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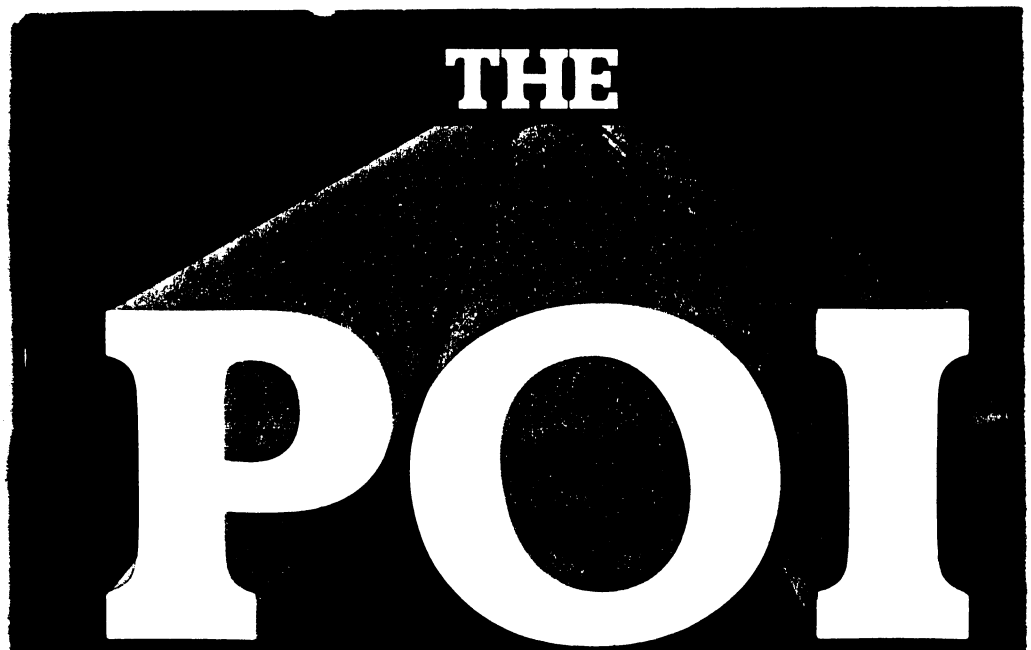

POI

PLAN OF INSURANCE

A Group Insurance Program providing

- **Medical Coverage**
- **Term Life Coverage**
- **Dependent Term Life Coverage**

Centrallife
Group Insurance Division
P. O. Box 5620
Madison, Wisconsin 53705

T7805 (Rev. 4/83)

MEDICAL RIDER
TO BE ATTACHED TO AND MADE A PART OF
GROUP MEDICAL PLAN OF INSURANCE POLICY NO. GM-2000

The provisions of this rider amend this policy. Except as stated in this rider, this policy remains unchanged. This rider is subject to the conditions and provisions of this policy.

WAIVER OF DEDUCTIBLE
(APPLICABLE TO $200 DEDUCTIBLE PLAN)

We will waive the Deductible if the Subscriber or his/her Dependents suffer an accidental Injury while covered under this Waiver of Deductible provision.

Benefits for Covered Charges are payable if Treatment or Service:

(1) begins within 30 days after the date of the accident; and
(2) is received prior to the end of a 180-day period immediately following the date of the accident.

The Coinsurance Rate applies.

This booklet is Your certificate while You are insured under the Plan of Insurance program. We suggest You read it carefully so that You will know all the coverages to which You are entitled. To help You fully understand the coverages We offer, a list of insurance terms has been included in the back of this certificate. These terms are printed in *italics* when they occur in the text.

The Plan of Insurance gives You group term life coverage and major medical coverage. The specific medical plan option You have chosen (W200, W500, W1000) is shown on the *Application* attached to this certificate. The *effective date* of Your Insurance coverages, including *Dependent* coverages, if any, is also shown on the *Application*.

These group coverages are provided under a Group Life Insurance Policy and a Group Medical Insurance Policy which were issued to trusts as the Group Policyholder. The trusts are situsued in the state of Wisconsin. The M&I Marshall & Ilsley Bank is the Trustee of the trusts.

The group insurance policies were issued and delivered in the state of Wisconsin. All provisions of these policies shall be interpreted by, governed by and are subject to the laws of the state of Wisconsin. This certificate is not an insurance contract. The group insurance policies and Your *Application* for Participation determine all rights and benefits You and Your *Dependents* (if any) have under the Plan of Insurance program. Your certificate is issued under these policies. Any reference to "Insurance" in this certificate shall mean Your coverages and Your *Dependent's* coverages (if any) under the group insurance policies. Any reference to "the policy" in this certificate shall mean the respective Group Life Insurance Policy or the Group Medical Insurance Policy.

You may examine the group insurance policies at *Our Office* at any time during our regular business hours by contacting Central Life Assurance Company, Group Insurance Division, Madison, Wisconsin.

PLEASE READ YOUR CERTIFICATE CAREFULLY

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PROVISIONS WHICH APPLY ONLY TO MEDICAL INSURANCE

PROVISIONS

Which Apply

To Both

LIFE & MEDICAL

COVERAGES

ELIGIBILITY

FOR SUBSCRIBER

The Subscriber is the person who applied for this Insurance. The Subscriber shall be called You or Your in this certificate. To be *eligible* for coverages as a Subscriber You shall:

(1) complete and sign the *Application* for Participation stating that You adopt and subscribe to the respective Agreement and Declaration of Trust; and
(2) agree to pay *premiums* on Our *Check-O-Matic Plan* through a named bank account; and
(3) agree to be underwritten on a special group accept or reject basis; and
(4) not be participating in a plan of similar coverages with an employer; and
(5) be at least 18 years of age; and
(6) reside in the United States of America; and
(7) be gainfully employed or self-employed; except in the case of a person who applies for this Insurance as a result of any of the following:
    (a) dependent coverage is not available under the employed spouse's plan; or
    (b) dependent coverage has been waived under the employed spouse's plan; or
    (c) the employed spouse is uninsurable.

If a husband and wife are both *eligible* and both apply for this Insurance, only one shall be enrolled as a Subscriber. The spouse of that person shall then be considered an *eligible Dependent* of that Subscriber.

FOR DEPENDENT

A person who qualifies as a *Dependent* as defined in this certificate is *eligible* upon *Application* being made and approved, if he/she is not *confined* or *totally disabled*.

EFFECTIVE DATES

APPLYING FOR COVERAGES

Coverages under the policy must be requested by You on the *Application* we provide. If You desire coverages on any existing *Dependent*, such coverages should be requested at the time of Your initial *Application*.

You must apply for coverages on Your first *Dependent* Child within 31 days after acquiring that *Dependent* Child. No *Application* is needed for a newly acquired *Dependent* Child if one *Dependent* Child is already covered under the policy.

Evidence of insurability is required on all persons to be covered at the time of Your initial *Application*. It is also required in the following cases:

(i) if coverage that was first waived on an *eligible Dependent* is later desired; or
(ii) if *Application* on a *Dependent* is made more than 31 days after acquiring that *Dependent*.

EFFECTIVE DATE OF YOUR COVERAGES

Your coverages will be *effective* on the first day of the month after We accept Your *Application* and approve Your *evidence of insurability*, if the first *premium* is paid by that date.

