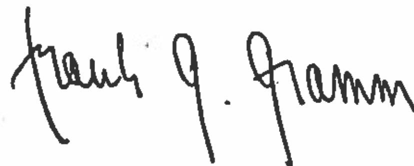
MAJOR MEDICAL EXPENSE COVERAGE

We will pay you benefits for covered loss due to Sickness and Injury as described in this Certificate. This Certificate is evidence of your coverage; it is not the Insurance Contract. Benefit payment is governed by the terms of the Insurance Contract.

NOTICE OF 10 DAY RIGHT TO EXAMINE CERTIFICATE

Please read your Certificate carefully. If you are not satisfied, return it to our Home Office or to your agent within 10 days after the date you receive it. We will then cancel your coverage as of its effective date and refund any premium you have paid for it.

Donald M. Peterson
President & Chief Executive Officer



Frank G. Gramm
Corporate Secretary & General Counsel

CERTIFICATE OF INSURANCE
MAJOR MEDICAL EXPENSE COVERAGE

TABLE OF CONTENTS

	Page
Alcoholism Benefit	10
Benefit Provisions	7
Certificate Number	3
Claims Provisions	15
Conversion Privilege	7
Coordination of Benefits	16
Cost Containment Procedures	11
Covered Charges	8
Covered Members	3
Deductible	8
Definitions	4
Effective Date of Coverage	3
Eligibility for Coverage	5
Exclusions	13
Extension of Benefits	7
Foreign Travel Coverage	10
Grace Period	15
Handicapped Dependents	6
Insured Percent	3
Lifetime Maximum Amount	8
Mental Illness Benefit	10
Newborn Children	6
Organ Transplants	11
Out-of-Pocket Limits	10
Pre-Certification Procedures	12
Preexisting Conditions Limitation	13
Premium Provisions	14
Reinstatement	15
Schedule	3
Termination of Individual Coverage	6

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

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

I. DEFINITIONS OF CERTAIN WORDS USED IN THIS CERTIFICATE

We, us and our: Means Benefit Trust Life Insurance Company.

You and your: Means the Insured named in the Schedule.

Covered Member and member: Means any person insured under this Certificate. Covered Members are listed in the Schedule (or its latest amendment).

Injury: Means injuries resulting, directly and independently of all other causes, from accidents which occur after the effective date of a member's coverage.

Sickness: Means illness, disease or Complications of Pregnancy which are first manifested after the effective date of a member's coverage; and such conditions disclosed in the application which are not specifically excluded.

Complications of Pregnancy: Are conditions which are not part of a normal pregnancy, but are caused by, or made worse by, pregnancy. This includes: ectopic pregnancy or similar surgery; spontaneous termination of pregnancy during a time a viable birth is not possible; eclampsia; puerperal infection; missed abortion; RH factor problems; severe loss of blood requiring transfusions; acute nephritis; nephrosis; cardiac failure; hyperemesis gravidarum; and other similarly severe conditions related to pregnancy.

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

Mental Illness: Means neurosis, psychoneurosis, psychopathy, psychosis and mental disease or disorders as defined in the Diagnostic and Statistical Manual of Disorders of the American Psychiatric Association which are first manifested after the effective date of a member's coverage; and such conditions disclosed in the application which are not specifically excluded.

Deductible: Means the amount of Covered Charges a Covered Member must incur in a calendar year before benefits are paid for him. The Deductible is shown in the Schedule.

Insured Percent: Means the percent of Covered Charges that we will pay. The Insured Percent is shown in the Schedule.

Physician: Means a duly licensed physician, surgeon or chiropractor who is acting within the scope of his license. This does not include a Family Member.

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

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

Speech Therapist: Means a licensed speech therapist. This does not include a Family Member.

Family Member: As used above means you, your spouse, parent, child, brother, sister or in-law.

Hospital: Means a place which is all of the following. (1) It is licensed as a hospital. (2) It provides inpatient care. (3) It provides 24-hour nursing service by, or supervised by, a Registered Graduate Nurse (R.N.).

