MAJOR MEDICAL EXPENSE CONVERSION POLICY

We will pay benefits for covered loss due to Sickness and Injury as described in this policy. Benefit payment is governed by the terms of this policy.

This policy is issued in consideration of the application and the first premium payment. A copy of the application is attached to, and made a part of, the policy. The first premium is shown in the Schedule. It is due on or before the Policy Date. It will keep the policy in force from the Policy Date to the first renewal date. Renewal premiums are then due each renewal date. Renewal dates occur at the start of each "Period of Insurance". This period is shown in the Schedule. It may be one, three, six or twelve months. All "Periods of Insurance" start and end at 12:01 a.m. standard time at your home.

RENEWABLE EXCEPT FOR STATED REASONS AT PREMIUM RATES IN EFFECT IN YOUR STATE ON RENEWAL DATES. BENEFITS REDUCE FOR PERSONS WHO BECOME COVERED BY MEDICARE.

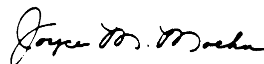
We may nonrenew the policy on a renewal date, but only for: (1) Overinsurance, as explained in Section XV; or (2) fraud or material misrepresentation in applying for benefits under the policy. We will not nonrenew because of a change in your health or physical condition, or of any other Covered Member. We will not nonrenew because of an increase in your age. We will not add to the policy, while it is in force, any restrictions due to a change in a member's health.

Subject to the above limitations, you may renew this policy as long as any Covered Member remains eligible for continued coverage. To keep the policy in force, pay each renewal premium when due or within the Grace Period. Premiums may be changed on a renewal date as provided in Section XVII. Only premiums due after the date of the change will be affected by the change.

NOTICE OF 10 DAY RIGHT TO EXAMINE POLICY

Read your policy carefully. If you are not satisfied, return it within 10 days from the date you received it. You may return it to our Home Office or to your agent. We will cancel the policy and refund your premium.

Ralph J. Eckert
President



Joyce M. Moehn
Secretary

Examined by ______________________ Countersigned by ______________________

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Additional Benefits, if any, are listed in the Schedule and attached to the policy.

Check the application. Notify us if information shown is not correct or complete.

SCHEDULE

FORM:

POLICY NUMBER:

INSURED:

POLICY DATE:

FIRST RENEWAL DATE:

FIRST PREMIUM:

PERIOD OF INSURANCE:

COVERED MEMBERS UNDER THIS POLICY . . . . INSURED:

SPOUSE:

CHILDREN:

	INSURED	SPOUSE	CHILDREN
MAXIMUM AMOUNT Per Sickness or Injury			
DEDUCTIBLE Per Benefit Period			
DEDUCTIBLE ACCUMULATION PERIOD			
DAILY ROOM & BOARD COVERED CHARGE*			
NUMBER OF DAYS OF ROOM & BOARD Per Benefit Period	70		
MAXIMUM SURGERY COVERED CHARGE*			
MEDICAL SERVICES COVERED CHARGE*			

*Paid at 80% until
out-of-pocket limit is met

OLDER AGE DAILY HOSPITAL BENEFIT (for persons covered by Medicare)	$30

I. DEFINITIONS

'We', 'us' and 'our' mean Benefit Trust Life Insurance Company.

'You' and 'your' means the Insured.

'Covered Member' and 'member' mean any person insured by this policy. This includes eligible persons named in the application or later added to coverage. Covered Members are listed in the Schedule (or its latest amendment).

'Injury', for persons covered under the prior group plan, means injuries resulting, directly and independently of all other causes, from accidents and which cause covered loss after the Policy Date. All injuries sustained in one accident, including all related conditions and recurrent symptoms, are considered as the same injury.

'Sickness', for persons covered under the prior group plan, means illness, disease or complications of pregnancy which cause covered loss after the Policy Date; and pregnancy which terminates while the member's coverage is in force.

'Injury', for persons not covered under the prior group plan, means injuries resulting, directly and independently of all other causes, from accidents which occur after the effective date of a member's coverage. All injuries sustained in one accident, including all related conditions and recurrent symptoms, are considered as the same Injury.

'Sickness', for persons not covered under the prior group plan, means illness, disease or complications of pregnancy first manifested more than 30 days after the effective date of a member's coverage; and pregnancy which commences more than 30 days after the effective date of a member's coverage and which terminates while the member's coverage is in force.

'Preexisting Condition' means a condition for which either:

(1) symptoms existed within the five years before the effective date of a member's coverage which would cause an ordinarily prudent person to seek medical advice or care; or

(2) medical advice or care was recommended by, or received from, a Physician within the five years before the effective date of a member's coverage.

'Physician' means a legally qualified physician or surgeon who is acting within the scope of his license. It does not include a family member.

'Nurse' means (1) a Registered Graduate Nurse (R.N.); or (2) a licensed practical or vocational nurse. It does not include a family member.

'Physical Therapist'' means a licensed physical therapist. It does not include a family member.

'Family Member' as used in this section means you, your spouse, parent, child, brother, sister or in-law.

