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 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 UNTIL MEDICARE ELIGIBILITY DUE TO AGE EXCEPT FOR STATED REASONS AT PREMIUM RATES IN EFFECT ON RENEWAL DATES.

During the first two years we may nonrenew the policy on a renewal date on or nearest the policy anniversary date, but only for Overinsurance, as explained in Section XVX. We may also on any renewal date, nonrenew the policy if we nonrenew all policies of this form after receiving approval to do so from the New York Superintendent of Insurance. This will be done only if it is in the public interest, such as in the event of a federal or state health care program.

Subject to the above limitations, you may renew this policy as long as any Covered Member remains eligible for continued coverage. We will not nonrenew because of a change in your health or physical condition, or of any other Covered Member. We will not add to the policy, while it is in force, any restrictions due to a change in a member's health. 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 XII. 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.

Donald M. Peterson
President & Chief Executive Officer

Frank G. Gramm
Corporate Secretary & General Counsel

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: GNM-186 NY

POLICY NUMBER:

INSURED:

POLICY DATE:

FIRST RENEWAL DATE:

FIRST PREMIUM:

PERIOD OF INSURANCE:

BENEFITS

COVERED MEMBERS UNDER THIS POLICY . . . . INSURED:

SPOUSE:

CHILDREN:

MAXIMUM AMOUNT
(lifetime) $200,000.00

MINIMUM DEDUCTIBLE
(except for Home Care)

HOME CARE DEDUCTIBLE

BENEFIT PAYMENT PERCENTAGE

HOSPITAL DAILY ROOM & BOARD MAXIMUM

MAXIMUM SURGERY BENEFIT

IN-HOSPITAL PHYSICIAN'S DAILY MAXIMUM

OUT-OF-POCKET LIMIT
(per Benefit Period)

I. DEFINITIONS

We, us and our: Mean Trustmark Insurance Company (Mutual).

You and your: Mean 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: 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: Means illness, disease or complications of pregnancy which cause covered loss after the Policy Date.

Pregnancy: Means normal pregnancy of a Covered Member which terminates after at least 10 consecutive months coverage under this policy; or after at least 10 consecutive months of combined coverage under this policy and the prior group plan from which conversion was made.

Complications of Pregnancy: Means conditions which are not part of a normal pregnancy, but are caused by, or made worse by, pregnancy. This includes: non-elective caesarean sections, ectopic pregnancy or similar surgery; spontaneous termination of pregnancy during a time a viable birth is not possible; eclampsia, puerperal infection, missed abortion, RH hyperemesis gravidarum; and other similarly severe conditions related to pregnancy.

'Complications of pregnancy' does not mean: false labor; occasional spotting; physician prescribed rest during pregnancy; morning sickness; preeclampsia; or similar conditions which are part of a difficult pregnancy, but which are not a separate complication of pregnancy.

Physician: Means a licensed practitioner or Nurse-Midwife 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.

Nurse-midwife: Means a certified nurse-midwife who is: (1) acting under qualified medical direction; and (2) connected or practicing with a facility licensed under the public health law.

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.

Nursing Home: Means a place which is either: (1) a nursing home as defined in the public health law; or (2) a skilled nursing facility as defined in Title XVIII of the Federal Social Security Act. '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.

Home Care: Means care and treatment furnished in the home: (1) by a Hospital or other facility licensed or certified to provide home health care; (2) under the supervision of a Physician who establishes and approves the home care plan in writing; (3) when hospitalization would otherwise be required if home care was not provided.

Confinement: Means being an in-patient in a Hospital or 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, Minimum Deductible, Daily Room and Board Maximum, Maximum Surgery Benefit and In-hospital Physician's Daily Maximum 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.
   4. Your, or your spouse's, child of any age who became mentally or physically unable to earn his own living before age 19 and who was covered by the prior group plan on the date your coverage ended.

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 19 years old.
   3. Your, or your spouse's, child age 19 or older and under age 23 who is a full time student at an accredited educational institution or who resides with you.
   4. Your, or your spouse's child of any age who became mentally or physically unable to earn his own living before age 19.