'Hospital' does not include: a convalescent, nursing or rest home; a Skilled Nursing Home or an extended care or intermediate care facility; a home for the aged; or a custodial care or educational care facility.

Intensive Care Unit: Is 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.

Free Standing Surgical Center: Means a place licensed as a free standing or ambulatory surgical center. The center must be operated for the purpose of providing outpatient surgical care. Services and supplies provided by such a center are covered as if they had been provided by a Hospital on an outpatient basis.

Skilled Nursing Home: Means a place which is all of the following. (1) It is operated lawfully. (2) It provides room and board accommodations at the patient's expense. (3) It keeps a daily medical record of each patient. (4) It regularly provides skilled nursing care supervised by a licensed Physician. (5) This skilled nursing care is provided by, or supervised by, a Registered Graduate Nurse (R.N.).

'Skilled Nursing Home' does not 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.

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 Member and his immediate family after he has been diagnosed by a Physician as terminally ill.

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.

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 your home. 'Confinement' must be caused by Sickness or Injury. The confined member must be under a Physician's care for the Sickness or Injury causing the Confinement.

Medically Necessary: Means drugs, therapies, procedures or treatments done or prescribed by a Physician that are required and appropriate for the Sickness or Injury; and are given in accordance with generally accepted principles of medical practice in the U.S. at the time furnished; and that are not experimental, educational or investigational in nature; and that are not furnished in connection with medical or other research; and are not solely for the convenience of the Physician or the patient.

Insurance Contract: The contract between us and the contract holder which governs payment of the benefits described in this Certificate. The contract holder is the Tele-Med Group Medical Insurance Trust.

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

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

II. ELIGIBILITY FOR COVERAGE

A. ELIGIBLE PERSONS

Persons who are eligible to become Covered Members are any of the following who meet our underwriting standards.

1. You.
2. Your spouse.
3. Your, or your spouse's, child who is over 14 days and 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 or who resides with you.

A child is eligible for coverage only if: (a) he is unmarried; and (b) he is dependent on you for support and maintenance. A 'child' includes an adopted child.

B. BECOMING COVERED

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

1. Apply in writing.
2. Provide us with evidence satisfactory to us of the insurability of the person.
3. Pay the premium for his coverage.

If we find an eligible person does not meet our underwriting standards, we may: refuse to insure that person; insure that person but exclude a specific disease or physical condition from coverage; or make a surcharge for that person's coverage.

Coverage starts at 12:01 a.m. standard time at your home, on the effective date shown in the Schedule.

C. NEWBORN CHILDREN

A child born to you while your coverage is in force is automatically covered. He remains so for 31 days, or until the end of the period for which premium has been paid, if later. To continue his coverage, notify us in writing within 45 days after his birth, or before the end of the period for which premium has been paid, if later, and make timely payment of the premium for his continued coverage.

A covered newborn has the same coverage as any other Covered Member, starting the day of birth. Birth abnormalities and congenital defects of such newborns which require medical care are covered as Sickness. The Preexisting Condition limitation does not apply. There is no coverage for: routine nursery care; well baby care; circumcision; or immunizations, medical examinations or tests of any kind not related to treatment of Sickness or Injury.

III. TERMINATION OF INDIVIDUAL COVERAGE

A. WHEN COVERAGE ENDS

A Covered Member's coverage ends at 12:01 a.m. standard time at your home at the earliest of the following.

1. On the premium due date next following the member's 65th birthday or earlier eligibility for Medicare.
2. At the end of the grace period for an unpaid premium.
3. For a spouse – on the premium due date next following the date of divorce or annulment.
4. For a child – on the premium due date next following the earliest of his 24th birthday; his marriage; or the date he stops being your dependent as provided in Section II.
5. When the Insurance Contract terminates. You will be given prior written notice if this occurs.
6. When coverage under the Insurance Contract is terminated for your insurance class. You will be given prior written notice if this occurs.

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 your Certificate.
2. His incapacity must continuously prevent him from earning his own living.
3. He must continue, except for his age, to be eligible for coverage.
4. Your Certificate must remain in force.
5. Proof of his incapacity and dependency must be furnished within 31 days of the age his coverage would otherwise end.

