MAJOR MEDICAL EXPENSE POLICY

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

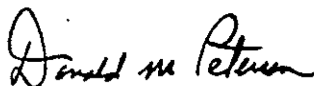
This policy is issued in consideration of the application and the first premium payment. A copy of the application is attached to, and made a part of, this policy. The first premium is shown on the Schedule. It is due on or before the Policy Date. The first premium will keep this policy in force from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

RENEWABLE EXCEPT FOR THE REASONS STATED HEREIN AT PREMIUM RATES IN EFFECT ON RENEWAL DATES

This policy is renewable as long as any Covered Person remains eligible as provided in Sections II, III and IV. We cannot cancel or refuse to renew this policy because of a change in the health of any Covered Person. We cannot add any restrictions due to a Person's health, or due to a change in a Person's health. You may renew this policy as long as any Covered Person remains eligible under the terms of this policy. To keep this policy in force, each renewal premium must be paid when due or within the grace period. Premiums may only be changed on a renewal date as described in Section XIII.

NOTICE OF 10 DAY RIGHT TO EXAMINE POLICY

Please read this policy carefully. If You are not satisfied, You may return it to Our Home Office or to Your agent within 10 days after the date You receive it. We will then cancel this policy as of the Policy Date and refund any premium You have paid for it.



Donald M. Peterson
President & Chief Executive Officer

Frank G. Graham
Corporate Secretary & General Counsel

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CHECK YOUR APPLICATION FOR THIS POLICY AND NOTIFY US PROMPTLY IF ANY INFORMATION SHOWN IS NOT CORRECT OR COMPLETE. INCORRECT OR INCOMPLETE INFORMATION COULD RESULT IN LOSS OF COVERAGE.

STANDARD HEALTH CARE PLAN SCHEDULE

POLICY NUMBER:

INSURED:

POLICY DATE:

FIRST RENEWAL DATE:

FIRST MODAL PREMIUM:

PERIOD OF INSURANCE:

COVERED PERSONS UNDER THIS POLICY .... INSURED:

SPOUSE:

CHILDREN:

DEDUCTIBLE

- $ 500 PER PERSON PER CALENDAR YEAR
- $1,500 PER FAMILY PER CALENDAR YEAR
- $ 500 PER HOSPITAL ADMISSION OR SURGERY (OUTSIDE PHYSICIAN'S OFFICE) WHEN PRE-CERTIFICATION IS **NOT** OBTAINED*
- $ 50 PER EMERGENCY ROOM VISIT PER PERSON*

NOTE: THE EMERGENCY ROOM DEDUCTIBLE WILL **NOT** APPLY IF THE PATIENT IS ADMITTED TO THE HOSPITAL AS A RESULT OF THE VISIT.

* THIS AMOUNT DOES NOT APPLY TOWARD EITHER THE PER PERSON OR THE FAMILY CALENDAR YEAR DEDUCTIBLES.

THE INSURED PERCENT DEPENDS UPON WHETHER YOU SELECT A PREFERRED PROVIDER (PPO) THAT HAS CONTRACTED WITH US TO RENDER SERVICES TO OUR INSUREDS AND THEIR DEPENDENTS, OR A PROVIDER THAT HAS NOT CONTRACTED WITH US (NON-PPO). A LIST OF PREFERRED PROVIDERS HAS BEEN PROVIDED YOU.

INSURED PERCENT FOR SERVICES GIVEN BY	PPO	NON-PPO
	80%	60%

OUT-OF-POCKET LIMITS	PPO	NON-PPO
INDIVIDUAL OUT-OF-POCKET LIMIT	$1,250	$3,000
FAMILY OUT-OF-POCKET LIMIT	$2,500	$6,000

THE INDIVIDUAL OUT-OF-POCKET LIMIT IS THE MAXIMUM AMOUNT A PERSON WILL HAVE TO PAY, EXCLUDING ANY DEDUCTIBLES AND THE FAMILY OUT-OF-POCKET LIMIT IS THE MAXIMUM AMOUNT ALL MEMBERS OF A FAMILY WILL HAVE TO PAY, EXCLUDING ANY DEDUCTIBLES. AFTER THAT, COVERED CHARGES WILL BE PAID AT 100% FOR THE REMAINDER OF THE CALENDAR YEAR OR UNTIL THE LIFETIME MAXIMUM IS REACHED, WHICHEVER OCCURS FIRST, EXCEPT AS NOTED.

NOTE: THE PORTION OF COVERED CHARGES A PERSON MUST PAY FOR OUTPATIENT TREATMENT FOR MENTAL ILLNESS, NERVOUS DISORDERS, ALCOHOLISM AND DRUG ABUSE DOES **NOT** COUNT TOWARDS THE OUT-OF-POCKET LIMITS. THESE CHARGES ARE NEVER PAID AT 100%.

BENEFIT MAXIMUMS

$1,000,000.........LIFETIME PER PERSON

**$ 100,000.........LIFETIME PER PERSON FOR ORGAN TRANSPLANTS

$ 10,000.........LIFETIME PER PERSON FOR ALL **INPATIENT AND OUTPATIENT BENEFITS RELATED TO MENTAL ILLNESS, ALCOHOLISM AND DRUG ABUSE

$ 2,000.........CALENDAR YEAR MAXIMUM PER PERSON FOR ALL **INPATIENT BENEFITS RELATED TO MENTAL ILLNESS, ALCOHOLISM AND DRUG ABUSE

$ 550.........CALENDAR YEAR MAXIMUM PER PERSON FOR ALL **OUTPATIENT BENEFITS RELATED TO MENTAL ILLNESS, ALCOHOLISM AND DRUG ABUSE

$ 50.........ELIGIBLE CHARGE PER VISIT PER PERSON **OUTPATIENT SERVICES RELATED TO MENTAL ILLNESS, ALCOHOLISM AND DRUG ABUSE

**$ 5,000.........CALENDAR YEAR MAXIMUM PER PERSON FOR TOTAL BENEFITS FOR SKILLED NURSING CARE FACILITY, HOME CARE AND HOSPICE CARE COMBINED

**$ 2,500.........CALENDAR YEAR MAXIMUM PER PERSON FOR OUTPATIENT PRESCRIPTION DRUGS

**$ 500.........CALENDAR YEAR MAXIMUM FOR CHILD WELLNESS FOR AN INSURED CHILD FROM BIRTH TO AGE ONE YEAR

**$ 150.........CALENDAR YEAR MAXIMUM FOR CHLD WELLNESS FOR AN INSURED CHILD FROM AGE ONE THROUGH AGE EIGHT

**$ 85.........PER MAMMOGRAPHY EXAM

**$ 40.........COVERED CHARGE PER VISIT PER PERSON FOR OUTPATIENT PHYSICAL THERAPY

**$ 25.........COVERED CHARGE PER VISIT FOR PER PERSON FOR MANIPULATIVE THERAPY

** 20.........OUTPATIENT VISITS PER CALENDAR YEAR PER PERSON FOR PHYSICAL THERAPY

** 10.........OUTPATIENT VISITS PER CALENDAR YEAR PER PERSON FOR MANIPULATIVE THERAPY

**BENEFITS PAID COUNT TOWARD THE $1,000,000 LIFETIME BENEFIT MAXIMUM.

COST CONTAINMENT PROVISIONS

THE FOLLOWING PERTAINS TO THE COST CONTAINMENT PROVISIONS. THESE COST SAVING PROCEDURES SHOULD BE FOLLOWED. IF THEY ARE NOT FOLLOWED WHEN THEY ARE REQUIRED, YOUR BENEFITS WILL BE REDUCED AS PROVIDED ON PAGES 18 – 19.