'Hospital' means a place which is all of the following. (1) It is operated lawfully. (2) It mainly and continuously provides medical, diagnostic and surgical facilities. These facilities may be on the premises or available on a prearranged basis. They must be supervised by one or more licensed Physicians. (3) It provides inpatient care. (4) It provides 24-hour nursing service by, or supervised by, a Registered Graduate Nurse (R.N.). 'Hospital' does not mean: (1) a convalescent, nursing or rest home; (2) a Skilled Nursing Home or extended care facility; (3) a home for the aged or a custodial care facility; (4) a sanatorium or clinic; or (5) a place mainly for drug addicts or alcoholics.

'Intensive Care Unit' is the part of a Hospital so designated by the Hospital. It must be permanently equipped and staffed to provide, for critically sick persons, more extensive care than is provided in the general Hospital rooms. This care must include constant observation by a staff of Registered Graduate Nurses (R.N.s) whose duties are confined to that unit.

'Free-standing Surgical Center' means a licensed free-standing or ambulatory surgical center. Services and supplies provided by such a center are covered as if they had been provided by a Hospital on an outpatient basis.

'Skilled Nursing Home' means a place which is all of the following. (1) It is operated lawfully. (2) It provides room and board accommodations at the patient's expense. (3) It keeps a daily medical record of each patient. (4) It regularly provides skilled nursing care supervised by a licensed Physician. (5) This skilled nursing care is provided by, or supervised by, a Registered Graduate Nurse (R.N.). 'Skilled Nursing Home' does not mean: (1) a rest home or a home for the aged; (2) a place mainly for drug addicts, alcoholics or the mentally ill; (3) a custodial care or educational care facility.

'Confinement' means being an in-patient in a Hospital or Skilled Nursing Home. 'Confinement' must be caused by Sickness or Injury. The confined person must be under a Physician's care.

'Overinsurance' means that your insurance benefits will be more than the cost of your medical expense.

'He' and 'his' also mean 'she' and 'her'.

'Medicare' means Title XVIII of the Social Security Act, as amended.

Other terms: Maximum Amount, Deductible, Deductible Accumulation Period, Daily Room and Board Covered Charge, Maximum Surgery Covered Charge, Medical Services Covered Charge and Older Age Daily Hospital Benefit are shown in the Schedule. The beneficiary is named in the application or later designated by the policy owner.

II. ELIGIBILITY FOR COVERAGE

A. Persons who may become Covered Members at the time this policy is issued, without evidence of insurability, are the following.
   (1) You.
   (2) Your spouse who was covered by the prior group plan on the date your coverage ended.
   (3) Your, or your spouse's, child under age 23 who was covered by the prior group plan on the date your coverage ended, subject to (C) below.

B. Persons who were not covered by the prior group plan and who may be added to this policy, with evidence of insurability, are the following.
   (1) Your spouse.
   (2) Your or your spouse's child who is less than 18 years old.
   (3) Your, or your spouse's, child age 18 or older and under age 23 who is a full time student at an accredited educational institution or who resides with you, subject to (C) below.

C. A child is eligible for coverage only if: (1) he is unmarried; and (2) he is dependent on you for support and maintenance. A 'child' includes a child legally adopted by you. For a child age 18 or older, the premium for his attained age must be paid.

D. Any eligible person may become covered if you take the following steps.
   (1) Apply in writing.
   (2) When required, provide evidence satisfactory to us of the insurability of the person.
   (3) Pay the premium for his coverage.

E. A child born to you while the policy is in force is automatically a Covered Member. He remains so for 31 days or until the end of the Period of Insurance during which he was born, if later. To continue his coverage, notify us in writing. Do this within 45 days after his birth, or before the end of the Period of Insurance during which he was born, if later. Make timely payment of the premium for the child's continued coverage. A covered newborn has the same coverage as any other covered child, starting the day of birth. Birth abnormalities and congenital defects of such newborns which require medical care are covered as Sickness or Injury. The Preexisting Conditions limitation will not apply. There is no coverage for (1) routine nursing care; (2) well baby care; (3) immunizations, medical examinations or tests of any kind not related to treatment of Sickness or Injury.

III. TERMINATION OF COVERAGE

Subject to the Renewal provision, a Covered Member's coverage under this policy ends at the earlier of the following.

(1) When the member stops being covered as described in Section III(A).
(2) At the end of the Grace Period for an unpaid premium.
(3) When the policy is terminated.
(4) When the member dies.

A. A member stops being covered as follows.

(1) Your spouse — at the end of the Period of Insurance during which the marriage ends by divorce or annulment.
(2) Your child — at the end of the Period of Insurance during which the earliest of the following occurs: (a) his 23rd birthday; (b) his marriage; (c) the date he stops being eligible for dependent coverage as provided in Section II.

If a dependent child is mentally or physically unable to earn his own living on the date his coverage would end because of age, his coverage may be continued. These conditions must be met. (1) The child must be, on that date, covered under the policy. (2) His incapacity must continuously prevent him from earning his own living. (3) He must continue, except for his age, to be eligible for coverage. (4) The policy must remain in force. (5) Proof of such incapacity and dependency must be furnished us within 31 days after the date the child reaches the age his coverage would otherwise end. (6) The premium for his attained age must be paid.