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.

C. CONTINUATION OF COVERAGE AFTER DEATH OF THE INSURED

If you die while this Certificate is in force, coverage may be continued for any surviving Covered Members until the last member's coverage ends according to Section 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. PREMIUM CHANGE

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

IV. EXTENSION OF BENEFITS

If a Covered Member is Disabled on any date we terminate the Insurance Contract or terminate coverage for your insurance class, an extension of benefits will be provided. Benefits will be extended:

1. only for a Disabled member; and
2. only while he remains continuously Disabled; and
3. only for the Sickness or Injury which causes him to be Disabled; and
4. only if he incurs the first Covered Charge for such Sickness or Injury before we terminate his coverage.

Benefits are extended to the earliest of:

1. the date he is no longer Disabled;
2. the date his Maximum Amount is paid;
3. the end of a 6 month period following the date we terminate his coverage; or
4. the date he becomes covered under any other group medical plan.

Extended benefits will be paid on the same basis that they would be paid if coverage had not ended.

As used above, 'Disabled' means a Covered Member is, due to Sickness or Injury, not capable of performing his normal duties or activities. A Physician must certify that the member is so Disabled.

V. CONVERSION PRIVILEGE

If a spouse's coverage ends due to divorce, or if a child's coverage ends due to age, the spouse or child can convert to his own coverage. In the case of divorce, the spouse will have the option of insuring any covered children under the new coverage. No information about health will be required. He must apply to our Home Office, in writing, within 31 days of the date his coverage under this Certificate ends. He must also pay the first premium for the new coverage within such 31 days. The new coverage will provide benefits we are then issuing which are most like, but not greater than, this Certificate's benefits. The premium will be based on our rates in effect at the time of conversion. The then attained age and insurance classification of the Covered Member will be used. The new coverage will not cover loss for which benefits are payable under this Certificate. It will exclude any condition which is excluded by this Certificate. The Maximum Amount of the new coverage will be the unused portion of the member's Maximum Amount under this Certificate as of the date of conversion. All probationary or waiting periods of the new coverage will be considered as starting from the member's effective date under this Certificate.

VI. BENEFIT PROVISIONS

A. BENEFIT PERIODS

This Certificate has a calendar year benefit period. Each benefit period starts on the first day of the calendar year on which a person incurs a Covered Charge and ends December 31 of the same year.

B. DEDUCTIBLE

This Certificate has a calendar year Deductible. Subject to the Cost Containment Procedures, the Deductible is the dollar amount shown in the Schedule as the Deductible. Once Covered Charges incurred by a Covered Member in a calendar year equal the Deductible, benefits are payable for any additional Covered Charges he incurs in that year.

Each Covered Member must meet a new Daductible each calendar year, with the following exceptions.

1. Once three Covered Members have met their Deductible for the year, no others need meet it for that year.
2. If two or more Covered Members are injured in the same accident, only one Deductible will be applied to all Covered Charges arising out of the accident during the calendar year.

C. LIFETIME MAXIMUM AMOUNT

There is a Lifetime Maximum Amount for benefits. It is the maximum amount of benefits we will pay for any one Covered Member during his lifetime for all Covered Charges incurred in all benefit periods. The Lifetime Maximum Amount is shown in the Schedule.

D. BENEFITS PAYABLE

After the Deductible has been met, we pay the Insured Percent of Covered Charges incurred by a Covered Member during a calendar year, up to the Lifetime Maximum Amount, subject to the Coordination of Benefits provision.

E. COVERED CHARGES

Covered Charges are only the charges listed below, up to any limits shown, which:

1. are Medically Necessary for the care and treatment of Sickness or Injury;
2. are prescribed by a Physician; and
3. do not exceed the Usual and Customary Charge made for the service or supply; and
4. are incurred while a member's coverage is in force or under the extension of benefits.

The 'Usual and Customary Charge' is 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.

A charge is considered to be incurred on the date the service is rendered or the supply furnished.

Covered Charges are the following.