1. PRE–CERTIFICATION OF HOSPITAL CONFINEMENT – AS OUTLINED ON PAGE 19, BEFORE ANY NON–EMERGENCY HOSPITAL ADMISSION, OUR PRE–CERTIFICATION SERVICE MUST BE CONTACTED AT THIS TOLL–FREE NUMBER:

   1–800–835–3633

2. NON–EMERGENCY WEEKEND HOSPITAL ADMISSION.

3. REQUIRED OUTPATIENT SURGERY – FOR THE PROCEDURES LISTED ON PAGE 18.

IN ADDITION, YOU SHOULD NOTIFY US PRIOR TO ANY PROPOSED HOME CARE AS OUTLINED ON PAGE 14 OR ORGAN TRANSPLANT PROCEDURE AS OUTLINED ON PAGES 16 – 17.

SECTION I. DEFINITIONS OF CERTAIN WORDS USED IN THIS POLICY

Certain words or phrases, when used in this policy, have only the meanings shown below. When a defined word or phrase is used in this policy, it is capitalized to indicate that it has been defined. The definitions are listed in alphabetical order.

Confinement: Means either being an inpatient in a Hospital, Skilled Nursing Home or hospice; or being continuously confined at home, except for necessary trips for medical treatment or for rest outdoors at or near home. "Confinement" must be caused by Sickness or Injury. The confined Person must be under a Physician's care for the Sickness or Injury causing the Confinement.

Covered Charge: Means expense incurred for the services and supplies listed as such in Section VI.G. which:

- is Medically Necessary for the care and treatment of Sickness or Injury; and
- is prescribed by a Physician; and
- is incurred while a Person's coverage is in force or under the extension of benefits; but
- is only that portion of the expense that does not exceed the Usual and Customary Charge for the service or supply.

An expense is considered to be incurred on the date the service is rendered or the supply furnished.

Covered Person and Person: Means any person insured under this policy. "Covered Persons" are listed on the Schedule (or its latest amendment).

Custodial Care: Means service and supplies provided to a Person, whether or not disabled, which are not intended to contribute greatly to the improvement of the medical condition according to generally accepted standards. Such care includes, but is not limited to: assisting the Person to walk, get in and out of bed, bathe, dress, prepare special diets, supervise medicine which can usually be self-administered and which does not require the attention of medical or paramedical personnel; and assisting the Person in other activities of daily life. Such care is custodial without regard to the provider by which it is prescribed, referred or performed.

Deductible: Means the amount of Covered Charges a Covered Person must incur in a calendar year before benefits are paid for him. Only the Covered Charge, and not the entire expense, will be used to meet the Deductible. No benefits are paid for charges used to meet the Deductible; but You must submit a claim for such charges so that they can be credited toward the Deductible. The Deductible is shown on the Schedule.

Emergency Admission: Means entering the Hospital as an inpatient due to Sickness or Injury that requires immediate treatment to prevent loss of life or impairment of body functions; or when the Confinement cannot be postponed for medical reasons.

Experimental: Means a service, drug or supply not accepted or approved under Medicare as beneficial for the diagnosis or treatment of the Sickness or Injury.

Family Member: Means a Covered Person's spouse; parents; children and step children; grandparents; grandchildren; brothers and sisters. This includes such persons whether related by blood or by marriage.

Free Standing Surgical Center: Means a facility licensed as a free standing or ambulatory surgical center. The center must be operated for the purpose of providing outpatient surgical care.

Home Care: Means an organized plan of treatment and care furnished in the home by a licensed or certified home health agency under a plan prescribed by a Physician as Medically Necessary.

Home Care Visit: Means a period of up to 4 hours in a row of Home Care services in a 24-hour period. The time spent by a person providing Home Care, or evaluating the need for or developing a Home Care plan, will be a Home Care Visit.

Hospice Benefit Period: Means 30 days during which services are provided on a regular basis.

Hospice Care: Means a program of palliative and supportive health care which is provided by a licensed or certified hospice; and is provided to a Covered Person and his immediate family after he has been diagnosed by a Physician as terminally ill with an anticipated life expectancy of 6 months or less as certified by a Physician. We must be provided a copy of the Hospice Care plan in writing.

Hospital: Means a facility, or any part of a facility, that:

- is operated pursuant to law; and
- provides 24–hour nursing service by, or supervised by, a Registered Graduate Nurse (R.N.); and
- provides treatment of or service for Sickness or Injury:

  under the supervision of one or more Physicians;

  with organized facilities for diagnosis of Sickness or Injury;

  and with surgical facilities on the premises or available through a formal arrangement with another facility. (This requirement is waived for a facility operated mainly to treat Mental Illness if the facility would otherwise qualify as a Hospital.)

"Hospital" does not include: a convalescent, nursing or rest home; a home for the aged; an extended care facility; a training facility; a facility for custodial care; or a health spa.

Injury: Means injuries resulting, directly and independently of all other causes, from accidents which cause a covered loss after the effective date of a Person's coverage, and which are not a Preexisting Condition.

Insured Percent: Means the portion of Covered Charges incurred that We pay. The Insured Percent is shown on the Schedule.

Intensive Care Unit: Means the part of a Hospital designated as an intensive care unit by the Hospital. It must be permanently equipped and staffed to provide, for critically sick or injured persons, more extensive care than is provided in the general Hospital rooms. This care must include constant observation by a Registered Graduate Nurse (R.N.) whose duties are confined to that unit. "Intensive Care Unit" includes cardiac care units and pediatric intensive care units.

Manipulative Therapy: Means the diagnosis, analysis, and adjustment of spinal subluxations; and diagnosis, manipulative therapy, heat treatment, ultrasound and related treatment of the musculoskeletal structure for other than fractures and dislocations of the extremities; regardless of the type of practitioner providing the diagnosis or treatment.