We may require proof of the child's continuing incapacity and dependency. During the first two years after he attains the age his coverage would otherwise end, we may require proof at reasonable intervals. After such two years, we may not require proof more than once a year. If such proof is not provided within 60 days after a request, the child's coverage will end on the 60th day after the request.

B. You must give us notice when a Covered Member stops being eligible to continue his coverage, except because he has reached the limiting age of the policy.

C. If we accept premium for a Covered Member after he is no longer eligible for coverage, we will continue his coverage to the end of the period the premium applies to. Otherwise, the member's coverage ends at the end of the Period of Insurance during which he stops being eligible. We will return any unearned premium we receive because of termination of coverage.

D. If you die while this policy is in force, and there are no other Covered Members, the policy ends. If there are other Covered Members, your spouse becomes the Insured. Your spouse's coverage, if any, will not change.

When a member's coverage ends, any premium change is made on the next renewal date. Termination of coverage will not affect a claim originating before the date of termination.

IV. CONVERSION PRIVILEGE

When a Covered Member's coverage ends, as described in Section III, he can be issued his own policy. No information about his health will be required. He must apply to our Home Office, in writing, within 31 days after the date his coverage under this policy ends. He must also pay the first premium for the new policy within such 31 days. The new policy will provide benefits we are then issuing which are most like, but not greater than, this policy's benefits. The premium for the new policy will be based on our rates in effect at the time of conversion. The then attained age and insurance classification of the Covered Member will be used. The new policy will not cover loss to the extent benefits are payable under this policy. All probationary or waiting periods of the new policy will be considered as starting from the earlier of the member's effective date under this policy or under the prior group plan.

V. BENEFIT PROVISIONS FOR PERSONS NOT COVERED BY MEDICARE

The following apply only to Covered Members: (a) who are not covered by Medicare; or (b) who are covered by Medicare but whose Benefit Period began before their Medicare coverage began.

A. Benefit Periods — A Benefit Period starts on the date a Covered Member first incurs a Covered Charge which is used toward meeting the Deductible for the Sickness or Injury. A Benefit Period ends after 24 months, or when the Maximum Amount is paid out, whichever is earlier. A new Benefit Period starts for each unrelated Sickness or Injury. A new Benefit Period starts each 24 months for the same Sickness or Injury, unless the Maximum Amount for that Sickness or Injury has been paid out.

B. Deductible — The Deductible is shown in the Schedule. It is the amount of Covered Charges which must be incurred by a Covered Member for each Sickness or Injury each Benefit Period before benefits are payable for that Benefit Period. A new Deductible must be met for each unrelated Sickness or Injury, and for each new Benefit Period for the same Sickness or Injury. The Deductible must be met during a period of time no longer than the Deductible Accumulation Period shown in the Schedule.

C. Maximum Amount — The Maximum Amount is a limit on total benefits. It is the maximum amount of benefits we pay for a Covered Member for all Benefit Periods for any one Sickness or Injury. This amount is shown in the Schedule.

D. Covered Charges — Covered Charges are the charges listed below which: (1) are necessary for care and treatment of Sickness or Injury; (2) are prescribed by a Physician; and (3) are not covered by Medicare. Covered Charges only include the portion of the charge which does not exceed the usual charge made for the service or supply. The 'usual' charge is the smaller of: (1) the charge made when there is no insurance; or (2) the usual level of charges made in the same county (or larger area if necessary to find this level) for the same or a similar service or supply. A charge is considered incurred on the date the service is rendered or the supply furnished.

   Covered Charges are: (1) Daily room, board and general nursing care charges during a Hospital Confinement, up to the Daily Room and Board Covered Charge shown in the Schedule for any one day of Confinement; and up to the number of days shown in the Schedule for any one Benefit Period. (2) Daily room, board and general nursing care charges during Confinement in an Intensive Care Unit, up to twice the Daily Room and Board Covered Charge for any one day of Confinement. For any day we pay this intensive care benefit, we will not pay the room and board benefit in (1) above. (3) Charges by a Hospital for services and supplies provided while the member is Hospital Confined and not included in (1) or (2) above. (4) Surgery and anesthesia charges, up to the limits described in Section VII. Surgery Benefit. (5) Physician's charges, except for surgery and anesthesia, up to the limits described in Section VIII. Physician's Benefit. Only one Physician's visit per day will be covered. (6) Skilled Nursing Home charges for daily room, board and skilled nursing care, up to one-half the Daily Room and Board Covered Charge for any one day of Confinement. Benefits are paid for up to 30 days following a Hospital Confinement. Confinement must start within 14 days after a Hospital Confinement of at least 3 days. (7) Charges by a Hospital for medical services, supplies, drugs and medicines provided on an outpatient basis. (8) Charges for diagnostic x-rays and laboratory tests. (9) Charges for drugs and medicines identified by a prescription number and purchased from a licensed pharmacist. (10) Charges for blood and blood plasma, oxygen and other medical supplies and prosthetic appliances. (11) Charges of a private duty nurse or physical therapist, up to the limits described in Section IX. These limits apply before the 80% computation to find the benefit payable. (12) Charges for local professional ambulance service.