DEPENDENT EFFECTIVE DATES

If Your coverages are in effect, coverages for a *Dependent* will begin on the latest of:

(a) the first day of the month after We approve that *Dependent's evidence of insurability*; or
(b) the date of marriage with respect to coverages for Your *Dependent* spouse if coverage is requested by You on an *Application* within 31 days of that date; or
(c) the date he/she qualifies as Your *Dependent* Child if coverage is requested by You on an *Application* within 31 days of that date.

Coverage shall not become *effective* for any person if he/she is *confined*, or *totally disabled*. Coverage will be *effective* on the first of the month following the date that person is no longer *confined*, and no longer *totally disabled*.

PREMIUMS

Premiums due under the policy shall be as determined by Us.

Premiums must be paid by You on or before their due date. The first *premium* is due on the *effective date*. If Your bank fails to honor the check drawn on Your account to pay Your first *premium*, You and Your *Dependents*, if any, are not insured under the policy and will not become insured hereunder until We receive that *premium* (assuming You are otherwise *eligible* for coverage at that time).

Premiums for this Insurance are paid using Our *Check-O-Matic Plan* of payment. Under this *Plan* We are authorized to draw checks monthly from a bank account You have named for the purpose of paying *premiums* due. The fact that We draw such a check for payment shall satisfy any need for giving notice of *premiums* due. A *premium* shall not be paid until We actually receive the funds at *Our Office*.

Using this *Check-O-Matic Plan* shall not change the provisions of this Insurance in any way. We may *terminate* this *Check-O-Matic Plan* if any check is not paid by Your bank. If any check is not honored by the bank, We are not liable by reason of that action.

We may change the *premium* for this Insurance. We must send You written notice at least 31 days before any *premium* rate increase. Such increase in *premiums* shall take effect on the next *premium* due date.

A *premium* may change without notice from Us due to a change in age or a change of address. Such *premium* change shall take effect on the first day of the month after the event which caused such change.

GRACE PERIOD

Except for the first *premium*, any *premium* not paid by its due date is in default. For each *premium* in default, there is a grace period of 31 days directly following the due date of an unpaid *premium*. The *premium* in default must be paid within the grace period for coverage to continue. If We have not received the required *premium* by the end of the grace period, coverage will *terminate* on the last day of the grace period. You are liable for all *premiums* due and unpaid, including the *premium* for any grace period. You are obligated to pay such *premium* to Us upon demand.

TERMINATION

Your coverages shall *terminate* on the earliest of:

(a) the date of Your death; or
(b) the day immediately before the first *premium* due date following Your 75th birthday (for life coverage only); or
(c) the last day of a grace period if You failed to pay a *premium* by its due date; or
(d) the last day of the month during which Your *Check-O-Matic Plan* ends; or
(e) the date We *terminate* all Insurance under the policy with respect to all Subscribers in a given state or a given plan option (We must give written notice to each such Subscriber at least 31 days prior to the *termination date*); or
(f) the date of *termination* of the policy; or
(g) the date You no longer qualify as an *eligible* Subscriber under the policy; or
(h) the date You enter the Armed Forces of any country; or
(i) the last day of the month for which We receive Your advance written request that Your Insurance be *terminated*; or
(j) the date You no longer reside in the United States of America.

Your *Dependent's* coverages will *terminate* on the earliest of:

(a) the date he/she no longer qualifies as an *eligible Dependent* under the policy; or
(b) the last day of the month for which the last *premium* is timely paid on his/her coverages; or
(c) the last day of the month for which We receive Your advance request that his/her coverages *terminate*; or
(d) the date Your *Dependent* no longer resides in the United States of America; or
(e) the date Your coverages *terminate*. However, please note the following:
   — Life insurance coverage on a *Dependent* spouse will not *terminate* when You reach age 75 if he/she is under age 75; and
   — Life insurance coverage on a *Dependent* Child will not *terminate* when You reach age 75 if he/she is more than 14 days but less than 19 years of age.

RENEWAL OF YOUR COVERAGE

Unless this Insurance is *terminated* as stated under the termination provision, We shall renew this Insurance each month if We receive Your *premium* before the grace period ends.

REINSTATEMENT

Reinstatement of this Insurance is at Our sole option. If this Insurance has *terminated* because You have not paid a due *premium* and the last day of the grace period has passed, We may request an *Application* for *reinstatement* from You before We consider *reinstating* Your Insurance. All due and unpaid *premiums* must be paid before *reinstatement* of this Insurance will be considered. We will require *evidence of insurability* before *reinstatement* is considered. If an *Application* is required, this Insurance will be *reinstated* only if We approve the *Application*. You must submit the *Application* for *reinstatement* and all due *premiums* within 90 days after You have paid Your last *premium*.

We will tell You whether We have accepted or declined Your *Application* for *reinstatement* as soon as We can after reviewing Your *Application*. If We decline You, coverages will remain *terminated* as of the date determined under the Termination provision.

GENERAL INFORMATION

ENTIRE CONTRACT. The policies, the *Application* of the Group Policyholder and Your *Application* for Participation are the entire contract between Us and the Group Policyholder. All statements made by You in Your *Application* are representations, not warranties. We rely on the statements made in Your *Application* to be true, correct and complete to the best of Your knowledge, information, and belief. No statements will be used to contest or void coverages under the policy or to deny or reduce payment of *Benefits* or be used in a defense to a claim under the policy, unless contained in a written document.

INCONTESTABILITY. After the policy has been in force for one year from its policy *effective date*, We shall not contest its validity except on the basis of nonpayment of *premiums*.

Except for Your failure to make timely payments of *premiums* or for fraudulent misstatement, We shall not contest the validity of Your or Your *Dependent's* coverages after such respective coverages have been in force for one year during Your lifetime or the lifetime of each of Your *Dependents*. No statement made by You will be used to contest coverage under the policy, or to reduce or deny a claim for loss incurred after the respective coverages have been in force for one year during Your lifetime or the lifetime of Your *Dependent* unless it is contained in a written document signed by You. We will send You a copy of the written document.

LEGAL ACTION. Neither You nor Your *Dependent* shall bring legal action on the policy until at least 60 days after We have received due written proof of loss as required. No legal action shall be brought after six years have passed from the time written proof of loss is required to be furnished.

INFORMATION TO BE FURNISHED. You shall furnish any information We need to administer the policy. If You make a clerical error with respect to the information given to Us: (1) this shall not cause Your coverage to be invalid, or (2) this shall not make any coverage which is *terminated* continue because of such error. If an error affects the *premium*, or the amount of coverages, an equitable adjustment will be made by Us if We determine this to be necessary.

We may inspect and copy the records of a Subscriber which relate to the policy. Such access shall continue for two years beyond *termination* of the policy.

WAIVER AND CHANGE. Only *Our Executive Officers* can change or waive any condition or provision of the policy. No other person can change any provision or condition of the policy in any way. We may change any provision or condition of the policy, if We notify the Group Policyholder and each Subscriber in writing at least 31 days in advance of the change. Such change will be *effective* on the first day of the month after We send such notification. Such change will be made by an endorsement or an amendment to the policy which is signed by the Group Policyholder and one of *Our Executive Officers*. Any endorsements or amendments will be binding on the Group Policyholder, You and Your *Dependents* and Us.

