NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE SOUTH DAKOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of South Dakota who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the South Dakota Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policy-holders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The South Dakota Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in South Dakota. You should not rely on coverage by the South Dakota Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.
Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.
Insurance companies or their agents are required by law to give or send you this notice. *However, insurance companies and their agents are prohibited by law from using the existence of the guaranty association to induce you to purchase any kind of insurance policy.*

The South Dakota Life and Health Insurance Guaranty Association
Lawrence L. Piersol, Executive Director
513 South Main Avenue
Sioux Falls, South Dakota 57102
Tel. (605) 336-2880

South Dakota Division of Insurance
Commerce Building, 910 East Sioux, Pierre, South Dakota 57501

The state law that provides for this safety-net coverage is called the South Dakota Life and Health Insurance Guaranty Association Act. Below is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law; nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the guaranty association.

(please turn back of page)

COVERAGE

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are **not** protected by this Association if:

- they are eligible for protection under the laws of another state (this may occur when the solvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy was issued by a nonprofit hospital or medical service organization (the "Blues"), an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy-holder is subject to future assessments, or by an insurance exchange.

The Association also does **not** provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate;
- dividends;
- credits given in connection with the administration of a policy by a group contract holder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if a.. insurance company administers them);
- unallocated annuity contracts (which give rights to group contractholders, not individuals).

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the Association is obligated to pay out: The Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Association will pay a maximum of $300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall $300,000 limit, the Association will not pay more than $100,000 in cash surrender values, $100,000 in health insurance benefits, $100,000 in present value of annuities, or $300,000 in life insurance death benefits - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. These general statements of the limits on coverage are only summaries and the actual limitations are set forth in South Dakota law.

MAJOR MEDICAL EXPENSE POLICY

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

RENEWAL PROVISION

This Policy is non-renewable for stated reasons only. We may refuse renewal only: (1) if we refuse to renew all policies of this form issued in your state; (2) if a Covered Member has other coverage in force under an individual, group or government sponsored plan that provides benefits reasonably similar to the benefits provided by this policy. Such non-renewal will: (1) take effect on the next policy anniversary date; and (2) not affect any existing claim except as stated in the Extension of Benefits provision. If we do not refuse renewal, you may renew this policy by payment of the renewal premium by the end of the grace period for the premium.

The premium for this policy may change as explained in the Premium Provisions Section of this policy.

NOTICE OF 10 DAY RIGHT TO EXAMINE POLICY

Please read your Policy 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

MAJOR MEDICAL EXPENSE POLICY

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

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

I. DEFINITIONS OF CERTAIN WORDS USED IN THIS POLICY

We, us and our: Means Trustmark Insurance Company.

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

Covered Member and member: Means any person insured under this Policy. 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 a member of your immediate family who resides in your household.

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.

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

All masculine pronouns used in this Policy 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 from the start of the 6 month adoption bonding period.

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 Policy Date shown in the Schedule.

C. NEWBORN AND NEWLY ADOPTED CHILDREN

A child born to you while your coverage is in force is automatically covered. A child you adopt while your coverage is in force is covered from the start of the 6 month adoption bonding period. 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 placement for the purpose of adoption, 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 or adopted child has the same coverage as any other Covered Member, starting the day of birth or placement. Birth abnormalities, congenital defects and prematurity of such children 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 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 we non-renew the policy as provided in the Renewal Provision.

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 the Policy.
2. His incapacity must continuously prevent him from earning his own living.
3. He must continue, except for his age, to be eligible for coverage.
4. The Policy must remain in force.
5. Proof of 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 the Policy 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 his coverage (except for non-payment of premium) 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.

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 Policy 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 Policy'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 Policy. It will exclude any condition which is excluded by this Policy. The Maximum Amount of the new coverage will be the unused portion of the member's Maximum Amount under this Policy 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 Policy.

VI. BENEFIT PROVISIONS

A. BENEFIT PERIODS

This Policy 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 Policy has a calendar year variable Deductible. Subject to the Cost Containment Procedures, the Deductible is the larger of: the dollar amount shown in the Schedule as the Deductible; or the amount of benefits paid by Other Medical Expense Coverage for Covered Charges. If a Covered Member has such other coverage which pays benefits more than the Deductible, then the amount of those benefits will be used 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 Deductible 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; and the Deductible will be the larger of the dollar Deductible or the amount of benefits provided for Covered Charges for all such Covered Members under Other Medical Expense Coverage.

"Other Medical Expense Coverage" as used above means: coverage for hospital, surgical or other medical medical expenses by: any other insurance plan, welfare plan; or prepayment plan (including Blue Cross and Blue Shield); or services provided or payments made under laws of any national, state or other government.

If coverage is given on a service basis, the amount of benefits under such coverage will be taken as the amount the services given would have cost in the absence of such coverage.

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.

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 the Policy.

- 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.
- 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 VIII.

VIII. ALCOHOLISM TREATMENT BENEFIT

Coverage for treatment of alcoholism will be provided if: it is diagnosed by, and treatment recommended by, a Physician; and the person is confined in a Hospital or in a residential primary treatment facility which has been approved by the State of South Dakota. Benefits are paid as for Sickness, but limited to 30 days in any 6 month period.

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 Policy; 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. 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.

XIII. PREEXISTING CONDITIONS LIMITATION

This Policy 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 5 years 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 5 years before the effective date of a member's coverage.

XIV. 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.

XV. PREMIUM PROVISIONS

PAYMENT OF PREMIUM

The first premium for your coverage is due on or before the Policy 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 the Policy 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 Policy 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 the Policy.

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 Policy. If we require an application, and if the application is approved, the Policy will be reinstated as of the approval date. Lacking such approval, the Policy will be reinstated on the 45th day after the date of the application unless we have previously written you of its disapproval. The reinstated Policy will only cover loss that results from an Injury sustained after the date of reinstatement and Sickness that starts more than 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 the Policy at the time it is reinstated. Any premium we accept for a reinstatement will be applied to a period for which premium has not been paid. No premium will be applied to any period more than 60 days before the reinstatement date.

XVI. 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 Policy 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 Policy 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.

XVII. GENERAL PROVISIONS

ENTIRE CONTRACT; CHANGES

This Policy with the attached application and any attached riders is the entire contract. No change in this Policy will be effective until approved by one of our executive officers. This approval must be endorsed on or attached to this Policy. No agent may change this Policy or waive any of its provisions. Any rider, endorsement or application which modifies, limits or excludes coverage under the Policy must be signed by you to be valid.

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 this Policy 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 Policy 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.

CONFORMITY WITH STATE STATUTES

Any provision of this Policy which, on its effective date, is in conflict with the laws of the state in which you reside on that date is amended to conform to the minimum requirements of such laws.

ASSIGNMENTS

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

NOTICE OF ANNUAL MEETINGS

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