LUTHERAN BROTHERHOOD
A Fraternal Benefit Society
Minneapolis, Minnesota

MAJOR MEDICAL EXPENSE COVERAGE

This is a legal contract between the Insured and Lutheran Brotherhood. We accept the Insured as a member. We issue this contract based on the Application signed by the applicant and the payment of the initial premium shown on page 3. We will pay benefits for loss due to Sickness or Injury, subject to all of the terms and conditions of this contract. Coverage starts at 12:01 a.m. of the date coverage begins. It ends at 11:59 p.m. of the date coverage terminates.

Renewal Provision — Renewal May be Refused. Unless we refuse to renew this contract, you may renew this contract by paying premiums when due provided Medicare Eligibility Age has not been attained. We may refuse to renew your contract only on a Contract Anniversary and only if we also refuse to renew all contracts in force on this form in your state of residence. We will give you at least 31 days notice of our refusal to renew.

Table of Premiums — Premiums May Change. The initial premium is shown on page 3. It applies to the first year of coverage. Renewal premiums will be charged according to our table of premiums in effect on each Contract Anniversary. We expect premiums to increase as age increases and as new tables of premiums 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. Any change will be based on the expected claim experience on all similar contracts. Any change will apply on a class basis to all contracts in force on this form in your state of residence.

Important Notice. Please read the copy of the Application attached to this contract. Check it carefully. This contract was issued on the basis that the answers to all questions and the information shown in the Application are correct and complete. Omissions or misstatements in the Application could cause an otherwise valid claim to be denied. If any information shown is not correct and complete, or if any past medical history has been left out of the Application, write to us immediately at our Home Office in Minneapolis, Minnesota.

Right to Cancel. Please read this contract carefully. We want you to be satisfied with your contract. If you are not satisfied, you may cancel the contract within 10 days of first receiving it. Do this by mailing or delivering it to us at our Home Office in Minneapolis, Minnesota or to the representative through whom you bought it. As soon as you deliver or mail the contract, it will be deemed void from the beginning. Within 10 days after we receive it, we will refund any premiums you have paid.

Pre-Existing Conditions Limitation. We will not reduce or deny coverage for any pre-existing condition that is admitted in the Application unless excluded by name or specific description in this contract. Any person's pre-existing condition not admitted in the Application will not be covered for 2 years after that person is first covered under this contract. A pre-existing condition is a condition for which a Covered Family Member received medical advice or treatment by a Doctor within 5 years before the date that person is first covered under this contract.

Signed for the Society at Minneapolis, Minnesota.

President

Secretary

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FOR INFORMATION ABOUT THIS CONTRACT, CONSULT YOUR LUTHERAN BROTHERHOOD DISTRICT REPRESENTATIVE OR WRITE TO US AT OUR HOME OFFICE.

LUTHERAN BROTHERHOOD
625 FOURTH AVENUE SO.
MINNEAPOLIS, MINNESOTA 55415

CONTRACT
SCHEDULE

		INITIAL ANNUAL PREMIUM
BASIC BENEFIT		
MAJOR MEDICAL EXPENSE INSURANCE		$698.00
DEDUCTIBLE	$250	
AVAILABLE BENEFIT	$1,000,000	
EXPENSE SHARING LIMIT		
PERSONAL LIMIT	$1,250	
FAMILY LIMIT	$2,000	
MENTAL CARE BENEFIT LIMIT	$20,000	
HOSPICE PROGRAM LIMITS		
HOSPICE CARE BENEFIT LIMIT	$7,500	
COUNSELING SERVICES LIMIT	$500	
ADDITIONAL COVERED FAMILY MEMBER ON DATE OF ISSUE		$1,050.00
SPOUSE --- JANE DOE		
PREMIUM CLASS		
INSURED --- NONSMOKER		
SPOUSE --- NONSMOKER		

TOTAL INITIAL ANNUAL PREMIUM	$1,748.00
INITIAL PREMIUM	$1,748.00
INTERVAL OF PAYMENT	ANNUAL

INSURED JOHN DOE AGE 35 SEX MALE

CONTRACT NUMBER M0012345 DATE OF ISSUE JULY 1, 1985

1. DEFINITIONS

You, Your, Yours. The Insured named on page 3.