AGE. Age means a person's age on his/her last birthday. If any person's age has been misstated, the *premium* will be adjusted fairly as determined by Us. The *premiums* due for that person will be based on the correct amount of coverages for that person as determined by Us.

PHYSICIAN EXAMS. We have the right to have You or Your *Dependent* examined when and so often as reasonably required while that person's claim is pending. We will pay for the full cost of any such exam.

FREE CHOICE OF PHYSICIAN. You and Your *Dependent* have free choice of any *physician*. We will in no way disturb the *physician*-patient relationship. However, please note that *treatment* or *service* provided by an *immediate family* member is NOT a *Covered Charge* nor eligible for *Benefits* under the policy.

PROVISIONS

Which Apply

Only To

LIFE

COVERAGE

AMOUNT OF LIFE COVERAGE

The following chart is used to determine the amount of term life insurance You and Your *Dependent* shall have under this Insurance.

The amount of *proceeds* paid will be based on Your or Your insured *Dependent's* age on the date of death.

At Your death if Your age is:	**Amount of Coverage ($)**
18 years through 44 years	30,000.00
45 years through 49 years	20,000.00
50 years through 54 years	10,000.00
55 years through 64 years	5,000.00
65 years through 74 years	5,000.00
75 years and over	None

At Your Dependent's death if Your Dependent's age is:	
Spouse—under 65 years	2,500.00
Spouse—65 years through 74 years	1,250.00
Spouse—75 years and over	None
Child—less than 14 days	None
Child—14 days but less than 6 months	100.00
Child—6 months but less than 19 years	1,000.00

HOW PROCEEDS ARE PAID

We agree to pay *proceeds* to the *Beneficiary* in the amount of life coverage in force on Your life:
(1) if You die while covered; and
(2) on receipt of written proof of Your death by *Our Office*.

We agree to pay *proceeds* to You in the amount of life coverage in force on the life of a *Dependent*:
(1) if the *Dependent* dies; and
(2) on receipt of written proof of the *Dependent's* death by *Our Office*.

However if You die before the *Dependent*, Your *Beneficiary* will be paid the amount of life coverage in force on the life of the *Dependent*.

If more than one *Beneficiary* is named by You, *proceeds* will be divided equally among any surviving *Beneficiaries* unless otherwise provided.

If Your *Beneficiary* dies at the same time as You or within 15 days after Your death, and proof of loss has not been received at *Our Office*, payment of *proceeds* will be made as if You had survived the *Beneficiary* unless otherwise provided.

If no *Beneficiary* is designated or surviving at Your death, We may make payments at Our option to:
(1) the personal representative of Your estate; or
(2) Your widow or widower; or
(3) Your mother or father; or
(4) Your surviving children.

HOW PROCEEDS ARE PAID (CONTINUED)

If, in Our opinion, You or Your *Beneficiary* or any person named in (2), (3), (4) above, is incapable of giving a valid receipt for any payment due and no guardian, executor or administrator has been appointed, We have the option to make payments to the individual or individuals who have, in Our opinion, assumed the main care and support of You or Your *Beneficiary* or any person named in (2), (3), (4) above. Any payment due a minor shall be paid at a rate not to exceed $100.00 per month.

Any payment made by Us in accordance with this provision shall fully discharge Our obligations under the policy to the extent of the payment.

BENEFICIARY

At least one *Beneficiary* should be listed on Your *Application* when You apply for coverage under the policy.

A *Beneficiary* may be changed by You at any time by sending Us a new *Application* requesting the change. The *Application* must be sent to *Our Office*, and no change will become effective unless We receive the request. Any *Beneficiary* change will then be effective on the date You sign the request unless otherwise specified in the request. If You die before We receive the request to change Your *Beneficiary*, the change will remain effective. If *proceeds* have been paid prior to Our receiving the request, Our obligations under the policy will have been met and We will not be obligated to alter or change the payment.

If Your coverage is *reinstated*, the *Beneficiary* will be the *Beneficiary* on record on the *termination* date unless You otherwise request in writing.

ASSIGNMENT

You may assign Your right or interest under Your coverage and Your *Dependent's* coverage.

Any assignment must be irrevocable and absolute in form.

We will not be charged with notice of any assignment until an assignment is received and filed at *Our Office*. We will assume no responsibility for the validity or effect on any assignment.

RIGHT TO AUTOPSY

Where not forbidden by law, We have the right to have an autopsy performed on You or Your *Dependent* who dies while covered under the policy. Such autopsies will be performed at Our expense.

SUICIDE

If You or one of Your *Dependents* commits suicide within one year from that person's *effective date* of coverage, no *proceeds* are payable on that person's death under the policy. We will return the total *premium* paid to Us for that person's life coverage.

CLAIMS INFORMATION FOR LIFE INSURANCE

NOTICE OF CLAIM

We must receive satisfactory written notice of a claim at *Our Office*. The notice must state Your group number and certificate number (found on the *Application*) and the person who is deceased.

PROOF OF LOSS

We will send You proof of loss forms within 15 days of Our receipt of the notice of claim. Proof of loss requires from Your *Beneficiary* or You:

(a) a certified copy of the Death Certificate; and
(b) any other necessary written verification We need to determine our contractual liability for *Benefits* under the policy.

If We do not send the proof of loss form to You within 15 days after We receive notice of claim, sending the above information in writing to Us within a reasonable time will be treated the same as filing the proof of loss form.

TIME OF PAYMENT OF CLAIMS

Proceeds due under the policy will be paid promptly after We receive due written proof of loss as required.

LIFE INSURANCE CONVERSION PRIVILEGE

You or Your *Dependent* has 31 days to *convert* this Insurance to another insurance plan, IF coverage under the policy *terminates* for one of these reasons:

(1) Your employment or Your membership, or Your *Dependent's* membership, in a class *eligible* for this Insurance *terminates*; or
(2) We cancel all Insurance on this form in the same state. (See Termination provision.)

— You and Your *Dependent* may *convert* to the smaller of:
  (a) the amount of coverage You and Your *Dependent* had on the *Termination Date* less any insurance You and Your *Dependent* is or will become eligible for through an employer's plan; or
  (b) $5,000.00.

(3) the policy *terminates* or is amended so as to *terminate* all coverage in Your or Your *Dependent's* class. (You or Your *Dependent* must each have been insured under the policy for at least five years in order to *convert*.)

— You or Your *Dependent* may *convert* to the smaller of:
  (a) the amount of coverage You or Your *Dependent* had on the *Termination Date* less any other group or franchise insurance You or Your *Dependent* is or will become eligible for within 31 days after *termination* or amendment; or
  (b) $5,000.00.

(4) Your *Dependent's* coverage *terminates* when he/she reaches the limiting age.

Any amount of insurance *converted* under (2) or (3) which is more than $2,000.00 is subject to a *conversion* fee.

LIFE INSURANCE CONVERSION PRIVILEGE
(CONTINUED)

We will not ask for any *evidence of insurability*. But We must receive Your written *Application* for this insurance and Your first *premium* for the *Conversion Coverage* before the end of the 31-day period. The *Conversion Coverage* will then be effective on the 32nd day after this Insurance *terminates*. If You or Your *Dependent* dies after *termination* of coverage, but within the period allowed for *conversion*, We will pay *proceeds* in the amount of life coverage that You or Your *Dependent* had the right to *convert* upon receipt of due written proof of loss.