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 stepchild, a child legally adopted by you, and a child dependent on you during any waiting period prior to finalization of his adoption by you. For a child age 19 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 or your spouse while the policy is in force is automatically a Covered Member. He remains so for 45 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, congenital defects and prematurity 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

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

   a. When the member is or can be covered by Medicare due to age, unless the member provides proof that he is not then eligible for all Medicare benefits. This proof must be sent to us within 31 days after the date we mail, to your last known address, notice that the member's coverage will terminate.
   b. When the member stops being covered as described in Section III(B) below.
   c. At the end of the Grace Period for an unpaid premium.
   d. When the policy is terminated.
   e. When the member dies.

B. A member stops being covered as follows.
   a. Your spouse – at the end of the Period of Insurance during which the marriage ends by divorce or annulment.
   b. Your child – at the end of the Period of Insurance during which any 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.

C. If a dependent child became mentally or physically unable to earn his own living before age 19, his coverage may be continued beyond the date it would otherwise end because of age. If such dependent child is not covered under the policy, he may be added to coverage by making application and paying the premium. Any Preexisting Condition limitation that applies to other Covered Members will apply to a child so added to coverage; except it will not apply to congenital anomolies of such child. These conditions must be met. (1) His incapacity must continuously prevent him from earning his own living. (2) He must continue, except for his age, to be eligible for coverage. (3) The policy must remain in force. (4) Proof of his incapacity and dependency must be furnished. (5) The premium for his attained age must be paid.

D. 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.

E. 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.

F. 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.

G. When a member's coverage ends, any premium change is made on the next renewal date.

IV. EXTENSION OF BENEFITS DURING DISABILITY

If a Covered Member is Disabled on the date his coverage ends an extension of benefits will be provided. Benefits will be extended:

1. only for the Disabled member; and
2. only while he remains continuously Disabled; and
3. only for the Sickness or Injury which causes him to be Disabled; and
4. only if he incurs the first medical service for such Sickness or Injury before his coverage ends.

Benefits are extended to the earliest of:

1. the date he is no longer Disabled;
2. the date his Maximum Amount is paid; or
3. the end of the Benefit Period during which his coverage ends.

Extended benefits will be paid to the extent they would be paid if coverage had not ended.

As used above, 'Disabled' means a Covered Member is, due to Sickness or Injury; not capable of doing any income producing work for which he has training, education or experience; or not capable of performing his normal activities.

V. CONVERSION PRIVILEGE

When a Covered Member's coverage ends, as described in Section III. B, he can be issued his own policy if he does not, on that date, have similar coverage which would, together with the converted policy, result in Overinsurance. 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, within those 31 days, the first premium for the new policy. The new policy will provide benefits which are the same as, or substantially the same as, 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 member's effective date under this policy.

VI. BENEFIT PROVISIONS

A. **Benefit Periods.** A Benefit Period starts on January 1 of each year and ends December 31 of the same year.

B. **Deductible.** The Deductible is the amount of Covered Charges which must be incurred by a Covered Member each Benefit Period before benefits are payable for him. But, any Covered Charges incurred during the last three months of a year which are used toward meeting a member's Deductible for that year will also be used toward meeting his Deductible for the following year. The Deductible is the greater:

1. the Minimum Deductible shown in the Schedule; or
2. the amount or value of any benefits provided on an expense incurred basis for Covered Charges by any other hospital, surgical or medical policy, contract, plan or program, whether insured or uninsured, voluntary or required by law, except those provided under Medicaid.

There is a separate Deductible for Home Care charges. It is also 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 any one Covered Member for all Benefit Periods for all Sicknesses, Injuries, and Pregnancies. This amount is shown in the Schedule. The Maximum Amount may be restored as next provided.

D. **Restoration of Maximum Amount.** At the start of each calendar year, if benefits have been paid for a Covered Member during the prior year, $1,000 or the amount of benefits paid, if less, will be added to the remaining balance of such member's Maximum Amount. The Maximum Amount may not be restored to an amount greater than its original amount.

E. **Covered Charges.** Covered Charges are the charges listed below which: (1) are necessary for care and treatment of Sickness, Injury or Pregnancy; (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.