We, Our, Us, Society. Lutheran Brotherhood.

Written Notice. A written request signed by you and received by us at our Home Office in Minneapolis, Minnesota.

Application. The application(s) and all amendments and supplements.

Contract Anniversary. The same month and day for years after issue as in the Date of Issue on page 3.

Calendar Year. A year as measured from January 1 to December 31.

Doctor. A licensed practitioner of the healing arts acting within the lawful scope of his or her license.

Complications of Pregnancy.

1) Miscarriage, ectopic pregnancy which is terminated, nonelective cesarean section and nonelective abortion; and

2) Conditions (when the pregnancy is not terminated) whose diagnoses are distinct from pregnancy but are adversely affected or caused by pregnancy. These conditions include toxemia, nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity. Not included are false labor, occasional spotting, Doctor-prescribed rest during pregnancy, morning sickness, and similar conditions associated with a difficult pregnancy but not constituting a classifiably distinct complication of pregnancy.

Injury. Accidental bodily injury sustained while this contract is in force.

Sickness. Sickness or disease, other than a pre-existing condition, which causes a loss that begins while this contract is in force.

Medicare. Title XVIII of the United States Social Security Amendments of 1965, as amended. It is also known as Health Insurance for the Aged and Disabled.

Medicare Eligibility Age. The age established by the Federal Government for eligibility in Medicare.

Hospice Program. A legally operated program of hospice care:

1) Which is accredited as a hospice program by the Joint Commission on Accreditation of Hospitals; or

2) Which:

   a) Is under the supervision of a Doctor and provides for the physical, psychological, social and spiritual needs of terminally ill patients and their families;

   b) Includes both inpatient services and a 24-hour home care service by or under the supervision of a registered graduate nurse (R.N.); and

   c) Is approved by us.

Primary Care Persons. Those persons who enter a Hospice Program with a patient and agree to participate with and provide care for that patient.

Hospital. A legally operated institution:

1) Which is accredited as a hospital by the Joint Commission on Accreditation of Hospitals; or

2) Which provides:

   a) Medical, diagnostic and major surgical facilities under the supervision of a staff of one or more Doctors for the care and treatment of sick or injured persons on an inpatient basis; and

   b) 24-hour nursing service.

Hospital does not include an institution or a part of one which is primarily:

1) A convalescent, rest or nursing facility; or

2) Operated for the care of the aged.

Skilled Nursing Facility. A legally operated institution which:

1) Is approved or is qualified to be approved, if so requested, for payment of Medicare benefits;

2) Primarily provides, in addition to room and board, skilled nursing care under the supervision of a Doctor;

3) Provides a 24-hour nursing service by or under the supervision of a registered graduate nurse (R.N.); and

4) Keeps a daily medical record of each patient.

Skilled Nursing Facility does not include any home, facility or part of one which is primarily:

1) Used for rest or custodial care; or

2) Operated for the care of the aged.

Separate Periods of Skilled Nursing Facility Confinement. Periods of Skilled Nursing Facility confinement for each Covered Family Member are separate if:

1) Confinement in a later period does not result from, or is not contributed to by, the same cause or causes as confinement in a prior period; or

2) The later period of confinement occurs after a continuous period of 90 days with no Hospital or Skilled Nursing Facility confinement.

2. MAJOR MEDICAL EXPENSE BENEFITS

2.1 THE BASIC BENEFIT. For Covered Expenses incurred for a Covered Family Member in excess of the Deductible in a calendar year, we will pay:

1) a) 80% of the Shared Expenses (see Section 3.2) until your Expense Sharing Limit is reached; then

   b) 100% of the Shared Expenses during the rest of that calendar year; and

2) 100% of the Fully Paid Expenses (see Section 3.3).

However, no benefits for a Covered Family Member will be paid in excess of that person's Available Benefit.

2.2 THE DEDUCTIBLE. The Deductible is shown on page 3. It is the amount of Covered Expenses for a Covered Family Member which you must meet before we will pay benefits for that person. You meet the Deductible when the person incurs that amount of Covered Expenses in a calendar year.