The *Conversion Coverage* may be on any of the forms (except term insurance) then usually issued by Us. The class of risk under the *Conversion Coverage* will be the same as the class of risk for this Insurance on the *Termination Date*. The *premium* for the *Conversion Coverage* shall be Our then published rate for the form issued, the amount of coverage, and the person's age at the time the *conversion* is effective.

PROVISIONS

Which Apply

Only To

MEDICAL

COVERAGE

SCHEDULE OF MEDICAL COVERAGES

PLAN OPTION W200

ANNUAL DEDUCTIBLE ..... $ 200
FAMILY DEDUCTIBE MAXIMUM 3
OUT-OF-POCKET EXPENSE MAXIMUM per person $ 1200
.....per family $ 2600
MAXIMUM LIFETIME PAYMENT $1,000,000*
MAXIMUM ROOM & BOARD DAILY LIMIT
..... hospital's average semi-private room rate

PLAN OPTION W500

ANNUAL DEDUCTIBLE ..... $ 500
FAMILY DEDUCTIBLE MAXIMUM 3
OUT-OF-POCKET EXPENSE MAXIMUM per person $ 1500
.....per family $ 3500
MAXIMUM LIFETIME PAYMENT $1,000,000*
MAXIMUM ROOM & BOARD DAILY LIMIT
..... hospital's average semi-private room rate

PLAN OPTION W1000

ANNUAL DEDUCTIBLE ..... $ 1000
FAMILY DEDUCTIBLE MAXIMUM 3
OUT-OF-POCKET EXPENSE MAXIMUM per person $ 2000
.....per family $ 5000
MAXIMUM LIFETIME PAYMENT $1,000,000*
MAXIMUM ROOM & BOARD DAILY LIMIT
..... hospital's average semi-private room rate

*NOTE: EXCEPTIONS TO THE ABOVE SCHEDULE

COINSURANCE RATE: After the *annual deductible* is satisfied, We will pay:

*(1) 80% of the first $5,000 of *Covered Charges* incurred in a *calendar year* in excess of the *annual deductible*.

*(2) 100% of any *Covered Charges* incurred in a *calendar year* in excess of $5,000 and the *annual deductible*.

SCHEDULE OF MEDICAL COVERAGES (CONTINUED)

OUT-OF-POCKET EXPENSES: The amount of *Covered Charges* that You pay to satisfy the *annual deductible* and *coinsurance rate* requirements for You and for Your *Dependent*.

*MENTAL DISORDERS: *Covered Charges* incurred for out-patient *treatment* or *service* of *mental disorders*, alcoholism, and drug abuse shall be payable at 50% *coinsurance rate* (instead of 80% or 100%) of the *Covered Charges*. However, in no event shall *Benefits* on such *Covered Charges* be more than $2,500 per person per *calendar year*. *Covered Charges* incurred for inpatient *treatment* or *service* of *mental disorders*, alcoholism, and drug abuse shall be payable the same as any other *sickness*. In no event shall *Benefits* on such *Covered Charges* for both inpatient and outpatient *Covered Charges* be more than $25,000 per person during the person's lifetime.

COVERED CHARGES
(For All Plans)

Covered Charges are limited to the lesser of the *usual charges* or *customary charges* for the type of *treatment* or *service* received.

For a *Covered Charge* to be considered for *Benefits* it must:
(1) occur while the person is covered; and
(2) arise out of a *treatment* or *service* that is prescribed, ordered, or administered by a *physician*; and
(3) arise out of a *treatment* or *service* that is medically necessary as a result of an *injury, sickness*, or pregnancy; and
(4) arise out of a *treatment* or *service* that is not excluded or limited from coverage.

A *Covered Charge* must be a medical expense charge made to You or Your *Dependent*:
(a) by a *hospital* for room and board, including general nursing care (not to exceed the Maximum Room and Board Daily Limit); and
(b) by a *hospital* for other *services* required for *treatment*; and
(c) by a *hospital* for intensive care *confinement*; and
(d) by a *hospital* for room and board and other essential *services* for an *eligible* newborn child (not to exceed the Maximum Room and Board Daily Limit) (These charges are subject to the *Dependent* Child's own *annual deductible* and *coinsurance* requirements); and
(e) by an ambulatory surgical center for *services* required for a surgical operation; and
(f) by a *physician* for professional *services*; and
(g) by a *physician* for circumcision and the physical exam before an *eligible* newborn baby's release (These charges are subject to the *Dependent* Child's own *annual deductible* and *coinsurance* requirements); and
(h) by a *physician* for *treatment* of malignant or invasive tumors; and

COVERED CHARGES (CONTINUED)

(i) by a *physician* or *dentist* or dental surgeon for repair of damage to the jaw and sound natural teeth directly caused by *injury* (except chewing injuries). Repair work must be finished within 180 days after the accident; and
(j) for *services* of a validly licensed physiotherapist and graduate registered nurse; and
(k) for *services* of a validly licensed midwife acting within the scope of that license; and
(l) for federally approved drugs that are obtainable only by a *physician's* written prescription; and
(m) for surgical dressings, casts, splints, braces, crutches, artificial limbs or eyes; and
(n) for monthly rental of a wheel chair, *hospital*-type bed or artificial respirator up to the purchase price, as precertified by Us; and
(o) for anesthesia, blood, blood plasma, oxygen (including rental of equipment for the administration thereof); and
(p) for X-ray (other than dental X-rays) and lab exam; and
(q) X-ray, radium and radioactive isotope therapy; and
(r) by a *hospital* or a licensed ambulance service for medically necessary transportation by ambulance to or from a local *hospital* (Note: Transportation will be only to the nearest *hospital* which can furnish a required *treatment* or *service*. Transportation cannot be undertaken to secure *services* of a personal *physician*, or *physician* or *hospital* of greater renown and/or specialization).

MATERNITY
Benefits for normal pregnancy shall be payable if conception occurred more than 12 months after the mother's most recent *effective date* of coverage. *Benefits* for *complications of pregnancy* shall be payable on the same basis as any other *sickness*. (See Effective Dates for coverage of the newborn).

Eliminated in 1979

HOME CARE SERVICES

"Home Care Plan" shall mean a plan of care that has been set up and approved in writing by the attending *physician* as medically essential for You or Your *Dependent*. Such plan must be reviewed at least every two months by the same *physician*. Each such Home Care Plan shall include (if medically essential):

(a) part-time or periodic home nursing care. Such care must be under or supervised by a graduate registered nurse; or

(b) part-time or periodic home health aide *service*. Such *service* may care for the patient only. Such *service* must be supervised by a graduate registered nurse or a medical social worker; or

(c) physical, respiratory, occupational, or speech therapy by a licensed therapist; or

(d) nutrition counseling. Such *service* must be under or supervised by a registered dietician; or

(e) medical supplies, federally approved drugs and medication, and lab service by or on behalf of a *hospital*. Such items will be covered to the same extent as if *hospital confined*.

The evaluation of the need for and the development of a Home Care Plan will also be covered. (Only one evaluation in a 12-month period or per disability will be covered, unless otherwise required by the attending *physician*.) Such Plan must also be requested and approved by the attending *physician*. Such Plan may be devised by a graduate registered nurse, physician-extender, or medical social worker.