E. Benefits — Subject to the Deductible, the Deductible Accumulation Period and the Maximum Amount, we will pay you benefits for the Covered Charges incurred by a Covered Member during a Benefit Period. For benefits based upon Hospital Confinement, the Confinement must start while the member's coverage is in force. For all other benefits, the expense must be incurred while the member's coverage is in force. Benefits will be paid for 80% of the Covered Charges, up to any limits shown.

F. Out-of-Pocket Limit — Benefits will be paid as described in (E) above until the 20% of the Covered Charges you must pay reaches $1,000 in a Benefit Period. For the rest of the Benefit Period, Covered Charges incurred are paid at 100%, up to any limits shown, subject to the Maximum Amount for the Sickness or Injury. At the start of each new Benefit Period, benefits will again be paid at 80% of the Covered Charge until a new $1,000 limit is reached.

VI. OLDER AGE HOSPITAL BENEFIT FOR PERSONS COVERED BY MEDICARE

This benefit applies only to Covered Members: (a) who are covered by Medicare; and (b) whose Hospital Confinement began after their Medicare coverage began and while their coverage is in force.

We will pay you the Older Age Hospital Benefit shown in the Schedule for each day a Covered Member is Hospital confined. The maximum paid for any 'One Confinement' will be 210 days.

'One Confinement' as used in this section means either: (1) consecutive days of Confinement; or (2) successive Confinements due to the same or related causes when discharge from and readmission to the Hospital occur within 180 days.

VII. SURGERY BENEFIT

Surgeon's fees are covered, up to the limit for the operation done. To find the maximum amount that will be covered, multiply the Maximum Surgery Covered Charge (in the Schedule) by the percent shown in the Table of Procedures for the surgery. We will always pay at least $5.00. The surgery benefit includes charges for the surgery and for post-surgery care for two weeks, or for the Hospital Confinement, whichever is longer.

Limits for anesthesiologist's and assistant surgeon's fees are found as follows.

(1) If the limit for the surgeon is $100.00 or more, the limit for the anesthesiologist is 25% of the limit for the surgeon.
(2) If the limit for the surgeon is $100.00 or more, the limit for the assistant surgeon is 15% of the limit for the surgeon.
(3) If the limit for the surgeon is less than $100.00, the limit for the anesthesiologist is the smaller of $25.00 or 50% of the limit for the surgeon.
(4) If the limit for the surgeon is less than $100.00, the limit for the assistant surgeon is the smaller of $25.00 or 30% of the limit for the surgeon.

The limit for anesthesiologist's fees is for: (1) administration of anesthetic and any fluids related to the operation; and (2) the usual visits made before and after surgery. This limit is only for fees of a Physician attending the surgery for the sole purpose of giving the anesthesia service. The limit will be 50% less if the operating surgeon or his assistant gives the anesthesia.

Not all surgical procedures are listed in the Table. For a procedure not listed, the Covered Charge is based on the percent listed for a procedure of similar complexity; but the Covered Charge for such procedure cannot exceed the Maximum Surgery Covered Charge shown in the Schedule.

Sometimes more than one procedure is done at the same time. If they are done through the same incision, we pay only for the procedure with the highest limit. If they are done through different incisions, we pay for the procedure with the highest limit plus 50% of the limit(s) for the other procedure(s). But, the total Covered Charges will not exceed the Maximum Surgery Covered Charge.

TABLE OF PROCEDURES

	Per Cent of Maximum Surgery Benefit
BONES AND JOINTS	
Arthrodesis, hip	50.0%
Excision of tumor or cyst, large bones	25.0
Small bones	12.5
Bone graft, radius or ulna	32.5
Spinal fusion, two or more segments	50.0
FRACTURES	
Jaw, closed reduction with wiring of teeth	15.0
Open reduction with wiring of teeth and/or local fixation	18.8
Wrist (Colles), simple, closed reduction	7.5
Open reduction	10.0
Vertebral body; one or more, requiring reduction	15.0
Clavicle, simple, closed reduction	7.5
Simple or compound, open reduction	20.0
Upper arm shaft, simple closed reduction	12.5
Simple or compound, open reduction	22.5
Lower arm shaft	
Radius or ulna, simple closed reduction	10.0
Simple or compound, open reduction	20.0
Radius and ulna, simple closed reduction	10.0
Simple or compound, open reduction	25.0
Finger or thumb, simple, closed reduction	2.5
Open reduction	10.0
Lower leg shaft	
Tibia, simple closed reduction	12.5
Simple or compound, open reduction	25.0
Fibula, compound, with uncomplicated soft tissue closure	10.0
Simple or compound, open reduction	15.0
Tibia and fibula, closed reduction	15.0
Simple or compound, open reduction	30.0
Ankle (Potts), simple, closed reduction	12.5
Open reduction	25.0
Puncture of joint, for aspiration	1.0
Excision of invertebral disc	45.0
With spinal fusion	60.0
Excision of semi-lunar cartilage of knee joint	25.0
Suture of collateral or cruciate ligament, knee, one	27.5
Collateral and cruciate ligament, knee	37.5
DISLOCATION	
Shoulder, simple, closed reduction, with anesthesia	2.5
Knee, simple, closed reduction	10.0
Open reduction	30.0
Tarsal or astragalo-tarsal, simple closed reduction	5.0
Open reduction	22.5
Toe, more than one, one or more joints, Simple closed reduction	3.5
Simple or compound, open reduction	10.0
BRAIN AND NERVES	
Craniotomy: Evacuation of hematoma, subdural, extradural or intracerebral	50.0
Elevation of depressed skull fracture, simple	37.5
Excision of brain tumor, abscess or cyst	62.5