- Daily room, board and general nursing care charges during a Hospital Confinement, up to the daily rate for the greatest number of 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 general nursing care charges during Confinement in an Intensive Care or Cardiac Care Unit. For any day we pay this benefit, we will not pay the above room and board benefit.

- Charges by a Hospital or a Free Standing Surgical Center for services, supplies, drugs and medicines needed for the Covered Member's care.

- Physician's charges for medical care, consultations or surgery, except charges for manipulative treatments, heat treatments or ultrasound.

- Physician's charges for manipulative treatment, heat treatments or ultrasound, up to 18 visits and a $1,000 maximum per calendar year. 'Manipulative treatment' means the diagnosis, analysis and adjustment of spinal subluxations and diagnosis, manipulative therapy and the related treatment of the musculoskeletal structure for other than fractures and dislocations of the extremities.

- Anesthetics and their administration.

- Skilled Nursing Home charges for daily room, board and skilled nursing care, up to 60 days per calendar year. Benefits are paid only for Confinement which starts within 14 days after a Hospital Confinement of at least 3 days; and which is for continuing treatment of the Sickness or Injury which caused the Hospital Confinement.

- Home Care charges for care which starts within 14 days after a Hospital Confinement of at least 3 days or after a Confinement in a Skilled Nursing Home for which benefits were payable. Benefits are paid for up to 60 Home Care visits per calendar year, limited to one visit per day. Benefits are paid only for Home Care provided in lieu of Hospital or Skilled Nursing Home Confinement; and for services or supplies that would be covered if provided in a Hospital or Skilled Nursing Home. One 'Home Care visit' is 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.

  Covered Home Care services are: nursing services; physical or speech therapy; medical supplies, prescription drugs and lab services; home health aide services that are mainly of a medical or therapeutic nature; nutritional services; and the evaluation of the need for and the development of a Home Care plan.

  Services and supplies not covered are: those provided by a person who usually lives in your home or who is a Covered Member; those provided mainly to aid in normal activities of daily living; those received for any period when the Covered Member is not under the continuing care of a Physician; or those furnished outside the Covered Member's home.

- Charges for services, supplies, drugs and medicines provided by a hospice as part of a Hospice Care plan. Benefits are paid for up to a $3,000 lifetime maximum, and a maximum of 30 days inpatient Hospice Care. This benefit will not duplicate any other benefits payable under your Certificate.

- Rental, not to exceed purchase price, of a wheelchair, hospital-type bed or iron lung.

- Casts, splints, trusses, crutches, surgical dressings and braces except dental braces.

- Rental or the first purchase of a prosthetic device when medically required because of Sickness or Injury. Covered devices are: heart pacemakers; braces for support or augmentation of a natural function; artificial limbs; artificial eyes, intraocular lens implant or the first contact lenses or glasses following cataract surgery; breast implants after removal due to Sickness and the first external breast prosthesis; kidney dialysis equipment that is not payable under Medicare; replacement of the devices listed above if due to progression of a Sickness or Injury; or growth of a child.

  These devices are not covered: glasses and contact lenses except as listed above; braces, spacers, retainers, artificial teeth or denture crowns; bridges and other dental prosthesis; hearing aids; support hose, corsets and other body support garments; wigs, hair pieces and hair transplants; breast augmentation; shoes, arch supports or other such items; replacement of a prosthesis due to loss, damage, wear or obsolescence.

- Private duty nursing charges for services that are: authorized by a Physician; and provided outside of a Hospital. Benefits are paid for up to 30 days per calendar year.

- Charges of a Physical Therapist or Speech Therapist for services authorized by a Physician.

- Charges for radioactive and x-ray therapy.

- Charges for x-rays, laboratory tests, and drugs and medicines which require a prescription and are purchased from a licensed pharmacist. Dental x-rays are covered only if required for removal of a cyst or tumor; or due to Injury to natural teeth and done within 6 months of the accident.

- Charges for blood and blood plasma, oxygen and rental of equipment for its administration.