The attending physician must also state, in writing, that:

(1) *hospital confinement* or *confinement* in an *extended care facility* would otherwise be required if home care *service* were not provided; and

(2) needed care and *treatment* can not be given by an *immediate family member* or by a person living with You without causing undue hardship. (*Benefits* will not be paid for *service* provided by an *immediate family member* or by a person living with You); and

HOME CARE SERVICES (CONTINUED)

(3) the Home Care Plan shall be provided or coordinated by a state-licensed or certified rehabilitation agency.

If *hospital confined* immediately before the Home Care Plan began, such Plan must also be approved by the *physician* who was the primary provider of *service* during such *hospital* stay.

The Home Care Plan must also be sent to Us. It will be reviewed by Our Medical Director. We may contest or question any items of the Plan before We pay any *Benefits*.

Only 40 Home Care visits per person in any 12-month period will be covered.

A Home Care visit shall mean a visit by a Home Care team or one of its members. It shall also mean a visit by a health aide providing *service* under the Home Care Plan. Each such visit will be thought of as one visit. A visit by more than one such team or member at the same time will be thought of as multiple visits. Up to four hours in a row in any 24-hour period will be thought of as one Home Care Visit.

EXTENDED CARE

We will provide coverage for up to 30 days of care if You or Your *Dependent* enters an *extended care facility* within 24 hours after discharge from a *hospital*. The attending *physician* must state, in writing, that such care is medically essential. Such written statement must be made and sent to Us every seven days.

Only continued *treatment* of the same *injury* or *sickness* that was treated in the *hospital* 24 hours earlier will be a *Covered Charge*.

EXTENDED CARE (CONTINUED)

The daily rate on which *Benefits* will be paid shall be the daily rate set at the time of *confinement* for that *extended care facility* by the appropriate state agency which sets rates/ standards. (The daily rate for *extended care facilities* not legally subject to review by a state agency shall be determined by Us.)

Care which is mainly domiciliary or *custodial care* is not a *Covered Charge*. Care which may be obtained without charge or cost to the person, or care available under a governmental health care program, is not a *Covered Charge*.

MENTALLY RETARDED AND PHYSICALLY HANDICAPPED DEPENDENT CHILDREN

Coverage for a *Dependent* Child will not *terminate* on the basis of age if:

(1) the *Dependent* Child is incapable of self-supporting employment as a result of mental retardation or a physical handicap; and
(2) the *Dependent* Child became incapable as described in (1) before reaching the *termination* age and while insured under the policy; and We receive written proof of the *Dependent* Child's incapacity within 31 days immediately following the date the *Dependent's* coverage would otherwise *terminate* as a result of age.

You must continue to pay *premiums* if any, on his/her coverage. At Our request, You must furnish further written proof that a *Dependent* Child's incapacity has continued without interruption. Upon receiving Your written proof of a *Dependent* Child's incapacity, We have the right to have the *Dependent* Child examined by a *physician* We choose. We may ask for an exam as often as is reasonably required, but not more often than once each year after the two years following the date the *Dependent* Child's incapacity began.

MENTALLY RETARDED AND PHYSICALLY HANDICAPPED DEPENDENT CHILDREN

The *Dependent* Child's coverage will immediately *terminate*:

(a) if We do not receive any required proof or medical exam as described above; or
(b) if the *Dependent* Child ceases to be incapable of self-supporting employment; or
(c) the date the *Dependent* Child's coverage *terminates* for any reason other than age. (See Termination provision.)

EXTENDED BENEFITS FOR TOTAL DISABILITY

We will continue to pay *Benefits* as described in the policy, to You and Your *Dependent* who are *totally disabled* on the date coverage would otherwise *terminate*. Such *total disability* must be continuous from the *termination date* to the date of such *treatment* or *service*. The *Benefits* payable under this provision shall be only for *Covered Charges* for *treatment* or *service* rendered as a direct result of the *injury* or *sickness* causing the *total disability*. *Benefits* will be payable until the earlier of:

(1) cessation of *total disability*; or
(2) 12 months after the *termination date*.

COVERAGE WITH MEDICARE

If *Covered Charges* are incurred by You or Your *Dependent* who is *eligible* for *Medicare*, We will determine the *Benefits* payable under the policy using the *Medicare* "Carve Out" method. When using this method *Benefits* will be determined as follows:

(1) *Covered Charges* are determined; and
(2) the amount *Medicare* pays or would pay for these same charges is subtracted from (1); and
(3) the balance, if any, is the amount We will use in computing the *Benefits* payable. (The *annual deductible* and the *coinsurance rate* will be applied before *Benefits* are paid on the balance.)

Persons eligible to apply for *Medicare* will be regarded as enrolled in and covered under both *Medicare* Parts A and B, whether or not they are actually enrolled in and entitled to *Benefits* under one or both Parts.

EXCLUSIONS AND LIMITATIONS

Covered Charges do not include and no *Benefits* are payable for:

(a) charges incurred while Your coverage is not in force, except as specifically provided for in the Extended Benefits for Total Disability provision;
(b) any *treatment* or *service* not medically essential to You or Your *Dependent's* health care;
(c) any *treatment* or *service* not prescribed or approved by a *physician;*
(d) charges for any *treatment* or *service* that is not accepted as essential to the *treatment* of an *injury* or *sickness* by all of the following: the American Medical Association, the U.S. Surgeon General, the U.S. Department of Public Health, or the National Institute of Health;

EXCLUSIONS AND LIMITATIONS

(e) any *treatment* or *service* for an *injury* or *sickness*:
  (i) covered by any Workers' Compensation Act or similar legislation; or
  (ii) arising out of or in the course of work for wage or profit if the employer is required or has the option to provide Workers' Compensation Coverage and does not (this exclusion shall not apply to sole proprietors and partners);
(f) charges due to cosmetic surgery, unless the following conditions are met:
  (i) the surgery must be required to remedy a condition that results from an *injury*; and
  (ii) the surgery is done within six months of an *injury*, or as soon as medically possible;
(g) charges for any of the following *services*, unless they are necessary for the diagnosis and *treatment* of a *sickness* or *injury*:
  (i) immunizations; and
  (ii) physical examinations (including lab charges, screenings, examinations and research studies);
(h) charges for routine well-baby care;
(i) charges for any of the following:
  (i) drugs for infertility; and
  (ii) in vitro and in vivo fertilization of an ovum; and
  (iii) artificial insemination; and
  (iv) birth control items or drugs;
(j) charges for marriage counseling and/or sex therapy;
(k) charges for:
  (i) any of the following items, including their prescription or fitting:
    (*a*) hearing aids;
    (*b*) optical or visual aids, including contact lenses and eyeglasses; and
    (*c*) wigs and hair transplants;
  (ii) any examination to determine the need for or the proper adjustments of any item listed above; and
  (iii) any procedure to correct refractive error;
(l) any dental X-rays or *treatment* or *service* to the teeth, gums or mouth (except as specifically provided for in the list of *Covered Charges*);