	Per Cent of Maximum Surgery Benefit
Obliteration of aneurysm	75.0%
Pneumoencephalography	7.5
Spinal puncture, lumbar, independent procedure	1.0
Laminectomy for lesion of spinal cord	50.0
For removal of intervertebral discs	45.0
Sympathectomy, lumbar, unilateral	27.5
Bilateral	37.5
Sympathectomy, cervico-thoracic, bilateral	50.0
BREAST	
Excision, biopsy of breast	7.5
Excision of cyst, tumor or part of breast	7.5
Simple removal of breast	15.0
Radical removal of breast	35.0
CARDIOVASCULAR SYSTEM	
Repair of heart valve, mitral	60.0
Aortic, pulmonic or tricuspid	75.0
Replacement of heart valve	100.0
Catheterization of heart, independent procedure	7.5
Excision and graft, thoracic aorta	75.0
Repair aneurysm of aorta	75.0
Sinus of Valsalva, Closure of Fistula	100.0
Aortography	5.0
Ligation of femoral vein	12.5
Ligation and division of common iliac vein	25.0
Varicose veins: Ligation and division of long saphenous vein at saphenofemoral junction	10.0
Ligation and division and complete stripping of long or short saphenous veins, unilateral	15.0
Bilateral	25.0
Ligation and division and complete stripping of long and short saphenous veins, unilateral	20.0
Bilateral	30.0
Venography	2.5
DIGESTIVE SYSTEM	
Removal of tonsils, with or without removal of adenoids under 18 years of age	7.5
18 years of age or over	10.0
Excision of stomach ulcer or benign tumor	30.0
Removal of stomach, subtotal, with or without vagotomy	40.0
Resection of small intestine, with anastomosis	35.0
Resection of large intestine, in two stages, including first stage colostomy	50.0
Removal of appendix	20.0
Proctosigmoidoscopy, diagnostic, initial	1.5
Subsequent	1.0
Incision of rectal fistula, superficial	5.0
Excision of hemorrhoids, external, complete	10.0
Internal and external	15.0
With excision of fistula	20.0
With excision of fissure	15.0
Removal of gall bladder	30.0
With open exploration of common duct	35.0

	Per Cent of Maximum Surgery Benefit
Repair of inguinal hernia, unilateral	17.5%
With excision of hydrocele	20.0
Recurrent	20.0
Repair of femoral hernia, unilateral	17.5
Recurrent	22.5
Repair of ventral hernia, incisional	22.5
Recurrent	25.0
Repair of epigastric hernia	17.5
Recurrent	22.5
Esophagectomy	60.0
Repair of umbilical hernia, under 5 years of age	15.0
5 years of age or over	17.5
EAR	
Incision of ear drum	1.5
Labyrinthotomy or labyrinthectomy	50.0
Tympanoplasty, Type 1, uncomplicated	35.0
Type V, two stages	70.0
Stapes mobilization	35.0
Stapedectomy, with or without vein plug	50.0
EYE	
Removal of foreign body from surface of cornea	1.0
Excision of pterygium	12.5
Needling of lens for cataracts, initial	10.0
Subsequent	5.0
Extraction of lens for cataracts, unilateral	40.0
Reattachment of retina, electrocoagulation, initial	50.0
Eye muscle operation, one or more muscles, one or both eyes, single stage	30.0
FEMALE GENITAL SYSTEM	
Repair of cystocele, independent procedure	17.5
Repair of cystocele, rectocele and perineoplasty	25.0
Excision of ovarian cyst or tumor, unilateral or bilateral, independent procedure	22.5
Removal of ovary, unilateral or bilateral, independent procedure	22.5
Biopsy of cervix or endometrium, independent procedure	1.5
Total hysterectomy, corpus and cervix	30.0
Radical hysterectomy for malignancy, including regional lymph nodes	50.0
Vaginal hysterectomy, with or without pelvic floor repair	35.0
Excision of lesion of cervix	1.5
Dilation and curettage of uterus, independent procedure	7.5
Insertion of radioactive substance into cervix, uterus or both	10.0
MALE GENITAL SYSTEM	
Excision of hydrocele, unilateral	15.0
Excision of variocele, independent procedure, unilateral	15.0
With hernia repair	20.0
Orchiectomy, radical	50.0
Resection of prostate, perineal, suprapubic, retropubic or transurethral	40.0