2.3 THE AVAILABLE BENEFIT. The Available Benefit is shown on page 3. It is the total benefit available to each Covered Family Member. Each person's Available Benefit is reduced by the benefits we pay for expenses incurred by that person. At the end of each calendar year we will restore $2,000 to each person's Available Benefit, but in no case will the Available Benefit exceed the amount shown on page 3.

2.4 EXPENSE SHARING LIMIT. The Expense Sharing Limit is a limit on the Covered Expenses you must meet in a calendar year. For purposes of this provision, the expenses you meet are of two types. They are:

1) Expenses used to meet the Deductible; and

2) The portion of Shared Expenses we do not pay because we are paying 80%, not 100%, of Shared Expenses.

The Expense Sharing Limit applies again each calendar year. There is both a Personal Limit and a Family Limit. These limits are shown on page 3.

The Personal Limit is the limit for each Covered Family Member. When the Personal Limit is reached we will then pay 100% of the Shared Expenses for that Covered Family Member.

The Family Limit is the limit on a family basis. All Covered Expenses that you meet for Covered Family Members will be used to reach the Family Limit. When the Family Limit is reached, you will not be required to meet any more Deductibles in that calendar year. Also, we will then pay 100% of the remaining Shared Expenses in that calendar year for all Covered Family Members.

2. MAJOR MEDICAL EXPENSE BENEFITS *(continued)*

2.5 EXPENSES INCURRED AFTER SEPTEMBER 30. Expenses in the prior calendar year may be carried over to the current calendar year to help meet the Deductible or reach the Expense Sharing Limit as follows:

1) Covered Expenses incurred after September 30 and used to meet the Deductible in that prior year will also be used to meet the Deductible in the current calendar year.

2) Covered Expenses incurred after September 30 which were used to reach the Expense Sharing Limit in that prior year will be used to reach the Expense Sharing Limit in the current calendar year.

2.6 COMMON ACCIDENT DEDUCTIBLE. For Covered Expenses which result from one accident involving two or more Covered Family Members, only one of those persons will have to meet the Deductible.

2.7 TRANSPLANT DONOR BENEFIT. If a Covered Family Member receives an organ from a live donor, we will pay benefits for medical charges incurred by the donor due to the transplant operation. Benefits will be determined as though the donor's charges were the charges of the Covered Family Member. Charges covered by other insurance are not covered by this benefit. If the donor is also a Covered Family Member, the donor's charges will be covered under this provision only.

3. EXPENSES COVERED BY BENEFITS

3.1 COVERED EXPENSES. Covered Expenses are the only expenses covered by this contract. They are incurred on the date services are rendered or supplies are furnished. Covered Expenses must be:

1) Incurred by a Covered Family Member while that person's coverage is in force;

2) The result of Sickness or Injury;

3) Reasonable and Customary Charges;

4) Necessary for medical care and treatment; and

5) Not otherwise excluded or limited under this contract.

There are two types of Covered Expenses. They are either Shared Expenses or Fully Paid Expenses. Either may be used to meet the Deductible. They are paid subject to the Available Benefit and the benefit limits shown on page 3.

3.2 SHARED EXPENSES. Shared Expenses are the Covered Expenses which are paid jointly by you and by us. Your share of these expenses is limited by the Expense Sharing Limit. The Shared Expenses are charges for:

1) Room, board and general nursing care while confined in a semi-private room, ward or intensive care unit in a Hospital. However, while confined in a private room, the daily Covered Expenses for the room, board and general nursing care are limited to the Hospital's most common daily charge for a semi-private room.

2) Other Hospital services and supplies.

3) Services of a Doctor for medical care, including diagnostic tests and surgery.

4) Local professional ambulance service to and from a Hospital.

5) Private duty nursing services by a registered graduate nurse (R.N.), licensed practical nurse (L.P.N.) or licensed vocational nurse (L.V.N.), while confined in a Hospital.