Medically Necessary: Means that a service, drug or supply is necessary and appropriate for the diagnosis or treatment of a Sickness or Injury in accordance with generally accepted standards of medical practice in the U.S. at the time the service, drug or supply is provided. When specifically applied to a Confinement, it further means that the diagnosis or treatment of the Person's symptoms or condition cannot be safely provided to that Person on an outpatient basis.

A service, drug or supply shall not be considered as Medically Necessary if it:

- is investigational, Experimental, or for research purposes; or
- is provided solely for the convenience of the patient, the patient's family, Physician, Hospital or any other provider; or

- exceeds in scope, duration, or intensity that level of care that is needed to provide safe, adequate, and appropriate diagnosis or treatment; or
- could have been omitted without adversely affecting the patient's condition or the quality of medical care; or
- involves the use of a medical device, drug, or substance not formally approved by the United States Food and Drug Administration; or
- involves a service, supply or drug not approved for reimbursement under Medicare.

Benefit payment is subject to Our determination that the service, drug or supply is Medically Necessary.

Medicare: Means Title XVIII of the Social Security Act, as amended.

Mental Illness: Means neurosis, psychoneurosis, psychopathy, psychosis, anorexia nervosa, bulimia, adjustment disorders, personality disorders and mental disease, regardless of the cause, and mental disease or disorders as defined in the Diagnostic and Statistical Manual of Disorders of the American Psychiatric Association which cause a covered loss after the effective date of a Person's coverage and which are not a Preexisting Condition.

"Mental Illness" does not include: alcoholism, drug addiction or chemical dependency; learning disabilities and conduct or development disorders; or marital, family or sexual problems.

Nurse: Means a Registered Graduate Nurse (R.N.); or a licensed practical or vocational nurse. "Nurse" does not include a Family Member.

Office of Technology Assessment: Means the entity, including any entity that succeeds it, that reviews new treatments for approval under Medicare.

One Transplant Procedure: Means all treatment related to any one body organ; or all treatment related to more than one body organ if more than one organ is transplanted at the same time; or all treatment related to the same condition (for example, a series of bone marrow transplants).

Other Medical Coverage: Means coverage for Hospital, surgical or other medical expenses by:

- any other insurance plan, or
- welfare plan; or
- prepayment plan (including Blue Cross and Blue Shield); or
- services provided or payments made under laws of any national, state or other government, except under Medicaid.

Out-Of-Pocket Limit: Means a limit on the amount of some expenses You must pay in a calendar year. The Out-Of-Pocket Limits are shown on the Schedule, and explained in Section VII.

Physical Therapist: Means a licensed physical therapist. "Physical Therapist" does not include a Family Member.

Physician: Means a duly licensed medical doctor (M.D.) who is acting within the scope of his license; and any other licensed practitioner required to be recognized for benefit payment purposes under the law of the state in which You live and who is acting within the scope of his license. "Physician" does not include a Family Member.

Pre-Certification: Means a determination of whether Hospital admission is required for treatment of a Sickness or Injury; and how long Hospital confinement is required.

Preexisting Condition: Means a condition for which either:

- symptoms existed within the 6 months before the effective date of a Person's coverage which would cause an ordinarily prudent person to seek medical advice or care; or
- for which medical advice or care was recommended by, or received from, a Physician within the 6 months before the effective date of a Person's coverage; or
- a pregnancy existing on the effective date of a Person's coverage.

Sickness: Means illness, disease, congenital abnormalities or pregnancy which cause a covered loss after the effective date of a Person's coverage and which are not a Preexisting Condition.

Skilled Nursing Home: Means a facility which is all of the following:

- it is operated pursuant to law.
- it provides room and board accommodations at the patient's expense.
- it keeps a daily medical record of each patient.
- it regularly provides skilled nursing care supervised by a Physician.
- this skilled nursing care is provided by, or supervised by, a Registered Graduate Nurse (R.N.).

"Skilled Nursing Home" does not include: a rest home or a home for the aged; a place mainly for treating drug addiction, alcoholism or mental illness; or a custodial care or educational care facility.

Usual and Customary Charge: Means the smallest of:

- the actual charge;
- the charge normally made by the provider; or
- the usual level of charges made in the same zip code (or contiguous zip codes, if necessary to find this level) for the same or a similar service or supply.

We have the sole right to determine the Usual and Customary Charge.

We, Us, and Our: Mean Trustmark Insurance Company (Mutual).

You and Your: Mean the Insured named on the Schedule.

All masculine pronouns used in this policy also include the feminine.

SECTION II. ELIGIBILITY FOR COVERAGE

A. ELIGIBLE PERSONS

Any of the following are eligible to become Covered Persons under this policy, but only if the person is not covered, or eligible for coverage, under:

- any employer sponsored health benefits plan including continuation of or conversion from such plan; or
- any other private health benefits plan; or
- any public health benefits plan including Medicare; or
- any plan with comparable benefits provided under federal or state law.

1. You, if You are under age 65.
2. Your spouse, if Your spouse is under age 65.
3. Your, or Your spouse's, child who is less than 19 years old.
4. Your, or Your spouse's, child age 19 or older and under age 24 who is a full time student at an accredited educational institution.

A child is eligible for coverage only if:

- he is unmarried; and
- he is dependent on You for support and maintenance.

A "child" includes an adopted child from the date of placement for the purpose of adoption.

B. BECOMING COVERED

Any eligible person may become covered if You take the following steps.

1. Apply in writing.

2. Pay the premium for his coverage.

C. NEWBORN CHILDREN

A child born to You while this policy is in force is automatically covered for 31 days. To continue his coverage, We must be notified in writing within 31 days after his birth; and timely payment of the premium for his continued coverage must be made.

A covered newborn has the same coverage as any other Covered Person, starting the day of birth. Birth abnormalities congenital defects and prematurity of such newborns which require medical care are covered as Sickness. The Preexisting Condition limitation will not apply.

SECTION III. TERMINATION OF COVERAGE

A. WHEN COVERAGE ENDS

A Covered Person's coverage under this policy ends at the earliest of the following, unless specifically provided otherwise in this Section III. or in Section IV.

1. At the end of the grace period for an unpaid premium.

2. When a Person reaches age 65 or becomes covered under Medicare, if earlier.

3. For Your spouse – on the renewal date next following the date of divorce or annulment.

4. For Your child – on the renewal date next following the earliest of his 24th birthday; his marriage; or the date he stops being eligible for dependent coverage, as provided in Section II.

5. The date the Person is covered by a mandatory national or state health care plan.

6. If we cease doing individual medical insurance business in this state with at least 90 days prior written notice.

You must notify Us when a Covered Person is no longer eligible as provided in Sections II, III and IV; except when the Person is no longer eligible due to reaching the limiting age of this policy.