F **Hospital, Surgical and Medical Benefits.** Subject to the Deductible 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; and for all other benefits, the expense must be incurred while the member's coverage is in force; unless the extension of benefits applies. Benefits will be paid for 80% of the Covered Charges for the following, up to any limits shown.

1. Daily room, board, general nursing care and special diet charges during a Hospital Confinement, up to the Daily Hospital Room and Board Maximum shown in the Schedule. This benefit does not apply to charges for Confinement in an Intensive Care Unit.

2. Daily room, board and general nursing care charges during Confinement in an Intensive Care Unit.

3. Nursing Home charges for daily room, board and skilled nursing care, up to one-half the Daily Hospital Room and Board Maximum for any one day of Confinement. Confinement must start immediately after a Hospital Confinement of at least 3 days.

4. Charges by a Hospital or Nursing Home for miscellaneous services and supplies consisting of:

   a. the use of operating, recovery and cystoscopic rooms and equipment;

   b. the use of intensive care or special care units and equipment;

   c. diagnostic and therapeutic items such as drugs and medications, sera, biologicals and vaccines, intravenous preparations and visualizing dyes, and administration thereof; but not including those which are not commercially available for purchase and readily obtainable by the Hospital;

   d. dressings and plaster casts;

   e. supplies and use of equipment in connection with oxygen, anesthesia, physical therapy, electrocardiographs, electroencephalographs, x-rays, laboratory and pathological examinations;

   f. blood products, except when participation in a volunteer blood replacement program is available to the Covered Member;

   g. radiation therapy, chemotherapy and cancer hormone therapy; and

   h. any other medical services and supplies, including x-rays, laboratory tests and care and treatment furnished on an outpatient basis by a Hospital.

5. Surgery and anesthesia charges, up to the limits described in Section VII. Surgery Benefit.

6. Physician's charges, except for surgery and anesthesia, while a member is Hospital Confined up to the In-hospital Physician's Daily Maximum shown in the Schedule.

7. Other Physicians charges for services rendered on an ambulatory basis. This includes diagnosis and treatment of Sickness or Injury; charges for diagnostic x-rays, laboratory services, pathological examinations, radiation therapy, chemotherapy, cancer hormone therapy and hemodialysis, when ordered by the Physician and related to diagnosis or treatment of Sickness or Injury; and drugs and medications available only on prescription of a Physician.

8. Initial prosthetic appliances and replacements which are functionally necessary.

9. Rental or purchase (at our option) of durable medical equipment required for therapeutic use; and repairs and necessary maintenance of purchased equipment not otherwise provided for under a manufacturer's warranty or purchase agreement.

10. Charges for physical therapy in a Hospital outpatient facility if furnished in connection with the same Sickness or Injury for which the member had been Hospital Confined or in connection with surgery. Only therapy which starts less than 6 months after discharge from the Hospital, or the date of the surgery, is covered. Only therapy given within 365 days after the date of discharge from the Hospital, or the date of the surgery, is covered.

G. **Pregnancy Benefit.** We will pay Covered Charges incurred by a Covered Member for Pregnancy the same as we would pay for Sickness or Injury, with one exception. We will only pay Hospital Charges for the first 4 days of Confinement which include the day of delivery. This benefit will be paid at reasonable intervals, and in at least two payments, for prenatal care. A separate payment will be made for the delivery and postnatal care.

H. **Home Care Benefit.** Subject to the Home Care deductible and the Maximum Amount, we will pay you 75% of Covered Charges incurred for the following Home Care services. The Home Care deductible is shown in the Schedule. (1) Part-time or intermittent home nursing care by or under the supervision of a registered professional nurse (R.N.); (2) Part-time or intermittent home health aide services which consist primarily of caring for the patient. (3) Physical, occupational or speech therapy. (4) Medical supplies, drugs and medication prescribed by a Physician, and laboratory services by or on behalf of a certified home health agency to the extent such items would have been covered if the Covered Member had been hospitalized or confined in a skilled nursing facility as defined in title XVIII of the Social Security Act. East visit by a member of a Home Care team shall be considered as one Home Care visit. Four hours of home health aide service shall be considered as one Home Care visit. Up to 40 visits will be covered in any calendar year or 12 consecutive months.