6) Medical care, treatment, services and supplies as listed below, when prescribed by a Doctor:

   a) Drugs administered while confined in a Hospital or Skilled Nursing Facility;

   b) Non-generic prescription drugs and over-the-counter drugs (see also Section 3.3);

   c) Therapy by a licensed physiotherapist or speech therapist;

   d) X-ray and laboratory examinations;

   e) Treatment by X-ray, radium, or other radioactive substances;

   f) Whole blood or blood plasma, if not replaced;

   g) Administration of whole blood or blood plasma;

   h) Casts, splints, trusses, braces and crutches;

   i) Artificial limbs or eyes if they replace natural limbs or eyes lost while this coverage is in force for the Covered Family Member;

   j) Oxygen and the rental of oxygen equipment;

   k) Heart pacemakers;

   l) Rental (not to exceed the purchase price) or purchase (if we give prior approval) of a wheelchair, special hospital bed, or other mechanical equipment necessary for treatment; and

   m) Anesthetics and their administration.

7) Treatment of drug abuse or addiction if recommended by a Doctor and given in:

   a) A Hospital; or

   b) A residential treatment program licensed or approved by the state.

8) Inpatient and outpatient treatment of alcoholism if recommended by a Doctor and given in:

   a) A hospital;

   b) A residential treatment facility licensed or approved by the state; or

   c) A detoxification facility.

   However, charges for outpatient treatment given in these facilities will qualify as Covered Expenses only if the treatment is provided:

   a) By certified alcoholism counselors and other professionals employed by these facilities; and

   b) Under a program approved by the New Jersey Division of Alcoholism.

9) Room, board and general nursing care and other Skilled Nursing Facility services and supplies while confined in a Skilled Nursing Facility provided:

   a) The Covered Family Member was confined in a Hospital for at least three consecutive days;

   b) Confinement in the Skilled Nursing Facility begins within 14 days after the Hospital confinement ends;

   c) The confinement is for the same Sickness or Injury for which the Covered Family Member was confined in the Hospital; and

   d) The attending Doctor certifies 24-hour nursing care is necessary for medical treatment of the Sickness or Injury.

   However, total charges each day will qualify as Covered Expenses:

   a) Only for the first 90 days of each Separate Period of Skilled Nursing Facility Confinement; and

   b) Only up to 50% of the most common daily charge for a semi-private room in the Hospital where last confined.

10) Home health care services if recommended by a Doctor and furnished under a public health program or a similar program which is licensed or accredited by government. These services include nursing services by a registered graduate nurse (R.N.), licensed practical nurse (L.P.N.) or licensed vocational nurse (L.V.N.).

11) Hospice care, services and supplies prescribed by a Doctor and furnished by a Hospice Program provided:

    a) Admission to the Hospice Program is recommended by a Doctor; and

    b) The attending Doctor projects a limited lifespan of 6 months or less.

    Except for bereavement counseling services, services and supplies which are provided by a Hospice Program are covered under this provision only. Benefits under this provision are not payable for a Covered Family Member in excess of that person's Hospice Program Benefit Limit shown on page 3.

12) Bereavement counseling services for the Primary Care Persons of a Covered Family Member who has died provided:

    a) The Covered Family Member was in a Hospice Program on the day before death; and

    b) The services are recommended by a Doctor and furnished by the Hospice Program within three months after the date of death.

    Bereavement counseling services are covered under this provision only. Benefits for these services are limited for each death to the Counseling Services Limit shown on page 3.

3.3 FULLY PAID EXPENSES. Fully Paid Expenses are the Covered Expenses which are paid by us in full. The Fully Paid Expenses are charges for:

1) Surgery performed while not confined in a Hospital and where Hospital confinement after surgery is not expected.

2) Generic drugs when prescribed by a Doctor and purchased while not confined in either a Hospital or a Skilled Nursing Facility.

3) Second surgical opinions. A third surgical opinion will be covered if the first two opinions are in conflict.

4) Pre-admission tests performed within 5 days before a period of Hospital confinement begins. Charges for tests which duplicate pre-admission tests and are performed while Hospital confined will not qualify as Covered Expenses.