If We accept premium for a Covered Person after We have been notified that he is no longer eligible for coverage, We will continue his coverage to the end of the period to which the premium applies. Otherwise, the Person's coverage ends at the end of the period of insurance during which he stops being eligible.

B. HANDICAPPED DEPENDENTS

If a dependent child is, due to mental retardation or physical handicap, unable to earn his own living on the date his coverage would otherwise end because of age, his coverage may be continued. All of the following conditions must be met.

1. The child must be, on that date, covered under this policy.
2. His incapacity must continuously prevent him from earning his own living.
3. He must, except for his age, continue to be eligible for coverage.
4. This policy must remain in force.
5. Proof of his incapacity and dependency must be furnished to Us within 31 days of the age his coverage would otherwise end.
6. The premium for his then 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 proof is not provided within 60 days after a request, the child's coverage will end.

C. CONTINUATION OF POLICY AFTER DEATH OF THE INSURED

If You die while this policy is in force, coverage may be continued for any surviving Covered Persons until the end of the term during which the last Person's coverage ends according to Sections II and III. Benefits will be paid to Your spouse. If no spouse survives, benefits will be paid to the child or, if he is a minor, to his legal guardian.

D. CONTINUATION OF COVERAGE FOR RESERVISTS CALLED TO DUTY

If You are a member of a reserve component of the armed forces of the Ohio national guard or the Ohio air national guard, and are called or ordered to active duty, coverage may be continued for any other covered persons. Coverage will continue for such Persons according to the terms and provisions of this policy.

E. PREMIUM CHANGE

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

SECTION IV. PROVISIONS APPLYING TO EMPLOYER SPONSORED COVERAGE ONLY

These provisions are in effect only while both of the following apply.

1. Your employer is providing medical coverage for his employees by paying part or all of the premium for this policy; and

2. You are a full-time employee of Your employer and are not retired.

A. If You, or a Dependent, apply for this policy following the initial enrollment period provided by Your employer You, or the Dependent, will be considered a late enrollee. But, You or the Dependent shall not be considered a late enrollee if:

   1. The Person:

      - was covered under another employer health benefit plan at the time the Person was first eligible for this coverage;

      - states at the time of initial eligibility that coverage under another employer health benefit plan is the reason for declining this coverage;

      - has lost coverage under another employer health benefit plan as a result of termination of employment or the termination of the other plan's coverage; and

      - requests within 30 days after the termination of the other employer health benefit plan.

   OR

   2. You are employed by an employer that offers multiple health benefit plans and You elect a different plan during an open enrollment period.

   OR

   3. A court has ordered coverage be provided for a spouse or minor child under Your health benefit plan and the request for coverage is made within 30 days after the issuance of the court order.

B. Coverage will not end for You or Your spouse at age 65 or eligibility for Medicare, but:

   - if Your employer has less than 20 employees or is not subject to the Age Discrimination in Employment Act (ADEA), benefits under this policy will be paid secondary to Medicare and Covered Charges will be reduced by any benefits payable by Medicare;

   - if Your employer has 20 or more employees and is subject to the ADEA, benefits under this policy will be paid primary to Medicare;

   - benefits will be paid primary to Medicare for a Person entitled to Social Security benefits solely on the basis of end state renal disease; but only for up to 18 consecutive months. This 18 month period starts with the earlier of: the month in which a regular course of renal dialysis is initiated; or in the case of a Person who receives a kidney transplant, the first month in which the Person becomes entitled to Medicare. After 18 months, benefits for that Person will be paid secondary to Medicare. Covered Charges for that Person will be reduced by any benefits payable by Medicare.

   The term 'payable by Medicare' means the amount that would be paid by Medicare if this policy did not exist.

SECTION V. EXTENSION OF BENEFITS

If a Covered Person is Hospital confined on the date his coverage ends, an extension of benefits will be provided. Benefits will be extended:

1. only for a Hospital confined Person; and

2. only while he remains Hospital confined; and

3. only for the Sickness or Injury which causes him to be so confined.

Benefits are extended to the earliest of:

1. the date he is no longer Hospital confined; or

2. the end of the calendar year during which his coverage ends (or during which he reaches age 65 or becomes eligible for Medicare, if earlier); or

3. the date he becomes covered under a mandatory national or state health care plan; or

4. the date his Lifetime Benefit Maximum, or any maximum for the type of expense, is paid.

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

SECTION VI. CONVERSION PRIVILEGE

When a spouse's or child's coverage ends, he can be issued his own policy, unless he is age 65 or eligible for Medicare; or unless he is covered by another health care plan and the benefits under such other plan plus the benefits of the conversion policy would result in overinsurance according to Our then current standards; or unless he is covered by a mandatory national or state health care plan. 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 under the policy form We are then issuing which are most similar to, but not greater than, this policy's benefits. The premium for the new policy will be based on Our rates in effect for that policy at the time of conversion. The then attained age and insurance classification of the Person will be used. The new policy will not cover loss for which benefits are payable under this policy. Any maximum benefit of the new policy will be reduced by the amount of benefits paid for the Person under this policy as of the date of conversion. Any benefits payable under the new policy during the calendar year in which conversion is made will be limited to the unused portion of the Person's Lifetime Benefit Maximum under this policy as of the date of conversion or the amount payable under the new policy, if less. All probationary or waiting periods of the new policy will be considered as starting from the Person's effective date under this policy. Any benefit maximums of the new policy will be considered to be met to the extent they have been met under this policy. The Deductible and Out-of-Pocket Limit, if any, of the new policy will be considered to be met to the extent they have been met under this policy for the calendar year in which the Person converts his coverage.

SECTION VII. BENEFIT PROVISIONS

A. DEDUCTIBLE

This policy has a calendar year variable Deductible. Except when a Person has Other Medical Coverage, as explained below, the Deductible is the dollar amount shown on the Schedule.

Once Covered Charges incurred by a Person in a calendar year equal the Deductible, benefits are payable for any additional Covered Charges he incurs in that calendar year. Only Covered Charges will be used to meet the Deductible.

Each Covered Person must meet a new Deductible each calendar year before benefits are paid for that Person, with the following exceptions.

1. Once an amount equal to three times the Deductible has been met by Covered Persons for the calendar year, no other Deductibles need be met for that calendar year.

2. An additional deductible, as shown on the Schedule, must be met when Pre-Certification procedures are not followed; and for emergency room visits not resulting in inpatient Hospital admission.

B. BENEFITS PAYABLE

After the Deductible has been met, We pay the amount of Covered Charges incurred by a Covered Person during a calendar year, up to the Lifetime Benefit Maximum.