EXCLUSIONS AND LIMITATIONS

(m) *treatment* or *service* for temporomandibular joint syndrome (TMJ), myofacial syndrome or related disorders;
(n) charges for orthognathic surgery;
(o) charges for any *treatment* or *service* which is primarily for weight or dietary control, including but not limited to:
  (i) gastric bypass or gastric stapling procedures;
  (ii) any exercise programs (formal or informal and whether or not recommended by a *physician*;
(p) charges for drugs that are not approved by the Food and Drug Administration for general use;
(q) any *treatment* or *service* of behavioral disorders or learning disabilities;
(r) charges for speech therapy;
(s) charges for *custodial care*, even if *totally disabled* or *confined*;
(t) any *treatment* or *service* which is experimental in nature or charges for any testing, training or rehabilitation for educational, vocational or developmental purposes;
(u) charges for items generally used for personal comfort and/or useful to one's household;
(v) charges due to any *injury* or *sickness* that results from any of the following:
  (i) war or any act of war declared or undeclared;
  (ii) the commission of a felony;
  (iii) self-inflicted injuries;
(w) charges that in the absence of insurance would not be made, or charges for which there is no legal obligation to pay;
(x) any *treatment* or *service* provided by an *immediate family member*;
(y) any charges which are compensated for or furnished by the United States government or any of its agencies; and
(z) any *treatment* or *service* for which payment or reimbursement is received by or for You or Your *Dependents* as a result of a legal action or settlement.

PRE-EXISTING CONDITIONS LIMITATION

Any *injury, sickness*, or pregnancy for which *treatment* or *service* was received within 12 months before Your or Your *Dependent's effective date* is a pre-existing condition. *Benefits* are payable on *Covered Charges* for such pre-existing condition IF:

(1) at least six consecutive months pass while that person is insured under this Insurance without *treatment* or *service* for such condition. (*Treatment* or *service* for such condition received after such six months will be eligible for *Benefits*); or
(2) You or Your *Dependents* have been insured under this Insurance for 18 months. (*Treatment* or *service* for such condition received after the 18 months will be eligible for *Benefits*.)

COORDINATION OF BENEFITS (COB)

These provisions only apply if You or Your *Dependent* is eligible for or is entitled to benefits under another plan.

A plan is any group arrangement providing benefits or services for medical care including:

(1) any group or blanket insurance coverage; or
(2) any service insurance plan contracts; or
(3) any group practice, individual practice and other prepayment coverage; or
(4) any no-fault automobile insurance plan or program unless prohibited by state law; or
(5) any other arrangement providing benefits or services for medical care on a group basis whether insured or uninsured.

An allowable expense is any reasonable *usual* or *customary charge* that is at least partly covered under at least one of the plans covering the person for whom claim is made.

COORDINATION OF BENEFITS (COB)

When a plan provides benefits in the form of services rather than cash, the value of each service rendered will be considered to be both:

(1) an allowable expense; and
(2) a benefit paid.

USE OF COB. In computing the *Benefits* payable under this Insurance, the benefits from other plans will be taken into account. This may require a reduction in *Benefits* under this Insurance, so that the combined benefits will not be more than the allowable expenses of this Insurance and any other plan.

COMPUTATION OF BENEFITS UNDER COB. In a *calendar year*, this Insurance will always either pay its regular *Benefits* in full, or it will pay a reduced amount which, when added to the benefits payable and the cash value of any services provided by other plans, will equal 100% of the allowable expenses incurred by the person for whom claim is being made.

COORDINATION OF BENEFITS

ORDER OF BENEFIT DETERMINATION. To administer this provision properly, and to determine whether We will reduce the *Benefit* We would have paid if COB had not been included, it is necessary to determine the order in which the various plans will pay benefits. This will be determined as follows:

(1) A plan with no COB provision will be considered to pay its benefits before a plan that contains such a provision.
(2) A plan that covers a person other than as a dependent will be considered to pay its benefits before a plan that covers that person as a dependent.

(3) A plan that covers a person as a dependent of a male employee will be considered to pay its benefits before a plan that covers that person as a dependent of a female employee. However, if the parents of a dependent child are separated or divorced the following rules apply:
   (a) If there is a court decree that sets responsibility for the child's health care, a plan that covers the child as a dependent of the parent with such responsibility will be considered to pay its benefits before any other plan that covers the child as a dependent child.
   (b) If the parent with custody of the child has not remarried, a plan that covers the child as a dependent of that parent will be considered to pay its benefits before a plan that covers the child as a dependent of the parent without custody.
   (c) If the parent with custody of the child has remarried:
      (i) a plan that covers the child as a dependent of that parent will be considered to pay its benefits before a plan that covers that child as a dependent of the stepparent; and
      (ii) a plan that covers such child as a dependent of the stepparent will be considered to pay its benefits before a plan that covers the child as a dependent of the parent without custody.
(4) Where (1), (2) and (3) above do not establish the order of payment, the plan under which the person has been covered for the longer period of time will be considered to pay its benefits before the other. However, a plan that covers a person as an employee actively at work will be considered to pay its benefits before a plan that covers that person as a laid-off or retired employee.

RIGHT TO GIVE AND RECEIVE NEEDED INFORMATION. We may give any information to or receive any information from any other insurance company, organization, or individual as is needed in order to enforce the terms of this provision or any similar provision in any other plan. Notice to and consent of You or Your *Dependent* is not needed. You and Your *Dependent* shall furnish any information We need to enforce this provision.

FACILITY OF PAYMENT. We have the right to make payment of *Benefits* to any organization making payments on allowable expenses which should have been made under this Insurance in accordance with this provision. We will determine the amount needed to satisfy the intent of this provision. Such payments shall be considered *Benefits* paid under this Insurance and We will be fully relieved of liability to the extent of such payments.

RIGHT OF RECOVERY. If We make payments on allowable expenses in excess of the total amount then needed to meet the intent of this provision, We have the right to recover such payments to the extent of any excess. We will determine the excess and may recover from any or all of the following:

(a) any person to, for, or with respect to whom such payments were made; or
(b) any other insurer; or
(c) any other organization.

RIGHT OF SUBROGATION

If a third party or its insurer may be liable for any *sickness* or *injury* on which We have paid *Benefits*, We will be entitled to be repaid first from, and shall have a lien against, any recovery by You or Your *Dependent* from that third party or its insurer. We are entitled to be repaid the total amount of *Benefits* We paid before You or Your *Dependent* shall take from the recovery. We are entitled to such repayment, whether the recovery be by judgment, settlement, or otherwise. We are so entitled even if the third party or its insurer does not admit to or denies any liability. Subject to Our prior written approval, reasonable and necessary attorney fees incurred in obtaining such recovery may be deducted from the amount We are to be repaid.

If You or Your *Dependent* does not try to recover from such third party or its insurer, We shall be subrogated to Your or Your *Dependent's* rights to directly seek recovery from such third party or its insurer for the total amount of *Benefits* We paid. You or Your *Dependent* agrees to and will execute any documents in any way We require, or to aid Us in any way We require to secure a recovery. You or Your *Dependent* shall do nothing to prejudice or hinder Our rights under this provision in any way, including by settlement or otherwise, without Our prior written consent. If You or Your *Dependent* does so prejudice or hinder Our rights in any way, all *Benefits* already paid by Us under the coverages of the policy for that *sickness* or *injury* will be immediately refunded by You or Your *Dependent* to Us. In such case We are not liable for any further *Benefits* for that *injury* or *sickness*.