I. **Out-of-Pocket Limit.** Benefits will be paid as described above until the Deductible plus the 20% of the Covered Charges you must pay (25% for Home Care) reaches $2,000 in a Benefit Period. For the rest of the Benefit Period, Covered Charges incurred are paid at 100%, up to any limits shown.

VII. SURGERY BENEFIT

Physician's fees for surgery are paid, up to the limit for the operation done. To find the maximum amount that will be paid, multiply the Maximum Surgery Benefit (in the Schedule) by the percent shown in the Table of Procedures for the surgery. The surgery benefit includes charges for the surgery and for post-surgery care for two weeks, or for the Hospital Confinement, whichever is longer.

Anesthesiologist's fees are paid, up to 15% of the limit for the surgery.

The limit for anesthesiologist's fees is for: (1) administration of anesthetic (except local infiltration types administered by the Physician during the surgery); and (2) the usual visits made before and after surgery. This limit is only for anesthesia ordered by the operating Physician and administered by another Physician.

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. This benefit cannot exceed the Maximum Surgery Benefit 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 benefit paid will not exceed the Maximum Surgery Benefit.

Charges for a second surgical opinion are paid, up to the limit shown in the Table of Procedures, as follows. The opinion must be related to an inpatient surgical procedure of a non-emergency nature which is covered by the policy. It must be given by a board certified specialist in the medical field relating to the surgery being proposed. The Covered Member must be examined in person by the Physician giving the opinion and a written report must be sent to us. In the case that the Physician giving such opinion also does the surgery, no benefit is paid for the second surgical opinion.

SCHEDULE	RELATIVE VALUE
	%
GENERAL	
Accidental lacerations of skin structures suture of face, neck, genitalia and hands, all lacerations combined	
1 inch or less	5.0
More than 1 inch up to 2 inches	6.7
Other body areas, all lacerations combined	
1 inch or less	2.5
More than 1 inch up to 2 inches	3.3
Bronchoscopy	
Diagnostic, with or without biopsy	15.0
Operative removal of tumors or foreign bodies	25.0
Cystoscopy	
Diagnostic, with or without biopsy	
Without ureteral catheterization	8.3
With ureteral catheterization	11.7
Operative, Transurethral resection of bladder neck, bladder tumors, or crushing of bladder stones	36.7
Operative, Fulguration of bladder tumors or removal of bladder stones without crushing	16.7
Cysts, excision of	
Pilonidal cyst	30.0
Sebaceous cyst	5.0
Mammary glands	
Excision of benign tumors or cysts	
Unilateral	16.7
Bilateral	25.0
Mastectomy	
Total	33.3
Radical, with axillary node dissection	66.7
Skin abscess, superficial, incision and drainage	
One	2.5
Each additional	1.3
Maximum	8.3
Thyroid gland	
Thyroidectomy, total or subtotal	58.3
Thyroid lobectomy, hemithyroidectomy	50.0
Excision of thyroid adenoma or cyst	41.7
Tumors, benign, superficial	
Excision from face, neck, genitalia, hands, or feet	
One	6.7
Each additional	3.3
Excision from other body areas	
One	3.3
Each additional	1.7
Electrocauterization or fulguration, with or without curettage, per day of such treatment	
One tumor, except plantar wart	1.7
More than one tumor, or each plantar wart	3.3