C. MAXIMUM AMOUNTS

This policy has a Lifetime Benefit Maximum. It is the total amount of benefits We will pay for any one Covered Person for all Covered Charges he incurs during a calendar year. The Lifetime Benefit Maximum is shown on the Schedule.

This policy also has maximum amounts for specific benefits, as shown on the Schedule.

D. OTHER MEDICAL COVERAGE

When a Covered Person has Other Medical Coverage which does not have a variable deductible or other provision as to nonduplication or coordination of benefits, the amount of benefits payable towards Covered Charges under such Other Medical Coverage becomes the Deductible, if greater than the Deductible dollar amount shown on the Schedule.

When a Covered Person has Other Medical Coverage, and such coverage also has a variable deductible or other provision as to nonduplication or coordination of benefits, benefit payments are calculated as follows.

1. We determine the amount of benefits We would pay if there was no Other Medical Coverage.

2. We determine the amount of benefits the Other Medical Coverage would pay towards Covered Charges if this policy did not exist.

3. We total these amounts.

4. We divide Our amount by the total in 3. above to find the percentage of the total Covered Charges for which We are liable.

5. We multiply total Covered Charges by this percentage to find the amount of benefits We will pay.

E. DELAY IN RECEIVING BENEFITS UNDER OTHER MEDICAL COVERAGE

If You cannot secure benefits under Your Other Medical Coverage without recourse to legal action; and if for purposes of a claim under this policy We have considered Your Other Medical Coverage in computing benefits payable; then We will reopen Your claim when We receive proof satisfactory to Us that You have made a reasonable effort to secure benefits under Your Other Medical Coverage and have not been successful. We will pay You the additional amount that would have been paid if benefits had been computed without considering such unpaid Other Medical Coverage; but, You thereby subrogate to Us the right to collect and receive a portion of the unpaid Other Medical Coverage that equals the amount by which We so increase Your claim payment.

F. SUBROGATION RIGHT

Upon payment of benefits, We will be subrogated to all rights of recovery a Covered Person may have against any person or organization. This includes but is not limited to recoveries against such third party, against any liability coverage for such third party or against a Covered Person's automobile insurance in the event a claim is made under the uninsured or underinsured motorist coverages. Such right extends to the proceeds of any settlement or judgement; but is limited to the amount of benefits We have paid. You must: do nothing to prejudice any right of recovery; execute and deliver any required instruments or papers; and do whatever else is necessary to secure such rights.

If We are precluded from exercising Our subrogation right, We may exercise Our right of reimbursement.

G. RIGHT OF REIMBURSEMENT

If benefits are paid under this policy, and a Covered Person recovers against any person or organization by settlement, judgement or otherwise, We have a right to recover from that Covered Person an amount equal to the amount We have paid. This includes but is not limited to recoveries against such third party, against any liability coverage for such third party or against a Covered Person's automobile insurance in the event a claim is made under the uninsured or underinsured motorist coverage.

Any payment We make prior to determination of a work related Injury will be reimbursed when a Covered Person receives payment for such Injury from another source. You must agree to: notify Us of any Worker's Compensation claim You make; and reimburse Us even when Worker's Compensation benefits are provided by means of settlement or compromise.

H. COVERED CHARGES

Covered Charges are the following, up to any limits shown below or on the Schedule.

If a Covered Person is provided more than one level of Hospital or other facility care on any one calendar day, only one benefit will be paid for that day. The benefit paid will be for the highest level of care billed for that day.

1. Hospital Benefits

   - Daily room, board and nursing care charges, including routine nursery charges for a covered newborn child, during a Hospital Confinement, up to the daily rate for the average semi–private (2–bed) rooms in the Hospital where confined, for any one day of Confinement. If a Hospital does not have a semi–private room rate, the most common semi–private room rate in the area is used.
   - Daily room, board and nursing care charges during Confinement in an Intensive Care Unit, up to 3 times the daily rate for the average semi–private room in the Hospital where confined, for any one day of Confinement.
   - Charges by a Hospital for services, supplies, drugs and medicines needed for the Covered Person's care and not included in the room and board charges.

2. Benefits For Care Provided By Other Facilities

- Skilled Nursing Home charges for daily room, board and nursing care that starts within 3 days after a Hospital Confinement; or that follows surgery which requires skilled nursing care. Custodial Care is not covered.

- Charges for Hospice Care, for one Hospice Care Benefit Period.

Benefits will continue for one additional Hospice Care Benefit Period, if the Person continues to live beyond the prognosis for life expectancy. In no event will benefits be provided for more than two Hospice Care Benefit Periods for any one Person.

Covered Hospice Care Services are: professional nursing services provided by or under the supervision of a Registered Nurse (R.N.); home health aide services under the supervision of a Registered Nurse or specialized rehabilitative therapist; physical therapy, respiration and inhalation therapy; speech therapy and audiology; occupational therapy; nutrition counseling by a nutritionist or dietitian; medical social services; family counseling related to the Person's terminal condition; medical supplies, including drugs and biologicals, prothesis and orthopedic appliances; and rental or purchase (whichever is lesser in cost) of durable medical equipment.

Covered Hospice Care services do not include: services or supplies for personal comfort or convenience, including homemaker services; food services or meals other than dietary counseling; services provided by volunteers; services provided by a Family Member of the Person, or anyone residing with the Person; or bereavement support services for family members following death of the Person.

- Charges for services and supplies provided by a Free Standing Surgical Center in connection with outpatient surgery. This benefit is paid only for services and supplies for which benefits would be paid if the surgery was done at a Hospital; and only for services and supplies provided on the day the surgery is done.

- Charges for Home Care that starts after a Hospital Confinement or after Confinement in a Skilled Nursing Home and when continued Confinement would otherwise be required.

Covered Home Care services are: part–time or periodic home nursing care by, or supervised by, a Graduate Registered Nurse (R.N.); part–time or periodic home health aide service; physical, nutrition, inhalation, respiratory, occupational or speech therapy; medical supplies and equipment which would be covered if provided by a Hospital.

Covered Home Care services do not include: food, housing, homemaker services, home–delivered meals; any services not listed above as a covered Home Care service; services or supplies not included in the Home Care plan established for the Person; or services provided by a Family Member of the Person or anyone residing with the Person.

It is important that You notify Us prior to the start of Home Care. We may be able to help You plan for appropriate and cost effective care through Our case management system.

3. Physician's Benefits

- Physician's charges, as limited herein and in the Schedule. Covered visits are limited to one per day for the attending Physician and one per day for any required specialist. This benefit is not paid for separate charges made by a surgeon to provide post-surgery care during the first two weeks after surgery. Assistant surgeon's charges are paid up to 20% of the amount payable for the surgeon.