3.4 REASONABLE AND CUSTOMARY CHARGES. Reasonable and Customary Charges is the lesser of:

1) The customary charge made by the provider for the service or supply when there is no insurance; and

2) The average charge for comparable services or supplies made by other providers within the same county.

4. LIMITATION FOR MENTAL OR NERVOUS DISORDERS

4.1 EXPENSES COVERED. Expenses which result from a mental or nervous disorder and meet the requirements of Section 3 Expenses Covered by Benefits will be considered Covered Expenses only if they are:

1) Incurred while confined in a Hospital; or

2) Charges for services of a Doctor while not Hospital confined, up to $50 per visit and limited to one visit per week.

4.2 MENTAL CARE BENEFIT LIMIT. The Mental Care Benefit Limit is shown on page 3. It is the total benefit for mental or nervous disorders available to each Covered Family Member. Also, expenses due to a mental or nervous disorder in excess of the Mental Care Benefit Limit will not be used to meet the Deductible or to reach the Expense Sharing Limit. A person's Mental Care Benefit Limit is reduced by the benefits we pay for expenses due to mental or nervous disorders incurred by that person. At the end of each calendar year we will restore $1,000 to each person's Mental Care Benefit Limit, but in no case will the Mental Care Benefit Limit exceed the amount shown on page 3.

4.3 BENEFITS PROVIDED. Benefits for Covered Expenses as a result of a mental or nervous disorder are payable as stated in Section 2 Major Medical Expense Benefits, but are further limited as follows:

1) These benefits are not payable for a Covered Family Member in excess of that person's Mental Care Benefit Limit.

2) For services of a Doctor while not Hospital confined:

   a) We will pay 50%, not 80%, of these Covered Expenses, not to exceed $25 per week. Even if the Expense Sharing Limit has been reached, the portion of these expenses which we will pay remains at 50%.

   b) These Covered Expenses, except those used to meet the Deductible, will not be used to reach the Expense Sharing Limit.

5. EXCEPTIONS

5.1 EXCEPTIONS. This contract does not cover expenses due to:

1) Routine exams or tests which are not necessary for treatment of Sickness or Injury. These include routine physical, eye and dental exams.

2) Pregnancy, childbirth or elective abortion. But, we will not deny coverage for expenses in the event of Complications of Pregnancy.

3) Routine well-baby care.

4) Dental X-rays, care or treatment, except when needed due to Injury to sound natural teeth and where care is provided within one year of the Injury.

5) Examinations for, fitting of, or purchase of corrective lenses or hearing aids.

6) Sickness or Injury for which the Covered Family Member is eligible to receive benefits under any workers' compensation, occupational disease, employer's liability or similar act or law of any government.

7) Care, treatment or supplies:

   a) Provided by or in a facility operated by any government, unless payment is legally required; or

   b) To the extent that benefits are provided by Medicare or any other law or program of the government, except Medicaid, under which the Covered Family Member is or could be covered.

8) Care, treatment or services performed by you, your spouse, or a brother, sister, parent or child of yours or your spouse.

9) Cosmetic surgery. But, we will not deny benefits for surgery:

   a) Due to accidental bodily injury, trauma, infection or other diseases of the involved part; or

   b) To correct a birth defect or congenital disease of a Covered Family Member which has caused a functional defect.

10) Any of the following, unless you receive prior approval from us:

   a) Procedures not commonly accepted in the Doctor's profession;

   b) Experimental care, treatment or supplies; and

   c) Care, treatment or supplies which are mainly educational or research in nature.

11) Drugs not approved by the Federal Food and Drug Administration.

12) Intentionally self-inflicted injury.

13) Any act of war, declared or undeclared, or any act incident to war.

6. COVERED FAMILY MEMBERS

6.1 ELIGIBILITY. Those eligible to become Covered Family Members are:

1) You;

2) Your spouse; and

3) Your unmarried, dependent children less than 21 years of age, including step children, adopted children and children for whom you are the legal guardian.

6.2 COVERED FAMILY MEMBERS AT ISSUE. The Covered Family members on the Date of Issue are those persons who are:

1) Eligible;

2) Named in the Application; and

3) Approved under our underwriting standards. A person who is named in the Application is approved under our underwriting standards unless excluded by an amendment attached to this contract.

