have a covered person examined as often as is reasonable while a claim is pending. In the event of death, we may make an autopsy if allowed by law.

48. **Legal Actions.** If you choose to bring legal action to collect on a claim, such action must be brought in the time period:

    - **beginning** 61 days after we receive written proof of claim; **and**
    - **ending** 5 years from the date we require written proof of claim.

GENERAL INFORMATION

49. **Contract.** This policy and any attached papers are the entire contract between you and us. Any change in the policy requires the written consent of our president, one of our vice presidents, our secretary, or our actuary. The change must be endorsed on or attached to the policy. An agent cannot change or waive any part of this policy.

50. **Time Limit on Defenses.** After a person has been a covered person for two years, we will not, because of misstatements made in the application for that person's coverage, deny a claim for that person or void the policy.

    After a person has been a covered person for two years, we will not reduce or deny a claim for that person because a disease or physical condition existed in the 5 years before the date he or she became covered, unless on the date of the claimed loss the disease or condition was excluded in this policy by name or specific description.

51. **Misstatement of Age.** If your age has been misstated, the benefits under the policy will be adjusted by the amount of premium underpaid or overpaid based on your current age. If this policy would not have been in force at your current age, our liability will be

limited to a refund of the premiums paid for the period not covered by the policy.

52. **Conformity with State Laws.** On the policy date, any provision of this policy in conflict with the laws of the state in which you reside on that date is amended to conform with those state laws.

53. **Assignment.** We will not be bound by an assignment of your policy or any claim unless we receive a written assignment at our Home Office before we pay the benefits claimed. We will not be responsible for the validity of any assignment.

54. **Participation.** This policy is a participating policy. Each year we determine its share in our divisible surplus, if any. We pay you the share in cash as a dividend.

55. **Pre-existing Conditions.** A pre-existing condition is a condition:

    - for which a covered person received medical advice or treatment by a physician within 5 years before that person's effective date of coverage; or
    - which, in the opinion of a physician, began within 5 years before the covered person's effective date of coverage and produced symptoms which would have caused that person to seek diagnosis or treatment by a physician.

56. **Pre-existing Conditions Limitations.** We will not pay covered charges incurred by a covered person during the first 2 years after his or her coverage becomes effective if the charges are incurred because of a pre-existing condition, including complications and recurrences, that was not disclosed on the application for his or her coverage. These charges will not be applied toward the deductible amount.

    We will not apply any preexisting conditions limitations to an adopted child who becomes the legal obligation of the insured.

    We will not apply preexisting conditions limitations beyond those unexpired in this policy for those persons exercising a right of continuation or right of conversion as stated in this policy.