- If more than one surgical procedure is done at the same time and through the same incision, We will pay only for the procedure with the highest limit. If they are done through different incisions, We pay for the procedure with the highest Covered Charge plus 50% of the Covered Charge(s) for the other procedure(s).

- Child Wellness Care for visits at birth, ages 2, 4, 6, 9, 12, 14, and 18 months; and 2, 3, 4, 5, 6, 7 and 8 years. Benefits will be paid for appropriate immunizations, physical examinations, laboratory tests and developmental assessments in keeping with prevailing medical standards. Payment shall be made to only one provider for all services covered for each visit. Services must be provided within 90 days prior to or after reaching each specified age.

4. Benefits For Other Services And Supplies

- Charges for diagnostic x-rays and laboratory tests.

- Charges for electrocardiograms.

- Charges for radiation therapy and nuclear medicine.

- Charges for radioisotope treatment of hyperthyroidism (not including radioactive drugs or diagnostic test).

- Charges for monthly rental, up to 6 months, of a wheelchair, hospital-type bed, artificial respirator, oxygen delivery equipment or other durable medical equipment prescribed by a Physician, up to the purchase price. At Our option We may, in lieu of payment of rental charges, use the amount of benefits We would pay for rental to purchase such supplies.

- Charges for crutches, braces (except dental braces), trusses, casts and splints.

- Charges for blood and blood plasma (unless replaced), oxygen; and initial prosthetic appliances (but not replacements of artificial limbs or eyes).

- Charges for local professional ground ambulance service.

- Charges for outpatient drugs and medicines which require a prescription, and are purchased from a licensed pharmacist, and which are not specifically excluded.

- Charges for an annual Pap test for cervical cancer for female Covered Persons and mammography examinations performed according to the following schedule: a baseline mammogram for each female Covered Person age 35 to 40; a mammogram every two years for a female Covered Person age 40 to 50 or every year if the Person has a risk factor for breast cancer; and a mammogram every year for each female Covered Person over 50 years.

- Physical Therapist charges.

5. Benefits for Human Organ Transplants

We will pay benefits for a Covered Person who is the recipient of a covered organ transplant; but, We will not pay for organ donation by a Covered Person. The total of all benefits We will pay in connection with all transplant procedures performed on one Person will not exceed the Lifetime Transplant Maximum shown on the Schedule.

Covered Charges for an organ transplant include diagnosis, testing, immunosuppressant drug therapy, complications resulting from the surgery or rejection, and repeat transplants of the same organ.

6. Benefits for High Dose Chemotherapy (HDC) followed by Stem Cell Infusion (SCI) or Autologous or Allogenic Bone Marrow Transplant (ABMT)

There is limited coverage for HDC and ABMT. Benefits are payable as described in this Section VII. But, they are only paid for the following.

High dose chemotherapy followed by stem cell infusion will only be covered when Medically Necessary for neuroblastoma, acute leukemia in remission, resistant non–Hodgkin's lymphomas, or advanced Hodgkin's disease, aplastic anemia, leukemia, hemoglobinopathies, metabolic storage disease, severe combined immunodeficiency disease (SCID), or treatment of Wiskott–Aldrich syndrome.

High dose chemotherapy followed by an autologous bone marrow transplant will only be covered when Medically Necessary for neuroblastoma, acute leukemia in remission, resistant non–Hodgkin's lymphomas, or advanced Hodgkin's disease.

High dose chemotherapy followed by an allogenic bone marrow transplant will only be covered when Medically Necessary for aplastic anemia, leukemia, hemoglobinopathies, metabolic storage disease, severe combined immunodeficiency disease (SCID), or treatment of Wiskott–Aldrich syndrome.

The HDC/SCI/ABMT benefit period starts 5 days before the date the procedure is done and ends 12 months after the procedure is done. Only charges incurred during the HDC/SCI/ABMT benefit period will be considered for payment.

It is important that You notify Us before such a procedure is done to make certain that it will be covered. The Physician must submit a complete medical history including current diagnosis. The Physician must certify that the procedure is Medically Necessary and that alternative procedures, services or courses of treatment would not be effective in the treatment of the Person's condition.

Covered organ transplants are only the following human–to–human organ or tissue transplant procedures when they are Medically Necessary.

Heart	Pancreas	Heart/Lung
Liver	Cornea	Bone Marrow
Kidney	Lung	(As limited in 7. below)

It is important that You notify Us before a transplant is done to make certain that it will be covered. The Physician must submit a complete medical history including current diagnosis. The Physician must certify that the transplant is Medically Necessary and that alternative procedures, services or courses of treatment would not be effective in the treatment of the patient's condition.

7. Out–Of–Pocket Limits

Except as provided below, We will pay benefits as described in this policy until the portion of Covered Charges You must pay for a Covered Person in a calendar year (excluding any Deductibles), equals the Out-of-Pocket Limit shown on the Schedule. Then, until the end of that calendar year, We will pay 100% of Covered Charges incurred by that Person. Once the amount You must pay for all Covered Persons equals twice this limit in any one calendar year, We will pay 100% of Covered Charges incurred by all Covered Persons until the end of that calendar year.

The Out-of-Pocket Limits do not apply:

- to the portion of Covered Charges You must pay for treatment of Mental Illness, alcoholism or drug abuse; or
- to the portion of any expense in excess of the Usual & Customary Charge; or
- to expense for services and supplies not covered by this policy; or
- to expense used to meet the Deductible.

The Out–of–Pocket Limits will not operate to provide benefits in excess of any policy maximums for the type of expense; or to provide benefits in excess of a Person's Lifetime Benefit Maximum.

SECTION VIII. COST CONTAINMENT PROVISIONS

Premium rates for this policy are based on factors that assume that these cost saving procedures will be followed. If a prescribed procedure is not followed, then benefits will be reduced as explained below.

A. REQUIRED OUTPATIENT SURGERY

The surgical procedures listed below must be done on an outpatient basis unless:

1. the Physician provides Us with acceptable certification that Hospital Confinement is required for medical reasons; or

2. appropriate outpatient facilities are not available within 50 miles of the Covered Person's home.

If the surgery is done on an outpatient basis, benefits will be paid as described in Section VII.

If the surgery is not done on an outpatient basis (and the exceptions above do not apply) benefits will not be paid for any Hospital room and board charges.