	Per Cent of Maximum Surgery Benefit
Radical	50.0%
MUSCLES AND TENDONS	
Excision of ganglion, wrist	7.5
Excision of Baker's cyst (synovial cyst in popliteal space)	15.0
Lengthening or shortening tendon	15.0
OBSTETRICAL CARE	
Total Obstetrical Care (including ante partum care, vaginal delivery, and post partum care)	17.5
Classic Caesarian Section (including ante and post partum care)	25.0
Caesarean Section with hysterectomy, subtotal (including ante and post partum care)	30.0
Therapeutic Abortion, by dilation and curettage	10.0
RESPIRATORY SYSTEM	
Excision of nasal polyp, single	1.5
Multiple, unilateral or bilateral, office	3.5
Complicated, requiring hospitalization	10.0
Submucous resection, including septoplasty	15.0
Antrum puncture, maxillary sinus, unilateral	1.0
Radical antrotomy (Caldwell-Luc), unilateral	25.0
Tracheotomy, independent procedure	10.0
Bronchoscopy, diagnostic	7.5
With excision of tumor	12.5
Removal of lung	50.0
Resection of lung with thoracoplasty	75.0
Lobectomy with decortication	62.5
Laryngectomy, without neck dissection	50.0
Laryngectomy, with neck dissection	70.0
SKIN AND SUBCUTANEOUS TISSUE	
Drainage of superficial abscess	1.0
Suture of small wounds (up to 2 ½ inches)	2.0
Excision of malignant lesion of face, below ¼ inch diameter	5.0
From ¼ to ½ inch	7.5
From ½ to ¾ inch	7.5
Excision of pilonidal cyst or sinus	15.0
Excision of ingrown nail for complete removal	2.5
THYROID	
Excision of small cyst or tumor of thyroid	20.0
Thyroidectomy, total	35.0
Subtotal or partial	30.0
For malignancy with neck dissection	50.0
URINARY SYSTEM	
Removal of kidney	40.0
Excision of cyst of kidney	35.0
Resection of bladder tumor, large, transurethral	30.0
Cystoscopy, diagnostic, office	2.5
Cystoscopy, diagnostic, hospital	4.0
With urethral catheterization	7.5
With biopsy	5.0
With fulguration of small tumor	12.5
With removal of stone from ureter	15.0
Cystectomy, complete	50.0
Cystectomy, radical with ureteral transplants	60.0

VIII. PHYSICIAN'S BENEFIT

Physician's fees are covered, up to the limit for the service given. To find the limit for any listed service, multiply the Medical Services Covered Charge (in the Schedule) by the percent shown below for the service.

No expenses are covered under this section for the post-surgery care covered by Section VII. SURGERY BENEFIT. No expenses are covered under this section for mental illness, except the mental illness expenses shown in Section X. MENTAL ILLNESS BENEFIT.

This section does not include diagnostic x-rays or laboratory tests.

Per Cent of Medical Services Benefit

Routine Visits

Service	Per Cent
Hospital	20.0%
Office	20.0
Home	35.0

Special Medical Procedures (other than routine visits)

Service	Per Cent
Consultation	
requiring examination	80.0
Electrocardiogram	
with interpretation and report	48.0
without interpretation and report	24.0

For a service not listed, the Covered Charge is based on the percent listed for a service of similar complexity; but, the Covered Charge cannot exceed the Medical Services Covered Charge shown in the Schedule. Benefits will not be paid if a service is excluded, by name, from coverage.

Radiotherapy and Nuclear Medicine

Limits include use of modality or radioactive substance. Limits for treatment of malignancies include one year of follow-up care. Limits for treatment of nonmalignant conditions include 60 days of follow-up care.

Per treatment:

Service	Per Cent
Superficial or Low-voltage therapy	
Dermatoses (3 fields or less)	24.0
more than 3 fields	32.0
Benign Tumors	32.0
Malignant Lesions	48.0
Orthovoltage (150-500 KVP)	
Benign Lesions	32.0
Malignant Lesions	48.0
Supervoltages, including cobalt	64.0
Surface application of sealed source to benign lesion	48.0

Radioisotope treatment of hyperthyroidism (not including radioactive drugs or diagnostic test)

Service	Per Cent
Initial	320.0
Subsequent	160.0

IX. NURSES AND PHYSICAL THERAPISTS BENEFIT

Nurse's and Physical Therapist's fees are covered, up to the limit for the service given. To find the limit for any listed service, multiply the Medical Services Covered Charge by the percent shown below for the service.