- Charges for transportation of a covered newborn to and from the nearest appropriately staffed and equipped treatment facility, when the attending Physician certifies that it is necessary to protect the health and safety of the child. Benefits are paid up to $200.00

- Local professional ambulance charges.

VII. MENTAL ILLNESS BENEFIT

There is limited coverage for Mental Illness. Benefits are payable as described in Section VI. BENEFIT PROVISIONS. But, they are only paid for up to 30 days of Confinement per calendar year at a Hospital or any other facility licensed to treat the condition. For outpatient treatment, they are only paid for 50% of Covered Charges incurred, limited to a $25 maximum benefit per visit, one visit per week, and 20 visits per calendar year. Benefits are paid up to the Mental Illness Lifetime Maximum shown in the Schedule. This maximum is the total amount of benefits we pay for any one Covered Member during his lifetime for all Covered Charges incurred for Mental Illness.

The 50% of Covered Charges you must pay for outpatient treatment of Mental Illness will not count toward the out-of- pocket limits described in Section IX.

VIII. ALCOHOLISM BENEFIT

There is limited coverage for alcoholism. Benefits are payable as described in Section VI. BENEFIT PROVISIONS. But, they are only paid for up to $1,000 per calendar year.

IX. OUT-OF-POCKET LIMITS

We will pay 100% of Covered Charges for the rest of the calendar year for each Covered Member after:

1. the 20% of Covered Charges you must pay for the member in that year reaches the Individual Out-of-Pocket Limit shown in the Schedule; or

2. the 20% of Covered Charges you must pay for one or more Covered Members in that year reaches the Family Out-of-Pocket Limit shown in the Schedule.

The following will not count toward the above limits: (1) the portion of any expense in excess of the Covered Charge; or (2) the 50% of Covered Charges you must pay for Mental Illness; or (3) any expense for services or supplies not covered by the Certificate; or (4) any additional amount you must pay due to your failure to follow the cost containment procedures; or (5) the Deductible.

The above limits will not operate to provide benefits in excess of any maximums for the type of expense; or to provide benefits in excess of a member's Lifetime Maximum Amount.

X. FOREIGN TRAVEL COVERAGE

There is limited coverage while a Covered Member is traveling outside of the U.S. and its territories or 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.

XI. ORGAN TRANSPLANTS

We will pay benefits for the recipient of an organ transplant; but, the total of all beneifts we will pay in connection with any one body organ will not exceed the Organ Transplant Maximum shown in the Schedule. In the event that total benefits payable for an organ transplant procedure are less than this maximum, the difference will be available to pay any medical expenses of a live donor which are related to the procedure and which are not payable by any other source.

XII. AIDS AND AIDS RELATED COMPLEX (ARC)

There is limited coverage for treatment of Acquired Immune Deficiency Syndrome (AIDS) and AIDS Related Complex (ARC). Benefits are payable as described in Section VI. BENEFIT PROVISIONS. But, they are only paid up to the AIDS and ARC Lifetime Maximum shown in the Schedule.

XIII. COST CONTAINMENT PROCEDURES

Your premium is based on factors that assume that the cost saving procedures explained next will be followed. If a prescribed procedure is not followed, then benefits will be reduced as explained next.

A. REQUIRED OUTPATIENT SURGERY

The surgical procedures listed below must be done on an outpatient basis unless: your Physician provides us with acceptable certification that Hospital Confinement is required for medical reasons; or appropriate outpatient facilities are not available within 50 miles of the Covered Member's home.

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

If the surgery is not done on an outpatient basis (and the exceptions above do not apply) benefits for charges related to the surgery will be reduced as follows:

1. the Deductible will be increased by $250 for each such surgery; and
2. the Insured Percent will be reduced from 80% to 70% for each such surgery.

The additional 10% that you must pay will not count toward the out-of-pocket limits and must be paid even if those limits have been reached. But, the additional 10% will only apply until this additional amount reaches $1,000 of charges per surgical procedure.

Procedures which must be done on an outpatient basis:

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

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.

All Hospital admissions 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. If our Pre-Certification Service is contacted less than 2 working days before admission, benefits will be reduced as if the member did not follow these Cost Containment Procedures. 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, 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.