Procedures which must be done on an outpatient basis are:

ARTHROSCOPY (examination of joint) AND CARTILAGE REMOVAL
BREAST BIOPSY (removal of breast tissue for examination)
CARPAL TUNNEL (relief of nerve pressure in wrist)
CATARACT REMOVAL (removal of lens)
CYSTOMETROGRAM (examination of bladder function)
CYSTOSCOPY (examination of bladder)
D&C – DILATATION AND CURETTAGE (scraping of uterus)
EXAMINATION UNDER ANESTHESIA
EXOSTOSIS EXCISION (removal of bony growth)
EYE MUSCLE SURGERY
GANGLION EXCISION (removal of mass of cystic tumors)
HAMMERTOE EXCISION (correction of abnormally bent toe)
HYDROCELECTOMY (removal of fluid in testes sac)
LAPAROSCOPY (examination of abdomen)
NEUROMA OR MORTON'S NEUROMA EXCISION (removal of nerve cell tumor)
PALMER FASCIECTOMY (removal of fibrous tissue of hand)
PILONIDAL SINUS (draining of abnormal skin cavity at base of spine)
SIMPLE FISTULECTOMY (removal of abnormal tube-like passage of rectum)
TYMPANOSTOMY WITH INSERTION OF VENTILATORY TUBE (repair of hole in eardrum)
UMBILICAL HERNIA REPAIR (reduction of protruding internal organ at navel)
INGUINAL HERNIA (repair of protruding internal organ in groin area)
HYSTEROSCOPY (examination of uterus)
ANY ENDOSCOPIC PROCEDURE SUCH AS:
  ESOPHAGOSCOPY (inspection of interior of esophagus)
  GASTROSCOPY (inspection of interior of stomach)
  E.R.C.P. (inspection of the bile ducts and pancreas)
  COLONOSCOPY (examination of lower part of colon)
TONSILLECTOMY (removal of tonsils)
ADENOIDECTOMY (removal of adenoids)
HEMORRHOIDECTOMY (removal of hemorrhoids)

B. PRE–CERTIFICATION OF HOSPITAL CONFINEMENT

All Hospital admissions and proposed surgery (except surgery done in the Physician's office) will be subject to Pre–Certification. The procedures listed next must be followed to avoid a benefit reduction.

Non–Emergency Admission:

1. Your Physician must call our Pre–Certification Service at the toll–free number shown in the Schedule at least 2 working days prior to the date of admission or surgery. If Our Pre–Certification Service is contacted less than 2 working days before admission or surgery, benefits will be reduced as if these Pre–Certification procedures were not followed. The information Your Physician gives the Pre–Certification service will be reviewed by it. If there is a disagreement about the need for admission to the Hospital or for the surgery, a consulting Physician will contact Your Physician for further discussion of the case.

2. You must complete and sign the authorization form and give it to Your Physician.

3. The Pre–Certification Service will then give written confirmation to Your Physician, to You, and to the admitting Hospital of the authorized number of days of Confinement or that the surgery has been authorized.

4. You or Your Physician may at any time ask the Service to re–evaluate or extend the number of days of Hospital Confinement deemed necessary.

5. If Your Physician and the Service do not agree about the medical necessity of the treatment, you will be informed of the right to a second opinion; and a list of Physicians will be provided You for this second opinion.

6. All authorizations will be valid for 60 days for the Physician and the named health care facility. A change in either will require a new form.

Emergency Admission: Your Physician must call within 48 hours after an Emergency Admission or by the next regular working day after the start of treatment, if later. The reason for admission and the details of the care or treatment received must be given. If it is not reasonably possible to make the call within the times provided, benefits will not be reduced for this reason if the call is made as soon as is reasonably possible.

If the Covered Person follows these procedures, we will pay benefits as described in Section VI.

If the Covered Person does not follow these procedures, an additional deductible will be required for each such Confinement or surgery. The amount of this additional deductible is shown in the Schedule.

If the Person will be having surgery done in the Hospital, Our Pre–Certification Service may require a confirming opinion on the need for the surgery before it will authorize the Hospital admission. If a confirming opinion is required, We will pay 100% of the Covered Charge for a second (and third if required) opinion on the need for surgery without requiring that the Deductible be met first.

C. NON–EMERGENCY WEEKEND HOSPITAL ADMISSION

If a Covered Person is admitted to a Hospital during the period of 12:01 p.m. on a Friday through 12:01 p.m. on a Sunday, benefits will only be paid for that period if:

1. surgery covered by this policy is scheduled for the day of, or the day after, admission; or

2. scheduled treatment is actually provided on the day of, or the day after, admission; or

3. the Covered Person is in the Hospital because of an Emergency Admission.

SECTION IX. PREEXISTING CONDITIONS LIMITATION

No benefits will be paid for expenses that result from care or treatment of any Preexisting Condition until the end of a 12 month period during which the Person with the Preexisting Condition is continuously covered under this Policy.

If this is employer sponsored coverage, the time a Person was covered under another employer health benefit plan will be credited against the above limitation if the previous coverage was continuous to a date not more than 30 days before the effective date of this coverage, exclusive of any applicable service waiting period, and if the Person was not late enrollee.

SECTION X. FOREIGN TRAVEL LIMITATION

This policy provides limited coverage while a Covered Person is traveling outside of the U.S. and its territories, except for travel in Canada. Benefits are paid for up to 30 days of treatment, but only for:

1. Injury occurring during the first 30 days of such travel; and

2. Sickness first manifest during the first 30 days of such travel.

No other coverage is provided for treatment given outside of the U.S. and its territories or Canada.

SECTION XI. EXCLUSIONS AND LIMITATIONS

A. No benefits are paid for loss due to any of the following.

- Any service or supply not specifically listed as covered in this policy.
- Any service or supply that is not Medically Necessary as defined in this policy.
- Any complications arising from, or related to, a surgical or medical treatment or procedure not covered under this policy.
- Care or treatment for Mental Illness except as specifically provided in this policy.
- Alcoholism or drug abuse except as specifically provided in this policy.
- Manipulative Therapy except as specifically provided in this policy.
- Organ or tissue transplants except as specifically provided in this policy.
- Cosmetic surgery, except reconstructive surgery related to or following surgery resulting from Injury, trauma, infection or other disease of the involved part; and except reconstructive surgery of a covered newborn child required due to birth abnormalities or congenital defects.
- Routine physical examinations, well child care, x-rays or test procedures not related to diagnosis or treatment of a specific Sickness or Injury, except as specifically provided in this policy.
- Evaluation or treatment of infertility by any method including, but not limited to, surgery of any kind, in vitro fertilization procedures of any type, artificial insemination and genetic counseling, testing or treatment.
- Surrogate pregnancy.
- Sterilization or reversal of sterilization procedures.
- Sexual dysfunction including, but not limited to impotence and implantation of penile prosthesis.
- Foot care due to treatment of weak, strained or flat feet for instability or imbalance of the foot; or treatment of corn, calluses or the free edge of toenails, except when necessitated for peripheral vascular disease or other Sickness of similar medical seriousness.