	Per Cent of Medical Services Covered Charge
Registered Graduate Nurse (Private Duty Only):	
Hospitalized care, per shift	48.0%
Non-hospitalized care, up to 30 days, per shift	48.0
Non-hospitalized care, after 30 days, per shift	32.0
Licensed Practical or Vocational Nurse (Private Duty Only):	
Hospitalized care, per shift	32.0
Non-hospitalized care, up to 30 days, per shift	32.0
Non-hospitalized care, after 30 days, per shift	20.0
Physical Therapist, per each half-hour of treatment or major fraction thereof	16.0

X. MENTAL ILLNESS BENEFIT

The policy provides coverage for mental illness and functional nervous disorders. Benefits are payable as described in Section V. BENEFIT PROVISIONS. However, they are only paid for expense incurred during a Hospital Confinement.

XI. COMMUNICABLE DISEASE

Under the following conditions, only one Deductible need be met for all Covered Members. (1) A Covered Member contracts a communicable disease. (2) Within thirty days of the start of the disease, one or more other Covered Members have the same or a related disease. The Maximum Amount will still apply for each Covered Member.

XII. MULTIPLE INJURY

If two or more Covered Members are injured in one accident, only one Deductible need be met. The Maximum Amount will still apply for each Covered Member.

XIII. PREEXISTING CONDITIONS LIMITATION

A. For persons not covered under the prior group plan, a Preexisting Condition that is properly disclosed in the application will be covered as Sickness or Injury as of the effective date of the member's coverage, unless excluded by a rider attached to this policy. A Preexisting Condition that is not properly disclosed in the application will not be covered for loss incurred during the first two years after the effective date of the member's coverage.

B. For persons covered under the prior group plan, only Preexisting Conditions that were covered under the prior group plan will be covered during the first two years after the Policy Date.

XIV. EFFECT OF PRIOR GROUP PLAN

Benefits paid by this policy may depend on any benefits payable by the prior group plan. Benefits for loss incurred in the first policy year may be reduced. They will be reduced to be no greater than benefits you would have received from the group plan, as of the last date of coverage, if your group coverage had stayed in force. Benefits paid by this policy will be reduced by the amount of like benefits paid or "payable" by the group plan for loss incurred after the Policy Date. "Payable" means benefits which would have been paid if you had made a claim.

XV. EFFECT OF OVERINSURANCE

To decide if you have Overinsurance, we may ask you for certain information. We may ask if you have similar benefits: (1) under another health insurance policy, subscriber contract, prepayment plan, or other plan of hospital or medical expense coverage; or (2) under any plan of group coverage on either an insured or uninsured basis. We may ask if similar benefits are provided or available to you under any state or federal law. You should answer this request within 31 days. You need not give information about coverage for accidents only, or for specified diseases only. If you are overinsured, or have duplication of benefits, we will send you notice that we will nonrenew. But, we will also advise you that we will renew if you discontinue enough other coverage to bring your total to an amount which will not be Overinsurance.

If you do not answer our request before you have a claim, and if you do have such other coverage, the benefits of this policy will be reduced. Our only liability will be that proportion of your expense as the amount otherwise payable by this policy plus the total of "like amounts" under valid coverages of which we had notice bears to the total "like amounts" under all valid coverages for such expense. We will return the portion of the premiums paid that exceeds the pro rata portion for the amount of benefits so paid. This refund will cover the period of time the excess coverage was in force while this policy was in force. If other coverage is given on a provision of service basis, the "like amount" is what the service would have cost you if you did not have the coverage.

XVI. EXCLUSIONS AND LIMITATIONS

This policy does not cover expense due to:

(1) suicide, or attempted suicide, while sane or insane;
(2) intentionally self-inflicted injury, while sane or insane;
(3) mental illness or functional nervous disorder, except as explained in Section X. MENTAL ILLNESS BENEFIT;
(4) rest cures;
(5) injury resulting from travel in any type of aircraft, except as a fare-paying passenger in a scheduled commercial airplane;
(6) war, or act of war, declared or undeclared;
(7) expense incurred while in the military, naval or air service of any country; any premium paid for a Covered Member for a period that he is in such service will be returned pro rata upon notice of entry into such service;
(8) diagnostic work, examinations or test procedures not related to treatment of a specific Sickness or Injury;
(9) dental surgery or treatment, unless caused by injury to sound natural teeth; bridgework attached to injured teeth is not covered;
(10) cosmetic surgery, except reconstructive surgery related to or following surgery resulting from injury, trauma, infection or other disease of the involved part and reconstructive surgery of a covered dependent child which has resulted in a functional defect;
(11) eye refractions or eyeglasses;
(12) hearing aids or fitting thereof;
(13) a condition for which a Covered Member is eligible to receive Workers Compensation or Occupational Disease Act or Law benefits;
(14) service or supplies provided by the Veterans Administration;
(15) service or supplies provided for under any law (including Medicare) or by any government unit for which you (or the Covered Member) are, or become, eligible; this exclusion will not apply if you are legally required to pay for such service or supplies, or to Medicaid.

XVII. PREMIUM PROVISIONS

A. Renewal Premiums. Renewal premiums are based on our rate schedule in use on the renewal date. We have the right to change this schedule. Renewal premiums for this policy then change accordingly. The change is made for all policies of this form in your state. Your premium will not change because of the health or claim experience of any Covered Member. Rates for each member are based on his age and insurance classification on the Policy Date, and sex. Rates for a person covered by Medicare are based on his age the date he becomes so covered.