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 the 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.

An "emergency admission" as used above means entering the Hospital for a Sickness or Injury that requires immediate treatment to prevent loss of life or impairment of body functions.

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

If the Covered Member does not follow these procedures, benefits payable for charges related to the Confinement will be reduced as follows:

1. the Deductible will be increased by $250 for each such Confinement; and

2. the Insured percent will be reduced from 80% to 70% for each such Confinement.

The additional 10% you must pay will not count toward the out-of-pocket limits and must be paid even if those limits have been reached. But, the additional 10% will only apply until this additional amount reaches $1,000 of charges per Confinement.

If the member 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.

XIV. PREEXISTING CONDITIONS LIMITATION

This Certificate does not cover any charge incurred or Hospital Confinement starting during the first two years of a member's coverage which is caused by a Preexisting Condition.

'Preexisting Condition' means a condition misrepresented or not disclosed in the application for which either: symptoms existed within the 12 months before the effective date of a member'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 12 months before the effective date of a member's coverage.

XV. EXCLUSIONS AND LIMITATIONS

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

- Suicide or attempted suicide, while sane or insane.
- Intentionally self-inflicted injury, while sane or insane.
- Rest cures or custodial care.
- The Covered Member's commission of, or attempt to commit, a felony.
- War, or act of war, declared or undeclared, and occurring after the member's effective date.
- Expense incurred while in the military, naval or air service of any country. Any premium paid for a Covered Member for period that he is in such service will be returned pro rata upon notice of entry into such service.
- Routine physical examinations, x-rays or test procedures not related to diagnosis or treatment of a specific Sickness or Injury.
- Dental surgery or treatment, unless caused by injury to natural teeth. Bridgework attached to injured teeth is not covered.
- 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.
- Radial keratotomy.
- Eye refractions or eyeglasses.
- Hearing aids or fitting thereof.

- A condition for which a Covered Member is eligible to receive Workers Compensation or Occupational Disease Act or Law benefits.
- Services or supplies for which no charge is normally made in the absence of insurance.
- Service or supplies provided by the Veterans Administration, under any law (including Medicare), or by any government unit for which you (or the Covered Member) are, or become, eligible. This exclusion will not apply if you are legally required to pay for such service or supplies, or to Medicaid.
- Normal pregnancy, childbirth or routine nursery care.
- External fertilization procedures.
- Sterilization procedures or reversal of such procedures.
- Sex change surgery. This includes all related services and supplies whether furnished prior to, after, or in lieu of such surgery.
- Drug abuse or chemical dependency.
- Drugs, therapies, procedures or treatments which are experimental; or are not approved for reimbursement by the Health Care Financing Administration (or its successor); or which we determine not to be Medically Necessary.
- Temporomandibular Joint (TMJ) Dysfunction Syndrome, except for surgery to the temporomandibular joint and expenses related to the surgery.

During the first 6 months after the effective date of a member's coverage, no benefits are paid, except for treatment on an emergency basis, for: hemorrhoids; removal of tonsils and/or adenoids; or disorder of the reproductive organs.

XVI. PREMIUM PROVISIONS

PAYMENT OF PREMIUM

The first premium for your coverage is due on or before your effective date. Premiums are then due on each subsequent premium due date or before the end of the grace period. All premiums are payable to us at our Home Office.

RENEWAL PREMIUMS

Renewal premiums are based on our rate schedule in use on the premium due date. We have the right to change our rate schedule. If such a change is made, it will be on an insurance class basis. Your premium will not change because of the health or claim experience of any Covered Member.

CHANGE OF PREMIUM DUE TO CHANGE OF RESIDENCE

Your premium may change if you move to a different zip code. You must notify us of any such move.

CHANGE OF PREMIUM DUE TO CHANGE IN AGE

Your premium will change due to a change in age. It will change on the anniversary of your effective date. It will be based on each member's age on his last birthday.

CHANGE OF PREMIUM DUE TO MISSTATEMENTS IN THE APPLICATION

Your premium may change if the age, sex, smoking status or zip code of a Covered Member has been misstated in the application.