SCHEDULE	RELATIVE VALUE
	%
MUSCULOSKELETAL	
Amputations	
One or more phalanges of one finger, thumb, or toe	8.3
One or more phalanges of each additional finger, thumb, or toe	5.0
Thigh, through femur	50.0
Dislocations	
Elbow, Closed Reduction	13.3
Open Reduction	33.3
Shoulder, Closed Reduction	11.7
Open Reduction	41.7
Fractures, simple or compound	
Ankle, Malleolus of tibia or fibula	
Closed Reduction	16.7
Open Reduction	33.3
Ankle, Bimalleolar (Potts)	
Closed Reduction	20.0
Open Reduction	50.0
Clavicle, Closed Reduction	10.0
Open Reduction	33.3
Elbow, distal end of humerus or proximal end of radius or ulna, one or more bones, Closed Reduction	20.0
Open Reduction	50.0
Femur (except Knee)	
Closed Reduction	40.0
Open Reduction	80.0
Fibula (except ankle)	
Closed Reduction	13.3
Open Reduction	26.7
Finger, thumb or toe, One	
Closed Reduction	6.7
Open Reduction	13.3
Finger, thumb or toe, Each additional	
Closed Reduction	3.3
Open Reduction	6.7
Humerus (except elbow)	
Closed Reduction	25.0
Open Reduction	50.0
Knee, distal end of femur or proximal end of tibia, one or both bones	
Closed Reduction	25.0
Open Reduction	50.0
Radius including Colles (except elbow)	
Closed Reduction	16.7
Open Reduction	33.3
Radius and ulna (except elbow)	
Closed Reduction	23.3
Open Reduction	46.7
Ribs, one or more, Closed Reduction	6.7
Tibia (except ankle and knee)	
Closed Reduction	25.0
Open Reduction	50.0
Tibia and fibula (except ankle and knee)	
Closed Reduction	33.3
Open Reduction	66.7

TABLE OF PROCEDURES

SCHEDULE	RELATIVE VALUE %
Fractures, Continued	
ulna (except elbow)	
Closed Reduction	13.3
Open Reduction	33.3
Closed reduction is correction of displacement by manipulation without incision including application of casts or fraction and including debridement at fraction site. For closed reduction of a fracture with skeletal pinning and external fixation, add 50% to the relative value shown for closed reduction.	
Open reduction is correction of displacement by manipulation and incision with or without skeletal traction or metallic fixation.	
Intervertebral disc, excision of	
Without spinal fusion	75.0
With spinal fusion	100.0
Tendons, Excision of ganglion	13.3
Suture of tendon laceration	
One tendon	16.7
Each additional tendon	8.3
EYE, EAR, NOSE AND THROAT	
Chalazion, excision or curettage	
Single	5.0
Multiple	8.3
Extraction of lens for cataract	66.7
Strabismus, operation for, One eye	45.0
Both eyes	58.3
Each subsequent strabismus operation, one or both eyes	25.0
Fenestration operation for otosclerosis	100.0
Myringotomy or tympanotomy	5.0
Nasal polyps, removal of one or more, one or more stages, Unilateral	5.0
Bilateral	8.3
Nasal septum, submucous resection of	33.3
Tonsillectomy with or without adenoidectomy	13.3
HEART AND BLOOD VESSELS	
Commissurotomy or valvotomy	100.0
Saphenous vein, long, ligation with or without retrograde injection or distal interruptions	
Without stripping, Unilateral	25.0
Bilateral	36.7
With stripping on same or subsequent days, Unilateral	33.3
Bilateral	50.0

SCHEDULE	RELATIVE VALUE %
CHEST	
Lobectomy, Total, subtotal or segmental	100.0
Wedge resection	75.0
Thoracotomy, for drainage of empyema	
Without rib resection	16.7
With rib resection	33.3
ABDOMEN	
Appendectomy, with or without incision and drainage of appendiceal abscess	36.7
Cholecystectomy, with or without exploration of common duct	58.3
Colon resection, with or without colostomy,	
Partial	83.3
Total	100.0
Gastrectomy, with or without vagotomy	
Partial	83.3
Total	100.0
Herniotomy, inguinal or femoral	
Single	36.7
Bilateral	50.0
PROCTOLOGY AND UROLOGY	
Fistulectomy or fistulotomy	
Single	21.7
Multiple	30.0
Single or multiple, with incision and drainage of ischiorectal abscess	30.0
Hemorrhoidectomy, by excision	
External (except tabs or tags)	8.3
Internal or both internal and external	
Without fistulectomy	26.7
With fistulectomy	33.3
Hydrocele or varicocele, excision of	
Unilateral	25.0
Bilateral	33.3
Ischiorectal abscess, Incision and drainage	11.7
Nephrectomy or heminephrectomy	75.0
Proctectomy, complete, combined abdominal, perineal procedure	
One or more stages	100.0
Prostatectomy	
Suprapubic, one or more stages	83.3
Transurethral, one or more stages including control of postoperative bleeding	66.7