B. Change of Premium for Persons Covered by Medicare. Because benefits change for a member covered by Medicare, premiums also change. We automatically adjust the premium at age 65. You must notify us if any member becomes covered by Medicare before age 65. We will return any excess premium paid for the period after such notification, or the date on which Medicare coverage starts, whichever is later. You should also notify us if any member age 65 will not be covered by Medicare.

XVIII. UNIFORM PROVISIONS

A. Entire Contract; Changes: This policy with the attached application and any attached riders is the entire contract. No change in this policy will be effective until approved by one of our executive officers. This approval must be noted on or attached to this policy. No agent may change this policy or waive any of its provisions.

B. Time Limit on Certain Defenses: (1) After 2 years from the date a person becomes a Covered Member, only fraudulent misstatements in the application for his coverage may be used to void the policy or deny any claim for loss incurred after the 2 year period. (2) No claim for loss incurred after 2 years from the date a person becomes a Covered Member will be reduced or denied because a condition not excluded by name or specific description on the date of loss had existed before the effective date of his coverage. For persons covered under the prior group plan, the 2 year limit in (1) and (2) shall start from the date of the person's coverage under the group plan.

C. Grace Period: This policy has a 31 day grace period. This means that if a renewal premium is not paid on or before the date it is due, it may be paid during the following 31 days. During the grace period the policy will stay in force. The grace period will not apply if, at least 30 days before the premium due date, we have sent to your last address shown in our records written notice of our intent not to renew this policy.

D. Reinstatement: If the renewal premium is not paid before the grace period ends, the policy will lapse. Later acceptance of the premium by us (or by an agent authorized to accept premium) without requiring a reinstatement application will reinstate this policy. If we, or our agent, require an application, you will be given a conditional receipt for the premium. If the application is approved, the policy will be reinstated as of the approval date. Lacking such approval, the policy will be reinstated on the 45th day after the date of the conditional receipt unless we have previously written you of its disapproval. The reinstated policy will cover only loss that results from an injury sustained after the date of reinstatement and sickness that starts more than 10 days after such date. In all other respects your and our rights will remain the same, subject to any provisions noted on or attached to the reinstated policy. Any premium we accept for a reinstatement will be applied to a period for which premiums have not been paid. No premium will be applied to any period more than 60 days before the reinstatement date.

E. Claims.

(1) Notice of Claim: Written notice of claim must be given within 30 days (60 days in Kentucky; 6 months in Montana) after a covered loss starts or as soon as reasonably possible. The notice can be sent to us at our Home Office, 1771 Howard Street, Chicago, IL 60626, or to our agent. Notice should include your name and policy number.

(2) Claim forms: When we receive the notice of claim, we will send you forms for filing proof of loss. If these forms are not given to you within 15 days, you will meet the proof of loss requirements by giving a written statement of the nature and extent of the loss within the time limit stated in the Proofs of Loss section.

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

(4) Time of Payment of Claim: Benefits for loss covered by this policy will be paid as soon as we receive proper written proof.

(5) Payment of Claims: Benefits will be paid to you. Any benefits unpaid at death may be paid, at our option, either to your beneficiary or estate. If benefits are payable to your estate, or a beneficiary who cannot execute a valid release, we can pay benefits up to $1,000 to someone related to you or your beneficiary 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.

F. Physical Examinations and Autopsy: We have the right, at our own expense, to have a Covered Member examined as often as reasonably necessary while a claim is pending. We may also, at our own expense, have an autopsy made where allowed by law (but not in Massachusetts or Mississippi).

G. Legal Actions: No legal action may be brought to recover on this policy within 60 days after written proof of loss has been given as required by this policy. No such action may be brought after 3 years (6 years in Kansas) from the time written proof of loss is required to be given.

H. Change of Beneficiary: You can change the beneficiary at any time by giving us written notice. The beneficiary's consent is not required for this or any other change in the policy, unless the designation of the beneficiary is irrevocable.

I. Misstatement of Age: If a Covered Member's age has been misstated, the benefits will be those the premium paid would have purchased at the correct age.

J. Unpaid Premium: When a claim is paid, any premium due and unpaid may be deducted from the claim payment.

K. Conformity with State Statutes: Any provision of this policy which, on its effective date, is in conflict with the laws of the state in which you reside on that date is amended to conform to the minimum requirements of such laws.

XIX. OTHER PROVISIONS

A. Statements in the Application: All statements made in the application for this policy are representations and not warranties.

B. Charter and By-Laws: Provisions of our charter or by-laws not contained in the policy will not void the policy or be used in defense in any legal proceedings hereunder.

C. Assignments: Assignments of interest under this policy must be received by us to be binding on us. We are not responsible for the validity of an assignment.

D. Notice of Annual Meetings: Our Annual Meetings are held at our Home Office at 2:30 p.m. on the first Thursday of March.