GRACE PERIOD

There is a 31 day grace period for payment of each premium after the first. During the grace period the coverage remains in force. The grace period will not apply if, at least 30 days before the premium due date, we have delivered or mailed to your last address shown in our records written notice of our intent not to renew your coverage.

REINSTATEMENT

If a premium is not paid before the grace period ends, coverage will end. If we later accept the premium without requiring a reinstatement application that will automatically reinstate the coverage. If we require an application, and if the application is approved, the coverage will be reinstated as of the approval date. Lacking such approval, the coverage will be reinstated on the 45th day after the date of the application unless we have previously written you of its disapproval. The reinstated coverage will only cover loss that results from an Injury sustained after the date of reinstatement and Sickness that starts more than 10 days after such date. In all other respects your and our rights will remain the same, subject to any provisions endorsed on or attached to your Certificate at the time coverage is reinstated.

XVII. CLAIMS PAYMENT PROVISIONS

Notice of Claim: Written notice of claim must be given within 30 days after a covered loss starts or as soon as reasonably possible. The notice can be sent to us at our Home Office, or to our agent. Notice should include your name and Certificate number.

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.

Proofs of Loss: Written proof of loss must be sent to us within 90 days after such loss. If it was 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 required must be sent no later than one year from the time specified unless you were legally incapacitated.

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

Payment of Claims: Benefits will be paid to you, unless you assign them to a health care provider. Any benefits unpaid at death will be paid to your estate. If benefits are payable to your estate, we can pay up to $1,000 of benefits to someone related to you 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.

PHYSICAL EXAMINATIONS

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

XVIII. GENERAL PROVISIONS

TIME LIMIT ON CERTAIN DEFENSES

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

No claim for loss incurred after two years from the date a person becomes a Covered Member will be reduced or denied because a condition not excluded by name or specific description on the date of loss had existed before the effective date of his coverage.

LEGAL ACTIONS

No legal action may be brought to recover on the Insurance Contract within 60 days after written proof of loss has been given as required. No such action may be brought after 3 years from the time written proof of loss is required to be given.

UNPAID PREMIUM

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

STATEMENTS IN THE APPLICATION

All statements made in your application are considered to be representations and not warranties.

ASSIGNMENTS

Assignments of benefits must be received by us to be binding on us. We are not responsible for the validity of an assignment.

ALTERATION OF INSURANCE CONTRACT

The Insurance Contract may be amended at any time as agreed upon by the contract holder and us. Any such amendment may be done without notice to, or consent of, any person insured under the Insurance Contract. Any such amendment will be binding on all persons covered under the Insurance Contract whether they became covered before or after the effective date of the amendment. But, no such amendment will affect any claim originating prior to the effective date of the amendment.

XIX. COORDINATION OF BENEFITS

A. DEFINITIONS

Coordination of Benefits: Means taking other Plans into account when we pay benefits. Coordination of Benefits apply separately to Major Medical and Dental Benefits.

Plan: Any plan, including this one, that provides benefits or services for medical or dental care expenses on a group basis. "Plan" includes group and blanket insurance and self-insured and prepaid plans. It includes government plans, plans required or provided by statute (except Medicaid), and no fault insurance (when allowed by law). "Plan" shall be treated separately for each contract or other program for benefits or services. "Plan" shall be treated separately for that part of a Plan which reserves the right to coordinate with benefits or services of other plans and that part which does not.

Allowable Expense: A necessary, usual and customary expense incurred due to Sickness or Injury which is covered by at least one of the Plans providing benefits to the person making claim. When a Plan provides benefits by services, the cash value of each service will be treated as both an Allowable Expense and a benefit paid.

Primary Plan: Means the Plan that pays benefits before all other Plans.

B. WHEN COORDINATION OF BENEFITS APPLIES

Coordination of Benfits will apply if the sum of 1. and 2. below would exceed Allowable Expense incurred during the calendar year.