6.3 COVERAGE OF NEWBORNS. After the Date of Issue any child born to you while this contract is in force will become a Covered Family Member. The child is covered from the moment of birth for 31 days or until the next premium due date, if later. Within 31 days of the later date you must apply to cover the child and pay the additional premium or the child will cease to be a Covered Family Member. If you and your spouse are covered by us under separate similar contracts, the child will only be covered under one of the contracts.

6.4 ADDITION OF COVERED FAMILY MEMBERS AFTER DATE OF ISSUE. A person who was not covered at issue or later ceased coverage may become a Covered Family Member if:

1) The person is eligible;

2) You apply to cover the person;

3) You pay the additional premium; and

4) We approve the person under our underwriting standards.

Whenever a person becomes a Covered Family Member after the Date of Issue, we will name the person, the effective date of coverage and the initial additional premium in this contract.

7. TERMINATION OF THIS CONTRACT

7.1 TERMINATION FOR NONPAYMENT OF PREMIUMS. If this contract terminates due to failure to pay a premium before the grace period ends, coverage on all Covered Family Members will then cease.

7.2 TERMINATION UPON OUR REFUSAL TO RENEW. This contract will terminate on any Contract Anniversary on which we refuse to renew it. See page 1, Renewal Provision - Renewal May be Refused.

8. TERMINATION OF INDIVIDUAL COVERAGE

8.1 TERMINATION OF CHILD COVERAGE. A child will cease to be a Covered Family Member on the first premium due date after the earliest of the child's:

1) 23rd birthday;

2) Marriage; and

3) Termination of dependency on the Insured.

We will reduce future premiums by the portion of the premium which would have been charged for the child. Coverage may be converted as in Section 9.1.

However, an unmarried child will remain a Covered Family Member beyond the child's 23 birthday while this contract remains in force on a premium paying basis if the child is and continues to be:

1) Incapable of self-sustaining employment due to mental retardation or physical handicap; and

2) Dependent upon the Insured for support and maintenance.

This coverage will be continued only if we receive proof that the child is incapable and dependent. This proof must be received at our Home Office within 60 days of the first premium due date after the child's 23rd birthday. Renewal premiums for this coverage will be based on adult rates at the child's attained age.

8.2 TERMINATION OF COVERAGE BY WRITTEN NOTICE. You may terminate coverage on you, your spouse or a child by giving Written Notice. Coverage will cease on the next premium due date. Future premiums will then be reduced by the portion of the premium which would have been charged for that person. Coverage may be converted as in Section 9.1.

8.3 TERMINATION OF COVERAGE DUE TO MEDICARE ELIGIBILITY AGE. Coverage for any Covered Family Member will cease on the date that person:

1) Becomes eligible for Medicare; or

2) Attains Medicare Eligibility Age.

We will reduce future premiums by the portion of the premium which would have been charged for that person. Coverage may be converted as in Section 9.1.

8.4 TERMINATION OF COVERAGE DUE TO DEATH. Coverage ceases on the date a Covered Family Member dies. We will reduce future premiums by the portion of the premium which would have been charged for that person.

8.5 STATUS OF CONTRACT UPON TERMINATION OF INSURED'S COVERAGE. If your coverage is terminated as in Section 8.2, 8.3 or 8.4, this contract will either be continued or terminated as follows:

1) Contract Continues. If your spouse is a Covered Family Member, this contract will continue in force with your spouse as the Insured. Coverage on any children will not be changed.

2) Contract Terminates. If your spouse is not a Covered Family Member or if you have no spouse, this contract will terminate when your coverage terminates. Coverage on each child may be converted as in Section 9.1.

8.6 PREMIUM REFUND UPON TERMINATION. We will refund the portion of any premium paid for the period beyond the date coverage ceases.

9. CONVERSION OF COVERAGE AND EXTENSION OF BENEFITS

9.1 CONVERSION PRIVILEGE. If the coverage on any Covered Family Member ceases other than under Section 7 Termination of this Contract, that coverage may be converted to a new contract of a similar type then issued by us. However, for termination due to Medicare eligibility the contract will be a Medicare Supplement contract if any is then issued by us. We will issue the contract without regard to the person's health.