GENERAL RIGHT OF RECOVERY

If We have paid any amount of money that is not due, We have the right to be repaid to the full extent of any overpayment. We shall be repaid by any person to, for, or with respect to whom such monies were paid by Us. Our right of recovery under this provision is in addition to any rights We have under common law.

WORKERS' COMPENSATION NOT AFFECTED

The policy is not in place of and does not affect any requirements for coverage by Workers' Compensation Insurance or a Workers' Compensation Act or similar law.

NOTICE OF CLAIM

We must receive written notice of a claim for *Benefits* under the policy within 20 days or as soon as reasonably possible after such *treatment* or *service* was received. This notice must:

(1) be sent by You or someone acting on Your behalf; and
(2) be sent to *Our Office* at the address provided on Our claim forms; and
(3) state Your group number and certificate number; and
(4) identify the person who sustained the *sickness* or *injury*.

PROOF OF LOSS

Benefits will not be payable until We receive proof of loss. We will send You proof of loss forms within 15 days after We receive written notice of a claim. If We do not send these claim forms, then this written information will be treated the same as filing the claim forms.

Due written proof of loss includes: (1) claim forms which You have completed in full; and (2) the actual itemized bills for such *treatment* or *service*; and (3) any other necessary information We need to determine Our contractual liability for *Benefits* under the policy on the claim.

PROOF OF LOSS

We must receive due written proof of loss at *Our Office* within 90 days of the loss. When You fail to provide proof of loss within 90 days, Your claim will not be reduced or made invalid if it was not reasonably possible to provide such proof within 90 days. Proof of loss must be given as soon as reasonably possible. In no event, other than in the absence of legal capacity, may proof of loss be given after one year from the time such proof is otherwise required.

TIME OF PAYMENT OF CLAIMS

Benefits payable for coverages provided under the policy will be paid as soon as reasonably possible after We receive due written proof of loss as required under the Proof of Loss provision.

PAYMENT OF CLAIMS

All *Benefits* will be paid directly to the provider of medical *services*, unless You send Us paid receipts before We pay *Benefits*. If We receive receipts marked paid before We pay *Benefits, Benefits* will be paid to You or Your estate.

MEDICAL CONVERSION

You or Your *Dependent*, whose coverage *terminates* may *convert* the Medical coverage under the policy to *Conversion Coverage* offered by Us for this purpose provided:

(1) Such person has been covered under the policy for at least the 90 days immediately prior to his/her *termination date* of coverage; and

(2) the *Conversion Coverage* will not result in overinsurance or duplication of coverage as determined by Us; and

(3) We receive the *Application* and the first *premium* for the *Conversion Coverage* within 31 days following the *termination date* of coverage under the policy; and

(4) You or Your *Dependent's* coverage *terminated* as described under (a), (b), (c), or (d) as follows:

(a) You are eligible for *Conversion Coverage* upon *termination* of Your coverage under the policy for any reason except non-payment of *premiums* if Your *Application* for *Conversion Coverage* includes all Your *Dependents* who are covered under the policy at the time coverage *terminates*.

(b) Your *Dependent* spouse is eligible for *Conversion Coverage* upon *termination* of his/her coverage due to Your death if his/her *Application* includes himself/herself and Your *Dependents* who are covered under the policy at the time coverage *terminates*.

(c) Your *Dependent* spouse may apply for *Conversion Coverage* upon *termination* of his/her coverage due to divorce or annulment, if his/her *Application* includes all *Dependent* children who are awarded to the custody of the *Dependent* spouse.

(d) Your *Dependent* Child may apply for *Conversion Coverage* for himself/herself upon *termination* of his/her coverage if he/she ceases to be a *Dependent* as defined in the policy.

MEDICAL CONVERSION

If all of the requirements of (1), (2), (3) and (4) above are met, *Conversion Coverage* will be issued by Us in accordance with this provision and will be effective on the day immediately following the date coverage under the policy *terminates.*

We will not ask for any *evidence of insurability* for *Conversion Coverage.* The class of risk under the *Conversion Coverage* will be the same as the class of risk under the policy on the *termination date.* The *premium* for the *Conversion Coverage* shall be our then published *premium* rate for the form issued, the amount of coverage and for the persons age at the time the *Conversion Coverage* is effective.

Benefits payable under the *Conversion Coverage* shall not be reduced or denied on the basis that there is a pre-existing condition if *Benefits* for the condition would have been paid under the policy had such coverages not *terminated. Benefits* provided under the *Conversion Coverage* shall be reduced by the amount of any *Benefits* available under the policy.

Conversion Coverage will not be provided if, at the time of application, it will result in overinsurance or duplication of coverage. Overinsurance or duplication of coverage exists if:

(1) there is overinsurance or duplication of coverage according to the standards We have on file in the state where the *Conversion Coverage* is to be issued; and

(2) an *Application* for *Conversion Coverage* is made while You or Your *Dependent* is:

(a) a participant under any other group policy or plan providing coverages similar to the coverages of the policy; or

(b) eligible to apply for any other group policy or plan providing such similar coverages; or

(c) eligible, by reason of state or federal law, for a policy or plan providing such similar coverages; or

(d) eligible to apply for *Medicare* (Part A or Part B or both).

ANNUAL DEDUCTIBLE. Amount of *Covered Charges* which You and each *Dependent* must pay before *coinsurance* begins.

APPLICATION. (1) The form the Group Policyholder filled out asking for issuance of the policy; or (2) the form which You fill out asking for Insurance.

BENEFICIARY. A person designated by You who should receive *proceeds* under the policy upon Your death.

BENEFITS. Amount We will pay to You or to an assignee in accordance with the provisions of Your medical coverage.

CALENDAR YEAR. The period beginning on January 1st and ending on December 31st of the same year.

CHECK-O-MATIC PLAN. Standard method used to pay *premiums* whereby We are authorized to draw checks monthly from Your bank account.

COINSURANCE RATE. The arrangement whereby We pay some stated percentage of the *Covered Charges* (after the *annual deductible*) and You pay the rest of these same charges.

COMPLICATIONS OF PREGNANCY. This shall include: (1) Caesarean sections; and (2) ectopic pregnancy which is terminated; and (3) spontaneous termination of pregnancy occurring when a viable birth is not possible; and (4) conditions whose diagnoses are distinct from pregnancy or are caused by pregnancy such as: (a) acute nephritis or nephrosis; and (b) cardiac decompensation; and (c) missed abortion; and (d) other similar medical and surgical conditions of comparable severity. Complications of pregnancy shall not include: (1) false labor; or (2) occasional spotting; or (3) *physician* prescribed rest during pregnancy; or (4) morning sickness; or (5) hyperemesis gravidarum; or (6) pre-eclampsia; or (7) other similar conditions associated with the management of a difficult pregnancy but not constituting a nosologically distinct complication of pregnancy; or (8) any condition of pregnancy resulting from (a) normal pregnancy; or (b) normal childbirth; or (c) normal multiple birth; or (d) elective abortions or complications resulting from elective abortion.

CONFINEMENT/CONFINED. The situation in which a person, as determined by a *physician*, is unable to leave his/her home, a *hospital*, or a similar medical facility due to *injury* or *sickness*.

CONVERSION COVERAGE. New coverage which may be issued to You or Your *Dependent* who qualifies under the Conversion Privilege.

CONVERSION/CONVERT. Your or Your *Dependent's* right to be issued a new insurance policy when this Insurance or coverage hereunder *terminates* (for reasons listed).