1. The benefits that would be paid under this Certificate in the absence of coordination.

2. The benefits that would be paid under all other Plans in the absence of provisions for coordination in those Plans

C. REDUCTION OF BENEFITS UNDER COORDINATION

When Coordination of Benefits applies and this is not the Primary Plan, benefits may be reduced. They will be reduced so that the sum of the benefits paid under this Certificate, plus benefits payable under all other Plans, does not exceed total Allowable Expense.

D. RULES FOR THE ORDER OF BENEFIT PAYMENT

1. When, by the rules below, this is the Primary Plan, we will pay benefits as if there were no other Plans.

2. When a person is covered by a Plan without a coordination provision, the Plan without the provision will be the Primary Plan.

3. When a person is covered by more than one Plan with a Coordination provision, the rules for the order of benefit payment are as follows.

   I. A Plan which covers a person other than as a dependent will pay before a Plan which covers that person as a dependent.

   II. A Plan which covers a person as a dependent of a person whose date of birth occurs earlier in the year will pay before a Plan which covers that person as a dependent of a person whose date of birth occurs later in the year. If the other Plan does not have this provision, but has one based on gender instead, and this results either: in each Plan determining its benefits before the other; or in each Plan determining its benefits after the other; then the rules in the Plan which has the gender provision will apply. But, in the case of a dependent child:

      a. if the parents are separated or divorced and the parent with custody of the child has not remarried, a Plan which covers the child as a dependent of the parent with custody of the child will pay before a Plan which covers the child as a dependent of the parent without custody;

      b. if the parents are divorced and the parent with custody of the child has remarried: (i) a Plan which covers the child as a dependent of the parent with custody will pay before the Plan which covers the child as a dependent of the stepparent; and (ii) a Plan which covers the child as a dependent of the stepparent will pay before the Plan which covers the child as a dependent of the parent without custody.

      C. If there is a court decree that sets forth which parent is to be financially responsible for the child's medical, dental or other health care expenses, a. and b. above will not apply. In the event of such a decree, the Plan which covers the child as a dependent of the parent with such financial responsibility will pay before any other Plan which covers the child as a dependent.

4. When these rules do not establish an order of payment, the Plan which has covered the person for the longer period of time will pay first.

E. COORDINATED BENEFITS NOT CHARGED TO BENEFIT LIMIT

If benefits under this Certificate are reduced because of coordination, each benefit that would otherwise have been paid will be reduced proportionately. Only the amount actually paid will be charged against any benefit limit. This will be done on a calendar year basis.

F. BENEFIT CREDIT DUE TO COORDINATION OF BENEFITS

If benefits under this Certificate are reduced because of coordination, the amount of the reduction for a claim will be a benefit credit for the same claim of the person. The credit may be used to pay that portion of Allowable Expense which would otherwise not be paid by any Plan, insurance policy or prepayment contract.

Allowable Expense shall not include any dental expense, unless coordination is being applied to a Dental Expense Benefit which has been made part of this Certificate.

The credit may only be used to pay the following.

1. That portion of a charge which does not exceed the Usual and Customary Charge in the area where the service is rendered.
2. That portion of a charge which the person is legally required to pay.
3. Expense incurred during the same calendar year in which the credit accrued.

Total benefits paid for any person for any calendar year under this Certificate shall not exceed the total which would have been payable in the absence of Coordination of Benefits.

G. RIGHT TO EXCHANGE INFORMATION

We may release to, or obtain from, any other insurance company, organization or person information necessary for Coordination of Benefits. This will not require your consent or notice to you. You are required to give us information necessary for Coordination of Benefits.

H. RIGHT TO MAKE PAYMENTS TO ANOTHER PLAN

Coordination may result in payments made by another Plan which should have been made by us. When this occurs we have the right to pay such other Plan all amounts it paid which would otherwise have been paid by us directly to you. Amounts so paid will be treated as benefits paid under this Certificate. We will be discharged from liability to the extent of such payments.

I. RIGHT TO RECEIVE PAYMENTS

Coordination may result in overpayments by us. We have the right to recover any excess amounts paid from any person, insurance company or other organization to whom, or for whom, payments are made.