- Dental surgery or treatment, unless caused by Injury to natural teeth and performed within 90 days after the accident causing the Injury. Dental treatment due to Injury caused by chewing is not covered. Bridgework attached to injured teeth is not covered.
- Temporomandibular Joint (TMJ) Dysfunction Syndrome or surgery on the jaw; but treatment of jaw fractures and removal of tumors of the jaw will be covered.
- Any treatment or service for obesity (excessive weight) or weight or dietary control including, but not limited to: surgery, complications of surgery, exercise or weight loss programs, formal or informal, whether or not recommended by a Physician.
- Any items primarily for personal comfort such as whirlpools, air conditioners, waterbeds, exercise equipment, motorized vehicles or items primarily useful for an individual living in the patient's household.
- Radial keratotomy, eye refractions, eye examinations, eyeglasses, or contact lenses.
- Drugs prescribed for birth control, weight control, obesity, cosmetic purposes, hair growth or infertility; growth hormones; or behavior modification programs such as but not limited to, smoking cessation.
- Non–prescription drugs, bandages, infant formulas and food supplements.
- Custodial Care.
- A condition for which a Covered Person is eligible to receive Workers Compensation or Occupational Disease Act or Law benefits; or which arises out of, or in the course of, employment for wages or profit.
- Service or supplies provided by a Family Member, by an individual who ordinarily resides in the Person's home, or by the Person's employer or partner.
- Private duty Nurses, unless provided as part of covered Home Care.
- Incremental nursing charges made by a Hospital as a charge separate from the room and board charge.
- The Covered Person's participation in the commission of, or attempt to commit, a felony, assault, unlawful act, strike, civil disorder or riot.
- Intentionally self–inflicted injury, while sane or insane.
- Suicide or attempted suicide, while sane or insane.
- Services or supplies for which no charge is normally made in the absence of insurance, or which the Person is not legally obligated to pay.
- Hearing examinations and hearing aids or fitting thereof.
- Speech or occupational therapy and related diagnostic testing arising from, or related to, a learning disability, speech impediment, or developmental delay even though therapy is recommended due to organic dysfunction, including, but not limited to, congenital deformity or birth trauma, except as specifically provided in this policy.
- Sex change surgery. This includes all related services and supplies whether furnished prior to, after, or in lieu of such surgery.
- Service or supplies provided by the Veterans Administration for service related Sickness or Injury, under any law (including Medicare), or by any government unit for which a Covered Person is or becomes eligible. This exclusion will not apply if the Person is legally required to pay for such service or supplies, or to Medicaid.
- Expense incurred while in the military, naval or air service of any country. Any premium paid for a Covered Person for a period that he is in such service will be returned pro rata upon notice of entry into such service.
- War, or act of war, declared or undeclared, and occurring after the Person's effective date.
- Recreational or educational therapy, or vocational rehabilitation.

B. This policy will not pay benefits which duplicate benefits payable by Other Medical Coverage for the same expense.

SECTION XII. FILING A CLAIM FOR BENEFITS

1. **Notice of Claim:** You must send Us written notice of claim 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 sent to You within 15 days, You will meet the proof of loss requirements by giving Us a written statement of the nature and extent of the loss within the time limit stated in the Proofs of Loss section.

3. **Proofs of Loss:** Written proof of loss must be sent to Us within 90 days after the loss. If it is not reasonably possible to send such proof in the time required, We shall not reduce or deny the claim for this reason if the proof is sent as soon as reasonably possible. In any event, the proof must be sent no later than one year from the time specified unless You were legally incapacitated.

4. **Time of Payment of Claim:** We will pay benefits for loss covered by this policy as soon as We receive a properly completed claim form, and any other proof required.

5. **Payment of Claims:** Benefits will be paid to You, unless You assign them to a health care provider. Any benefits unpaid at death may be paid, at Our option, either to Your beneficiary or to Your estate. If benefits are payable to Your estate, or a beneficiary who cannot execute a valid release, We can pay up to $1,000.00 of benefits 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 from liability to the extent of any such payment made in good faith.

SECTION XIII. PREMIUM PROVISIONS

Renewal premiums for this Policy are based on Our rate schedule in use on the renewal date. We have the right to change this schedule:

If a change to Our rate schedule is made, it will be on an Insurance Class basis for all policies of this plan in this state. Your premium will not change because of the health or claim experience of any Covered Person. Rates for each Person are based on age, sex and insurance classification on the Policy Date; except when a child attains age 19, his rate becomes based on that age and not on the child rate.

SECTION XIV. UNIFORM PROVISIONS

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 endorsed on or attached to this policy. No agent may change this policy or waive any of its provisions.

TIME LIMIT ON CERTAIN DEFENSES

After two years from the date a person becomes a Covered Person no statements, except fraudulent misstatements in the application for coverage, may be used to void this policy or deny any claim for loss incurred after the two year period.

No claim for loss incurred after 12 months from the date a person becomes a Covered Person will be reduced or denied because the condition existed before the effective date of his coverage.

GRACE PERIOD

This policy has a thirty–one day grace period for payment of each renewal premium. During the grace period this policy remains in force.

REINSTATEMENT

If a renewal premium is not paid before the grace period ends, this policy will lapse. If We (or Our authorized agent) later accept a premium without requiring a reinstatement application, that will automatically reinstate this policy. If We, or Our agent, require a reinstatement application, this policy will be reinstated as of its approval date. Lacking such approval, this policy will be reinstated on the forty–fifth day after the date of the reinstatement application, unless We have previously written You of its disapproval. The reinstated policy will only cover loss that results from an Injury sustained after the date of reinstatement and Sickness that starts more than ten days after that date. In all other respects, Your and Our rights will remain the same, subject to any provisions endorsed on or attached to the reinstated policy.

PHYSICAL EXAMINATIONS

We have the right, at Our own expense, to have a Covered Person examined as often as reasonably necessary while a claim is pending on that Person.

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.

CHANGE OF BENEFICIARY

You can change Your beneficiary at any time by giving Us written notice. Your beneficiary's consent is not required for this or any other change in this policy, unless the designation of the beneficiary is irrevocable.

MISSTATEMENT OF AGE OR SEX

If a Covered Person's age or sex has been misstated in the application, the premium for that Person will be adjusted for the correct age or sex. If We would not have issued coverage for that Person at the correct age, such coverage will be void as of its effective date; and We will refund any premium paid for that Person, less the amount of any claims paid for that Person.

UNPAID PREMIUM

When a claim is paid, We have the right to deduct any premium due and unpaid from the claim payment.

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.

SECTION XV. OTHER PROVISIONS

STATEMENTS IN THE APPLICATION

All statements made in the application for this policy are representations and not warranties.

CHARTER AND BY-LAWS

Provisions of our charter or by-laws will not void this policy or be used in defense in any legal proceedings hereunder, unless they are contained in this policy.

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.

NOTICE OF ANNUAL MEETINGS

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