COVERED CHARGES. Those charges for medical care or supplies for You or Your *Dependent* which qualify for consideration for *Benefits* under this Insurance.

CUSTODIAL CARE. *Treatment* or *service* which is rendered mainly to assist in daily living activities.

CUSTOMARY CHARGE. All or a portion of a provider's actual fee that does not exceed the amount regularly charged by other providers for the same *treatment* or *service* in that locality. A locality means a county or other geographical area as is needed to establish a representative base of charges. We will determine what is a *Customary Charge*.

DENTIST. A person who is validly licensed to practice dentistry and is acting within the scope of his/her license. A *dentist* shall also mean a licensed *physician* performing dental *services* within the scope of his/her license.

DEPENDENT. Your legal spouse and any of Your children who are unmarried and less than 19 years of age. (Life coverage begins at 14 days of age; medical coverage begins from the moment of birth;) A *Dependent* can not be either an insured employee under a similar plan with Us or in the Armed Forces of any country. A "child" includes Your natural child, legally adopted child, stepchild or *foster child* who is dependent upon You for his/her main care and support and for whose medical care You are responsible. For medical coverage only, a "child" also means any child who is 19 or over, but less than 24 years of age and is: (1) not married; and (2) a *full-time student*.

EFFECTIVE/EFFECTIVE DATE. The date Insurance begins as determined by Us. The date the policy begins.

ELIGIBLE. Qualified for coverage under the policy by meeting the requirements of the Eligibility provision.

EVIDENCE OF INSURABILITY. Health history information We need to make a decision to insure You or Your *Dependent*. This information must be provided to Us on forms provided by Us for this purpose.

EXTENDED CARE FACILITY. An institution, or part of one, which is operated pursuant to law. As its main function, it must provide *treatment* and *services* to persons convalescing from *injury* or *sickness* and have: (1) organized facilities for medical *treatment* or *service*; and (2) 24-hour nursing service under the full-time supervision of a *physician* or graduate registered nurse; and (3) daily clinical records; and (4) transfer arrangements to one or more *hospitals*; and (5) a utilization review plan in effect; and (6) rules for operation set up and reviewed by a professional group including at least one *physician*. A facility which is, or is used primarily as, a hotel, nursing home, rest home, home for the aged, or a place for the *treatment* or *service* of *mental disorders* or for training or custodial purposes is excluded.

FOSTER CHILD. A child who qualifies as a *Dependent* under the policy and for whom: (1) You have a legal document which shows that You are responsible for the medical expenses of such child; and (2) You are licensed by Your state of residence to act as a foster parent, if such license is required.

FULL-TIME STUDENT. A person attending an accredited school and continuously enrolled in enough class hours to be considered full-time by such school. Coverage on a *full-time student* will continue during school vacations if: (1) he/she was enrolled as a *full-time student* immediately prior to school vacation; and (2) he/she plans to return to full-time status the next school term.

HOSPITAL. An institution, or any part of one, that is not an *extended care facility* as defined under the policy and which: (1) is operated pursuant to law for the *treatment* or *service* of sick or injured persons; and (2) has all of the following: (a) organized facilities for diagnosis of *injury* or *sickness*; and (b) organized facilities for *treatment* or *service* by or under the supervision of one or more *physicians*; and (c) surgical facilities or a formal arrangement with another institution for surgical facilities (requirement [c] is waived for an institution for the *treatment* or *service* of *mental disorders* which would otherwise qualify as a *hospital*); and (d) 24-hour nursing care by graduate registered nurses. A facility which is, or is used mainly as, a hotel, rest home, nursing home, or for training or custodial purposes is excluded.

IMMEDIATE FAMILY. Your spouse, children, parents, grandparents, grandchildren, brothers and sisters. This includes such persons whether related by blood or marriage.

INJURY. Accidental bodily injury that occurred while insured under this Insurance that is: (1) unforeseen; (2) unexpected; (3) involuntary; and (4) due to violent and external means. All complications of such injury are included.

MEDICARE. Federal program of medical care benefits provided under Title XVIII of the Social Security Act of 1965, as amended.

MENTAL DISORDER. Illness for which psychotherapy is required.

OUR EXECUTIVE OFFICERS. The President, one of the Vice Presidents and the Secretary of Central Life.

OUR OFFICE. Central Life Assurance Company's address as shown on the front cover of this certificate.

PHYSICIAN. Any person who is validly licensed to practice medicine in the state where the *treatment* or *service* is provided. It includes any validly licensed chiropractor, psychologist, podiatrist, optometrist or osteopath acting within the scope of his/her license.

PREMIUMS. The amount due on the first of each month to maintain coverage in force for You and Your *Dependent*.

PROCEEDS. Amount payable under Your life coverage upon Your death as stated in the policy. It is also the amount payable under Your *Dependent's* life coverage upon the death of Your *Dependent*.

REINSTATE/REINSTATEMENT. Our decision to put Your Insurance in force again.

SERVICE. (1) Diagnosis; or (2) consultation; or (3) advice; or (4) referrals; or (5) supplies, provided by or ordered by a *physician.*

SICKNESS. (1) Any condition of the body which hinders and prevents an organ from normally functioning; or (2) any affliction of the body which deprives it temporarily of the power to fulfill its usual functions.

DEFINITIONS

TERMINATE/TERMINATION DATE. When coverage under the Plan of Insurance ends.

TOTALLY DISABLED/TOTAL DISABILITY. Unable to carry on the normal activities of a healthy person of the same age and sex.

TREATMENT. Medical, surgical, or psychiatric management of a patient by a provider of medical *services.* This includes medication which requires a prescription from a *physician*.

USUAL CHARGE. The actual fee a provider regularly charges and receives for a given *treatment* or *service*. We will determine what is a usual charge.

WE/US/OUR. Central Life Assurance Company.

YOU/YOUR. The Subscriber under the Plan of Insurance.

Centralife

January 30, 1989

Dear Certificateholder:

As you may be aware, there has been a continuing increase in the utilization of health care services across the United States. This, combined with the increasing health care costs, has made it necessary for us to make revisions to your Central Life Plan of Insurance Certificate.

Listed below are the Benefit revisions which will be effective on your first six month renewal:

1. Normal maternity charges, including elective C-Sections, will no longer be covered.

2. Mental and Nervous disorder charges, including those for alcohol and drug-related disorders, will no longer be covered.

3. The extension of benefits for Total Disability will be reduced to 45 days maximum coverage, with the exception that, if you or your Dependent is currently on extension of benefits, this revision will not apply.

4. Treatment or service pertaining to the performance of or the reversal of any of the following will be excluded from coverage:
   a. voluntary tubal ligation
   b. voluntary vasectomy
   c. voluntary sterilization

5. Treatment or service provided by a physician for manipulative and physical therapy will be limited to $500.00 per calendar year.

6. Treatment or service pertaining to optometric vision therapy and orthoptics will be excluded from coverage.

You may expect to receive the revised Certificate Booklet pages 31 days prior to your first six month renewal.

We hope that these revisions to your Plan of Insurance Certificate will enable us to provide you with health care coverage at a cost which is affordable to you.

If you have any questions, please call us at 1-800-456-4515 or 1-800-456-4516.

Sincerely,

Dave Astar
Vice President, Group Products

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