Conversion is subject to the following:

1) Written application with the first premium must be made to us at our Home Office within 60 days after the date the coverage ceases under this contract.

2) The benefits of the new contract may not exceed the benefits of this contract nor may they be of an amount which by our published standards at the time of conversion will result in overinsurance.

3) The person's remaining Available Benefit and Mental Care Benefit Limit under this contract on the date of conversion will carry over to the new contract.

4) The first premium will be based on the person's age on the date of issue of the new contract.

5) The new contract's date of issue is the date the coverage ceases under this contract.

9.2 EXTENSION OF BENEFITS. From the date coverage terminates for any Covered Family Member, coverage will be extended for expenses due to:

1) A disabling Sickness or Injury, other than pregnancy, provided the person is totally disabled and under the care of a Doctor when coverage terminates. These benefits will be extended while the total disability continues, but not for more than 12 months.

2) Complications of Pregnancy for a pregnancy which began while coverage was in force. These benefits will be extended while the pregnancy continues and while continuously confined in a Hospital after the pregnancy terminates.

Total disability is a disability:

1) Which results from Sickness or Injury;

2) Which prevents the person from performing his or her usual duties and activities;

3) Which is certified by a Doctor; and

4) During which the person does not engage in any gainful occupation.

10. CLAIMS

10.1 NOTICE OF CLAIM. A notice of claim must be given to us within 60 days after any loss occurs, or as soon after this as possible. It may be given to us in writing at our Home Office in Minneapolis, Minnesota or to one of our representatives.

10.2 CLAIM FORMS. We will send you claim forms after we receive your notice of claim. If we do not send them within 15 days, you may satisfy the proof of loss requirements by giving written proof of the occurrence, nature and extent of the loss for that claim. You must submit proof within the time stated in Section 10.3.

10.3 PROOFS OF LOSS. Written proof of loss must be given to us at our Home Office. This should be done within 90 days after the loss occurs. Failure to give proof within 90 days will not affect the claim if proof is given as soon as is reasonably possible. However, proof must be given within one year from the time that proof is otherwise due except in the absence of legal capacity.

10.4 TIME OF PAYMENT OF CLAIMS. We will pay benefits as soon as we receive sufficient proof of loss.

10.5 PAYMENT OF CLAIMS. All contract benefits will be paid to you, if living. Any accrued benefits unpaid at your death will be paid to your estate.

However, we may pay any benefit up to $1,000 to any relative of yours by blood or marriage whom we consider to be equitably entitled if:

1) You are a minor or otherwise not competent to give a valid release; or

2) The benefit is payable to your estate.

Any payment that we make in good faith by this provision will fully discharge us to the extent of the payment.

10.6 PHYSICAL EXAMINATIONS. In addition to other proof of loss, we may require any Covered Family Member for whom a claim is made to have a physical examination as often as is reasonable while the claim is pending. It will be at our expense.

10.7 LEGAL ACTIONS. No legal action may be brought to recover on this contract:

1) Until at least 60 days after written proof of loss is given as in Section 10.3; or

2) After three years from the date written proof of loss must be given.

11. PREMIUMS AND REINSTATEMENT

11.1 PREMIUM PAYMENTS. The initial premium and interval of payment are shown on page 3. Renewal premiums are charged according to our table of premiums in effect on each Contract Anniversary (see page 1, Table of Premiums-Premiums May Change). You may pay premiums at other intervals using our published rates and rules in effect on each Contract Anniversary. The initial premium is due and payable on the Date of Issue. Each subsequent premium is due and payable at our Home Office on the first day of its interval of premium payment. If we accept a premium for a person whose coverage should have ceased, we will continue that person's coverage until the end of the period paid for by the premium. However, if we accept the premium due to misstatement of age, we will not continue coverage after coverage should have ceased, but will instead refund the premium paid.