SCHEDULE	RELATIVE VALUE
	%
GYNECOLOGY	
Conization of cervix	10.0
Cystocele, repair of	33.3
Rectocele, repair of	25.0
Cystocele and rectocele, repair of	46.7
Dilation of cervix and curettage of uterus, non-puerperal, with or without elctrocauterization, conization or polypectomy .	13.3
Electrocauterization of cervix, nonpuerperal	5.0
Hysterectomy, with or without dilation and curettage, Complete (pan-hysterectomy), with or without adnexa	60.0
Subtotal or supracervical, with or without adnexa	50.0
Radical, for malignancy	83.3
Salpingectomy or oophorectomy, or both, unilateral or bilateral	41.7
Uterus, suspension of, any type, with or without dilation and curettage or surgery on tubes or ovaries	41.7
OBSTETRICS	
Abdominal operation for extrauterine or ectopic pregnancy	41.7
Cesarean section - delivery of child or children	50.0
Cesarean section - delivery of child or children and hysterectomy	60.0
Delivery of child or children.	25.0
Miscarriage - with dilation and currettage . .	13.3
Miscarriage - without dilation and curettage	8.3
SECOND SURGICAL OPINION	
Consultation requiring LIMITED examination and/or evaluation of a given system but not requiring a comprehensive history and examination, home, office or hospital . . .	3.0
Consultation requiring MORE EXTENSIVE examination and/or evaluation but not requiring comprehensive history and examination, home, office or hospital	5.0
Consultation requiring COMPREHENSIVE history and examination and/or evaluation, office, home or hospital	7.0

SCHEDULE	RELATIVE VALUE
	%
NEUROSURGERY	
Craniotomy (other than trephination only)	
Decompression, unilateral or bilateral	58.3
Excision of brain cyst, neoplasm, or abscess	100.0
Lumbar sympathectomy, Unilateral	50.0
Bilateral	75.0
Trephination	
Drainage of subdural, epidural or brain abscess or hemotoma	
Initial trephination	50.0
Subsequent needling	10.0
Pneumoventriculography	33.3

VIII. PREEXISTING CONDITIONS LIMITATION

A. For persons not covered under the prior group plan, a Preexisting Condition that is 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 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 excluded under the prior group plan will be excluded under this policy; and only until the date they would have been covered under the prior group plan if coverage under that plan had remained in force.

C. Preexisting Condition means a condition for which either:
   1. symptoms existed within the two years before the effective date of a member's coverage which would ordinarily cause a prudent person to seek medical advice or care; or
   2. medical advice or care was recommended by, or received from, a Physician within the two years before the effective date of a member's coverage.

IX. 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.

X. 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.

XI. EXCLUSIONS AND LIMITATIONS

This policy does not cover expense due to:
(1) suicide, or attempted suicide;
(2) intentionally self-inflicted injury;
(3) mental illness, emotional disorder, alcoholism or drug abuse;
(4) rest cures;
(5) injury resulting from travel in any type of aircraft, except as a fare-paying passenger in a scheduled or charter flight operated by a scheduled airline;
(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; a member still eligible for coverage when such service ends may again be covered under the policy with no new Preexisting Condition limitations, if the length of such service is no longer than 5 years; coverage will take effect the date such service ends if you send written application and the applicable premium within 60 days after such date.;

(8) routine physical examinations, x-rays or test procedures not related to diagnosis or 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 because of congenital disease or anomoly 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, under any law 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;
(15) duplicate routine services provided by both a Physician and a Nurse-Midwife.

XII. PREMIUM PROVISIONS

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 issued in the State of New York. 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.

XIII. 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 on the date of the person's latest effective date of coverage under the group plan; and the limit in (2) shall end on the date it would have ended had the person's group coverage remained in force.

C. **Grace Period:** This policy has a 31 day grace period. 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 after a covered loss starts or as soon as reasonably possible. The notice can be sent to us at our Home Office 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:** We have the right, at our own expense, to have a Covered Member examined as often as reasonably necessary while a claim is pending.

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 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.

XIV. 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.