11.2 PREMIUM IN DEFAULT AND GRACE PERIOD. Any premium not paid on or before the date it is due is a premium in default. Except for the first premium, you may pay the premium in default within a grace period of 31 days after the date it is due. During the grace period, this contract will remain in force. If the premium in default is not paid within the grace period, this contract will terminate at the end of the grace period. 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 our records a written notice of our intent not to renew this contract.

11.3 REINSTATEMENT. If this contract terminates at the end of the grace period for nonpayment of premiums, you must pay any premiums in default to reinstate it. However, no premium will be applied to any period more than 60 days before the reinstatement. This contract is reinstated when we accept the payment, unless we also require a reinstatement application.

When an application is required, we will give you a conditional receipt for the premium paid. We must give you notice of approval or disapproval within 45 days after we receive the application. We will reinstate the contract as soon as it is approved. If we do not notify you within the 45 day period, the contract will be automatically reinstated on the 45th day.

The reinstated contract covers only a loss as a result of:

1) Sickness which appears at least 10 days after the date of reinstatement; or

2) Injury sustained after the date of reinstatement.

All other rights that you or we had immediately before the default in premium payment again apply, subject to any provisions endorsed on or attached to this contract when reinstated.

Section 12.3 will apply from the date this contract is reinstated with regard to statements made in the application for reinstatement.

12. GENERAL PROVISIONS

12.1 ENTIRE CONTRACT. The Entire Contract consists of:

1) This contract including any attached riders or amendments;

2) The Application attached to this contract; and

3) The Articles of Incorporation and Bylaws of the Society and all amendments made to them after the Date of Issue. Benefits will not be reduced by any future amendments to our Articles of Incorporation or Bylaws.

12.2 CHANGE OF CONTRACT. No change in this contract is valid unless it is made in writing and signed by our President and Secretary; all changes must be endorsed on or attached to this contract unless waived by us. No agent may change this contract or waive any of its provisions.

12.3 TIME LIMIT ON CERTAIN DEFENSES.

1) Misstatements in the Application. We will not contest any statements made in the Application for a Covered Family Member after this contract has been in force during that person's lifetime for two years from the date that person is covered, except for any claim for a loss that occurs within the two years or for fraudulent misstatements.

2) Pre-Existing Conditions. No claim for a loss incurred for a Covered Family Member that begins more than two years after the date that person is covered will be reduced or denied because a disease or physical condition existed prior to the date that person is covered, unless excluded by name or specific description in this contract.

12.4 MISSTATEMENT OF AGE OR SEX. If the age or sex of any Covered Family Member has been misstated, any amount payable will be that which the premiums paid would have bought at the correct age and sex of the Covered Family Member. However, if coverage would not have been provided at the member's correct age on the date the member was first covered, our liability for that member is limited to a refund of any premiums paid for that member.

12.5 MAINTENANCE OF SOLVENCY. The benefits provided by this contract will not change. If the solvency of the Society becomes impaired, you may be required to make an extra payment. The Board of Directors will determine the amount of any extra payment. It will be based on each member's fair share of the deficiency.

12.6 CONFORMITY WITH STATE LAWS. On the Date of Issue, any provision of this contract in conflict with the laws of the state in which you reside on that date is amended to conform with those state laws.

12.7 MEMBERSHIP. You and your spouse, if covered, are members of the Society. Rights and privileges of membership are set forth in the Bylaws of the Society or in the Application.

12.8 ASSIGNMENT. No assignment of this contract or of any benefits payable under this contract will bind us unless and until the original or a duplicate of it is filed in our Home Office. We are not responsible for the validity or effect of any assignment. You will keep all membership rights and privileges.

12.9 DIVIDENDS. Each year we will determine our divisible surplus. This contract's share, if any, will be paid as a dividend on the Contract Anniversary.

LUTHERAN BROTHERHOOD

A Fraternal Benefit Society

Minneapolis, Minnesota

MAJOR MEDICAL EXPENSE COVERAGE

Benefits for hospital and medical expenses as described in this contract.
Contract renewable to Medicare Eligibility Age.
Lutheran Brotherhood may refuse renewal on any Contract Anniversary.
Premiums expected to increase.